



Assessing the Institutionalization of Traditional Aboriginal Medicine

Report Prepared for:

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7/16/2009

Acknowledgements

This research would not be possible without the support of staff at Noojmowin Teg Health Centre and Mnaamodzawin Health Services Inc. and the help of research assistants Tracey Snow, Velma Pheasant and Dana Hickey. Special thanks to Irene Camillo of Mnaamodzawin for scheduling client interviews. Thanks to Lenore Manitowabi of Noojmowin for providing project updates in the newsletter and scheduling community presentations. Thanks also to Debbie Francis of Noojmowin Teg for budgetary oversight. Lastly, thanks to the Traditional Advisory Committee members for taking time out of your schedules to provide input for this project. Chi-miigwetch!

Executive Summary

With a grant from the Indigenous Health and Research Development Program, Darrel Manitowabi (Native Studies, University of Sudbury), Pam Williamson (Executive Director, Noojmowin Teg Health Centre) and Marjory Shawande (Traditional Coordinator, Noojmowin Teg Health Centre) initiated a research project assessing the integration of traditional Aboriginal medicine at Noojmowin Teg Health Centre during the period August, 2008 to June, 2009. The short-term objective is baseline research identifying the strengths and weaknesses of traditional health delivery and recommendations for improved delivery. In the long-term it is expected Noojmowin Teg will consider the implementation of recommendations for improved delivery of traditional Aboriginal health services.

Research methods consisted of personal interviews with traditional medicine program clients, First Nations community members, clinical health care providers and an analysis of program client statistics and resources. Based on the 43 completed interviews, strengths of the program include: subsidized services, home visits, enhanced client culture and identity, length of healing sessions and overall satisfaction with quality of care. Weaknesses of the program are: communication between the program and other sectors of Noojmowin Teg, unpredictable healer availability, availability of the coordinator (due to workload), program resources and concern over long-term funding of the program. Recommendations include the following: 1) communication (improved program involvement); 2) increased traditional program funding and resources (coordinator assistant and space); 3) continued and increased community education (promotion of traditional healing); and 4) program development (support and resources for current future healers and helpers).

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Background

Manitoulin Island is a large island located in northern Lake Huron in north-central Ontario. The island is home to seven Ojibwa/Anishinabe First Nations including: Wikwemikong, Sheguiandah, Whitefish River (north of Manitoulin), Aundeck Omni Kaning, M'Chigeeng, Sheshegwaning and Zhiibaahaasing.¹ There is also a growing Aboriginal presence in the Town of Little Current.

History, population and Aboriginal-Government relations shape health care delivery on Manitoulin. The United Chiefs and Councils of Manitoulin (UCCM) is a territorial First Nations organization representing Sheguiandah, Whitefish River, Aundeck Omni Kaning, M'Chigeeng, Sheshegwaning and Zhiibaahaasing. Wikwemikong operates independent of UCCM. Each community has a health clinic and until 2008, Wikwemikong's clinic had an integrated traditional health delivery component.² Wikwemikong and M'Chigeeng manage local health care services, while Mnaamodzawin Health Services Inc. manages health care services for UCCM First Nations (excluding M'Chigeeng).

Translated as “a place of healing,” the Noojmowin Teg health centre “offer(s) a blend of traditional Aboriginal approaches to health and wellness along with contemporary primary health care in a culturally appropriate setting” (www.noojmowin-teg.ca). Noojmowin Teg is a provincially-funded Aboriginal Health Access Centre (AHAC).³ AHACs offer culturally-appropriate health care that blends tradition, wellness and contemporary primary health care (www.ahwsontario.ca/programs/hact.html). Noojmowin Teg provides access to: nurse practitioners, a dietitian, nutritionist, psychologist, fetal alcohol syndrome program, child nutrition program and a traditional medicine program. The mission statement of Noojmowin Teg is as follows:

The Noojmowin Teg Health Centre is committed to support and promote the overall holistic health and well-being of Anishinabek and Aboriginal individuals, families and communities within the District of Manitoulin Island.

To do this, we will operate quality community-based programs, establish partnerships and promote healthier communities through both traditional and western healing methods.

(Noojmowin Teg Health Centre Annual Report 2009: 1)

The traditional medicine program is administered by a traditional coordinator and is overseen by a traditional advisory committee that is representative of Elders and members from all Manitoulin Island First Nations. Program operations are guided by a bi-cultural program and policy manual (Noojmowin Teg Health Centre 2006). Central terms in the manual include

¹ Each First Nation varies in population. In 2002, the reported on-reserve populations were as follows: Wikwemikong 2 792, Sheguiandah 136, Whitefish River 265, Aundeck Omni Kaning 320, M'Chigeeng 872, Sheshegwaning 131 and Zhiibaahaasing 35 (Noojmowin Teg Health Centre Annual Report 2003).

² At the time of writing, Wikwemikong's traditional program is on hold due to the retirement of Ron Wakegijig, the program's healer. Based on personal conversations with various individuals, there is no indication when a replacement will be sought.

³ In 1990, the Province of Ontario initiated the Aboriginal Healing and Wellness Strategy to promote health and healing among Aboriginal people in reaction to poor health and family violence. Part of this strategy included the establishment of Aboriginal Health Access Centres with the objective of providing culturally-appropriate health care by blending tradition, wellness, and primary health care. Ten locations exist in Ontario including sites at Cornwall, Cutler, Fort Frances, Hamilton, Keewatin, Manitoulin Island, London, Ottawa, Sudbury and Thunder Bay (<http://www.ahws.ontario.ca>).

“Manitou” which refers to ‘Creator’ and “Nadamaganung” referring to “helpers of the Creator.” The term “relative” refers to “client” in recognition that the Anishinaabek are friends and family. “Bgnidniged” refers to ceremonial or customary offerings or gifts that accompany a request for traditional healing which is the responsibility of the relative or advocate. “Michidoumowin” refers to breaking the sacred trust in the healing relationship.⁴ These examples affirm the Anishinabek have the innate ability to promote and provide healing for Anishinabe relatives and that the traditional healing service is an integral part of the services provided by Noojmowin Teg. It also recognizes that the Anishinabek live in a bi-cultural social environment and have maintained cultural values that are based on (w)holistic health of individuals, families, communities and Nations (ibid.).

