

Maintaining Balance in Times of Change: An Investigation into the Contemporary Self-Regulatory Dynamics which Operate in and around First Nations Traditional Healing Systems

A Dissertation Submitted to the Committee on Graduate Studies in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy in the Faculty of Arts and Science

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Abstract

Maintaining Balance in Times of Change: An Investigation into the Contemporary Self-Regulatory Dynamics that Operate in and around First Nations Traditional Healing Systems

By

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The evolution of health regulation processes in Canada has focused on the development of standards of practice premised upon the principle of ‘do no harm’ and the approval of these by government regulatory agencies. This thesis examines three emerging communities of practice that bring traditional indigenous knowledge and indigenous healers forward into health care and their approaches to regulation. The results indicate that surrounding contexts of meaning influence understandings about self-regulation and that these understandings are dynamic because contemporary practices of First Nations traditional healing can occur in different contexts. The study cautions that unless we remain close to these ‘healer centred’ contexts, there is no guarantee that the self-regulatory value systems stemming from modern Western medical communities of practice will not be applied by default or that the emerging ‘integrative’ models of self-regulation developed between governments and First Nations will continue to reflect First Nations’ understanding of self-regulation.

Keywords: Indigenous health and wellness, self-regulation, self-determination, traditional healing.

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Chapter 1: Introduction

In general, mainstream perceptions and thinking about the nature of regulation in its societal institutions can, to varying degrees, be linked to productivity concepts (such as: the hierarchical nature of bureaucracies the role of leaders vs. subordinates; the professionalization/specialization of services people perform in the greater society; and worker) that are described throughout classical and even neo-classical literature of Western Organizational Theory (Weber, 1968; Frederick, 1967; Weber 1973; Trahair, 2005; Fielder, 1986). From within this larger context, regulations are viewed as rules and/or directions that are supposed to exist in the interest of making life better for the collective. Such rules/laws are also usually maintained by an authority like a regulatory board. If not followed, these ‘objectified’ rules can be enforced by law enforcement through penalties. For example, Weber in particular believed that bureaucracies should be impersonal/objective entities based on legal and absolute authority, logic and order. In this ideal structure, behaviour is tightly controlled by rules and policies and procedures of the organization (Weber, 1973; U.S. Legal, n.d.).

Many mainstream institutions (including government, academia and medicine) understand regulation/self-regulation in these contexts and apply it accordingly within their organizations. Since materials (e.g.: written Western literature literature) that describe these kinds of approaches to regulatory processes are more easily accessed than Indigenous processes (which can often be housed within the oral knowledge of a Nation), a ‘cautious eye’ is required from the outset in discussions about ideas of regulation/self-regulation and First Nations traditional health and healing.

Ideas/understandings/practices of regulation that are present in the operation of mainstream Western institutions may not always be compatible with Indigenous ones (e.g.: First Nations traditional health practices that arise from the Indigenous Knowledge system of a particular community or tribe).

Indigenous knowledge as a generalized subject describes a vast area of inquiry and, in this thesis, I am not going to be referring to this body of knowledge in its entirety. In the academic context, several Indigenous scholars (Battiste & Henderson, 2000; Smith, 1999, Brant-Castellano, 2000; Hall, Sefa Dei, Goldin Rosenberg 2000) have already insightfully written about many subjects concerning Indigenous peoples (e.g.: social, political, legal, economic, health, epistemology, etc.) contained under this ‘umbrella’ concept.

For this thesis, we are concerned with a specific subset of Indigenous Knowledge that deals with health and wellness and how it is defined through the lens of traditional health and healing. Throughout this document, but particularly in the literature review, several direct experiential communications, with Aboriginal Elders and healers are referenced in an effort to further illuminate this particular subset of Indigenous Knowledge and to present a more balanced view.

For the purposes of academic research it is important to explore the issue of self-regulation in depth which means taking into consideration as many aspects of it as possible (both traditional and mainstream) that are currently operating in contemporary healthcare systems of First Nations communities.. However, with respect to the

processes of First Nations traditional health and healing, it is important to mention that this knowledge system is complete and stands on its own. This point was further driven home to me during a dialogue circle/focus group conducted for this this project at Elsipogtog First Nation. During our conversation the late Mi'kmaq healer David Gehue indicated to me:

Let me say this to you. Traditional healing knowledge can stand on its own merit. You don't have to defend it. You never have to defend your traditional belief system...I never defend what I believe in and what I practice, I don't have to. (D. Gehue, Focus Group, May 16, 2010).

In line with this type of thinking, Métis/Cree Elder and Adjunct Professor (Trent University) Michael Thrasher indicated to me that I should mention that it is not wrong if people want to learn about the current, unaltered, traditional process of self-regulation and First Nations traditional health and healing. Particularly, as it is originally taught through, for example, ceremonial activities, as there are qualified people in First Nations communities to teach this (M. Thrasher, Personal Communication, April 2, 2013).

While holding some of these basic understandings about Indigenous health and wellness knowledge in our minds, this thesis explores some of the realities that may need to be addressed in a world that, at least since settler contact, has been both friendly and unfriendly to notions of First Nations traditional healing knowledge and practices. This exploration takes place through the issue of self-regulation and traditional health and healing.

Thus, given the existence of these two world views, some general questions that could be considered in a discussion about regulation/self-regulation and First Nations traditional

health and healing are: What is the role of First Nations protocols around healing? What does 'holistic' mean in First Nations contexts of health and wellness? What constitutes an authority? How is 'authority' understood? Who or what makes the rules and what are the underlying reasons for following them? Where and with whom does authority lie? Why does the authority lie there? How is a particular regulation maintained?

In the assessment of regulations in contexts of First Nations traditional health and healing, sincere answers to these questions are required, yet answers to these sorts of questions become especially complex when we begin to consider that, in contemporary contexts, they can sometimes be informed by both Indigenous and mainstream knowledge. These tensions between worldviews can result in situations where regulations developed by governments are not in the best interest of First Nations. This point was substantiated during a conversation with Onondaga Confederacy Chief Arnie General at Six Nations. In addition to speaking about the environment and its relationship to health, purification processes, the role of education, the power of the Haudenosaunee Peacemaker and spirituality, Chief General offered the following thoughts (paraphrased in the next paragraph) about regulation:

The basic perspective on regulation generally offered is one of imposition where the government is using regulations to further take away from the First Nations land base and taking away freedoms. General felt that the attitude has to change about regulation being only for good purposes. He indicated that, "People only make money off it. They make the law but they don't necessarily abide by it." With respect to ideas about self-regulation and First Nations traditional health and healing, Chief General put forth the

idea that it would not have much function or use if the natural environment/medicines continue to be destroyed and polluted. The priority should lie in cleaning up the environment (Arnie General, Personal Interview, December 11, 2010).

From this example, and others, we can gauge that it is simply not enough to apply existing mainstream health regulatory models to First Nations and expect them to work or even to be accepted by traditional healers and their communities. At the very least, genuine answers to these types of questions require an awareness that human communities can be connected to (and function in) systems of knowledge other than those that are fundamentally of a Euro-centric nature.

Background

The relationship between mainstream forms of regulation and self-regulation

Public Interest Theory suggests that in large collective communities such as countries, provinces or states, formalized regulations are put into place to protect the public interest (e.g.: the environment, food security, health and safety) (Pigou, 1932; Misham, 1969; Stigler, 1972). In Canada, for example, it is stated that the government “is committed to creating a performance-based regulatory system that will protect and advance the public interest in the areas of health, safety and security, the quality of the environment, and the social and economic well-being of Canadians” (Government of Canada, Regulatory Affairs Sector, n.d.). Thus, in the mainstream, ‘regulation’, in a broad sense, refers to a set of principles –developed on behalf of public interest– governing the behaviour of citizens and organizations. It is common knowledge that regulations that are developed

by bureaucratic entities can often have the force of law behind them –which can be applied if the regulatory rules are not followed.

Within this mainstream regulatory context, 'self-regulation' usually refers to rules that govern the behaviour of individuals within a particular professional organization (Randall, 2000). In mainstream Canadian society, as in many developed economies, self-regulation has become the mark of an established profession. It is the norm that professional associations engage in self-regulation and the policing of practising members (2000). Governments, in turn, hold dialogue and negotiate with professional schools/associations in order to establish appropriate licensing and competency criteria (Brascoupé & Obomsawin, 2008). When these agreements become ratified and/or passed into legislation, these professional self-regulating associations now have the benefit of having government support –in the form of the force of law– behind them (D. Embuldeniya, Personal Interview, August 31, 2011).¹

Professional self-regulation is a regulatory model that allows a government to have some type of control over the practice of a profession and services provided by its members (Randall, 2000). In essence, this control is maintained through the transference of varying degrees of legal authority from government to a profession's regulatory body (2000). Although the idea of 'government control' does not sound particularly appealing, in reality, a mainstream professional organization that is granted self-regulatory status gains greater autonomy and control for their organization, professional prestige, exclusivity and, often, financial rewards (2000)

¹ D, Embuldeniya is a representative of the Health Professionals Regulatory Advisory Council (of Ontario). Mr. Embuldeniya was interviewed for this research project.

Most mainstream self-regulated professions are built on three key pillars: Registration, licensure and certification (2000). While registration may simply involve the registration of a person's name in a database, licensing and certification are much more complex and often involve the attainment of certain educational and/or mentored work training requirements. In this sense, through negotiations with the government of the respective Nation, a mainstream self-regulatory body of professionals addresses things such as: setting up requirements for entering and the practice of the profession, ongoing evaluation of competencies for members, and setting up disciplinary processes (2000).

Regulation and self-regulation in the mainstream healthcare field

In general, regulation in mainstream health care professions is illustrative of this symbiotic relationship between the regulatory powers of a Nation's government and self-regulating professional groups within the Nation. For example, In Ontario, the Health Professions Regulatory Advisory Council (HPRAC) plays a middle role between professional organizations and the Ontario Minister of Health (HPRAC, n.d.):

HPRAC advises on whether unregulated health professions should be regulated, whether regulated professions should no longer be regulated, amendments to the *Regulated Health Professions Act*, a health profession act or a regulation under those acts, quality assurance and patient relations programs of Ontario's health regulatory Colleges, and on other matters referred to it by the Minister (HPRAC, n.d.).

In the dominant medical profession, the need for self-regulation was reinforced by those studying medicine in the mid 1800's to the early 1900's (Starr, 1984). They believed that the complexity of knowledge and skills required (especially as technology advanced)

would make the development of regulatory rules for those outside their profession difficult. However, by the later part of the 20th century, some social scientists concluded that the medical profession had abused its privileged status and public trust and that its regulatory procedures had some serious flaws (Cruess and Cruess, 2005). As a consequence of this, constant review and implementation of regulation is crucial in modern societies, especially those with large populations, due to many influences that present themselves. For example, Cruess and Cruess (2005) also note that medical students could be considered to be in a conflict of interest when they are offered food supplied by pharmaceutical companies at 'grand rounds'. Pressures such as these (as well as an unbalanced focus on financial reward), could serve to negatively influence people coming into the profession through swaying them from the principle of 'do no harm' contained in the Hippocratic Oath (Edelstein, 1943).

With respect to regulation in the mainstream Canadian health care field in particular, the primary legislative principle within every Canadian jurisdiction is the "protection of the public from harm" in the delivery of health care (Conference Board of Canada, 2007, p. 9). Although there is merit to this generalized principle, "studies suggest that state centralization, culture, and geographical differences lead to variations in professional regulation across time and place." (Adams, 2009, p. 5).

In Canada, the present mainstream health care system is managed through many interrelated federal, provincial and territorial rules and regulations (Conference Board of Canada, 2007, p. 3). For example, with respect to Aboriginal populations in Canada: health legislation in the Yukon respects traditional healing practices; in both Ontario and

Manitoba it is recognized that Aboriginal midwives should be exempt from control that is specified under in the mainstream manifestation of this profession; and Ontario additionally extends this exemption to include traditional healers of First Nations origin.

Subsequently, nuances with respect to various types of health regulation in Canada make a universal definition of the term at the very least complex and, in reality, often unfeasible. As a whole, the government of Canada is aware of this and believes that moving towards a system of inter-professional collaborative care will significantly help to provide a greater responsiveness, accountability and flexibility of the health care system (Conference Board of Canada, 2007). Self-regulation –or how governments transfer their responsibility and authority to protect the public through allowing groups of health practitioners to govern their respective professions– is seen as a manifestation of this type of collaboration (Conference Board of Canada, p. 3).

The question concerning definitions of regulation and self-regulation in contexts of First Nations traditional health and healing²

While regulations are important to protect the public from harm, they are, at the same time emphasized as rules or orders backed by the laws issued and executed through the authority of a government (Webster's Dictionary 1983, p. 992). In a perfect world, this 'power' would be delegated in a way to benefit and protect all citizens, but this elevated objective sometimes proves to be unrealistic. For example, while individual First Nations communities and tribes are collectively referred to by Canada's government as 'First

² *Traditional Health and Healing* was a term that was introduced through the Royal Commission on Aboriginal Peoples (RCAP). The term refers to practices that promote holistic wellness and are that are rooted in knowledgesystems that predate the spread of Western 'scientific' biomedicine (RCAP Vol. 3. Chap. 3, Appendix 3A).

Nations of Canada', there are, in reality, many differences in First Nations languages and cultures between –and even within– tribes. In addition, there is sometimes a lack of clarity around which government is responsible for delegating regulatory powers in particular situations. For example, is it with the Canadian government or the First Nations government where the authority lies? Or, within First Nations communities, is it the more traditional factions of government or a Band Council? Consequently, many complications arise in attempts to uniformly apply the same mainstream regulatory methodologies to First Nations that are collectively applied by a government within the jurisdiction of its Nation State.

'Regulation' has been referred to as being a concept incapable of having the principle of universality in its definition (Black, 2002). For example, Black indicates that anyone who has attempted to study regulation outside of English-speaking environments would note that there is often not a parallel word or even a parallel concept (2002, p.2). This, however, does not mean that other socio-linguistic communities, like First Nations, do not have the equivalent of regulations that are represented through different terms, connotations and meanings and applied under different circumstances (Black, 2002, p.2). One does not have to look primarily to First Nations in Canada to illustrate this point. In Canada, health professionals have been given the responsibility to self-regulate. Although this is the way governments, for the most part, have in fact delegated their authority to regulate health professionals, depending upon who is asked, self-regulation can mean a number of different things (Black, 2000, p. 7).

When considering what self-regulation means within a context of First Nations traditional health care and healing one has to begin to start thinking within the parameters of Indigenous health and wellness knowledge and outside of the mainstream regulatory processes through which a mainstream government relates to self-regulated professional bodies . In this light, it is questionable whether the Government of Canada has any legitimate authority with respect to the transference of regulatory responsibilities and/or legal powers to First Nations regarding traditional healing practices –especially if what is being transferred is *only* the machinery that drives the current mainstream regulatory model.

In First Nations cultural/professional dialogues with the mainstream, concepts of ‘self-regulation’ and traditional health and healing are unique in that they are tied into Indigenous epistemologies and issues such as the status of treaty rights, sovereignty, tribal autonomy and nationhood. These notions are, for example present in a story (paraphrased below) told to Michael Thrasher, (Metis/Cree Elder and Adjunct professor at Trent University) by one of his teachers, the late respected Elder Peter O’Chiese:

Peter O’Chiese told of a place where they use to go do ceremony because the ancestors used to do ceremony there and there were some old physical signs of this. Over time, a park built near the grounds attracted tourists which eventually began to cause some disturbances to the ceremonies. Someone suggested to the Elder to build a fence around the ceremonial area stating that, ‘No one will bother you then’. O’Chiese’s response was that if the fenced in land becomes ‘ceremonial ground’, then that becomes the only place

I can do ceremony and that is in violation of my treaty rights (M. Thrasher, Personal Communication, March 12, 2013).

Thrasher then complemented this story by indicating that we (Indigenous people) have an inherent right to create a system of order. That system of order is based on traditional processes (M. Thrasher, Personal Communication, March 12, 2013).

In this light, general discussions about self-regulation need to be brought into balance so that, when they occur, mainstream assumptions do not confuse or cloud intended meanings.

Why an investigation into the self-regulatory dynamics in and around First Nations traditional health and healing is important

Although First Nations traditional healing did endure a historical decline, traditional healing continues to play a significant role in First Nations communities. For example, just recently, some healers that I spoke to in Winnipeg, Manitoba indicated that they have a difficult time keeping up with the demand for their services (Manitoba Healers, March 11, 2013).

Although mainstream medicine is promoted the most forcefully in Canada amongst First Nations, healers continue to be significant health care service providers for First Nations people. In the First Nations and Inuit 1997 Regional Health Survey, two thirds of respondents believed that First Nations and Inuit spirituality, ceremonies and traditional health practices were gaining importance in their communities (First Nations Information Governance Centre, 1997). Another study indicated that out of 256 Aboriginal

respondents, 72% reported consulting with traditional healers and 42% sought out medicine people (Ontario Women's Health Council, 2003).

In a final example, a recent scan on traditional medicine conducted by the First Nations Health Board in British Columbia had positive findings as well. Of the 74% of the BC communities that participated, 66% stated that they have traditional healers practicing in their communities and 33% stated that traditional healers operate in their health centers. Moreover, 55% incorporate traditional medicines and practices into their health programs. Of those who responded, 90% wanted to see traditional medicines and practices incorporated into their health programs and not one respondent disagreed that traditional practices and medicines would be beneficial in addressing health issues of the communities (First Nations Health Council, BC, March 2010).

In some Canadian jurisdictions, the reality of this increased community interest in traditional health and healing are beginning to be reflected in Aboriginal health policy. In Ontario for example, the Aboriginal Healing and Wellness Strategy (AHWS) is noted by a recent report of National Collaborating Centres for Aboriginal Health (2011) to be the most comprehensive Aboriginal-specific policy framework in Canada. Sylvia Maracle states:

I think organizations like AHWS office and the organizations that were created as a result of the Aboriginal Healing and Wellness strategy (in Ontario) like the health centres and the birthing centre, even the Aboriginal health authorities... many of which are now looking at the traditional healing notion (S. Maracle, Personal Interview, December 6, 2010).

In addition, this investigation is important because without clearer understandings of First Nations self-regulation in traditional health and healing, First Nations traditional medicine in Canada could face several important challenges.

First, in instances where First Nations traditional health and healing is harmonized with other health programming offered to First Nations, determining the terms of accountability is crucial. Without prominent First Nations value systems, the default value system would be that of Western medicine, which is not entirely compatible with traditional medicine. For example, the World Health Organization's (WHO's) recommendations and policy checklists look to bring Indigenous healers into the mainstream fold by including things like establishing the registration and licensing of providers, establishing a national regulation and registration of plant medicine and selective clinical research into use of safe traditional medicine treatments (Brascoupe & Obomsawin 2008). By accepting a subordinate value position, traditional medicine would be relegated to a secondary, or at best a 'complementary' position. Many First Nations believe their medicine should be their primary system. To protect from the occurrence of this phenomenon, it would therefore be considered important for other socio-linguistic communities, like First Nations, to begin discussion and dialogue about whether or not there are different terms, connotations and meanings that are the equivalent to mainstream conceptualizations of 'regulation' and 'professionalism'.

Second, in my opinion, without thinking about questions regarding self-regulation from an Indigenous perspective, views which claim that there is no guarantee in authenticity in traditional healing could be magnified. This in turn would threaten the economic

sustainability of traditional medicine as its technologies and tools are appropriated in a hotchpotch way by an eclectic 'New Age' and alternative healers. Without proper recognition of First Nations self-regulatory bodies in health, the transfer of First Nations health knowledge (and subsequent use) to future generations could continue to be negatively impacted.

Third, with respect to First Nations health policy, Canada might continue to lag behind other countries (such as New Zealand as well as various countries in South America and Africa) which promote the engagement of traditional healers due to a recognition of the central role traditional medicine can play in contemporary health care. These sorts of developments should proceed with caution because, while economic realities need to be faced, too much focus could be placed by governments on including First Nations healing systems for economic savings and their commercial value rather than implementing them because of their health benefits or approach to healing. Elder Michael Thrasher pointed out that commercialization of culture can cause a community based model of healing to become heavily influenced by an economic and money based one (M. Thrasher, Personal Communication, May 21, 2010).

Jagged Worlds Colliding: What makes discussions about First Nations self-regulation and traditional healing unique?

One reason an investigation into the dynamics of First Nations self-regulation in health care in general, and traditional healing in particular, differs from mainstream approaches to self-regulation and health professions is because of significant differences in the relationship to the Nation-State. For First Nations, unlike many mainstream self-

regulated health professionals, the relationship to governmental regulatory powers is more complex. For example, it would be very difficult to discuss concepts of self-regulation and First Nations health care (in the context of a relationship with Canada's government) without referencing certain biases stemming from a historical colonialism that resulted in a rather uncomfortable union. Even though externally sponsored studies and research projects have been conducted with the intent of reversing these sorts of stereotypes, many of these studies have succeeded in documenting customs but missed the deeper significance of those customs (Little Bear in Brant-Castellano, 2004, p. 103)

Blackfoot scholar Leroy Little Bear (2000) used the term 'jagged worldviews colliding' to describe the results of Aboriginal encounters with colonization. The term captures some of the complexity of First Nations health care, which includes traditional healing. Little Bear argues that colonization resulted in a fragmentary worldview amongst Aboriginal peoples. While it attempted through coercive methods to replace the Indigenous world view with its own, it failed. What remained was a heritage of 'jagged worldviews' among Aboriginal people:

They no longer had an Aboriginal worldview nor did they adopt a Eurocentric worldview.... No one has a pure worldview that is 100 percent Indigenous or Eurocentric; rather, everyone has an integrated mind, a fluxing and ambidextrous consciousness, a precolonized consciousness that flows into a colonized consciousness and back again. It is this clash of worldviews that is at the heart of many current difficulties with effective means of social control in postcolonial North America. It is also this clash that suppresses diversity in choices and denies Aboriginal people harmony in their daily lives. (Little Bear, 2000, pp. 84-85).

Describing what self-regulation is for First Nations health care, and particularly traditional healing, has become increasingly more complex due to this dynamic interplay

between interpretations that stem from Eurocentric and First Nations epistemologies.

Furthermore, due to ‘jagged worldviews’ perspectives, contemporary First Nations self-regulatory models in community health care can range from one end of this epistemological spectrum to the other.

The term ‘Traditional Healing’ in a post ‘jagged-worlds colliding’ environment

Beginning to understand more about traditional healing requires a person to have some real experience of it in an Aboriginal health and wellness context. However, a ‘post-colonial/post worlds-colliding’ environment, it is important to provide some overview with respect to the complications of defining traditional healing, particularly within the academic context. In reality, in a ‘post-jagged worlds’ environment, there can be many definitions of traditional healing. I have previously written about this with a colleague, Jonathan Dewar, in *Traditional Indigenous Approaches to Healing and the modern welfare of Traditional Knowledge, Spirituality and Lands: A critical reflection on practices and policies taken from the Canadian Indigenous Example* (Robbins and Dewar, 2011).

Some of the complications presented by this article with respect to defining traditional healing as well as some critical commonalities are summarized in the points below:

- Mainstream misconceptions are associated with Indigenous traditional healing because of a general disagreement as to where exactly it should be placed on the broad spectrum of the Western sciences and religions:

Many mainstream institutions that have developed out of these Eurocentric knowledge paradigms have examined traditional healing – and the tools and remedies associated with it – through the lenses of their own

disciplines (e.g., university departments, self-help/new-age communities, governmental departments and others). Relatively speaking, these institutions represent external lenses of interpretation that alter how traditional Indigenous healing is both perceived and interpreted (Robbins and Dewar, 2011).

- Indigenous cultures are noted for their oral tradition where knowledge of healing and medicine is passed orally from one generation to the next:

This means that direct experience with healers and traditional healing is one of the most important factors in being able to grasp the nature of traditional healing. Often, an examination of research literature only allows one to formulate concepts and opinions about traditional healing. Thus, analysis and presentation of these concepts and opinions can reflect different levels of 'rootedness' with respect to the true nature of traditional healing. In part, the accuracy of this reflection depends upon the personal experience of the individual author(s) /researcher(s). (Robbins and Dewar, 2011).

- Indigenous languages and cultures are different and extremely diverse across the globe and a subsequent definition of traditional healing in a respective Indigenous language may not be directly translatable into English, or across Indigenous languages and cultures. For example:

In the Cree language, *Kihteayak* describes an old or mature individual that does ceremonies whereas *Otsapahcikewenaw* are people who do ceremonies. An *Otsapaheak* is one who sees into the future or helps with things; a *Maskikiweniow* is like a medicine person who deals with medicine (Edge and McCallum, 2006 in Robbins and Dewar, 2011). While there is sometimes no literal translation for *medicine* in many Native American cultures (Hershman and Campion, 1985 in Robbins and Dewar, 2011), there are often several words which identify people who function in a healing capacity within the community (Robbins and Dewar, 2011).

- The word *traditional* is a British Colonial concept is disliked by many Indigenous peoples and it is a term that scholars have introduced to Indigenous Peoples in

English speaking parts of the world (Martin-Hill, 2003 in Robbins and Dewar 2011).

Most Indigenous healing practitioners would have referenced a complex set of medical practices and beliefs as simply *medicine*. In addition, specialized fields exist within the practice of traditional healing/medicine. For example, one could consult with a spiritualist, herbalist, diagnosis specialist, and medicine man/woman. It is also possible that a person may possess one, some or all of these gifts (Martin-Hill, 2003 in Robbins and Dewar, 2011). Elders and healers Martin-Hill spoke with in the development of her paper “Traditional Medicine in Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicine” (2003) were uncomfortable with the term *traditional medicine* because it is not an Indigenous concept. Therefore, it becomes a rather nebulous term that does not engage the full spectrum of knowledge interpretation that Elders and healers have to offer (Martin-Hill, 2003 in Robbins and Dewar 2011).

Although difficulties are noted with respect to defining Indigenous traditional healing, Robbins and Dewar (2011) also argue that there are some commonalities in approaches to Indigenous traditional healing worth mentioning. For example, the definition of traditional healing developed by Velimirovic (1990) and modified by Royal Commission on Aboriginal Peoples (RCAP) (1996) describes traditional healing as “practices designed to promote mental, physical and spiritual well-being that are based on beliefs, which go back to the time before the spread of western scientific bio-medicine” (Wagemakers-Schiff; 2003; Velimirovic, 1990 and RCAP Vol. 3, 1996). When Indigenous people refer to traditional healing, reference is made not only to the use of herbal remedies but also specific ceremonies and rituals that are used to promote spiritual, mental, physical and psychological well-being (RCAP, Vol. 3, 1996).

The fact that Indigenous traditional healing can address several different areas of health means that it is 'holistic' in both concept and practice:

The physical, mental, emotional and spiritual aspects of the human being are all interrelated; weakness in any of these areas causes a person to become unbalanced. For example, physical manifestations of illness may continue to appear until the individual accepts the teaching of how their illness ties into the laws of the universe or natural law (Lee, 1996, in Robbins and Dewar, 2011). Healers may use certain traditional medicines and/or ceremonies in their work to keep away illnesses and/or improve physical, mental or spiritual health (Cooke, 2010 in Robbins and Dewar, 2011).

With respect to a common sense expansion of the concept of 'holistic health', there is often an emphasis in Indigenous traditional healing focussing on the connection that a human being has to the earth's environment (Robbins and Dewar, 2011). For instance, Arvol Looking Horse emphasized that Indigenous health systems “view the earth as a *source* of life rather than a *resource*” (Looking Horse, November, 2009). Thus, in the holistic science of Indigenous traditional healing, the health of the planet is very much connected to human health (November 2009).

When 'traditional healing' is mentioned in this dissertation, a robust and broad description of the term –which includes issues such factors as the ones that are discussed above– is what I am intending to convey.

Research Question and its Origins

This discussion takes place in a context of protection and support for Indigenous systems of medicine. It departs from the understanding that Indigenous systems exist, although not always in full harmony with Western systems, and this has implications for interpretations of self-regulation in traditional health and healing. Many, if not most,

First Nations healing practitioners currently have little support and face many obstacles from the mainstream. Through its results, this project tries to gauge what support they need in their profession without ceding or divulging any intellectual or cultural property. To attempt to address this issue, the study is concerned with how Indigenous healers (and those that work with Indigenous healers) can inform a discussion about self-regulation.

The research question is: In contemporary environments, can traditional understandings about of self-regulation be /applied/used/articulated within contexts of First Nations health in ways that continue to simultaneously support and protect the autonomy of traditional healers and their practices? If yes, how could/does this occur? If not, why not?

The research question became clearer to me in the course of my opportunities to meet, consult and work with several First Nations Elders and healers from 2005-2009 while employed at the First Nations Centre (FNC) at the National Aboriginal Health Organization (NAHO). While working at NAHO, it seemed to me that, if left unchallenged, concepts held in and derived from modern Western medicine would dominate the discussion of Aboriginal health issues (at least in the context of politics and research at the national level). Thus, without asserting Indigenous value systems in these health and healing contexts, default value systems stemming from Western science/modern Western medicine could be inappropriately applied in the grey areas of First Nations health policies that claim to be comprehensive.

I credit the continued development of this understanding to the Elders, healers and other

members of First Nations communities who took the time to teach me about the First Nations part of my heritage. They have undoubtedly played a vital part in the formulation of this research question. In addition, I would also like to thank my immediate family, extended family members and friends whose kind-hearted acts throughout the years have afforded me the time and space to address this complex research question.

I am not a medicine man or a conductor of First Nations ceremonies, but these along with other experiences I have had while being around First Nations traditional healers and healing have, I believe, allowed me to contemplate this research question of self-regulation from an position of some experience. Thus, for me, writing this thesis is more than an academic exercise. I hope that the words offered here will benefit First Nations now and in the future through helping to illuminate some of the realities associated with this issue.

Research Objectives

The primary concern of considering First Nations self-regulation here is not just to identify formal self-regulation strategies to be recognized by federal laws and/or provincial governments. It is also not the intention to uncover and discuss at length the sacred protocols of traditional medicine. The intent is to acknowledge and to build on self-regulatory processes (although maybe not named as such) that have been in place as long as First Nations traditional healing has existed.

A first objective of the thesis is to identify and outline a self-regulatory model that, at least partially, finds its merit based on the accumulated medical knowledge held by First Nations communities. Although this model is not intended to be a definitive one, as it is only based on the knowledge gathered in the case studies for this thesis. It is hoped that some insight is provided to those who might be, as I have, struggling for the correct words and ideas needed to begin to articulate self-regulatory approaches to Indigenous health that find their origins in First Nations traditional healing.

A second objective would be internal validation of this model through consensus among some practitioners of First Nations traditional healing, traditional community members, and those community members involved with implementing traditional healing approaches in their health and social programming.

With this identified, a third objective is to engage in a discussion that supports the advancement of proposals to have First Nations traditional healing recognized for its own value, capacity to heal and cultural relevance.

Lastly, this is not intended as a comparative study that illustrates, for example, concepts of Western self-regulation and professionalization involves 'a, b and c' while Indigenous ones involve opposite elements of 'd, e and f' (i.e.; one model versus another). There may be differences or similarities, but the focus is intended to be on the nature of First Nations self-regulation and not a contrast between systems in terms of opposites. In retrospect, I came to realize this objective's connection to Indigenous Knowledge through a conversation with Indigenous Studies professor (Trent University) Mark Dockstator.

From an Indigenous Knowledge perspective, Professor Dockstator indicated that, like the title of this thesis indicates the environment in and around the issue is dynamic. If we were to undertake this study from a Western binary perspective you would have to have one and then the other. From an Indigenous Knowledge perspective, things are dynamic and changing. Differences are allowed to exist, but the models do not have to be mutually exclusive (Dockstator, Personal Communication, March 25, 2013).

Chapter 2: Literature Review

Overview

For this project, the two areas identified for the literature review were:

- Self-Regulation and First Nations traditional health and healing; and
- First Nations/Aboriginal midwifery –First Nations/Aboriginal midwifery as one example that brings to light some issues that occur when two health paradigms (modern Western and First Nations) are functioning together in contemporary environments.

Self-regulation and First Nations Traditional health and healing literature

For reasons indicated earlier, such as their not being a definitive First Nations term (or sometimes even a concept) paralleling the English term ‘regulation’ or the related term ‘self-regulation’, there is, accordingly, not a great deal of written literature that focuses specifically on the self-regulation processes of First Nations traditional healers. Most of the sparse literature that does exist, while mentioning regulation and/or self-regulation in concert with First Nations traditional healing, does not attempt to explain what self-regulation means in these contexts.³ Therefore, in First Nations contexts of traditional health and healing, concepts of regulation/self-regulation appear to remain open to mainstream assumptions and interpretation/misinterpretation.

³ See, *Addressing literature specific to Self-Regulation and First Nations Traditional Health and Healing* section of this literature review.

Differences between mainstream self-regulation in healthcare and notions about what might constitute First Nations self-regulation are, in the written literature, most often implicit rather than explicit. Bearing this in mind –in addition to the first section which addresses literature specific to self-regulation and First Nations Traditional health and healing– what I have endeavoured to do in this literature review is to search for (and bring to the surface) some of these implicit issues relevant to a discussion about self-regulation in Indigenous traditional health and healing. As a result of these contemporary environments where First Nations traditional systems of medicine exist alongside the mainstream one, several implicit enquiries related to the self-regulation question remain unaddressed. This can partially be attributed to the fact that healing knowledge is primarily kept as an oral record amongst First Nations. In addition we might also consider that we are exploring the issue of First Nations self-regulation and traditional health and healing within a ‘post-jagged-world views colliding’ world.

The following issues are discussed in the traditional health and healing part of the literature review:

- *Addressing the literature specific to Self-Regulation and First Nations Traditional Health and Healing*
- *‘Grey Areas’ in Canadian Law and Policy regarding First Nations/Indigenous traditional healing and medicines*
- *Institutionalization of Traditions*
- *Expanding approaches to ethics and efficacy when evaluating Indigenous medicines*

- *Epistemological Uniqueness of First Nations Traditional Health and Healing Systems*
- *Intangible Elements in First Nations Traditional Healing*
- *Suppression of Indigenous Healing Traditions*
- *Authenticity*

First Nations/Aboriginal Midwifery Literature

In addition, the second part of the literature review addresses the specific subject of First Nations/Aboriginal midwifery in Canada. First Nations midwifery literature contains material that elicits interesting discussions about some of the innovative ways being used to conceptualize self-regulation contemporary health environments. There are both traditional and mainstream health elements in First Nations midwifery and it, therefore, provides a rather practical grounding for a discussion of predicaments that occur when different health paradigms are functioning together in contemporary settings. Notably, the province of Ontario is currently the only one that has legislated exemptions for First Nations traditional healers and midwives from its self-regulatory health processes which are more structured for mainstream healthcare. At the very least, the reviewed midwifery material is a specific example that directly begins to address some of the gaps in the literature with respect to some of the complexities of self-regulation and First Nations traditional health and healing. The subjects addressed in the First Nations midwifery section of the literature review are:

- *Jurisdiction*
- *Improving Health Outcomes*

- *Institutionalization and epistemological/philosophical differences*
- *Accreditation and Training*
- *Community Inter-connectedness and Spiritual Gifts*

Self-Regulation and First Nations Traditional Health and Healing

Addressing the fact that there is such a large gap in written literature specific to self-regulation and First Nations traditional health and healing leads to questions about where this type of inquiry could lead. Depending on our area of focus, the scope of these types of considerations in this context could be relatively specific or very broad. For example, are we implying any, none, or a combination of the following ideas when we consider self-regulation and First Nations traditional healing?

- An ethical consensus amongst healers in various communities such as in the Haudenosaunee Code of Traditional Healers or the Colombian *yajecero* healers (Mitchell, 2006, UMIYAC, 1999)?
- Creating an entity to act as a watchdog and respond on behalf of traditional healers to respond to government proposals which might harm the practice or authenticity of First Nations medicine? These types of large legislative “slashes” can make healers uneasy and even more resolute (RCAP Vol. 3, Chapter 3).
- Creating something much more comprehensive (on the institutional level) that would involve healers developing ethical standards around use and practice of traditional medicines? This type of entity would then directly negotiate with

government towards the development of a tribal model for controlling traditional health and healing service delivery.

What seems to be clear is that the issue of self-regulation in traditional health and healing is something Elders and healers themselves have the authority to address within the context of the larger First Nations community (RCAP Vol. 3, Chapter 3). The few sources that we can legitimately identify as self-regulation literature for First Nations traditional health and healing vary in their descriptions and explanations. In general they consider: the role to be played by First Nations traditional value systems; the integration of First Nations traditional concepts with mainstream ones; the more formalized/mainstream development of self-regulatory associations.

In *The Haudenosaunee Code of Behaviour for Traditional Medicine Healers*, Mitchell (2006) argues that through the community voice, it is already known that the Haudenosaunee had well developed systems of traditional medicine. Regarding ethical behaviour that would necessarily factor into understandings about self-regulation, healers are known by communities as supportive people. They are identified as those who 'walk the talk' and have clean minds and habits (Mitchell 2006). Each healer had certain professional responsibilities to fulfill including the maintenance of high ethical and professional standards.

Along these lines of maintaining high ethical standards, an Anishinabe Elder relayed the following paraphrased information to me at a Three Fires Gathering (August 21-24, 2007) as one of the foundational elements in their approach to traditional health and healing:

The *Niizhwaaswi Kchitwaa Kinomaadiwinan* (Seven Grandfathers' Teachings) are seven basic teachings, often referred to as the Seven Grandfathers' teachings (and often mentioned in Three Fires Circles) are: love, honesty, respect, truth, humility, bravery and wisdom. These elements of integrity are all connected. For example, "being truthful to yourself about your past is important. It takes humility to be truthful. Being respectful of yourself and others leads to being able to love again, and in order to love again one also needs courage" (Anishinabe Elder, Personal Interview, August 22, 2007). Thus, the relationship between the healer and the person in need of healing is different than the standard patient/doctor relationship.

At *Noojmowin Teg* Health Centre this is evident through their inclusion of Anishinabe concepts of *bgidniged* and *relative* in their practices. *Bgidniged* is the Anishinabe concept of a gift that should be given to a healer by the *relative* (*relative* is the term here used to refer to the person requesting to see a healer rather than 'client') or their advocate (Maar and Shawande, 2010, p. 21-22).

In contemporary times, some health programs that choose to incorporate First Nations traditional healing can sometimes address common self-regulatory concepts which govern relationships –like codes of conduct or ethical behaviour. For example, at the *Noojmowin Teg* Health Centre, Anishinabe concepts were recognized as vital during consultations and were also integrated into their health policies. At *Noojmowin Teg*, *Debweyendaa* is the Anishinabe concept of the sacred trust between people and the Creator. It is used 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 the *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 offered by a healer (Maar and Shawande, 2010, p. 22).

While some parallels can be drawn, in an ‘integrative’ self-regulatory environment, it is important to continue to remain on the side of caution. On the one hand, although informal and more traditional processes may still be at work in some communities, some argue that there are Aboriginal people and mainstream health professionals who do not have the traditional knowledge necessary to distinguish a traditional healer from a charlatan (Waldram, Herring & Young, 2007). Here there would seem to be some benefit in integrative services where mainstream self-regulatory principles can at least be paralleled.

Bearing this in mind, Maar and Shawande state that, “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” (2010, p.25). At the same time, finding fitting answers to questions related to policies and regulations would be critical for the complementary use of traditional healing 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 such as malpractice lawsuits (Maar and Shawande, 2010).

While these sorts of things might work on a community by community basis, the reality of accomplishing this on a large scale across all First Nations is questionable. The Non-Insured Health Benefits program for First Nations and Inuit (NIHB) is not in a position to either identify or fund a full consultation with all traditional healers across the country. In the meantime, however, Canada's Royal Commission on Aboriginal Peoples (RCAP) recommended that federal support needs to be clarified and systematized until traditional healers become self-regulating and access to their services is fully controlled by Aboriginal health authorities (RCAP Vol. 3, Chapter 3, 1996). Obviously the scope of this PhD thesis is not one that is capable either of undertaking a large consultations with First Nations traditional healers either. However, it is hoped that insights will be gained and avenues of discussion opened concerning self-regulation and First Nations traditional health and healing.

The Institute on Governance asks, "Are there ways in which healthcare organizations could play a role in helping traditional healers develop their existing means of self-regulation?" (1997). Probably so, but again, one has to exercise caution here as well. Mainstream health self-regulation (as indicated in Chapter 1) is defined through symbiotic relationship with governmental regulation entities. This definition does not apply in First Nations contexts because a uniform definition of First Nations self-regulation in traditional health and healing do not exist. While some First Nations concepts may parallel mainstream ones, others may not be translatable at all. Maar and Shawande state, "particular First Nations values present in traditional health and healing my often be anchored in words and expressions whose meanings can be lost in

translation” (Maar and Shawande, 2010). Even in Ontario where policy improvements have been made to promote traditional healing practices (including legislation which protects traditional healers, medicine people and midwives from government regulation), *mainstream self-regulating health* practitioners still seem to benefit considerably more than *self-regulating First Nations traditional health* practitioners who are members of communities that have treaty based relationships with the government. Indeed, these are the kinds of complications that can arise when the two systems of health care meet. However, on the positive side of things, the meeting of these two worlds mean that First Nations health care has the potential of becoming more culturally appropriate as the greater collective society is transformed. More often than in the past, clinicians are becoming aware of the hazards of medicalizing Aboriginal spirituality (Marr and Shawande, 2010).

Some Indigenous groups have more robustly embraced mainstream ideas of self-regulation and have decided to form their own associations that employ some of these principles. For example the *Dine Hatatali’ Association* is an organization of medicine people recognized by the Navajo Nation in the four corners region of the United States. Internally, this organization, based on Navajo traditional healing protocols, has its own way of allowing Navajo into the association and training them to be healers (Draper, 2007). Externally, this organization has gained the respect of the mainstream and has used its powerful influence as a sort of ‘watchdog’ in several different arenas (many outside of what the mainstream might consider to be health care). For instance, because of their influence, a Bill introduced to regulate the use of traditional Native American

practices off of Native territories was not to be heard (Thursday, Feb. 11, 2010) by the Senate Committee on Government Institutions at the request of Sen. Albert Hale, Dist. 2, the sponsor of the Bill:

"I asked to have the Bill held at the request of the Diné Medicine Men Association. After a lengthy discussion with the Association it appears that they still have significant questions about the bill. I explained to the Association that the bill intends to direct the Arizona Department of Health Services, in conjunction with the Arizona Commission on Indian Affairs, to develop rules to regulate the off-reservation practice of Native American traditional ceremonies by non-Indians or others, and did not apply to ceremonial practices on Indian reservations. (Censored News, February 2010).

Dine Hatatali' has also been able to use its influence in other areas. With respect to Indigenous sacred sites, the Association voiced an open challenge to the 'American Great Outdoor Initiative', proposed by the Department of Interior and the Obama Administration which proposes to expand National Park and Recreation boundaries and Forest Services for development, fishing and hunting. The Association States that, "This action completely draws away from protecting Sacred Sites of Indigenous Sacred Spots" (Dine Medicine Men's Association, n.d.).

In an unrelated incident, the Association influenced the return of one of their members from military service. In February of 2007, a Marine commandant reversed his earlier decision Wednesday and granted conscientious- objector status to Pvt. Ronnie Tallman, a young Navajo from Tuba City, Arizona stating that Tallman believed his new found calling as a medicine man makes it impossible for him to go to Iraq without spiritually harming himself and his community (Draper, 2007).

While it may not work for all Indigenous groups/communities, it would seem that in the case of the Navajo Nation, a more formalized self-regulatory body (consisting of Navajo healers) has, at the very least, resulted in them having a stronger and more direct voice (in the mainstream) through which they have been able to influence concerns that are in are in some way in violation of Navajo traditional laws and values.

'Grey Areas' in Canadian Law and Policy regarding First Nations/Indigenous traditional healing and medicines

Knowledge about some traditional medicines can be possessed by different First Nations community members and not just 'specialist' healers. Métis author, playwright, broadcaster, filmmaker, and Elder Maria Campbell stated during a Keynote speech, that when you lived in the bush, you learn all of the basic medicines. Even children would be able to go out and get medicines and know the protocols associated with retrieving these medicines. Why? Because in more traditional environments there were no options of drugstores in the bush and you had to know what to do (Campbell, Wabano Health Centre, Ottawa, March, 21, 2013).

Interestingly, Canada (compared to other countries) actually has laws that could be considered supportive to the use of traditional plant based medicines. Currently, if it can be proven that a plant medicine has been used traditionally, the plant(s) does not have to go through the same clearance processes as in other cases.⁴ Herbal medicines are regulated as 'drugs' in Canada and must therefore conform to labelling and other

⁴ Of course the drawback here is that the policy is still not able to fully capture the holistic nature of First Nations medicine. Even with Indigenous plant medicines the fusion with mental and spiritual elements is an essential part of the remedy.

requirements as set out in *The Food and Drugs Act and Regulations*. This means that, in contrast to the USA, large numbers of herbal medicines with 'traditional' claims are legally available on the Canadian market (WHO, 1998b).

Under Canadian law, herbs that are designated as traditional medicine are normally those which have received relatively little attention in scientific literature and, therefore, not that well known to the scientific medical community. These products which are based on traditional or folkloric use can be designated as traditional medicines. The assessment is primarily based on traditional references for efficacy and dosage. The claims are restricted to those that are acceptable for self-monitoring. If there are safety concerns, modern scientific research is taken into greater account –trumping references from First Nations traditional knowledge/science (WHO, 1998a).

There should be concern over outside regulatory measures potentially being applied, by default, to aspects of First Nations medical systems. Though these outside regulatory measures are not directly applied to the practices of First Nations traditional healers, there are indeed sufficient 'grey areas' that merit cause for concern. The alternative health industry in Canada is steadily growing (Ramsey, Walker, & Alexander, 1991). As industries expand past a certain point, future regulatory possibilities are usually considered by governments. For example, Bill C-51 (a proposed *Regulatory Bill for Natural Health Products in Canada*) was introduced in Parliament by the present Conservative government in 2008. C-51 was met with much opposition from the Canadian public, including First Nations. The Assembly of First Nations (AFN) passed Resolution 11, at their Annual General Assembly in 2008, which raised several concerns

about the Bill including the fact that ‘therapeutic medicines’ might include traditional medicines (Assembly of First Nations, 2008). Orr (2009) indicates that the Bill could affect practitioners of First Nations medicine in the following ways:

- Regulation of the collection, preparation and administration of medicinal herbs which are potentially subject to classification, under the Bill as drugs (in particular prescription drugs) – If so classified, they could not be administered by a traditional First Nations healer because such a healer is not defined by the Bill as a ‘practitioner’;
- Establishment of a legislative model that would require traditional medicines to obtain market authorization –unless exempted by regulation;
- Establishment of a legislative model that would require a license to collect, process, label, package distribute or test a traditional medicine product –unless exempted by regulation; and
- Establishment of a legislative model that would require clinical trial authorization for investigation into therapeutic benefits of traditional medicines on human subjects (resulting in displacement of the authority of Indigenous knowledge) – unless exempted by regulation.

Bill C-51 ended up ‘dying on the table’, so to speak, and was not passed in Parliament and Leona Aglukkaq, the current Canadian Health Minister tried to reassure First Nations through a letter to the *National Association of Friendship Centres* that indicated, “Natural Health Products Regulations are not aimed at regulating the practice of complementary and alternative health care practitioners or the practice of traditional Aboriginal

medicine” (July 29, 2009). Even if we take the Minister’s words to be completely valid it does not appear that issues around grouping, by default, traditional Aboriginal medicine with a growing industry of complimentary/alternative health care has been fully addressed. For instance while Minister Aglukkaq indicated in her response to the National Association of Friendship Centres that the regulations are not aimed *at the practice* of complementary or traditional Aboriginal medicine, there is no reference to the non-regulation of *certain herbs* that might be used in the making of remedies that Aboriginal practitioners administer to their patients. Thus, even though C-51, due to much opposition, ended up fizzling out and the Health Minister indicated there is really no cause for concern for Canada’s practitioners of Aboriginal traditional medicine, ‘grey areas’ still remain.

A second ‘grey area’ of concern with respect to natural health products is represented by the recent passing of Bill C-6 –*The Canada Consumer Product Safety Act* on December 14, 2010. Although the Bill does not include Natural Health Products (as Bill C-51 did), C-6 contains enforcement and penalty provisions very similar to C-51. Buckley (2009) had the foresight to see how C-6 remained relevant to the Natural Health Product community in two ways:

- Bill C-6 could be made applicable to Natural Health Products by introducing a simple regulatory amendment. Regulatory amendments do not require Parliamentary approval. (After successfully fighting Bill C-51, Canadians could find Natural Health Products threatened by the same provisions found in Bill C-51 applied through Bill C-6); and

- Bill C-6 passing through the Senate means that a precedent is set. (It is therefore unrealistic to assume that similar enforcement provisions and penalties would not be applied to drugs and Natural Health Products). (Buckley, 2009).

Additionally, while there is currently still 'legal room' for traditional healing and its associated medicines (with proof) to exist within the context of a Nation-State such as Canada, nuances in related policies indicate that ultimately, 'modern scientific research' is seen as the universal way to clear up these grey areas. Ethical questions arising at this point are:

- What constitutes 'proof'?; and
- What constitutes 'modern research'?

Kathy Bird, a registered nurse who works in traditional medicine at the Peguis First Nation Health Services in Manitoba, described the long process (paraphrased below) of coming to be able to work with traditional plant based medicines during a workshop at the Wabano Health Centre in Ottawa (March 21, 2013):

During her apprenticeship, the 'the old man' showed her several medicines taking them out one at a time and said, This is what it is, this is what it smells like and this is where it grows'. He said, don't harvest them but just go out and find them and sit with them. Sitting with plants she found to be important because many plants look similar. After a few years, she was allowed to harvest the plants for the 'old man' and after seven years of harvesting medicines for the 'old man', she started working with him helping people. (C. Bird, Workshop Teaching, March 21, 2013). These types of processes are 'proof' and

‘modern research’ in the context of Indigenous health and wellness that continue to stand the test of time.

If Indigenous knowledge references to medical uses of plants are continuously subsumed by explanations discovered by western scientific method, this means that, in such contexts, the *template* of ‘proof’ is held by modern Western science and the *burden* of proof unfairly rests with Indigenous Knowledge. As they currently stand, Canadian laws would have to be further developed to more accurately reflect (or be applied to) the realities of First Nations plant medicines that are associated with First Nations systems of healing.

Finally, under the ‘grey area’ theme, it cannot be assumed that provincial and federal laws designed to regulate biomedical practitioners and protect their clients would also serve the interest of First Nations traditional health and healing objectives. Different provincial and/or federal regulations might affect the dialogue about self-regulatory processes amongst First Nations traditional healers in various jurisdictions. For example, in the Yukon, supportive programs usually exist in pockets –such as in Whitehorse Yukon General (Whitehorse General Hospital, pamphlet n.d.) while in Ontario, the Aboriginal Healing and Wellness Strategy is much more comprehensive in its support of traditional healing. Supportive programs for First Nations traditional healing such as the Aboriginal Healing and Wellness strategy (AHWS) are currently the exception rather than the norm. In Ontario, *The Regulated Health Professionals Statutes of Ontario* (Province of Ontario, 1991) does not apply to traditional healers providing services to members of the Aboriginal community. These types of policies, however, can sometimes be a double-

edged sword. On the one hand, they can allow healers the space they need to freely offer their services in a more public way. On the other hand, it can also leave greater space for charlatans looking to make a ‘quick buck’ –which can have a negative effect on collective authenticity.

Institutionalization of Traditions

There is a prevailing and rather uncontested belief that –within institutions of a Euro-centric nature– mainstream establishments are universally functional and that these singular institutions exist to fulfill the needs of individuals and social collectives. Thus, a valid concern with respect to the progressive institutionalization of First Nations self-regulation and traditional health and healing is the possible gravitation towards a stance in the that declares Eurocentric institutions are the only socially valid contemporary settings in which learners can get formally educated (Burns, 1999). The institutionalization of Aboriginal traditions remains an interesting challenge (RCAP, 1996; Waldron 1997), especially for urban First Nations communities.

In the context of 'Canada' or –other such diverse large settlements– where there are many Indigenous cultural expressions and language groups, there are perhaps greater pressures for an Indigenous institution to default to Euro-centric philosophical perspectives rather than the Maori of New Zealand, for instance, who represent and project one unified language group and culture.

The late esteemed Standing Rock Sioux scholar Vine Deloria Jr. provided some discussion that can be applied to the institutionalization of traditions. That is, the actual

workability of the “world religions” outside of their cultural contexts and localities.

Deloria declares, “it is questionable whether or not religious experience can be distilled from its original cultural context and become an abstract principle that is applicable to all peoples in different places and of different times” (Deloria, 1994, pp. 66-67). Essentially, there is not a substitute for the lived sacred experiences that occur within a particular culture.

In American Indian religion, religious experience is taken directly from the world around them (e.g.: the relationship with other forms of life and sacred landscapes) and remains as close as possible to the original location of sacred revelation (p. 68). This raises interesting questions with respect to Native cultural adaptability to foreign environments (e.g.: urban centres). How we begin understand context is an important consideration when discussing self-regulation and professionalization of First Nations healers.

If institutions are considered to be a part of this process, a good start for transitioning to an Indigenous institution which focuses on traditional health and healing might find some insights through examining the Maori case. The government of New Zealand has formally agreed that Maori health and its future lies with Maori models of health and traditional healing (Mitchell, 2006). It is important that ‘all parties are on board’ so to speak. By starting with such an agreement, it would seem that genuine expressions of self-regulation amongst Maori would face fewer obstacles. Maori currently have the *Naa-Ringu Whakahaere O Te Iwi Maori* (National Organization of Traditional Maori Healers) that is primarily concerned about setting their own directions and goals with respect to

their healing traditions. They are also discussing situations where Maori medicines can be available to all but controlled by Maori (Mitchell, 2006).

For Maori, while institutionalization, in this respect may be a workable option, in Canada it becomes more difficult due to the greater cultural and linguistic diversity that exists among First Nations. This diversity should not, however, be presented as a barrier, but an opportunity to demonstrate the inherent strength and knowledge of First Nations medical systems in a contemporary context (Martin-Hill, NAHO, 2003). Dialogue leading towards greater comprehension of First Nations self-regulatory health issues could be a part of this process.

What is recommended, among other things, by organizations such as NAHO is that more spaces need to be created (either conceptual, physical or both) in which healers can practice and enhance their skills along with support for mentorships between youth and healers (NAHO, 2003). This being said, due to past exploitation there is still great apprehension about government regulation of First Nations traditional medicine due to a strong but not unfounded belief that, as in the past, the government would try and control the activity of First Nations healers (2003). In addition, there are also concerns about traditional healers being exposed to (and unprotected from) the mechanics of malpractice law if they were to increasingly offer their services in institutionalized spaces.

Expanding approaches to ethics and efficacy when evaluating Indigenous medicines

As a result of factors such as lagging mainstream perceptions and stagnant policies put forth by some governments (Martin –Hill, 2003; Anderson, 2010; Anderson et. al 2003;

Bakx, 1991), ethical issues arise with respect to research about traditional healing and programs that utilize traditional healing as part of their mandates.

An example illustrative of this is the diminishing the role that Indigenous Knowledge plays in the evaluation of Indigenous plant extracts. Western scientific research on the use of plant extracts for traditional purposes has been growing exponentially over the last 19 years. Obomsawin (2008) measures this by the number research articles on this particular subject. The articles listed in *Pub Med* has grown from just a few in 1990 to the present day where there are now close to 7000 researched articles. As well, prominent peer reviewed medical journals such as the *Canadian Medical Association Journal*, *New England Journal of Medicine* and *Lancet* seem to have a negative bias towards herbal remedies (Obomsawin, 2008).

It could be argued that having a strong scientific base could possibly mean strengthening the future usage of traditional plant medicine by Indigenous people. However, questions are rarely asked as to whether or not using biomedical testing procedures on Indigenous medicines is appropriate. Problems/complications in proper evaluation of a *holistic* Indigenous medicine lie in the fact that *scientific* protocols for testing pharmaceuticals use techniques which isolate chemical compounds. This information is, subsequently, used as a primary evaluator for its function and safety. A lot of First Nations medicine is not made up of 'isolated compounds' making it more complex to analyze than conventional pharmaceuticals (Obomsawin, 2008). Indigenous medicines often use an entire 'leaf' or 'berry' of a plant and sometimes in combination with another leaf or berry of another plant. For example, Juniper which for the Gitksan translates into "boughs of

the supernatural” is used widely by First Nations people in Canada as a treatment for a wide range of health conditions including a variety of infections. Juniper berries and other parts of the plant include compounds that exhibit diverse activities including antiseptic, bactericidal, fungicidal, antiviral, analgesic, anti-histamic, anti-inflammatory, spasmologic spasmogenic, sedative, antiedemic, antidiabetic, anticancer and cancer preventative, anti- atherogenic, liver protection and fever reduction (Obomsawin, 2008).