The traditional program employs a coordinator, healers and helpers. The number of healers and helpers depends on funding, turnover and healer availability. During the years 2001 to 2004, the program employed one healer.⁵ During the years 2004 to 2005, two healers were employed. In 2005, this number increased to five and in 2007/08, the number of healers increased to eight, with one helper being employed. The drastic increase in healers in 2008 reflects additional program funding from the Indian Residential School (IRS) initiative from the federal government. The IRS funding is intended to provide support for Elders and families affected by the legacy of Residential Schools (Noojmowin Teg Health Centre Annual Report 2009: 8). The core funding of the traditional program is acquired from the Aboriginal Healing and Wellness Strategy.

The activities of the program are diverse. Aside from providing traditional healing (see Figure 2.), members of the program engage in a variety of activities such as harvesting medicines, providing workshops and teachings, research support, program support and advice for other sectors of Noojmowin Teg such as dietetics and mental health. In particular, the role of the coordinator is multi-faceted. A herbalist and trained nurse, the coordinator is a liaison between the Executive Director and other sectors of Noojmowin Teg, supervisor of healers and helpers, program secretary, liaison between Manitoulin Island First Nations and Noojmowin Teg, harvester of medicines, research associate of various project (including this one, see also Maar et al. 2007; Maar and Shawande n.d.), associate of Mnaamodzawin Health Services, healer and most importantly, “cultural mediator.”⁶ Cultural mediator refers to the coordinator’s role of balancing clinical accountability and the integrity of Ojibwa/Anishinabe traditional healing. A principal achievement of the coordinator is the development of a “Traditional Healing Services Policy and Program Manual” in 2006. To give insight into this role, the guiding program philosophy is as follows:

(The policy) recognizes that the Anishinabe live in a bi-cultural social environment and the Anishinabe functions within this social environment. The Anishinabe have maintained cultural and social systems that are uniquely Anishinabe. For many years, these cultural and social systems have withstood diffusion, and as a result Traditional Healers and their practices are resurfacing.

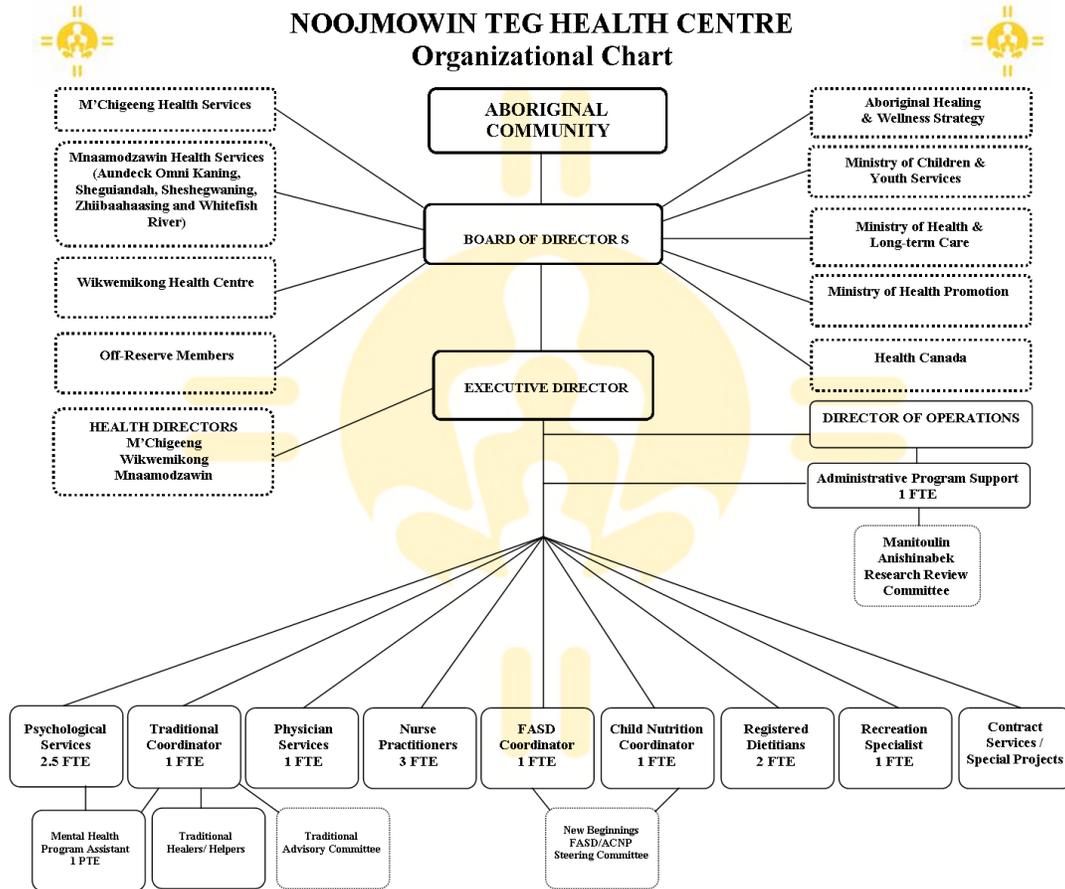
⁴ This refers to an ethical code of conduct that relates to the patient/client (relative) relationship.

⁵ Though her role is primarily program coordination, if necessary she provides herbal healing services.

⁶ Noojmowin Teg and Mnaamodzawin share the same building. Noojmowin Teg and Mnaamodzawin provide a shared model of care for mental health services (see Maar et al. 2007; Maar and Shawande n.d.). It is also common for sectors of Mnaamodzawin to invite or consult with the traditional program coordinator on a variety of issues ranging from services, evaluation to research.