Western scientific techniques for making pharmaceuticals are, in some cases, also being used to determine toxicity levels in traditional medicines⁵. Nonetheless, these pharmaceutical techniques are not exhaustive when applied to remedies derived from First Nations medical systems. The available time and financial resources required to test all potentially active ingredients in a First Nations remedy is simply not possible using the isolationary science used to develop the drug compounds that are administered through the modern Western medical system. Western techniques pre-select an ingredient (or two) to be tested in isolation of all others. Doing this will usually result in toxicological unwanted adverse reaction with no acknowledgement that perhaps an antitoxin might exist in other parts of the plant used in Indigenous medicine. Safety in Indigenous medicine can be determined over time through trial and error, through transmission of knowledge, through instructions coming from the Creator or through

⁵ Of course there are uses for toxicity research on plants in an Indigenous context. For example, it is possible to measure levels of various contaminants in plants due to various forms of pollution. However, to assume that a practitioner of First Nations medicine does not know if a medicine is toxic or not is, to some extent, a discredit to their ability as a healer, their teachers and their system of medicine.

other spirit intelligences. The primary notion of Indigenous medicine is to heal the sick, wounded and end suffering, and not to make anybody rich (Obomsawin, 2008).

Some efforts, in a more exploratory and balanced type of scientific research, have been made to put First Nations medicine on an equal playing field with modern Western medicine. A research team at the University of Saskatchewan exploring the components of First Nations heart medicine was inclusive of two northern First Nations communities as research partners in their research design. The team started gathering information on 26 First Nations plants used to combat cardio-vascular disease. The team lead, Physiologist Dr. Rui Wang, is also trained in Traditional Chinese medicine. Since Dr. Wang is also trained in a system of medicine that is holistically based, this could have contributed positively to the synergy of the research design. Dr. Wang takes a more positive approach to enhance the use of traditional herbal medicines through scientific research. He indicates the team is interested in what parts of the plants are used and how different medicines are prepared and administered. Generally, a pharmaceutical model that tests chemical compounds would not show this kind of interest in the process by which First Nations medicines are prepared and administered (University of Saskatchewan News, June 21st, 2004).

In the context of 'big business', some pharmaceutical companies have been involved for quite some time in a rather unethical practice of excavating and extracting compounds from Indigenous peoples' medicines without compensation. Modern Indigenous groups—whether through self-regulation or other forms of organization—have begun to block these types of unethical practices. For example, in a relatively recent case involving the

San Bushmen, attempts at uncompensated biopiracy by a pharmaceutical conglomerate were successfully blocked. The San, an Indigenous community in Southern Africa, successfully organized themselves through the *Working Group of Indigenous Minorities in Southern Africa* and challenged a pharmaceutical company that had already begun to patent the extract of the *Hoodia succulent*. The San use the *Hoodia* plant as a thirst and appetite suppressant when food supply is low or when hunting. This serves as one modern day examples of how Indigenous organizing can block these types of unethical practices. The company argued that it was patenting a scientific ‘discovery’ without any acknowledgement that the discovery was made after crucial leads from San Indigenous knowledge sources (Channells, 2003).

Traditional approaches to Indigenous medicines arise out of holistic worldviews and it is, therefore, also necessary to take into consideration ethical issues that address the ‘interdependence’ between the human species and the environment. An example of this what this ‘expanded’ view of ethics might include from an Indigenous health and wellness perspective was described in a workshop I attended at the Wabano Health Centre (March 22, 2013) led by Christi Belcourt (who described herself as a Métis visual artist with a deep respect for the traditions of her people). Belcourt indicated that when we study plant and medicine within the context of First Nations traditional health and healing, we cannot take it out of the whole and we cannot study it as a separate scientific study. In addition, she stated that when we are talking about medicine, plants are called ‘first family’. In Indigenous thought they are our relatives. They are our first family because all other organic life is dependent upon plant life to exist. All is equal and

everything is part of the whole which is another reason for ‘including’ plants in our definition of family.⁶

Another example that references the connectedness between environmental and human health from an Indigenous health and wellness perspective occurred during a NAHO dialogue circle I facilitated with a few Elders from the Morley community on the Nakoda (Stoney) Nation in Alberta (July 17, 2007). These words are paraphrased in the paragraph below:

Everything that moves has a spirit. In the old days, spring waters were used for healing and people used to go. Now the spirit of this healing mechanism has been compromised and marginalized by mainstream consumer economies (e.g.: Banff hot springs). Places like Nakoda Lodge (where the conversation took place) are important, especially for those who have lost their way in the cities and towns. As they sit in the fresh air and beauty of the mountains they start to feel better. They start to feel health and to feel good about themselves (Nakoda Elders, Stoney Nation July 17, 2007).

Today, due to neglecting the existence of the reality of this interdependence –knowledge that is contained within First Nations traditional teachings –we are now forced to ask what types of modern human industrial activities are sustainable. A stance on First Nations environmental values is an ethical issue that also requires clearer articulation (and possible integration into) in an agenda for self-regulation and First Nations medicine. For example, the plants used to make medicines need to be available and

⁶ Example paraphrased from Belcourt’s workshop at the Culture As Treatment Symposium, Wabano Health Centre, Ottawa, March 22, 2013.

healthy (i.e.: non-polluted) for the First Nations healer to most effectively practice his/her medicine. Also, if these medicines were to eventually be shared with non-First Nations, the possibility of overharvesting is an issue that would need to be addressed. Even if First Nations were to be monetarily compensated for their Indigenous plant knowledge, like in the example of the San Bushmen, the issue of overharvesting still arises.

In concert with systems of First Nations medicine, Western medical technology, in its various forms, has been used responsibly, irresponsibly and sometimes without proper understanding.

With regard to plant medicines, technological advances in the Western system have most often served to harm Indigenous systems of medicine. Sefa Dei, Budd and Rosenberg (2000) indicate that the annual value from medical pharmaceuticals derived from Indigenous people exceeds 34 billion US and 25 % of Americans have prescriptions derived from plants Indigenous people know or knew about. Scientific technologies have been used for decades in order to 'extract' certain botanical properties from Indigenous plant sources. It is only recently that Indigenous people are beginning to resist pharmaceutical companies that over harvest Indigenous plants. For example, in the American Southwest the Navajo have instituted legal punishment in those Navajo or non-Navajo engaging in unauthorized research and trade of cultural property (Battiste and Henderson, 2000). The Navajo example uses a western/Indigenous hybrid model in order to address overall problems of cultural theft.

The World Bank sees the solution to protecting biological and cultural diversity in developing countries as specifically tied to the diversity of medical plants combined with

the knowledge that traditional healers have about them (World Bank, May 2006). This solution, argues the World Bank, “can successfully mitigate health, economic and environmental dilemmas due to rapid globalization” (World Bank, May 2006). A challenge, however, for First Nations in Canada is that, at least from my observation of the literature, large global organizations like World Bank and the World Health Organization, do not seem to see much use for traditional healers in ‘developed’ countries such as Canada. This could make the task of maintaining biodiversity for the continued development and use of First Nations medicine difficult.

This ‘environmental’ issue, with respect to the supply of raw materials used to make medicine, is an ethical consideration not only for First Nations but for all systems of medicine. When one considers interrelationships between society, nature and the intimate relationship between environmental health and human health, the questions concerning over-development begin to quickly reveal ethical implications. Put simply, biodiversity losses have direct impacts on human health. Losses in biodiversity diminish supplies of the raw materials for drug discovery and biotechnology. The resulting loss of medical models affects larger issues such as water quality and the spread of human diseases (Aves and Rosa, 2007). Most villages in the world are no longer surrounded by natural habitats that formally served as “medicine cabinets” (Aves and Rosa, 2007). First Nations communities are still somewhat fortunate in this regard as some of this ‘medicine cabinet’ preserved through treaties, is still available to First Nations traditional healers –though environmental pollution and overharvesting of natural resources continues to encroach on First Nations environments.

Some argue that more 'space' needs to be available so that, in contemporary contexts, more balanced methods of ethical evaluation can be developed. Willie Ermine's work focuses on the ethical practices of research involving Indigenous peoples. Ermine, a Cree philosopher takes particular interest in *ethical space*, a term coined by Roger Poole in 1972. For Ermine, this space creates a contrast by dislocating and isolating two disparate knowledge systems and cultures. He states,

“‘There have been lots of good attempts by sincere people who have tried to build bridges, but these undercurrents are powerful and keep washing away good intentions,’ said Ermine. ‘When we have had breaches and ruptures in the past, it is because we have failed to look at the area in between our two worlds. It is in this ethical space that we can understand one another’s knowledge systems’” (Ermine in Ford, 2006).

People seem to equate ethical procedure as constituting something that is ‘universally good’. However, just because universities have ethics protocols in place, does not mean that it will be beneficial to a different community (Lamouche, 2010). Creating an appropriate ethical space in research and programs that are interested in engaging Aboriginal traditional healers or traditional healing methodologies is critical. Otherwise one can run into unethical situations which only result in the further commodification of Indigenous Knowledges. There is still a critical debate over the transformation of healing, ceremony and ritual into a commodity. The unethical marketing of Aboriginal traditional healing knowledge poses one of the central concerns for traditional healers and knowledge carriers (Martin-Hill, 2003).

Epistemological Uniqueness of First Nations Traditional Health and Healing Systems

On some level, philosophical differences in healing models are allowed to co-exist in contemporary societies. For example, there appears to be greater acceptance of comprehensive health care models in contemporary society and the outlawing of First Nations healing ceremonies no longer occurs. Complementary therapies such as massage, chiropractry, and acupuncture are seen more often along with health food stores which carry natural remedies. Rather than simply dismissing these things as inferior, some people are now making efforts to understand them – this includes First Nations healing traditions. In this light, it does not seem that farfetched those First Nations communities (rural or urban) could one day publicly have comprehensive health care that more positively recognizes and engages First Nations healers.

An overview of the literature on Aboriginal traditional healing (with a North American focus in particular) suggests that:

... there has been a historical progression of perception or attitude, towards Aboriginal traditional healing in general and in North America in particular, from one of disfavour (and something that does not have a place in modern society) to one favour (and one that has a place in contemporary Aboriginal communities.... (Robbins and Dewar, 2011, p.8).

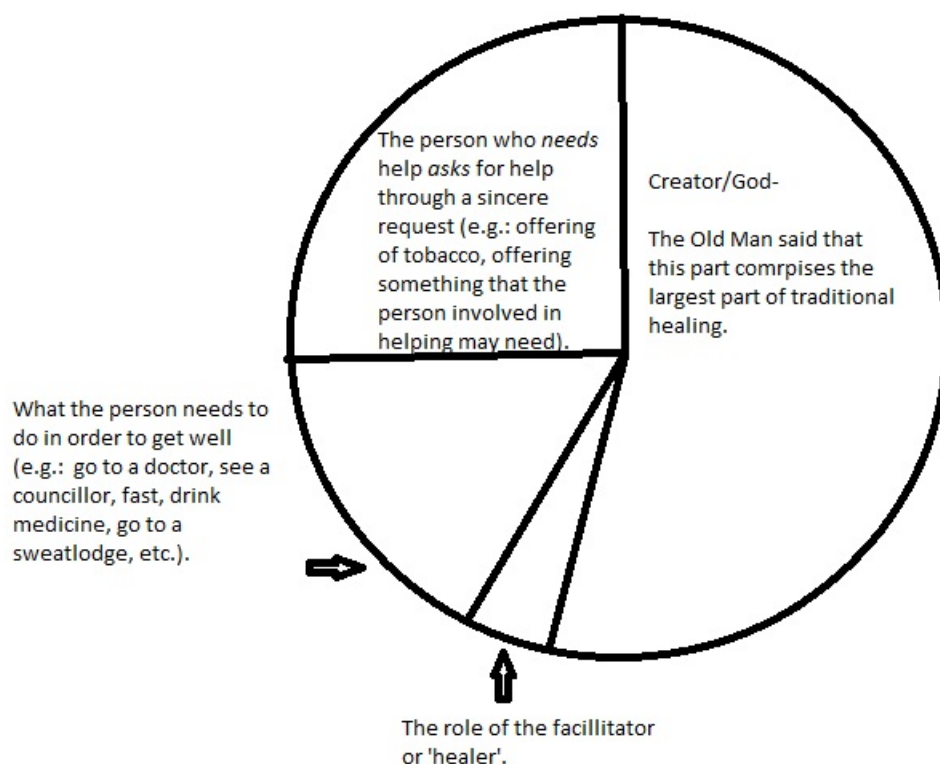
Generally speaking, recent recognition and affirmation of the importance of traditional healing practices for Indigenous peoples by RCAP (1996) has accelerated a reversal of the historic efforts to eradicate Indigenous traditions and created an upsurge in interest in traditional healing practices (Wagemakers-Schiff and Moore, 2003).

While the trends in the literature coupled with an upsurge of interest is encouraging, it is also important to be vigilant with respect to whether or not allowing for the co-existence of *philosophical* difference is supported by a tolerance for differences that exist on a deeper *epistemological* level. Sometimes, possibly due to a lack of awareness about the deeper epistemological underpinnings in their inherent worldviews, even those who appear to show sympathy to First Nations perspectives often continue to see traditional healing methods as unsophisticated or ‘primitive’ versions of Western medical principles (RCAP Vol. 3, Chapter 3). Hawaiian philosopher Manulani Myer contends that epistemology, the study of knowledge, is the starting point for any discussion of Indigenous Knowledge because understanding what people believe about their knowledge origins, priorities and exchange teaches us more about its continuity. The rich heritage that a Nation of Aboriginal people possess is often overlooked by the wider view of empirical realities (Meyer, 2000). In contemporary society, what is understood about the epistemological uniqueness/differences between worldviews can lead to more carefully thought out agendas with respect to self-regulation and First Nations traditional health and healing.

The following example and insight into the epistemology of health and wellness from an Indigenous perspective is paraphrased from the words of registered nurse and traditional medicine practitioner Kathy Bird. Bird offered this example during a workshop I attended at the *Culture as Treatment* symposium (Wabano Health Centre, Ottawa, March 22, 2013):

The 'old man' that trained her said that none of this making of medicine would work if we didn't give acknowledgement to the Creator first and foremost. He also said that, medicine people do ceremony different all across the country, but it still all starts with the Creator. In that way everything is sacred because we are all of the Creator. Always put tobacco down first, apologize, give thanks, and talk to the plant and ask the plant permission to use it. Explain to it why you are going to use it because that which you are taking is alive. Only after that can you begin to harvest it. Without that, our herbal medicines are not possible.

The 'old man' that trained her also said that by learning about medicine you are not going to heal people and that he had a hard time with the term 'traditional healer'. He then proceeded to draw a diagram (below) about why this was the case.



From an epistemological perspective, this drawing illustrates the holistic nature of traditional medicine and through the illustration, one can understand why many who have some knowledge about First Nations traditional health and healing are uncomfortable with the term 'healer'. The healer plays a role of facilitator but in the grand scheme of things, it is a small one. In that way, Bird says, the old man says that we need to have humility and we are not supposed to boast about it' (K. Bird, March 21, 2013).

Nevertheless, being in the role of this kind of 'facilitator' to healing is sometimes no easy task. The late Mi'kmaq healer David Gehue indicated that:

You have to surrender everything. We have had to surrender everything. It's no longer our lives anymore. When that phone rings, it is possible that I have to perform a service for someone. I have to take my prejudice and put it aside and be able to help that person. It is no longer about me... it is about that other person. And if I can't help them I have to also be able to say.. I can't help you and guide them somewhere else (David Gehue, Personal Interview, May 16, 2010).

Thus, with a word of caution, structured governmental programs around First Nations healing –not led by those who, through direct experience, understand the meaning of these types of holistic notions could become problematic. At its core, a procedure for strengthening a process for self-regulation in First Nations medicine would have to be led by people that are able to clearly distinguish and articulate some of the key epistemological differences and similarities between the two different systems of medicine. In my opinion, the people to lead this process would have to be the First Nations healers/Elders. Governments (First Nations, federal and provincial) can support this process in many ways, such as: providing forums for discussion, funding, providing cultural competence training, and supporting culturally safe places for patient/health professional interaction, etc.

Like First Nations, traditional Chinese medical practitioners who practice in Canada and other Westernized Nations sometimes face similar (although not identical) challenges. Quah states, “the challenge of science to traditional healing and medicines is represented by the requirement to comply with standards of medical research and practice applied to biomedicine and adopted and implemented by the state” (Quah, 2003). Thus, often in these types of forums, the epistemological meanings contained in traditional medicine become misinterpreted and/or incorrectly defined due to an overweighting of principles

associated with a Euro-centric worldview. As a result, non-Western healing methodologies are evaluated based on a 'test' whose parameters are set by certain requests and the standards of biomedicine. This is evidence of epistemological imbalance where one view is hastily given greater preference than another.

Intangible Elements of First Nations Traditional Healing

Transference of skills in healing knowledge are learned in different ways than, for instance, a Westernized schooling environment. First Nations self-regulatory processes are not overseen and implemented through entities such as formal colleges of health professionals. One reason why First Nations traditional health does not fit into mainstream self-regulatory models is because of the intangible property used within Indigenous healing systems. For instance, the holistic view purported in Indigenous healing systems is one where nature and Aboriginal sacred sites can be the equivalent of hospitals and educational institutions (Looking Horse, 2009). Indigenous people across the globe are busy using and trying to protect these natural healing spaces. While mainstream medicine would likely relegate anything 'sacred' to the realm of religion, in Indigenous traditional systems of healing, the unseen, intangible world can also become part of the medicine.

A healing song is an example of intangible property that could a tool used in Indigenous healing. Although not copyrighted in the sense of Western intellectual property law, a song could accompany the administration of a plant medicine by a healer –or may even

be a medicine in its own right. Young (2001) in Industry Canada (n.d.) notes that of all the songs sung by Plains First Nations people:

Medicine songs used in healing and disease prevention can only be sung by individuals who have received them in dreams or who are initiates in the transfer of bundles.Although the Blackfoot of the time found Horse Medicine songs 'particularly attractive' and would like to sing them outside the ritual context, they were forbidden to do so (Young, 2001, pp. 1032-1033 and pp. 2033 in Industry Canada, n.d.)

In this example with respect to the technical knowledge and songs associated with healing, the owner has a variety of obligations, restrictions and opportunities for holding and transferring these rights. This is his privilege against any other person in the tribe because the song came through this particular person's vision. While there is no 'legal' claim for this, traditionally other members of the tribe respect and follow the 'supernatural' order (Thom and Bain, 2004). Clearly mainstream self-regulatory policy would have a difficult time regulating such a phenomenon but in contexts of First Nations traditional health and healing, these types of intangible –and in this case, 'supernatural'– regulatory laws can exist. Such laws are respected by healers and tribal members.

Suppression of Indigenous Healing Traditions

Because of the decline of traditional healing, due to various means of suppression throughout history, many Aboriginal people say they do not know as much about traditional healing as they wish. However, the majority continue to use traditional healing in one form or another. (First Nations Centre at the National Aboriginal Health Organization, 2003) In addition, many feel that returning to traditional healing practices

would improve their health (Edge, 2003).

In the context of a legalized suppression of their science, practice and livelihood, notions of self-regulation and professionalism remain a sensitive issue for First Nations traditional health practitioners. Juneau (2007, p. 45) notes that when economic, political and social worlds collide, formidable belief systems (and systems of knowledge) go underground where they remain until it is safe to return. First Nations healers in contemporary times can often struggle to pass on their knowledge in addition to have it properly recognized in the mainstream. In addition to First Nations healers bringing these traditions underground, this lack of recognition could be due to factors such as a heavily promoted modern Western system of medicine or hodgepodge New Age interpretations of Indigenous healing systems –which exist in mainstream contexts.

Traditionalists are often quoted as opposing any form of regulation, based on very valid concerns over past colonial policies that have resulted in the suppression of First Nations cultures and healing (Martin-Hill, 2010). One reason that many traditional healers are opposed to formal regulation of their healing practices and services is a belief that it would reduce the legitimacy of both their healing system and the traditional practitioner's role as a healer (Health Canada 2003). Regulation is a term that, in the context of First Nations traditional health and healing that has, in many cases, become synonymous with unwelcome government intervention and attempts to control.

At the same time, when this suppression of First Nations healing traditions is combined

with the influence of a fast-paced mainstream society after a 'quick fix' (I, Anonymous Personal Interview, November 23, 2010) forms of self-regulation and community control that operated through various societies have been weakened and are sometimes non-existent (RCAP Vol. 3, Chapter 3, 1996).

For Canada in particular, the general integrity of existing Indigenous healing systems was interrupted when the government forbade First Nations traditional medical practices and ceremonies. This intrusion was mirrored in policies like the amendment to the Indian Act⁷ in 1884, which banned ceremonies, such as the Sundance of the Plains people and the Potlatch of First Nations on the west coast. First Nations traditional healing was practiced during these events (and many others) but they were often deemed as 'unholy' or 'witchcraft' by Christians. Some First Nations people were sent to prison if they were discovered to be practicing traditional healing (Assembly of Manitoba Chiefs, n.d.).

This ban on Indigenous healing in Canada was reinforced through initiatives by people like Duncan Campbell Scott who served as Deputy Superintendent of the Department of Indian Affairs in Canada from 1913 to 1932. On December 15th, 1921, Scott wrote a letter to all of his Indian Agents in Canada stating that,

“it is observed with alarm that the holding of dances [healing ceremonies] by the Indians on their reserves is on the increase, and that these practices tend to disorganize the efforts with the Department is putting forth to make them self-supporting” (Campbell-Scott, 1921).

7 The Indian Act is a document that attempts to regulate the majority of activities in the lives of First Nations people in Canada.

It further instructs the Indian agents to use their utmost endeavours to “dissuade the Indians from excessive indulgence in the practice of dancing” and it likens First Nations healing ceremonies to “demoralizing amusements” (1921). This ban lasted until 1951, but during this time there were always Elders and medicine people that managed to preserve the knowledge of medicines and discipline of ceremonies of their communities by practicing them underground (Robbins and Dewar, 2011).

Also, during this time, the modern Western medicine and Euro-centric education which were delivered as services by the government to First Nations had started to take root in First Nations communities. These activities created new understandings about medicine amongst First Nations.

By approximately the late 1960’s to early 1970’s, the utilization of First Nations traditional healing methodologies, to a certain degree, began to resurface and communities began again to *openly* look to their community knowledge holders to refresh their cultural memories and deal with the new set of wounds resulting from the colonization processes. These ‘wounds’ resulted from activities such as the banning of First Nations ceremonies (mentioned earlier) and the operation of residential schools.

Robbins and Dewar (2011) note that in addition to the banning of healing ceremonies,

“Indian Residential schools in North America, which operated for a significant time, are now viewed as a devastating period when children were separated from their parents to be *educated* in the ways of the colonizer. In these schools, reports of physical, sexual and mental abuse were not at all uncommon.” (p. 4)

Next, in this developing post-contact socio-political landscape, transfer of control of health from Canada back to First Nations occurred in 1989—twenty years after the transfer

of control of First Nations education (Health Canada, 1999). Yet, while this transfer of control and authority was significant, what was essentially transferred (like in the transfer of First Nations education), at least at the beginning, was the administrative system of Western healthcare delivery. Thus, for those who practiced traditional healing, mainstream acknowledgement of their skills and medical knowledge was still next to none, as was their initial inclusion in the development of community health programs under First Nations control.

Over the last 20 years or so, at the request of Aboriginal communities in Canada, First Nations and Inuit Health has been seeking alternative ways of facilitating greater First Nation and Inuit control:

First Nation and Inuit organizations are now beginning to express a desire to provide a scope of service greater than the simple delivery of community-based health programs. First Nations and Inuit Health Branch needs to develop mechanisms to support an expanded scope of service such as those which have been identified by First Nation organizations wishing to undertake a more "holistic health approach" toward First Nation health service delivery (Health Canada, Health Transfer, 1999).

These holistic models can, and often do, include the presence of First Nations healers who can provide input that is rooted in a healing approach utilized within their First Nations communities. Many First Nations communities now include traditional concepts, traditional healing and healers as part of their health and social programming. Regardless of the current socio-political environment, like their ancestors, contemporary First Nations healers, ceremonialists, Elders, traditionalists, apprentices, etc., still have to devote a great deal of their time and energy to develop the discipline required to utilize

their healing gift. For example, in a study of the language utilized by First Nations Elders use to communicate, it is noted that:

....formal and long-established ways, procedures, and processes that First Nations persons are required to follow when seeking particular kinds of knowledge that is rooted in spiritual traditions and laws. The rules that are applied to this way of learning are strict, and the seekers of knowledge are required to follow meticulous procedures and processes. (Cardinal and Hildebrandt, 2002, p. 2).

From the resulting suppression, Little Bear's 'jagged worldviews' has brought a new set of questions and complications with respect to the identification and clarification of First Nations issues in contemporary environments. One of those issues comprises the discussion areas of this thesis, namely the self-regulatory procedures associated with First Nations traditional health and healing. Thus, it is with this 'jagged worldviews colliding' background in mind that currently, some First Nations communities are beginning to articulate models of self-regulation in health in the form of cultural/professional dialogues with the mainstream. These models are often driven by traditional First Nations value systems, languages and connection to land bases.

Authenticity

In a workshop I attended led by Anishinabe Elder and Professor Emeritus (Trent University) Enda Manitowabi at the Wabano Health Centre, (March 21, 2013), a teaching on four principles (paraphrased below) were mentioned that, I believe, if followed can be taken as an example of what authenticity and the nature of self-regulation can mean when working from within an context of Indigenous health and wellness:

RESPECT

Manitowabi considers and refers to herself to be a ‘gather of roots’ that passes that knowledge on, not a healer or a medicine woman. Humility is present in respect. We also have to respect where we come from and who we are.

RESPONSIBILITY

We have to be responsible for the knowledge that we gather. We have to use it in a good way, not go/work with knowledge/medicines beyond our own understandings. Use knowledge responsibly to help others.

RECIPROCITY

Offering Tobacco is an example of how we have to give something back when we take things from the earth.

RELATIONSHIP

Relationship with the Creator, with Mother Earth, Grandmothers, Grandfathers, extended family biological family, etc. When we do our fast, we sit on Mother Earth’s lap and ask her to embrace us. We acknowledge all of creation in that way. For plants, relationship involves better understanding what they do and how they give us life (E. Manitowabi, March 21, 2013).

On the other side of things, people in the mainstream and even amongst First Nations continue to have confused perceptions about traditional health and healing. This uncertainty can, at the very least, partially be attributed to the suppression of healing traditions that was discussed in the last section. In any case, these types of confused perceptions about Indigenous health knowledge can cause people to question its authenticity.

Issues about the authenticity of health practitioners have been documented since early times. Three kinds of medical practitioners are easy to characterize, according to Charaka: “the impostor in physicians robes; secondly the vainglorious pretenders; and thirdly, those endowed with the true virtue of the healer”- (Caraka sutra VI, 7 in Handbook of Medical Ethics, 1995). Authenticity of a good healer is connected to their knowledge, their compassion and the sincerity of their vow to not do harm to their patients. Distinguishing between who is and who is not authentic is a recurring theme throughout health care the world over and is one of the reasons that we there are self-regulatory processes in place for service deliverers of modern Western health care.

In contemporary society, even with the checks and balances of self-regulation for health professionals in place, there is no guarantee that medical authenticity will not be compromised. For example, many commercials and advertisements for pharmaceutical products entice us to believe that modern Western medicine is always the better to solution to a health problem (even though the side effects stated in these same commercials and advertisements seem to be numerous and complex). There seems to be a strong drive (through advertisements) to ‘sell’ consumers on pharmaceutical solutions in the name of science. In contemporary society we are urged to ask the question of whether this is then an altruistic desire to heal or primarily a corporate drive to move more product?

It is no secret that modern healthcare, inclusive of large pharmaceutical companies, has become a very big business conglomerate. ‘Business-like’ competition amongst health

care providers, while healthy, can and *has* also interfered with scientifically validated (and peer reviewed) research: Geiger notes, “scientists and inspectors at the federal agencies responsible for food safety say they face political and corporate interference with their work, according to a survey released Monday by the Union of Concerned Scientists, a nonpartisan advocate for unbiased science in government” (2010). Put simply, at some point ethical conflict is bound occur because there are activities in the realm of science and the realm of business that are not the same.

A recent study by Dr. Joel Lexchin, (York University News, 2012) noted that drugs streamed into Health Canada’s accelerated review process are exposing the public to greater risk because they had a greater than 1 and 3 chance of having a serious safety warning or being withdrawn from the market for being unsafe. This compares to a 1 and 5 chance of the same consequences for drugs approved through Health Canada’s standard review process. The question to be asked here is what processes or influences led the regulatory entity within Health Canada to implement this accelerated review process for drugs? Lexchin’s study, however, seems to imply that there can be consequences if shortcuts are taken in the science used to develop pharmaceuticals.

In the mainstream health sector of mental health and addictions, the increasing problem of crystal methamphetamine use also speaks to this issue medical integrity. Crystal Methamphetamine Hydrochloride – or crystal meth – that is sold illegally today on the streets is a dangerously addictive super-concentrated form of methamphetamine. It is derived through a cooking process that cannot be completed without the inclusion of ephedrine or pseudoephedrine. The primary ingredient in crystal meth is ephedrine or

pseudoephedrine –found in over-the-counter cold medicine like Sudafed– which is known to provide sinus relief and temporarily boost energy.

The cold medication industry is multi-billion dollar business. In the United States, Jay Hayslip of the *Drug Enforcement Administration* (DEA) wanted to go after the chemical components of crystal meth in order to combat the growing problem of meth addiction. A Bill was introduced to the United States Congress targeting the production of ephedrine and pseudoephedrine, but unfortunately the billions of dollars involved in the cold medicine industry was too much for the Bill to have a significant impact (First Nations Centre, National Aboriginal Health Organization, 2006). Some pharmaceutical representatives of the cold/sinus industry complained they were being treated like Columbian drug lords for producing medical products. These representatives then managed to get cold medicine exempt from the Bill (Byker, 2006). Recently, a study done in the city of Portland, Oregon (a city known for high crystal meth usage) on convenience stores uncovered that over 75% of the pseudoephedrine sold was still being used to make crystal methamphetamine. Even with this evidence, however, spokespeople for pharmaceutical companies remained opposed to supply side intervention tactics. It seems the current compromise is that most drug-stores have made efforts to regulate the way they deliver (previously over the counter) products that contain pseudoephedrine.

The tendency of Eurocentric worldviews to label First Nations (or ‘other’) medicine as not as effective or sophisticated coupled with the activities of pseudo-business minded people who have no actual training has resulted in the ‘New Age’ appropriation and selling of the proclaimed spiritual components of First Nations medicine. This

subsequently results in the clouding of authenticity issues around the contemporary expressions of First Nations medicine. During a conversation I had with an Anishinabe Elder at the Three Fires Gathering, (Garden River First Nation, August 21-24th, 2007) he emphasized that, “These things are not to be sold”, and “It is very important to protect ceremonial practices and information from misuse” (Anishinabe Elder, Personal Interview, August 22, 2007).

An example of this type of appropriation, occurred on October 8, 2009, at a New Age "Spiritual Warrior" retreat, conceived and hosted by James Ray at the Angel Valley Retreat Center near Sedona Arizona, three participants died as a result of participating in a sweat lodge exercise. Eighteen others were hospitalized after suffering dehydration to kidney failure (CNN, 2009; Katz, 2012). On October 29th, 2009, Lakota traditional spokesperson Arvol Looking Horse issued a statement in response to the tragic event. In the statement, Looking Horse affirms that this event did not represent Indigenous ceremonial way of life. He indicates that the *Inikag'a* (sweat lodge) is the oldest ceremony brought to the People by the Creator and death has never been a part of it when it is conducted properly. Furthermore, in order to earn the right to be able to conduct the *Inikag'a* an intensive multi-year training period is required and one does not have money on their mind (Looking Horse, 2009). In order to give proper respect to this serious issue, Looking Horse's full statement is cited in Appendix A. In the statement, the true origin of the *nikag'a* healing rite (and its purpose for helping the People) is very clearly articulated.

Generally speaking, a serious question to be asked is whether or not increased attention to First Nations controlled self-regulation developed by healers and/or other First Nations knowledge keepers could have a positive effect on the perceptions about the authenticity of these practices. In times past, customary practices and informal norms were enough to safeguard First Nations people against fraudulent practitioners and to provide acknowledged healers with a livelihood through community support. Communities were small enough to realize this. However, times have changed and forms of self-regulation and community control (in many communities) that once operated through various societies (or through local reputation) have been weakened and are, in some cases, non-existent (RCAP Vol. 3, Chapter 3, 1996).

Regardless of the medium (self-regulation or others), in order to have continued development of First Nations medicine, inappropriate use of culturally sensitive information, commercial use of information, unauthorized claims of ownership of community or personal information and incorrect interpretations of information should not be tolerated (Nason, 1997).

First Nations/Aboriginal Midwifery

The miracle of birth and the presence of midwives is common ground amongst all cultures. Therefore, this could be an excellent starting point to build intercultural cooperation in areas of health self-regulation. First Nations midwifery also provides an interesting example with regard to self-regulatory processes and professionalism due to the fact that it often 'walks the line' between First Nations traditional expressions of

birthing and mainstream ones. Midwifery is viewed by some as an important aspect to healing through its strengthening of contemporary First Nations communities (Couchie and Nabigon, 1997). Although there has been a surge of activity in the last 10 years or so amongst First Nations midwives (NAHO, 2008) there still remains a limited data base in the area of *traditional practices* of pregnancy and child birth for First Nations communities in Canada (Kioke, 1999). It is only recently that, relative to mainstream society, pregnancy and birthing experiences for First Nations women have gone through a transition from birth in a home and family environment to one that is under the control of bio-medical physicians.

The following discussion points emerged from the literature written about First Nations midwifery.

Jurisdiction

First Nations midwifery programs that integrate First Nations traditional midwifery and midwifery that is based in western science has caused jurisdiction to become a significant issue. Health care for Canadians is under provincial jurisdiction but tensions still exist between federal matters –such as including health care in comprehensive First Nations treaty rights– and what constitutes the role of the province in First Nations midwifery healthcare. The present landscape of midwifery in Canada has been referred to as ‘a patchwork quilt’ because the following jurisdictional arrangements currently exist:

- midwives as a regulated publicly funded profession;
- midwifery as a regulated but not publicly funded profession;
- midwifery as funded but unregulated; and

- midwifery as unregulated and unfunded (NAHO, 2004).

First Nations are unique groups with respect to their relationships with provincial jurisdictions in Canadian society. At the same time, while regional and community diversity exists between First Nations communities, tribal unity may extend beyond provincial boundaries. Since jurisdictional issues of midwives are different, depending on the policy and legislation existing in a particular province, it makes it somewhat complicated to indicate what a National self-regulatory body of First Nations midwives would look like. There is no Aboriginal Midwifery Associative conglomerate in Canada, however, there are several First Nations midwifery associations and organizational support is an ongoing need. (NAHO, 2004).

Some argue that due to the support or absence of provincial legislation, there still remains space for more grassroots community based traditional midwifery in Ontario, Quebec and Nunavut. In the rest of Canada, however, others argue that this space is declining because midwifery has become increasingly associated with an accredited four year program at neighbouring post-secondary institutions that include aspects of Aboriginal midwifery (NAHO, 2004). At the same time, it is also thought that such programs at post-secondary institutions can create room for rather unique innovations.

In some instances, jurisdictional windows seem to be closing to greater involvement of First Nations traditional midwives. British Columbia has had a fully self-regulated college of midwives since 1988 through the *Health Professions Act* but only midwives who practiced on reserve before the Act are exempt. (NAHO, 2004). What does this

type of arrangement mean for future First Nations midwives in British Columbia who now might face subsumption into the self-regulatory processes of the provincial college of midwives? Particularly, as levels of subsumption into the provincial midwifery collective continues, what would exemptions look like for First Nations based on knowledge arising from traditional birthing practices?

Regardless of provincial jurisdiction the need for a National Organization for Aboriginal Midwives has been voiced by Aboriginal midwives to deal with their collective concerns.

Aboriginal midwives want an association that:

- validates traditional forms of Aboriginal midwifery;
- articulates concerns of Aboriginal midwives; and
- supports Aboriginal women who want midwifery services (NAHO, 2004).

Improving Health Outcomes

For Aboriginal peoples, it is important to see that improving maternal child health care outcomes is a multi-layered issue that touches many different aspects of a community's health, as well as acknowledging the social determinants of health (NAHO 2008).

Although multilayered, evidence in the literature does suggest that an increasing amount of contemporary success stories result from centralizing the role of the community in maternal health.

In mainstream medicine, technological advances in birthing and maternal healthcare, are implemented to improve health outcomes. During the 1600's and 1700's it was the development of scientific tools, particularly forceps, that helped alleviate major causes of

infant and maternal death due to obstructed labour or shrunken pelvises (Carr, n.d.). This appears to be a technological invention that can benefit all midwife/birthing activity. Nevertheless, for Aboriginal communities, sometimes with the imposition of Western technological advances there are sometimes good intentions with bad results. *Mothers Medicine and Midwifery* (Webber, 1992) explored the evacuation of James Bay Cree women to larger hospitals for the pregnancy –something not possible without the technology of rapid mobility. To say the least, the health policy was implemented as standard care for mothers by the Medical Services Branch of Health and Welfare Canada (Webber, 1992; Kioke, 1999). For communities that usually medically evacuate women for birth it was noted that women suffered from an increase of premature infant births and babies with low birth weights –even at maternal centers with very high standards (Smith, 2002). Thus, while certain technologies can be of benefit to the birthing process, this is not always the case.

Canada is currently facing a shortage of maternity care providers that grows more urgent by the year (Kornelson et al., 2005; Milne, 2001). The shortage impacts rural and remote communities the most and has resulted in an increased acceptance of midwives as appropriate care providers for low risk pregnancies (NAHO, 2008). Couchie and Sanderson (2007) reported that based on their study, Aboriginal maternity centres can safely manage low-risk births. Thus, for Aboriginal communities, this development provides opportunities for the restoration of midwifery and community births. (NAHO, 2008). In addition, with respect to overall maternal health outcomes, Skye (2010) notes that researchers (Couchie and Sanderson, 2007; Archibald and Grey, 2000) were also

able to show that training Aboriginal midwives to work in the community resulted in that training Aboriginal midwives to work in the community was shown to improve prenatal care, birthing experiences and overall community health and healing.

Also significant to improving health outcomes is the ability to strike an appropriate balance between the application of modern Western medical knowledge and the knowledge that comes from Indigenous medical systems. Global/international understandings about Indigenous versus modern midwifery seem to have implied undercurrents suggesting that the Indigenous versions are less skilled (WHO, 1998a). An Elder from Stoney Creek First Nation in British Columbia explained that modern medicine has for the most part taken over today. In the 1930's however, midwives used medicines for dealing with rituals.... 'they helped with the in-between' (Carroll and Benoit, 2001). In essence, training an Aboriginal person in a midwifery program that neglects to include traditional knowledge of birthing practices is not enough on its own to improve health outcomes associated with maternal health. Skye (2010) speaks to this issue saying:

“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 postpartum 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.”

Lastly, while an increase in Aboriginal midwifery, particularly in Canada, has been shown to positively affect the health outcomes of communities, it has been found that community support for midwifery is an essential factor to the discussion of bringing birthing back to communities (NAHO, 2008). While things like funding, infrastructure

and other components are necessary, without community support, the potential successes of a community based midwifery initiative will be compromised (2008).

Institutionalization and epistemological/philosophical differences

In the Euro-centric context, midwifery was institutionalized in the mid 1850's when the *Royal College of Midwives* in Britain was established as a response to maternal and infant mortality rate of approximately 500/100000 birth (Royal College of Midwives, n.d.). In a context where scientific knowledge regarding birthing was the new norm, midwives fought to access to this knowledge to curb infant mortalities.

The international definition of a midwife from the International Confederation of Midwives (ICM) that has been used in World Health Organization (WHO) documents is:

“A person who, having been regularly admitted to a midwifery educational program, duly recognized in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery. She must be able to give the necessary supervision, care and advice to women during pregnancy, labour, and the postpartum period, to conduct deliveries on her own responsibility, and to care for the newborn and the infant.” (ICM, 2011).

The definition appears to be arrived at primarily through epistemological notions of Euro-centric education models with no mention of traditional Indigenous midwifery practices. RCAP (Vol. 3, Chapter 3, 1996) notes that while global health organizations such as the WHO and Pan American Health Organization recognize that traditional medicine and healing are the main means of providing care to the majority (80-90%) of the world, their policy documents tend to treat such services as a stop-gap transitional measure until

adequate modern medical services can be provided to disadvantaged populations in developing countries.

While scientific knowledge/qualifications are something that European midwives have desired to implement, the same tactic does not necessarily apply to First Nations midwives. A self-regulatory process for First Nations midwives might look quite different and, for example, focus more on preserving, using and/or relearning various herbal remedies and ceremonies associated with natural birthing techniques. Some of these techniques might have long been forgotten in European societies because their notion of 'advancement' is most often associated with the influx of Western scientific knowledge and technology.

The *Kanaci Otinawawasowin* (Aboriginal Midwifery) Baccalaureate Program at the University College of the North (UCN) could be considered to be part of the trend towards institutionalization of the practices of First Nations midwifery. There is a minimum amount of Euro-centric education needed to enter the program (i.e. high school diploma or GED equivalent). The program is four years in length and contains a mixture of bio-medical and First Nations traditional instruction. There are, of course, issues that are cross-cut and are similar to both traditions but also those that are radically different (such as Cree language instruction and cultural camps). (UCN, n.d.). This 'blending' of Western and traditional techniques appears to be the direction that most First Nations midwife collectives are taking. There are benefits and drawbacks of 'blended' approaches. A benefit would be, for example, the ability for First Nations to more easily move between systems of modern western medicine and First Nations

medicine. A drawback might be that in delivering such ‘blended’ programs in an epistemological context of Euro-centrally designed institutions, one always runs into the risk that, over time, the traditional First Nations element of the midwifery program might be hegemonically displaced by mainstream midwifery.

Accreditation and Training

With respect to accreditation in discussions about First Nations traditional health and healing, some Elders from the Saddle Lake Cree First Nation offered insight into this issue during a circle dialogue (July 17, 2007) that I helped facilitate while I was working at NAHO. The following information is paraphrased from the conversation that we had about accreditation:

The Elders said that, “healers and their medicines are like a natural resource —like oil and gas— and protection of these community resources should be viewed in the same way.” They noted that accreditation is a particularly sensitive issue due to attempts to suppress First Nations culture, ceremony and healing traditions. Since this occurred in the not so recent past, it is natural that red flags would go up when ‘accreditation’ is mentioned since it is almost automatically associated with mainstream notions in modern Western health care. A primary issue of concern for them was *who is it* that is giving the so called accreditation?

Elders from Saddle Lake indicated:

- A concern about who would give the accreditation to traditional healers. “That information has to come out through the Elders themselves rather than governments” (Canadian or Band Councils).
- Today the newcomers are trying to know our medicines. Certain organizations give recognition to traditional healers, but this recognition still comes from government which causes a problem.
- With regard to medical doctors working with traditional healers, participants noted that it was important for the person to have their “heart in the right place”. Some people are just using it for profit and their own self-benefit. There is a great risk to the integrity of the medicine when a healing mandate begins to be driven by political or economic gains.
- Since the spirit of the original way is housed in the respective First Nations language, this absolutely needs to be taken into consideration when discussing issues or guidelines for any type of accreditation (Cree Elders ,talking circle, July 17, 2007).

With respect to accreditation that occurs internally in First Nations context of First Nations traditional health and healing, one Elder, during the same visit to Saddle Lake, shared a story with me as an example how healing knowledge was passed on to her:

A story was told of a two year old who a mainstream doctor said needed kidney dialysis in order to survive. The little girl had eaten some bad chicken and the doctor said the child would need kidney dialysis for the rest of their life. The distraught parents knew that the mother of the Elder I was talking to was a medicine person and thus, brought her

daughter searching for the woman. The healer was away, so the mother of the little girl spoke to the daughter who had worked with her mother helping her prepare the medicines throughout the years. She, thus, knew the medicines but, at the time, felt she had not enough experience in order to help people. Nonetheless, the situation called for immediate action so she agreed to prepare the medicine herself for the sick little girl. The little girl shortly thereafter recovered and did not need kidney dialysis like the Western medical doctor had indicated. For this Elder lady that I talked to, this was, for her, the beginning of knowing that she knew the medicine. She remembers the good feelings that occurred when she was able to help the little girl. Along with this came the validation and confidence that these traditional remedies taught to her by her mother are effective. (Cree Elder, Paraphrased personal communication at Saddle Lake, July 17, 2007).

The circle dialogue with Elders from the Saddle Lake Cree Nation about accreditation and traditional health and healing helps to set the stage for contemplating similar accreditation issues that Aboriginal midwives are facing. In the Canadian mainstream, the shortage of doctors and nurses in maternity wards has resulted in contemplating strategies designed to delegate greater responsibility in the process of birthing to midwives (Kornelson et al., 2005; Milne, 2001). This, in turn, has fuelled debates over issues of accreditation.

For Aboriginal communities:

“Current debate about appropriate legislation, educational requirements, models of training, registration, licensing and questions concerning safety issues and

financial costs must include Inuit, Métis and First Nations women who have a vested interest in any outcome or decision” (NAHO, 2004, p. 4).

Essentially, for Canada’s Aboriginal population, the issue of who determines that someone is qualified to be a midwife is an important one (NAHO, 2008). Traditional Aboriginal midwifery practices cannot be validated by the modern Western medical systems because the knowledge is contained within Aboriginal communities. Some Aboriginal midwives prefer to be exempt from regulations of mainstream midwifery because they believe that the sacredness and safety of birth is supported by Indigenous knowledge about the life cycle and healing. The *medicalization* of childbirth is seen by some Aboriginal midwives (and communities) as simply another manifestation of colonialism (Benoit, Carroll and Eni, 2006; NAHO, 2008).

Other Aboriginal midwives choose to work with the Midwifery Colleges in their respective provinces. This ‘integrative’ environment combines traditional and contemporary midwifery practices (NAHO, 2004). Through partnering with midwifery programs offered in universities, these midwives graduate with credentials that are more comprehensively recognized by mainstream health regulatory bodies. Thus, they “enjoy the flexibility, portability and financial rewards of an accredited health profession” (NAHO, 2008, p. 43).

For Aboriginal midwifery in Canada, the accreditation issue is one that is still very much up for debate. Aboriginal midwives who choose to practice outside the Provincial Colleges of midwives know their traditional life-cycle knowledge is valid and accredited. Nonetheless, it still may be more difficult for their practices to be accepted by the mainstream medical settings. Indeed, it is safe to say that in the eyes of Canadian

society as a whole, it is the provincial Midwifery colleges who are responsible for deciding who and who are not accredited. These are the credentials that are most easily recognized as valid by doctors, nurses, hospitals, insurance companies, etc.

More needs to be clarified around the issue of accreditation processes in Aboriginal midwifery to ensure that the right credentials are given and supported by the right people. Regardless of this, one thing is clear: Aboriginal women across Canada have made strides towards reclaiming their position in their communities as accredited 'givers of life' (Skye, 2010; Carroll and Benoit, 2001). Further development of community based midwifery training models designed by Aboriginal communities could play a significant role in helping to sort out the accreditation issue. Recent transitions of many First Nations to community controlled health care are providing more solid and supportive ground for such models to be developed (Skye, 2010; Van Wagner, 2004; Carroll and Benoit, 2004).

For Aboriginal midwifery in Canada, the design and implementation of training methodologies is an area that continues to require increased attention. Where there is community support, many are looking at ways of developing training models that are best suited to the current infrastructures and capacities of their home communities (NAHO, 2008). There are four main Aboriginal midwifery training programs in Canada today (2008). Ontario and Québec, both have community based training programs where First Nations apprentice midwives can learn from practicing midwives at local birthing centres in the community. The other two programs which are affiliated with university degree programs are located in Manitoba and Nunavut (2008). In each of these cases, midwifery

education and practice are inextricably linked and all programs have both these components.

At least in Ontario, there have been some misconceptions about differences between the Aboriginal midwifery training models versus registered ones supported by College of Midwives. Julie Wilson, Director of *Tsi Non:we Ionnakeratstha Ona:grahsta* (the Six Nations Maternal and Child Centre of the Six Nations of the Grand River) notes that practicing under a First Nations controlled midwifery model is about choice and autonomy:

It's an issue of not having to be regulated by a government College of Midwives, by not having to be told how you're going to practice or.... some outside government body to create your policies, your procedures, to provide really definite direction into how your going to provide care to your people. The women who practice here at the Centre, they believe that it's our right as Aboriginal people to provide care to our own community members. They're the ones that direct and guide us on how we should practice and provide midwifery care. It's not an outside body.... We are Aboriginal midwives because we choose to practice under the Aboriginal midwifery model and we choose not to be registered. It's definitely not a lesser than model.... It's a model that works for our people and our community and we believe it's a superior model for Aboriginal communities (NAHO, 2008, p. 43).

The Six Nations midwifery model and training program continues with great success while choosing not to affiliate themselves with university programs or the College of Midwives. They feel that, currently, such partnerships could compromise the integrity of their life-cycle teachings and interfere with the passing of this knowledge to younger generations of midwives. There is a current, and understandable, awareness that these types of affiliations with mainstream institutions are not safe and could eventually result in subsumption of their model into mainstream ones –where the wrong people might

become responsible for falsely granting accreditation for their Indigenous Knowledge about maternal health.

Community Inter-connectedness and Spiritual Gifts

Something that is unique to processes of healing in First Nations medicine (including traditional birthing) are particular inclusions and expressions of spirituality or spiritual power. In Sandra Kioke's study of traditional birthing amongst the Attawapiskat Cree (1999), several indications of spiritual sensitivity were commented upon by research participants. For example, women were known to have exceptional or instinctual ways of 'knowing' through their breasts. Any woman in the community could experience this – which would now be considered to be an unusual ability. For example, if she breastfed with the left breast, she would be able to know that someone isn't happy or someone was sick at a distance. If she experienced a feeling in the right breast, she knew a person was feeling okay (Kioke, 1999). Other participants noted that it was not just women who breastfed that experienced this.

Dreams and visions were an important part of what Kioke (1999) refers to as the *holistic family*. Spiritual power /exceptional gifts came to certain people in the community while it did not come to others. Those with special power were considered leaders (or potential leaders) and were able to help guide others into the future. The aspect of community recognition of spirituality and/or spiritual power is an important distinguishing component of First Nations midwifery practice in particular and First Nations traditional health and healing in general. In my opinion, this type of recognition has not changed much for identifying gifted practitioners of First Nations medicine within communities.

Summary

The literature clearly reflects the difficulties in arriving at definitive definitions of traditional First Nations self-regulatory health processes in a post 'jagged-worlds colliding' environment. What the literature review gives us is material that can be used towards the development of a context(s) where we are able to think about and discuss this wide ranging issue. While some concepts in First Nations self-regulatory processes appear to have the ability to be paralleled in the mainstream (such as codes of conduct), other elements within Indigenous healing systems continue to remain 'intangible' to the mainstream. The literature affirmed that: the First Nations methods of traditional healing that we see today continue to use the healthcare knowledge that has been passed from one generation to the next; and that in contexts of Indigenous health and wellness, understandings about the nature of self-regulation are embedded in the processes that accompany these types of traditional health practices.

At the same time, in contemporary health care environments that can sometimes involve a cultural/professional dialogues with the West, First Nations are contemplating self-regulation and traditional healing in community health programming that offers both mainstream and traditional health services. In particular, the literature on First Nations midwifery provides a practical grounding for discussing self-regulatory processes in these more 'harmonized' environments.

In general, while there continues to be a resistance amongst First Nations traditional healers to entertain any form of outside or parallel regulatory processes, some (like

factions of the Navajo) have embraced the idea of formalizing self-regulation and have used it to move some of their community's concerns (e.g.: health, environment, human rights, etc.) forward in the mainstream.

Many of the issues discussed in this literature review that surround self-regulation and First Nations traditional health and healing (like legal grey areas, efficacy of traditional medicine, institutionalization of tradition and authenticity) arise through a general failure in mainstream society to recognize the *non-universality* of the underlying patterns of thought contained in their Euro-centric worldviews.

Chapter 3: Conceptual Framework/Theoretical Approach

Overview

The purpose of the theoretical approach used in this thesis is to provide a lens through which one can potentially view various nuances that arise when considering self-regulatory processes of First Nations traditional health and healing. In contemporary times –in a post ‘jagged worldviews colliding’ environment– these nuances could potentially span the spectrum of First Nations traditional conceptualizations of self-regulation to mainstream ones. Particularly in generalized contemporary First Nations community health programming, there is often a mix of concepts (from First Nations traditions and mainstream health care) used to formulate a self-regulatory process.

In an attempt to accommodate this broad spectrum, two theoretical components, ethnogenesis and professionalization theory with cultural safety, are explored –and explained– below. In addition, it is also explained how these two components, when put together, create a context of analysis for the theoretical approach taken in this thesis.

Ethnogenesis

Processes of self-regulation are partly addressed in this thesis through a theoretical lens of ethnogenesis. Ethnogenesis, as generally defined by the Oxford Dictionary, is the formation or emergence of an ethnic group (Oxford, n.d.).

Ethnogenetic theory was first popularized by Russian scholar Lev Gumilev who lived from 1912-1992. Gumilev rather extensively examined the presence of ethnic groups and

interactions and conflicts between different ethnic groups, (primarily Europe and Asia) in a context made up of historical, geographical, psychological and philosophical elements (Gumilev, 1979). In doing this, he arrived at a central concept in ethnogenesis called *passionality*. Gumilev defines the term *passionality* as a type of energetic driving force that results in the formation of a particular ethnic group and their activities (Epstein, 2006, p.194).

This driving element of *passionality* has been explained to be either *passive* or *active*, in the form of group markers accumulated over time or such as physical group separation or cultural revival (Neill, 2008, p. 3). For instance, the accumulated Indigenous knowledge of a particular tribe and how it continues to be passed from one generation to the next within its own epistemological context could be considered to be a *passive* ethnogenetic identifier.

As settler societies arrived in North America and interacted with Indigenous tribes, they required land bases and they also brought with them their own knowledge systems. These Euro-centric knowledge systems (religion, science philosophy, etc.) eventually were considered to be ‘universal’ and were therefore heavily promoted in Indigenous lands. This phenomenon could also be classified as ‘cultural hegemony’ –a philosophical and sociological approach articulated by Marxist Philosopher Antonio Gramsci (1985). Gramsci argued against this cultural hegemony saying that the prevailing cultural norms should not be viewed as ‘natural’ or ‘inevitable’ and that mainstream institutions, practices and beliefs should not be considered to be relevant in a universal sense (Emery, 2012).

Cultural hegemony put pressure on Indigenous groups to assert their own knowledge systems and demarcate physical land bases for themselves (i.e.: where new power relations caused Indigenous groups to think about the preservation of their own and imposition of other certain cultural values). This assertion on behalf of Indigenous groups in North America can be described as an *active* expression of ethnogenesis.

For example, many First Nations communities in Canada have decided to use Indigenous language names for their communities (which previously had English names). As an expression of active ethnogenesis, an Indigenous language identifier enables one to more accurately describe meaning in an Indigenous context. While this project is by no means one of linguistic analysis, it recognizes that an Indigenous language is a 'doorway' to the worldview and knowledge possessed by an Indigenous group and is thus, important to the cultural cohesion of a tribe.

Whether considered a passive or active expression of ethnogenesis, it is fairly clear that, throughout time, all cultures go through changes. How they continue to make decisions in choosing to adapt or not adapt to new situations can play a significant role in how they endure the presence of the hegemonic forces that emanate from other cultural groups.

In Indigenous South America, there is overwhelming evidence that a synthesis is beginning to crystallize around the concept of ethnogenesis (Swartz and Salomon, 1999; Hill, 1994; Whitten, 1976; Ogburn, 2008). Hill (1994) notes that, at least in lowland South America, an ethnogenetic/dynamic view of cultures is starting to replace older theories that 'preserved' and discussed Indigenous societies as artifacts of the past. For

Hill, this synthesis has the potential to improve Indigenous policies on Indigenous lands, human rights and health in Lowland South America (1994). For example, from an ethnogenetic perspective, in the South American lowlands, what was once previously perceived –through lenses of western biology and ecology –as a ‘natural ecosystem’ devoid of people may, in reality, not be so at all. Through acknowledging an ethnogenetic process as a context, which necessarily contained various elements of Indigenous knowledge systems, environments previously defined as ‘natural ecosystems’ are now being perceived as ‘managed forests’ that, to some degree, resulted from past activities of Indigenous people (1994). In other words, in opposition to the *terra nullius* argument utilized by the Catholic Church, people were on the land and interacting with it (using their own knowledge systems) before the arrival of colonial societies.

As a theoretical concept, ethnogenesis has not been applied nearly as much to First Nations and Native Americans (and is entirely new as it is applied to First Nations systems of traditional health and healing). Nonetheless, there are some examples worth noting.

Linda Matt Juneau’s thesis, *The Small Robe Band of Blackfeet: Ethnogenesis by Social and Religious Transformation*, uncovers elements of an ethnogenetic process through an examination of a period of 100 years (from 1780-1880) of Blackfoot history. Juneau notes that within the Blackfoot Confederacy, the disappearance of certain ‘sub-tribes’ or ‘bands’ within the Confederacy (like the *Inuck’siks* or Small Robe Band) from many history books was sometimes matter of survival. For the Blackfoot, in the 1800’s, revealing their tribal name to a soldier or government official could often point to a

favoured geographical location or result in other types of scrutiny. Thus, Juneau indicates that people would 'secretly' remember their respective band while not forgoing any information that might have resulted in harming their people.

Disappearance of certain 'band names' within the Blackfoot confederacy became a form of underground resistance to the occupiers of the land (Juneau, 2007, p. 32). For the *Inuck'siks* band of Blackfoot in particular, Juneau notes that, in addition, their populations were significantly decreased due to smallpox and an intense war with the Crow people in 1845. During this time many captured *Inuck'sik* Blackfoot were, over time, integrated or 'fused' into Crow society.

Juneau notes throughout the thesis how the oral tradition of the Blackfoot Confederacy remained relatively intact through periods of war, disease and encroachment by European settlers (2007, p. 25). He states, "... important cultural meaning embodied in 'living' medicine bundles and their accompanying ritual processes continued to be transmitted to people who sought to maintain their relationship to important powers and beings that transcended the human realm" (p. 22). For the Blackfoot, most people approach a 'bundle holder' for health and healing on behalf of a sick person. When the person regains health, a feast is held on behalf of the animal(s) represented in the bundle and gifts and payments are given to the bundle holder (p. 38). As an example, Juneau notes that during the 100 year period of her study, when genocide and disease that was occurring, most Blackfoot bands refused to hunt beaver (a much sought after trading commodity by the Europeans) even when it was plentiful in their territory because the beaver bundle was particularly sacred to them.

This example illustrates how the ethnogenetic process is seen as such because the seed decisions and adjustments made at the core of a process (which in the case of Juneau's research, are the spiritual, mental and physical aspects of First Nations medicine) managed to be passed on to subsequent generations. In the Blackfoot (or in other Indigenous) universe(s), we might say that how one relates to natural and spiritual forces with respect is included among the fundamental elements that make up ethical and moral conduct (p. 36).

Gregory E. Smoak reveals similar observations in parts of his book, *Ghost Dances and Identity: Prophetic Religion and American Indian Ethnogenesis in the 19th Century* (2006). During post-European contact, Smoak (2006) notes, that in part, the pan-tribal introduction of the Ghost Dance ceremony by Nevada Paiute Prophet Wovoka contributed to the strengthening of a shared Native American identity (6). Smoak notes that it was deep cultural practice (including kinship and Native American spirituality) that provided the means to make sense of the new challenges faced upon the arrival of Euro-centric peoples and their ideologies. Generally speaking, connections maintained by communities (and individuals within these communities) to Indigenous knowledge systems helped to sustain a *passive* ethnogenetic process while using this to strengthen shared ideas of Native American Identity (through the Ghost dance) promoted an *active* one. In contemporary times we can note that ceremonies that have been shared inter-tribally (like the Sweatlodge or the peyote ritual) also help provide meaning to a 'Native American' or 'First Nations' identity and contribute to the sustainment of Indigenous ethnogenetic processes.

In a final example of expressions of ethnogenesis amongst an Indigenous North American group, we can refer to the principles contained within the *Kaswhenta* (Two-Row Wampum belt) of the Haudenosaunee people. The Haudenosaunee are comprised of six Nations of people who apply sophisticated yet simple diplomatic principles in their dealings with other Nations. These principles are conveyed and reiterated in a visual and tactile way through Wampum Belts (Akwasasne: Kaswhenta, n.d.).



The Kaswhenta (Akwasasne: Kaswhenta, n.d.).

The *Kaswhenta* in particular embodies principals of peace, friendship and mutual respect. In an *active* ethnogenetic sense, from the time of the first newcomers onward, these principles formed the basis of numerous treaties and agreements between Haudenosaunee and non-Haudenosaunee nations including the Dutch, French, British and Americans (Akwasasne: Welcome Page, n.d.).

It is two rows of purple wampum, this wampum being quahog (clam) shell – this is the purple part of the shell. This is on a field of white. The purple lines represent the Haudenosaunee travelling in their canoe. Parallel to them, but not touching, is the path of the boat of the Europeans that came here. In our canoe is our way of life, our language, our law and our customs and traditions. And in the boat, likewise are the European language, customs, traditions and law. We have said, please don't get out of your boat and try to steer our canoe. And we won't get out of our canoe and try to steer your boat. We're going to accept each other as sovereign – we're going to travel down this road of life together side by side. (G. Peter Jemison Faithkeeper, Cattaraugus Reservation, Seneca Nation, Public Broadcasting Service, n.d.).

The *Kaswhenta* is a treaty of respect that uplifts the dignity and integrity of each other's nation and stresses the significance of non-interference of one nation in the business of

the other (Kaswhenta, Akwesasne, n.d.) These principles are still being effectively utilized in similar ways by Haudenosaunee Nations today. For example, the Cayuga Nation of the Haudenosaunee invoked *Kaswhenta* principles of respect, non-interference and open dialogue in their collective statement on global climate change at the 14th annual Indian Nation Leadership Meeting, November 18-19, 2009, Syracuse, New York.

Part of the statement reads:

Because of the Haudenosaunee's long history in standing up for Indigenous Rights, and because of the critical importance of protecting these rights while working to combat climate change, we stand ready to work with other Indigenous Peoples and with the nations of the world on these issues. We do so in accordance with the principles of non-interference and open dialogue confirmed by the 2 Row and handed down to us in our Great Law. (Haudenosaunee Environmental Task Force, 2010).

In a *passive* ethnogenetic sense, origins of *Kaswhenta* and other wampum are woven into the story of the Great Peacemaker who inspired the unification of the six Nations long before the arrival of Europeans (Johansen and Pritker, 2008). Thus, deeply rooted in the Indigenous knowledge systems of the Haudenosaunee, *Kaswhenta* is a grounded life teaching that has a long history of application towards the building of respectful relationships between communities internal and external to the Haudenosaunee Confederacy. Through mentioning the *Kaswhenta*, we are, in a sense, conveying the great importance of giving life to its principles (such as respect, integrity, peaceful co-existence, etc.) through our actions and in our relationships.

Across a broad scope, applying the lens of ethnogenesis can aid in considering different types of nuances and/or meanings of self-regulation in First Nations traditional health and healing. In its *active* sense, a process of ethnogenesis (due to such occurrences as hegemonic forces being fueled by such things as over-promotion of the modern western

medical model) could be seen as eventually resulting in First Nations healers and First Nations communities contemplating and asserting enhanced self-regulatory measures around traditional health and healing informed by their own respective cultures and traditions. In its *passive* sense, ethnogenesis addresses the issue of self-regulation amongst First Nations traditional health practitioners in that it refers to a process that continues to be directed and maintained by the appropriate knowledge keepers in the community – rather than political, academic or self-appointed spokespeople.

In contemporary contexts, a positive self-regulatory/ethnogenetic case would be one where First Nations/Indigenous traditional healing is able to retain its effectiveness and use in modern First Nations communities. These recognized ‘gifted’ and knowledgeable people in First Nations communities are the ones that have possession of –or access to– Indigenous Knowledge (e.g.; medicines and ceremonies passed down through oral traditions, dreams, visions etc.). As Kioke (1999) noted in the previous chapter of this thesis, spiritual power did not come to everyone in a community and these people who were able to access this plane of power were often placed in positions of community leaders. Today, this may or may not be the case. Since first Nations traditional healing systems are holistic –and includes physical, mental and spiritual components– the people best to take the lead in any self-regulatory process of First Nations traditional health and healing would be those who hold necessary pieces of Indigenous Knowledge needed to ensure components of First Nations medicine remain intact and are effectively passed on to future generations.

As a theoretical approach, ethnogenesis seems to be appropriate for this thesis because it provides some workable ways of thinking for a contemporary discussion of self-regulation among First Nations healers. This thesis is in favour of strengthening systems of First Nations medicine in our present times and the approach remains flexible enough to allow space for further exploration of First Nations holistic conceptualizations about health.

Professionalization and Cultural Safety

The second theoretical component of the thesis is one which postulates the importance of having ‘external support systems’ where ethnogenetic processes have occurred (or are occurring). That is, when the ethnogenetic process of bringing First Nations traditional health and healing forward is occurring from *within* a First Nations community, proper supports from *without* could be additionally helpful (e.g.: design of institution spaces, appropriate payment systems, respect for and implementation of cultural protocols, harmonization of First Nations and western medical approaches to medicine, etc.). Importantly, for this harmonization of ethnogenesis and professionalization/cultural safety to occur in cultural hegemonic contexts, forces such as compassion, mutual respect and trust should also be at play.

The word ‘professional’ is used quite intentionally in this study to illustrate some of the work that needs to be done when using this kind of mainstream lexicon in reference to the practices of Indigenous healers. Indigenous healers exhibit ‘professionalism’ in that it is they who *are* the experts in what they do in their respective Indigenous systems of health

and healing. Nevertheless, there are many assumptions that come along with what it means to use the word 'professional'. For example, in the field of medicine, schools, offices, hospitals and salaries in a wage economy are things that immediately come to mind. The problem is not necessarily about whether or not First Nations communities should decide to use the term 'professional' with respect to the services provided by traditional healers. The problem lies in how this term can be informed and defined by Indigenous healers, Elders and those that work with them.

Upon examination of mainstream professionalization literature, it was found that it does not particularly allow for a direct addressing of First Nations situations because it does not examine conceptualizations of cultural safety. Thus, for this research project, relevant examples are taken from professionalization theory (examined in its non-hegemonic/non-mainstream sense) as they relate to theories of cultural safety. Cultural safety illuminates professionalization in contexts that are particular to Indigenous medicine. Implementations of cultural safety components have proven to be key elements in developing realms of professionalization in many Indigenous communities.

In the mainstream, when a group of people 'professionalize', there are certain realities that accompany this process. Dixon-Woods (2007) offers a viewpoint from associations (in this case the medical sociologists in the United Kingdom) that have considered professionalizing. Maintaining a coherent professional association could enhance a sense of community and assist in marketing particular skills. On the other hand, what usually accompany many mainstream processes of professionalization are increased levels of bureaucratization and formalized governance (Dixon-Woods, 2007). One has to decide

whether or not they want this type of ‘added structure’ and the associated economic costs that are required to maintain the professional association. Some of these measures are (or would be) undoubtedly necessary if First Nations communities explore the possibilities of engaging their healers in jointly determined medical systems. Some of the ‘added structure’ that could accompany professionalization may be practical and necessary, while other parts could simply represent tedious obstacles. For the use and practice of First Nations traditional healing in complimentary healing environments, a challenge appears to be figuring out what type of ‘added structure’ is necessary and what is not.

Another challenge lies in the fact that determining an appropriate model for delivery of First Nations health and healing can vary from region to region and even from community to community. Morgan (1998) notes that sociologists have only recently recognized that, depending upon which jurisdiction they reside in, professions can evolve in different ways. In the UK, for example, professionalization evolved ‘bottom up (through activities of professionals). In Germany, on the other hand, professionalization occurred more often through a ‘top down’ process due to state interaction (1998). The point to be made here that is applicable to First Nations is that governments do not have to standardize ‘professionalization’ and believe that it always has to occur in a certain way. We can afford to be creative in designing ‘what works’ in a particular environment. For First Nations, employing cultural safety mechanisms may be helpful in addressing this phenomenon.

In some cases, researchers have noted that further professionalization is not always the way forward. In the mainstream, long held notions of professionalism have become

increasingly open to challenge in contemporary society. Dent and Whitehead (2002) suggest that loss of faith; trust and a sense of increased perception of risk in social arenas are helping to shape modern day professionalism. They also postulate that professionals have no escape from being managed (or from managing others). These powerful discourses of accountability and efficiency that accompany professionalization give rise to discourses of resistance.

Since professionalization can result in a creation of distance between workers and those who they serve, there can be an identifiable strand of reluctance towards moves to professionalize (Banks, 2004). For First Nations communities, where cohesiveness of families and communities are among the core values, similar resistances to strongly held mainstream conceptualizations about professionalizing First Nations medicine are also likely to occur.

The formalization of relationships that accompany professionalism is something being challenged in other mainstream circles as well. For example Schmidt (2001) notes that apprenticeships and other relationship-based methods of skill transfer are becoming replaced by formal and automated methods associated with institutions. In replacing personal relationships with financially regulated ones, the resulting sacrifice is that professionalization can weaken friendships, dilute altruistic activity, sharing and other things that tend to make up a healthy community (Schmidt, 2000). Whenever this occurs, we move closer to a world in which money, not love, becomes the central motivating force (2000).

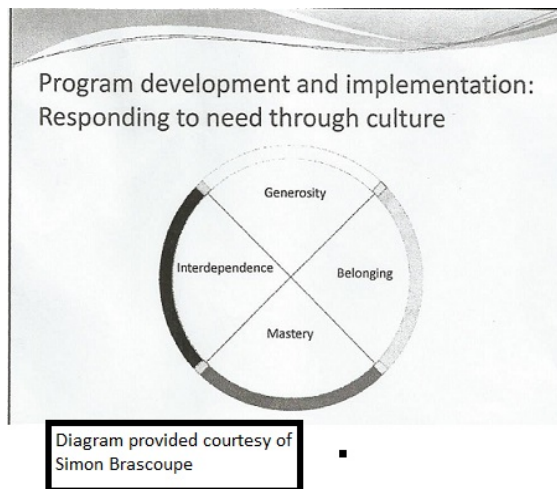
At the same time, in First Nations contexts, First Nations traditional health practitioners *are* ‘professional’ in what they do – in the sense that they are the experts. We would not want them to be regulated to a realm of ‘amateurs’ in contemporary environments of professionalism where ‘amateurs’ are constantly being replaced by professionals.

Part of the way that certain mechanisms of professionalization have been expressing themselves uniquely in First Nations communities –and indeed in Indigenous communities worldwide– is through a lens of cultural safety. To some extent, cultural safety has served to buffer some of the (what might be considered harsh) realities of professionalized environments in our contemporary world. In the Indigenous context, concepts that promote models of cultural safety have often been used in professional environments.

Cultural Safety is a nursing concept that was developed in New Zealand. The concept continues to be practically applied within Maori healthcare (Wepa, 2005). It puts forth the idea that to provide quality care for people from different ethnicities, nurses must provide care within a context of cultural values and norms of the patient. The concept has spread around the world and to other fields of human services, such as education. A growing and promising body of literature that demonstrates a link between cultural safety and healing methodologies could provide a base of indicators of First Nations community health or risk (Brascoupé & Waters, 2008).

The definition of cultural safety is an evolving one (NAHO, 2006). While it is valid to consider that cultural safety may not be particularly useful beyond the context of nursing

in which it was developed, the originator of the concept of cultural safety, Maori nurse and educator Irihapeti Merenia Ramsden, meant for cultural safety to be a ‘big picture’ concept that encompasses broad political issues common to Indigenous people including notions of citizenship and sovereignty (Brascoupe & Waters, 2008). As an example, Algonquian/Haudenosaunee Carlton University professor, Simon Brascoupe indicated in a personal conversation that Elders who work with the Wabano Health Centre in Ottawa identified part of cultural safety in program development and implementation as fostering an environment of ‘belonging’ and where ‘one does not have to be afraid to learn more about, use and pass on their culture’ (S. Brascoupe, Personal Communication, March 22, 2013). These principles of cultural safety are reflected in the diagram below that Wabano uses for their program development and implementation.



It is still important to recognize here that the concepts of cultural safety, cultural competency and others were utilized originally in mainstream medical practice. In *Eradicating Essentialism from Cultural Competency Education*, Kathleen Fuller (2002) points out that trying to apply a concept such as cultural competency (one that recognizes

groups, cultures and the individuals within them are fluid) in an essentialist context (mainstream medicine) could result in cultural competency teachings that lead to a perpetuation of existing stereotypes. These types of pitfalls would be something to be aware of when applying cultural safety theory to real life situations.

For the subject examined in this research project, the concept of cultural safety should be considered as something applicable to both the ‘provider’ and ‘receiver’ of health services. Most of the cultural safety literature, it seems, still sees the ‘provider’ of health care flowing from Western modern medicine rather than First Nations medicine and does not really discuss instances where this ‘provider’ may be a practitioner of Indigenous medicine. That is, with respect to engagement with modern Western medicine, it is only the receiver of health services that requires greater accommodation. Thus, in First Nations contexts of traditional health and healing, it would also be appropriate, due to past marginalization, to develop effective strategies that would make traditional healers ‘culturally safe’ as well.

Thus, regarding the theoretical approach used for this thesis, concepts of cultural safety are combined with mainstream professionalism theory in order to grant potential for more genuine representation and inclusion of all aspects of Indigenous traditional health and healing in contemporary health contexts. Scholars state, “the quality and professionalism of healthcare providers cannot be compromised, but rather enhanced by cultural safety considerations” (Brascoupe & Waters 2008, page number unavailable). Considering professionalism and cultural safety together is, in a sense, what Linda Tuhiwai Smith (1999) means by reframing.

Reframing an issue means to make "decisions about its parameters, about what is in the foreground, what is in the background and what shadings of complexities exist within the frame" (Tuhiwai Smith, p. 153). Part of reframing might involve considering some or all of the several expressions of Aboriginal Knowledge that are outlined by Marlene Brant-Castellano (2000, 21-26). Brant-Castellano's categories of Indigenous knowledge include empirical and experiential knowledge which would be acknowledged by the community of mainstream medicine as 'scientific' and relevant. However, certain other categories of an 'expanded science' –such as revealed, holistic and sacred knowledge– are going to be found primarily in Indigenous contexts. Within the parameters of Indigenous health and wellness knowledge, reframing could mean that for First Nations, ensuring cultural safety could involve the creation of more spaces for gentle community re-education about healing traditions that were suppressed during various periods of European contact.

Ethnogenesis, professionalization and cultural safety: A synthesis

The overall theoretical approach of this thesis can be summarized as follows:

In theory, an ethnogenetic discourse involving First Nations knowledge keepers is a factor that results in the intergenerational transfer of tribal knowledge and successful adaptations of First Nations traditional health and healing into contemporary settings. Proposing a model of professionalism and cultural safety for First Nations medicine and First Nations healers without acknowledging ethnogenetic processes runs the risk, in my opinion, of being a rather empty structure. Such structures empty of the true spirit of First Nations traditional health and healing run the risk of being hegemonically

dominated by Euro-centric epistemologies and the paradigms of modern Western medicine. Thus, a proposed process that is primarily external is without positive meaning but an internal proposal can be legitimately supported by external translations and expressions.

On the other hand, if the ethnogenetic process occurs without these types of external supports, First Nations traditional health and healing could run the risk of its knowledge continuing to be misinterpreted, misrepresented and misunderstood by the mainstream – which can contribute to the erosion of knowledge. The *Ese Eja*, an Indigenous Amazonian community existing on the border regions of Peru and Bolivia exemplify the reality of these types of risks. Throughout history, the *Ese Eja*, being a border region community, were caught between the Euro-centric nation forming forces of both Bolivia and Peru. In contemporary times Peluso and Alexiades (2005) indicate that one way the *Ese Eja* survive is through contact with the environmental industry. The authors note that ‘environmental’ companies – who promote such things as eco-tourism, conservation and sustainable development projects –take advantage of the *Ese Eja* to authenticate their own environmental agenda. For example, with respect to eco-tourism, traditional knowledge is strategically edited and repackaged based on its appeal to the curious tourist. This same edited version of Indigenous Knowledge is then channeled back to the *Ese Eja* community through a lens of ‘cultural revitalization’ or ‘cultural preservation’ programs (Peluso and Alexiades, 2005, pp. 6-7).

Without mechanisms of cultural safety in place to buffer business agendas, companies and bureaucracy appropriate the Indigenous voice for their own economic benefit. The

authors further note that these types of activities sustained by the environmental industry have a negative effect on the *actual* knowledge systems the *Ese Eja* people that sustain the ethnogenetic process. For example one young *Ese Eja* man indicated:

I ask my father to teach me *Ese Eja* but he says nothing.
If someone from far away, like a “gringo,” asks him something,
then he shows them things. Suddenly my father
speaks *Ese Eja*. With me, he can’t be bothered (p. 8).

Both of these components –ethnogenetic self-regulatory processes from within and environments of professionalization that are culturally safe from without– are considerations in support of other continued efforts to support First Nations traditional health and healing and bring it forward for future generations.

Chapter 4: Research Design

Overview

The overall approach to the research design applicable to this thesis is best described as *exploratory*. Generally speaking, exploratory research is a common type of research that is used when determining directions for further research. The goal of exploratory research is “the production of inductively derived generalizations about the group, process, activity or situation under study” (Stebbins, 2001, p. 6).

The research is exploratory because there is no underlying or beginning hypothesis that posits a singular solution for defining self-regulatory processes in First Nations traditional health and healing. However, this type of exploratory research helps to lay foundations for the future formulation of hypotheses for related research questions (Panneerselvam, 2004, p. 6). As indicated in the introductory paragraphs of this thesis, expressions of mainstream self-regulation in health care may not necessarily translate well into other systems of health care that exist in other cultures/knowledge systems. In this respect, there is very little known, especially by the more mainstream factions, about self-regulatory processes that apply to First Nations traditional health and healing. At the same time, this by no means indicates that there is no order amongst practitioners of First Nations traditional healing. For example, ‘codes of conduct’, although not formally expressed like in the mainstream, may often be inherent within the processes of training new healers where the experienced healer guides the development of healing gifts within the trainee.

Although exploratory in nature, an underlying assumption of the research design is that it should be congruent with the inherent right to self-determination amongst different First Nations communities –meaning that every First community should, if they so desire, have the choice to use and/or develop models of self-regulation in tradition and healing to fit their purposes. Additionally, the research was not conducted to ‘explore’ or expose any of the secrets of First Nations traditional healing and/or medicines. Rather, a goal of the research was to explore what can be done to strengthen and develop Indigenous healing systems in the present and into the future. Thus, in the historical shadow of repression of this science, contemporary activities which involve an engagement with expressions of First Nations traditional health and healing should ideally be undertaken in supportive environments that strive to protect and respect the Indigenous health and wellness knowledge on which these systems are based.

To explore the question of what self-regulation might signify in First Nations contexts of traditional health and healing, this project considered the following **four** guiding elements in its research design:

Firstly, the core contribution is an analysis of self-regulation and traditional health and healing. This analysis is based on a review of the literature (written and oral) in concert with key informant and focus group interviews conducted amongst a wide range of people (e.g.: Elders, healers, administrators, program managers and others) from three First Nations communities in Canada, an Aboriginal Organization, and a mainstream health regulatory association. Specifically, it includes:

- a) exploring the example of First Nations midwifery,

- b) discussions with community members at Akwesasne –all of whom worked in some area of health service;
 - c) discussions with traditional healers at Elsipogtog First Nation;
 - d) a discussion with a person who was involved in the development of the Aboriginal Healing and Wellness Strategy (AHWS) in Ontario; and
 - e) A discussion with a representative from the Health Professions Regulatory Advisory Council (HPRAC) in Ontario.
- a) First Nations midwifery has, in recent history, made a resurgence with practices that tend to integrate traditional First Nations women’s roles with mainstream midwifery qualifications. Without diminishing this step forward, an interest here is what aspects, if any, of Indigenous methodologies were sacrificed – and what were not – in order to have First Nations midwifery recognized as a legitimate practice in Canada? In addition what are the implications for cultural safety in relation to concerns about subsumption into the Canadian Association of Midwives? Finally, what components of the practice today are reflective of First Nation traditional birthing practices?

The example of self-regulation in First Nations midwifery was explored by: a literature review of First Nations midwifery (Chapter 2); and an exploration of the alternatives to the subsumption to the Canadian Association of Midwives through key informant and focus group interviews with midwives, support staff and associated Elders from the *Tsi Non:we Ionnakeratstha Ona:grahsta* (Maternal and Child Care Centre, Six Nations Ontario).

b) Akwesasne's integration of First Nations traditional health and healing into their health department as well as their social services department is presented through key informant interviews and focus group sessions with select community members. Many of these members were involved in processes which resulted in traditional medicine programs and traditional healers becoming more embedded into the delivery of their community health services.

c) The discussions with healers at Elsipogtog First Nation for this particular thesis project were **not** conducted from within any contexts associated with the formal structures of health services in the community (i.e.: the Elsipogtog Health and Wellness Centre). This is significant because interviewing healers and Elders in a more non-formal setting led to discussions about aspects of self-regulation processes in traditional health and healing that may have not been voiced in more formal contexts (such as an office or within the confines of funded health programming that includes traditional healing agendas). For example, spiritual elements to healing such as the importance of traditions of fasting and rites of passage ceremonies were among the several 'healer centred' aspects of self-regulation discussed. It should also, however, be noted, that the healers interviewed were often called upon to work in concert with various aspects of health delivery in the community. For this reason, permission to conduct interviews in Elsipogtog was received from the Elsipogtog Health and Wellness Centre (Appendix B). Also of note, past health research projects that this researcher has been involved in at Elsipogtog did involve a more robust engagement of people associated with the more formalized health structures of the community.

d) Consultation with a central representative that was involved in the AHWS formative processes was considered important in order to gain some insight on the role that Indigenous based strategies and organizations can play in the development of self-regulatory processes. In this case, these types of developments have been used in actualizing the delivery of traditional healing services to First Nations community members in Ontario through the vehicle of community health programming.

e) Finally, discussions with a representative from HPRAC was regarded as important to the study in order to further clarify the differences and similarities that exist between instances of First Nations self-regulation in traditional health and healing and the self-regulatory processes that are currently in place for mainstream health professionals.

Second, based on an analysis of the collected research data, the intention of this research project is to present a consensus view of the people interviewed in the key informant interviews and focus groups. Questions used to stimulate discussion amongst the project participants concerning self-regulation and First Nations traditional healing were generally based on the clarification of themes/issues discovered in the literature review.

Some examples of discussion questions include:

- How do Indigenous healers regulate themselves? What internal self-regulation mechanisms have been successful and unsuccessful, and why?
- How should ethical issues (e.g.: scientific and legal evaluation of First Nations medicine, biopiracy, declining biodiversity) be addressed?

- How can modern mainstream institutions (academic, government, western medical system, etc.) support the development of First Nations medicine?
- How do healers maintain the integrity of their practice in an increasingly corrupting environment (e.g.: mainstream temptations of large amounts of money for even delivering the promise of healing)?
- Can access to healers by First Nations communities be improved if Indigenous self-regulatory bodies were to interface in a more direct way with the mainstream health system?
- What are some of the obstacles to maintaining the cohesiveness of the holistic nature of First Nations medicine in contemporary contexts?
- Followers of mainstream ‘New-Age’ movements continue to exploit Indigenous traditions and spirituality claiming false credentials and misleading clients for commercial gain. Are self-regulatory Indigenous bodies responding, if at all, to this phenomenon?

A full list of discussion questions and focussing probes developed for this thesis project can be found in Appendix C.

Third, based on the literature review, theoretical framework and analysis of the research data, it was decided that a framework of First Nations self-regulation with respect to traditional healing needed to be identified in order to properly present the results (Chapter 5). The representation attempts to clarify some of the general differences among currently existing arrangements and situations in First Nations communities. In acknowledgment of the fact that there may be many approaches to First Nations self-

regulation in traditional healing and First Nations health care, discussions relating to this model are not intended to be exhaustive and/or definitive but, rather, relevant examples that might shed some light on current circumstances of First Nations in Canada. The resulting model is very much tied to data gathered during the conducting of field research for this thesis. While it is hoped that some of the principles identified in this thesis can be useful for First Nations who are contemplating similar issues, the reality of proposing any type of definitive model for all First Nations is beyond the scope of this thesis. The cultural and linguistic diversity that exists among First Nations in Canada is simply too vast to make such wide-ranging claims.

Fourth, although the scope of this PhD project is limited for the reasons discussed above, there is value in applying the findings to the larger discussion about self-regulatory themes and their significance to Indigenous health and healing (Chapter 7). It was also considered important to present the research findings in a more succinct way that might resonate with First Nations and be more widely accessed by communities. To accomplish this, the issue and results are presented through a medicine circle model (Chapter 7).

In addition to these aforementioned guiding principles of the research design, the

remainder of

- this Chapter outlays: how I position myself as a researcher
- how I felt I became prepared for this type of data collection; and
- the data collection process and research methodology

Positionality of myself as a researcher

Although I did not grow up in a First Nations community, I am a mixed blessing person with Aboriginal ancestry. On my mother's side, my Indigenous roots reside within the Mi'kmaq Nation. I also carry Indigenous ancestry on my father's side of the family that originates in the south-eastern United States.

Since 1990, when I actively began to pursue a greater understanding of the traditions associated with my Indigenous roots, I have been privileged to be able to take part in several ceremonial and social rites that occur in First Nations communities. As a young adult, I was led back to understanding more about my Indigenous identity through several people from First Nations communities including, for example, Mi'kmaq Elder and pipe-carrier Gabriel Yellowhawk Marshall from Eskasoni First Nation whom I have known for almost 20 years. He is a very good friend of mine and was also a good friend to my late father. To my partner and I, Mr. Marshall is an uncle and will always be a part of our extended family. Gabe was one of the people who made me realize that I was very fortunate to grow up in the environment that I was raised in. He helped me to see that many the values that I grew up with are those that are described in traditional Indigenous value systems. Uncle Gabe and others like him, helped me to further reconnect to the knowledge traditions that accompany my Indigenous roots. He often has said to me over a cup of coffee, 'what I am passing on to you is the teachings of our forefathers (Grandmothers and Grandfathers) as they were passed on to me through my teacher(s)'.

In reality I know that I know very little about Indigenous knowledge. As I grow older, I endeavour to continue learning more about the traditional ways of our people and, to the

best of my ability, incorporate these good teachings into my life. For me, I do not see an end to this learning.

As an Indigenous person who does research, if and when I am called upon, I strive to use these research skills in Indigenous communities and organizations where and how they are needed. To the best of my ability, I have tried to represent Indigenous realities in this type of work. Like other Indigenous academics, I find the process of research and writing sometimes difficult because of the tensions that exist between Indigenous approaches to knowledge and Western ones. Métis/Cree Elder and Adjunct Professor (Trent University) Michael Thrasher described this tension one way by indicating that in First Nations communities the criteria for knowledge is preceded by the notion of becoming a better human being but for academic knowledge this is not necessarily the case. For instance, getting into medical school is weighted towards previous academic achievement in Western academic institutions but not necessarily on learning how to become a better person (e.g.: kinder, more honest, more respectful, less jealous, etc.) (M. Thrasher, Personal Communication, March 12, 2013).

Thus, insofar as how I situate myself in this research project, I recognized that there needed to be a balance but like all Indigenous scholars, acknowledged that –taking all things into account –decisions have to be made about how to best go forward. For example, in this thesis, the carriers of Indigenous healing knowledge and other First Nations community members are informing the issue of ‘self-regulation’ and traditional health and healing, yet the research and writing process also needs to conform with the general

parameters of a 'doctoral degree program' that is delivered in a mainstream academic institution.

In *Research is Ceremony*, Cree Scholar Shawn Wilson (2008) talks about this balancing act and argues that for Indigenous researchers, "...to be accountable to all our relations, we must make careful choices in our selection of topics, methods of data collection, forms of analysis and finally in the way we present information." (2008, from book description) I am of the same mind as Wilson and for this research project, "accountability to all our relations" is described further in the 'Indigenous Research Methods' section of this Chapter.

Preparation for Data Collection

I am indebted to the many people from First Nations communities (Elders, healers, friends, colleagues, teachers and acquaintances) that I have met throughout my life who have collectively helped me to understand some of the complex issues and basic protocols with respect to healing traditions in First Nations contexts.

An important point to be made here is that, while the protocol of offering tobacco to research participants was followed, this alone does not necessarily allow access to the types of information that was shared by people in this thesis. It is most important to get to know people on a human level rather than viewing them simply a 'research participant' that will respond to your questions simply because you followed the protocol of offering them tobacco. The research question and the ability to answer it evolved over numerous years of spending time, making friends and learning with Elders and traditional people.

As Elder, Michael Thrasher has told me, becoming part of a (First Nations) community requires 'a thousand cups of tea'. In other words, -in this kind of First Nations research context- it is necessary to become part of the environment you are interested in exploring.

For me it was important to be open to the fact that research questions, such as this one, are best developed in partnership with the people that the research pertains to. Not only is this a respectful way to move forward, it also allows the researcher to have a greater understanding of the nature of the research question. Thus, the research process was a dynamic where my understanding of the research question changed over the years based on the relationships that I was building with First Nations Elders, healers and other community members.

In the more immediate years, and as an example, from August 2005 to September 2009, I was employed as a Research Officer for the First Nations Centre (FNC) of the National Aboriginal Health Organization (NAHO) in Ottawa, Canada. Through this experience, I became very familiar with the several aspects of the First Nations health service landscape insofar as they relate to research. In addition, during this time I also made further valuable friends and acquaintances amongst First Nations peoples. This has also enhanced my ability to undertake a research study within research context of First Nations traditional health and healing.

My time spent at the FNC, helped me to become more robustly aware of the complex array of issues within the First Nations health field and I was able to build several relationships with Elders from across the country. I became aware of the importance of

community research principles such as Ownership, Control, Access and Possession (OCAP) when considering First Nations research data (). Generally speaking, OCAP involves implementing various mechanisms that ensure that a First Nation garners benefit from research that is conducted in their community. Part of this philosophy was developed at the FNC and the ethical principles of OCAP have become an essential part in community based research involving First Nations peoples and communities in Canada.

One principle activity at the FNC that has helped enable me to explore the primary research question I have undertaken is one that I helped to spearhead in 2006. On the FNC work-plan it was called The First Nations Traditional Healing Circle of Elders/Medicine People. This activity/event could be held one (if a larger initiative) to four times a year and was hosted in a First Nations territory. The intent of adding this recurring item to the FNC work-plan was to support the creation of an environment where traditional First Nations healers and/or Elders could come together and discuss needs and priorities related to traditional health, healing and related knowledge. Through experience, what had proven to work best in this type of research was to attend and/or help to support an already planned or occurring activity (in a First Nations community) related to traditional health and healing. Thus, the FNC obtained permission to attend and/or partially support a community event and then, sometime over the course of that event, discussions with Elders/healers occurred in order to gather some pertinent information.

From September 17-24, 2006 the inaugural *Traditional Healing Circle of Elders/Medicine People* event took place in Mi'kmaq traditional territory at the Elsipogtog First Nation in New Brunswick. The event, which was called the Gathering of Nations, was planned around a core of ceremonial activities. Over the course of the week, 700-800 people attended the various events. With regard to the presence of Elders and healers, there was representation at the gathering from every region in Canada except for British Columbia. Many members from Elsipogtog and surrounding First Nations communities on the East coast attended ceremonies and teachings that occurred throughout the week.

Similarly, in 2007, I held discussions with:

- Cree healers in Saddle Lake (International Healers Gathering, July 18th, 2007). Amongst topics discussed here were perspectives on the accreditation of traditional healers and increased access to traditional medicine;
- Medewiwin Lodge Ojibwa Healers (Ojibwa) at Garden River (Three Fires Gathering, August 21st-24th, 2007). Topics discussed here included self-healing and self-transformation, and;
- Nakoda Healers in Nakoda Sioux territory (National First Nations Youth Suicide Prevention Forum, September 20th, 2007) in Alberta. The primary topic of discussion here was traditional perspectives on First Nations youth suicide.

The success of this activity was recognized and in 2008, \$160,000 was earmarked to facilitate an organizational goal of supporting a much more comprehensive national traditional gathering in the Mi'kmaq territory of Elsipogtog, New Brunswick. The First

Nations Centre (FNC) of the National Aboriginal Health Organization (NAHO) in partnership with the Elsipogtog Health and Wellness Centre (EHWC) hosted *Geganoatatolting: Sharing the Knowledge*, during September 8-15, 2008. The purpose of the gathering was to bring people together and to share knowledge on healing –body, mind and spirit. Many opportunities for healing and dialogue about healing were available through the gathering to participants. This event was local, regional and national in scope and many valuable insights were gained as a result of helping with the organization and subsequent participation in the Gathering. A list of *Geganoatatolting*'s activities can be viewed in Appendix D. Sincere thanks are to be given to the late Mi'kmaq healer David Gehue who was the catalyst for both the first and the last events of this FNC program as well as an inspiration exploring this thesis topic. Before his untimely passing, David Gehue was also interviewed for this research project.

Data Collection Process

'Data collection Process' refers to the following aspects:

- Procedures
- Community Entry and Participant Selection
- Community Samples/Research Participant Descriptions

Procedures

‘Procedures’ refers to the several steps that needed to be taken by the investigator in order to complete the data collection process. They include:

- Ethical Review Processes
- Interview Consent Form
- Proposal Defence
- Subject Areas for Semi-Structured Interviews, Guiding Questions and Focusing Probes
- First Nations Protocols
- Dates for Data Collection
- Delays
- Instruments
- Research Methods

Ethical Review Processes

Before being able to begin the actual research, the investigator was required to complete ethical review processes and successfully defend a research proposal for the thesis project.

In the past, it had been a common practice for researchers to enter an Aboriginal community, collect the data needed for their research and leave without taking steps to, in some way, return the research to the community –never to be heard from again:

The clash between Western and Indigenous ways of knowing has been epitomized by the “parachuting model” of the Western researcher who drops onto the reservation, collects data, and leaves, never to be heard from again. The strengths

of indigenous science, for example, observation and contextual factors, are either ignored or appropriated (Scott, 2010, abstract).

As a result, many academic institutions and governments have now put in place ethical procedures and guidelines to ensure that benefits from the research are in some way returned to Indigenous communities that have contributed their knowledge to an academic research project. In addition, these types of ethical procedural guidelines have also been put in place by Indigenous communities, tribal organizations and other groups in order to protect aspects and expressions of Indigenous knowledge belonging to specific Indigenous groups. In light of these details, the commencement of data collection for this particular thesis project required that the investigator to be approved by four separate ethical review processes:

Research Ethics Board (REB)

The Research Ethics Board or REB oversees all research involving human subjects at Trent University. REB refers to a research standard put forth by the university and reviews are conducted according to the principles and spirit of the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans*, adopted by the Senate at Trent University, April 13, 1999 (Trent University REB, n.d.). REB includes reference to Chapter 9 of the Tri-Council Policy Statement entitled *Research Involving the First Nations, Inuit and Métis Peoples of Canada* (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada, 2010).

Department of Indigenous Studies, Trent University

In addition to the standard ethical review process from Trent University, the Department of Indigenous Studies at the University required that an ethical review be completed as well. While some of the information required by the review was ‘standard’ and similar to the one required by the University, other aspects were unique. For example, some questions asked about relevance of the research project to Indigenous scholarship through ensuring that the “physical, mental, emotional and spiritual dimensions of Aboriginal Knowledge, as reflected in traditional and contemporary worldviews are expressed in practice, are articulated, discussed, documented, recognized and experienced” (Indigenous Studies PhD Vision Statement, n.d.). Ethics approval was based on a written submission and a follow-up interview that was conducted by a panel of Indigenous Studies Professors and a First Nations Elder.

Six Nations Council

While no formalized permission from the community was needed to interview staff members at *Tsi non we Ionnakeratstha Ona Grahsta*’ (Six Nations Maternal and Child Centre), it was needed to interview members from a group of community Elders, known as *Grandparents* who advised the staff at the *Tsi non we Ionnakeratstha Ona Grahsta*’. Due to the importance placed on Indigenous knowledge for this Indigenous Studies doctoral research project, familiarization with the function of this group and subsequent discussion with some of its members was considered important. Therefore, formalized permission was sought through a research ethics application to the Six Nations Council – which was graciously granted (See Appendix E). Some of the questions in the

application were standard, but others dealt specifically with ownership issues regarding Haudenosaunee knowledge held by Six Nations and benefits of the research to the community.

Mi'kmaq Ethics Watch

The Mi'kmaq First Nations territories in eastern Canada have established a unified approach to monitoring research in their territories. On July 25, 1999, the *Sante' Mawio'mi* (Grand Council of Mi'kmaq) established a committee to study and develop principles and guidelines to protect Mi'kmaq peoples and their knowledge. The committee studied the issues involved in research among Indigenous peoples. From there, they developed a set of standards so that Mi'kmaq people could be informed about research occurring in their communities. In this way communities members can be treated fairly and ethically in their participation in any research, and have an opportunity to benefit and gain from any research conducted among them (Mi'kmaw Ethics Watch, n.d.). An application to the Mi'kmaw Ethics was made by the investigator of this research project which was also subsequently approved (See Appendix F).

Interview Consent Form

The Consent Form was a required inclusion in the ethics review proposals to REB, Six Nations and the Mi'kmaq Ethics Watch. The Consent Form for this project was developed and fine tuned as part of the research project proposal through taking into consideration the ethical principles outlined in the four aforementioned ethical review processes (See Appendix G).

Proposal Defence

Another requirement for the commencement of research for this project was a research project proposal defence. The Proposal Defence Committee significantly –and knowledgeably– decreased the amount of investigative research to be conducted through interviews. The original amount of interview research proposed by the investigator would have been too large of a task to complete within the time frame and scope of a PhD research project. The proposal was successfully defended to members of the investigator’s thesis committee and one external member on April 19, 2010.

Subject Areas for Semi-Structured Interviews, Guiding Questions and Focusing Probes

The subject areas, guiding questions and focusing probes for the interviews were developed in the thesis project proposal phase of this research project. The list was developed by way of information that presented itself in the literature review, discussions with some members of the thesis committee, discussions with First Nations Elders and healers previously known to the investigator and past work experience of the investigator in the field of First Nations health. The list (See Appendix C), which contains numerous subject areas and questions related to the thesis topic, was only used as a guide in discussions with research participants. Over the duration of the interviewing process, the more relevant questions to be asked by the investigator –and areas to focus on – with respect to First Nations self-regulation traditional health and healing became clearer. In addition, for the purposes of interviewing First Nations Elders and healers, sometimes

asking fewer questions and employing listening skills can be a more effective approach. During the interview process, this was unquestionably found to be the case.

First Nations Protocols

A general protocol of making a tobacco offering to all research participants was implemented and followed during the course of the interview process. Efforts were made to give special attention and respect to First Nations healers and Elders that were interviewed during this research project. An 'Elder Interview Guide Sheet' was included as part of the original proposal for the thesis project (See Appendix H). In some cases, when it could be afforded, other gifts were offered after the completion of an interview.

Dates for Data Collection

Six Nations

August 27, 2010 –1 Focus Group (5 midwives)

December 11th, 2010 –1 Key Informant Interview (Confederacy Chief, Onondaga Nation)

December 17, 2010 – 2 Key Informant Interviews (healer, maternal care worker)

January 28, 2011 –1 Key Informant Interviews (maternal care worker)

Akwesasne

March 3, 2010 –1 Key Informant Interview (Maternal Care worker/midwife)

March 5, 2010 1 Key Informant Interviews (Healer/Elder, youth/maternal care worker).

November 23, 2010 – 1 Key Informant Interview (Director Emeritus Traditional Healing Program)

November 24th, 2010 – 1 Focus Group (Director, Director, traditionalist)

November 24th, 2010 –1Key Informant Interview (Elder)

January 25th, 2011 –1 Focus Group (Family Services Worker, Faithkeeper)

January 27th, 2011 –1 Key Informant Interview (Clan Mother/Community Worker).

Elsipogtog

May 16th, 2010 –1 Focus Group Interview (3 Healers)

May 16th, 2010 –1 Key Informant Interview (Healer).

Ontario Federation of Indian Friendship Centres (OFIFC)

December 6, 2010 –1 Key Informant Interview (Elder/Director)

Health Professionals Regulatory Advisory Council (HPRAC), Ontario

August 31, 2011– 1 Key Informant Interview (Executive Coordinator)

Delays

Data collection took longer than anticipated because of delays at the community level that resulted from additional ethics reviews and the unfortunate occurrences of some untimely illnesses and deaths. As well, during the interviewing process, delays resulted because of the decision to expand the interview pool to include:

- an example from someone who knows about the formative processes within Aboriginal Organizations' leading to implementation of community based traditional healing initiatives (OFIFC participant).
- An example of someone who has knowledge about the mainstream procedures of self-regulation (HPRAC participant).

Instruments

'Instruments' simply refers to the tools used to during discussions with the research participants. These were:

- interview guide
- tape recorder
- notebook
- computer

Participants were asked what type of recording method they were comfortable with.

Some chose written and others consented to audio recordings. During the audio interviews, written notes were also additionally taken by the investigator. Following all interviews, the data was transcribed using a word processing program into a computer belonging to the investigator.

*Research Methods*⁸

Multi-method Research and Indigenous Methods

Qualitative Research

- Sampling (purposive and snowball)
- Talking circles/focus groups (4 total)
- individual key informant interviews (13 total)

Community Entry and Participant Selection

The data gathering for this project took place primarily in 3 different First Nations communities: Six Nations in Ontario; Canada, the multi-jurisdictional First Nations community of Akwesasne; and Elsipogtog First Nation in New Brunswick, Canada. Two additional interviews were conducted with: The Executive Director of the Ontario Association of Indian Friendship Centres (for insight into the AHWS strategy); and the Executive Coordinator for the Health Professions Regulatory Advisory Council (HPRAC). Both of these organizations are located in Toronto Ontario, Canada.

Six Nations

The *Tsi Non:we Ionnakeratstha Ona:grahsta*, or the Six Nations Maternal and Child Centre, on the Six Nations Reserve in southern Ontario, provides a wide range of services including: prenatal, birthing, postnatal, midwifery training, traditional wellness and parenting programs, FASD community awareness and education, FASD assessments,

⁸ While only mentioned here, these interview techniques are discussed further in the 'Research Methodology' section of this Chapter.

FASD diagnosis assistance and many others. This First Nations midwifery organization is self-regulating and operates independently of jurisdiction –which is why it was selected as an example.⁹ Funding is provided by the Government of Ontario through the Aboriginal Healing and Wellness Strategy (*Tsi Non:we Ionnakeratstha Ona:grahsta*’, n.d.)

The self-regulated midwives practicing through the *Tsi Non:we Ionnakeratstha Ona:grahsta*’ (the Six Nations Birthing Centre) are in the unique position of being formally recognized and authorized to practice midwifery by the Six Nations of the Grand River elected council (Six Nations Health Services, n.d.) The *Tsi Non:we Ionnakeratstha Ona:grahsta*’ is an exceptional example that documents some of the trials and tribulations involved whilst moving towards situations of genuine harmonization between two medical paradigms (modern Western and First Nations) in contemporary health care contexts.

Initially, contact was made with the Health Director in the community and instructions were followed as how to proceed with contacting *Tsi Non:we Ionnakeratstha Ona:grahsta*. From this point, discussions were initiated with the Director of *Tsi Non:we Ionnakeratstha Ona:grahsta*’. Interviews occurred within the period from August 27th, 2010 to January 28th, 2011. Several visits were made to Six Nations during the data collection process.

⁹ First Nations midwives practicing in Ontario have the choice of being self-regulating and, thus, not subject to being part of the regulated Ontario College of Midwives. The Ontario College of Midwives is profession regulated under the Ontario arm of the Health Professionals Advisory Committee.

Mohawks of Akwesasne (the Land where the Partridge Drums)

Akwesasne is a unique Mohawk community whose territories include an international border between Canada and the United States and a provincial border between the Canadian provinces of Ontario and Quebec. Akwesasne territory in the United States includes part of New York State. Having an international boarder running through the community makes Akwesasne unique. On the Canadian side of Akwesasne, the Mohawk Council of Akwesasne is the elected system of government. The Mohawk Council of Akwesasne is composed of twelve (12) District Chiefs and a Grand Chief. The twelve (12) District Chiefs are representatives of the three (3) Districts, namely, *TsiSnaihne*, *Kanatakon*, and *Kawehnoke*. Each of these three (3) Districts elects four (4) Chiefs, and the Grand Chief is elected by all three Districts. (Akwesasne Welcome page, n.d).

In the spirit of a self-regulatory approach to health that strives to develop their programming from First Nations healing traditions, the mission statement of the Akwesasne Health Department is *Ion tsi the wah kwat to ne onkwehonweneha* which translates into 'To go back to our ways- who we are, our traditions, medicines, values and languages'. (Akwesasne Health Department , n.d.) The Health Department houses a traditional medicine unit where various services of healers are provided to community members.

For Akwesasne, the initial permission for collaboration and communication with research participants in Akwesasne was given by a representative (Clan Mother) from the traditional Mohawk system of government. The introduction to the clan mother was

made through representatives of CIET International¹⁰. This particular Clan Mother was involved in some of the original processes that resulted in traditional healers being able to utilize their knowledge of healing and deliver services within the formalized Akwesasne community health system.

At the time, CIET was currently involved in other research projects with Akwesasne. Subsequently, discussions were held with select community members who were involved in issues that resulted in traditional approaches to healing becoming more embedded in the health and social services of the community. Interviews were conducted during three 2-3 day visits by the researcher to the community. The interview process commenced March 3, 2010 and ended on January 25, 2011.

Elsipogtog

Elsipogtog (River of Fire) is a Mi'kmaq First Nation in New Brunswick, Canada. The area of Elsipogtog was also considered to be the stronghold of *Sikniktuk* –one of the seven Mi'kmaq traditional districts in eastern Canada.

Significant to the context of research at Elsipogtog, access to the research participants resulted in part from a relationship that was developed between the researcher and the community through other projects. In particular, these projects refer to Gathering of

¹⁰ The acronym CIET comes from the name of the research centre in Mexico where the organization began in 1985: *Centro de Investigación de Enfermedades Tropicales* (Tropical Disease Research Centre). When CIET registered in February 1994 as a non-profit, non-governmental organization based in New York, the name became "Community Information and Epidemiological Technologies," reflecting the broader application of epidemiological methods to research areas beyond the health field. More recently, in South Africa and Europe, CIET has come to stand for "Community Information, Empowerment and Transparency." (www.ciet.org, n.d.).

Nations (September 17-24, 2006) and *Gegenootatolting/Sharing the Knowledge* (September 8-15, 2008). Both of these activities were described in greater detail in the ‘Preparation for Data Collection’ section of this Chapter. Also significant to the context of research, the support to the thesis subject matter offered by several Mi’kmaq Elders was additionally complemented by more formalized community support graciously offered from the *Elsipogtog Health and Wellness Centre* (EHWC). In addition, permission to conduct research in Mi’kmaq territory was also granted by the *Mi’kmaq Ethics Watch*.

The interviews were conducted during the day of May 16, 2010. While some of the interviewees were from the community of Elsipogtog others were from other Mi’kmaq communities or Wabanaki tribes.¹¹

Aboriginal Healing and Wellness Strategy (AHWS) /Ontario Federation of Indian Friendship Centres (OFIFC)

The Aboriginal Healing and Wellness Strategy (AHWS) “combines traditional and mainstream programs and services to help improve Aboriginal health and reduce family violence” (AHWS, n.d.). In the province of Ontario, the AHWS provides funding for the *Tsi Non:we Ionnakeratstha Ona:grahsta* at Six Nations and other community health

¹¹ The Wabanaki Confederacy consisted of several northeastern Algonquian-speaking tribal nations, although its composition could fluctuate somewhat according to time and circumstances. Its original core consisted of a group of closely related Abenaki tribal communities, and extended to similar clusters of Maliseet and Passamaquoddy. Later, it widened even more and included the more numerous Mi’kmaq. This expanded group, which gradually developed a cultural relationships, is what is now considered the Wabanaki Confederacy (Speck 1915:498) In the present day, there have been discussions among some traditional factions of these Nations with respect to the benefits of more formally reviving this Confederacy.

initiatives. The AHWS is managed by a Joint Management Committee (JMC), a unique consensus decision making model with both Aboriginal and government representation. The following Provincial Ministries have representatives on the JMC: Ministry of Community and Social Services, Ministry of Children and Youth Services, Ministry of Health and Long Term Care, Ministry of Aboriginal Affairs and Ontario Women's Directorate of the Ministry of Citizenship and Immigration (OFIFC Aboriginal Healing and Wellness Strategy, n.d.).

The working relationship between AHWS and the midwifery Centre at Six Nations was described by the Director of the *Tsi Non:we Ionnakeratstha Ona:grahsta* as a very good one. This led to more thinking around the role that Indigenous based strategies and organizations are playing in the maintenance and development of First Nations self-regulatory models in traditional health and healing. Since the AHWS funds several traditional healing initiatives in Ontario, including Midwifery Program at Six Nations, it was considered to be a relevant 'snapshot' of the role that Aboriginal organizations can play in self-regulatory initiatives.

The person that was interviewed to provide some insight into the AHWS strategy was Sylvia Maracle. Ms. Maracle was an integral player in the development of the AHWS and is the current and longtime Director of the Ontario Federation of Indian Friendship Centres (OFIFC). The OFIFC is a provincial Aboriginal organization representing the collective interests of twenty-nine member Friendship Centres located in towns and cities throughout the province. Significant to the relevance of this particular key informant

interview with Ms. Maracle, the OFIFC has two representatives on the JMC of the AHWS. Additionally, an OFIFC representative sits on all sub-committees of the JMC.

Health Professions Regulatory Advisory Council (Ontario)

The Health Professions Regulatory Advisory Council (HPRAC) was established under *The Regulated Health Professions Act, 1991 (RHPA)*, with a legislative duty to advise the Minister on health professions regulatory matters in Ontario. This includes providing advice to the Minister on:

- Whether unregulated health professions should be regulated;
- Whether regulated health professions should no longer be regulated;
- Amendments to the Regulated Health Professions Act (RHPA);
- Amendments to a health profession's Act or a regulation under any of those Acts;
- Matters concerning the quality assurance programs and patient relations programs undertaken by health colleges; and,
- Any matter the Minister refers to HPRAC relating to the regulation of the health professions. (HPRAC, n.d.).

A key informant interview with a policy analyst at HPRAC was considered important to the thesis research in order to clarify any similarities and differences between definitions of mainstream self-regulatory activities in the health field and First Nations ones. In addition, the interview at HPRAC is significant because its activities relate to the health field in Ontario where: firstly, Aboriginal midwives are exempt from the regulated College of Midwives; and secondly, because two of the communities that were

investigated for this study reside in the provincial jurisdiction of Ontario.

Community Samples/Research Participant Descriptions

Research Sample by Community/Organization

- Six Nations– 9
- Akwesasne – 10
- Elsipogtog– 2
- Indian Brook/Shubenacadie– 1
- Penobscot Indian Island– 1
- Ontario Federation of Indian Friendship Centres– 1
- Health Professions Regulatory Advisory Committee– 1

Research Sample by Tribal Affiliation

- Haudenosaunee Confederacy– 20
- Wabanaki Confederacy– 4
- Non-affiliated– 1

Sample by Community Role and/or Profession¹²

- Midwives practicing– 4

¹² Sample by Community role or Profession is greater than the total number of people interviewed because some participants have more than one role in their particular community.

- Midwives non-practicing– 2
- Elders– 12
- Healers– 6
- Directors– 2
- Health Program Workers– 5

Haudenosaunee Specific Community Roles

- Seer– 1
- Clan Mother– 1
- Faithkeepers– 2
- Confederacy Chiefs– 1

Research Sample by Gender

- Women– 18
- Men– 7

Research Methodology

The research methods were of a qualitative nature that combined Indigenous and mainstream processes. **Four** focus groups and **thirteen** individual interviews were conducted at **five** locations. I used the Interview Guide (containing questions and focusing probes) for structural support when necessary but as the interview process progressed, the Guide was not required as much. I recorded the data, transcribed it and

then analyzed these responses. Through the process of analysis, I began to categorize the information. During this process, I also used the thesis research question, the literature review and the theoretical framework to determine the major and minor topics.

Repeating this process of analysis several times allowed me to collapse this information into 4 larger themes, each of which contains several subthemes. This resulting structure is what is used to present the research results in Chapter 5. Lastly, in Chapter 7, the value and implications of these findings are assessed with respect to the larger debate regarding self-regulatory processes and First Nations/indigenous health and healing.

The following sections explain in greater detail the terminologies that are associated with the way the research methodology was executed. These sections are:

- Multi-method Research Methodology
- Indigenous Research Methods
- Qualitative Research Methods
- Sampling Methods
- Data Collection Methods
- Data Analysis Methods

Multi-method research methodology

The research methodology for this study was comprised of Indigenous methods and conventional qualitative research methods. Using a combination of methods in mainstream research is generally described by the term multi-method research methodology.

The term multi-method research comes closest in describing the methodological approach used to conduct the research for this project. Some use the term multi-method and mixed method interchangeably as a way to allow for the generation of data from different sources and to arrive at a more comprehensive understanding of the research question (Brewer & Hunter, 2006; Morgan, 1998). At the same time since multi-method is a term that can be used to describe diverse approaches within *conventional* qualitative methods (Collier and Elman, 2008, pp. 781-782), one could say that Indigenous methodology which flows from another knowledge base does not really fit.

For the reader coming from a background of little knowledge of Indigenous methods, you may have to extend your thinking beyond what you have originally thought to be ‘conventional’ qualitative multi-method research methodology. Importantly though, a multi-method approach is not unusual for this type of subject matter as there is a predominance of inter-disciplinary/multi-method approaches in research carried out by Indigenous researchers who work from within Indigenous realities (Weber-Pillwax, 2004; Tuhiwai-Smith, 1999). What we should, however, be cautious of is tendencies, especially in academic contexts, towards the subsumption of Indigenous methodologies under the label ‘qualitative methods’. This would be an incorrect assumption in that it would, potentially, only be glossing over other possibilities that flow from bases of Indigenous Knowledge. In the literature review, the section entitled ‘the institutionalization of traditions’ explored this phenomenon in greater detail through the lens of self-regulation and traditional health and healing.