This policy is intended to solidify cultural revivalism through Aboriginal healing ways while maintaining an integrated health model.
 (Noojmowin Teg Health Centre Traditional Healing Services Policy and Program Manual 2008: 4)

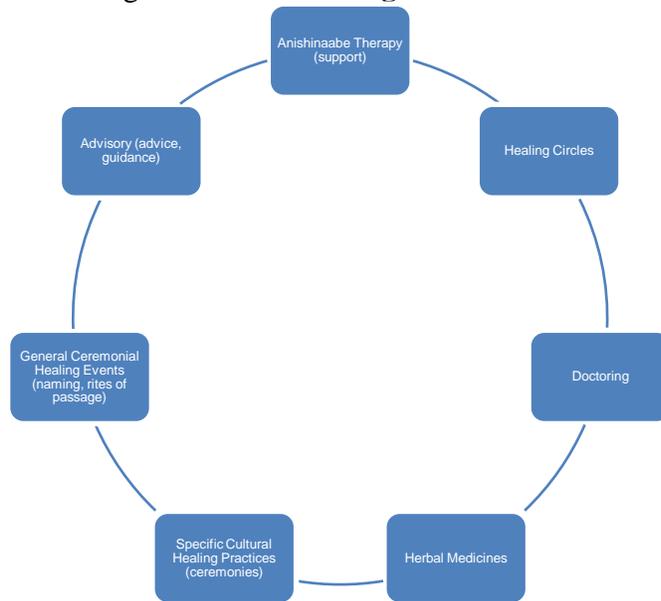
Figure 1. Noojmowin Teg Health Access Centre Organizational Chart



Source: Noojmowin Teg Health Centre Annual Report 2007/2008 pg. 1

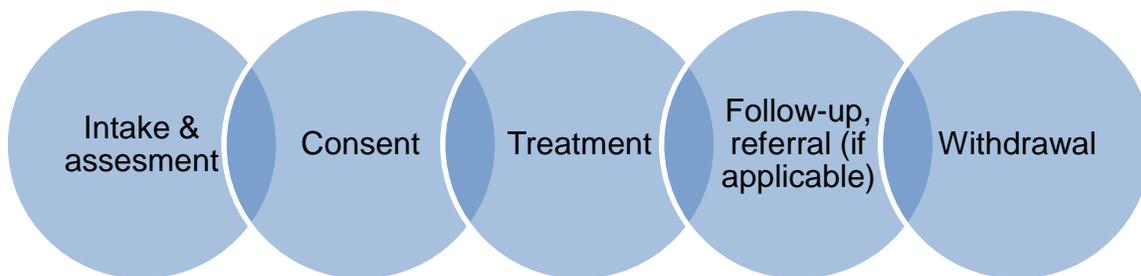
For treatment, potential clients seek healing services by self-referrals, community referrals or by clinical health practitioners such as by psychologists, psychiatrists or nurses. The coordinator conducts an intake/assessment, seeks consent for treatment and arranges a healing session with one of the healers associated with the program. A helper may take part in sessions by assisting the healer. The coordinator and relative decide on an appropriate healer depending on the need. At the conclusion of treatment, a follow-up takes place and in some cases a referral is made to a clinical health care provider. If treatment is successful, the relative withdraws from the program (see Figure 3.).

Figure 2. Noojmowin Teg Traditional Healing Services



Source: Noojmowin Teg Health Centre Traditional Healing Services Policy and Program Manual 2007 pg. 6

Figure 3. Traditional Program Healing Cycle



Source: Noojmowin Teg Health Centre Traditional Healing Services Policy and Program Manual 2008

Research Methods

This research project has been initiated by Marjory Shawande, Traditional Coordinator and Pamela Williamson, Executive Director of Noojmowin Teg. Shawande and Williamson contacted the university-based applicant (Darrel Manitowabi, University of Sudbury) to collaborate on a research project evaluating traditional health delivery. A subsequent project meeting resulted in consensus to apply for community-based research funds to evaluate Noojmowin’s traditional health service. Part of this need results from a perceived schism between traditional and clinical health sectors of Noojmowin Teg. A recent Mnaamodzawin and Noojmowin Teg mental health services study (Maar et al. 2007) provides insight into this issue. A portion of the study focused on the integration of traditional health services and clinical mental health services. The report indicates some mental health clients sense a division between traditional and clinical services. For instance, at the institutional level, a clinical

recommendation for traditional health services is rare. In contrast, the traditional health coordinator and healer often recommend clinical health services. Maar et al. (2007) suggest education is a possible solution to bridge differences and barriers. Since the report focused on mental health, the traditional health component is limited. This proposed research is important since the intention of AHAC traditional healing programs is to promote a collaborative relationship between traditional healing and clinical health care. There is some concern that this is not taking place.

The core question driving this research is: “In the context of history, how effective is the integration of traditional medicine at Noojmowin Teg Health Centre?” Given the sensitivity of traditional Aboriginal medicine in the past and present, the research investigators decided semi-structured interviews in a private setting (clinic or home) was most appropriate. It was further determined those intimately aware of the program should be consulted with equal representation from Manitoulin Island and off-Reserve Aboriginals. This included community members cognizant of traditional medicine and the program (17 in total consulted), traditional medicine program clients (8), frontline health workers at Noojmowin Teg and Mnaamodzawin (13), and traditional healers or helpers of the program (3). In total 43 interviews were conducted. An attempt was made to have equal representation from all communities and health providers. The total community representation is as follows: Wikwemikong (11), Whitefish River (8), non-Aboriginal⁷ (7), Aundeck Omni Kaning (5), M’Chigeeng (4), off-Reserve Aboriginals (3), Shesguiandah (2), Zhiibaahaasing (2) and Sheshegwaning (1).

Interviews took place from August to December 2008 and were facilitated by two research assistants (Tracey Snow and Velma Peasant) and Darrel Manitowabi. Each interview comprised of seven semi-structured questions with the purpose of probing interviewees for detailed information. The interview questions follow with summaries.