Also of note, what we do not mean by the using the term multi-method, at least in this particular study, is reference to a second commonly (and more often used) definition that refers to the linking of qualitative and quantitative methods (Kulig, Edge, Joyce, 2008; Collier, and Elman, 2008, p. 782).

Indigenous Research Methods

Indigenous methodologies tend to include things like Indigenous values and cultural protocols as an integral part of the methodology (Aboriginal Education Research Centre, n.d.; Porsanger, 2004; Hart, 2011). The Aboriginal Education Research Centre states,

“They are ‘factors’ to be built into research explicitly, to be thought about reflexively, to be declared openly as part of the research design, to be discussed as part of the final results of a study and to be disseminated back to the people in culturally appropriate ways and in a language that can be understood.”
(Aboriginal Education Research Centre, n.d.)

In this thesis, this aforementioned description refers to things like:

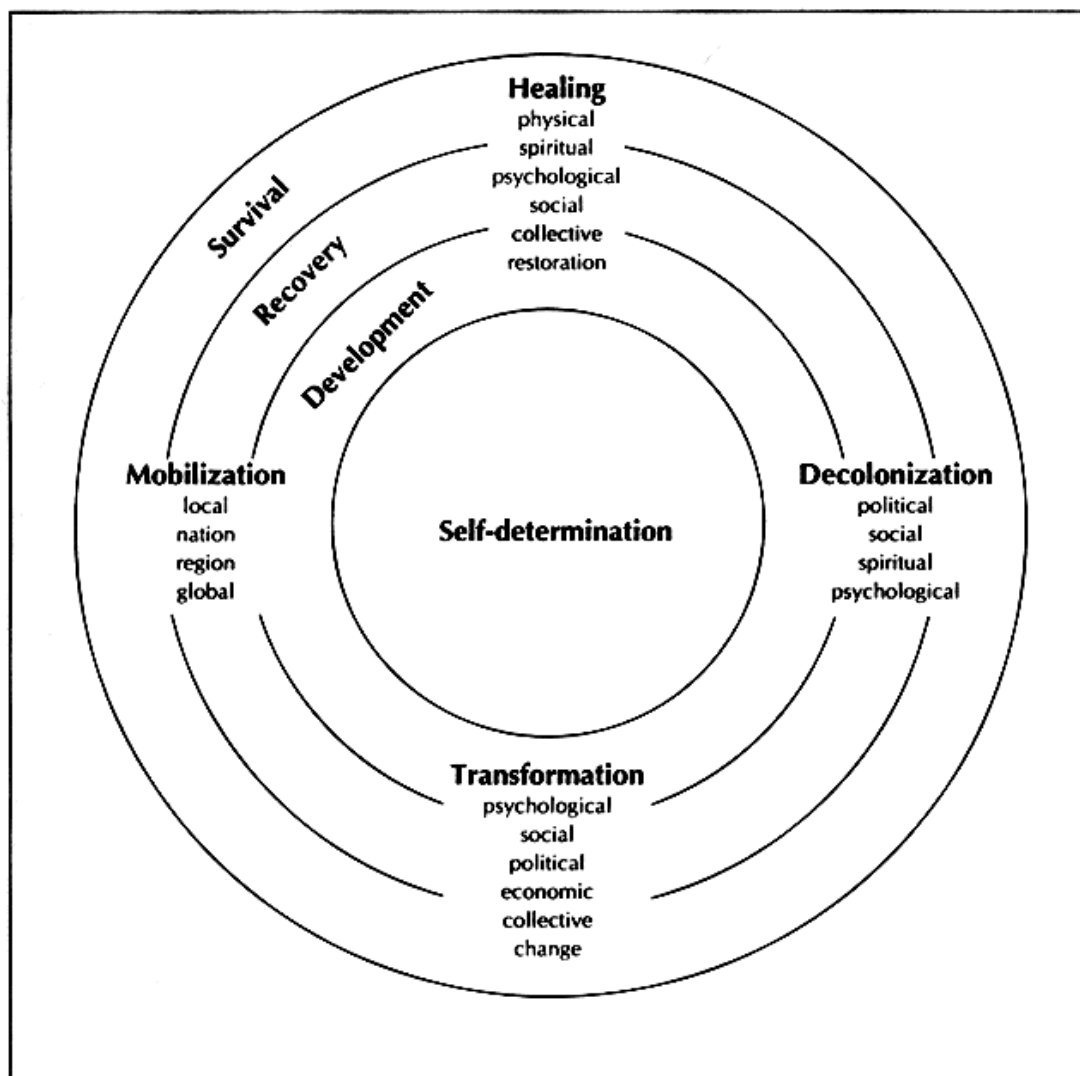
- Implementing the protocol of offering tobacco as a humble but sacred gift to all of the research participants who shared their knowledge for this project.
- Subjecting the research project to the ethical protocols that are Indigenous specific (i.e.: Indigenous Studies at Trent University, Mi’kmaq Ethics Watch and the Six Nations Council Research Ethics Committee Protocol).
- The inclusion of specific things to be aware of when interviewing Indigenous Elders (Appendix H).
- Finding ways to make the research more generally accessible to First Nations communities (e.g.: medicine circle in Chapter 7).

- Citing conversations, meetings and interviews with Elders as literature in order to provide a more balanced representation of Indigenous knowledge in a healing and wellness context. All Elders/healers who are mentioned by name in this thesis were asked for permission to use their information. Elders' words were referenced in a standard APA format, however, efforts were made to cite their credentials and, where appropriate, to provide a few sentences that illustrate the place where the information was received and/or other contextual identifiers.
- Following from the previous point, more emphasis/weight is put towards including knowledge from oral traditions and on the processes of community engagement rather than writing alone. For First Nations oral transmission plays a large part in how knowledge is shared. Writing is two-dimensional and experiences arrive in a minimum of four dimensions. With writing, some Elders fear that their words will be used out of context because if the person writing was at a ceremony or in experiences, it might not come out the way it's meant to. Similarly, in Tibetan Buddhism oral transmission is considered more important than written because it sets a person up for a direct realization of knowledge through experience (Conze, 1993. p. 23).

One of the primary objectives (as outlined in Chapter 1, pg. 25) of this research project is an expression of an Indigenous worldview. That is, it is not a comparative study in the sense of a Western binary perspective where you would have one and then the other (Indigenous and Western). Rather from an Indigenous knowledge perspective differences are allowed to exist and definitions and models do not have to be mutually exclusive.

These points also imply that Indigenous methodology means that the researcher should be aware of “a relational accountability” –meaning that the researcher is fulfilling his or her relationship with the world around him or her (Wilson 2001 in Hart, 2011, p.9).

Additionally, Porsanger indicates that Indigenous methodologies should be designed to ensure that the intellectual property rights of indigenous peoples will be observed and that Indigenous knowledge is both demystified and protected from misinterpretation and misuse (2004, p. 117). With Indigenous self-determination at the centre, Indigenous methodologies aim to strengthen and support efforts to be independent in all realms. Smith’s circle diagram below –in Porsanger (2004, p.114) – illustrates an example of the kinds of relationships that exist in Indigenous research methodologies.



For this thesis, one might say that the central role of self-determination illustrated here is a principle motivating force towards why we are asking the question about self-regulation and First Nations traditional health and healing in the first place. Without this important component –that manifests itself through things like treaty relationships, Indigenous knowledge systems, Indigenous languages and Indigenous cultures– there is an increased risks that predominantly mainstream ideas about self-regulation and health care could

inappropriately prevail. If this were the case, this would most definitely do more harm than good to traditional First Nations healing systems as there would be even less space in 'healthcare' for the existence and further development of self-regulatory processes that are anchored in Indigenous knowledge systems.

Qualitative Research Methods

Qualitative research methods were used in combination with the Indigenous ones described above. Qualitative ways of inquiry are traditional research methods used in the social sciences. Qualitative research is used to explore and understand people's beliefs, experiences, attitudes, behaviour and interactions. It also generates non-numerical data. This is opposed to quantitative research that *does* generate numerical data or data that can be converted into numbers (e.g.: clinical trials or a National Census) (Bandolier, Oxford University, n.d; Mack et. al 2005).

Sampling Methods

Methods for data sampling in the qualitative research context are best described as *purposive*. To say you will engage in purposive sampling signifies that the sampling is a result of a series of strategic choices about with whom, where and how to do your research (Mack et.al 2005; Palys, n.d.). For example, for this study, it made sense to try and elicit perspectives from: First Nations Healers; First Nations midwives that were self-regulating; and First Nations people with knowledge about health programming that includes traditional healing.

Building on existent relationships that I had with people in various communities, I utilized the *snowball method* as a way to recruit additional people to be interviewed.

‘Snowballing’ is considered a type of purposive sampling.

In this method, participants or informants with whom contact has already been made use their social networks to refer the researcher to other people who could potentially participate in or contribute to the study. Snowball sampling is often used to find and recruit “hidden populations,” that is, groups not easily accessible to researchers through other sampling strategies. (Mack et.al.,2005)

Snowballing proved to work well for recruiting the participants that were interviewed at Six Nations, Akwesasne, OFIFC and HPRAC.

Interviews that occurred with the four Wabanaki healers at Elsipogtog were *purposive* but not *snowball* because they came about primarily as a result of past research the investigator had conducted in the community while employed with the National Aboriginal Health Organization.

Data Collection Methods

A variation of two standard qualitative research techniques –**focus groups** and in-depth **key informant interviews**– were used to collect the research data. These variations are a result of employing a research approach that takes account of Indigenous methods as well as qualitative.

Variation of Qualitative Focus groups

Focus groups are effective in drawing out data on the cultural norms of a group and in generating broad indications of issues of concern to a cultural group represented (Mack

et. al. 2005). Interview guides and focussing probes are often used to elicit the data that one wants to draw out. One could say that a First Nations talking circle, as a recognized and familiar cultural method of knowledge sharing, helped to boost or enrich the flow of information in the data gathering section:

“Talking Circles or Circle Talks are a foundational approach to First Nations pedagogy-in-action since they provide a model for an educational activity that encourages dialogue, respect, the co-creation of learning content, and social discourse. The nuance of subtle energy created from using this respectful approach to talking with others provides a sense of communion and interconnectedness that is not often present in the common methods of communicating in the classroom. When everyone has their turn to speak, when all voices are heard in a respectful and attentive way, the learning atmosphere becomes a rich source of information, identity, and interaction. Talking Circles originated with First Nations leaders - the process was used to ensure that all leaders in the tribal council were heard, and that those who were speaking were not interrupted.” (First Nations Pedagogy Online, n.d.)

During the talking circles/dialogue circles, the interview guide was not consulted as much as it might have been in a standard focus group. This was done in order to not interrupt the flow of the circle. What I found, however, was that the information collected could be, without a doubt, applied to many of the pre-determined questions in the interview guide. In the end, it just took a little more time to sift through the data to make these kinds of links. The talking circles were opened by a protocol of respect through offering the participants a gift of tobacco for sharing their knowledge. In some instances, other traditional gifts were offered at the end of the talking circle.

Variation of Qualitative In-depth key informant interviews

In depth key informant interviews are optimal for collecting data on individuals' personal histories, perspectives, and experiences, particularly when sensitive topics are being

explored (Mack et. al. 2005). To some extent, the Interview Guide (Questions and Focusing Probes) were used. The use of the interview guide indicated that there was some structure to the interviews, even though they were more or less viewed as conversations where information was drawn out. Patton states, “one way to provide more structure than in the completely unstructured, informal conversational interview, while maintaining a relatively high degree of flexibility, is to use the interview guide strategy” (Patton as cited in Rubin & Babbie, 2001, p. 407).

Indigenous methods provide a variation to the standard qualitative interview. Partially, this is a result of following the protocol of offering tobacco and explaining the request to the interview participant. In addition, when interviewing First Nations Elders in particular, methods of data gathering were congruent with Indigenous methods. For example, a more conversational approach was taken (Kovach, 2010). Out of respect, Elder participants were not interrupted by the investigator as this might be perceived as impolite and an unnatural 'forcing' of the conversation.

Data Analysis Methods

The Department for Family, Youth and Community Sciences at the University of Florida (n.d.). indicates that important aspects of qualitative data analysis involve asking the three following questions:

(1) What are the data “telling” you? What patterns, themes, and concepts emerge from the data?

(2) Do the themes, patterns and concepts that emerge from the data conform to what my theoretical framework indicates should emerge? Are you seeing what you “expected” to see –based on theory – or are there unanticipated results? If so, what do those results mean?

(3) How can you validate the conclusions that you draw from the data? Have I made sure that I have taken appropriate steps to ensure that the conclusions that you draw from the data are justified? (University of Florida, Family Youth and Community Sciences, n.d.)

In order to accomplish these objectives, the two types of data analysis techniques that best describe the process used for this project are *interim analysis* in combination with *framework analysis*

Interim Analysis

For qualitative studies, such as this one, data analysis tends to be an ongoing and non-linear process. The term traditionally used to describe this cyclical process is *interim analysis* – which Johnson and Christensen (2012) describe in Chapter 19 of *Educational Research: Quantitative, Qualitative and Mixed Approaches*. The interim analysis for this project took place over several months and consisted of several sessions of analyzing and synthesizing the data. Interim analysis continues until the process or topic the researcher is interested in is understood (2012). The end result for this project was a clearer picture of the relationships that existed (or did not exist) amongst the data collected during the interviews.

Framework Analysis

This approach to analysis has been developed over time by the *National Centre for Social Research (NatCen)*.¹³ Here, a thematic framework is utilised to classify and organise data according to key themes, concepts and emergent categories that evolve and are refined out of a process of repetition. The final stage of the framework method involves summarizing/synthesizing the original data from each interview within the appropriate part of the thematic framework (Ritchie, Spencer, & Lewis, 2003). These themed categories are used to encapsulate and present the data/results.

For this study, through ongoing review of the data, the process of analysis consisted of categorizing the information as well as collapsing it into representative themes and sub-themes. In addition, the data was further substantiated by looking for consistencies/non-consistencies among the data in comparison to the research question, literature review and theoretical framework. Chapter 5 presents the data/results of this research project through these four categories.

In applying these two types of analytical approaches, four themed categories emerged:

- Healer Centred Self-Regulation in First Nations Traditional Health and Healing (i.e.: A healer's relationship to their respective Indigenous knowledge system –for example, codes of conduct arrived at through apprenticeships, connection to mother earth, observance of natural law, ceremonies and the Creator)

¹³ Since they were founded 40 years ago, NatCen has grown to become Britain's largest independent social research organisation (NatCen, n.d.).

- Community Based Self-Regulation and First Nations Traditional Health and Healing (i.e.: What a community knows about their healing traditions and their healers. Non-formalized but evident through things like Creation stories, stories about prophetic healers, medicine stories, medicine passed down through families or medicine societies).
- Community Public Self-Regulation and First Nations Traditional Health and Healing (i.e.: There has to be some sort of designated 'public space' associated with aspects of traditional health and healing. Usually there is some interaction with an external funding source needed in order to have it there –for example having a traditional healing unit in a health centre or a First Nations midwifery centre as part of the community health programming).
- Mainstream Regulatory and Self-Regulatory Processes and First Nations Traditional Health and Healing. (i.e.: In reference to the health regulatory system that is used to determine the protocols for mainstream doctors, nurses and other western health practitioners).

Chapter 5: Results

Overview

To restate the primary research question concerning this thesis:

In contemporary environments, how can traditional understandings about of self-regulation be /applied/used/articulated within contexts of First Nations health in ways that continue to simultaneously support and protect the autonomy of traditional healers and their practices? If yes, how could/does this occur? If not, why not?

The results of the key informant studies and focus groups are categorized and presented within the following themed framework that was arrived at and briefly described in the 'Research Methodology' section of the previous Chapter:

- Healer Centred Self-Regulation in First Nations Traditional Health and Healing
- Community Based Self-Regulatory Aspects and First Nations Traditional Health and Healing
- Community Public Self-Regulation and First Nations Traditional Health and Healing
- Mainstream Regulatory and Self-Regulatory Processes and First Nations Health and Healing Agendas

Aside from the details that occur through the illuminating personal experiences put forward during the interview process, the responses obtained from the research participants are congruent with the general findings of the literature review. In the first

two categories of this Chapter, (and some instances of the third) notions of self-regulation and traditional health and healing are those that are implied when one begins to look through the lenses of First Nations cultures and traditions. Within these contexts rest the mechanisms that assure the quality of healers within Indigenous communities.

One might say that the third and fourth self-regulatory themes in this Chapter lean more towards Little Bear's (2000) notion of a post 'jagged -world views colliding' world – where notions of self-regulation might be viewed as a way that First Nations speak to the mainstream in terms of a cultural professional dialogue. Tensions that exist between ideologies in modern Western health care and First Nations ones spawn questions with respect to understanding and defining self-regulatory processes in First Nations health care agendas that include traditional healers in meaningful ways. For example: What does it mean (and who determines what it means) to be a 'professional?; How does one understand ethics and protocols that govern the behaviour of traditional healers?; What kind of information informs the efficacy of medicines that a healer uses?; What type of training is necessary for a healer to become a healer?; and What can be done to protect the integrity of First Nations traditional healing practices in varying degrees of 'non-traditional' settings (e.g.: issues concerning insurance, mal-practice)?

Thus, concepts that inform the presence of self-regulatory processes in First Nations traditional health and healing can span across large and varying terrains. Contemporary use of First Nations traditional healing occurs in many different situations (e.g.: in hospitals, within health programs of First Nations communities, or solely using the Indigenous knowledge contained within the healing system of a particular Indigenous

community, etc.). Thus, depending upon the specifics within these varying contexts, these encounters can bring with them different *layers of meaning* with respect to understanding the differences and similarities concerning self-regulatory processes. These *layers of meaning* are informed by understandings about the particular health system a healer/doctor is trained in and what a particular community understands to be ‘knowledge’ –First Nations, modern Western, or both.

Through exploring some of these different layers of meaning, it is hoped that a greater understanding will be gained about some of the factors that inform self-regulatory processes of First Nations traditional health and healing in a variety of contemporary situations and arrangements. The information provided by the all research participants during the field research contributed significantly towards this objective.

Healer Centred Self-Regulation in First Nations Traditional Health and Healing

Ultimately, the issue of self-regulation amongst traditional healers is something that Elders and healers are capable of addressing within the larger First Nations community (RCAP Vol. 4, Chapter 3). This section presents the responses of the research participants that inform aspects of First Nations self-regulation that are, for lack of a better term, ‘healer centred’. Specifically, the research participants addressed areas of:

- how a healer becomes a healer;
- how a healer becomes known in a community; and
- self-organization amongst healers

While the above three items are not at all considered to be an exhaustive list, these are at least some factors identified by research participants that are relatable to self-regulatory processes within Indigenous healing systems.

As indicated in Chapter 1, it is important to keep in mind that striving to arrive at a definition for the term ‘traditional healing’ is an idea that needs to be approached with relative caution. In relative parallel, the term ‘healer’ is also used with some reservation and also needs to be used in a non-definitive sense. Like the example given in Chapter 2 regarding Kathy Bird’s teacher, many First Nations people with the knowledge and ability to facilitate healing prefer not be referred to as a ‘healer’.

In addition, while my current academic and personal understanding of what this category may truly entail is limited, this category remains critical to the discussion about self-regulation because it is about the input from healers themselves.

How a healer becomes a healer

Relationship between the a Healer, the Creator and the Spirit world

First Nations traditional healing is holistic and, therefore, intangible elements such as the relationship a healer has with the spirit-world plays a significant role for First Nations healers. With respect to the practice of ‘good medicine’, principles of efficacy and ethics in First Nations healing practices can arise naturally from these types of powerful relationships. In speaking about healers one research participant indicated:

“These individuals had a good relationship with the Creator. They were guided. They had gifts and they understand the properties of those plants and how they

could help the people. Still today you can see that we have those individuals in our community that have that relationship and it's a strong relationship. If you've been around it long enough (and listen long enough) then you would understand. If you watch what they are doing and listen to them telling you the reason why and you understand what Creation is all about, then you would say 'Oh yeah, now I know how that works with that and that works with that (what the relationship is).' (A, Focus Group, November 24, 2010).

The Gift for Healing

People watch the children as they are growing; some people have certain gifts that put them on the path. The child is then encouraged to hone these skills and to have a support system along the way (G, Personal Interview, January 26, 2011).

Having a particular 'gift' for healing was also something that some research participants noted as an important quality for healers. Certain signs that an individual exhibits, that are observable by other community members, help to identify this gift (C. Skye, Personal Interview, November 17th, 2010). Everyone is born with a particular aptitude or 'gift' to succeed in an area that will benefit their community –this includes a traditional healer. In other words, having a gift in a particular area influences the choices that a person makes in their life paths. For instance, consider the case of Private Ronnie Tallman, a Navajo, who believed his calling of a medicine man made it impossible to go to war without the consequence of spiritually harming himself or his community (Draper 2007). Two participants noted the importance of this notion of 'gift' and how acknowledging one's gift(s) can differ from choosing a career path in the mainstream:

“In the name giving ceremony, a baby is named. Everyone is born with certain gifts. Just because you choose to go into a particular 'field' doesn't necessarily mean you have the ability or gift to pursue it effectively.” (D and E, Focus Group, January 27, 2011)

Training and Apprenticeship

Participants agreed that in most cases, once a person who has healing gifts is recognized, a training period or apprenticeship takes place. Training under other healers was considered to be very important:

Now that is not to say that people can't be directed by spirits themselves or are not gifted, but even then you should be going and testing your knowledge with people that know (so that you know you are valid...). So anyways, I'm talking in large circles here but I don't mean to. It's a very long term commitment to apprentice with someone. Healers are conduits to the spirits, not personal healers. (S. Maracle, Personal Interview, Dec 6, 2010)

The seriousness of undertaking such an endeavour is exemplified in this study because, while there is no set time limit to the training period, an apprentice healer could be looking at a very long term commitment:

“Well KA (an apprentice) is one of them. He has been in training for 6 years.... maybe more.... When they (the spirits) say teach him, they mean everything. So he is in training right now and whenever I get a chance I help.” (D. Gehue, Focus Group, May 16, 2010).

Regarding another trainee's learning about a particular healing ceremony, it was noted that:

“..... he has been learning/doing this ceremony for 15 years, but this is the first time he is going to be doing it outside. I don't teach fast, but I teach thoroughly because there are going to be a lot of people that are going to depend on him so he has to be good.... and he is good.” (D. Gehue, Focus Group, May 16, 2010)

Another participant further validated the commitment necessary to become a healer's apprentice by referring to the Navajo community in the American Southwest.

“.... they have a very stringent process of apprenticeship. They don't call it 'helpers' like the way we do here. They are very clear...There you make your offerings and you make a very long term commitment to apprentice with someone.” (S. Maracle, Personal Interview, December 6, 2010)

When addressed with the issue of how an apprentice was chosen or whether or not we needed to worry about passing on tradition, one healer was rather animate about removing himself from the equation stating that, “when I am training someone, it isn’t me that chooses the person, they are chosen by the spirits.” (D. Gehue, Focus Group Interview, May 16, 2010). Thus, while it would seem important that an apprentice has a desire to learn about healing traditions, the process of being selected is unlike the competitive one undertaken when applying to a mainstream medical school. That is, the relationship between the healer and the spirit world is of vital importance in guiding the healer towards a person who is capable of ‘carrying’ the Indigenous healing knowledge necessary to legitimately continue healing practices.

How a healer becomes known in a community

Participants indicated that how a healer becomes known and/or authenticated within a community happens through a rather organic process that can be informed by intergenerational knowledge that is held by a community. This validation process occurs through respecting and adhering to community and traditional healing protocols in combination with making use of ‘word of mouth’ –which refers to the important component of oral tradition that is effectively utilized by communities of Indigenous peoples to pass on knowledge. Essentially, over time, a healer gets to know the community that they work with. Conversely, a community gets to know the work of the healer.

Observation of 'Living' Community Protocols

Different communities, and Indigenous traditional healing systems, have different protocols that need to be observed in order to authentically serve a community as a traditional healer. The following conversation describes some of the protocols associated with the process of attaining the privilege to practice traditional healing within a particular community:

D. Gehue- “Where we got our recognition from my perspective was from JA’s dad. When I first came here, he knew I was going to keep coming here and every morning I was here, he was here, because he wanted to hear more about traditional stuff.”

J. Augustine- “My dad called Dave sir. Hello Sir.”

D. Gehue- “I’ve come to see you sir lets have tea. You know that guy was 80 years old. When he needed help he said let’s call Dave. He said, 'He’s coming? I’ll be there'. He wouldn’t leave his house for weeks but when I came, he was there. So we had recognition by the Elders here.”

F. Augustine- “We were appointed by the People. You don’t take that name yourself. You don’t take it, People give it to you.”

D. Gehue- “When I came here over 25 years ago, there was a meeting of the Elders. I walked up to each Elder and gave them tobacco and said, 'Can I have permission to come and work and to be in your community'? I was the only one that did that.... and I was welcomed by the Elders. I’ve never had problems since.... the spirits protected me all the way.... and I’ve been coming here over 25 years. 'KA' was just a little kid.”

F. Augustine – “Yes it has been a while.” (D. Gehue, F. Augustine, J. Augustine, Focus Group Interview, May 16, 2010).

This authentication process is something that develops over time through the relationship between a healer and a community (rather than through, for example the presentation of a résumé or other qualifications on paper).

Oral Traditions

Oral tradition or ‘word of mouth’ is another method that research participants indicated to be important with regard to how a healer becomes known and/or authenticated within a community. When asked about this healer authentication process the following response was put forth by two research participants:

B – “It’s interesting how when you were talking about community self-regulation, there is almost like a lot of word of mouth type information that people will say, ‘Gee you should go see somebody, or this person can do that’”

C- “Or don’t go see this person, or this person isn’t who they say they are. Our community does our own policing and it’s something that is not formalized or advertised. It’s just the word of mouth and then it becomes known.”

J. Robbins (investigator) – “It becomes knowledge?”

B- “Or somebody is way off base and is going in a different direction and is calling themselves something that they aren’t. People will say things like, ‘Where did that term come from? Why are you a minister now?’ that kind of discussion. They will ask, ‘Where is this coming from?’. The people will express some concerns.”

C- “Like B says, we have the knowledge holders (key people) in our community and we go to those people to check.... We ask, ‘Do you know so and so? Do you recognize this type of medicine?’, and maybe they will say no. They might say get a second opinion. That does happen.” (B and C, Focus Group Interview, November 24, 2010).

The passing of information through word of mouth within a First Nations community can play a significant role in validating a traditional healer. In a sense, discussions about the qualifications of a person’s healing abilities are ‘checks and balances’ which influence the authentication of that individual –whether it is in their own community or other Indigenous communities they may work in.

For First Nations, authentication of a person’s healing abilities by word of mouth entails more than just talking about someone or superficially exchanging information about

them. As one research participant indicated, ‘word of mouth’ knowledge in Indigenous oral tradition also takes into consideration the history of an individual’s life:

“I was given a teaching by a man named Peter O’Chiese...and we asked him, ‘How do we know?’. He said, ‘Look behind them, don’t look at them and listen to them, look behind them... and see how is their family’. Were their children cared for were they around?... all these kinds of things.... again not implying to us that people can’t change. But really I think Peter O’Chiese was saying to us, Indigenous Knowledge is an old knowledge and so you can’t just come to it just like that... like a snap.... so you have to look behind and make sure.... and that if people had had a difficult life, a hard life, that they had gone about trying to make peace, that they had sort of created the relationships that they could. And so there was a lot of notions in the community about how do we respond to these things.... and I think that there was this notion of a ‘push back’ saying, ‘Oh well, so and so just flew into town’ and really he is just more interested in young women as opposed to the (sacred)¹⁴ pipe, being in a community, living in a community, having knowledge of those communities and knowledge of those families. Because that is the real hard work... and then sort of being recognized by them as to how to proceed.” (S. Maracle, Dec 6, 2010)

Self-Organization amongst healers

Contrary to New Age appropriations of shamanism that tend to compartmentalize the practices of Indigenous healers into an locale that emphasizes a solitary practice (Sleeping Crow, 2007, pp. 180-181; Shaman’s Door, 2011, Quantum Shaman, n.d.), evidence offered by research participants suggests the contrary. Any type of self-regulatory body that governs a group of healing practitioners (whether it be for First Nations communities or modern Western medicine) seems to be preceded by some level of self-organizing (small or large, formal or informal) amongst its practitioners. Amongst some First Nations communities, these instances of self-organization could refer to both the past and present existence of such healing networks.

¹⁴ My parentheses.

These healing networks could be perceived as *formal* (such as the medicine societies that exist in some First Nations communities) or *non-formal* (such as healers who simply know of each other's work and sometimes work together). A third option is also possible. In some contemporary situations some groups of healers –such as the *Dine Hataalii* Association discussed in the literature review of this thesis– have added suitable mainstream self-regulatory components –such as licensing healers – suitable to their needs in order to shape their community based approach to self-organization. In Canada, with respect to this third option, RCAP (Vol. 3, Chapter 3, 1995) recommends that the federal government clarify and systematize their support to traditional healers until access to traditional healing services is fully controlled by Aboriginal health authorities.

Medicine Societies

Not much information was given by participants about the inner workings of First Nations medicine societies in contemporary times. This, however, does not entail that these societies do not continue to operate. It is important to take into consideration the fact that during the time when healing ceremonies were outlawed by the Canadian government, many of these societies were forced to take their practices underground. Even though the laws have changed, it probably would not be farfetched to assume that these types of societies remain cautious about revealing themselves to the public eye. For the Haudenosaunee, these types of traditional healing societies continue to function (C. Skye, Personal Interview, November 17, 2010).

One participant indicated that for his particular Mohawk community, self-organization within traditional medicine societies, which diminished during a time of outlawing traditional healing ceremonies and widespread conversion to Christianity, are now becoming strengthened again. He also indicated, however, that due to the numerous modern day distractions, it is difficult to see beyond what this will look like beyond the current generation:

“But there were also those other (medicine) societies that were out there.... those medicine societies, that we didn’t have here, but we used to have to go down to Six Nations, we had to go to Buffalo, Allegheny, until our people started to get a little bit stronger and our people, even though we had lost a lot of our language, we had a core of people that understood the importance of it and that we needed to start bringing that stuff back to us, so our people didn’t have to travel those long distances and we could start taking care of our own people. So, it was only in the last 30 or 40 years, where that began to build strength.....and where we are today, based on that information, we are good where we are now. But on the other side (there is concern about)¹⁵ who is coming behind us right now. This is the big question mark. Are we only strong for the time right now and after that we will struggle? We don’t know those things. That’s why we try to get those young guys and say, 'Come on get in here'. But we don’t have that opportunity to sit around like we are doing here and to discuss what are issues are. We are too nine to five westernized that’s what it is, it is the biggest problem to be able to move forward.... 'gotta pay that electric bill, gotta go to the Wal-Mart'. All that daily stuff.” (A, Focus Group, November 24, 2010)

Informal Networks of Healers

In addition to the presence of medicine societies, other research participants maintained that, ‘less formal’ (for lack of a better term) healing networks , should be considered no less important. During a focus group with Wabanaki healers, it was emphasized that being part of a strong network of people doing traditional healing work is important in the practice of good traditional medicine:

¹⁵ My parentheses.

J. Robbins- “So it is important to have a team?”

J. Augustine- “You cannot work alone.”

D. Gehue- “It is important to have that team and that family unit. If there are people that need a certain type of work, I can send them to the person and then they will be waiting. I share the history of that person with another person (in the team), so they know what is going on. If you don’t have that team, then you’ve lost it.... The key is this... you need that team and family unity. If you don’t have that then you don’t have nothing.” (D. Gehue, J. Augustine, Focus Group, May 16, 2010)

Whether they be First Nations traditional medicine societies or informal networks of healers, the lesson here from the research participants seems to be that the strength of healing networks continues to be an important factor within the practice of First Nations traditional healing. In addition, this strength should not be measured by how it resembles the concept of ‘organization’ in a mainstream sense –which is often equivocated with things like the existence of written codes of conduct, doctrines and licensing procedures.

Utilizing mainstream Elements of Self-Regulation in self-organization processes amongst traditional healers

Adapting mainstream elements of self-regulation into some contemporary First Nations health settings, that desire to utilize traditional healers, has occurred with measured success (Maar and Shawande, 2010). One research participant indicated that although he was aware of the various obstacles that come with this type of integration, "ability to be licensed by our own people in our respective fields" (D. Gehue, Focus Group, May 16, 2010), should be something to be considered in discussions about contemporary self-regulatory processes amongst First Nations healers. He states,

“They do have a licensing board in Navajo country. There is a board out there. If the medicine men pass that board, they are recognized and licensed by the hospitals in region. So they go out and get as paid as much as a doctor does when they go out and see people. It’s taken 20 or 30 years.... but it is not going to take

as long here because we can copy the model.” (D. Gehue, Focus Group, May 16, 2010).

In the Navajo example, the mainstream aspect of licensing in health self-regulation has been used to successfully expand some aspects of community access to traditional healers in less traditional settings such as hospitals and community health centres. Nonetheless, in utilizing mainstream self-regulatory elements in combination with those arising from traditional healing, a certain balance that is appropriate for the needs of the community needs to be achieved. Mainstream evaluation models of self-regulation should not attempt to force traditional healing into mainstream models because they are likely inappropriate (Maar and Shawande, 2010, p. 25).

Another participant implied that adapting mainstream elements of health self-regulation such as licensure proved to be particularly successful for the Navajo because it was preceded by a process where the community sorted out who their healers were:

“What happened was that there was this great recovery that was occurring (and this happened in the '70's by the way). There was this great recovery that was occurring in our community and all of a sudden people who purported to have Traditional Knowledge or Indigenous knowledge started popping up all over the place. And the Navajo in particular, but Hopi as well, became concerned that people were co-opting their knowledge or worse yet saying this was their knowledge when in fact it wasn't.... So they called/created a council.... I think in those days they were calling it the Nations Elders Council, and anybody who had the traditional knowledge, were carrying the stories, the medicines, the songs the teachings, who could do sand paintings or who could do certain spirit calling that needed to be done.... all were asked to gather.... and they gathered and they kind of stood up.... and I want to say that it was in the community college, either in Chinle or Flagstaff.... they stood up for days and said this is who I am, this is my family lines.... very complex clan relationships. So this is what they did. And they said, anyone who doesn't come before this council doesn't have a right to say that they are teaching Dine (Navajo) ways.” (S. Maracle, Personal Interview, December 10, 2010)

Sorting out this process internally within the community exposed charlatans and others trying to profit from claiming to have Navajo traditional healing knowledge. Through undergoing this process, the community became much clearer about their own healing base. Subsequently, adapting elements of mainstream self-regulatory processes such as the administration of healing licenses by the *Dine* Association brought with it a lesser chance of corruption, healer misrepresentation and/or eventual subsumption into mainstream self-regulatory ideologies.

Networks of First Nations traditional healers have existed before the arrival of modern Western medical systems. In contemporary times, self-organization amongst healers remains important. One participant from Akwesasne indicated, “our medicine people need to band together and make a really sound statement that this is our medicine” (F, Personal Interview, May 3, 2010). This response was echoed when the same question was posed in *Wabanaki* territory. With respect to contemporary self-organization amongst healers, one participant said:

“No, I think it is a good thing. I think it is like anything else... strength in numbers. Any man can break a single arrow, but if you put fifty of them together, no man can break it –as the saying goes). That is how all species survive by sticking together.” (B. Altivator, Personal Interview, May 16, 2010)

Each of these situations (whether it be medicine societies, informal networks of healers, and those where some mainstream aspects of self-regulatory health processes have been adapted) indicates that some parallels can exist between First Nations approaches to self-regulation and those in modern Western medicine. In either system, a unique set of protocols are used to assess things like: the practice of good medicine as opposed to bad medicine; the admittance of new healers into a particular group; the training of new

healers by an experienced healer; and determining when a healer is ready to practice what they have learned on their own. In addition, the Navajo example suggests that First Nations communities who have or are working towards a strong sense of identity with respect to who their traditional knowledge holders are will be the ones who will have success in adapting elements of self-regulation that are present in mainstream healthcare.

Community Based Self-Regulatory Aspects and First Nations Traditional Health and Healing

In order for First Nations healers to self-organize and subsequently self-regulate, they require a First Nations community in which to self-organize and self-regulate.

Community-based aspects of self-regulation in First Nations traditional health and healing refers to a perspective that draws knowledge from the collective Mind of a community. These perspectives are 'grassroots' ones that begin on the land and occur from within Indigenous communities. For example, Mitchell (2006) noted that with the Haudenosaunee, self-regulation for traditional healing is based on the Original instructions which start at story of Creation.

Creation stories, Indigenous land bases, languages, oral traditions, ceremonies, traditional ways of organizing within a community (such as traditional governments like the Haudenosaunee Longhouse system), et cetera, are elements that when considered together, contribute to the existence of a valid context in which the self-regulatory processes concerning traditional healers can be accurately assessed. Traditionally, this might have been in reference to situations where a First Nations healer functioned in an environment void from the disruptions arising from mainstream society and non-

Indigenous healing systems. Even though this type of situation might be considered as nearly impossible today, research participants identified critical issues within their respective communities that they thought supported the regulation and the continued practice of traditional healing. Contemplating these factors also plays an important role in the further understanding the epistemological bases of First Nations self-regulatory processes in traditional health and healing.

A basic understanding of the stories of a particular First Nations community, can play a critical role in being able to contemplate and discuss community based aspects of self-regulation as they apply to traditional health and healing. These types of answers lie within the community rather than from without. Elder and Oneida language Professor Emeritus Grafton Antone once told me, after attending his language class, ‘if you don’t know the stories then you don’t know anything...’ and that there are all aspects of medicine to be understood and learned through the stories and ceremonies.

Based on the discussions with the research participants, the following sub-themes speak to these community based self-regulatory aspects of First Nations traditional health and healing:

- Traditional Teachings and Practices
- Growing into Cultural Roles
- First Nations Languages
- Disruptions in Territorial and Cultural Integrity

Traditional Teachings and Practices

‘Traditional teachings and practices’ makes reference to participants who, through their responses, portrayed some of the unique foundational (epistemological) elements of their respective First Nations communities. Native Hawaiian philosopher, Meyer (2000) notes that epistemology (or the study of knowledge) is the starting point for discussions about Indigenous Knowledge. For instance, through discussions with participants, it became evident that understanding First Nations approaches to self-regulation for traditional health and healing also hinges on an awareness of tribal teachings that describe inter-relationships (relationship to: self, others, community, environment, spirit-world, sacred, Creator) within a community. When taken as a whole, the practice of these teachings can result in the achievement of ‘health’ through the living of healthy lifestyles:

“Our traditional teachings tell us how we should interact with all each other during our lifetime to preserve the future for those ‘whose faces are coming from under the earth’. Two concepts, one of balance and one of harmony were found in the (Haudenosaunee) traditional teachings as the ultimate measure of health. Balance and harmony can be exercised and experienced by an individual or among people in general.” (La France, n.d., my parentheses)

Based on the data that was collected, this section focuses solely on the responses of participants from communities of Six Nations and Akwesasne. These participants are members of a larger community called the *Haudenosaunee Confederacy*.¹⁶

¹⁶ While I think that the inclusion of this general concept of community ‘teachings and practices’ remains significant to self-regulatory processes in First Nations traditional health and healing, my knowledge of actual Haudenosaunee traditions is limited. Therefore, my use of the few Haudenosaunee terminologies used in this section is also limited and by no means exhaustive. One should look to community members and its knowledge holders for a deeper understanding of Haudenosaunee teachings and how they might contribute to a context for community based self-regulation in traditional health and healing. Additionally, if interested, a great deal of highquality Haudenosaunee information resources (written, visual and oral), can be found on-line and in libraries. These resources speak to their traditions in both past and contemporary times.

“Rotinonshonni have long held onto traditional philosophy, principles teachings and methods that promote peace and harmony among our people” (LaFrance, n.d.).

Viewing Health in terms of Relationships

The fact that Indigenous traditional healing can address several different areas of health means that it is a holistic concept. Physical, mental, emotional and spiritual aspects of the human being are all interrelated; deficiencies in any of these areas can cause a person to become unbalanced (Robbins and Dewar, 2011, p. 3). Physical manifestations of illness may continue to appear until the individual accepts the teaching of how their illness ties into the laws of the universe or natural law (Lee, 1996).

Thus, viewing health in terms of relationships in these types of contexts can encompass much more than simply the interpersonal relationships between people. A. General indicates:

“I believe in the Creation and what is here for me, my children and the future generations of our people. In our teachings we say thank you. We don’t ask for more. Educate our children to not be greedy and to value life. It’s Important to come to a subtle agreement between all people because so much has been disrupted.” (A. General, Personal Interview, December 11, 2010)

This short quote by Cayuga Confederacy Chief A. General was chosen because it explicitly, weaves together some important (but by no means exclusive) principles contained in the Haudenosaunee worldview that speak to the concept of 'health' in terms of the maintaining wholesome relationships within one’s world. These principles are:

- *Tsyotasaw*^ -Creation
- *Kanuhelatuksla* – Giving thanks (the thanksgiving address)

- *Sk[^]n[^]kowa* –The Great Peace¹⁷

Tsyotasaw[^] -by saying ‘ I believe in the Creation...’, General is making reference to the Creation Story. In its various versions, the Haudenosaunee Creation story talks about the Creator developing life on earth, with the human being the last invention (LaFrance, n.d.). Key elements of Haudenosaunee cosmology include: the existence of the Sky-World; the fall of Sky-Woman and her landing on Turtle's back; the origins of humankind and society; and the moral battles between the good and bad twins brothers (Elm & Antone, 2000). Maintaining a healthy relationship with Creation ensures that it, as General says, “remains available for me, my children and the future generations of our people”.

Kanuhelatuksla- by General saying , “In our teachings we give thanks’ we can make reference to the Thanksgiving Address which is used in gatherings to acknowledge and give thanks for relationships that sustain the people. The Thanksgiving Address alludes to such things as: relationship to self; relationship to others; relationship to the land; and relationship to the sacred (LaFrance, n.d.).

Sk[^]n[^]kowa – The Great Peace –or Great Law of Peace (*Kay[^]lakowa*)– was brought to Haudenosaunee by a person sent by the Creator. The purpose was to guide Haudenosaunee back to their original instructions when people started to fall by the wayside. Mr. General extends this understanding of this event and its traditional

¹⁷ All translations are done in the Oneida lexicon. Translations are courtesy of an Oneida Language Course (ABS220Y) Introduction to an Iroquoian Language-Oneida, University of Toronto, 2010-2011 taught by Elder/Professor Emeritus, Grafton Antone.

teachings outward to the world by indicating, “It’s important to come to a subtle agreement between all people because so much has been disrupted.”

Viewing health in terms of relationships is something to consider in discussions about community based aspects in First Nations traditional health and healing. For the Haudenosaunee, giving thanks for and practicing the right relationships with all of Creation, is important for the maintenance physical, mental and spiritual health of the individual, the nation, the natural world and the spirit world.

Traditional Community Structures and Spaces: The Longhouse tradition

In the literature review, the term 'institutionalization of traditions' was used to describe situations where there could be an eventual risk that a First Nations tradition might be inappropriately subsumed by a Euro-centric educational institution. In contrast, the *Kanúshes* or the Longhouse, as the political and spiritual institution for Haudenosaunee, could be considered as an 'institutionalization of tradition' in a positive sense. Originally, these long rectangular structures housed a number of families belonging to a particular matrilineal clan family (Kanawake Branch of the Mohawk Nation, n.d.).

“In our ways... we had a discussion on this on another day. Different longhouses were based on the clans. And the women of the clan would raise those children. And when the boys got the point that their voices were changing the uncles and fathers would come out and pull them out... and even sooner, and teach them how to do the things they needed to do to take care of their families.. to take care of their nation.” (A, Focus Group, November 24, 2010)

“Many ceremonies of the traditional Haudenosaunee take place in the Longhouse”

(Iroquois Museum, n.d.). Today, traditional value systems that are taught and practiced in contemporary longhouses extend outwards into the realm of everyday living.

“Attending the longhouse means that you practice in certain ways. This means a certain value system is in place even in places of employment . At the same time, it was also viewed as important for the kids to have contact with traditional people in public. There is a sacred role for the faith-keepers anywhere in the community.” (H, Personal Interview, November 24, 2010)

As a traditional community space, the Longhouse is demonstrative of cultural continuity across time and space. Its existence, and the teachings and practices contained within it (for physical, mental, emotional and spiritual health), implies a sovereign self-regulatory process for Haudenosaunee traditional health and healing.

Collective Community Mind/Memory

All community members who may not necessarily be endowed with the title of ‘knowledge carrier’ or ‘healer’, or even consider themselves to be ‘traditional’ may have knowledge about healing traditions. Family/community ties and cultural understandings form a web of relationships that, in turn, cause individuals to be receptive to traditional teachings and practices. In addition, these ties and cultural understandings also lend meaning to the traditional spaces that exist in the community. General states, “lessons from the past are important because they teach us how to live in a unified way” (A. General, Personal Interview, December 11, 2010).

One research participant indicated:

“I remember having a certain medicine made for me when I was a child. I remember going and picking some of those medicines, but not being given the whole teaching of “this is what you are doing and this is why you are doing it”. There was just kind of the underground where we went and did these things and it wasn’t explained ... We just had this cultural sensitivity training and, I don’t know, it is difficult to differentiate between something that is just within us and natural and we don’t realize it as being ‘cultural’ or ‘traditional’. It’s who we are and we

don't see the difference. It is only when it is pointed out for us that we are different that we becomes aware.” (C, Focus Group, November 24, 2012)

Undoubtedly, there are many more people like this in First Nations communities. When taken together, these basic types of understandings represent a collective community memory about traditional healing practices. This collective memory can be the basis in forming a context for the sovereign self-regulatory health practices of a particular First Nations community. In addition, the quote from the participant illustrates that healing knowledge is not necessarily 'privileged' knowledge that has to be exclusive to a healer. Teachings about traditional medicines and transmissions of healing techniques can be received through what we might consider to be mundane things like every day family activities. This factor is an important one and adds an entirely new dimension to discussions about self-regulation for First Nations traditional health and healing –as opposed to mainstream self-regulation where knowledge about the components of medicines, in particular, are held by medical professionals and the companies that produce them.

Growing into Cultural Roles

Having the time and space to grow into specific cultural roles (from a child to an adult) also plays a role in maintaining the cultural continuity necessary to support sovereign self-regulatory processes in First Nations traditional health and healing. Two participants noted that if you are truly raised from a child in the traditional world view it is different than when people come back to it. Some people come into it and if it doesn't fit what they like, they start to change it (D and E, Focus Group, January 27, 2011).

Recognition of gifts and abilities

For the Haudenosaunee, the ability for adults and Elders to observe children growing into specific roles is important for things like choosing leaders and identifying healers.

Mohawk Elder, Tom Porter indicates that mothers watch the children carefully as they grow up. The ones who are kind, unselfish and do not have to be told to help others are considered candidates for future leadership positions (Porter, 1986, p. 412). One participant echoed this phenomenon stating:

“But during that time when they were being raised by the women, the women would always observe those kids and how they interacted. So they would observe the kids and certain individuals (children). All the women would raise the children and observe them every day. And certain individuals would have things about them.... certain gifts that would start to surface and show themselves. Then people would say, ‘he is good at that, or she is good at this’ And they would help them along to help them understand and develop those gifts that the Creator had given them so they could offer them to the people.” (A, Focus Group, November 24, 2010)

Mutual Responsibility of Healers and the Community

Independence of self-regulatory processes in First Nations traditional health and healing past (and present), required an understanding about the mutual responsibilities between healers and the community:

“... but I know at that time, the people that had that gift, those gifts that turned into responsibilities to the people and to the Nation, and they knew the reasons why they had to carry on these things. (In turn)¹⁸ The community took care of them. They knew that based upon those gifts and their responsibilities they were continuing on to meet the needs of the people. The people still had to support them.... they went to get there wood and their food.” (A, Focus Group, November 24, 2010)

¹⁸ My parentheses.

A healer grew into his/her role as a healer and the people around them helped to affirm and develop their gifts. Thus, the healer was able to focus on his/her responsibility to help the people because the community supported the healing work. The community did this through offering up the things necessary for the healer to make a living. Today one might say that the understanding of this responsibility has been somewhat compromised because –due to mainstream ideas that influence, for example, definitions of 'work'– there is less time to fully grow into such cultural roles:

“Sometimes we forget about this because the Western world is so much a part of our lives. We forget our responsibilities to those individuals. We forget the importance of their (healers)¹⁹ responsibilities to us and how it benefits us and keeps us going.... we forget about those things.” (A, Focus Group, November 24, 2010)

Rites of Passage

Some participants noted that community practices and/or reintroductions of traditional rites of passage at different stages of life would help provide the sufficient base necessary to ensure that the transference of healing knowledge can pass more smoothly from one generation to the next. Thus, when asked about what would aid the transference of community healing knowledge from one generation to the next participants noted:

“I would say rites of passage. Going through the steps of rites of passage. So if it's a woman, they would go through the womanhood feast. Married, they go through rites of passage, if they have children, they go through the rites of passage of becoming a mother.... the other one is for the clan system. See... all those rites of passage build character for that person.... So when that person gets to JA (as an apprentice), that person is not going to have that emotional baggage.” (D. Gehue and J. Augustine, Focus Group, May 16, 2010)

¹⁹ My parentheses.

If more community members participated in rites of passage from their community, one can see how, through a common ceremonial understanding, this could aid in the re-affirmation and strengthening of collective community value systems –which in turn provide a strong base for decision making in matters of self-regulation and traditional health and healing.

First Nations Languages

“Put language on the top of the list. Language is the most important” (H, Personal interview, November 24, 2010).

Without much use of the interview questions or focusing probes developed for this thesis, the majority of participants made reference to knowledge about First Nations languages as being critical to this issue (i.e.: with respect to comprehending some of the unique nuances that lend meaning to First Nations self-regulation in traditional health and healing circles).

Language and understanding First Nations Self-Regulatory Concepts

First Nations languages act as a kind of *doorway* into larger concepts that are representative of First Nations worldviews.

“We have a lot of words where there are no English words for it. You can have something that is close, but there are many words in our language like that. I was always a strong believer that you should honour your own people, ancestors, practice your own traditions, your own culture and most importantly, your own language...” (B. Altivator, Personal Interview, May 16, 2010)

First Nations languages play an important part in both: distinguishing First Nations self-regulatory concepts from mainstream ones and offering traditional health services to the community. One participant noted that:

“There are words you can’t even translate into English and have the full meaning. So we would not only be losing our language, but big concepts and big understandings and principles. Because English is very different.... even the concepts. Like there are concepts of ownership (in English) that we don’t have. We would be losing big concepts and principles. It is very different, we don’t have that. Even here we are trying to learn Mohawk and Cayuga. They translated a glossary of words that we would use during birthing (like push, the baby’s head there, you’re doing good, etc.). We know that this is critical. A lot of our people want it. There are so many of our client’s that will say that they don’t want any English. It’s part of our traditions that we have to do this because our practices say that the baby’s first words they hear should be in the language.... Even if some of us (the older generation) are not fluent, we try to use it because it brings so much richness to the birth.” (J. Wilson, Focus Group Interview, August, 27, 2010)

Congruity between First Nations Languages and Healing Traditions

“Well I think that the language is very important. That is where our culture is. They go hand in hand. If we didn’t have languages the culture would die out soon after that. Because you are not able to do the ceremonies the way they are meant to be done.” (S. Smoke, Focus Group Interview, August, 27, 2010)

While an understanding of a First Nations language does not necessarily entail that one is in the possession of traditional healing knowledge, participants noted that there is a level of congruity between the two that should be recognized. One participant noted that a reason for this being the case is that participation in healing ceremonies provide an opportunity for people to either use or re-familiarize themselves with the Indigenous words and concepts of their particular tradition:

B. Altivator: “You know in my home town, *Passamaquoddy* is taught in the school. Sometimes the children come home with words that the parents have to fumble around and find the meaning for them and that is good. But, one of the most rewarding things for me is when I do a ceremony I do it in my language.... so that forces me to go to Elders and go to people that are very fluent in the language and ask them the meaning of various species of trees, directions, animals and all this other stuff.... and to use those words in the Lodge.”

J. Robbins: “So that’s saying that ceremony and traditional way of life is a good methodology for teaching the language and passing it on to the next generation. If you do the ceremony in the language, it teaches you what things are.”

B. Altivator: “Some of the folks that are not knowledgeable don’t use the language that much, when they come to ceremonies that I go to, they say ‘oh, that’s how you say’ inside the ground, or that’s what you call different animals or that’s what you call a fire or the pipe.’ and then they start using it too.” (B. Altivator, Personal Interview, May 16, 2010)

Within communities, First Nations languages serve as important vehicles of communication that help to support traditional healing through the maintenance of cultural integrity. One participant noted the importance of instilling language skills in community members at an early age:

“In the mainstream public school(s) there are no cultural teachings or language. At Akwesasne, there is a private (non-government funded) school that is a full Mohawk immersion school. The school goes all year around and is in sync with the traditional ceremonies.” (I, Personal Interview, November 24, 2010)

Cultural Hegemony and First Nations Languages

When the two systems of health and healing come together (modern western and First Nations traditional), it is no secret that they can often clash. When they do clash and fail to come together in more harmonized ways, more often than not, it is the models that arise from modern Western medicine that end up filling in the resulting, ill defined, grey areas. One participant keenly observed that a reason for these types of occurrence is that:

“First Nations (whether it be healers or community members) can go towards the Western medicine because most have some understanding of the English language. But the community of modern western medicine cannot come towards First Nations because they don’t speak the language.” (J, Personal Interview, May 3, 2010)

If the two systems of healing are to come together in a genuinely complementary fashion, this observation points to the logic of including traditional healers, Elders and language speakers in the formative processes of the relationship –rather than as an afterthought.

Such was the case at the *Noojmowin Teg* health centre where Anishinabe concepts and language (describing things like the ethical relationship between healers and the community) were identified as vital components of the original consultation process and their health policies (Maar and Shawande, 2010, p. 21-22).

Disruptions in Territorial and Cultural Integrity

One might say that disruptions in territorial and cultural integrity has had a negative impact on some of the foundations that would have normally supported the practice of more community based self-regulatory practices around traditional health and healing.

Environment/Land Base

“When I look outside I see the Creation and beautification. How many in the world will look at life that way now with purity and contentment. Every tree has a life. Today’s society is destroying the thought of the purification of life.” (A. General, Personal Interview, December 11, 2010)

Indigenous people across the globe are active in trying to protect natural healing spaces. In Canada, while First Nations ceremonies and healing traditions are no longer outlawed, many First Nations members and communities –in the presence of new resource development projects – still meet opposition from governments and corporations when they attempt to defend their relationship to the land (Robbins and Dewar, 2011, p. 6). One participant noted that self-regulation for healers is not going to have much of a function if the environment continues to be destroyed (A. General, Personal Interview, December 11, 2010). Support for the obvious 'interdependence' between the human species and the environment was referred to in the literature review as an ethical issue

that needs to be taken into consideration, especially for Indigenous healing practices. Losses in biodiversity due to resource development and pollution diminish supplies of traditional medicines, and not to mention the supply of raw materials for drug discovery and biotechnology in Western medicine (Alves and Rosa, 2007). Since resource development can and has impacted the availability of traditional medicines to healers, it can, consequently, have a negative impact on their practices.

Importantly, whether it is ‘self-regulation’, ‘regulation’ or any other variation of this term, in the context of First Nations territories, it is a term that can come with negative connotations. Additionally, ‘regulation’—and its derivative terms— is often thought of as something that is normally imposed from the outside:

“The attitude has to change that regulation is for good purposes only. People only make money off it. They make the law but they don’t necessarily abide by it.... The government is taking away from the land base, taking away freedoms and imposing regulation.” (A. General, Personal Interview, December 11, 2010)

Cultural Integrity

“We are going into the modern way so much that we are losing the knowledge.”
(A. General, Personal Interview, December 11, 2010)

Participants noted that disruptions in cultural integrity have negatively impacted the original self-regulatory processes associated with their traditional health and healing systems. In earlier days, these disruptions caused traditional healing practices to go underground as a protective measure:

“At the time of colonization when a lot of people converted to Christianity, they had a strong connection with the priest. A lot of ceremonies that were going on in the territory had to go underground, because a lot of the converted said they would tell the priest. This continued up until around the 30's or 40's. This is how strong an influence the Catholic religion had on us on presenting obstacles for the

things we needed to do –with people not really understanding how important these things were to us based on their belief system or whatever. Nobody was to blame for that.... that is just how things happened here.” (A, Personal Interview, November 24, 2010)

Another participant echoed this concern claiming that part of the problem was that their own people did not believe in traditional ways anymore. They stated, “this is an intergenerational problem originating in the past where people were brainwashed and forced into believing other views of the world” (E, Focus Group, January 27, 2011).

These types of events coupled with components that represent modern ways of living have resulted in fragmentation across communities (A, Personal Interview, November 24, 2010). One participant noted that the Western system is “bleeding in from the outside” and traditional healers are being forced to deal with such things as liability issues (which they never had to deal with before (G, Personal Interview, January 26, 2011).

In some contemporary situations, altered foundations of traditional self-regulatory processes continue to be seen due to the influences from a ‘speedy’ outside society:

“The family and social networking in the community has shifted from talking, listening and learning to quick short gatherings where there is no time to absorb and process information.” (I, Personal Interview, November 23, 2010)

With respect to potential solutions, one participant noted that ‘brainwashing’ can go both ways. In the sense of inter-generationally passing on knowledge about community traditions, 'brainwashing' in its contemporary meaning is good and means something much different to First Nations communities than it did in the past (E, Focus Group, January 27, 2011). Another noted that the solution for First Nations traditional medicine in particular does not lie in the mainstream suggestion of ‘blending’ the two traditions. It

was suggested that we cannot blend but have to use one or the other. In the spirit of the Haudenosaunee *Kaswhenta*, there needs to be a respect for the two because there is a need for the two (I, Personal Interview, November 23, 2010).

Aspects of Community Public Self-Regulation and First Nations Traditional Health and Healing

In a way, it is almost as if, notions of self-regulation in Indigenous health contexts only exist in relationship to mainstream models of self-regulatory health (as a way of harmonizing or communicating between different systems of healing). At the same time, the first two categories that were presented in this Chapter are necessary and critical for a collective dialogue about self-regulation and traditional health and healing to exist in the first place.

Community Public Self-Regulation refers to the physical expressions of where ‘Jagged world views collide’. With respect to the theoretical/conceptual framework of this thesis, community public self-regulation could be seen as an aspect of active ethnogenesis where cultural safety protocols are often the most observable and where one can find discussions about the nature of professionalism.

The theme of Community Public Self-Regulation –with respect to First Nations traditional health and healing– is meant to refer to a visible, public place (like a community health centre or a birthing centre) within the community where people can go to access the traditional First Nations aspects of health care. Essentially, these are places where we often see the operation of both mainstream and traditional First Nations aspects

of healthcare and self-regulation. For example, in the literature review, we saw this in the example of the Anishinaabe *Noojmowin Teg* Health Centre where some harmonization of mainstream and First Nations traditional conceptualizations about self-regulatory health procedures has occurred (Maar and Shawande, 2010). These are places where First Nations values associated with traditional healing and self-regulation are meant to be practiced. They can be, at the same time, places where pressures exist to conform to outside health models of self-regulation, due to arrangements with mainstream funding sources and/or governments.

The results for ‘Aspects of Community Public Self-Regulation and First Nations Traditional Health and Healing’ are presented through sub-themes under the following categories:

- Six Nations: *Tsi Non:we Ionnakeratstha Ona:grahsta* (Maternal and Child Care Centre)
- Designated Public Spaces for Traditional Healing at Akwesasne
- Interviews at Elsipogtog: Healer/Elder Perspectives on Community Public Self-Regulation
- Roles for Aboriginal Centred Strategies and Organizations: The case of the Aboriginal Healing and Wellness Strategy (AHWS) in Ontario

The presentation of the results in this section differs slightly from how they have been presented in the previous two sections of this chapter. The reason for this is primarily to illustrate the connections between the place where the interviews were conducted and the ‘public healing space’ that the research participants referenced.

Six Nations: Tsi Non:we Ionnakeratstha Ona:grahsta' (Maternal and Child Care Centre)

The following themes are those that were emphasized by the self-regulated First Nations midwifery organization at Six Nations:

- Public Spaces for traditional healing in the community
- First Nations explanations of self-regulation and accountability in healthcare
- Traditional health aspects in contemporary First Nations midwifery
- Working with traditional healers
- Midwifery training
- Negative Stereotyping
- Exclusion of First Nations Traditional Knowledge in perceptions/definitions of efficacy
- Predetermined Definitions and Assessment of Risk
- Acknowledgement/Accreditation: Innovative solutions vs. conforming to the mainstream

Public Spaces for Traditional Healing in the Community

In contemporary 'community public' contexts of self-regulation in First Nations midwifery, traditional First Nations knowledge and knowledge from mainstream midwifery are often applied in complimentary ways:

“As midwives we are self-regulating that is a nice mix. A lot of the knowledge we have includes traditional knowledge, medicine, ceremonial practices and western midwifery practice stuff as well. It is a nice mix.” (L. Jacobs, Focus Group Interview, August, 27, 2010).

Like other First Nations traditional healing practices, traditional First Nations midwifery practices went underground during the time when these healing practices and ceremonies were outlawed:

“Just sixty years ago people were shocked to know that people were birthing (at Six Nations) with midwives.... people were shocked to hear that. That is how much we have been westernized.... But then only a certain number of people knew it was happening because it was hidden.” (J. Wilson and S. Smoke, Focus Group Interview, August 27, 2010)

With respect to having such a public space for maternal health care, at Six Nations, one participant noted:

“I think it helps to identify where that traditional healing is happening here. I think having this big building helps people to identify and become more familiar with the birthing centre, midwifery. I think you need a dedicated space. That worked for us.” (J. Wilson, Focus Group Interview, August 27, 2010)

Regarding the revitalization of First Nations healing traditions in contemporary times, having a public space for some element of traditional First Nations practices (such as midwifery) can result in an increased awareness about First Nations healing practices, not only in the mainstream, but also within First Nations communities:

“Off reserve 3 to 5 percent choose midwifery. Here, last stat we got was 30 to 33 percent. People come here knowing that we don’t do hospital births.... They come here knowing that there are no drugs or epidurals at all. We have people that are afraid of pain, but they're so committed to having our midwifery care that they will opt out of hospital meds and care. I think that speaks a lot. There is a huge difference and our numbers are going up. I don’t think other centres have such a high success rate. That’s amazing really. People can’t believe that when I tell them that. There is something about the self-regulated model that draws people in.” (J. Wilson, Focus Group Interview, August, 27, 2010)

In some cases, honing or rekindling community support for traditional healing can be positively impacted by having a public space, even if surveys conducted in the

community indicate a lack of support. Sometime this petitioning might come from off reserve members who experience something lacking when they move to urban environments.

“Maybe the people (in other First Nations communities)²⁰ said no because they didn’t know what it was. Our numbers are double to what people said they would be. We got this beautiful building and people didn’t even know what midwifery was. Off reserve members.... the petitioning came from them, but we got the building.” (S. Smoke, Focus Group Interview, August, 27, 2010)

While this ‘public space’ model may work for the self-regulating midwives at Six Nations, it does not mean that it would work for *all* traditional healers in the community.

“Maybe it wouldn’t work for traditional medicine people. But they had talked about having a facility (physical space) close to their home. I think it might be important. It definitely helps us. We have all kinds of names (in Mohawk, Cayuga, etc.), but we are talked about as ‘the birthing centre’.... But Legally listed on the ‘outside’, we need to use our proper name... because we fall under all different categories for building codes even.” (S. Smoke, Focus Group Interview, August 27, 2012)

First Nations Explanations of Self-regulation and Accountability in health

While the literature review in this thesis indicated that the few sources that can be specifically identified as self-regulation literature for First Nations traditional health and healing varied in their descriptions and explanations, there is, nonetheless, a continuous role to be played by First Nations value systems with respect to the harmonization of First Nations traditional concepts with mainstream ones. For these value systems to be applied appropriately, First Nations people and First Nations communities are integral to the process of determining aspects of self-regulation associated with public community spaces.

²⁰ My parentheses.

At Six Nations, the importance that people's community roles in the surrounding Haudenosaunee community play in determining appropriate mechanisms of self-regulation in midwifery was emphasized. J. Wilson noted:

“We practice under the exemption code. We are regulated by the band council we have an advisory committee (Friendship centres, community centres, Elders, etc.) We are all self-regulated by the Aboriginal community. I don't know of any other's around that practice like we do. We are unique.” (J. Wilson, Focus Group Interview, August, 27, 2010)

Just because the midwives at Six Nations are self-regulated by a different set of principles than the mainstream, in the focus group conducted at the maternal health centre at Six Nations, it was emphasized that one should not assume that there is no accountability. Given the small size of the community compared to the mainstream (cites), it was argued that there was an even greater deal of accountability in this particular instance of self-regulation than that required for mainstream midwifery organizations:

“For us, since we are governed by our Band Council, if anything was done that was incorrect or unsafe, the midwife would be disciplined. It's not to say people can practice unsafely. The thing people don't understand is the high level of accountability in the practice (Band Council, Grandparents group, and most importantly the community). It's not like we practice and do our own thing. Off reserve you are your own man and not accountable in the same way. Here on reserve, we are accountable every day to the community. There is a big difference. So with traditional medicine people, if you have a concern, simply don't go. There is a level of anonymity when living in a city of 4 million vs. a small community. We are accountable to many people we see. We all work together as a team. There are so many levels of accountability but they don't understand that. For them there just needs to be one College. Because we don't have the one College we are seen as practicing recklessly with no one to govern us.” (J. Wilson, Focus Group interview, August, 27, 2012)

Lastly, even within the context of public community spaces, participants from the Six Nations Maternal and Child Health Centre emphasized that accountability in big picture of traditional First Nations midwifery is a matter of spirituality and living one's life

congruently with traditional value systems. Accountability is based on “.... our own morals, our own self that we are accountable to and the Creator. We chose this, not just as a job, but as a calling. It’s a lifestyle and a way of living” (S. Smoke, Focus Group Interview, August 27, 2010).

Some Traditional Aspects in Contemporary First Nations Midwifery

“We keep that going in our community and for the midwives. If you don’t use it you lose it. We keep it going in our community. Sometimes people that come through here want to learn the knowledge because they might not know it. They want to get it for their children.” (S. Smoke, Focus Group Interview, August 27, 2010)

As the above quote implies, for the midwives at Six Nations, part of the reason for choosing to self-regulate and to practice apart from the College of Midwives in Ontario is not only to *preserve* traditional teachings about midwifery in isolation but to develop it through its continued use. Thus, the knowledge behind these practices continues to be relevant so that it can be *used* in contemporary contexts.

The path of self-regulated midwifery at Six Nations is a holistic one that, for instance, involves addressing concerns about the health of the whole person and the quality of the relationship between the midwife and their clients:

“A big piece with self-regulation (and midwifery)²¹ is making people well generally, not just physically. How we do that is we take care of ourselves. We recognize and acknowledge that we have the power to heal ourselves (through our traditions). We can make ourselves well through our old teachings and traditions. This is why we self-regulate ourselves.” (S. Smoke, Focus Group Interview, August 27, 2010)

²¹ My parentheses.

Working with Traditional Healers

One of the benefits of having a space for midwifery in a First Nations community is being in close contact with people in the community who may have traditional knowledge about ceremonies and medicines that were traditionally used in the process of pregnancy and child birth. Nonetheless, tensions can arise when mainstream ideologies, that are part of the package of an externally funded public space in the community, clash with the beliefs and value systems of traditional medicine people. For example, it was noted:

“Something that comes up all the time with traditional medicine people, is trying to get them to sign papers that go against their beliefs....Things that interfere with them practicing in their own way.” (J. Wilson, Focus Group Interview, August 27, 2010)

Types of tensions that arise because of these clashes sometimes have to do with things like different understandings about systems of compensation and concerns about the protection of a medicine person’s identity.

“Normally people sign contracts but the traditional medicine person that works with midwives is not always comfortable signing contract agreements to provide services. The typical finance system does not work for traditional people. It is often very difficult, yet at the same time you want to give them a payment as they need to live as well. It is a very conflicting issue even for them as to how to go about doing that.” (J. Wilson, Focus Group Interview, August 27th 2010)

The midwifery participants alluded to the fact that the element of ‘trust’ in the relationship between the healer and those in need of being healed is something that still exists strongly in the spiritual outlook that is present within systems of First Nations traditional healing. Part of the reason for the clash between traditional healers and proponents of mainstream medicine is that this element of ‘trust’ has been significantly eroded in mainstream models.

“I think it boils down to what people teach us in the mainstream education system. It’s something that we learn out there. You learn not to trust things. But when you are living amongst people like us, there is a certain amount of trust that is there because we have been that way for a long time. People wouldn’t even think of doing that (suing you) if you were given medicine for a medicine man. Now, it’s a way of thinking putting blame on someone else for something that goes wrong in your life. This is really not true though because you have to take responsibility for your own life. I think if people make a choice to go to a traditional healer, they shouldn’t be able to sue. If they are thinking like that, maybe they should go see a doctor instead. People need to accept some responsibility. If they make this choice, they shouldn’t be able to sue. You chose to see a medicine person and therefore you are responsible. When you enter a relationship, you have to trust. It’s about power to choose... not just medicine – healer or doctor- but the person making the choice.” (J. Wilson and Sharon Smoke, Focus Group Interview, August 27, 2010)

One participant alluded to the fact that there is no danger of traditional medicine being assimilated by the mainstream because there is a collective awareness in the community about the importance of protecting the identity of these special people (traditional healers):

“The herbalist(s) that the Centre works with for traditional medicine are very well respected in the community. If someone did try to say something or blame these medicine people, they would be shunned by the community. At the same time the identity of these people remains and continues to remain to be protected. This medicine practice has been in these people’s families for generations.” (J. Homer, Personal Interview, January 28, 2011)

Midwifery Training

Whether it be in modern Western medicine or traditional First Nations health systems, some form of training is necessary to pass the knowledge on to others that will continue the craft. Many First Nations communities are looking at ways of developing training models that are best suited to their infrastructures and capacities that exist locally (NAHO, 2008). In a ‘community public’ context, training of midwives at the Six Nations

program consists of elements taken from Haudenosaunee and mainstream health practices:

“We have a training program that trains Aboriginal midwives. It’s not a big program.... but they do apprentice with the midwives one on one. Some book work is also involved. We don’t advertise, it’s not like that. We believe that midwifery is a lifestyle and it’s a gift that we are given. We don’t want people that just are there to leaf through a book (doing the career for primarily a reason that is financially lucrative). Its more than that. You are an example of a person who is being well. We are all are working on being well. We’ve all fought our battles.” (J. Wilson, Focus Group Interview, August, 27, 2010)

At the same time, an awareness exists among the midwives that they *are* self-regulating and in this respect, a certain measured distance is kept from mainstream institutions (e.g.: universities, medical institutions and governments) in order to protect their traditional knowledge, stay connected to the grassroots and avoid subsumption into the mainstream.

“When we first started it (the training program) there was a request from McMaster University and the University of British Columbia that they wanted to buy our curriculum. They wanted to work with us and collaborate and have an Aboriginal midwife school through McMaster. We decided to remain autonomous. They would make us quantify our traditional courses. How do you put a unit on learning how and where to pick medicine? You can’t so we decided not to go that way. They would create a big curriculum doing so much work for other courses and our people would not be able to keep up with it. That would somewhat diminish and loose the emphasis on what is important to us. We train them..... and we graduate really great midwives.” (J. Wilson Focus Group Interview, August 27, 2010)

The midwives at Six Nations noted that their training program and practice is about operating under the exemption (offered to First Nations healers and midwives in Ontario) as opposed to simply being an Aboriginal person in a midwifery program. While their funding may be limited due to their non-affiliation with universities or medical schools, the benefit is that the community is able to develop, control and regulate the program as they see fit:

“So it’s small, and we never got funding for it because we are not affiliated with any colleges or universities. But it’s our program. Basically it’s a simple grassroots program where we train people. It’s all ours. The midwives come out knowing exactly with they need to know. There are others that graduate from University that happen to be Aboriginal. It is about the training and practicing under the exemption. Not simply because you are an Aboriginal person.” (J. Wilson, Focus Group Interview, August 27, 2010)

Negative Stereotyping

“We always joke that as soon as something has the label of Aboriginal on it, it is always seen as less than. Here we are all Aboriginal midwives and we practice under the exemption code under the Ontario Midwifery act. So there are two models, there is the Aboriginal midwife and the registered midwife. By the registered midwives and other practitioners (doctors) we are viewed as Aboriginal midwives, as inferior and less respected. We are self-regulated by our Chief and Council here at Six Nations. I think this is a big issue that we are always fighting.” (Focus Group Interview, August 27, 2010)

Even if self-regulation in health sounds like a good idea in terms of First Nations being able to take control of their health policies (and subsequently implement their traditional knowledge), persisting negative stereotypes in the mainstream about First Nations continue to obstruct this ideal from fully flourishing.

“One of the big thing about regulating ourselves is it is not respected by outside (mainstream). They don’t acknowledge our self-regulation... or any organization that is self-regulating is seen as not as valuable as something that is regulated by the outside governments and/or authorities.” (J. Wilson, Focus Group Interview, August 27, 2010)

While the negative opinions of outsiders may not matter to the midwives themselves, there was an agreement among them that these negative stereotypes make it more difficult for them to do their job under their own self-regulatory policies. While First Nations midwives are often required to adopt certain policies from mainstream governments and modern Western medicine, the reverse rarely occurs. For example, one participant noted that sometimes maternity care workers and midwives feel limited due to

self-regulation. Certain privileges are not given. If a resident of Six Nations is transferred to the hospital, the maternity care worker is not allowed to go and see the client (J. Homer, Personal Interview, January 28, 2011).

In an obvious example of negative stereotyping, it was noted that if someone has what is labelled in the mainstream system as post-partum depression, it seems to be a stigma for mental health in the community. In such cases, one participant noted that nurses automatically seem to get the Children Aid Society (CAS) involved in the process. If anything, the mother may not say anything if she knows that this is a possibility. This puts additional stress upon the mother (J. Homer, Personal Interview, January 28, 2011).

Exclusion of First Nations Traditional Knowledge in perceptions/definitions of 'efficacy'

"We trust the Creator and the cycle of life and death and acceptance. Not to say that safety isn't an issue, because it is, but we don't work from the perspective of fear. We are holistic in the way that we do wellness. Sometimes the emotional and mental wellness is just as important as the physical." (S. Smoke, Focus Group Interview, August 27, 2010)

Problems can arise in the area of efficacy, particularly with First Nations plant based medicines, when Western scientific techniques are inappropriately applied to determine active the active ingredients in these medicines. For example, it was noted in the literature review that First Nations plant medicines are not made up of 'isolated compounds' making it more complex to analyze than conventional pharmaceuticals (Obomsawin, 2008).

One criticism about current efficacy standards from the midwives at *Tsi Non:we Ionnakeratstha Ona:grahsta'* was that people from the outside constantly ask about the

safety of their traditional medicines even though they are limited by preconceived ideologies about efficacy:

“But what it is like being self-regulating is that you always have to prove to someone else what you have. They say to you, well you never have showed us what you do or how you do it. Or how do we know that this is safe and how do we know that this isn’t safe? and even though that it has been information/knowledge in tradition and information and that it has been a gift that has been passed down forever, yet they want to have their stamp of approval on it to know that it is safe. Because we don’t have that stamp of approval on it, they want to see how they can get at that to make sure that it is still safe because they don’t trust or have faith or even allow us to have that self-regulation because they need to have that control.” (L. Jacobs, Focus Group Interview, August 27, 2010)

Furthermore, little or no understanding by the mainstream of First Nations traditional health concepts can magnify these kinds of disconnects:

“One time, we went to a hospital to give a talk and there was a huge discussion/gathering of nurses, doctors consultants, health professionals. They were saying, 'well how we know that those traditional medicines are safe that you give people. What are they? Tell us the names'. So we had to explain that these are guarded and they are gifts that we have been given from the Creator. We have to protect that. You can pick a medicine and you know where it grows. You go out into the bush and it will hide on you or won’t grow if you abuse it. And then you will no longer have that medicine to use. If enough people do that, then it’s not going to be there at all.” (L. Jacobs, Focus Group Interview, August 27, 2010)

While educational initiatives may help to solve part of the problem, one participant warned that if they shared some of their traditional practices and made it common knowledge, people can ‘pull it apart’ and use these parts out of context (L. Jacobs, Focus Group Interview, August, 27, 2010).

If the dominating ideology is that assessing the safety of First Nations traditional medicines should come only from the scientific method (i.e.: what they use to test medical compounds in their own medical system), continuing to follow such a path remains problematic in correctly assessing the true benefits of these medicines:

“Plus with traditional medicine too, it’s not just the plant itself. It’s the spirit in the plant and the Creator, plus the person that’s it’s made for (all these things play a factor). It’s not even herbal medicine, it’s different from that because it has that spiritual component to it. It makes me feel not so good when people refer to our traditional medicine as herbal medicine because it is not the same thing.” (S. Smoke, Focus Group Interview, August 28, 2010)

Predetermined definitions and Assessments of 'Risk'

In this instance of ‘community public self-regulation’, definitions, and the subsequent assessment of risk are predominated by the mainstream and non-inclusive of First Nations traditional health knowledge. In a practical sense, the midwives noted that this makes life difficult with respect to things like acquiring funding and insurance:

“Really we live in a world where money is the currency we use to buy, to live, to survive. You can’t blame the practitioner for needing money or a wage. That is a big part. Even for the malpractice insurance, its difficult. At one point we went to get better liability and malpractice insurance. We even went to all sorts of companies all over the world, even those that normally deal with high risk, they wouldn’t accept us. We were unsuccessful because we were not regulated by the College of Midwives. Because we were self-regulated, they said, ‘we can’t be certain you are following a certain standard’. They said they can’t be certain that we were credible. Right now we are lucky, we have limited insurance. Not as good as we would like to get. For new practitioners, I don’t really know what they would do.” (J. Wilson, Focus Group Interview, August 27, 2010)

In regard to creating more genuine spaces that incorporate First Nations ‘community public’ aspects of self-regulation in traditional health and healing, the midwives indicated that things like definitions and assessment of risk should not be predetermined by mainstream powers:

“Thinking outside the box is important. The functional model is different than the theoretical model. The funder needs to go out of their comfort zone a bit and work a bit grey. There is a trust issue there. In order to help different Native communities, you have to think outside the box. A lot of people are scared of the functional model because it is different.... There needs to be recognition by everyone to accept and acknowledge that there are different types of models out

there. Everything can't be black and white." (J. Wilson, Focus Group Interview, August 27, 2010)

Acknowledgement/Accreditation: Innovative Solutions vs. Conforming to the mainstream

Lastly, in the context of community public self-regulation for in traditional health and healing, the conversations with representatives of *Tsi Non:we Ionnakeratstha*

Ona:grahsta' indicated that solutions were needed so that they could practice the values associated with traditional Haudenosaunee midwifery while, at the same time, being accredited in the eyes of their mainstream colleagues and funding partners (Focus Group Interview, August 27, 2010).

Aboriginal women in Canada continue to make strides towards reclaiming their role in their communities as 'givers of life' (Skye, 2010; Carroll and Benoit, 2001). There are certain values that are not worth compromising and Aboriginal midwives know that the life-cycle knowledge passed onto them through oral traditions is valid and accredited.

One participant noted that giving birth is a thing of beauty and that the woman is empowered in childbirth: "When someone involved in the hospital birth tells you we will do this and we will do that, it takes away from the mother's power as a woman" (J.

Homer, Personal Interview, January 28, 2011). Furthermore, the participant indicated that there is a serenity and sacredness around birthing at home. Part of this specialness in the mainstream is taken away. In the West, one might think that giving birth is almost seen as a sickness rather than simply what people do (procreate) (J. Homer,

Personal interview, January 28, 2011).

In the literature review, it was noted that the accreditation issue for Aboriginal midwifery in Canada (in the context of 'community public' self-regulation) was one where, on the whole, the balance of power would seem to lie with the Provincial Midwifery Colleges because these are the credentials most recognized as valid by mainstream doctors, nurses, hospitals and insurance companies. It was noted in the Focus Group interview that practical issues (that are much less apparent with midwives who practice under the Provincial College) such as lack of funding, obtainment of insurance and, individual provider/billing numbers have put pressure on the self-regulating midwives at Six Nations to contemplate potential future innovations:

“We have talked to Director of Health about possibly establishing a governing body. Perhaps a Body made up of community members, health care practitioners and some traditional healers to function similarly to the College of Midwives. We wouldn't call it a college. We hope that the government might see it as a model that they would see as equivalent to the College and we could get more insurance, funding and provider numbers/ billing numbers.... It would be different –whether we would call it a circle or a council– and the members would be different and it would be in our territory, but there might be other midwives that might want to be part of this.... in other communities that need the help. But the thing is we don't want to intrude on territory of other communities.... so we wouldn't want to say this is the Ontario Aboriginal College of Midwives. Each Native community has always regulated their own.” (J. Wilson, Focus Group Interview, August 27, 2010)

Even in contemplating compromises, such as the one outlined in the quote above, concerns about subsumption of their midwifery model into the mainstream persist. In the literature review of this thesis, these types of concerns were discussed under the term *institutionalization of traditions* which Waldram (1997) and RCAP (1996) state remain an interesting challenge. One participant noted that, “it is maddening that we have to go and create something that is something similar to theirs in order to receive the acknowledgement” (J. Wilson, Focus Group Interview, August 27, 2010).

Designated Public Spaces for Traditional Healing at Akwesasne

Akwesasne has a unit dedicated to traditional healing in their Health Centre. Although not everyone interviewed currently worked at the traditional healing unit, several of the participants held positions in the past either with the Health Centre or Traditional Healing Unit. Other participants worked with Social Services and were involved in either providing or facilitating the delivery of cultural programming that included traditional Mohawk understandings of health and healing. All of the participants were aware of the Traditional Healing Unit. The following themes address the results obtained from research participants at Akwesasne pertaining to *community public self-regulation* in First Nations traditional health and healing:

- Self-Regulation and Healers at Akwesasne
- Health Systems: Shifts in Preferences and Offering Choices
- Compensation Issues and the Para-Professional Paradox
- 'Fitting a Circle into a Square': Defining and Evaluating 'Knowledge'
- Over-Commercialization and the Devaluation of Culture
- Protection from Unwarranted Claims About Healers
- Program Sustainability

Self-Regulation and Healers at Akwesasne

Even though the Health Centre at Akwesasne has a traditional healing unit, the general consensus among participants about self-regulation in traditional health and healing was that the term ‘self-regulation’ was one that implied some type of interference from mainstream governmental regulatory models, rather than something that promoted a greater internal independence and control over traditional systems of healing. One participant noted:

“Healers at Akwesasne don’t have governing bodies that regulate so it ends up being different than midwives. If regulation did begin to show a rather forceful presence then healers might go underground and find alternative ways to administer their healing. Ultimately, there is still a significant trust issue with the government. But given the seriousness of what we are talking about there is no compromise” (I, Personal Interview, November 23, 2010)

This is a perspective that we should not consider unusual. In the introduction of this thesis, it was noted that while regulations are important to protect the public from harm, they are, at the same time, rules or orders backed by the laws issued that are issued by governments and enforced by public servants. In a *perfect* world, this ‘power’ would be delegated in a way to benefit and protect all citizens, but this lofty objective sometimes proves to be unrealistic in the *real* world. Additionally, it was also noted that while mainstream self-regulation refers to the regulating of health professions, similar concepts do not begin to translate very well into contexts of First Nations traditional health and healing.

While the reality of human death does not escape either modern Western or First Nations traditional medical systems, one participant felt that trying to blend different ideas of self-

regulation would eventually result in collective perspectives that favour the former,²²

“It still isn’t a safe environment for our medicine people to come out in. All the negative attention is focussed on First Nations when someone dies trying to be helped by traditional medicine . People die on operating tables and in hospitals every day from similar ‘complications’” (F, Personal Interview, May 3, 2010).

With respect to self-regulation ‘F’ also then indicated that there are drawbacks from forming formalized self-regulated associations of traditional healers like they have in other parts of the world. ‘F’ indicates, “associations are about money and power. If we follow this route, what does that make us?” (F, Personal Interview, May 23, 2010).

Health Systems: Shifts in Preferences and Offering Choices

Even though participants indicated that the mention of self-regulation (or regulation) should elicit cautious responses, they also indicated that one of the reasons that a traditional healing unit exists in the Health Centre at Akwesasne is because there was some indication that people in the community wanted a greater ability to access it.

According to some participants, for certain ailments, there has been a shift of preference from using mainstream medicine to traditional medicine. The Traditional Healing Unit at the Health Centre partially came into being due to a community survey which showed that the majority of Akwesasne community members wanted greater access and usage of traditional medicine (J, Personal Interview, May 3, 2010).

A positive notion concerning aspects of 'community public' self-regulation and traditional health and healing is the importance of offering First Nations community members a choice in their health care options. Specifically, this involves the ability to access

²² This is similar to the *Institutionalization of traditions* issue discussed in Chapter 2 (literature review) or the phenomenon of cultural hegemony (Emery 2012), discussed in Chapter 3 of thesis.

traditional healers and medicines as well as Western doctors and medicines within a public space that can be utilized by all community members. Some, like Cree philosopher Willie Ermine, argue that more 'spaces' like these need to be available so that better methods of ethical evaluation can be developed. This being the case, Ermine also indicates that one has to be cautious about the undercurrents of cultural hegemony that interfere with the good intentions behind collaborative efforts. (Ermine in Ford, 2010).

In the 'public space' of Traditional Healing at Akwesasne both the positive and negative notions of the space that Ermine describes can be seen. On the one hand, it would seem as if Euro-centric ideas of consent predominate the space.

“If the client chooses to do this, medical centre protocol requires them to sign off on papers that basically state they are going to follow the traditional medicine ways and take instructions from the healer. When they do give them traditional medicine, a nurse will still monitor progress..... Cases are taken on an individual basis. If a physician doesn't feel like any benefits are lost, the person can continue to use traditional medicine.” (J, Personal Interview, May 3, 2010)

At the same time, it would seem that offering the choice allows the people being treated to be benefited by both healing systems. One participant stated, “the good thing is that it provides more access to healers and more people are talking about it and using it” (G, Personal Interview, January 26, 2011). 'J' indicated that, “the client has the option of choosing traditional medicine approach or mainstream Western medicine.” Also according to 'J', a lot of people, use the Western medicine for diagnosis (e.g. doctor examination, x-ray) and then choose to come down to traditional medicine to receive treatment (e.g.: natural herbal, ceremony etc.). (J, Personal Interview, May 3, 2010).

Compensation Issues and the Para-Professional Paradox

“In the past healers were given whatever they needed. It was an exchange that came from the heart. The issue is when it becomes institutionalized, healers are getting paid and this affects the relationship between the healers and the healed. Now we have people getting paid and people not giving gifts. This influences the healers as well but some shy away from the institutionalization.” (G, Akwesasne-January 26, 2011)

With respect to compensation, the quote above illustrates a tension between traditional practices, such as giving a gift for being helped by a healer versus monetary compensation that is usually associated with Euro-centric conceptualizations of professionalism. In Chapter 3 of this thesis, it was noted that since professionalization can result in a creation of distance between workers and those who they serve, there can be an identifiable resistance towards moves to professionalize. (Banks, 2004). For First Nations communities, where cohesiveness of families and communities are among the core values, resistance to a fully mainstream approach of professionalizing First Nations medicine is likely to occur. At the same time, Morgan (1998) noted that sociologists have only recently recognized that professions evolve in contrasting ways that depend on jurisdiction. This implies that for First Nations, definitions of professionalism that strive to model homogenous mainstream standardizations may be inappropriate. In contrast, it is important to investigate further into what might work in particular First Nations jurisdictions.

Regarding compensation for the healers who work at the Traditional Healing Unit, participants indicated that that this was also something they had to figure out for themselves as a community. What Akwesasne decided was to hire the healers on as employees of the Health Centre. One person shared,

“In our ways, if you have someone who is a traditional healer then it is the responsibility of the community to take care of them. So how do you bring them into a system and actually pay them or compensate them or allow them to continue living? So we did this. We convened a group of people that helped us figure this out. How do we bring this people on? We actually involved our human resource people because we asked are we going to provide them with heating, fuel, food. How will we compensate them for their work? It was a consensus and that is how the group came up with it. In previous days, this is how we compensated a person. People deserve to be compensated for their work. It was a consensus and this is how the group came up with it. Everyone has the opportunity to work and be compensated for it. So we agreed that we would do that and we would bring them on as an employee.” (B, Focus Group Interview, November 24, 2010).

Even though healers were hired as employees/professionals, it was indicated that they still struggle with things like rates of pay.

“We didn’t want to bring them in at a rate of pay that would be a slap in the face for them because they were bringing to us a professional service.... But we are still struggling. I’ve had that conversation with our Executive Director as how do we compensate a person as a cultural adviser? How do we differentiate rates of pay for someone in an apprentice program, vs. someone who has their PhD? So how do you do that? So there some questions as an organization that we are still struggling with.” (B, Focus Group Interview, November 24, 2010)

In a sense this presents a paradox because, practically speaking from a financial perspective, people need to have a job to support themselves and their family. However, also part of the community reality is the notion healers gradually receive responsibilities and grow into their duties within a community over time (G, Personal Interview, January 26, 2011). One participant joked that:

“Down here in traditional medicine we like to call ourselves “para-professionals” The reason for this is that healers and staff at the healing centre are the lowest paid. They don’t get compensated for the work that they do compared to Western professionals.” (J, Personal Interview, May 3, 2010)

In this ‘community public space’, although there is a place for Indigenous knowledge and traditional healing methodologies, cultural hegemony still exists, at least with respect to

compensation issues and traditional healers. To some extent then, the current mechanisms of mainstream professionalism do not take into full account the reality that healers are accredited in their community based on the fact that people know them and rely on them (J, Personal Interview, May 3, 2010).

'Fitting an Circle into a Square': Defining and Evaluating 'Knowledge'

The recent recognition of the importance of traditional healing practices of Indigenous peoples has somewhat reversed historical efforts to eradicate Indigenous traditions (Wagemakers-Schiff and Moore, 2003). This is a positive development. However, some argue that the true epistemological uniqueness of Indigenous healing knowledge has yet to be accepted and/or implemented in these 'community public' spaces. Some participants emphasized that who gets to set the standards for what counts as knowledge presents obstacles for good health/social programming that remains rooted in their cultural value systems:

“Often when we try to implement a program that is good and rooted in traditions, it’s hard to get the education out there when people in places of authority try to stop it from happening. Even with the traditional medicine, the Ministry still wants to see credentials and numbers.” (D and E, Focus Group Interview, January 27th, 2011)

For a First Nations person who holds a management position in their community, it can be a struggle to reconcile the abilities that they know a particular healer has with an external system –for the assessment and evaluation of professionals– that gives little or no recognition to the merits and/or understanding of person’s understanding of Indigenous knowledge:

C- “That was my question is, 'How do you put a value on their service and their knowledge?' We have had that struggle. From a management perspective, I see us as devaluing that service and qualification.... Because a lot of times the cultural advisor comes to us with a wealth of knowledge and experience but then may have a grade eight education. So trying to juggle that and justify to Human Resources or to other entities within our Organization as to how we respect this person and how this person is the equivalent to a doctor or a Masters at a certain level. That is one issue that we have always had a problem with.”

B- “Trying to fit a circle into a square world.... It’s odd.” (B and C, Focus Group Interview (November 24, 2010)

With respect to a ‘community public’ self-regulation in traditional health and healing that would truly benefit First Nations communities, reconciling the problem of who defines and evaluates knowledge is critical:

“Just because you have a degree from a Western Institution doesn’t mean you have the ability to assess traditional knowledge. You still may be following guidelines not developed or even influenced by traditional healers.” (D and E, Focus Group Interview, January 27th, 2011)

Over-Commercialization and the Devaluation of Culture

In an extreme case, a New Age "Spiritual Warrior" retreat, which took place near Sedona, Arizona, was discussed in the literature review as an example of how authenticity of First Nations healing traditions can be diminished through commercialization and misrepresentation. Some participants from Akwesasne talked about the balancing act that is sometimes necessary to provide traditional healing services in a community public space. While a public space may be the only place where some community members can have the opportunity to learn or re-learn about the traditional healing values in their culture, there was also an awareness of the danger of traditional healing being over commercialized:

“.....we have talked a lot about actually commercializing our culture, our ceremonies and our practices. I know just from our discussion that it is devaluing that whole traditional cultural component of who we are... as we put it out into market we are selling this kind of thing and providing it. Whereas before it was devalued in the community (because of the church) and it wasn't seen as something that was allowable or respectable... it was looked down upon, and I don't know if that's a good thing or a bad thing as we put it in a new light, because I see our cultures and traditions really taking off and coming back and being reintroduced to our community, and that's a good thing.” (C, Focus Group Interview, November 24, 2010)

One interviewee stated that the reason for this pressure towards greater commercialization of traditional medicine is because medicine in the mainstream has shifted from a wisdom and healing focus to money making ventures:

“Part of the problem that suppresses this type of ideology from manifesting lies in the fact that society is after the ‘quick fix’. They want instant results and if they don't see that, then their commitment tends to wane rather quickly. This doesn't lead to that commitment that is necessary to build a trust in traditional medicine.” (I, Personal Interview, November 24, 2010)

In the past, communities were small enough and customary practices and informal norms were enough to protect First Nations people against false practitioners.

Protection from Unwarranted Claims against Healers

As First Nations traditional healing continues to have a greater presence in public spaces, something of great concern is the protection from unwarranted claims against healers. For instance, it was noted in the literature review that in response to the tragic Spiritual Warrior incident outside of Sedona Arizona, where people lost their lives, Lakota traditional spokesperson Arvol Looking Horse had to issue a statement outlining the correct understandings about the sweat-lodge ceremony. Looking Horse also affirmed

that the events that occurred outside of Sedona did not in any way represent the Indigenous ceremonial way of life (Looking Horse, 2008).

At Akwesasne, they are developing their own Code of Ethics to protect against such unwarranted claims about healers (J, Personal Interview, May 3, 2010). 'J' also noted that protection from unwarranted claims comes from the simple fact that healers "...are living examples of what works" and that "there is nothing experimental happening here" (J, Personal Interview, May 3, 2010).

Self-regulatory policies for First Nations traditional health and healing that occurs in 'community public' spaces was not always seen as an issue about attracting charlatans. 'G' believed that this should not be a focus for the government, as it is an issue best resolved at the community level. They stated,

"It is not something government or funders should focus on. It is up to the community to decide. A main issue is that the government should not get involved too much because it's our intellectual property rights. They should stay out of our domain with respect to traditional healing because it is an insult to our capabilities and to who we are as a people" (G, Personal Interview, January 26, 2011).

Program Sustainability

First Nations traditional healing or the hybrid health programming (inclusive of traditional healing) that exists in 'community public' spaces often finds itself faced with contemplating issues of sustainability. This is the case due to themes discussed in the literature review such as non-recognition of the unique healing knowledge possessed by Canada's First Nations communities or 'grey areas' in Canadian law and policy regarding First Nations traditional health/healing. One aspect of sustainability that continues to

impact programming at Akwesasne (and no doubt many other First Nations communities) is financial resources for cultural, social and traditional health programming:

“Pots of funding have tended to shift every few years. For example now it seems to be shifting to long-term care. It is a vicious cycle. This means that healers and cultural and social programmers in the community sometime need to be creative in order to provide the services that the people want.” (I, Personal Interview, November 23, 2010)

‘I’ went on to say that, at least for First Nations, mainstream governments should begin to look at the complexities of holistic wellness and they should to develop models beyond their current ones which tend to ‘compartmentalize’ health based on mainstream approaches (I, Personal Interview, November 23, 2010). Another interviewee stated, “one thing that is needed is for program managers to understand who we are and where we come from” (F, Personal Interview, May 3, 2010).

Sustainability with respect to traditional health and healing, however, does not necessarily always *start* with the need for funding and *end* with a program. ‘F’ indicated (Personal Interview, May 3, 2010) that it is not governmental resources that are needed, as there are still too many uncertainties about how the government would want to support it. Part of the answer to sustainability should come from healers organizing themselves in greater numbers: “This has to do with protecting our medicines. Our medicine people need to band together and make a really sound statement that ‘this is our medicine.’” (F, Personal Interview, May 3, 2010)

A final observation from participants at Akwesasne with respect to sustaining the knowledge that can be sometimes introduced through community based traditional health

and healing programs has to do with education and facilitating a community approach to health and healing.

“Community people may not be a ‘medicine man’ or ‘medicine woman’, but they may have pieces of knowledge that has been passed down to them over the years. This is a community approach to health and healing.” (F, Personal Interview, May 3, 2010).

Thus, for Akwesasne, part of the answer to sustaining traditional health and healing practices in the community would seem to involve facilitating a greater role for people in directing their own healing. Through the Traditional Healing Unit at the Health Centre and other programs, they are trying to provide more education and learning so that members can tend to their own health needs. If they problem is beyond their own ability to help themselves, then the person can be referred to a healer (J, Personal Interview, May 3, 2010):

“Taking people on a slow walk through the bush to study can be a very good way of transferring Haudenosaunee medicinal knowledge. Training in medicine walks can occur at any age and now people are picking medicines on their own and using them to heal themselves because they remember what they have been shown. If they have questions they can always call and ask the healer.” (J, Personal Interview, May 3, 2010).

As well, ‘J’ notes that certain representatives from Akwesasne are helping other First Nations communities to develop their prowess in similar issues around how traditional medicine as being used in contemporary contexts (J, Personal Interview, May 3, 2010).

Interviews at Elsipogtog: Healer/Elder Perspectives on Community Public Self-Regulation

A fewer amount of interviews were conducted at Elsipogtog (four in total) than at Six Nations and Akwesasne. However, a distinguishing quality of the Elsipogtog interviews is that they were conducted exclusively with healers and/or Elders (whereas not all research participants interviewed at Six Nations and Akwesasne were healers and/or Elders). The following are results from one key informant interview and one focus group session that fell under the 'community public' self-regulation category. Two research participants are from the community of Elsipogtog while the other two are from other communities in the Wabanaki Confederacy.

Themes that were discussed, with respect to aspects of 'community public' self-regulation, were as follows:

- Community Spaces for Healing
- Native Licensing
- External Supports for Traditional Healing: Validation and Acceptance
- Formalized/Publically Recognized Associations of Healers

Community Spaces for Healing

In the context of this discussion at Elsipogtog, a rather interesting viewpoint was presented when participants were asked about the importance of a physical space in the community to do healing work (and that work only). For D. Gehue, good spaces to do healing work were paralleled with the importance of things like safety and relationships with others that were built on trust:

“That is so important. The haven I have at the healing lodge is JA’s office and that is all. Because lots of people that come in and out (of the healing lodge)²³ are screwed up. I know in that office it is safe. If for some reason, I have the inclination that it is not safe enough, then I come to FA’s house.... because I know I’m safe.” (D. Gehue, Focus Group Interview, May 16, 2010)

With the idea of safety and confidentiality (for the healer and the client) at the centre, the public healing space at the Health Centre can be considered to be connected to other less public healing spaces (i.e.: people’s homes) in the community. In this case, this arrangement worked out very well:

“.... and the clients that come here (to FA's house)²⁴, they know they are safe.... and they want to come back. They don't want to see me at the health centre; they want to see me over here.... Because they find this place is very safe. It's being smudged all the time and we look after this place.There have been hundreds of people that have sat where FA is sitting and where you are sitting and their lives have been changed...” (D. Gehue, F. Augustine, J. Augustine, Focus Group Interview, May 16, 2010)

These types of safe spaces, where First Nations traditional healing occurs in a post 'jagged world-views colliding world', are ones where the epistemological uniqueness of Indigenous healing knowledge is both fully respected and fully operational.

Native Licensing

Licensing is often one of the core elements particular to mainstream self-regulatory health processes. It is the norm that professional associations engage in self-regulation and the policing of practising members. Governments, in turn, negotiate with professional schools/associations in order to establish appropriate licensing and competency criteria (Brascoupe & Obomsawin, 2008). A suggestion offered to contribute

²³ My parentheses.

²⁴ My parentheses.

to self-regulation processes with respect to traditional health and healing by participants was a type of Native licensing. Specifically, 'Native Licensing' was referred to as, "Our ability to be licensed in our respective fields and governed by our own people". (D. Gehue, Focus Group Interview, May 16, 2010).

When asked about obstacles to this type of process (e.g.: such as dangers of this type of licensing being subsumed by mainstream perspectives) participants agreed that there would be lots of obstacles that come with trying to implement such a process. However, they also expressed some of these obstacles have already been overcome as this kind of approach had been implemented with some success in other Indigenous communities:

"They do have a licensing board in Navajo country. There is a board out there. If the medicine men pass that board, they are recognized and licensed by the hospitals in region. So they go out and get as paid as much as a doctor does when they go out and see people. It's taken 20 or 30 years.... but it is not going to take as long here because we can copy the model." (D. Gehue, Focus Group Interview, May 16, 2010).

Strengthening First Nations self-regulation in traditional health and healing in this particular way could have some external and internal benefit. For example, in addition to internally developing their own way of training and licensing members, the *Dine Hatatali'* (Navajo Medicine Man's Association) has been able to use its powerful influence to affect 'external' issues -such as the attempt to regulate the use of traditional Native American practices off Indian lands (Censored News, February 2010).

External Supports for Traditional Healing: Validation and Acceptance

As indicated in the description of *Aspects of Community Public Self-Regulation and Traditional Health and Healing*, there is often some type of partnership that occurs with a

funder (usually a governmental branch) in order to sustain any type of programming that occurs in these types of spaces. Somewhat parallel to the discussion in the literature review about 'grey areas' in Canadian law and policy, it was noted in one discussion at Elsipogtog that appropriate government legislation in support of First Nations traditional health and healing might play a role, particularly in better sustaining programming in contemporary times (B. Altivator, Personal Interview, May 16, 2010). This might aid in reducing some of the currently existing tensions resulting from the hegemonic imbalance which favours mainstream models of health self-regulation. In a similar light, this same interviewee noted that, in a broad sense, the State of Maine had undertaken an initiative that aims to raise general mainstream awareness of the about Native American tribes that reside in the state through legislation:

“They recently passed a law in the state of Maine that college students had to take a course in Indigenous Studies, or Wabanaki Studies and then people within the tribes of the state of Maine, they also have to bring somebody on board so many times a year... (from the communities)... to do workshops for the staff to educate the teachers and the staff themselves. so it is accepted on the State level, it's supported on the State level... on the local level, it becomes part of the curriculum, right from kindergarten through college. So if we did something like that similar on a state, regional and, maritime, or even a national level.... and took that similar approach, I think we could go a long way with healing, Indigenous healing and spirituality and this way of life.” (B. Altivator, Personal Interview, May 16, 2010)

In addition, it was noted that greater validation and inclusion of traditional healing in current health centre models (that are normally structured according to principles in modern Western medicine) could: help to normalize the presence of traditional healers and aid in providing the holistic health services desired by many First Nations communities. B. Altivator stated:

“I would say that if you go to a health centre, that usually there is someone there to help you physically, mentally, and emotionally. But the aspect that is missing is

the spiritual one.... (the spiritual aspect of the person) There is a void there in the health system. So I think if you had seers or healers, medicine people.... that that would be more accepted. If they saw people like D. Gehue and J. Augustine and F. Augustine in the clinic every day, they wouldn't think twice about it. But because it doesn't happen much, when we go to the health centre, they look at us like we are foreigners and some of these people are our own people...." (B. Altivator, Personal Interview, May 16, 2010)

Formalized/Publically Recognized Associations of Healers

In one sense, participant response was positive with respect to healers self-organizing:

"... I think it is a good thing. I think it is like anything else.... strength in numbers. Any man can break a single arrow, but if you put 50 of them together, no man can break it (as the saying goes). That is how all species survive by sticking together." (B. Altivator, Personal Interview, May 16, 2010)

In another sense, tensions exist between First Nations healers that may work together at the grassroots level and the self-regulation processes in mainstream health that often focus on groups of health professionals/experts forming some type of financially self-benefiting association. In the mainstream, it is these latter associations of professionals that then usually negotiate the terms of the self-regulation with a mainstream government:

"You know, I've been introduced as someone who is this and that or an 'expert'. I always say, no, I am not a medicine man, I am not a healer. I don't get caught up in that because you are feeding your ego.... Your ego can get you in a lot of trouble..." (B. Altivator, Personal Interview, May 16, 2010)

It was noted that the idea of having *formalized* or public associations of traditional healers that are recognized in the mainstream should be approached with caution. In response to a discussion about a group of healers in South America that had attempted such an association, with limited success, it was noted:

“There is a possibility, that they were targeted because they were labelled. If their names are in some type of directory or registry, then they are singled out there and they can be targeted. Especially since there are certain people in mainstream society that don’t want this to happen.” (B. Altivator, Personal Interview, May 16, 2010)

In addition to being targeted or labelled by powerful members in the mainstream medical business whose goals are purely for profit, the lure of money and power could result in inner conflict among an Indigenous self-regulating group:

“.... because...you know, you could sort of be teetering there thinking but I am going to be the expert or consultant of my tribe, I will sell this to the white man and be rich..... It’s very tempting because when you start feeding your ego and your greed, it pushes the spirituality and all those other things to the outer circle.” (B. Altivator, Personal Interview, May 16, 2010)

On the other hand, other groups like the *Dine Hatatali'* have made such a formalized association work to their benefit. The discussion with B. Altivator also implied that it is possible for healers (if they so choose) to navigate through some of the more mainstream requirements of formalized associations, as long as they are able to remain true to the values and practices (i.e.: ethical principles of self-regulation) of their respective Indigenous healing systems.

“Hopefully the ceremonies would keep the healers strong and above water. So you need to protect that centre and there is nothing that can draw you away from that like being famous or notoriety. People praise you, they pat you on the back, monetary rewards etc.” (B. Altivator, Personal Interview, May 16, 2010)

In a personal example of what it meant to remain centred on the healing task in a contemporary environment that contains so many external influences, the following description was offered:

“It’s like what I do.... For example, one of the things I do is sweats in prison. I let the committees take care of the politics and all the other stuff. I just go and do the sweats.... I let them talk.... the lobbyists, legislators, prison staff and such.... That is the way I like it.... I just run the sweat and that is how I like it... I am not a

politician...I can hold my own with respect to representing different issues, but those were not my instructions I was given. My instructions were to provide sweat ceremonies to native inmates and that is what I do. That makes my job so much easier. I need to keep my mind clear and focus, not only on the intent, but at the ceremonies at hand.... Your ego can get you in a lot of trouble.... Like D. Gehue was saying, your mind will start making dates your body can't keep.” (B. Altivator, Personal Interview, May 16, 2010)

Roles for Aboriginal Centred Strategies and Organizations: The case of the Aboriginal Healing and Wellness Strategy (AHWS) in Ontario

“A good funder works in partnership. It is important to support organizations like AHWS that allow communities to develop their own plans.” (J. Wilson, Focus Group Interview, August 27,2010)

This particular category originally arose from discussions that occurred with the research participants at *Tsi Non:we Ionnakeratstha Ona:grahsta*. In the context of ‘community public’ aspects of self-regulation in traditional health and healing, Aboriginal centred strategies and organizations can act as a kind of buffer between First Nations communities and the mainstream. They provide a type of bridging mechanism where First Nations health models can become more genuinely inclusive of a community's traditional knowledge and where external pressures on First Nations to conform to mainstream health models, due to arrangements with mainstream funding sources and/or governments, can be reduced. Professor David Newhouse (Onondaga Six Nations, Chair of Indigenous Studies at Trent University), indicated that organizations like AHWS act as a segue into effectively and appropriately using traditional healers in contemporary environments (D. Newhouse, personal communication, October 15, 2010).

With respect to the AHWS in particular, the Director of *Tsi Non:we Ionnakeratstha Ona:grahsta* noted:

“I really think AHWS is a very good model as to how that system could work. It’s a partnership between the funder and the Native community and organization, and they really do give us freedom to create our own programs.” (J. Wilson, Focus Group Interview, August 27, 2010)

For J. Wilson, what has been problematic in the past is trying to apply a 'cookie cutter' model from the mainstream to First Nations health programming (including ideas that are used to determine self-regulation):

“Trouble is people have come in the past say I want a clinic right here. I’ll give you doctors and nurses. This is how we want you to run it. They take the blueprint from off reserve and try to put it into the community. But this doesn’t work for us. The mainstream model is not how we function. And then what happens because we are not getting better (according to those outside standards) they blame us and say well it’s just you. They say we tried, why aren’t you any better and less diabetic than before 10 years ago. It is because that design doesn’t fit our reality and adhere to what we value.” (J. Wilson, Focus Group Interview, August 27, 2010)

With respect to the role that can be played by Aboriginal centered strategies and organizations in general and the AHWS strategy (and its accompanying organizations) in particular, a key informant interview was conducted with Sylvia Maracle. In Ontario, Ms. Maracle was a key person in the AHWS's early stages of development. Several community based Aboriginal organizations have resulted from this strategy, along with several 'community public' healing spaces. Ms. Maracle (who is also the Executive Director of the Ontario Federation of Indian Friendship Centres) continues to be involved in the positive application of the AHWS throughout First Nations communities in Ontario.

During the conversation with Ms. Maracle, three themes arose with respect to the role that the AHWS and their associated organizations are playing in positively affecting self-regulatory issues in First Nations traditional health and healing:

- Access to Resources and the Promotion of First Nations Traditional Understandings of Health
- Preservation and Contemporary use of Traditional First Nations Health knowledge
- Development and Sustainment of 'bridges of understanding' between Traditional First Nations Health Practitioners and Mainstream ones

Access to Resources and the Promotion of First Nations Traditional Understandings of Health

First Nations who desire to include their traditional understandings of health when applying for mainstream health funding often face a difficult path. Funding is not always available for initiatives that do not comply with the standards for validity used in Western science and medicine. For funding projects in the area of First Nations traditional health and healing, "Thinking outside the box is important. The functional model is different than the theoretical model. The funder needs to go out of their comfort zone a bit and work a bit grey" (J. Wilson, Focus Group Interview, August, 27, 2012).

With respect to this challenge, the AHWS in particular is able to more accurately understand and promote the health needs that are occurring at the community level, as opposed to more mainstream funding organizations that are not necessarily in tune with First Nations communities. Ms. Maracle indicates:

“I think organizations like AHWS office and the organizations that were created as a result of the Aboriginal Healing and Wellness strategy like the health centres and the birthing centre, even the Aboriginal health authorities... many of which are now looking at the traditional healing notion. I think their role is one of

promoting....saying this [request for traditional healing services]²⁵ is now occurring and providing resources.” (S. Maracle, Personal Interview, December 6, 2010) .

Through more accurately understanding the health needs in First Nations communities, AHWS provides a channel for directing resources to programs, such as community based traditional health and healing initiatives, that in the past might not have been supported in mainstream health agendas:

“Some of the groups that you are seeing, like the traditional healing unit at Akwesasne and the birthing centre at Six Nations, they may well have been ideas and concepts in the community, but it took AHWS to come along to the community and say this is how to resource it... because there are not a lot of ways to resource traditional healers. There are not a lot of ways for the communities, because of the economic status to be able to support these things. So processes like AHWS are important for that.” (S Maracle, Personal Interview, December 6, 2010).