Table 1. Research Project Participants

Participants:	Role(s):
Douglas Graham, Mnaamodzawin Health Services Inc. Roger Beaudin, M’Chigeeng Health Services Rosella Kinoshameg, Wikwemikong Health Services Pam Williamson, Noojmowin Teg Health Centre	Liaison with First Nations Chief and Councils
Manitoulin Aboriginal Research Review Committee	Aboriginal Ethics Review
Noojmowin Teg Traditional Advisory Committee and Marjory Shawande (Traditional Coordinator)	Project oversight and input
Darrel Manitowabi, U. of Sudbury Tracey Snow, Laurentian U. (Nursing student) Velma Pheasant, Laurentian U. (Native Studies student) Dana Hickey, Laurentian U. (Political Science student)	Research lead (Manitowabi), interviews (Snow and Pheasant), and transcriptions (Hickey)
Mnaamodzawin Health Services Inc. M’Chigeeng Health Services Wikwemikong Health Services Noojmowin Teg Health Centre	Clinical input (voluntary interviews)
Manitoulin Island First Nations (Aundeck Omni Kaning, M’Chigeeng, Whitefish River, Shesguiandah, Wikwemikong, Sheshegwaning, and Zhiibaahaasing) and off-Reserve Aboriginals	Community input (voluntary interviews, community presentations)

⁷ All non-Aboriginals consulted are health providers of Noojmowin Teg and Mnaamodzawin.

Table 2. Research Methodology and Project Timeline

PHASE:	TIMELINE:	DESCRIPTION:
Aboriginal Ethics Review	May/08	Research approval June/08
Project Interviews	Aug.-Dec./08	43 personal interviews completed
Project Updates	Aug./08-June/09	Periodic Noojmowin Teg newsletter updates and project committee meetings completed. ⁸
Data analysis	Jan.-Mar./09	Transcriptions completed
Conference dissemination	Oct/08-May/09	Papers presented at three conferences. ⁹
Community dissemination	June/09	69 attended public presentations at various First Nations ¹⁰
Project Report	July/09	Final report submitted to all First Nation Band Offices, Health Centres and IHRDP

Results

The following seven questions served the basis of semi-structured interviews (question probing also took place). The following provides a summary of the answers with notable quotes. A statistical analysis of the number of clients, client visits and program resources follows the interview results.

a) *What does traditional medicine mean to you?*

All participants evoked a sense of holism in response to this question. Clients of the program further added that it was an integral part of their identity as Anishinabek and most stated healing is a lifelong process. The following comments illustrate these issues:

“...to me, it is more less holistic, it’s the whole four elements of the self, emotional, mental, physical, spiritual, I guess it’s the balance of the self, and if one is affected then there’s no balance, you need to take a look at that and it takes time, it’s a lifelong healing process, it doesn’t, you just don’t heal one day, or two sessions, three sessions, it’s a lifelong process and you get better and better, to me that’s what it means, traditional medicine.”

“I think traditional medicine would be, well to me anyways like, everything all in one. When you go to a like, doctor, you know what I mean, it’s about medicine it’s about pills it’s about masking things. Where traditional medicine for me

⁸ The Noojmowin Teg newsletter is mailed to every First Nation home on Manitoulin Island monthly. In total, four project updates were provided in August, November, March and May. Additionally, three project updates were provided to Noojmowin Teg’s Traditional Advisory Committee in October, January and July.

⁹ All papers were presented by Darrel Manitowabi and Marjory Shawande. Conferences included: the 40th Algonquian Conference, Minneapolis, Minnesota (October 2008); Indigenous Earth Summit, Marquette, Michigan (April, 2009); and the Canadian Anthropology Society and American Ethnological Society Conference, Vancouver, British Columbia (May 2009).

¹⁰ The community presentations took place on the following dates and places: Aundeck Omni Kaning Health Centre, June 15, 2009 (4 participants); M’Chigeeng Health Centre, June 16, 2009 (7 participants); Whitefish River Health Centre, June 17, 2009 (7 participants); Sheguiandah Health Centre, June 18, 2009 (6 participants); Wikwemikong Health Centre, June 23, 2009 (3 participants); Sheshegwaning Complex, June 24, 2009 (12 participants); and at the Noojmowin Teg Annual General Meeting, June 29, 2009 at the Zhiibaahaasing complex (30 participants).

personally is more about my body spirit. And bringing it all together and healing instead of just masking.”

The purpose of this question was to examine client and provider conceptions of traditional medicine. All 43 interviews commented on “holism” or used words to describe this concept indirectly. This suggests all are familiar that holism as an integral element of traditional Aboriginal medicine.

b) Prior to Noojmowin Teg, how did a person acquire traditional medicine?

Answers to this question fell into three categories. The first category is non-exposure to traditional Aboriginal medicine in the past due to lack of access to healers (or in the case of non-Aboriginals, the reason is due to lack of exposure) or due to the underground nature of the practice of traditional medicine in the past in light of the legacy of colonization (eg. residential school and/or dominance of biomedicine). The second category was kin-based access, where a direct family member practiced traditional medicine (usually a grandmother), thus was easily accessible. The third category was through social networks (or “word of mouth”) where a healer from another First Nation or region was consulted. The complexity of access was evoked by the following client responses:

“I had a great uncle that did this, I was young then when he was doing it and... we sort of made fun of him I guess you could say...we were brought up with the church, I guess there was [sic] people that did it (traditional medicine), like I say, my great uncle did it and we just didn’t grow up with it, if anything was wrong, they would take us in town to the doctor.”

“(Traditional medicine was not practiced)... in a public sense but I would hear stories like family wise, my aunts and uncles, and my dad is, well, he is a product of residential school. So I would hear like he would have, he wants to believe it but at the same time he is ashamed of himself or ashamed of our people and I would get that from his message as well. But I know there’s stories about what happened to my sister when she was little and my mom went to go see a medicine man in Sagamok, and I still knew that man’s name once in a while, it’s in the language and I can’t repeat it cause I can’t say it but I recognize it when I hear the word. So they talk about this man. People used to come from all over to come over and see him. And my mom went to see him. And my dad would tell the story right, so they do have a strong belief system still. It was there but it was kept quiet. They believe but don’t admit it. So I think that yeah, there was a resurgence in using the traditional medicine of our people and acknowledging it.”

The purpose of this question was to compare access to traditional Aboriginal medicine in the past to access in the present at Noojmowin Teg. This is further explored in the next question.

c) How does Noojmowin Teg's traditional medicine program compare to traditional medicine in the past?

Those familiar with traditional medicine prior to Noojmowin Teg were unanimous on the convenience of subsidized service and home visits.¹¹ In the past, payment (in-kind or monetary) was necessary for healers and sometimes costs associated with travel were necessary. For others, Noojmowin Teg was the first time they became aware of traditional medicine, as such it had an educational effect by exposing and enhancing culture. Most significantly, the mere presence of a traditional medicine program in an institutional context generated a holistic sense of empowerment since it affirmed a non-Aboriginal accommodation of traditional medicine. This is especially pertinent given the legacy of colonization, oppression and indifference toward Aboriginal people in Canada. One interviewee remarked she was nearly drawn to tears at the sight of a sign on the door indicating a "traditional healer."

d) What are the strengths and weaknesses of Noojmowin Teg's traditional medicine program?

For this question, it was easier to elicit strengths rather than weaknesses. Aside from strengths already mentioned (access, subsidized care), length of time with healers is a strength. Healers have one hour sessions per client with a maximum of six sessions in one day. Another stated strength is quality of care and empowerment. For instance, not all visits include medicine; some include counseling, recommendations for prayer and in some instances a healer might provide instruction regarding picking and harvesting medicines. It is common for the traditional medicine program to make referrals to other sectors of Noojmowin Teg such as mental health. Another important strength is program operation. Providers mentioned the coordinator does an exceptional job with coordination and ensuring protocols are adhered to. Linked to this is program policy. Healers are recruited based on social standing in the community and must abide by a code of conduct. This is to ensure the best interests of the client are taken into consideration. The statements below reflect the importance of these issues.

"I think they are doing an awesome job from personal experience that I've had with the cultural component of Noojmowin Teg. They responded, from maybe about four years ago to that crisis we had in this community, they responded to that crisis to attend to all of the community and to support them and to sit with them when we were going through that crisis so that was a really, really big help to, for me anyway, I can't speak on behalf of the rest of the community but I was glad that they were there when they jumped in you know to help us out and what not."¹²

"I think it's running in a smooth transition right now. As long as there's, like, background checks on each, like an Elder... they'll be offensive [sic] to them but if that's the case. But you got to take a look at that life. There's some clients out

¹¹ Healers are paid through the program, but it is acceptable for clients to provide payment in the form of tobacco (an Indigenous medicine and form of reciprocity) or other gifts.

¹² In this particular instance, a tragic death occurred in one of the communities and one program healer immediately established a presence in the community to provide grief counselling and ceremony. This action had a powerful effect on the community.

there that really has [sic] deep emotional scars and then, that might affect them, but certain things happen that were performed. You just got to be careful that's all. You got to respect client's, you know, privacy, their background, their level of development, things like that. So I think that's essential for a good program to run smoothly. Do all of that, background checks on a person – you just don't know. You don't want any...something to bite you in the butt kind of thing.”

“For one, most foremost, it's there. The weakness is that it is not there enough. And that you know, it is sad that our community that you know, we have to go to them, they can't come to us. You know what I mean, in a way because I think that if a lot more people's eyes were open then, you know, it would be a lot better community than what it is. There is just so much hurt and despair that has been in our communities for, you know, generation after generation. That it is a long healing process and I really think that we need more.”

“People sometimes tend to want to have a quick fix and that's it. There's no follow up kind of thing, it just doesn't stop there. Being positive about things, people just have to learn to adapt to new ways to know. If they were brought up in a hard life then it takes time to change that to become more positive. It takes work because that is how it was for me. Cause I never knew about this stuff until 1994, 1995. Sweat lodge things like that. Once I took part in more and more ceremonies like that, it really helped me spiritually to look at life holistically. Just opened my eyes and I just share that with people who want to learn. I just don't go up telling people this is what you got to do, I can't do that.”

In terms of weaknesses some mentioned communication. Since healers have an unpredictable schedule, it can be a challenge for clients to accommodate a healing session (healer schedules are determined on a monthly basis which is dependent on their availability). Some clients desired greater access.

At the institutional level, there is a concern that the program operates within “silo” with little communication and effective integration with other health care providers. Those health providers who arrive at Noojmowin Teg with no previous exposure to traditional medicine remarked that there was a sense of “mystery” with the program due to an unpredictable presence of healers and irregular communication. It can take up to a year for such workers to gain an effective understanding of the program under such circumstances. The following quote best illustrates this:

“Traditional aspects should be interwoven into dietetics, it should be interwoven into health promotion, it should be interwoven into baby wellness, like every part of the approach you're taking, the health, wellbeing, preventative medicine. Everything should have a traditional part of it, and I think what's happening is, what they're having is this kind of discrete little silos of stuff happening and then traditional medicine is almost like an afterthought...”

Finally, within the Aboriginal community, it is not clear if there is uniform support for traditional medicine given the legacy of residential schools and colonialism. There is a sense

that indifference exists amongst some Christian Aboriginals. Some interviewed had firsthand experience with Christian Aboriginals labeling traditional medicine as “bad” or “superstitious.”

e) How would you describe the relationship between traditional and clinical medicine at Noojmowin Teg?

Answers to this question fell into three categories. The first was no comment, due to lack of familiarity of this relationship. The second category of answers related to a positive relationship with effective integration. The third category was the lack of a relationship due to the “silo” mentioned earlier.

Though not specified in the question, some clients remarked that their family physicians were supportive of traditional healing. Others remarked of experiences of indifference expressed by other doctors in clinical settings such as in hospital visits. The following quotes illustrate this.

“For the most part I think it does (relate). I use (medical doctor) that’s my family doctor and when I talk to him a little bit about stress I was having and that I needed some time to go and seek out some help. (Healer) was off sick, and I needed him to look for somebody. So he (medical doctor) was in agreement that if I felt comfortable using traditional medicine then he would give me the time off from work with a certified sick leave note that I would need. So I appreciate that, I can’t really speak for other doctors only what I have experienced myself, and then (healer) never, he always encourages people to utilize the western medicine that they have.”