Preservation and Contemporary use of Traditional First Nations Health Knowledge

The AHWS and other similar organizations might be seen as positive cases of *institutionalization of traditions* rather than the version discussed in the literature review, where Euro-centric institutions can dilute First Nations traditional understandings to the point where they may become trivial or even unrecognizable. Organizations such as the AHWS help to protect the First Nation traditional healing knowledge that currently exists:

“The other thing is that AHWS type projects and even other programs like the Association of Friendship Centres, we have a role to play in terms not just in promoting the traditional healing, but also to make investments to make sure that we don’t lose anything more through the colonization process. That this memory, blood memory, teachings, songs, ceremonies, and practices or identifications of medicines aren’t lost, or further lost And as you know we have lost a great deal

²⁵ My parentheses.

of things over a period of time. Most traditional healers will tell you that they only know a very little bit based on the people that taught them. And they will talk about who taught them... their grandparents, learned people in their community.... So I think that organizations like ours are a bit of a break-wall to try and slow down the loss or further loss of our Indigenous knowledge in this area.” (S. Maracle, Personal Interview, December 6, 2010)

Through help from the AHWS to more seriously facilitate the contemporary use of First Nations healing traditions in health programming, some First Nations community members are being positively reintroduced to their own traditions, from which they may have become disconnected (S. Maracle, Personal Interview, December 6, 2010). Ms. Maracle notes that, at least with respect to the AHWS, request for traditional health services are on the rise:

“In the health programming one year they saw more than 50,000 people, and every one of them also asked for traditional services. I think that speaks to the notion partly that your paper has relevance.... because I think this is only going to grow. I think the issue of community self-regulation is important as people are coming to grips with these sorts of things.... and come up themselves with a process that people understand here is what we are going to do and here why we are going to do it.” (S. Maracle, Personal Interview, December 6, 2012)

Development and Sustainment of 'bridges of understanding' between Traditional First Nations Health Practitioners and Mainstream ones

There have been lots of good attempts by sincere people who have tried to build bridges, but these undercurrents are powerful and keep washing away good intentions," said Ermine. "When we have had breaches and ruptures in the past, it is because we have failed to look at the area in between our two worlds. It is in this ethical space that we can understand one another's knowledge systems. (Ermine in Ford, 2010)

While some practitioners of traditional First Nations healing methods are looking to build 'bridges of understanding' with mainstream practitioners, one interview participant at *Tsi Non:we Ionnakeratstha Ona:grahsta'* noted that often in contemporary environments:

“It seems that whatever they create, if we don't fit into a category that their Body recognizes that it is not good enough. There needs to be recognition by everyone

to accept and acknowledge that there are different types of models out there. Everything can't be black and white." (J. Wilson, Focus Group Interview, August 27, 2010)

The AHWS, and First Nations organizations that have similar strategies, can help to bridge these types of epistemological gaps that exists between the two healing systems:

"It's about saying to mainstream people, 'we have traditional people, mainstream people, regulated midwives, nurses and doctors involved.... and all these things that can work alongside of our people'. So here is an opportunity in an organized way, in the establishment of strategic approaches, policies, programs and organizations where people can actually work together. So there is nothing wrong with a traditional midwife working alongside a doctor in the instance where there is some risk in the pregnancy. And everybody understands is what we are trying to do is make the best possible outcome for the person involved." (S. Maracle, Personal Interview, December 6, 2010)

This being said, it was also emphasised that these types of bridging negotiations, although cost effective, did not come without reposition from mainstream organizations that had, in the past, exclusively delivered health services to First Nations:

"We were also recognizing that mainstream was going to push back because they were going to perceive (or perceiving) it as a loss of authority. Their right and authority over certain issues that they had had authority over for a certain period of time. But also, it was undermining their economic liability. If all of a sudden, a doctor doesn't have 50 or 100 women to monitor through a pregnancy there is going to be a financial impact. But really, the financial impact when you think about it is a savings. There is no way that the cost of annually running a birthing centre, or a traditional healing program at Akwesasne is as much as taking away certain systems from a mainstream cost perspective... it is a huge savings on the system.... so if people in the end are well and healthy and it saves the system money, I don't get why everybody are not lining up to do it...". (S. Maracle, December 6, 2010)

Articulating, or in some cases developing, First Nations specific policies of self-regulation especially in the context of 'community public self-regulation in traditional healing' is important with respect to restoring the power of choice back to First Nations with respect to their health care options. For further leveraging this choice, Ms. Maracle

made note of the fact that many business and government sectors in the mainstream have benefitted economically from Aboriginal customers:

But I do get it because it is about this challenge to authority that mainstream has and an economic challenge. And if we were not a business.. Aboriginal people in this country... to the health care system, to jails, to child welfare, to policing...then what would the system look like?....So some of what we were up against was saying, 'you can regulate all you want here and if people choose to be a regulated health professional... that's what they want to do....' (Example) they want to go through the College of Midwives and they want to have their credentials through that than that is clearly a choice that should exist through our community. However, if they didn't want that, then we had to come up with this space....like you talked about.... where we said, 'Ok, in this space, this is how we are going to behave.... Here are the credentials, here are the experts in our field that can help us, here is the type of training we are going to go through, here is the passing of the mantle that periodically has to occur.'" (S. Maracle, December 6, 2010)

In Ontario, new spaces for healing are being created using the values and protocols contained in First Nations cultures. In some cases, this has led to discussions between the Province and First Nations stakeholders, such as the OFIFC or the AHWS, about existing provincial laws that may not necessarily be compatible with the logic contained in tribal traditions. For example:

“In the case, for instance, of the Smoke Free Ontario legislation...again it may not sound that it applies to traditional healing....but you have to remember that you can't smoke anywhere in Ontario...it is much broader than it used to be....but then it was public institutions, schools (including places like the birthing centre, healing lodges)... so if you needed to burn tobacco or use your pipe, we thought, how do you do that without breaking the law?" (S. Maracle, Personal Interview, December 6, 2012)

At the other end of this spectrum, however, *mainstream legislation* is often intimately connected to *mainstream regulation* (as they are part of the same system of thought). Therefore, if not thought out properly, the danger exists that the negotiated spaces for First Nations traditional health practitioners to operate, could actually become more restricted:

“Do I think there is another side to the equation? Yes. I think that some of the regulation....some of the pieces....I don’t know if they are legislation, but some of the regulations that apply. To pick on NIHB and Health Canada, they can be really controlling with respect to the kind of access that a community can have to Indigenous Knowledge holders....and they do that through saying ‘you have to X number of people’, or asking, ‘how much travel are you going to pay, how many sessions are you going to have, what is the rate of pay’ ...In those cases, they will argue that the regulations flow from the legislation. If that is true, then in fact the legislation becomes not the space that I am talking about, but a very clear box and a very small box prescribing how you can behave.” (S. Maracle, Personal Interview, December 6, 2010).

Ms. Maracle thinks that activities such as opting for an exemption for First Nations traditional healers and midwives from mainstream self-regulatory mechanisms, implemented by the Health Professions Regulatory Advisory Council (HPRAC) of Ontario, has led to more recent discussions between First Nations representation and the federal government about the potential effects of proposed legislation such as Bill C-51 (S. Maracle, Personal Interview, December 6, 2010). As indicated in the literature review, Bill C-51 (a proposed *Regulatory Bill for Natural Health Products in Canada*) was introduced in Parliament by the present Conservative government in 2008. C-51 was not implemented and met with much opposition from the Canadian public, including First Nations. In addition to the concern about some of the key properties of Bill C-51 returning in a recently passed Bill C-6, *The Canada Consumer Product Safety Act* (Buckley 2009), governmental forces have also been pushing back against some First Nations community groups that are studying exemption options for their traditional healers and the medicines they use:

“Thus, in some instances, I think that because we took the road to exemption.... we are having exactly that discussion now to look at some of the work that is going on federally around creating legislation around natural health products (Bill C-51). So natural health products....we have chosen as community groups across the country to look at exemptions and they are pushing back saying that we need

to regulate traditional healers and how much they harvest and what do they do with it...”. (S. Maracle, Personal Interview, December 6, 2010)

The idea of a 'bridge' is to create a pathway or a route that, somewhat equally, helps individuals on either side of it in a balanced way. The fact that traditional teachings and science can sometimes be congruent is a plus and shows the strength of Creation (S. MacDonald, Personal Interview, January 28, 2011). This being said, developing and sustaining a bridge between the First Nations traditional healing community and the mainstream is one that will take great deal more work due to some of the complexities that come with this territory. For instance, with respect to issues about First Nations medicines and natural health products, Ms. Maracle notes:

“It is not our intention you know.... um.... to modify genetically.... which is the other act that is coming up.... they are trying to regulate that and share the profits. We don't want sweetgrass that is growing six feet tall... that is not the intention. We also do not want our traditional people.... including medicine people, healers and midwives to then have to be regulated and come up with the Latin word for stuff and how much of it they are using or prescribing. So you have the notion of creating space, you have this notion of this little box, then you have this really unknown out there on how will this impact on this community driven process in terms of moving it forward.” (S. Maracle, Personal Interview, December 6, 2012)

Mainstream Regulatory and Self-regulatory Processes and First Nations Community Health and Healing Agendas

For First Nations, understanding some of the basic principles of mainstream self-regulatory processes can be helpful for at least four reasons:

- Firstly, mainstream self-regulatory processes can affect a healer who sometimes may find themselves responding to community's members needs in modern Western medical contexts.
- Secondly, contemporary First Nations communities have regular contact with mainstream health professionals and it is helpful to have some understanding of the ideologies that qualify/certify these people who come and work in Indigenous territories.
- Third, we now live in the reality where there are doctors and nurses, as well as other mainstream health professionals, who are of First Nations origin. Sometimes these First Nations people are even referred to as modern day healers. If they continue to work in Indigenous communities, how do these people navigate the boundaries between the mainstream understandings of self-regulation associated with their Western training and the more traditional understandings of health regulation that arise out of their respective Indigenous knowledge systems? One example of this 'navigation' is portrayed in *The Scalpel and the Silver Bear* where the first Navajo woman surgeon, Dr. Lori Alviso-Alvord, M.D describes how, for her, the two healing systems complement each other towards a goal of better overall health. She says,

“...although I was a good surgeon, I was not always a good healer. I went back to the healers of my tribe to learn what a surgical residency could not

teach me. From them I have heard a resounding message: Everything in life is connected. Learn to understand the bonds between humans, spirit, and nature. Realize that our illness and our healing alike come from maintaining strong and healthy relationships in every aspect of our lives” (Alvord and Cohen, 1999, p.3)

- Fourth, with respect to First Nations traditional healing, this understanding could prove to be important in more precisely identifying any similarities and differences between the two systems healing that might otherwise go unnoticed.²⁶

The results in this section that collectively speak to these sorts of issues are presented through the following themes:

- Provincially/State based Health Professions Regulatory Mechanisms: The Case of the Health Professions Regulatory Advisory Council (HPRAC), Government of Ontario;
- Pathways to ‘credibility’ in the eyes of the Mainstream Health System: Statutory Self-Regulation in Ontario;
- First Nations Hiring of Western Trained Health Professionals; and
- ‘Walking the line’: Community Perspectives from a First Nations Health Professional

²⁶ For First Nations, it was noted earlier in the literature review of this thesis that one of the dangers of ill-defined definitions of self-regulation is the resulting ‘grey areas’ in policy and law. For example, even though there is an exemption of Ontario’s Aboriginal healers and midwives from Regulated Health Professions Act (Regulated Health Professionals Act, 1991), legal and policy challenges that remain undefined still exist (Waldram, Herring, & Young, 2007).

Provincially/State Based Health Professions Regulatory Mechanisms: Case of the Advisory Council (HPRAC), Government of Ontario

Importantly, self-regulation for health professionals is not the same throughout Canada. It varies from jurisdiction to jurisdiction (i.e.: Provinces and Territories). This, in and of itself can cause difficulties for First Nations. For example, as discussed in the literature review, while health care in Canada is under provincial jurisdiction, the debate continues with respect to how comprehensive First Nations health care should be in the context of treaty rights, which are supposed to be delegated by the federal government.

Thus, while we might be able to generalize *some* of these self-regulatory principles in Ontario and apply them to situations of other health professionals in Canada, the interview with the Executive Coordinator of Research at HPRAC has greater relevance in Ontario. Similarly, the insights gained in the HPRAC interview may have greater meaning to First Nations residing in the jurisdiction of Ontario.

In reality, even within the jurisdiction of Ontario, self-regulation within mainstream contexts can mean different things:

“.... most of these models are affected through legislation.... the State is involved in that form. Then you also have a sort of voluntary self-regulation where there is no State mechanism affecting that self-regulation. For example, one form of self-regulation is midwives –under a College, under HPRAC, under an Act. Whereas Dental Assistants, for example, they have entry practice model, certification model, they have an association, they have a registry....so it is more of a voluntary self-regulation, but there is no statutory mechanism behind that. So you have different models of self-regulation in place from more statutory type regulation to voluntary self-regulation.” (D. Embuldeniya, Personal Interview, August 31, 2011)

Generally speaking, the participant interviewed from HPRAC noted that the advantage, from a mainstream perspective, of statutory self-regulation is that the force of law

provides a strong external incentive towards quality assurance, whereas a voluntary model of self-regulation does not provide this. (D. Embuldeniya, Personal Interview, August 31, 2011).

This being said, the HPRAC interviewee was aware that First Nations do have their own laws based in their cultures and traditional value systems and that these laws factor into determining appropriate self-regulatory measures. Mr. Embuldeniya says:

“But it would mean something different in a First Nations community where the self-regulation and self-governance is seen in a very different light and from a very different perspective.” (D. Embuldeniya, Personal Interview, August 31, 2011)

How a self-regulated health profession gets on the radar of HPRAC

HPRAC does not have the legislative capacity to self-initiate the review of a particular health profession. However, there are two ways that a particular health profession can, so to speak, ‘get on the radar’ of this governmental regulatory body:

“One way is that an association or professional group can convince the Minister that this profession should be regulated under Regulated Health Professions Act (RHPA). They have to make this initial case, then the Minister can decide whether or not there is risk of harm posed by a particular profession, or that there is some public interest in regulating a profession. The second way is that the Minister on their own can decide that there is merit to review a particular profession based on public interest or risk of harm.” (D. Embuldeniya, Personal Interview, August 31, 2011)

Notably, while many health professionals, for various reasons, want to 'be on the radar' of HPRAC and similar organizations, First Nations health practitioners such as the midwives at *Tsi Non:we Ionnakeratstha Ona:grahsta* prefer to not engage with governmental health regulators. They believe that the sacredness and safety of birth is

supported by Indigenous knowledge about the life cycle and healing. The over-medicalization of childbirth (including mainstream self-regulation in this arena) is seen by some Aboriginal midwives as another manifestation of colonialism that if followed would dilute their traditional knowledge bases (Benoit , Carroll and Eni, 2006; NAHO, 2008).

Mechanisms for Risk Assessment

Governments often make the case that a significant reason for regulating a health profession is to manage risk. Risk management activities started to permeate the health care industry during the late 1970's in response to growing instances of malpractice insurance (Core Risk Services Inc., n.d).

Managing risk is a proactive function...it is taking action to reduce the frequency and severity of unexpected incidents, reduce the impact of legal claims, and promote high reliability performance and outcomes because of awareness that performance, system design, and the uniqueness of each patient exposes an organization to the potential for adverse outcomes.” (Core Risk Services Inc., n.d.)

Risk management strategies are a part of the mainstream health care system that influence (and are influenced by) other mechanisms that operate in this system. These interrelated mechanisms factor into what is referred to as ‘quality assurance’:

“Once we determine that there is a risk of harm proposed by a particular profession, then there is a case to be made to regulate it. Once it is done, then you have a number of mechanisms in place for quality assurance. There is a mechanism for discipline, there is a mechanism for continuing education, etc... and those are all interconnected things. Then you also have under the regulatory framework, you set the practice requirements.” (D. Embuldeniya, Personal Interview, August 31, 2011)

In conventional systems, these interrelated pieces (e.g.: education, risk assessment, discipline etc.) often result in developing codes of conduct and disciplinary measures:

.... in the mainstream regulatory system you have certain guidelines and codes of professional conduct. So any kind of misconduct would trigger a disciplinary process and if there is misconduct there would be some sanctions.” (D. Embuldeniya, Personal Interview, August 31, 2011)

Pathways to ‘credibility’ in the eyes of the mainstream health system: Statutory Self Regulation in Ontario

As indicated in the introductory chapter of this thesis, although 'government control' does not sound particularly appealing, a professional organization that is granted self-regulatory status, in reality, gains greater autonomy and control for their organization, professional prestige, exclusivity and, often, financial rewards (Randall, 1993c).

Similarly, but unlike groups such as the self-regulated traditional midwives at Six Nations, many health professions in Ontario desire to raise their credibility level in the mainstream by being self-regulated through the standardized statutory processes offered by HPRAC:

D. Embuldeniya –“How it happens in Ontario, in 1991²⁷, they looked at close to 40 professions to see if they should be regulated under the RHPA and only 21 actually got regulated.”

J. Robbins – “So some professions want to be regulated?”

D. Embuldeniya - “That’s right. For example, Shiatsu Therapy was one group that requested to be regulated but were not accepted. Some others requesting regulation were Medical Physics, Hearing Aids, Health Records, Family Therapy.” (D. Embuldeniya, Personal Interview, August 31, 2011)

²⁷ This was the year that the Regulated Health Professions Act was implemented in Ontario.

This process of ‘becoming credible’ can sometimes be lengthy and can often take years to implement (as is the case with traditional Chinese medicine):

“Members of the Traditional Chinese Medicine community also asked the Minister to be referred to HPRAC to review them and make recommendations back in 2006...Right now it is in a ‘Transitional Council’ phase. They are developing the quality assurance regulations and others regulatory requirements. In about two years they will start to admit members to the College and then at that point it will be considered a regulated health profession, along with Naturopathy, Kinesiology Mental Therapy and Homeopathy.” (D. Embuldeniya, Personal Interview, August 31, 2011)

First Nations traditional health and healing systems often have an oral tradition through which knowledge is transferred to the next generation of healers. In the mainstream, the path to credibility primarily uses written documentation as the accepted ‘domain of knowledge’ for assessing regulation:

[To determine] whether this particular culture has a domain of knowledge in most Western type professions, such as medicine or dentistry, there is a most often a long history of written documentation... When you go back in Chinese traditions or homeopathy, you also see a history of documentation.” (D. Embuldeniya, Personal Interview, August 31, 2011)

First Nations Hiring of Western trained health Professionals

At present, hiring health professionals trained in modern Western medicine is a common occurrence in many First Nations communities. Therefore, at the community level, some understanding of the self-regulatory processes, particularly those processes associated with accreditation of mainstream health professionals, is often necessary. For example, at Akwesasne, the *Kanonhkwatsheriio* (Health Facility), which opened in December 1993, houses offices for 15 separate programs and employs more than 180 people with specialized health related skills. The programs include the:

- Department Of Health Administration;
- Akwesasne Non Insured Health Benefits Program;
- Community Health Nurses Program;
- Akwesasne Medical Clinic;
- Traditional Medicine Program;
- Holistic Health And Wellness Program;
- Akwesasne Mohawk Ambulance;
- Department Of Community And Social Services;
- Akwesasne Child & Family Services;
- Akwesasne Community Support Program;
- Akwesasne Child Care Program;
- Akwesasne Ambulance Service;
- Akwesasne Dental Clinic;
- Optometry; and
- Ononkwasona Pharmacy; and (Akwesasne, n.d.).

Akwesasne: Hiring of mainstream health professionals and the protection from imposters

Documentation of imposters in the medical field has occurred since early times. As indicated in the literature review, Charaka (120-162 AD) characterized three kinds of medical practitioners: the imposter in physicians robes; the vainglorious pretenders; and those endowed with the true virtue of a healer. In contemporary times, but still to this effect, one research participant clearly indicated that a reason for the contemporary

Western health regulatory system is for protection against unqualified persons claiming to be credentialed medical professionals:

“Well, I am a trained nurse so.... my knowledge is more of the western model. In a previous lifetime I was Director of Health with the St. Regis Mohawk tribe, our counterparts south of the border. It’s a credentialing process with physicians coming in and nurses coming in. It was my responsibility, as an administrator, that those were coming in as a nurse or doctor into the program.... that they really were who they spoke of. Because in at least one instance we had one physician apply for a position and in the credentialing process, we were looking into the state they had been licensed from, data registries to make sure they were a credible doctor, that there were not any complaints against them or pending medical liability suits. We called the State Department of Health and found that they were actually an imposter.” (B, Focus Group Interview, November 24, 2010)

Thus, even with the internal checking mechanisms that are part of a particular system of healing, whether it be modern Western or First Nations traditional, the possibility exists that imposters will try to ‘slip through the cracks’:

“So it happens.... that there are those that present themselves as a healer or a learned person but they are actually not who they say they are. This happened in the medical profession. This is my familiarity with it in that regard. So this regulation in the Western model is so that that people who present themselves as a professional are actually qualified and respected and are able to carry out the functions that they say.” (B Focus Group Interview, November 24, 2010)

‘Walking the line’: Community Perspectives from a First Nations Health Professional

Notably, the term ‘First Nations Health Professional’ is very broad based. For example, with respect to economic disparity, mirroring the mainstream system, a First Nations doctor would be eligible to earn significantly more money than a First Nations midwife and would most likely in greater demand. In addition, even though First Nations traditional healers are the experts/professionals in what they do, it currently seems that an endless amount of issues would still need to be resolved before we could see First

Nations traditional healers and mainstream Western medical professionals practicing side by side as a common occurrence.

Although clearly the number of mainstream trained health professionals with Aboriginal ancestry remains disproportionate to mainstream populations, today the number of Aboriginal people in health professions is unquestionably higher than at any other point in history. Given the unique positioning of these individuals it is interesting to observe some insights into the some of the challenges faced in 'walking the line' (i.e.: the reconciliation of the teachings and processes of two different systems of knowledge).

In Akwesasne, one such person was interviewed who articulated some of the challenges faced in reconciling the teachings of two different systems of knowledge. 'K' is a resident of Akwesasne and possesses a midwifery certification from a mainstream institution.

Community resources and demand for health services

'K' noted that while, in Ontario, there is legislation in place that allows for First Nations midwives to practice, the demand in her community is not at the point where a birthing centre, like they have at Six Nations, is needed. Furthermore, 'K' indicated that it was difficult coming back to the community from the educational institution where she studied midwifery because there was not enough community interest to have a birthing centre in the community. Rather, it was mostly the non-Native population that wanted midwifery (K, Personal Interview, May 3, 2010).

If the demand is not there, it can be difficult for youth who go off to school and come back full of energy when there is nothing to do in the line of work in which they studied (K, Personal Interview, May 3, 2010). These observations echo a point in the literature review relaying that while things like funding and infrastructure were necessary to success, without community support, potential successes of these efforts will be compromised (NAHO, 2008).

Mainstream health systems and the 'access' issue

'K' indicated that what she is seeing is that some people are moving towards alternative healing paths such as naturopathy or homeopathy because these disciplines *are* regulated. One reason for this is that because of regulation, it is easier, on a larger scale, to access and use the medicines associated with various alternative approaches.

This being said, 'K' also indicated that she thought moving towards greater community cohesion amongst First Nations healers, through things like the facilitation of First Nations healers gatherings and greater promotion of First Nations traditional philosophies, could help to strengthen aspects of First Nations healing. This in turn could begin to be seen as an alternative to the currently monopolized promotion of remedies offered by pharmaceutical industries (K, Personal Interview, May 3, 2010).

Chapter 6: A Comprehensive Summary of the Research Study

This chapter provides a comprehensive summary of the research study which is meant to set the stage for the discussion that follows in Chapter 7. With respect to notions of self-regulatory health processes and First Nations traditional health and healing, the following aspects of the study are addressed here:

- The Dilemma
- Purpose and Context
- Theoretical Approach
- Study Design
- Data Collection and Sampling Methods
- Data Analysis
- Results

The Dilemma

Since the arrival of Western medicine here on Turtle Island, describing elements of self-regulation for First Nations traditional health and healing has become increasingly more complex, particularly in relation to Canadian mainstream health agendas. These complexities have arisen, in part, due to a dynamic interplay that occurs regarding the interpretations of healing that arise from First Nations and Eurocentric epistemologies. For First Nations, it is simply not good enough to apply mainstream health models of self-regulation to contexts of First Nations traditional health and healing and expect them to generate the same kind of conventional benefits afforded in the mainstream. If the

self-regulatory authority lies outside the hands of First Nations, the imbalance of power that is created in these types of processes can result in numerous concerns about the ethics, use and practices of Indigenous healing knowledge. In addition, such unbalanced approaches can only result in the continued suppression of First Nations healers and their practices.

At the same time, in a post-‘jagged worldviews colliding’ world, it is also important to try and understand how First Nations and modern Western approaches to healing can better work together. In part, in order to arrive at these greater types of understanding, the history of colonialism in Canada needs to be more directly acknowledged and forms of cognitive imperialism have to be cut through. *Cognitive imperialism* is described by Mi’kmaq scholar Marie Battiste (2000, p. 198) as a process that denies people their language and cultural integrity through maintaining the legitimacy of only one culture, one language and one form of reference. Thus, for our purposes at least, part of the answer lies in the realization that, although regulations are developed in the interest of protecting communities from harm, ‘regulation’ is a non-universal notion that sometimes does not translate particularly well between socio-linguistic communities (i.e.: what is done in the best interest of one may not translate to the best interest of another). With particular reference to the dominance of mainstream regulatory policies, it is important to recognize that other socio-linguistic groups understand and practice forms of regulation/self-regulation in their own contexts of knowledge (Black 2002, p.2).

Purpose and Context

Particularly with respect to mainstream and joint venture initiatives that want to involve First Nations traditional health and healing, a more robust appreciation for the validity of the Indigenous health and wellness knowledge held by the community is necessary. This seems evident because many, if not most, First Nations healing practitioners currently have little support and face many obstacles from the mainstream. This problem needs to be more clearly addressed in contemporary times because, although First Nations traditional healing did endure a decline, there is now a greater interest in it amongst First Nations. Many First Nations consider their spirituality, ceremonies and traditional health practices to be gaining importance in their communities. Greater respect and appreciation for the protocols guiding First Nations traditional healers and their students becomes particularly important as we continue to see aspects of this traditional health resurgence reflected in Aboriginal health policy and programming.

This discussion takes place in a context of protection and support for Indigenous healing systems. Although exploratory in nature, an underlying assumption of this thesis is that self-regulatory models in First Nations traditional health and healing should be congruent with the inherent right to self-determination amongst First Nations communities. This means that every First Nations community should, if they so desire, have the choice to use existing and/or develop models of self-regulation in traditional healing to fit their purposes.

The research was not conducted to investigate or expose any of the sacred aspects of First Nations traditional healing and/or medicines. Instead, the purpose of the research was to explore some of the current issues that exist around interpretations of self-regulation and First Nations traditional health and healing. With regard to the current picture presented by such issues, what can be done to help support, strengthen and develop Indigenous healing systems in the present and into the future? It is hoped that, through this work, some insight might be provided to those who are interested in self-regulatory approaches to Indigenous health that are imbedded in First Nations healing systems and the protocols followed by First Nations traditional healers.

Theoretical approach

The theory applied in this thesis is best viewed as a conceptual tool that can be used in thinking about what measures, for First Nations, can be taken to cut through any preconceived assumptions that have arisen due to a sustained contact with mainstream society in self-regulation in traditional health and healing. Notably, the theoretical approach, which combined ethnogenetic theory with theories of professionalization and cultural safety, that was used for this research project is one that grew out of processes that contemplated the sustainment and development of present and future Indigenous healing systems.

As a theory, ethnogenesis is concerned about factors that might allow/not-allow a cultural group to transmit knowledge from one generation to the next. The accumulated Indigenous knowledge of a particular tribe and how it continues to be passed from one generation to the next within its own epistemological context could be considered to be a

passive case of ethnogenesis. However, as external factors change (i.e.: the influences of mainstream society), sometimes these processes of knowledge transmission can become interrupted. For Indigenous groups, past repression of cultures and traditions at the hand of a settler society elicited responses where it becomes necessary to more openly assert the right to: use their knowledge, practice their culture and speak their language. These instances could be considered representative of *active* cases of ethnogenesis.

The second theoretical piece of the thesis is one which considers the importance of having 'external support systems' where ethnogenetic processes have occurred (or are occurring).

For our purposes, it was found that professionalization theory on its own did not adequately help to conceptualize some features of the 'external supports' particular to this research problem.²⁸ However, when combined with cultural safety theory, the approach became much more appropriate for addressing this research problem. Cultural safety basically entails that appropriate measures (based on Indigenous Knowledge of healing and cultural protocols) be taken so that Indigenous healers and community members feel unthreatened and comfortable when they are, respectively, administering and receiving care. For Indigenous communities, the implementation of cultural safety has served as a buffer to the rules and regulations of mainstream professionalized environments, as these rules and regulations do not always translate well into Indigenous contexts or adequately reflect Indigenous knowledge systems.

²⁸ Primarily because the majority of the body of literature on professionalization theory either described, was built on, or reacted to the more conventional situations of work and employment.

When an ethnogenetic process of advancing First Nations traditional health and healing is occurring from *within* a First Nations community, it is beneficial to have a support system from *without*. One might say that this can be particularly relevant in cases of *active* ethnogenesis (i.e.: where the two worlds meet). Things like the respect for and adoption of First Nations cultural protocols, new ways of understanding efficacy, harmonization of First Nations and modern Western approaches to medicine, funding arrangements, design of institutions and thinking about appropriate payment systems, are all things that need to be considered when contemplating health self-regulation in contemporary First Nations communities.

Study Design

The overall approach to the research design of this project is best described as ‘exploratory’ because some generalizations were arrived at about the meaning of self-regulatory processes and First Nations traditional health and healing. It is hoped that these observations will stimulate future discussion and research about a question with several layers of complexity. The methodological approach that comes closest to describing this research methodology for this project is ‘multi-method’. Both Indigenous and qualitative research methods were used. A core element in the research design was an analysis of self-regulation and traditional health and healing that was supported by a review of the literature in concert with key informant and focus group interviews.

The literature review addressed explicit and implicit issues relevant to discussions about self-regulation with respect to Indigenous health and healing. In addition to this, First Nations/Aboriginal midwifery was also explored in the literature review in order to more concretely bring to light some self-regulatory issues that have been occurring when two health paradigms (modern Western and First Nations) attempt to work together in contemporary environments. Of great significance, conversations, meetings, workshops, and interviews with Elders were cited in this project *as* literature. This was done to provide a more balanced approach through providing examples of Indigenous health and wellness knowledge.

The key informant and focus group interviews conducted amongst a wide range of people (e.g.: Elders, healers, midwives, administrators, program managers and others) from three First Nations communities in Canada (Elsipogtog, Six Nations and Akwesasne), an Aboriginal Organization and a mainstream/governmental health regulatory association in Ontario.

Based on the analysis of the collected research data, the project aimed to present a consensus view of the people interviewed in the key informant interviews and/or focus groups. Questions used to stimulate discussion amongst the project participants concerning self-regulation and First Nations traditional healing were generally based on the clarification of themes/issues discovered in the literature review.

The research design also aimed to develop a framework through which we could look at some of the underlying dynamics that occur when attempting to interpret the meaning of self-regulation and First Nations traditional health and healing. The framework that was

arrived at is based on the literature review, theoretical/conceptual outlook and the analysis of the research data. This framework was used to present research results in an attempt to clarify some of the general differences amongst currently existing arrangements and situations in First Nations communities.

Finally, the 'Discussion' and 'Implications' sections in Chapter 7 are intended to serve as a critical reflection on how this investigation has contributed to a larger debate regarding self-regulatory themes, their significance to Indigenous health and healing and their potential implications for practice, theory and research. In addition, it was considered important in Chapter 7 to offer a concise presentation of the research problem and findings in a manner that would make this information more generally accessible to First Nations communities. This was achieved through the use of a medicine circle model. The medicine circle was used to illustrate: the research issue, its findings; and the conditions required for understanding this research issue *wholistically*.

Data Collection and Sampling methods

Data collection for this qualitative study took place mostly in three First Nations communities: The multi-jurisdictional community of Akwesasne (Ontario, New York, Quebec), Six Nations in Ontario and Elsipogtog First Nation in New Brunswick. An interview was also conducted with Sylvia Maracle (Executive Director of the Ontario Federation of Indian Friendship Centres) for insights into the roles of: Aboriginal organizations in general; and Ontario's Aboriginal Health and Wellness Strategy in particular. Finally, insight into the mechanisms mainstream self-regulation in healthcare

was gained through an interview with a representative from the Health Professions Regulatory Advisory Council of Ontario.

In total, four talking circles/focus groups and thirteen in-depth key informant interviews were conducted at five locations. An Interview Guide, containing questions and focusing probes, was used for structural support when necessary, however, as the interviewing process progressed, the Guide was not often required.

The method for data sampling was identified as *purposive*. In contrast to random sampling, the strategy for this study was to try and elicit perspectives about the research problem from: First Nations healers; First Nations midwives who are self-regulating; and people with knowledge about First Nations health programming –particularly health programming that includes a traditional healing perspective. Building on the existing relationships that I had with people in various communities, I utilized the snowball method as a way to recruit additional people to be interviewed. ‘Snowballing’ is also considered a type of purposive sampling.

Some of the data collection techniques illustrated the ‘multi-method’ nature of the research methodology. For example, First Nations protocol of making an offering of tobacco and explaining my purpose was followed in the interview process. As well, an ‘indigenized’ variation of two standard qualitative research techniques –focus groups and in-depth key informant interviews– were used to collect the research data. A talking circle was described as an Indigenous variation of a focus group and putting a greater

emphasis on free flow conversation and listening (preceded by a tobacco offering) was described as an 'indigenized' version of an in-depth key informant interview.

Data Analysis

For qualitative studies, data analysis tends to be something that is ongoing and non-linear. Interpretation of the data collected for this research project is best described as a blend of two types of data analysis processes –*interim analysis* and *framework analysis*.

Interim analysis describes a cyclical process that took place over several months and sessions of analyzing and synthesizing the data. This process continued until a clear picture emerged about the relationships among the data. In addition, this process of analyzing the key informant interviews and focus groups provided experiential grounding for the information uncovered in the literature review and the ideas that were brought forth in the theoretical framework.

With *framework analysis*, a focus is also placed on organizing and classifying the data according emergent themes and sub-themes, in addition to the clarifications arrived at through *interim analysis*. The framework method culminates by summarizing/synthesizing the original data from each interview within the suitable part of the thematic framework. In turn, these categories are used to present the research results.

Through the application of these two types of data analysis strategies, four generally themed categories (each of which was complimented by several sub-themes) emerged with respect to interpretations of self-regulation and First Nations traditional health and healing:

- **'Healer Centred' Self-Regulation and First Nations Traditional Health and Healing** The clarifying aspects of a First Nations healer's relationship to their healing knowledge passed on to them by their forefathers. For example: acknowledgement of the role the Creator plays in healing; codes of conduct/protocol arrived at through their own apprenticeships; connection to mother earth; knowledge about the functioning of natural law; and ceremonial knowledge, etc.
- **Community Based Self-Regulation and First Nations Traditional Health and Healing:** The collective knowledge context that an Indigenous community has about their healing traditions and their healers. Although non-formalized ²⁹, it is apparent through things like Creation stories, Indigenous languages, stories about tribal prophets and/or healers, medicine stories, medicines and healing knowledge passed down through families, medicine societies, etc.
- **'Community Public' Self-Regulation and First Nations Traditional Health and Healing:** Self-regulation that is associated with a public space in the

²⁹ It is 'Non-formalized' if we consider 'formalized' to be a term which describes processes that govern the self-regulation health professionals in the mainstream. In reality, it could also be described as simply a different kind of 'formalization', because different cultural protocols can result in different types of formalities.

community, like a building or section of a building, dedicated to some aspect of traditional health and healing. These spaces are often where 'jagged world-views collide' and/or the two worlds meet, for example having a traditional healing unit in a health centre or a First Nations midwifery centre as part of the community health programming. The efforts made to maximize the use of tribal healing knowledge in such public spaces sometimes become increasingly complex because pressures on First Nations to interpret self-regulation in traditional health and healing through more conventional lenses often arrive with the acceptance of funding arrangements.

- **Mainstream Regulatory and Self-Regulatory Processes and First Nations Traditional Health and Healing:** In reference to the health self-regulatory system that is used to determine certain protocols followed by mainstream doctors, nurses and other health practitioners who submit to this model. These types of self-regulatory processes can affect a First Nations healer who could find his or her self-responding to the needs of a community member's in modern western medical contexts such as hospitals or health clinics.

These themes (and the sub-themes contained within each theme) are the ones that were used to present the results of the research study.

Results

The results highlight numerous variables that can factor into arriving at conceptualizations of self-regulation in First Nations traditional health and healing.

Through their responses to this issue, research participants validated that assessing the self-regulatory concepts and First Nations traditional health and healing requires the ability to understand/recognize that there is a surrounding context of information which imbues these concepts with their meaning. This surrounding context can change (rather than being static) because contemporary practices of First Nations traditional healing occurs in many different circumstances (e.g.: solely within the bounds of a traditional Indigenous healing system, within the context of First Nations health programming or even in a hospital).

Healer Centred Self-Regulation in First Nations Traditional Health and Healing

presented responses from research participants that described things such as the natural gifts a healer has and/or their relationship to the spirit world and the Creator. Once these types of are recognized, some participants also talked about the importance of apprenticeships with more experienced healers.

A healer can become known to a community through their observation of community protocols (e.g.: offering tobacco, requesting permission and getting to know the Elders of the community). 'Word of mouth' /oral tradition community is another way participants noted that a healer can become authenticated in a community. In First Nations communities, 'Word of mouth' authentication is not the same as gossip or the superficial exchange of information about a person. Rather, a person's authentication as a healer can be assessed by taking into account a history of community interpersonal relationships that have occurred both during and preceding that person's life.

Contrary to New Age stereotypes of the ‘solitary healer on a mountaintop’, participants were quite animate about the fact that whether small or large, formal or informal, some level of self-organization amongst healers has occurred in both past and present First Nations communities. Whether it be a more formalized network (such as a medicine society) or an informal network (such as healers who work together), the message from the research participants indicated that there was strength in numbers and that a supportive healing network/ family is important in the practice of healing.

Some of the research participants talked about the successes in adapting elements of mainstream self-regulation of health professionals to their needs. In such cases, it was noted that the most success is gained through these types of endeavours in communities that either have (or are working towards having) a strong sense of identity with respect to their healers and knowledge holders.

Both my current personal and academic understandings of what this category may truly involve are limited. However, it seems to me that this theme remains the most significant the discussion about self-regulation in First Nations traditional health and healing because, above and overall, it necessitates that responses to these sorts of issues are best determined and discussed by First Nations healers themselves.

Community based self-regulation and First Nations traditional health and healing

described the notion that healers have required (and require) the cultural contexts of First Nations communities in order to self-regulate. Elements such as Indigenous languages, Indigenous land-bases, Creation stories, ceremonies and traditional ways of organizing

contribute to the formation of the genuine contexts through which the 'rules' and 'regulations' associated with traditional healing practices become self-apparent.

'Traditional teachings and practices' made reference to Haudenosaunee participants who through their interview responses referred to some of the unique elements that helped describe a foundational context for traditional understandings about health and healing. Research participants noted that viewing health holistically placed an importance on maintaining wholesome, interpersonal relationships. This view was also extended to include relationships with the natural and supernatural world. Even though a First Nations community member might not be endowed with the extra gifts for their community to consider them a 'healer', they may still have certain understandings about particular medicines, healing techniques or ceremonies. When taken together, these types of awarenesses form the 'collective community Mind/Memory' about the realities of First Nations traditional health and healing.

Growing up in a First Nations community and growing into various cultural roles along the way is also reflective of the cultural continuity that sustains self-governing qualities which factor into self-regulatory processes in First Nations traditional health and healing. In the past, there was an understanding of mutual responsibility between healers and communities. This entailed that the healer took care of the community and the community took care of the healer. It was suggested clarity about self-regulation and traditional health and healing could be enhanced via a greater focus on traditional rites of passage. Particularly for children and youth, this would help to build, reinforce and strengthen understandings about cultural responsibilities. In another instance it was noted

that, in Haudenosaunee communities, it was (and still is) normal for women to be able to identify and help develop children who have gifts to help the people.

Many research participants emphasized the great significance that First Nations languages have in being able to comprehend the unique factors about the nature of First Nations self-regulation in traditional health and healing. Participants noted that sometimes there is no translation for certain First Nations words and/or concepts and that there is a congruity that exists between First Nations languages and healing traditions. Without knowledge of the respective First Nations language of a particular community, many protocols and nuances which help to formulate self-regulatory principles in the traditional health care system of a First Nation could be either overlooked or misinterpreted. In such cases, it can often happen that any ill-defined 'grey areas' about self-regulatory concepts in traditional First Nations healthcare could be filled by language and concepts contained in modern Western medicine.

Finally within this 'community based' theme, reference amongst some participants was made to the impact that disruptions to the integrity of their territories and cultures have had on mechanisms that, under normal circumstances, would have supported the self-regulatory practices around traditional health and healing.

With respect to the environment and First Nations land bases, 'regulation' and any derivative of this term are often viewed with negative connotations. While First Nations healing traditions may no longer be outlawed, problems arise where the presence of unsustainable natural resource development occurs in the same environments that also provide the resources used for things like traditional foods and medicines. In this sense,

First Nations understandings about health and the environment continue to be suppressed. In contemporary times, First Nations are met with increased levels of opposition when they confront mainstream governments and corporations who eagerly opt to implement plans for the large scale mining and development of natural resources on treaty lands.

When the religion, culture and science of early settler societies began its advancement on First Nations, the subsequent disruptions in cultural integrity resulted in communities taking their healing practices underground as a protective measure. Some participants noted that these intergenerational disruptions, coupled with the current lure of modern living, have greatly contributed to fragmentation across First Nations communities. In contemporary First Nations communities, one way this fragmentation has expressed itself is through a more fragile understanding about the uses and value of traditional health practices.

Potential solutions mentioned to address this problem included: the idea of 'reverse brainwashing' led by people who still carry the correct traditional understandings about how their forefathers understood health and the suggestion that the answer does not lie in trying to blend modern Western medicine and traditional healing.

Community Public Self-Regulation and First Nations Traditional Health and Healing,

which was the longest themed section in the Results Chapter, was used to describe instances when traditional First Nations understandings about health meet mainstream ones. In essence, this theme also refers to a visible 'public space' in a First Nations community where people go to access some of the traditional healing and medicines

possessed by holders of tribal healing knowledge. In addition, it is often in these types of 'public spaces' where traditional First Nations and modern western ideas about self-regulation and professionalism in healthcare meet. For traditional health and healing, these types of spaces cannot exist without an understanding of the first two self-regulatory categories. For this theme, results based on data collected from the research participants were presented in the following way:

- Six Nations: *Tsi Non:we Ionnakeratstha Ona:grahsta'* (Maternal and Child Care Centre)
- Designated Public Spaces for Traditional Healing at Akwesasne
- Interviews at Elsipogtog: Healer/Elder Perspectives on Community Public Self-Regulation
- Roles for Aboriginal Centred Strategies and Organizations: The case of the Aboriginal Healing and Wellness Strategy (AHWS) in Ontario

At *Tsi Non:we Ionnakeratstha Ona:grahsta'*, the self-regulated First Nations midwifery organization at Six Nations, they use a mix of traditional and modern approaches to midwifery. The presence of this 'public space' has helped to raise community awareness about their traditional midwifery practices that, until recently, had previously remained underground. While this type of arrangement works for them, participants indicated that it may not work for other types of healers in the community.

Part of the reason the midwives at Six Nations choose to self-regulate and practice apart from the Ontario College of midwives is so that they can more freely train in practices

which reflect their traditional teachings about child birth. Participants noted that an extended benefit of having such a community space is that close contact can be maintained with traditional healers in the community. This, however, does not mean that tensions don't arise when mainstream ideologies, which come with such publicly funded spaces, clash with the value systems of traditional medicine people. Overall, there is community awareness about these kinds of value system clashes and for this reason, the identities of some people/healers continue to remain protected.

In addition to having the responsibility of being self-regulated by their traditional values and the Creator, the midwives at Six Nations noted that their self-regulation comes from their Band Council, an advisory committee, Elders and others, all of which oversee and have a stake in their activities. In a small community, this makes their degree of accountability equal to or greater than the self-regulation policies that are followed by any mainstream midwifery organization. Nonetheless, persisting negative stereotypes about First Nations in the mainstream create obstacles in the path to what these midwives consider to be the 'self-regulatory ideal' in their practice.

Predetermined notions from the mainstream about assessing risk and efficacy places continuous pressure on midwives, for example, to reveal the ingredients used in traditional childbirth medicines. These sorts of pressures become manifest when there is a lack of awareness or understanding about the context in which these medicines are used. Innovative solutions are still required in these types of situations so that the values of Haudenosaunee midwifery can be practiced in an unobstructed way while

simultaneously being accredited in the eyes of their mainstream colleagues and funding partners.

'Designated Public Spaces for Traditional Healing at Akwesasne' addressed the responses from interview participants pertaining to aspects of 'community public' self-regulation and traditional health and healing.

At Akwesasne, the general consensus among research participants was that the term 'self-regulation' itself implied imbalanced 'collaboration' between the proponents of First Nations and the proponents of self-regulatory health models, rather than something that resulted in greater independence and control over providing services associated with their traditional systems of healing. Thus, even though there is a space for traditional medicine in the community health centre, there seemed to be a strong opinion among some participants that the general environment is still one in which it is not safe for their medicine people to practice. At the same time, others noted that community members have increasingly wanted to have the choice to access traditional medicine either exclusively or in addition to modern Western treatment. The presence of the Traditional Healing Unit at the health centre is helping to address this growing community shift in preference.

Determining how to compensate healers who regularly work at the Traditional Healing Unit was something that the community is continuing to figure out for themselves. Complexities have arisen due to a clash between understandings about how healers were compensated in the past versus how they are compensated in the context of mainstream wage economies with self-regulated health professionals. Some participants were

concerned that too much modernization might be changing the relationship between healers and community members that come to them for help. On the other side of the issue, even when healers are hired as employees of the health centre, participants noted that they still struggle with things like rates of pay. The healer is undoubtedly the 'professional' in what they are hired to do, however, mainstream templates for determining the levels of professionalism/rates of pay (often required for fulfillment of funding agreements), were not developed with traditional healers in mind. Indeed, one participant noted working through these types of issues was sometimes like trying to 'fit a circle into a square world'.

When First Nations traditional healing and medicine becomes available in these types of collaborative 'public spaces' which are backed by outside funding, some warned about the dangers of traditional healing becoming over-commercialized. One person stated that the pressure towards commercialization can be in part attributed to shifts in mainstream medicine from a focus of healing and wisdom to a focus of monetary gain. In addition pressures towards commercialization can arise because First Nations hybrid health programmes that desire to include traditional healing often have the burden of thinking about program sustainability issues from year to year.

Nonetheless, some argued that the sustainment of community traditional healing does not have to begin and end with funding sources for a particular program or agenda. Some argued that solutions lie in healers organizing themselves in greater numbers. Others noted the importance of 'self-care' and commented on how healers are facilitating ways for people to take greater responsibility of their own health.

At Elsipogtog First Nation, unique qualities of the interviews were that they were conducted exclusively with healers/Elders and they were not conducted under any auspices of participant affiliation with any health organization (community based or other).

A distinctive viewpoint was put forth when research participants were asked about the importance of a physical space for healing in the community. Factors such as safety, privacy and relationships based on trust were considered to be essential foundations for healing spaces.

A licensing process is often one of the core defining elements of mainstream self-regulatory processes for health professionals. One suggestion offered by participants was the consideration of a Native licensing process which would allow for First Nations to be licensed in their respective fields in a self-governing way. While the presence of obstacles was acknowledged in respect to the potential implementation of such a process, it was also noted that some of these obstacles have already been overcome because this approach has been implemented in other Indigenous communities elsewhere.

It was noted that validation and acceptance of traditional healing, especially in 'community public' contexts can potentially be expatiated through legislative and policy support from mainstream governments. This would help to decrease some of the 'grey areas' in policy legislation around First Nations traditional health and healing. Additional validation for traditional healing practices can occur through facilitating the normalization of First Nations healers in mainstream health environments that are primarily modelled after the workings of modern Western medicine.

A differentiation was made by one participant between possibilities of First Nations healers self-organizing at a grassroots level versus self-organization that accompanies the receipt of some type of formalized recognition by mainstream governments. It was noted that the subsequent lure of fame and money that can accompany the latter type of self-organization could compromise a person's humility and value system. In addition, healers could be targeted or labelled by people in the mainstream who perceive their knowledge about human health as competition or a type of economic threat. Words of caution are offered to those who decide to navigate through some of the more mainstream requirements of formalized self-regulatory associations.

Aboriginal centred strategies and organizations can act as a kind of buffer between First Nations communities and the mainstream in contexts of 'community public' self-regulation in traditional health and healing. In essence, through such organizations, a bridging mechanism is created where: pressures on First Nations to conform to mainstream health modelling is reduced; and health models which are more inclusive of a community's traditional healing knowledge can be created and implemented. In Ontario, the AHWS and its affiliated organizations is an example of this. Their work in the area of making First Nations traditional health and healing more accessible to communities has been held in high regard by groups like the *Tsi Non:we Ionnakeratstha Ona:grahsta*' at Six Nations. The AHWS and like-minded groups are more likely able to accurately understand and promote health needs while they are occurring at the community level. Mainstream funding organizations may not necessarily be in tune with these different needs as they are happening. In Ontario, the AHWS provides an alternative channel for

funding First Nations traditional health programs that, in the past, may not have been supported in the health agendas of mainstream governments.

The AHWS and other similar organizations might be seen as positive cases of *institutionalization of traditions*, rather than cases where the Euro-centric notions dilute the authenticity of First Nations traditions. In the case of the AHWS some First Nations healing traditions are being 'preserved' through their contemporary use. Indeed, through such health programming, some First Nations community members are being positively reintroduced to their healing traditions –traditions that they may have come to not understand as a result of colonization processes.

Development and sustainment of 'bridges of understanding' between proponents of First Nations traditional health and healing and mainstream health tends to be an ongoing discussion with both positive and negative connotations. For example, on the positive side, new First Nations health spaces are being created using values, protocols and teachings contained in Indigenous Knowledge perspectives. In the case of the AHWS in Ontario, this has even led to First Nations being exempted for certain laws that are not compatible with the logic contained in tribal traditions. At the other end of the spectrum, however, it was noted that system responsible for mainstream governmental legislation is the same system that administers mainstream regulation. Thus, if not thought out carefully, there is always the danger that the legislation designed to support a particular First Nations claim could turn out to be restrictive in the sense that it ends up prescribing how one is supposed to behave and when and where they are supposed to behave that way. In addition, the participant noted that building these bridges with the mainstream

did not come without a fight because essentially, the AHWS was taking business away from mainstream sectors that had, in the past, financially benefited from serving some of these First Nations health needs.

Mainstream Regulatory and Self-Regulatory Processes and First Nations Health and Healing Agendas was the final major theme discussed in the Results Chapter.

Mainstream self-regulatory processes are important to understand because contemporary First Nations communities have regular contact with mainstream health professionals and there are now many First Nations people who are work as mainstream health professionals. In addition to providing an aid in being able to better understand the similarities and differences between the two approaches to healing, unravelling this theme can also help us to better understand how these processes impact healers who, in some cases, operate within modern Western medical contexts.

The case of HPRAC in Ontario gave an example of the mechanisms for self-regulation used by a province. Self-regulation for health professionals varies from province to province and in Ontario, self-regulation is still non-uniform. In the Ontario mainstream, both voluntary and statutory models of self-regulation exist. It was noted that, from the perspective of HPRAC, an advantage of the statutory model was that it had the force of law behind it. This was considered as an external incentive towards quality assurance that was not necessarily replicated in voluntary models.

HPRAC does not itself have legislative permission to self-initiate a review of a health profession In fact, unlike First Nations organizations like such as the midwives at *Tsi*

Non:we Ionnakeratstha Ona:grahsta (who prefer not to engage with governmental health regulators) many other groups of health professionals want to be 'on the radar' of HPRAC or similar organizations. Once approached by a health profession, organizations like HPRAC would ask them to go through a process of developing quality assurance measures (e.g.: risk assessment, discipline, education, training models, etc.). Based on these sorts of elements, a claim submitted for statutory self-regulatory status would then be evaluated.

This process of a group of health professionals becoming 'credible' in the eyes of the mainstream is defined by greater autonomy and control, more exclusive rights provide services, professional prestige and monetary gains. In addition, this mainstream path to credibility primarily uses written documentation as the accepted 'domain of knowledge' for in its evaluation. This process can sometimes be lengthy and take numerous years to implement, however, in the end, there is no guarantee that the process will result in statutory self-regulation of a health profession.

There are currently many self-regulated, mainstream, health professionals who work in some capacity with First Nations communities. It was noted that First Nations health administrators who hire these people have to understand the mechanisms of the mainstream self-regulatory system. One reason given for this was that they could protect themselves from unqualified persons claiming to be credentialed medical professionals.

First Nations people who have received training as a mainstream health professional can be faced with challenges when trying to: bring these skills back to their home community where there is an absence of demand for what they have been trained in; and/or

reconciling within themselves teaching and practices from two different systems of healing knowledge. In addition, it was noted that some people (in this case at Akwesasne) are moving towards health professions like homeopathy and naturopathy, that have recently become regulated, because their programs, medicines and practitioners are sometimes easier to access than the traditional system of medicine from their home community. It was noted that greater unity and cohesion amongst First Nations healers and their medicines might be a way to combat these sorts of trends.

In the first two categories of the Results Chapter, (and some instances of the third) the foundations of self-regulation and traditional health and healing start to divulge themselves as one begins to look through the lenses of First Nations cultures and traditions. Within these foundations one can find the self-regulatory mechanisms that assure the quality of healers within Indigenous communities. One might say that the third and fourth self-regulatory themes in this Chapter address Little Bear's (2000) notion of a post 'jagged -world views colliding' world –where notions of self-regulation might be viewed as an ongoing cultural-professional dialogue between First Nations and the mainstream.

Chapter 7: Discussion, Implications, Limitations and Final Thoughts

Discussion

Contexts of meaning

Essentially when viewed in its entirety, the post-colonial issue of self-regulation in traditional health and healing is another page in what Blood scholar Leroy Little Bear has termed 'jagged worldviews colliding'. The results of this research study indicate that the influences which imbue self-regulation in First Nations traditional health and healing with its meaning are somewhat dependent upon the context(s) that surrounds it. For this research project, it was shown that these contexts that define self-regulation can range from: those that are more centred around the traditional healer; to those that appear to more freely utilize mechanisms found in self-regulatory models for mainstream health professionals. For First Nations traditional health and healing, none of these variations are necessarily wrong and there can be different sets of reasoning behind deciding which approach works best for a particular community.

Generally speaking, when one is trying to further understand an issue, the fact that context influences meaning is by no means a new or unique observation. In fact, it is even more reasonable to assume that this is the case with respect to trying to understand: the meaning of a particular concept in one cultural context versus another; or when knowledge held by different cultures comes together to create situations that did not previously exist. Essentially, the core contribution of *this* research project was to show

that, for First Nations, self-regulation in healthcare is not a universal/cognitive imperialistic concept whose meaning is solely determined through its use in the mainstream. This was achieved through a research exercise which involved an in-depth articulation about how questions and answers about the issue can be further clarified through a careful consideration of the surrounding context(s).

This being said, my sense from doing this research, however, is that there is a depth to the more healer centered notions of this issue that the majority of us rarely see ('majority' in this case meaning mainstream or even some of those who are involved with the more contemporary notions of First Nations community health programming). This occurs for at least three reasons. The first reason is because, similar to doctors and interns, most of us are not healers or apprentices of healers! A second reason involves notions to protect Indigenous medicines and healing traditions from mainstream forces that would end up appropriating them for their own purposes. Indeed, many First Nations traditional healing practices still remain 'underground' and healers prefer not to engage in any processes at this time that would involve bringing these practices out further into mass society. A third reason as to why it is difficult for many of us to collectively visualize the aspects of self-regulation that are more akin to the reality of traditional health and healing is because it requires some understanding of concepts articulated through Indigenous cultures and languages. These ideas may not translate very well into the dominant tongue and/or culture. It is an interesting paradox because, at the same time, this 'depth' (reflective of how healing is understood in Indigenous health and wellness knowledge systems) which is sometimes only glimpsed in mainstream society, is what

continues to drive the dialogue around the overall issue of self-regulation and First Nations traditional health and healing.

What the literature review and results of this study *did* reaffirm, however, is that when considering First Nations traditional health and healing, there is a requirement to look beyond the recognizable interpretations of self-regulation and how these notions primarily describe the protocols followed by mainstream health professionals. The literature clearly reflected some of reasons why definitive definitions of self-regulatory health processes in a post-jagged-words colliding environment' do not exist. The literature helped to prepare the ground for the idea of 'contexts' through which we are able to think about and discuss this wide ranging issue.

With regard to the generalized issue of First Nations traditional health and healing, the 'contextual' argument taken in this research project illustrated that interpretations of self-regulatory processes need to be more inclusive and reflective of the Indigenous health and wellness knowledge held by First Nations communities. While some progress has been made in this area, greater levels of respect and trust still need to be afforded to First Nations who are choosing to bring their self-regulatory conceptualizations about health and healing forward in the form of a cultural/professional dialogue with the mainstream. In genuine situations, Creation stories, Indigenous languages, ceremonies, traditional birthing practices, tribal knowledge held by healers, etc., provide the foundations for these sorts of 'community based' conceptualizations.

For these Indigenous healing realities to maintain acceptable levels of cultural integrity in 'community-public' or even mainstream contexts of self-regulation and First Nations

traditional health and healing, governments have to be able to 'think outside the box' (J. Wilson, Focus Group Interview, August 27, 2010). In addition, First Nations should not feel as if these types of collaborations always have to involve 'fitting a circle into a square world' (B and C, Focus Group Interview (November 24, 2010) when they respond to their community's desire to see a greater inclusivity of healers in their health programming.

Ethical considerations

The ethical issues around self-regulation and First Nations traditional health and healing arise, in part, because on some level, the different contexts through which the issue can be interpreted have not been acknowledged. For this study, this 'non-acknowledgement' seems to apply more robustly to the 'healer centred' and 'community based' contexts that were discussed in the Chapter 5. Following this line of thinking, the non-desire for First Nations traditional healers to entertain any form of outside or parallel regulatory processes can occur for at least two reasons. First and foremost, First Nations healing systems, that have arisen in contexts of Indigenous Knowledge accumulated over millennia, simply have their own internal methods for determining the identity of a 'healer' and the nature of 'medicine'. Secondly, in colonial and post-colonial contexts, there are countless situations where Indigenous healing knowledge has been disrespected in the Western world. In this environment, Indigenous healing systems and medicines have either been hastily dismissed and overlooked or inappropriately diluted and appropriated by some proponents from Western science and/or New-Age movements. In the literature review of this study, many of the ethical issues surrounding self-regulation

and First Nations traditional health and healing (e.g.: legal grey areas, efficacy of traditional medicine, institutionalization of tradition and authenticity) are representative of this latter concern.

The ideas of 'universality vs. non-universality' and the presence of 'contexts of meaning' are important to consider in a discussion about the ethical issues that relate to this topic.

Indeed, Lamouche (2010) notes that even within ethical concepts themselves, people seem to equate ethical procedures with something that constitutes a 'universal good'.

Lamouche (2010) also argues that just because universities have ethics protocols in place does not mean that they will necessarily reflect the needs and realities of different

Indigenous communities. At this point, the mention of Willie Ermine's work on ethical space in relation to Indigenous issues is also appropriate and useful. For our purposes in particular, this concept is useful in considering notions of self-regulation and traditional health and healing in 'community public' contexts and also the more genuine inclusion of First Nations healers in mainstream self-regulatory contexts.