“But yeah I’d have to say that our doctor, our family doctor is a little on the ignorant side of the Native medicines. I’ve been at the hospital too where you know, they ask you what kind of medicine that you are on and you mention that you are on Native medicine and they kind of look at you like you know... And then they tell us ‘well no wonder you are sick.’ And try to blame it on that.”

f) How can the traditional medicine program delivery be improved?

Those who identified weaknesses suggested increased communication take place between the program and other sectors of Noojmowin Teg and Mnaamodzawin. For instance, one provider remarked that within a health service environment there is normally regular contact and visibility between providers leading to a greater sense of collegiality and tendency for referrals. It is however acknowledged that communication does take place between some healers and other providers so this is not a universal issue.

Another area of improvement suggested was education at the community level. Clients remarked that a significant portion of Manitoulin First Nation communities are unaware of the program and/or desire a greater understanding of traditional teachings, culture and medicines. Furthermore, there is a concern that greater exposure to Aboriginal traditions in communities might enhance collective community healing.

g) Is there anything else you would like to say?

In most cases, interviewees reiterated earlier statements when asked this question. Most ended by indicating satisfaction and happiness for the existence of the program. Despite the acknowledgement of weaknesses, there is a collective sense that the program is important and integral to the healing taking place in First Nation communities. The following quote best summarizes the overall sense of those familiar with the history and state of traditional healing:

“I don’t really have criticism of the traditional program, I’m thankful that it’s there, because trust me, twenty years ago, you would be hard pressed to find this anywhere....”

h) Program Statistics and Program Resources

A final component of this research project included an analysis of program statistics and program resources. In regards to program statistics, it was not possible to acquire detailed statistics due to a statistical software upgrade at the time of research. Furthermore, it is only recently (circa 2004) that reliable statistics have been made available. The program relies on healers and communities to track number of clients and number of visits and this has not always occurred in the best possible way. The following charts reflect program clients and visits from the period 2004 to 2008. Furthermore, a breakdown per community is provided from the period 2004 to 2007.

With respect to program resources, traditional program services are provided either at the Noojmowin Teg Health Centre, at a client’s home, or within the community. For services provided at Noojmowin Teg, space is an issue. One room is allocated to the program, and when services are provided the coordinator must vacate the room while a healer provides services.