Creating appropriate ethical spaces in research and programs that are interested in using Aboriginal traditional healers or traditional healing methodologies is critical. Otherwise one can run into situations of questionable ethical merit which could involve, for example, the commoditisation of Indigenous Knowledge. The unethical marketing of Aboriginal traditional healing knowledge poses one of the central concerns for traditional healers and knowledge carriers (Martin-Hill, 2003). In addition, creating these sorts of 'ethical spaces' for dialogue can be useful for things like expanding our understanding about current definitions of efficacy, clarifying 'grey areas' in policy and legislation,

enhanced presentations about views on nature/environment, and others. The location of true ethical space, however, has been difficult. Ermine notes that although there have been many sincere past attempts to build bridges, good intentions have been washed away because of a failure to look at the area between the Indigenous and Western worlds (Ermine in Ford, 2010).

In the Results Chapter, many of the ethical issues that arose in the literature review were substantiated through some of the concerns brought up by the research participants. Such commonalities were particularly noticeable through the in the presentation of the 'community public' self-regulatory context. Ideally, this context would be the one that arises out of ethical space that Ermine talks about. However, the actual responses from the research participants who navigate these 'community public' space on a daily basis suggests that either this type of ethical space is difficult to locate or that greater efforts need to be made towards sincere dialogue about the *real* area that exists between First Nations and modern Western systems of healing.

The dynamics of self-regulation and First Nations traditional health and healing

So far we have made reference to some different possible contexts through which issues of self- regulation and traditional health and healing can be viewed. In addition, we have also noted some important ethical considerations that accompany this issue in contemporary 'post-jagged world view' situations. *The dynamics of self-regulation and First Nations traditional health and healing* is a term which is meant to reflect how these different self-regulatory contexts begin to relate to one another through the interactions of

people. While helpful for exercises in conceptual clarity, in the real world it can be difficult to clearly separate out issues that surround this research problem and to then, subsequently, decide to have a discussion about them solely within the boundaries of their appropriate contexts. The issues which concern self-regulation and traditional health and healing are dynamic ones because, in reality, we cannot only be concerned about good ideas. We also have to be concerned about current realities faced by First Nations communities and the healers that are serving them and then working to turn these good ideas into reality.

With the goal of achieving balance in this dynamic relationship across contexts of meaning, considerations about how traditional healing protocols and the integrity of Indigenous healing systems can remain intact are paramount as First Nations communities move between different self-regulatory realities. Given the background that, in the past, expressions of First Nations traditional health and healing were severely suppressed, it is important to consider the extra means necessitated to accommodate traditional healers in any self-regulatory context where their services are wanted.

The current situation seems to be one where undercurrents of mainstream self-regulatory understandings become more powerful and confining when we begin to lose sight of insights that represent understandings that are more 'healer centred' and/ or refuse to open our minds to other epistemological realities. These types of situations can cause the dynamics present in these relationships to become unbalanced. For example, some mainstream medical professionals do have sincere desires to work along-side of First Nations healers in contemporary contexts. However, if in this relationship they fail in

being able to relinquish their ideas of self-regulation as it applies to situations of mainstream health professionals (and consider 'healer centred' and 'community based' ones), we will be left with unbalanced, one-sided approaches that only aim to consider inappropriate and/or diluted understandings of First Nations healing systems.

At least part of the reason behind why obstacles occur when First Nations communities attempt to bring their traditional health and healing knowledge forward into contemporary contexts, can be found in the perspective taken by Sami researcher Jelena Porsanger. Porsanger (2011) indicates that for those who are working in the field of Indigenous Traditional Knowledge, one is always met with an inevitable question: "How do you determine what is traditional and what is modern in your Indigenous culture"? For Porsanger (and she says many Indigenous scholars), the question is based on the mainstream knowledge paradigm which purports a rigid dichotomy between the idea of 'modern' and the idea of 'tradition' (Porsanger, 2011, p. 225). In addition, (and in reference to the work of Sami scholar, Rauna Kuokkanen) Porsanger (2011) argues that this dichotomy has resulted in causing the epistemologies of Indigenous peoples to become invisible and/or tends to place the Indigenous outside the contemporary world which is considered to be 'modern'.

Personally, I came to better understand the truth of Porsanger's observations after a presentation I did on this research at Six Nations on May 26, 2012. I, along with some other researchers who were also working on projects with the Six Nations community, were asked by the Ethics Committee to do presentations on our research at a Six Nations Ethics Forum. The Forum, which was promoted as an information session for Six

Nations community members, took place in front of a small community audience. What struck me about the responses to my presentation was that, even though I presented definitions of self-regulation and traditional health and healing in various contexts (like in the Results Chapter of this study), people still seemed to understand the concept of ‘self-regulation’ to be something that primarily determines protocol followed by mainstream health professionals.

One participant spoke about his experience as a member of a community of traditional healing practitioners in Manitoba. This person talked about the various struggles they went through and what they did (like establishing a Council of Elders) to have their practiced recognized as ‘legitimate’ in the eyes of the mainstream (Robbins, 2012).

Another respondent to the presentation indicated that I should make sure that I do not portray the healers of Six Nations as being associated with ‘community public’ entities in the community –such as the birthing centre. The reason for this was because, realistically, many healers still choose not to engage with these types of things (Robbins, 2012). Thus, it would seem that with regard to engaging with ‘community public’ aspects of traditional health and healing, many healers prefer anonymity because they are acutely aware that their understandings of Indigenous healing knowledge might be overlooked and/or misrepresented.

At the same time, positively affecting the dynamics with regard to these types of reoccurring situations has involved an infusion of Indigenous knowledge perspectives into contemporary environments. For example, in *Ganigonhi:oh: The Good Mind Meets the Academy* (2008), Haudenosaunee scholar, David Newhouse discusses the

experience of the Department of Indigenous Studies and the process over the last 30 years that brought Indigenous Knowledge perspectives into the intellectual life of the university. With Indigenous Knowledge at the centre, this perspective does not aim to categorically reject other knowledge perspectives. In fact, argues Newhouse, not engaging with the knowledge of others or denying the knowledge of others is inconsistent with the Haudenosaunee *Kaswhenta* (Two Row wampum) teachings. Rather, engagement with others with whom one shares the world is essential to living well (2008, p. 188).

In situations where these 'infusions' of Indigenous Knowledge are occurring, Indigenous Studies departments like the one at Trent University is making sure that credit is given where credit is due. In the past, with particular reference to the work of academics Carl Jung and Abraham Maslow, a disturbing trend existed where Indigenous peoples were not credited for knowledge contributions that were mined by mainstream academic researchers (Newhouse, 2008, p. 186). In addition, Newhouse notes that with respect to the genuine development of Indigenous Knowledge in the intellectual life of the university, the teachers of Indigenous Knowledge should be Elders (2008, 191). When Indigenous Knowledge became further established in curriculum and research, it became important that Elders be given the same recognition on par with other academics. Shirley Williams was the first person in the history of Canada to become a full professor based on Indigenous Knowledge criteria (Newhouse, 2008, p. 191).

In a recent lecture at a conference entitled *Indigeneity and the University: Activism, Scholarship and Pedagogy* (McMaster University, Hamilton, Ontario November 23,

2012), Professor Newhouse noted that institutions have difficulty in understanding new interpretations of institutionalism and that the job of bringing Indigenous Knowledge into the intellectual life of the university is an ongoing one. New university presidents and administrators usually bring the same mainstream institutional perspectives which are devoid of Indigenous understandings. As a result, Newhouse describes Indigenous people as ambassadors of this knowledge gap that exists between world views. Bringing people into what Newhouse terms this *Kaswhenta space* is something that is not an easy task as it has to be accomplished in a way that does not threaten their identity and has to bring them to a point of understanding where it is realized that change is not necessarily a bad thing.

With reference to this research about self-regulation and First Nations traditional health and healing, this example offers some illuminating parallels. Those involved with Aboriginal organizations, such as those associated with Aboriginal Healing and Wellness strategy or the Indigenous Physicians Association of Canada can play significant roles in the establishment of these real 'ethical spaces' between worlds. Over time, we may be able to look to a future where traditional perspectives held by Indigenous Elders and their communities could more genuinely appreciated by modern Western medicine and viewed as something that can continue to develop in modern Indigenous environments.

The Medicine circle

We have seen from this research that larger contexts of meaning, often reflective of knowledge 'institutions' (Indigenous /non-Indigenous/or both), influence how self-

regulatory processes are perceived and interpreted. Nonetheless, what is missing is the dynamic portrayal of these contexts of meaning because, in reality, they are not static and they do not exist in isolation.

The medicine circle is a powerful traditional tool that has been used by some First Nations communities to depict animated and dynamic states of balance. In the context of Indigenous health and wellness, the medicine circle can be used to reflect upon and implement any necessary changes required in one's physical, mental and spiritual relationships in order to bring one back into a state of health and balance. Similarly, this expression of the medicine circle has also been used by First Nations to reflect upon and find solutions to issues affecting the health of their communities. For this research project in particular, it was noted in the research design that part of the 'giving back' to First Nations communities would involve interpreting the findings in a way that would be more accessible. The medicine circle is such a vehicle through which I think that this objective can be further realized.

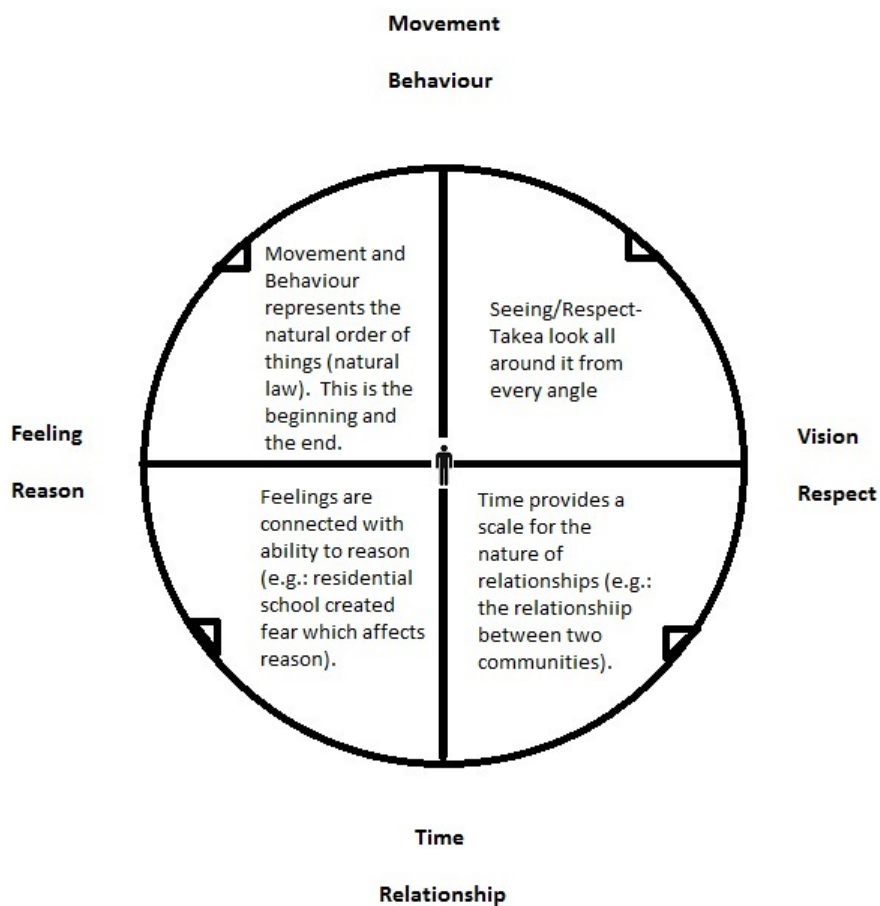
What follows from here uses medicine circles to dynamically illustrate the understanding about self-regulation and First Nations traditional health and healing that was achieved through the engagement of this research project. Through following the processes depicted in the two medicine circles below, your community should be able to more clearly identify some of the actions necessary for balanced and locally relevant understandings about the self-regulatory processes in and around traditional health and healing practices.

Using the traditional medicine circle as a background to see your world

The medicine circle specifically developed to illustrate the findings of this project (Figure 2), as you will see, finds its foundations in a powerful³⁰ representation of a traditional wheel (Figure 1) below that was graciously shared with me (and most certainly many others) on several occasions by one of its current knowledge keepers, Metis/Cree Elder and Adjunct Professor (Trent University) Michael Thrasher. The traditional wheel represents earned knowledge that was arrived at through ceremony/First Nations traditional processes. I myself am not a knowledge keeper of this traditional medicine circle or any of the ceremonies that are associated with earning this type of knowledge. I have only been given permission to use it insofar as it might assist in the development of community resources from this research.

³⁰ Powerful because of its ability to be practically applied to many situations that one may encounter in life.

Traditional Medicine Circle



Note: A version of the traditional medicine wheel as shown to me several times by Elder/Adjunct Professor, Michael Thrasher (Teachings, 2000-2013).

Figure 1

The following points provide some basic insights about the traditional medicine circle (Figure 1) and one way to use it. These points are paraphrased from notes that were taken

during a teaching session led by Michael Thrasher at the *Gegenoaatatolting: Sharing the Knowledge* gathering (Elsipogtog Mi'kmaq First Nation, September 8-15, 2008).

- Traditional philosophies and teachings from what are known as Medicine Circles provide a background grid to understand and work within the laws of nature that assure that harmonious growth potentials can be realized.
- Connecting to a method such as this will allow you to "See" your universe and your "Journey Around It". It can foster the necessary balance, growth and change you seek.
- Although we are born in perfect balance—a balance at the core of life which is caring, listening and loving—as we go through life we develop various behaviours due to situations we are faced with. Patterns begin to develop in our behaviour and, once established, they are difficult to change. As adults, we can often become 'set in our ways' and we have to use our spiritual strength in order to create new ones.
- First Nations traditional health and healing practices are meant to bring us back into balance so that we are able to properly sort out negative emotions. We do ceremony and work on ourselves because it helps us to clarify issues in our lives through separation of the emotions/feelings from the facts. An issue may have created an emotion but the emotion may not help the issue at all.
- After the issue is separate from the emotion, it is necessary to develop an action plan and work on it. Once you have your plan it is necessary to take action or else it

doesn't count. He indicated there is a 'rascal' you will usually face at this point, which is fear. So in carrying out your plan you will have to face fear at some point.

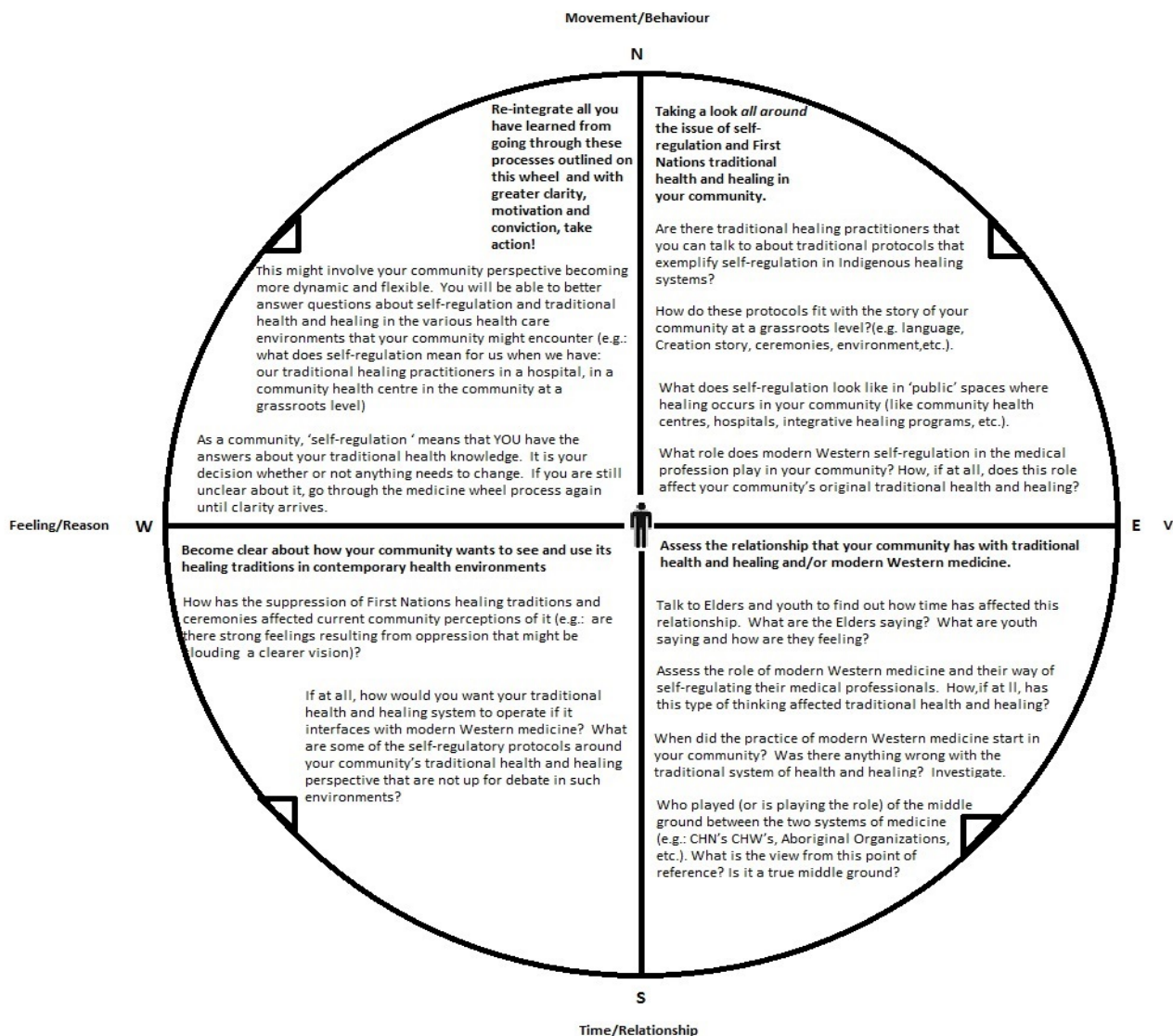
- If you did not receive the results you envisioned when you began, journey around the wheel another time. Revise, 're-vision' or take another look (north-east quadrant). Then, take some more time (south-east quadrant), reason out a new plan (south-west quadrant) and when it seems workable, do it over/take action again (north-west quadrant).

Greater comprehension about issues of self-regulation and traditional health and healing in your community

First Nations traditional knowledge and viewpoints can be used to address contemporary issues. Building on the concepts contained in the traditional wheel, the medicine circle below shows a process that can be used to achieve more clarity about issues concerning self-regulatory processes and the traditional health knowledge within a First Nations community.

Figure 2

Understanding the issues around self-regulation and traditional health and healing in your community



Below, some of the thoughts, words and experiences of people who were interviewed for this project are offered as possible ways of addressing the questions and concerns contained in the Figure 2 medicine circle.

North-East Quadrant

Taking a look all around the issue of self-regulation and traditional health and healing

- Are there traditional healing practitioners that you can talk to about traditional protocols that exemplify self-regulation in Indigenous healing systems?

The following conversation that took place at Elsipogtog is an example of protocol associated with permission to practice traditional healing in particular community:

D Gehue-“Where we got our recognition from my perspective was from JA’s dad. When I first came here, he knew I was going to keep coming here and every morning I was here, he was here, because he wanted to hear more about traditional stuff.”

J. Augustine- “My dad called Dave sir. Hello Sir.”

D. Gehue- “I’ve come to see you sir lets have tea. You know that guy was 80 years old. When he needed help he said let’s call Dave. He said, 'He’s coming? I’ll be there'. He wouldn’t leave his house for weeks but when I came, he was there. So we had recognition by the Elders here.”

F. Augustine- “We were appointed by the People. You don’t take that name yourself. You don’t take it, People give it to you.”

D. Gehue- “When I came here over 25 years ago, there was a meeting of the Elders. I walked up to each Elder and gave them tobacco and said, 'Can I have permission to come and work and to be in your community'? I was the only one that did that.... and I was welcomed by the Elders. I’ve never had problems since.... the spirits protected me all the way.... and I’ve been coming here over 25 years. 'KA' was just a little kid.”

F. Augustine – “Yes it has been a while.” (D. Gehue, F. Augustine, J. Augustine, Focus Group Interview, May 16, 2010).

- How do these protocols fit with the story of your community at a grassroots level?(e.g. language, Creation story, ceremonies, environment, etc.).

With regard to language and ceremonial protocol, a midwife at the Six Nations birthing centre noted that:

“Well I think that the language is very important. That is where our culture is. They go hand in hand. If we didn’t have languages the culture would die out soon after that. Because you are not able to do the ceremonies the way they are meant to be done.” (S. Smoke, Focus Group Interview, August, 27, 2010).

Protocol might also be defined through the activities at traditional cultural spaces or sacred sites. At Akwesasne one person noted that :

“Attending the longhouse means that you practice in certain ways. This means a certain value system is in place even in places of employment . At the same time, it was also viewed as important for the kids to have contact with traditional people in public. There is a sacred role for the faith-keepers anywhere in the community” (H, Personal Interview, November 24, 2010).

- What does self-regulation look like in ‘public’ spaces where healing occurs in your community (like community health centres, hospitals, integrative healing programs, etc.)?

At the Six Nations birthing centre one person noted that with respect to their self-regulation process, mainstream practitioners do not understand the many levels of accountability that actually exist:

“For us, since we are governed by our Band Council, if anything was done that was incorrect or unsafe, the midwife would be disciplined. It’s not to say people can practice unsafely. The thing people don’t understand is the high level of accountability in the practice (Band Council, Grandparents group, and most importantly the community). It’s not like we practice and do our own thing. Off reserve you are your own man and not accountable in the same way. Here on reserve, we are accountable every day to the community. There is a big difference. So with traditional medicine

people, if you have a concern, simply don't go. There is a level of anonymity when living in a city of 4 million vs. a small community. We are accountable to many people we see. We all work together as a team. There are so many levels of accountability but they don't understand that. For them there just needs to be one College. Because we don't have the one College we are seen as practicing recklessly with no one to govern us." (J. Wilson, Focus Group interview, August, 27, 2012) .

- What role does modern Western self-regulation in the medical profession play in your community? How, if at all, does this role affect your community's original traditional health and healing?

At Akwesasne it was noted that understanding self-regulation processes from the modern Western perspective can help protect the community when hiring mainstream health professionals:

"Well, I am a trained nurse so.... my knowledge is more of the western model. In a previous lifetime I was Director of Health with the St. Regis Mohawk tribe, our counterparts south of the border. It's a credentialing process with physicians coming in and nurses coming in. It was my responsibility, as an administrator, that those were coming in as a nurse or doctor into the program.... that they really were who they spoke of. Because in at least one instance we had one physician apply for a position and in the credentialing process, we were looking into the state they had been licensed from, data registries to make sure they were a credible doctor, that there were not any complaints against them or pending medical liability suits. We called the State Department of Health and found that they were actually an imposter." (B, Focus Group Interview, November 24, 2010)

South-East Quadrant

Assess the relationship that your community has with traditional health and healing and/or modern Western Medicine

- Talk to Elders and youth to find out how time has affected this relationship. What are the Elders saying? What are youth saying and how are they feeling?

One participant indicated that for his particular Mohawk community, self-organization within traditional medicine societies, which diminished during a time of outlawing traditional healing ceremonies and widespread conversion to Christianity, are now becoming strengthened again. He also indicated, however, that due to the numerous modern day distractions, it is difficult to see beyond what this will look like beyond the current generation:

“But there were also those other (medicine) societies that were out there.... those medicine societies, that we didn’t have here, but we used to have to go down to Six Nations, we had to go to Buffalo, Allegheny, until our people started to get a little bit stronger and our people, even though we had lost a lot of our language, we had a core of people that understood the importance of it and that we needed to start bringing that stuff back to us, so our people didn’t have to travel those long distances and we could start taking care of our own people. So, it was only in the last 30 or 40 years, where that began to build strength.....and where we are today, based on that information, we are good where we are now. But on the other side (there is concern about)³¹ who is coming behind us right now. This is the big question mark. Are we only strong for the time right now and after that we will struggle? We don’t know those things. That’s why we try to get those young guys and say, 'Come on get in here'. But we don’t have that opportunity to sit around like we are doing here and to discuss what are issues are. We are too nine to five westernized that’s what it is, it is the biggest problem to be able to move forward.... 'gotta pay that electric bill, gotta go to the Wal-Mart'. All that daily stuff.” (A, Focus Group, November 24, 2010).

- Assess the role of modern Western medicine and their way of self-regulating their medical professionals. How, if at all, has this type of thinking affected traditional health and healing?

Sometimes the little or no understanding in the mainstream of First Nations protocols that form their self-regulatory processes creates a disconnect. For example a midwife from Six Nations noted:

³¹ My parentheses.

“One time, we went to a hospital to give a talk and there was a huge discussion/gathering of nurses, doctors’ consultants, health professionals. They were saying, ‘well how we know that those traditional medicines are safe that you give people. What are they? Tell us the names’. So we had to explain that these are guarded and they are gifts that we have been given from the Creator. We have to protect that. You can pick a medicine and you know where it grows. You go out into the bush and it will hide on you or won’t grow if you abuse it. And then you will no longer have that medicine to use. If enough people do that, then it’s not going to be there at all.” (L. Jacobs, Focus Group Interview, August 27, 2010).

- When did the practice of modern Western medicine start in your community?

Was there anything wrong with the traditional system of health and healing?

Investigate.

While you will have to investigate around what time modern Western medicine started to be practiced in your community, the fact that First Nations traditional healing practices went underground indicates repression by the mainstream rather than their being something wrong with them. At Six Nations:

“Just sixty years ago people were shocked to know that people were birthing (at Six Nations) with midwives.... people were shocked to hear that. That is how much we have been westernized.... But then only a certain number of people knew it was happening because it was hidden.” (J. Wilson and S. Smoke, Focus Group Interview, August ,27, 2010).

- Who played (or is playing the role) of the ‘middle ground’ between the two systems of medicine (e.g.: CHN’s CHW’s, Aboriginal Organizations, etc.). What is the view from this point of reference? Is it a true middle ground?

One function that The Aboriginal Healing and Wellness Strategy in Ontario has in its middle ground role is protecting First Nations traditional health and healing knowledge from eroding:

“The other thing is that AHWS type projects and even other programs like the Association of Friendship Centres, we have a role to play in terms not just in promoting the traditional healing, but also to make investments to make sure that we don’t lose anything more through the colonization process. That this memory, blood memory, teachings, songs, ceremonies, and practices or identifications of medicines aren’t lost, or further lost. And as you know we have lost a great deal of things over a period of time. Most traditional healers will tell you that they only know a very little bit based on the people that taught them. And they will talk about who taught them... their grandparents, learned people in their community.... So I think that organizations like ours are a bit of a break-wall to try and slow down the loss or further loss of our Indigenous knowledge in this area.” (S. Maracle, Personal Interview, December 6, 2010).

More acknowledgement and use of First Nations languages could play a role in establishing a true middle ground. For example, during interviews at Akwesasne, one person said;

“First Nations can go towards the Western medicine because most have some understanding of the English language. But the community of modern western medicine cannot come towards First Nations because they don’t speak the language.” (J, Personal Interview, May 3, 2010).

South-West Quadrant

Become clear about how your community wants to see and use its healing traditions in contemporary health environments

- How has the suppression of First Nations healing traditions and ceremonies affected current community perceptions of it (e.g.: are there strong feelings resulting from oppression that might be clouding a clearer vision)?

A person from Akwesasne gave an example of how clear vision was clouded in his community:

“At the time of colonization when a lot of people converted to Christianity, they had a strong connection with the priest. A lot of ceremonies that were going on in

the territory had to go underground, because a lot of the converted said they would tell the priest. This continued up until around the 30's or 40's. This is how strong an influence the Catholic religion had on us on presenting obstacles for the things we needed to do –with people not really understanding how important these things were to us based on their belief system or whatever. Nobody was to blame for that.... that is just how things happened here.” (A, Personal Interview, November 24, 2010)

- If at all, how would you want your traditional health and healing system to operate if it interfaces with modern Western medicine? What are some of the self-regulatory protocols around your community’s traditional health and healing perspective that are not up for debate in such environments?

At Elsipogtog First Nation, the late respected Mi’kmaq healer David Gehue indicated that Native licencing was one way to interface with the regulatory process used in modern Western medicine. Native licencing was referred to as “Our ability to be licenced in our respective fields and governed by our own people” (D. Gehue, Focus Group Interview, May 16, 2010).

Also at Elsipogtog, B. Altivator spoke about traditional values and practices not being up for debate in such integrated environments. He also, however, cautioned against temptations in such environments that can challenge personal value systems:

“Hopefully the ceremonies would keep the healers strong and above water. So you need to protect that centre and there is nothing that can draw you away from that like being famous or notoriety. People praise you, they pat you on the back, monetary rewards etc.” (B. Altivator, Personal Interview, May 16, 2010).

North-West Quadrant

Re-integrate all you have learned from going through these processes outlined in this wheel and with greater clarity, motivation, and conviction, work through your fears and take action!

- This might involve your community perspective becoming more dynamic and flexible. You will be able to better answer questions about self-regulation and traditional health and healing in the various health care environments that your community might encounter (e.g.: what does self-regulation mean for us when we have: our traditional healing practitioners in a hospital, in a community health centre in the community at a grassroots level) .

With respect to this notion, the Director of the Ontario Federation of Indian Friendship Centres, Sylvia Maracle described how the Navajo and the Hopi tribes of the American Southwest took action that strengthened their own self-regulatory processes regarding their healing knowledge.

“What happened was that there was this great recovery that was occurring (and this happened in the 70’s by the way). There was this great recovery that was occurring in our community and all of a sudden who purported to have Traditional Knowledge or Indigenous knowledge started popping up all over the place. And the Navajo in particular, but Hopi as well, became concerned that people were co-opting their knowledge or worse yet saying this was their knowledge when in fact it wasn’t.... So they called/created a council.... I think in those days they were calling it the Nations Elders Council, and anybody who had the traditional knowledge, were carrying the stories, the medicines, the songs the teachings, who could do sand paintings or who could do certain spirit calling that needed to be done.... all were asked to gather.... and they gathered and they kind of stood up.... and I want to say that it was in the community college, either in Chinle or Flagstaff.... they stood up for days and said this is who I am, this is my family lines.... very complex clan relationships. So this is what they did. And

they said, anyone who doesn't come before this council doesn't have a right to say that they are teaching Dine (Navajo) ways.” (S. Maracle, Personal Interview, December 10, 2010).

Sorting out this process internally within the community exposed charlatans and others trying to profit from claiming to have Navajo traditional healing knowledge. Through undergoing this process, the community became much clearer about their own healing base and adapting elements of mainstream self-regulatory processes such as the administration of healing licenses by the *Dine Hataalii* Association brought with it a lesser chance of corruption, healer misrepresentation and/or subsumption into mainstream self-regulatory ideologies

As a community, ‘self-regulation’ means that YOU have the answers about your traditional health knowledge and its uses now and into the future. It is your decision whether or not anything in your current community perspective needs rebalancing or change. If you are still unclear about it, just like in the traditional medicine circle, ‘re-vision’ and go through the process again until clarity arrives.

As a further exercise:

1. Take a look at the people’s words in the interview chapter of this paper (Chapter 5) and identify some responses from others that also answer these types of questions noted in the medicine circle above.
2. Now that you’ve done this, ask yourself how would your community address these types of questions and concerns outlined in the medicine circle?
3. These are only a sample of potential concerns and questions. Are there other questions and concerns not listed here that are relevant to your community? If so,

identify them and try to answer them using the medicine circle process that was described here.

Implications for research, theory and practice

Based on the results of this research study new questions with respect to the issue of self-regulation and First Nations traditional health and healing can be considered. First, a logical place to start might be to continue a line of inquiry that was beyond the scope of this research project but put forward as an idea in the original project proposal. The question involved an inquiry about the sorts of measures that have been taken in addressing this same issue in other regions of Canada and in other countries.

Specifically, contact about this research was made with the *Cree Working Group* (Ahtahkakoop First Nation, SK), *Ingano Association of Taitas*, *UMIYAC* (Colombia), *Te Tapenakara Mo Te Iwi Charitable Trust* (New Zealand,) and a ‘spinoff’ *Sangoma Lodge* (Southern Botswana). Through facilitated Indigenous ‘*inter-nation*’al dialogues, are there any lessons that can be learned and/or applied now that this problem has been further explored here?

Another important line of future research questioning could involve more diligent work on healer centred contexts of self-regulation and the role indigenous languages play in articulating systems of self-regulation. A question might include: “What role can Indigenous concepts that are voiced through Indigenous languages play in making ‘community public’ situations of self-regulation and traditional health and healing more reflective of collaborative realities that may exist between worldviews?” Answers to

similar questions are significant in the establishment of a true middle ground. A research participant at Akwesasne relayed their insight into this issue when they stated:

“First Nations can go towards the Western medicine because most have some understanding of the English language. But the community of modern western medicine cannot come towards First Nations because they don’t speak the language.” (J, Personal Interview, May 3, 2010).

Furthermore, *Language* is how the knowledge is encoded and the belief among Elders is that Aboriginal languages developed organically from the land (Lamouche, 2010).

Other general directions of deeper research involve the further determination of self-regulatory process that do not cause any disruptions in First Nations traditional healing practices. Lines of questioning might include: ‘What sorts of environments/relationships need to be nurtured between researchers and First Nations healers/Elders in order to afford healer centred approaches to self-regulation the respect that they deserve in contemporary contexts?; ‘What role can Aboriginal organizations play in facilitating this process?; ‘What sorts of activities need to be undertaken in order to positively affect what Porsanger labeled the dichotomy between ideas of ‘modern’ and tradition –where Indigenous epistemologies are overlooked and seen as being not part of the ‘modern’ world?’ In addition, based on interviews with proponents of First Nations traditional healing and those from modern Western medicine, ‘What are some of the reasons behind why there continues to be such a disconnect between people who represent these different institutions?’

While the research findings have not refuted the theoretical approach taken in this study, the theory would seem to work best when applied on a community by community basis, rather than something that we would want to try and generally apply across all First

Nations. Different communities have different needs. For example, some communities may have a greater confidence in their *passive* ethnogenetic processes that allows for them transmission of traditional knowledge from one generation to the next. Other communities that have had their processes of knowledge transmission interrupted in more severe ways could require greater external supports based in cultural safety initiatives. What it means to have more genuine involvement of traditional healers into the more public aspects of First Nations community health, which could involve things like a re-examination of ideas about the meaning of professionalism, is something for communities to work out for themselves on their own terms. Such initiatives that are developed by First Nations should be supported from any external partners through the appropriate cultural safety mechanisms.

The theoretical approach can be viewed as a tool for thinking about the some of the necessary factors that are needed for First Nations community to achieve greater balance when considering the different contextual understandings about self-regulation and traditional health and healing. For example in, a ‘community public’ context, how could ideas of ethnogenesis, professionalism and cultural safety help support the greater realization of the ‘ethical space’ in Indigenous contexts, as put forth by Ermine.

The theoretical approach provides some conceptual grounding for a community to ask itself questions like: ‘Who are our knowledge holders?’, ‘What are the traditional knowledge elements that determine self-regulatory processes for our original ways of healing?’, ‘Are our healing traditions being misused in any way? (If so, what can be done to reverse this trend?)’, ‘If we decide to bring it out further in the community, what

kinds of support programs are needed to have adequate levels of protection/cultural safety?', and 'Can a dialogue about 'professionalism' take place or is there too much of a disconnect between the systems of medicine?'

I think that a significant practical application that the results of this research project might have is with particular regard to the identification of and discussion about 'grey areas' in Canadian legislation and policy. Part of the difficulty in trying to bring together First Nations health systems and modern Western medical models in an environment where the latter is so heavily promoted can lead to, for example, a First Nations healer being unfairly subjected to laws and regulations that govern mainstream health professionals. This notion was discussed in the literature review and the results of the study confirmed that where these 'grey areas' do exist, in an environment of dichotomy between the 'modern' and the 'traditional', the default system of evaluation is most likely to be grounded in understandings based in Euro-centrism. While grey areas can cause us to think about the numerous ethical issues associated with them, they can also become quite problematic for proponents of First Nations traditional healing if they are not adequately addressed. We have to remember that regulations in a society are backed by the force of law. While the law intends to be clear, in some instances, it is not. Concerns about the methods used to determine efficacy in the evaluation of traditional medicines or about how the regulation of natural health products would affect First Nations traditional healing practices should be more adequately addressed. If not, First Nations healers could continue to see continued suppression of, and even attacks on, their science. With regard to First Nations traditional health and healing, mainstream regulation (whether

they be municipal, provincial or federal) should not impede the facilitation of Indigenous paths to community based self-regulation in healthcare.

In jurisdictions like Ontario, dialogue between First Nations/Aboriginal groups and the province has led to some solutions where exemptions for First Nations have been legislated into law and greater space has been made for community based avenues to self-regulation. At the same time, such advances do not mean that the problem has been solved. Although economically viable, First Nations traditional medicine/midwifery should be viewed by mainstream policy makers and regulators as more than a stop-gap measure to mainstream Western medicine.

In the Results Chapter, it was indicated by the self-regulating midwives at Six nations that, due to the cognitive imperialism projected through mainstream models of self-regulation for health professionals, many obstacles still exist for them. For example, difficulty was noted about receiving appropriate malpractice insurance. A practical contribution to clearing up this grey area could involve something like the Minister of Health adding an addendum to the exemption clause for Aboriginal midwives and traditional healers in Ontario. It might read something to the effect of: 'First Nations midwives who choose to practice and/or self-regulate under the exemption clause in the Act are self-regulating in their communities through senior Aboriginal midwives, their community governments, and other keepers of community traditional health knowledge. While they are not self-regulating in the mainstream sense like the College of Midwives, the Government of Ontario equally supports their self-regulating processes. The Government of Ontario declares that self-regulating midwives of Aboriginal decent

should be treated equally in considerations about the validity of their accreditation processes and midwifery practices’.

A second implication for potential practical applications associated with this research has to do with the idea that, through a greater articulation of self-regulatory contexts and an expanded definition of self-regulation and traditional health and healing, First Nations communities/organizations could begin to have increased mobilization around the issue. It is envisioned that a community’s coming together around this issue could be sparked by an awareness that a certain ‘threshold’ has been crossed. In such instances, notions of crisis, disrespect, lack of understanding can cause a community to further mobilize towards their own type of self-regulation. In an interview for this project, Sylvia Maracle talked about how for the Navajo experiencing this ‘threshold’ eventually resulted in the internal strengthening of its community based self-regulation around healing practices. Too many people were appropriating Navajo healing traditions so the community came together and engaged in a community directed self-regulation process. For the Navajo, one of the results was the creation of the *Dine* society (S. Maracle, Personal Interview, December 6, 2010).

These types of processes internal to First Nations communities could include defining and asserting community based models that work with regard to healer accreditation. They might also involve educational campaigns about traditional health practices. While some resources could be developed for the community, others could be developed for external audiences. These sorts of activities are those which can bring unwholesome activities around traditional health and healing to a halt.

Limitations

A limitation which constrained this study is that the results are rather intimately tied to the perspectives that were uncovered in the literature review and in the interviewing process. Sampling a greater amount of First Nations communities, which was beyond the scope of this thesis, could have given the findings the strength to be interpreted in a more definitive way across the greater First Nations community in Canada. Overcoming this issue in similar future research might be difficult because the cultural/linguistic diversity that exists among First Nations in Canada is vast. Perhaps one solution might be to develop a study that is more directly comparative in nature where the similarities and differences between community approaches could be even more carefully assessed. Another solution might involve a study of this nature amongst different geographical factions of one particular Indigenous tribe. Research could be used in this manner to support the strengthening of relationships between the proponents of traditional healing in the tribal population.

Another limiting factor involves the use of terminologies such as 'traditional healing', 'healer' and even 'self-regulation'. For example, in the introductory Chapter of this thesis it was argued that in contemporary contexts, complications can arise with respect to defining 'traditional healing'. Especially in academic contexts, there can be many nuances to (or even definitions of) traditional healing that are put forth.

These same sorts of considerations can also be given to the term 'healer'. One research participant implied that there can be a sort of stigma attached to this word. People who go around First Nations communities calling themselves 'healers' are often caught up in

feeding their own egos (B. Altivator, Personal interview, May 16, 2010). Thus, unlike referring to one's self as a doctor, self-advertisement for one's self as a healer has come to be seen as a violation of humility. Indeed, one might say that First Nations healers are like First Nations Elders in that they are appointed by their communities rather than self-appointed.

Lastly, even though the intent was to push the boundaries with respect to the current notions that define health self-regulation –especially in contexts of First Nations traditional health and healing– it was with some reservation that I decided to use the term ‘self-regulation’ in concert with the first two categories (‘healer centred’ and ‘community based’) in the Results Chapter. I became particularly aware of this reluctance after the presentation I did on this research at the Six Nations Ethics Forum, as discussed earlier. Based on the audience responses, I had to ask myself, are the forces of cultural hegemony so strong that trying to understand self-regulation differently will result in more confusion than understanding?

The issue of ‘correct terminology’ is one that can often arise when we are involved trying to articulate a similar idea from different epistemological perspectives. One solution is to address the issue before hand, as was done in the Chapter 1 for ‘traditional healing’. Secondly, I think another important point to make is that once you put something like an expanded definition of self-regulation ‘out there’, it's important to not expect changes overnight. Change takes time and people in learning environments are open to being educated about new ways and innovative ways of thinking that are sensible and grounded in research. Finally, I believe a solution to this terminology issue in future

research would involve a greater focus on ideas/concepts/understandings about healing that are coded through Indigenous languages. In contemporary environments, more balanced understandings can result from more sustained efforts to ‘go towards Indigenous concepts and languages’ rather than the other way around.

Final Thoughts

The central question to this research project was: “In contemporary environments, how can traditional understandings about of self-regulation be /applied/used/articulated within contexts of First Nations health in ways that continue to simultaneously support and protect the autonomy of traditional healers and their If yes, how could/does this occur? If not, why not?”

The research that was conducted for this study indicated that there are many factors involved in the further clarification of the answers to these questions. This being said, the most illuminating finding of this study for me was that the best answers to these questions depend upon how we can start to correctly build our understanding about self-regulation as it is defined through First Nations epistemological perspectives. The research conducted here is considered to be only a start and it is hoped that some of the ideas presented here will benefit First Nations and others who are contemplating similar issues.

The research cautions that unless we remain close to the sources of First Nations traditional healing, the forces of cultural hegemony in the mainstream are strong and there is no guarantee that the tenants of mainstream self-regulatory models or even

integrative models developed with First Nations will ever truly be representative of First Nations self-regulation as it occurs in an Indigenous healing and wellness context. For example, Algonquian/Haudenosaunee University of Ottawa professor Simon Brascoupé indicated in such cases , ‘How do you go about ‘regulating’ the Creator’s gift?’(S. Brascoupé, Personal Conversation, March 22, 2013).

Thus, given that, as this research illustrated, that there are several different dynamics to the self-regulatory processes that operate in and around First Nations traditional healing systems, the creation of a ‘regulatory authority’ for First Nations traditional healers does not appear to be a viable solution. Every situation is different and, therefore, the emphasis at this point should be primarily on building and strengthening community practice. For example, it was indicated in the thesis that while the Navajo people of the American Southwest have had some success in creating such a self-regulatory authority for their traditional healers, the most important background piece to this was building that strong sense of their community practice. This was accomplished, as Sylvia Maracle said, through several community meetings where people who claimed to have traditional healing knowledge had to stand up before the community and state their family lineages and their connections to Navajo healing knowledge (S. Maracle, Personal Interview, December 10, 2010).

The Navajo situation is also different from most other smaller Indigenous Nations in North America as their enrolled population is over three hundred thousand- the equivalent to a mid-sized city. With so many people, like in larger urban environments, it may become difficult to keep track of ‘who’s who’ and therefore a question that could be

asked is whether or not the implementation of a self-regulatory authority for traditional healers might work better in urban environments rather than rural ones. However, at the same time, many urban First Nations health centres that provide traditional health services are influenced by the territories of surrounding First Nations communities and their members. These are most often smaller communities where people do tend to know 'who's who' with respect to people who are gifted with traditional healing knowledge. Following from this point, is important to acknowledge, and even start from a perspective, that the 'regulatory authority' with respect to traditional health and healing already exists, albeit in diverse ways, within individual First Nations communities and tribes.

Finally, it is important to acknowledge that we are talking about an entirely different system of healing from modern Western medicine and contemporary understandings about 'regulatory authority' may not translate well.. Although the general goals are the same in that they both aim to improve health, the differences of how they arrive at this state of improved health need to be respected. Metis/Cree Elder Michael Thrasher indicated to me that amongst some First Nations, like the Cree, the concept of a 'regulatory health authority' makes little logical sense with respect to understandings about how health is understood traditionally. For instance, in a powerful healing ceremony like the Sun Dance, traditionally, a leader was never the leader beyond the event of conducting the ceremony. The fact that leadership is a shared responsibility and that everyone who is a capable will get a chance to lead is built right into the culture. Similar concepts can be found in many First Nations cultures and thus, in such contexts,

the idea of a 'regulatory authority' that keeps healers in their position and/or makes decisions about someone's healing abilities is inappropriate (M. Thrasher, Personal Conversation, August 22, 2013).

Even though this might be the case, perhaps it is not the most important thing to consider. What is important to consider is how, through this type of research, we can begin to have a greater understanding of the larger terrain/territory/context of self-regulation in healthcare. This expanded terrain is one where fewer *preconceived* notions about models of self-regulation and First Nations traditional health and healing exist. In addition, it is a terrain which helps to prepare the ground for a greater freedom of choice in the healthcare that one decides to utilize. On the cautionary side, however, Métis/Cree Elder Michael Thrasher indicates that changes are meant to occur in a balanced way but the way technology has developed in contemporary society has introduced a new dynamic of 'travelling medicine'. For instance communication, with things like the internet makes some people actually think they are learning it even though it is not through another person. In addition, the commercialization of culture can cause a community based model of healing to become heavily influenced by an economic and money based one (M. Thrasher, Personal Communication, May 21, 2010).

Thus, in a more balanced sense, when people hear the term 'self-regulation and traditional health and healing', positive images should be the ones that come to mind. These sorts of references should be associated with things that allow First Nations communities to have the comfort of knowing, 'This is representative of the traditional health values of our community', and, 'We have the ability to choose our own healthcare

path' that is rooted in our own traditions. In order for these sorts of things to be realized, First Nations healers and their understandings need to be approached with openness and respect rather than from viewpoints which further result in the actualization of environments that are dominated by undercurrents of cognitive imperialism. Modern Western medicine and First Nations healing systems each have their own merit and knowledge base and it is a mistake to try and evaluate one by the mechanisms of the other. First Nations should be free to ask and provide answers to the question, 'What is self-regulation in the context of Indigenous health and wellness'. A parallel and relevant example of this kind of idea was given by Nakoda Elders during the Nakoda the dialogue circle at Morely (September 20, 2013) when they talked about the role of 'education'.

There words are paraphrased in the paragraph below:

With regard to education, people need to ask the question more often "What is education?" Rather than trying to indoctrinate youth into mainstream (as was the case in residential schools), more focus should be put on getting young people to speak their mind and analyze the falsity and/or validity in what they say. Youth can learn from healthy debate where they must defend their views. They should be encouraged to be who they are rather than making them attempt to deal with conflicting concepts (which creates a mental burden) of who they are.

Now that this idea of self-regulation and traditional health and healing has been explored, the solution to positively affecting this issue lies in development of a deeper level of understanding about the questions raised in this research project. For First Nations communities, greater understandings about the nature of this issue from a community

perspective can occur collectively through continuing to learn and practice their traditions as they move through the different stages of life. In situations, which involve the issue being discussed between First Nations and non-First Nations, we should eventually come to expect that powerful, honest and respectful collaborations on health and healing will occur on a trusted middle ground which reflects an expanded understanding of the public interest. In looking towards these sorts of healthy endeavours, Métis Elder Maria Campbell indicated that 'life force' was one of respected Elder Peter O'Chiese's favourite terms and that this emphasizes how we strengthen each other through giving to each other. This is how we build strong communities (Campbell, March 21, 2013).

Ms̄it No'kmaq (All my Relations)!

References

- Aboriginal Healing and Wellness Strategy. (n.d.). *Aboriginal Healing and Wellness Strategy*. Retrieved from <http://www.mcass.gov.on.ca/en/mcass/programs/community/programsforaboriginalpeople.aspx>
- Adams, T.L. (2009, Autumn). , Regulating professions in Canada: Interprovincial differences across five provinces. *Journal of Canadian Studies* 43(3) 94-221.
- Akwesasne Health Department. (n.d.). Mission Statement, Department Goals, Programs and Services. Retrieved from <http://www.akwesasne.ca/Health.html>
- Akwesasne. (n.d.). *The Kaswhenta/Two row wampum*. Retrieved from <http://www.akwesasne.ca/tworowwampum.html>
- Akwesasne. (n.d.). *Welcome page* [Description of Akwesasne Territory]. Retrieved from <http://www.akwesasne.ca/>
- Alviso- Alvord, L. (MD)., & Cohen, E. (1999). *The scalpel and the silver bear*. New York: Bantam Books.
- Anderson, J., Perry, J., Blue, C., Browne, A., Henderson, A., Koushambhi, B.K., Reimer Kirkham, S., Smye, V. (2003, July/September). Rewriting cultural safety within a postcolonial and postnational feminist project: Towards new epistemologies of healing. *Advances in Nursing Science*. 26(3), 196-214.
- Anderson, Marsha (MD). (2010, February 12). [A presentation given for the First Nations health session]. *Aboriginal Peoples Health within the Health Sciences: A Métis, Inuit & First Nations Specific Health Series*, McMaster University, Hamilton, Ontario. Unpublished raw data [participant/non-presenter notes].
- Anishnawbe Health. (2000). Approaching a Traditional Healer, Elder or medicine person. *Native teachings are about a way of life pamphlet series*. Toronto: Anishnawbe Health.
- Archibald, L. & Grey, R. (2000). *Evaluation of models of health care delivery in Inuit regions*. Ottawa: Inuit Tapiriit Kanatami.
- Alves, R.R.N., & and Rosa, I.M.L. (2007, March). Biodiversity, Traditional Medicine and public health: Where do they meet?" *Journal of Ethnobiology and Ethnomedicine* (3)14. doi:10.1186/1746-4269-3-14

- Assembly of First Nations. (2008, July). Resolution No. 11. *Proceedings form the Assembly of First Nations Annual General Assembly* [Québec]. Ottawa: Assembly of First Nations. Retrieved from <http://64.26.129.156/article.asp?id=4274>
- Assembly of Manitoba Chiefs. (n.d.). *Manitoba First Nations chronology*. Retrieved from <http://www.manitobachiefs.com/amc/culture/chronology.html>
- Bandolier, Oxford University (n.d.) Qualitative and Quantitative Research retrieved from <http://www.medicine.ox.ac.uk/badolier/booth/glossary/qualres.html>
- Banks S. (2004). *Ethics, accountability and the social professions*. London: Palgrave MacMillan.
- Bakx, Keith. (1991). The eclipse of folk medicine in Western society. *Sociology of Health and Illness*, 13(1), 19-38.
- Battiste, M. (2000). Maintaining Aboriginal identity, language and culture in modern society. In M. Battiste (Ed.), *Reclaiming Indigenous voice and vision* (pp. 192-208). Vancouver: University of British Columbia Press.
- Battiste, M., & Henderson, S. (2000). *Protecting Indigenous Knowledge and heritage: A global challenge*. Saskatoon, SK: Purich.
- Benoit, C., Carroll, D., & Eni, R. (2006, Autumn). To watch, to care, stories of Aboriginal midwifery in Canada. *Canadian Journal of Midwifery Research and Practice*, 5(5), 11-17.
- Brant-Castellano, M. (2000). Updating Indigenous Knowledge. In G.J. Sefa Dei, B.L. Hall, & D. Goldin Rosenberg (Eds.), *Indigenous Knowledge in global contexts: Multiple readings of our world* (pp. 21-36). Toronto: University of Toronto Press.
- Brant-Castellano, M. (2004). Ethics of Aboriginal research. *Journal of Aboriginal Health* 1(1), 98-114.
- Brascoupé, S., & Waters, C. (2008). *Cultural safety, exploring a concept in Aboriginal health and healing*. Unpublished manuscript. [Used with permission from author].
- Brascoupé, S., & Obomsawin, R. (Phd). (2008, April). *Issues and framework for development of a policy on traditional medicine* [Draft for dialogue and

feedback]. Unpublished manuscript, National Aboriginal Health Organization, Ottawa, Canada.

Brewer, J., & Hunter, A. (2006). *Foundations of multimethod research: Synthesizing styles*. Thousand Oaks: Sage.

Buckley, S. (2009). *Draft discussion paper on bill C6, the Canada Consumer Product Safety Act*. Kamloops, BC: Natural Health Products Protection Association. Retrieved from http://nhppa.org/wp-content/uploads/2009/02/discussion_paper_on_bill_c-61.pdf

Burns, G.E. (Dr.). (1999). *Towards a redefinition of formal and informal Learning: Education and the Aboriginal People*. Toronto: The Research Network for New Approaches to Lifelong Learning, Ontario Institute for Studies in Education, University of Toronto.

Byker, C. (Writer, Producer). (2006). *The meth epidemic*. [documentary]. United States of America Public Broadcasting System (PBS). Retrieved from <http://www.pbs.org/wgbh/pages/frontline/meth/view>

Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada and Social Sciences and Humanities Research Council of Canada (2010, December). *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans* (2nd ed.). Retrieved from http://www.pre.ethics.gc.ca/pdf/eng/tcps2/TCPS_2_FINAL_Web.pdf

Campbell-Scott, D. (1921, December 15). [Letter to Indian Agents about concern of the resurgence of dances by First Nations on their reserves]. Canada: Department of Indian Affairs.

Carr, I (Dr.). (n.d.). *Some obstetrical history: Dying to have a baby – The history of childbirth*. Retrieved from <http://www.neonatology.org/pdf/dyingtohaveababy.pdf>

Cardinal, H., & Hildebrandt, W. (2000). *Treaty Elders of Saskatchewan*. Calgary, AB: University of Calgary Press.

Carroll, D., & Benoit, C. (2001, Spring). Aboriginal midwifery in Canada: Blending traditional and modern forms. *Network Magazine* 4(3). Retrieved from <http://www.cwhn.ca/node/39589>

- Carroll, D. & Benoit, C. (2004). Aboriginal midwifery in Canada: Merging traditional practices and modern science. In I.V. Bourgeault, C. Benoit & R. Davis-Floyd (Eds.), *Reconceiving midwifery* (pp. 263-286). Montreal & Kingston: McGill-Queens University Press.
- Censored News: Indigenous Peoples Resistance and Human Rights.* (2010, February 11). Re: *Dine' Medicine Men's Association halts bill to regulate ceremonies* [online forum article reposting]. Retrieved from <http://bsnorrell.blogspot.ca/2010/02/dine-medicine-mens-association-halts.html>
- Channells, R. (2003, April). *Working group of Indigenous minorities in Southern Africa (WIMSA)*. Paper presented at the Biodiversity, Biotechnology and Protection of Traditional Knowledge Washington University Law Conference, St Louis, MO.
- CNN. (2009, October 18). *Third person dies in Arizona 'sweatbox' case*. Retrieved from http://articles.cnn.com/2009-10-18/us/arizona.sweatbox.death_1_angel-valley-retreat-center-james-arthur-ray-spiritual-warrior?_s=PM:US
- Conference Board of Canada. (2007). *Achieving public protection through self-regulation: Reflections for a new paradigm*. Ottawa: Conference Board of Canada.
- Conze, E. (1993). *A short history of Buddhism* (2nd ed.). London: Oneworld.
- Core Risk Services Inc. (n.d.). *History of health care risk management programs*. Retrieved, from <http://www.coreriskservicesinc.com/history.php>
- Couchie, C., & Nabigon H. (1997). A path towards reclaiming Nishnawbe birth culture: Can the midwifery exemption clause for Aboriginal midwives make a difference? In F. Shroff (Ed.), *The new midwifery: Reflections on renaissance and regulation* (pp. 41-50). Toronto: Women's Press.
- Couchie, C. & Sanderson, S. (2007, March). A report on best practices for returning birth to rural and remote Aboriginal communities. *Journal of Obstetricians and Gynaecologist of Canada*, 188, 250-254.
- Cruess, S. R. (MD), & Cruess, R.L. (MD). (2005, April). The medical profession and self-regulation: A current challenge. *Virtual Mentor*, 7(4). Retrieved from <http://virtualmentor.ama-assn.org/2005/04/toc-0504.html>
- Deloria, V. (Jr.). (1994). *God is red: A Native view of religion*. Golden, CO: Fulcrum.