Figure 4. Traditional Program Clients and Visits 2004-2008

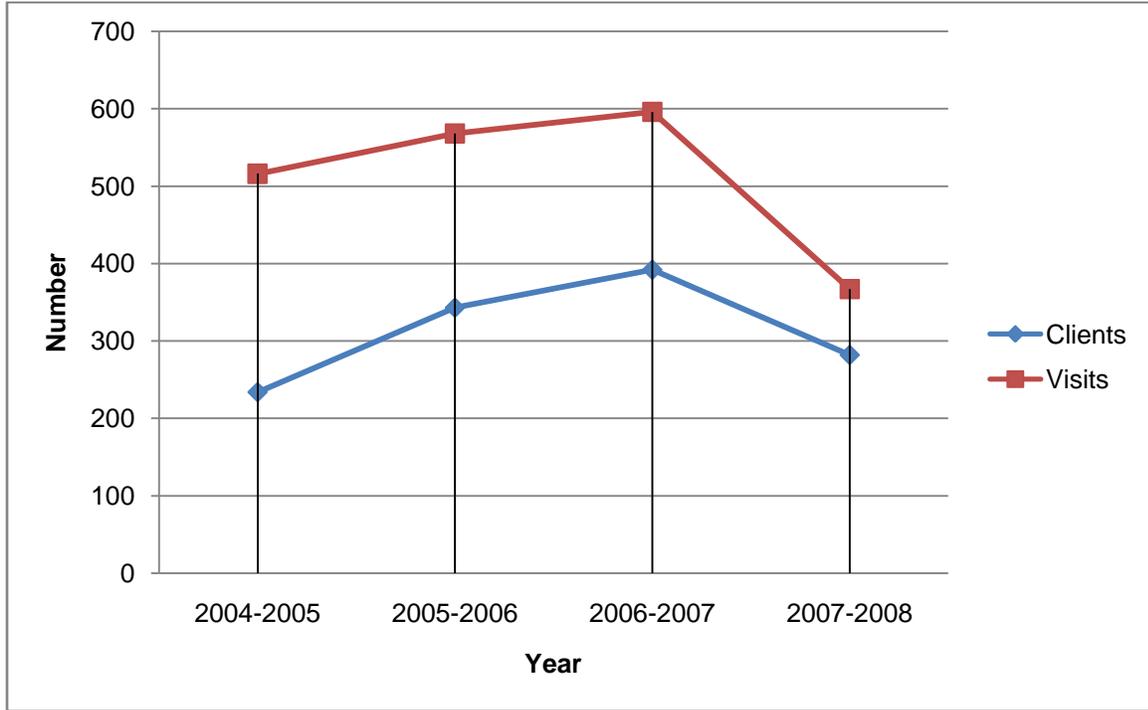


Figure 5. Traditional Program Clients Per Community 2004-2007

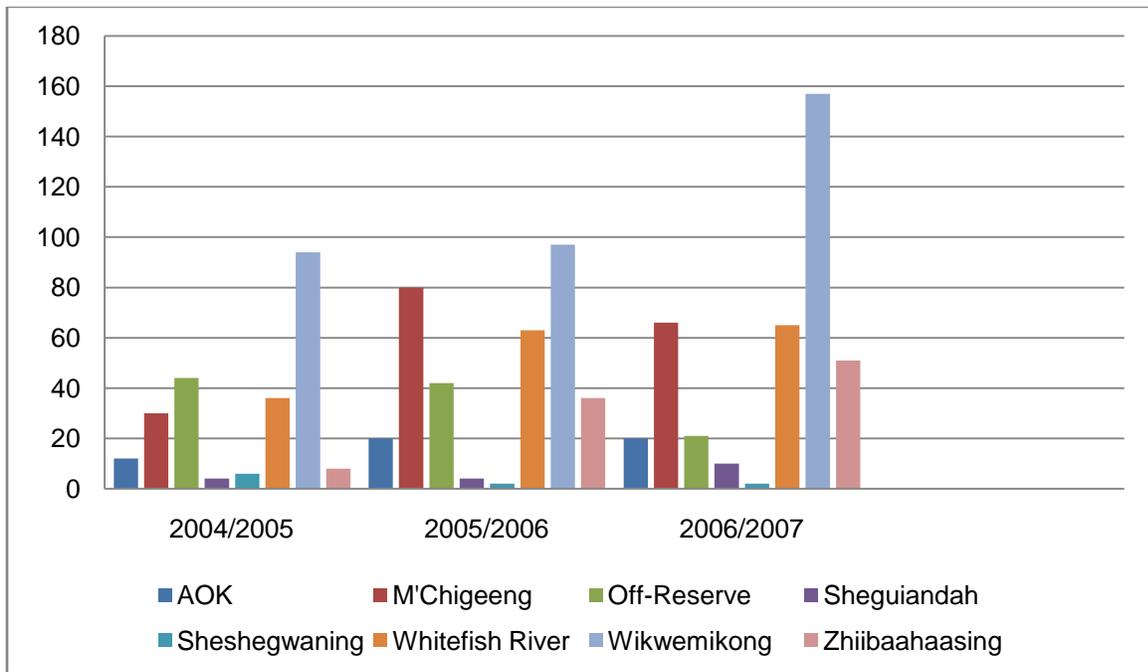
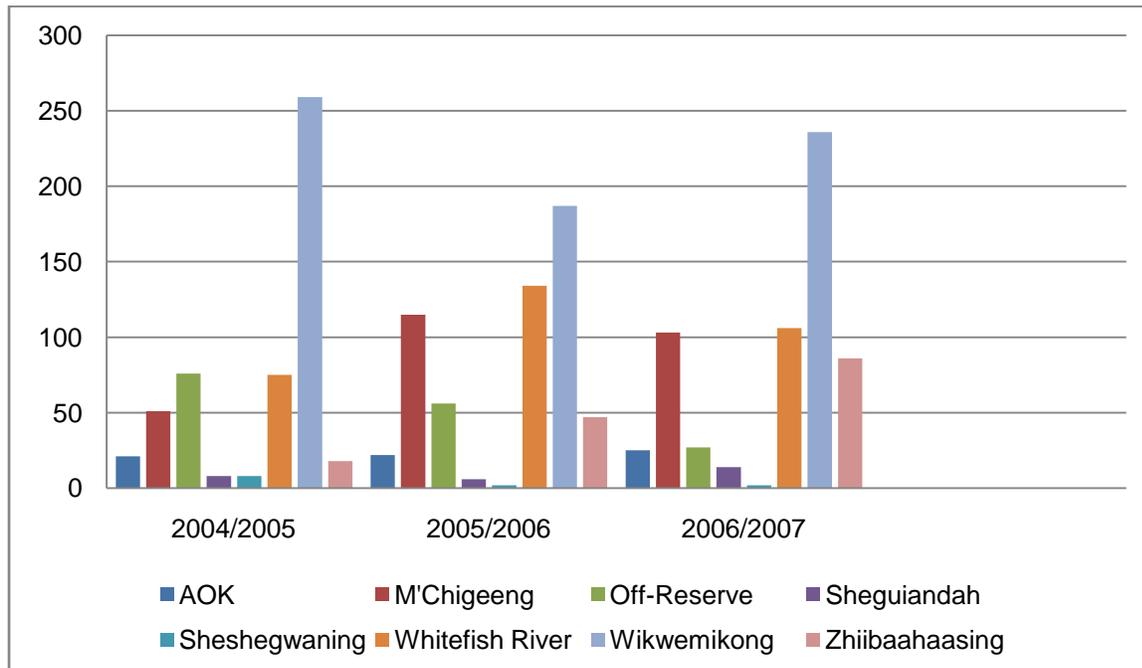


Figure 6. Traditional Client Visits Per Community 2004-2007



Discussion

It is worthwhile to examine the issue of referrals in light of the Maar et al (2007) study mentioned earlier. For this issue, it is only possible to rely on the perspectives of clinical health care providers associated with Noojmowin Teg. When interviewing those that fit this category, all were in agreement that this was an inaccurate assessment. During intakes all mentioned traditional healing is mentioned as an option for clients, even nurse practitioners ensure clients are informed of this possibility. One clinical health provider indicated that in the past the issue of referrals might have been an issue, but this is no longer the case. Unfortunately it is not possible to validate this claim without a statistical analysis. This is a limitation of this study.

Despite this limitation, it is possible to draw on insight in the interviews for a partial answer to this perceived “schism”. Based on personal communication with the traditional coordinator, most clients enter the traditional program through self-referral and a community-based referral, such as those within First Nations communities who are aware of the program and suggest it to potential clients. Essentially, this is a continuation of “word of mouth” referrals that occurred within First Nations communities before Noojmowin Teg’s program. Furthermore, it is possible that given the legacy of colonialism (eg. shame of Indigenous healing, hegemony of biomedicine, and outright banning of Indigenous ceremonies in the Indian Act of Canada until 1951) clients carry memories of the past.¹³ Clients may therefore be uneasy with sharing

¹³ This is also in reference to the continuing oppression of First Nations and denigration of Indigenous healing practices. Interviews revealed these are still issues. Specific to Canada, various scholars have examined the issue of Indigenous healing and biomedical hegemony (cf. Waldram, Herring and Young 2006; Waldram 2000; Warry 2007, 1998; Martin-Hill 2003).

information on the use of traditional healing with clinical health providers and are most comfortable with a separation. This is not to suggest a defined separation exists, it is one that is negotiated—some may practice a separation, while others willingly admit the use. Translated in a clinical setting such as Noojmowin Teg, it might appear that it results from within the institution. There are solutions to these issues such as enhanced integration of the traditional program within Noojmowin Teg and continued education within Noojmowin Teg and within First Nations communities. These are addressed in greater detail in the recommendations.

Despite the issues of concern, overall it is apparent the traditional medicine program is an important healing option and resource for First Nations served by Noojmowin Teg. However, by glancing at client statistics, it appears there is decreased demand (see Figure 4.). Through personal communication with the traditional coordinator this is possibly attributed to quality over quantity of care. A change in the program has been increased care and time with clients which reduces the amount of clients seen.

Another issue that can possibly contribute to the decrease in clients is community-based healing initiatives outside of the program. Various members of each First Nation community are hosting healers and ceremonies. For instance, in recent years, one First Nation has hosted shaking tent ceremonies. It is possible that clients in need of cultural healing services are able to access services locally outside of Noojmowin Teg.

Though the above two issues may account for the decrease in clients, it is not possible to determine this without subsequent years to compare to. Overall, various consultants, both clinical and community-based indicated the program operates well and is important.

Recommendations

1. COMMUNICATION

There is some indication that communication is an issue and the program functions as a relative isolate in comparison to other sectors of Noojmowin Teg. Though this is an issue, it does not affect quality or delivery. Options to overcome this issue could include increased communication, collaboration and possible integration with other sectors of Noojmowin Teg. Currently the traditional program participates in a shared model of care with Mnaamodzawin mental health services. This model of care incorporates a team-based approach with involvement from the traditional coordinator, psychologist, mental health workers and mental health nurse. Contracted services by a psychiatrist, psychologist and traditional healer are also incorporated (Maar et al. 2007; Maar and Shawande n.d.).

Outside of the above example of integration, for the most part the program is separate. A portion of clients simply choose not to disclose the use of traditional healing to clinical providers. Furthermore, there is a sense that clinical providers are not always entirely cognizant of the services the traditional program offers. A possible solution to this issue is increasing the profile of the program within Noojmowin Teg. There is a sense that the program does not have a direct and influential role in program operations. This is an important issue since Noojmowin's mandate is to be "culturally-appropriate" and this is the expertise of the traditional program. One clinical health care provider even used the word "token" to explain the incorporation of the traditional program. During some of the interviews, it was suggested the program is incorporated after decisions are made. To engage in "culturally-appropriate" health care, the program needs to be a key stakeholder in the decisions.

2. TRADITIONAL PROGRAM RESOURCES

Linked to the previous recommendation, if greater integration takes place, the issue must be addressed whether adequate resources are available or accessible to accommodate this. Under such a scenario, it is likely clients will increase resulting in an increased workload for the coordinator, healers, helpers and more space will be required.

It is apparent the program does not have an adequate share of space. Some of the healing sessions are held at the Noojmowin Teg site and when this occurs the coordinator must vacate this office space. Furthermore, the current office space resembles a hybrid administrative and healing room. It is appropriate for one room to be dedicated for traditional healing services, as is the case with clinical medicine.

Another important issue is financial and human resources. This again pertains to the context of the mission statement of Noojmowin Teg to offer “a blend of traditional Aboriginal approaches to health and wellness along with contemporary primary health care in a culturally appropriate setting” (www.noojmowin-teg.ca). This issue is also an important one for the community. Throughout many interviews and during community dissemination, many echoed the importance the coordinator plays within Noojmowin Teg and throughout the broader community.

3. EDUCATION

The issue of education and community outreach is important and complex. Health providers are not entirely cognizant of the healing methods and the effectiveness of traditional Aboriginal medicine (though there are exceptions). One clinical provider admitted to knowing nothing of the program upon arrival at Noojmowin and best described the encounter as “mysterious.” This despite a genuine interest of the clinician to learn and understand the program and only a year later became familiar with the program. This also relates to the issue of referrals—one cannot refer to something that is not understood. Outside of this example, there is some indication an informal separation between clinical and the traditional medicine exists evidenced by the “silo” comments. This is not entirely problematic since the program is functioning and communication does take place. Again, this is an issue that can be addressed more effectively. A possible option is the creation of a traditional healing “handbook” designed for clinical providers to serve as a basic reference for traditional healing. If this is pursued, it must be done in a way that ensures there is adequate education while at the same time protecting Indigenous knowledge.¹⁴

4. COMMUNITY OUTREACH

Considering many clients remarked that many First Nation community members are unaware of the program, greater community outreach can be undertaken to educate community

¹⁴ This is not to suggest a handbook is necessary to provide “step-by-step” instructions on ceremonies or ingredients in medicines. It is possible to produce a handbook that indicates the kinds of medicines employed in traditional healing using Indigenous terminology (as in the program policy manual) while explaining their purpose and explaining ceremony in a general way. There is a growing literature highlighting the efficacy of Indigenous ceremonies in the context of healing, thus publications exist elsewhere (cf. Waldram 1997; Mehl-Medrona 1997; Jilek 1982).

members. This is despite the fact that the newsletter is delivered to all Manitoulin Island First Nations homes. It is apparent more effective means of outreach are necessary to educate community members of the program. Possible options include attending First Nation schools to do information presentations and increased workshops. Many clients remarked on the importance and benefit of workshops. This outreach does occur, but it must be continued and even increased. This again is directly related to program resources.

5. PROGRAM DEVELOPMENT

Noojmowin Teg's traditional medicine program represents a non-Aboriginal accommodation of this healing tradition. Though this is a positive step forward, there is some concern among those interviewed that there are not enough healers to handle the demand. Others remarked that community members possess the gift to heal, but do not have the resources and/or direction to realize their potential. In light of this it is useful to explore a community-based formal traditional medicine program that recruits, trains and retains current and future healers and helpers. Currently the program incorporates an informal training model that mentors helpers and future healers. While this informal model is sufficient, a formal program could enhance the skills of future traditional healers in the context of traditional medicine integration in an institutional context. This is new territory for Manitoulin Island Indigenous healing traditions.

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