- Dent, M., & Whitehead S. (2002). Introduction: Configuring the new professional. In M. Dent, & S.Whitehead, (Eds.), *Managing professional identities, knowledge, performativity and the “New” professional* (pp. 1-16). London: Routledge.
- Dine Medicine Men Association Inc. (n.d.). *Our four requests*. Retrieved from <http://www.dinemedicineman.com/Four-Requests>
- Dixon-Woods, Mary. (2007, November). Opinion piece: Should Medical Sociology professionalize? *Medical Sociology Online*, 2(2), 17-19. Retrieved from <http://www.medicalsociologyonline.org/oldsite/archives/issue22/pdf/dixonwoods.pdf>
- Draper, E. (2007, January 25). Navajo Marine given conscientious –objector status. *Denver Post*. Retrieved from http://www.denverpost.com/news/ci_5081755
- Edelstein, L (Trans.). (1943). *The Hippocratic Oath: Text, translation, and interpretation*, Baltimore: Johns Hopkins Press.
- Edge, L. (2003, August). *The Métis Centre at the National Aboriginal Health Organization*. Presentation made at the Annual General Meeting of the Canadian Medical Association , Winnipeg, Manitoba.
- Edge, L., & McCallum, T. (2006, Autumn). Métis identity sharing traditional knowledge and healing practices at Métis Elders gatherings. *Pimatisiwin*, 4(2), 83-115. Retrieved from <http://www.pimatisiwin.com/online/?s=M%C3%A9tis+Identity%3A+Sharing+Traditional+Knowledge+and+Healing+Practices+at+M%C3%A9tis+Elders%27+Gatherings>
- Elm, D., & Antone, H. (2000). *The Oneida Creation story*. F, and Antone, Harvey. 2000. *The Oneida Creation Story*, F.G Lounsbury, & B. Gick (Eds.). Lincoln, NB: University of Nebraska Press.
- Emery, M. (2012, March). Cultural hegemony. Retrieved from http://www.sunray22b.net/cultural_hegemony.htm
- Epstein, M.T. (2006). Russian philosophy of national spirit from the 1970’s to the 1990’s. In T. Botz-Bornstein and J Hengelbrock (Eds.), *Re-ethnicizing the minds? Cultural revival in contemporary thought* (pp. 185-218). [Volume 17 of *Studies in Intercultural Philosophy*]. Amsterdam/New York: Rodopi.
- Ermine, W. (2006, March 16). [About ethical space between Indigenous and Eurocentric contexts]. In D. Ford, *The space between two knowledge systems*. *ExpressNewsUniversity of Alberta*. Retrieved from <http://www.folio.ualberta.ca/43/14/11.html>

- Family Youth and Community Sciences, University of Florida. (n.d.). *Brief comments about qualitative data analysis*. Retrieved from http://fyics.ifas.ufl.edu/swisher/6802_12/Comments%20about%20Qualitative%20Data%20Analysis.pdf
- Fiedler, F. E., Garcia, J. E. & Lewis, C. T. (1986) *People management, and productivity*, Boston: Allyn and Bacon.
- First Nations Centre, National Aboriginal Health Organization. (2003). *Public opinion poll on Aboriginal health and health care in Canada: Summary of Findings*. Ottawa: National Aboriginal Health Organization.
- First Nations Centre, National Aboriginal Health Organization. (2006). *The emerging issue of crystal methamphetamine use in First Nations communities*. Ottawa: National Aboriginal Health Organization.
- First Nations Health Council, British Columbia. (March, 2010) *Best practices of traditional models of wellness scan*. Retrieved from http://www.fnhc.ca/pdf/Traditional_Models_of_Wellness_Report_FIN-2010.pdf
- First Nations Information Governance Centre. (1997). *First Nations and Inuit regional health survey*. Ottawa: First Nations and Inuit Regional Health Survey Steering Committee. Retrieved from http://www.rhs-ers.ca/sites/default/files/ENpdf/RHS_1997/rhs_1997_final_report.pdf
- First Nations Pedagogy Online. (n.d.). *Talking circles*. Retrieved from <http://firstnationspedagogy.ca/circletalks.html>
- Fuller, K. (2002, March). Eradicating essentialism from cultural competency education *Academic Medicine*, 77(3), 198-201. Retrieved from http://journals.lww.com/academicmedicine/Fulltext/2002/03000/Eradicating_Essentialism_from_Cultural_Competency.4.aspx
- Geiger, K. (2010, September 14). Government food safety scientist report political corporate interference. *Los Angeles Times*. Retrieved from <http://articles.latimes.com/2010/sep/14/nation/la-na-scientists-obama-20100914>
- Government of Canada, Regulatory Affairs Sector (n.d.). *Cabinet Directive on Regulatory Management*. Retrieved from <http://www.tbs-sct.gc.ca/rtrap-parfa/cdrm-dcgr/cdrm-dcgr01-eng.asp#chal>
- Gramsci, Antonio. (1985). *Selections from cultural writings*. London: Lawrence & Wishart.
- Gumilev, Lev. (1979). *Ethnogenesis and the biosphere*. Moscow: Progress.

- Handbook of Medical Ethics – Medical ethics as prescribed by Caraka, Susruta and other ancient Indian physicians. [No Authors or Trans. listed]. (1995, January-March). *Indian Journal of Medical Ethics*, 3(1).
- Hart, M.A. (2010, February). Indigenous worldviews, knowledge and research: The development of an Indigenous research paradigm. *Journal of Indigenous Voices in Social Work*, 1(1), 1-16.
- Haudenosaunee Environmental Task Force. (2010, August 2). Cayuga Nation's statement on global climate change. *Cayuga News –HETF*. Retrieved from <http://hetf.org/index.php/cayuga-nation/18-cayuga-nations-statement-on-global-climate-change>
- Health Canada. (1999). Ten Years of Health Transfer First Nations and Inuit Control. Ottawa: Health Canada. Retrieved from http://www.hc-sc.gc.ca/fniah-spnia/pubs/finance/agree-accord/10_years_ans_trans/index-eng.php
- Health Canada. Closing the gaps in Aboriginal health. (2003, March). *Health Policy Research: Strengthening the Policy/Research Connection* [Bulletin, Issue 5].
- Health Canada's fast-tracked drug approvals can put public at risk: York U study*. York University News. (2012, October 9). Retrieved from <http://news.yorku.ca/2012/10/09/health-canadas-fast-tracked-drug-approvals-can-put-public-at-risk-york-u-study/>
- Health Professions Regulatory Advisory Council (HPRAC). (n.d.). *About HPRAC*. Retrieved from http://www.hprac.org/en/about/mandate.asp?_mid_=2247
- Hill, J.D. (1994). South America: Lowlands [Vol. 53, Social Sciences]. Introductory Essays from the Handbook on Latin American Studies. Washington, DC: Library of Congress. Retrieved from <http://lcweb2.loc.gov/hlas/ss53anthro-hill.html>
- Indian and Northern Affairs Canada. (2002). Aboriginal Elder protocol. *Service Excellence Series*. Ottawa: Minister of Public Works and Government Services Canada.
- Indigenous Studies PhD Program, Trent University. (n.d.). *Indigenous Studies PhD Program, program objectives*. Peterborough, ON: Indigenous Studies Department, Trent University. Retrieved from <http://www.trentu.ca/indigenousstudiesphd/programobjectives.php>
- Indigenous Studies PhD Program, Trent University. (n.d.). *Indigenous Studies PhD Program, vision statement*. Peterborough, ON: Indigenous Studies Department, Trent University. Retrieved from <http://www.trentu.ca/indigenousstudiesphd/>

- Industry Canada, (n.d.). Intellectual Property Policy: Aboriginal Intangible Property in Canada: An Ethnographic Review (5. Plains Religion, 5.2 Sacred Bundles). [Young (2001) is the reference taken from this document]. Retrieved from <http://www.ic.gc.cadppi.nsf/eng/ip01233.html#note131>
- Institute on Governance. (1997, October). *Summary of the final Report of The Royal Commission on Aboriginal Peoples: Implications for Canada's health care system*. Ottawa: Institute on Governance. Retrieved from <http://iog.ca/sites/iog/files/healthrcap.pdf>
- International Confederation of Midwives (ICM). (2011). *ICM international definition of Midwife*. [Revised]. Retrieved from <http://www.internationalmidwives.org/Portals/5/2011/Definition%20of%20the%20Midwife%20-%202011.pdf>
- Iroquois Indian Museum. (n.d.). *Iroquois beliefs*. Retrieved from <http://www.iroquoismuseum.org/ve9.htm>.
- Jemison G. P. (Faithkeeper). (n.d.). Two row wampum. *Warrior in two worlds* [teaching modules]. USA: Public Broadcasting Service. Retrieved from <http://www.pbs.org/warrior/content/modules/tworow.pdf>
- Johansen, B.E., & Pritzker, B. (Eds). (2008), Wampum. *Encyclopaedia of American Indian history, Volume 2* (pp. 480-495). Santa Barbara: ABC CIOLO.
- Johnson, M. (2006, June). Gitskan medicinal plants, cultural choice and efficacy. *Journal of Ethnobotany and Ethnomedicine*, 2(29). doi:10.1186/1746-4269-2-29
- Johnson, B., & Christensen, L. (2012). *Educational research: quantitative, qualitative and mixed approaches* (4th ed.). Los Angeles: Sage.
- Juneau, L.M. (2007). *Small Robe Band of Blackfeet: Ethnogenesis by social and Religious transformation* (Master's Thesis, University of Montana, Missoula, Montana). Retrieved from <http://etd.lib.umt.edu/theses/available/etd-05082007-144843/unrestricted/02MATHesis.pdf>
- Kanawake Branch of the Mohawk Nations, Six Nations Iroquois Confederacy. (n.d.). The Longhouse: Symbol of the Iroquois League. *Government*. Retrieved from <http://www.kahnawakelonghouse.com/index.php?mid=1>
- Katz, Neil. (2009, October 18). Third Death from Sweat Lodge Ceremony Led by James Arthur Ray. *CBS News*. Retrieved from http://www.cbsnews.com/8301-504083_162-5394208-504083.html

- Kioke, S.J. (1999). *Revisiting the past: Discovering traditional care and the cultural meaning of pregnancy and birth in a Cree community* (Master's Thesis, Queens University, Kingston, Ontario). Retrieved from <http://www.collectionscanada.gc.ca/obj/s4/f2/dsk2/ftp01/MQ45280.pdf>
- Klein, M., Johnston, S., Christilaw, J., & Carty, E. (2002, April). Mothers, babies and communities: Health care centralization risks safe maternity care and community sustainability. *Canadian Family Physician*, 48, 1117-1179 [Editorial]. Retrieved from <http://171.66.125.180/content/48/7/1177.full.pdf>
- Kornelson, J., & Grzybowski, S. (2005). *Rural women's experiences of maternity care in British Columbia: implications for policy and practice*. Ottawa: Status of Women Canada.
- Kovach, M. (PhD). (2011, July). *Indigenous methodologies and modified grounded theory method* [Discussion Points for a PhD thesis- University of Victoria]. Retrieved from <http://static.wordever.com/we/file/000/131/875/Indigenous-Methodologies%20&%20modified%20grounded%20theory.pdf>
- Krause E. (1996). *Death of the guilds: Professions, States and the advance of capitalism, 1930 to the present*. New Haven, Conn: Yale University Press.
- Kulig, J., Edge, D.S., & Joyce, B. (2008). Understanding community resiliency in rural communities through multimethod research. *Journal of Rural and Community Development*, 3(3), 77-94.
- LaFrance, B. (n.d.). *The role of the Great Law of Peace and other traditional teachings in promoting health among the Haudenosaunee*. Unpublished manuscript, B. LaFrance, Akwesasne Mohawk Territory.
- Lambert, J. (In collaboration with J.N Turner, E. Dickenson, R Martes, F. Gasengayire, J.T Arnason, & K. Wilde). (2006, May). IK Note [Excerpt]. *Biodiversity and Health Symposium: Conclusions and Recommendations* [Proceedings of the International Symposium, Biodiversity &Health: Focusing Research to Policy, Ottawa, Canada. <http://www.worldbank.org/afr/ik/iknt92.pdf>
- Lamouche, J. (2010, February 12). [A presentation given for the First Nations health session]. *Aboriginal Peoples Health within the Health Sciences: A Métis, Inuit & First Nations Specific Health Series*, McMaster University, Hamilton, Ontario. Unpublished raw data [participant/non-presenter notes].
- Lee, G. (1996, Winter). Defining traditional healing. *Justice as healing: A newsletter on Aboriginal concepts of justice*, 1(4), 1-5.

- Little Bear, L. (2000). Jagged worldviews colliding. In M. Battiste (Ed.), *Reclaiming Indigenous voice and vision* (pp. 77-85) Vancouver: University of British Columbia Press.
- Looking Horse, A. (2009, October 20). *Sedona sweat lodge deaths*. Retrieved from http://www.manataka.org/page108.html#October_20,_2009
- Looking Horse, A. (2009, November). *Indigenous philosophies and ceremonies as the basis for action*. Presentation made at Our People, Our Health, National Conference of the National Aboriginal Health Organization, Ottawa, Ontario. Unpublished Raw Data [participant/non-presenter notes].
- Maar, M.A. (PhD)., & Shawande, M. (2010, January). Traditional Anishinabe healing in a clinical setting: The development of an Aboriginal interdisciplinary approach to community-based Aboriginal mental health care. *Journal of Aboriginal Health, January, 2010,18-27*
- Mack, N., Woodsong, C., MacQueen, K.M., Guest, G., & Namey, E. (2005). *Qualitative research methods: A data collector's field guide*. Research Park, NC: Family Park International.
- Martin-Hill, D. (PhD). (2003). *Traditional Medicine in contemporary contexts: Protecting and respecting Indigenous Knowledge and Medicine*. Ottawa: National Aboriginal Health Organization. Unpublished raw data [conference participant notes].
- Martin-Hill. D. (PhD). (2007, December 5). *The Lubicon Lake Nation: Indigenous Knowledge and power* . Presentation at the National Aboriginal Health Organization, Ottawa, Ontario.
- Meyer, M. (2000). Native Hawaiian epistemology: Sites of empowerment and resistance. *Equity and Excellence in Education, 31*(1), 22-28.
- Milne, J. K. (2001, October). Human resources crisis in obstetrics and gynaecology. *Society of Obstetricians and Gynecologists of Canada News, 1* [editorial].
- Mitchell, M. (Kanentakeron) (2006). *The Haudenosaunee code of behaviour for Traditional Medicine Healers*. Mohawk Nation territory and Ottawa: Center for Nation Building & National Aboriginal Health Organization.
- Mi'kmaq Ethics Watch. (n.d.). Research principles and protocols. *Mi'kmaq ethics watch*. Retrieved from <http://www.cbu.ca/academics/mikmaq-studies/mikmaw-ethics-watch>

- Misham, E. J. (1969). *Welfare economics: an assessment*. Amsterdam: North Holland.
- Morgan, D.L. (1998, May). Practical strategies for combining qualitative and quantitative methods: Applications to health research. *Qualitative Health Research* 9, 362-376. doi: 10.1177/104973239800800307
- Morgan, J.F.W. (1998). Natural history of professionalization and its effects on valuation theory practice in the UK and Germany. *Journal of Property Valuation and Investment* 16(2), 185-206.
- Nason, J.D. (1996, Fall). Tribal research: Tribal models for controlling research. *Tribal College Journal* 8(2). Retrieved from <http://www.tribalcollegejournal.org/archives/16104>
- National Aboriginal Health Organization. (2004). *Midwifery and Aboriginal midwifery in Canada*. Ottawa: National Aboriginal Health Organization.
- National Aboriginal Health Organization. (2006). *Cultural Safety fact sheet*. Ottawa: National Aboriginal Health Organization.
- National Aboriginal Health Organization (2008). *Celebrating birth: Aboriginal midwifery in Canada*. Ottawa: National Aboriginal Health Organization.
- National Association of Friendship Centres. (2009). *Memorandum on natural health products regulations –Aboriginal exemption*. Ottawa: National Association of Friendship Centres.
- National Centre for Social Research [United Kingdom]. (n.d.). *Our History*. Retrieved from <http://www.natcen.ac.uk/about-us/history>
- National Collaborating Centre for Aboriginal Health (NCCAHA). (2011, June). *Aboriginal health: A patchwork of policies and legislation*. [News article about highlights in a report published by NCCAHA] Prince George, BC: NCCAHA. Retrieved from http://www.nccah-ccnsa.ca/252/Aboriginal_health_A_patchwork_of_policies_and_legislation.nccah#1
- Neill, J. (2006, July, Updated). *Analysis of professional literature class 7: Qualitative research 2 (observations and comparison of 2 qualitative methods in two studies)* [Lecture Notes of James Neill, University of Canberra]. Retrieved from <http://www.wilderdom.com/OECourses/PROFLIT/Class7Qualitative2.htm>

- Neill, S.R. (2008). Wee warriors: Youth involvement in the northern Irish troubles. *Vanderbilt Undergraduate Research Journal*, 4, 1-10. Retrieved from <http://ejournals.library.vanderbilt.edu/index.php/vurj/article/view/2777>
- Newhouse, D. (2008). Ganigonhi:oh: The Good Mind meets the Academy. *Canadian Journal of Native Education*, 31(1), 184-197.
- Newhouse, David (2012, November 23) . *The Good Mind Meets the Academy*. Presentation made at the Indigeneity and the University: Activism, Scholarship and Pedagogy Conference, McMaster University, Hamilton, Ontario. Unpublished raw data [conference participant notes].
- New University of Saskatchewan research group to study heart-healthy benefits of Traditional Aboriginal Medicine*. (2004, June 21). University of Saskatchewan News. Retrieved from <http://announcements.usask.ca/news/archive/2004/06/>
- Obomsawin, R. (2008). *Efficacy and safety of traditional plant medicines*. Ottawa: National Aboriginal Health Organization.
- Ogburn, D.E. (2008). Becoming Saraguro: Ethnogenesis in the context of Inca and Spanish colonialism. *Ethnohistory*, 55(2), 287-319.
- Ontario Federation of Indian Friendship Centres (OFIFC). (n.d.). *Aboriginal Healing and Wellness Strategy*. Retrieved from http://www.ofifc.org/programmes/Aboriginal_Healing_And_Wellness_Strategy.php
- Ontario Federation of Indian Friendship Centres (OFIFC). (n.d.). *About the OFIFC*. Retrieved from <http://www.ofifc.org/about/>
- Ontario Women's Health Council. (2003). *Learning more today for ourselves and our children: An assessment of consumer health information for Aboriginal women*. Ottawa: Ontario Women's Health Council.
- Orr, P.H. (2009, July). *Bill C-51: Proposed Federal Regulation of Traditional Medicine*. Paper presented at the 14th Annual International Congress on Circumpolar Health, Yellowknife, North West Territories.
- Oxford Dictionaries. (n.d.). *Ethnogenesis*. Retrieved from <http://oxforddictionaries.com/definition/ethnogenesis>
- Panneerselvam, R. (2004). *Research methodology*. New Dehli: Prentice Hall (India).

- Palys, T. (PhD). (n.d.). *Purposive sampling*. Retrieved from <http://www.sfu.ca/~palys/Purposive%20sampling.pdf>
- Peluso, D. M., & Alexaides, M.N. (2005). Urban ethnogenesis begins at home: The making of self and place amidst Amazonia's environmental economy. *Traditional Dwellings and Settlements Review*, 16(11), 1-10. Retrieved from http://www.academia.edu/446963/Urban_Ethnogenesis_Begins_at_Home_The_Making_of_Self_and_Place_Amidst_Amazonias_Environmental_Economy
- Pigou, A. C. (1932) *The economics of welfare*. London: Macmillan and Co.
- Porsanger, Jelena. (2004, Summer). An essay about Indigenous methodology. *Nordlit* 15, 105-120.
- Porsanger, J. (2011). *The problematisation of the dichotomy of modernity and tradition in Indigenous and Sami contexts*. In J. Porsanger & G. Gottorm (Eds.). *Working with Traditional Knowledge: Communities, Institutions, Information Systems, Law and Ethics* (pp. 225-252). Guovdageaidnu, Norway : Sámi allaskuvla / Sámi University College
- Porter, T. (2008). Iroquois Great Law of Peace/Kanianerekowa [Personal communication recorded in 1986]. In B.E. Johansen, & B.M. Pritzker (Eds.), *Encyclopedia of American Indian history* (pp. 411-412). Santa Barbara, CA: ABC-CILO
- Province of Ontario. (1991). *Regulated Health Professions Act*. Toronto: Province of Ontario. Retrieved from http://www.elaws.gov.on.ca/html/statutes/english/elaws_statutes_91r18_e.htm
- Quah, Stella R. (2003, November). Traditional healing systems and the ethos of science. *So Sci Med*, 57(10), 997-2012.
- Quantum Shaman. (n.d.). *Evolutionary workshops for the solitary warrior*. Retrieved from <http://www.quantumshaman.com/html/workshops.htm>
- Randall, G.E. (MA, MBA). (1993). *Understanding professional self-regulation*. Unpublished manuscript. Retrieved from http://www.oavt.org/self_regulation/docs/about_selfreg_randall.pdf
- Ramsey, C., Walker M., & Alexander, J. (1991). *Alternative Medicine in Canada: Use and public attitudes*. *Public Policy Sources* (21) [Fraser Institute Occasional Paper]. Vancouver: Fraser Institute. Retrieved from <http://www.fraserinstitute.org/WorkArea/DownloadAsset.aspx?id=2174>

- Ritchie, J., Spencer, L., & O'Connor, W. (2003) Carrying out qualitative analysis. In J. Ritchie and J. Lewis (Eds.) *Qualitative research practice: A guide for social science students and researchers*. Thousand Oaks
- Royal Commission on Aboriginal Peoples'. (1996). Appendix 3A: Traditional Health and Healing. *Report of the Royal Commission on Aboriginal Peoples'* [Volume 3, Chapter 3]. Ottawa: Indian and Northern Affairs Canada.
- Royal Commission on Aboriginal Peoples'. (1996). 5.7: Elders in Traditional Health and Healing. *Report of the Royal Commission on Aboriginal Peoples'* [Volume 4, Chapter 3]. Ottawa: Indian and Northern Affairs Canada.
- Robbins, J. (2008). *Gegenootatolting: Sharing the Knowledge: Gathering technical report*. Ottawa: First Nations Centre, National Aboriginal Health Organization.
- Robbins, J.A., & Dewar, J. (2011, November). Traditional Indigenous approaches to healing and the modern welfare of Traditional Knowledge, spirituality and lands: A critical reflection on practices and policies taken from the Canadian Indigenous example. *The International Indigenous Policy Journal*, 2(4). Retrieved from: <http://ir.lib.uwo.ca/iipj/vol2/iss4/2>
- Robbins, J. (2012, May 26). Self-regulation and First Nations traditional health and healing [presentation]. *Six Nations Ethics Forum*. Unpublished raw data [presenter's notes].
- Royal Canadian Mounted Police Public Affairs Directorate. (1993). Native spirituality guide. *Community, Contract and Aboriginal Policing* [Section of larger resource]. Retrieved from <http://publications.gc.ca/collections/Collection/JS62-80-1998E.pdf>
- Royal College of Midwives. (n.d.). *About RCM: History*. Retrieved from <http://www.rcm.org.uk/data/about/data/general/history.htm>
- Rubin, A., & Babbie, E. (2001). *Research methods for social work* (4th ed.). Belmont, CA: Wadsworth/Thomson Learning.
- Schmidt, Jeff. (2000). *Disciplined minds: A Critical look at salaried professionals and the soul-battering system that shapes their lives*. Lanham, Maryland: Rowman and Littlefield.
- Scott, S. (2008, Autumn). Drawing on Indigenous ways of knowing: Reflections from a community evaluator. *Canadian Journal of Program Evaluation*, 23(2), 73-92.

- Sefa Dei, G.J., Hall, B.L., & Goldin Rosenberg, D. (Eds.). *Indigenous Knowledge in global contexts: Multiple readings of our world*. Toronto: University of Toronto Press.
- Shaman's Door. (2011, April 4). *What is shamanism?* Retrieved from <http://www.shamansdoor.com/?p=41>
- Skye, A.D. (2010, January). Aboriginal midwifery: A model for change. *Journal of Aboriginal Health, January*, , 28-37.
- Sleeping Crow. (2007). *The red Tao: A Native American path to learning*. Retrieved from <http://sleepingcrow.files.wordpress.com/2007/03/redtao.pdf> [Note: Link is no longer available as free resource. Publisher website listed as <http://www.Lulu.com>].
- Smith, D. (2002). *Comprehensive maternal childcare in First Nations and Inuit communities*. Unpublished Manuscript, First Nations and Inuit Health Programs Branch, Health Canada, Ottawa, Ontario.
- Smith, L. (Tuhiwai). (1999). *Decolonizing methodologies: Research and Indigenous Peoples*. London: Zed Books.
- Smoak, G.E. (2006). *Ghost Dances and identity: Prophetic religion and American Indian ethnogenesis in the nineteenth century*. Berkeley, CA: University of California Press.
- Smoke, M.L. (n.d.). *How do I find out more about traditional 'Indian Medicine'?* Ottawa: Canadian Health Network Public Health Agency of Canada. Retrieved from <http://www.canadian-health-network.ca> [Note: Services for this domain have been discontinued].
- Starr P. (1984) . *The Social transformation of American medicine*. New York, NY: Basic Books.
- Stebbins, R.A. (2001). *Exploratory research in the social sciences* [Volume 48 of Qualitative Research Methods]. Thousand Oaks, CA: Sage.
- Schwartz, S.B., & Salomon F. (1999). Chapter 12: New peoples and new kinds of people: Adaption, readjustment and ethnogenesis in South American Indigenous societies (colonial era). In F. Salomon and S. B. Schwartz (Eds.) *South America*. Cambridge, UK: Cambridge University Press.
doi:10.1017/CHOL9780521630764.009

- Stigler, G.J. (1972). The theory of economic regulation. *Bell Journal of Economics and Management Science*, 11. 3-21..
- Taylor, F.W. (1911). *The principles of Scientific management*. New York: Harper Brothers.
- Thom, B. (PhD), & Bain, D. (2004). *Aboriginal intangible property in Canada: An ethnographic review* [prepared for Industry Canada]. Ottawa: Industry Canada.
- Trahair, R.C.S. (2005). *Elton Mayo: The Humanist Temper*, New Jersey: Transaction.
- Trent University, Research Ethics Board (REB). (n.d.). [REB application and guidelines]. Peterborough, ON: Trent University. Retrieved from <http://www.trentu.ca/research/certification.php>
- Tsi Non:we Ionakeratstha Ona:grahsta, Six Nations Health Services. (n.d.). *Vision of Onkwehon:we midwifery care*. Retrieved from <http://www.snhs.ca/bcMCare.htm>
- Unión de Medicos Yageceros de la Amazonia Colombiana (UMIYAC) [Union of Yagé Healers of the Colombian Amazon]. (2000). *Yurayaco declaration of the Union de Medicos Indigenas Yageceros de la Amazonia Colombiana* [Code of Ethics for Indigenous Medicine of the Colombian Amazon. Columbian Amazon: UMIYAC.
- University College of the North. (n.d.). *Kanaci Otinawawasowin* [Aboriginal Midwifery Bachelareate Program]. Retrieved from <https://sites.google.com/site/ucnmidwifery/about-me>
- U.S. Legal. (n.d.) *Organization theory, law and legal definitions*. Retrieved from <http://definitions.uslegal.com/o/organization-theory/>
- Van Wagner, V. (2004). Why legislation? Using regulation to strengthen midwifery. In I.V. Bourgeault, C. Benoit & R. Davis-Floyd (Eds.), *Reconceiving midwifery* (pp. 71-90). Montreal & Kingston: McGill-Queens University Press.
- Velimirovic, B. (1990). Is integration of traditional and western medicine really possible? In J. Coreil, & J. D. Mull (Eds.), *Anthropology and primary health care*. Boulder, CO: Westview Press.
- Wagemakers-Schiff, J. (PhD), & Moore, K. (MSW). (2003). The impact of the sweat lodge ceremony on dimensions of well-being. *American Indian and Alaska Native Mental Health Research: The Journal of the National Centre American Indian and Alaska Native Programs*, 13(3), 48-69.

- Waldram, J. B., Herring, D. A., & Kue Young, T. (2007). *Aboriginal health in Canada*. Toronto: University of Toronto Press.
- Webber, G. (1992). *Mothers, medicine and midwifery: Conversations with Native Canadian Women About evacuation for childbirth* (Unpublished Master's Thesis). York, England.
- Weber, Max.(1968). Bureaucracy. In *Economy and society: an outline of interpretive sociology*. (pp. 956-969). Berkeley: University of California Press...
- Weber, Max. (1978). *Economy and Society: an outline of interpretive sociology (2 Volume Set)*. Eds., Gunther Roth & Claus Wittich. Berkeley: University of California Press, (Original published in 1922).
- Weber-Pillwax, C. (2004, Spring). Indigenous researchers and Indigenous research methods: Cultural influences or cultural determinants of research methods. *Pimatisiwin*, 2(1) 2004, 77-90. Retrieved from <http://www.pimatisiwin.com/uploads/1470824524.pdf>
- Webster's Ninth New Collegiate Dictionary (1983). *Regulation* [definition]. (p. 992).
- Wepa, D. (Ed.). (2005). *Cultural safety in Aotearoa New Zealand*. Auckland, NZ: Pearson Education.
- Whitehorse General Hospital. (n.d). *First Nations Health Program* [pamphlet]. Whitehorse, YT: Whitehorse General Hospital
- Whitten, N.E. (1976). Ecuadorian ethnocide and indigenous ethnogenesis: Amazonian resurgence amidst Andean colonialism Work Group for Indigenous Affairs [Vol. 23 of International Work Group for Indigenous Affairs (IWGIA) document]. Copenhagen,
- Wilson, S. (2009). *Research is ceremony: Indigenous research methods*. Winnipeg: Fernwood.
- World Bank. (2006, May). *Biodiversity and Health Symposium Conclusions and Recommendations*. Retrieved from <http://www.worldbank.org/afr/ik/iknt92.htm>
- World Health Organization (WHO), Division of Reproductive Health (1998a, April 7). *Ensuring skilled attendants at delivery* [Paper developed for WHO, World Health Day –'Safe Motherhood' theme]. Geneva, Switzerland: WHO. Retrieved from <http://www.who.int.archives/whday/en/pages1998/who98.06.html>. [Note: Link to full text no longer available. Excerpt and reference information available at: <http://www.popline.org/node/529260>].

World Health Organization (WHO). (1998b). *Regulatory situation of herbal medicines, A world wide review*. [non formal publication of the WHO]. Retrieved from <http://apps.who.int/medicinedocs/pdf/whozip57e/whozip57e.pdf>

Appendix A: Sedona Sweat Lodge Deaths

Sedona sweat lodge deaths

October 20, 2009

As Keeper of our Sacred White Buffalo Calf Pipe Bundle, I am concerned for the 2 deaths and illnesses of the many people that participated in a sweat lodge in Sedona, Arizona that brought our sacred rite under fire in the news. I would like to clarify that this lodge and many others, are not our ceremonial way of life, because of the way they are being conducted. My prayers go out for their families and loved ones for their loss.

Our ceremonies are about life and healing, from the time this ancient ceremonial rite was given to our people, never has death been a part of our *inikag'a* (life within) when conducted properly. Today the rite is interpreted as a sweat lodge, it is much more than that. So the term does not fit our real meaning of purification.

Inikag'a is the oldest ceremony brought to us by *Wakan Tanka* (Great Spirit). 19 generations ago, the Lakota/Dakota/ Nakota *Oyate* (people), were given seven sacred rites of healing by a Spirit Woman – *Pte San Win* (White Buffalo Calf Woman). She brought these rites along with our sacred *C'anupa* (pipe) to our People, when our ancestors were suffering from a difficult time. It was also brought for the future to help us for much more difficult times to come. They were brought to help us stay connected to who we are as a traditional cultural People. The values of conduct are very strict in any of these ceremonies, because we work with spirit.

The way the Creator, *Wakan Tanka* told us; that if we stay humble and sincere, we will keep that connection with the *inyan oyate* (the stonepeople), who we call the Grandfathers, to be able to heal ourselves and loved ones. We have a “gift” of prayer and healing and have to stay humble with our *Unc'i Maka* (Grandmother Earth) and with one another. The *inikag'a* is used in all of the seven sacred rites to prepare and finish the ceremonies, along with the sacred eagle feather. The feather represents the sacred knowledge of our ancestors.

Our First Nations People have to earn the right to pour the mini *wic'oni* (water of life) upon the *inyan oyate* (the stone people) in creating *Inikag'a* - by going on the vision quest for four years and four years Sundance. Then you are put through a ceremony to be painted - to recognize that you have now earned that right to take care of someone's life through purification. They should also be able to understand our sacred language, to be able to understand the messages from the Grandfathers, because they are ancient, they are our spirit ancestors. They walk and teach the values of our culture; in being humble, wise, caring and compassionate.

What has happened in the news with the make shift sauna called the sweat lodge is not

our ceremonial way of life! When you do ceremony - you cannot have money on your mind. We deal with the pure sincere energy to create healing that comes from everyone in that circle of ceremony. The heart and mind must be connected. When you involve money, it changes the energy of healing. The person wants to get what they paid for; the Spirit Grandfathers will not be there, our way of life is now being exploited! You do more damage than good. No 'mention' of monetary energy should exist in healing, not even with a can of love donations. When that energy exists, they will not even come.

Only 'after' the ceremony, between the person that is being healed and the Intercessor who has helped connect with the Great Spirit, the energy of money can be given out of appreciation. That exchange of energy is from the heart; it is private and does not involve the Grandfathers! Whatever gift of appreciation the person who received the help, can now give the Intercessor whatever they feel their healing is worth.

In our Prophecy of the White Buffalo Calf Woman, she told us that she would return and stand upon the earth when we are having a hard time. In 1994 this began to happen with the birth of the white buffalo, not only their nation, but many animal nations began to show their sacred color, which is white. She predicted that at this time there would be many changes upon Grandmother Earth. There would be things that we never experienced or heard of before; climate changes, earth changes, diseases, disrespect for life and one another would be shocking and there would be also many false prophets!

My Grandmother that passed the bundle to me said I would be the last Keeper if the *Oyate* (people) do not straighten up. The assaults upon Grandmother Earth are horrendous, the assaults toward one another was not in our culture, the assaults against our People (*Oyate*) have been termed as genocide, and now we are experiencing spiritual genocide!

Because of the problems that began to arise with our rebirth of being able to do our ceremonies in the open since the Freedom of Religion Act of 1978, our Elders began talking to me about the abuses they seen in our ceremonial way of life, which was once very strict. After many years of witnessing their warnings, we held a meeting to address this very issue of lack of protocol in our ceremonies. After reaching an agreement of addressing the misconduct of our ceremonies and reminding of the proper protocols, a statement was made in March 2003. Every effort was made to insure our way of life of who we are as traditional cultural People was made, because these ways are for our future and all life upon the Grandmother Earth (*Mitakuye Oyasin* –All my relations), so that they may have good health. Because these atrocities are being mocked and practiced all over the world, there was even a film we made called “Spirits for Sale”.

The non-native people have a right to seek help from our “First Nation Intercessors” for good health and well-being, it is up to that Intercessor. That is a privilege for all People that we gift for being able to have good health and understand that their protocol is to have respect and appreciate what we have to share. The First Nations Intercessor has to

earn that right to our ceremonial way of life in the ways I have explained.

At this time, I would like to ask all Nations upon Grandmother Earth to please respect our sacred ceremonial way of life and stop the exploitation of our *Tunka Oyate* (Spiritual Grandfathers) .

In a Sacred Hoop of Life, where there is no ending and no beginning!

Namah'u yo (hear my words),

Chief Arvol Looking Horse, 19th Generation Keeper of the Sacred White Buffalo Calf Pipe Bundle.

Appendix B: Elsipogtog Health and Wellness Centre Letter of Support



Elsipogtog Health & Wellness Centre

205 Big Cove Road Elsipogtog, NB, E4W 2S1
 Phone: 506.523.8227 * Fax: 506.523.8232 * Web: www.ehwc.ca * ISDN: 1.506.523.4007

January 29, 2010

To Whom It May Concern:

**Re: Letter of Support
 Mi'kmaq Ethics Watch**

This letter is in support of Mr. Julian Robbins with regard to his research work in the area of First Nations traditional health and healing.

Mr. Robbins is a mixed race person with Mi'kmaq ancestry and was a recently a research officer with the First Nations Centre (FNC) of the National Aboriginal Health Organization (NAHO) (August 2005-August 2009). Since August, 2005, Mr. Robbins focused on work at the FNC to support and communicate the role that traditional knowledge plays in First Nations health (through including First Nations Elders and Healers in the FNC's research agendas).

In 2006, Julian spearheaded an ongoing activity on the FNC work-plan coined **The First Nations Traditional Healing Circle of Elders/Medicine People**. Discussions with Healers and Elders from various First Nations eventually led to the facilitation of a National gathering called **Geenoatatotim: Sharing the Knowledge** (September 8-15, 2008).

The First Nations Centre (FNC) of the National Aboriginal Health Organization (NAHO) in collaboration with the Elsipogtog Health and Wellness Centre (EHWC) hosted a traditional health and healing gathering which included many opportunities for healing and dialogue. *Geenoatatotim* was local, regional and national in scope and took place at the EHWC and surrounding grounds of Elsipogtog Mi'kmaq First Nation in New Brunswick, Canada. The event focused on taking a very "hands on" approach to knowledge transmission and healing.

The Mi'kmaq concept of *geenoatatotim* or 'sharing the knowledge' communicates the main priority of this week long activity. "Mi'kmaq and other First Nations people hold sharing in high regard because they know the more you share, the more you receive", says Josie Augustine (FNC, Ottawa, February 11th, 2008). The gathering was, in part, an effort to examine ways of restoring inter-generational knowledge transmission practices (e.g.: loss of language, separation from families during residential school times, negative propaganda against ceremonial rites, etc) that were diminished by consequences resulting from effects of colonization.

We believe in the promotion and provision of holistic health and wellness services responsive to our community needs to affirm confidence, pride and self-responsibility.

People who attended the event were able to examine their own experiences through diversified opportunities to learn and share from one another in a First Nations traditional context of language, culture, traditional values, traditional medicines and spiritual beliefs. If they so desired, participants were also offered opportunities to receive "hands on" healing" during the gathering from fully qualified Elders and medicine people who were present.

Furthermore, the proceedings provided several exploratory/potential research and policy directions in areas of community based First Nations traditional health and healing.

Some of the activities during the week included:

- Sweat Lodges
- Traditional Healing
- Community Elders Circle on the grief
- Elders teachings
- Medicine walk (through the community to identify various herbs and what they are used for)
- Elder/Youth Dialogue Circle
- Youth Circle
- Traditional and Western Medicine in service delivery
- Wampum Belt Teachings
- Women's Discussion Forum
- Shaking Tent Ceremonies

Before joining the FNC, Mr. Robbins had completed course work and comprehensive examinations through Trent University towards a doctorate degree in Indigenous Studies. He now has the necessary foundations to actualize his thesis topic. His goal is to finish his doctoral degree in Indigenous Studies which will focus on the area of documenting and analyzing the realities of self-regulation and professionalism within communities that practice and use Indigenous medicine. Part of this work would involve Mr. Robbins doing some of his research in Elsipogtog --primarily with some of the people associated with the Traditional Healing Program at the Elsipogtog Health and Wellness Centre.

Sincerely yours,



Claudia Simon, Director
Elsipogtog Health and Wellness Centre

Appendix C: Subject Areas, Guiding Questions and Focusing Probes for Semi-Structured Interviews

Subject Areas for Semi-Structured Interviews

Indigenous protocols/practices related to Indigenous conceptualizations of self-regulation and professional behaviour amongst Traditional healers

1. Self-Regulation
2. Professionalism
3. Cultural Safety
4. Ethnogenesis
5. Health/Illness
6. First Nations medicine
7. Western medicine
8. Technology
9. Medical systems
10. Economics
11. First Nations Traditional Health and Healing
12. Holism
13. Spirituality
14. Philosophical/Epistemological underpinnings
15. Midwifery
16. Traditional Midwives
17. Institutionalization
18. Jurisdiction
19. Scope
20. Authenticity

Guiding Questions and Focusing Probes for Semi Structured Interviews

General Questions

1. How do Indigenous healers regulate themselves? What internal self-regulation mechanisms have been successful and unsuccessful, and why?
2. How should ethical issues (e.g.: scientific and legal evaluation of First Nations medicine, biopiracy, declining biodiversity) be addressed?
3. What is necessary to foster and support the successful transmission of First Nations medical knowledge?

4. In all examples, how has emerging 'Indigenous professionalism' been tempered by combined concepts in mainstream professionalism and cultural safety?
5. How can modern mainstream institutions (academic, government, western medical system, etc.) support the development of First Nations medicine?
6. How are healers able to maintain the integrity of their practice in an increasingly corrupting environment (e.g.: mainstream temptations of large amounts of money for even delivering the promise of healing)?
7. Money is needed today for basic necessities (for example, travel and food). Can self-regulation and mainstream recognition as professionals increase opportunities for funding traditional medicine, and hence its long term sustainability? What if anything would be sacrificed in the process of obtaining credentials that would be acceptable to the mainstream?
8. Is access to healers by community members improved when Indigenous self-regulatory bodies interface in a more direct way with the mainstream health system?
9. There is often stigma in Indigenous communities about getting paid for healing services as it is somehow perceived as compromising the integrity of the medicine. How do Indigenous traditional health and healing self-regulatory bodies respond to this?
10. The scientific biomedical paradigm of Euro-centric "modern" medicine maintains a monopoly on what constitutes "genuine" medical care and in many cases has driven traditional health and healing practitioners underground. How do self-regulatory bodies of traditional healers view and respond to this phenomenon?
11. Followers of the New-Age movement continue to exploit Indigenous traditions and spirituality claiming false credentials and misleading clients for commercial gain. Are self-regulatory Indigenous bodies responding, if at all, to this phenomenon? What happens when an authentic Indigenous healer is independent and not connected to a self-regulatory body?

Sample Focusing Probes

1. How do we protect against unwarranted claims against healers?
2. How should we continue to provide these types of services to the community when the modern Western medical model is promoted so forcefully?

3. If we were to begin a self-regulatory process, how should it begin? What would it look like?
4. What is it that you need from participating in this process? Is translation of the thesis into useful material and some control over copyright enough?
5. What elements should an organization promote that supports First Nations traditional health and healing practitioners?
6. What are your thoughts on how to return this study back to the First Nations community at large in a meaningful way?
7. How far does the self-regulatory process of your organization extend? How far would you like it to extend?
8. As a First Nations self-regulatory entity for traditional health and healing practitioners, what issues require immediate, intermediate and long-term attention or decisions. (e.g. apprenticeship training programs for youth, providing traditional medicine services to community members, protecting the medicines, etc.)?
9. Could you please explain a bit your thoughts on how self-regulation would help in the development of holistic health care delivery for First Nations that is culturally responsive?

****Note: All subject areas and focusing probes may or may not be applied during or after the data collection process.**

Appendix D: Gegenoatatolting: Sharing the Knowledge (Events)

GEGENOATATOLTIMG: Sharing the Knowledge



The First Nations Centre (FNC) at the National Aboriginal Health Organization (NAHO) in partnership with the Elsipogtog Health and Wellness Centre (EHWC) are co-hosting:
GEGENOATATOLTIMG: Sharing the Knowledge
 September 8-15, 2008 – Elsipogtog First Nation, NB

The following events will be provided during the Gegenoatatolting: Sharing the Knowledge Gathering, September 8-15, 2008 in Elsipogtog First Nation, New Brunswick.

Monday, September 8

All Day Participant Arrival
 9:00am Information Booth Opens
Time TBA Sweat Lodge

Tuesday, September 9

9:00am - 11:00am Opening Ceremony and Gathering Orientation: Drum, Pipe, Welcome from Migmag Elders, Elsipogtog Chief and Council Representative, Elsipogtog Health and Wellness Centre
 11:00 am - 12:00pm Registration for Doctoring (limit according to capacity of healers)
 12 :00pm - 1:00 pm Lunch
 1:30pm - 3:30 pm Sweat Lodge teachings
 1:30pm - 3:30 pm Women's Teachings
 4:00pm - 5:30pm Law and Order in the Medicines
 4:00pm - 5:30pm Women's Teachings
 6:00 pm Dinner
Time TBA Sweat Lodge

Traditional Doctoring – ongoing throughout day

Wednesday, September 10

9:00am – 10:00am Registration for Doctoring (limit according to capacity of healers)
 10:30am - 12:00pm First Steps in Self-discovery, the Eeyou Way
 10:30am - 12 :00pm Grandmother Teachings : Dreaming and the Medicines
 12 pm - 1:00pm Lunch
 1:30pm - 3:30pm Medicine circles and Mental Health
 1:30pm - 3:30pm Wampum Belts
 1:30pm - 3:30pm Medicine Walk
 4:00pm - 5:30pm Dene Prophecies
 4:00pm - 5:30pm Cree Prophecies, Meaning of Ceremonies and Youth Protocols
 6:00 pm Dinner
Time TBA Sweat Lodge

Traditional Doctoring – ongoing throughout day

Thursday, September 11

9:00am - 10:00am Registration for Doctoring (limit according to capacity of healers)
 10:30am -12:00pm Medicine circles and Mental Health
 10:30am - 12:00pm From the North: Teachings and Games for Kids and Adolescent

12 :00pm - 1:00pm	Lunch
1:30pm - 3:30pm	Dene Prophecies
1:30pm - 3:30pm	Haudenosaunee Healing Ceremonies
1:30pm - 3:30pm	Medicine Walk
4:00pm - 5:30pm	Rites of Passage
4:00pm - 5:30pm	Medicine circle Teachings
6:00 pm	Dinner
Time TBA	Sweat Lodge

Traditional Doctoring – ongoing throughout day

Friday, September 12

9:00 am - 10:00 am	Plenary Address NAHO Chief Executive Officer, Paulette Tremblay EHWC Executive Director, Eva Sock Registration for Doctoring (limit according to capacity of healers)
10:00am - 10:30am	Rites of Passage
10:30am - 12:00pm	Medicine circle Teachings
10:30am - 12:00pm	Medicine Walk
12:00pm - 1:00pm	Lunch
1:30pm - 3:30pm	Haudenosaunee Healing Ceremonies
1:30 pm - 3:30 pm	Dene Prophecies
4:00pm - 5:30pm	Medicine circles and Mental Health
4:00pm - 5:30 pm	Medicine circle Teachings
6:00 pm	Dinner
Time TBA	Sweat Lodge

Traditional Doctoring – ongoing throughout day

Saturday, September 13

8:00 am - 12:00 pm	Collecting Materials for Ceremony
12:00pm - 1:00pm	Lunch
1:30pm - 3:30 pm	Women's Teachings Discussion Group
1:30pm - 3:30 pm	Sharing Circles -Share what you know and what you've learned!
1:30pm - 6:30 pm	Building the Shaking Tents (at the shaking tent grounds)
9:00 pm -	Shaking Tent Ceremonies

No Activities in Doctoring Tent on this day

Sunday, September 14

9:00am - 10:00 am	Registration for Doctoring (limit according to capacity of healers)
10:30 am - 1200 pm	Grandmother Teachings: Dreaming and Medicines
10:30 am - 12:00pm	Medicine Walk
12:00 pm - 1:00 pm	Lunch
1:30 pm - 3:30 pm	From the North: Teachings and Games for Kids and Adolescents
1:30 pm - 3:30 pm	Cree Prophecies, Meaning of Ceremonies and Youth Protocols
4:00pm	Community Social
Time TBA	Sweat Lodge

Traditional Doctoring – ongoing throughout day

Monday, September 15

9:00 am - 12:00 pm	Gathering Closing
12:00 pm -	Participant Departure

Appendix E: Six Nations Council Ethics Approval



September 22, 2010

Julian Robbins
Trent University
851 Queenston Road, Suite 905
STONEY CREEK, ON
L8G 1B4

Dear Julian

The Six Nations Council Ethics Committee met on September 21, 2010 and reviewed your Ethics Application titled "Contemporary Expressions of Self-Regulation and Indigenous Protocols for Professional Behaviour among Traditional Practitioners of First Nations Medicine".

This will confirm that full approval has been granted by the Six Nations Council Ethics Committee.

The Committee reserves the right to request your attendance at upcoming meetings to provide written and/or verbal progress reports. Should this be a requirement, you will be provided notice in writing.

The Committee looks forward to receiving a final report upon completion of your research and is requesting that you send two copies of your final report.

Thank You


Teresa Longboat,
Council Secretary

Appendix F: Mi'kmaq Ethics



March 22, 2010

**Julian Robbins, PhD Candidate
Indigenous Studies PhD Program
Trent University
Email: jrobbins@trentu.ca**

Dear Mr. Robbins:

I wish to inform you that the Mi'kmaq Ethics Watch committee has reviewed and approved your ethics application: " Contemporary Expressions of Self-Regulation and Indigenous Protocols for Professional Behaviour among Traditional Practitioners of First Nations Medicine".

This enables you to move forward with your project.

While we are overseeing Mi'kmaq districts ethics, each person/organization/agency seeking to do research in Mi'kmaq communities must determine what other ethics processes they must go through. It is your responsibility to do this as we have not been given information from all the communities as to their various ethics processes. We do not oversee university, government, health/medicine, law, or community ethics processes. They have their own.

We would be pleased or appreciative if and when the study is completed that it be provided so as to allow our students to build further academic foundations and a better understanding of Indigenous knowledge.

If you have any questions concerning same, please do not hesitate to contact us.

Sincerely,

**Lindsay Marshall
Associate Dean
Mi'kmaq College Institute**

LM/vl



Watch Approval

Appendix G: Research Participant Consent Form



Appendix C

Trent University

Indigenous Studies PhD Program

Research Consent Form

Contemporary Expressions of Self-Regulation and Indigenous Protocols for Professional Behaviour Among Traditional Practitioners of First Nations Medicine

Julian Robbins, HBA, MA

PhD Candidate Student in the Indigenous Studies Program at Trent University

Contact Information:

Julian Robbins

Tel (Home): 1 905 664 3746

Tel (Cell): 1 289 808 1874

Email: jrobbins@trentu.ca

You are being asked to participate in a research study carried out by Julian Robbins as part of his PhD thesis research. The purpose of the study is to help support and protect Indigenous health and healing systems.

What do we mean by contemporary expressions of self-regulation and professionalism?

The study is concerned with how Indigenous healers can inform a discussion about self-regulation and professionalism with respect to the protection and support of Indigenous medical systems.

For First Nations, concepts of 'self-regulation' and 'professionalism' in health care are tied into issues of sovereignty, autonomy and nationhood. That is, in some form, these concepts are already present in autonomous First Nations systems of medicine. This thesis is *in favour of strengthening systems of First Nations medicine in our present times*. Part of the effort of this thesis involves gaining some clarity around what First Nations mean (and don't mean) when we talk about concepts of self-regulation and professionalism in the context of First Nations medicine.

As a modern mainstream practice, self-regulation is the mark of an established profession. It is the norm that professional association bodies engage in self-regulation and the policing of practicing members. In several other parts of the world, traditional healers have been constructing self-defined self-regulatory associations in order to protect their practices from an onslaught of mainstream forces. Measuring the successes and failures of such associations can be quite wide ranging.

What is the aim of the study?

The aim of the study is to reflect your contributions as Indigenous healers, Elders and/or community members on how Indigenous protocols *have been used, are used or can be used* to articulate and support the autonomous nature of traditional First Nations medicine. It is also hoped that the results of this study will assist the following:

- The rebuilding and/or positive expression of autonomous First Nations medical systems in contemporary contexts.
- Greater access for First Nations peoples to their traditional medicines and healers.
- Greater understanding for First Nations peoples and non-First Nations peoples of First Nations medical systems.
- Protecting traditional health and healing practitioners against being judged by the default value systems of biomedicine and its subsequent legal consequences.
- Positively impact the transfer of First Nations health knowledge (and subsequent use) to future generations.

What is not the aim of the study?

This study DOES NOT aim to include and/or collect specific knowledge about Indigenous medicines or ceremonies. While it is understood that during the interview process, the researcher may become exposed to certain sensitive materials and knowledge (e.g.: a remedy for a specific health ailment or particulars associated with ceremonial processes), this type of information considered by the researcher to be off limits for inclusion in the thesis.

What is involved?

You will be asked to participate in at least one (possibly two) interview(s) during the duration (12-18 months) of the



project. In some cases these might be group interviews while in others individual key informant interviews will occur. Some of these

interviews will take place in person whereas others will take place over the telephone. A first set of interviews will be done in a two to three month period before any analysis in the thesis takes place. These interview responses will be incorporated into the results over a four month period. A second smaller set of interviews will be conducted in a two month period after the analysis so that a selection of First Nations research participants can provide feedback as to whether or not my analysis seems to be on the right track. I would ask that when you participate that you are also thinking about other ways that this study can be returned for First Nations to effectively use.

Benefits and Risks

Benefits include the fact that you will be able to freely use the results of this study in your respective work areas. There is also evidence that sharing your knowledge will be helpful in some way to future generations with regard to the, protection and support and transmission of systems of First Nations medicine. Risks include stirring up possible emotional distress stemming from the fact that not so long ago, traditional health and healing practices had to go underground due to threats of persecution by Euro-centric society.

Voluntary Participation

Participation in this study is voluntary. You may decide to withdraw at any time and for any reason without consequence. If you choose to withdraw your participation from the study, please contact Julian Robbins (whose contact information at the beginning of this document) and the data collected from you will be destroyed. If you choose to join the study, you will receive a copy of the consent form for your own information. If you do not wish to sign a consent form however, you may choose to give your consent verbally only. This is also a valid way to agree to participate in the study.

Confidentiality

You have the full option of remaining anonymous as a participant in this research project. The audiotapes, notes and transcribed interview will be strictly confidential. The researcher and the faculty supervisor are the only people who may listen to the taped interviews or access the transcripts. In the case that there are interview tapes, they will be transcribed from tape to paper by the researcher. All raw data associated with this interview can either be returned to you or destroyed upon the completion of the project. You should know that the copyright of the final thesis product belongs to the investigator and that the final product becomes a public document of Trent University. I will, however, remain present after the completion of the thesis to be directed by the research participants regarding any suggested useful variations of the end product (e.g.: leave as is, develop into a book or other resource, build on it for future work in this area, etc.). Furthermore, I grant full permission to all research participants to use information in the final thesis as they see fit.

Consent to participate in the study

I have read and understand the information and consent form for this study. I have had the aim and the process of the study explained to me. I understand that I may choose not to participate in this study or withdraw at any time, with no effects resulting from my decision. I understand that I will not be identified by name in any written report if I so choose and those records from this study will be kept in a confidential manner.

I am voluntarily signing this consent form. If I have any questions or concerns about this study, I may contact Julian Robbins' PhD supervisor Professor David Newhouse (Department of Indigenous Studies, Trent University, Peterborough, Ontario K9J 7B8, tel: 1 705 748 1011 x 7497 or dnewhouse@trentu.ca).

By signing this consent form I am agreeing to participate in this study.

Signature of Participant

Date

I have to the best of my ability explained to the participant the nature of the above research study. I certify that to the best of my knowledge, the participant understands clearly the nature of the study, its aim and demands, benefits and risks involved to participants in this study.

Signature of Investigator

Date

Appendix H: Guidelines for Interviewing Elders and Healers

Guidelines for Interviewing Elders and Healers

Generally speaking, principles of respect and humility will be reflected during contact and interaction with Elders and healers before, during and after this research project.

Several guidelines, in a variety of contexts, have already been published for interviewing First Nations Elders and healers (National Aboriginal Health Organization, 2007; Anishnawbe Health, 2000; Indian and Northern Affairs Canada, 2002; Royal Canadian Mounted Police, 1993; M.L. Smoke, 2005).

Some of the general assertions from these principles are relevant and can be utilized during the data collection process of this thesis. Applicable principles are described below in a way that tailors them to this specific research project.

Elders and Healers

First Nations/Indigenous people have a great respect for the wisdom gained over the course of individual lives which means that any knowledge flowing from holders of knowledge (i.e. Elders and healers in this case) needs to be handled responsibly and with respect. Importantly, it should be noted that an Elder or healer does not necessarily have to be physically old to be considered as such by their communities.

Helpers

First Nations Elders often have helpers that work with them and who receive training. For this study, there are several Elders and healers that I know directly and others that I have approached and gotten to know through their helpers. These already established relationships will be built upon in a similar way when requesting their participation in this study.

Tobacco and Offerings

For First Nations Elders and healers, a gift of tobacco will be offered when approaching them before the interview. As well, I also plan to offer a small gift at the end of the interview.

Learning to Listen and Listening to Learn

This principle is an effective one to apply when interviewing Elders and healers. In First Nations culture, being loud or rushing the conversation of an Elder is generally seen as rude and may lead to the questions being answered in a way that is not complete.

While principles described in Appendices B and C of this proposal will be applied to the interview process, I feel they need to be applied in a non-intrusive way. For the purposes

of interviewing Elders and healers, sometimes asking less questions and employing listening skills can be a more effective approach. In this case, questions will need to be formulated in a way which evoke detailed responses. Information can then be categorized from the interview in a way that reflects relevant the analytical categories articulated in Appendices B and C.

When in Doubt

If there is doubt, I would employ the principle of asking the Elder, healer or the helper for help with my request. Since each situation is different, I will not presume permission is granted for everything all the time. Permission should be sought in each situation and should never be considered to be implied from previous interactions or use of information. In this research project, this principle may especially come into play when engaging with non-First Nations Elders and Healers (i.e. from the International Indigenous community).

Further to this, if there is doubt in how to proceed, I am able to consult with Elders Frank and Josie Augustine from Elsipogtog at any stage of the project for advice (as mentioned in the **Aboriginal Context of the Research and Research Ethics** section of this proposal (# 5). Having an First Nations Elder on the thesis committee is also to be of aid to this process.