



STS'AILES PRIMARY HEALTH CARE PROJECT: REPORT

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Funders & Partners:



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EXECUTIVE SUMMARY

This report documents a long-term collaboration between representatives from Sts'ailes, Fraser Health Authority (FHA), and academic researchers at the Centre for Addictions Research of BC, University of Victoria (UVic) and University of British Columbia (UBC). All participants are committed to exploring ways to enhance health services for the Sts'ailes people and other FHA clients who reside in the region. It summarizes and celebrates a new knowledge legacy created as a result of the Sts'ailes Primary Health Care Project, the joint work of partnership members over the last five years.

Years of relationship building have created a space for learning that allows members to discuss and understand potentially competing traditions or worldviews. Through the development of trust and respect, an intimacy has emerged that levels the playing field among participants creating an ethical space where Aboriginal and non-Aboriginal perspectives are treated equally. Our collaboration has allowed full expression of the voices of the Sts'ailes community unimpeded by academic hubris and over-ride that is common in research collaborations where academic experts identify problems and then advise the community what to do and how to do it. By moving away from the Aboriginal/non-Aboriginal dichotomy frequently cited in the literature, we have been able to re-define often disparate worldviews using concepts common to both Aboriginal and non-Aboriginal cultures whilst acknowledging important differences and allowing multiple discourses to emerge. As a result, we express the dichotomy more in terms of health promotion versus illness models with respect to health care and the inviting and inclusive nature of egalitarian systems versus the elitist and exclusive nature of hierarchical structures with respect to power dynamics and social justice. Renaming or rebranding the Aboriginal and non-Aboriginal dichotomy has allowed us to address stigma and misunderstanding and to discover values common to

multiple knowledge and cultural traditions that help to shape the vision for the new community primary health and wellness centre.

Our findings support the ongoing relationship between Sts'ailes and FHA by advising Fraser Health's Aboriginal Health department how it can work to influence Fraser Health to adapt its organizational processes to better fit the needs of Aboriginal health centres. The findings will be used to make recommendations to the organization around how to adapt services to better meet the needs of the new Sts'ailes Primary Health Centre and other Aboriginal health centres in the region. Recommendations include developing plans to: 1) facilitate the partnership of healers from across traditions – traditional and spiritual healers, medical model physicians, nurses and other health providers – to support the health and well-being of the Sts'ailes and other people accessing the new community health centre; 2) ensure a central role to community elders in providing direction and consultation related to the day-to-day operations of the centre; and 3) provide opportunities for service providers as well as knowledge mobilizers and animators to understand the historical, social, cultural, political, geographical and economic contexts of providing care to Aboriginal communities. Finally, the research project has provided insights into traditional health, wellness and healing practices and protocols, but more work is required to operationalize the knowledge into the work of services within the medical health care model. The findings from the Project has helped both Fraser Health and Sts'ailes better understand each other's needs, challenges, and perspectives in delivering primary health care to Aboriginal communities.

We hope this report on our relationship experience and research findings generates an energetic response from our readers. We are calling for a new type of action that

goes beyond the academic discourse of concepts like cultural competency, safety and diversity and moves toward the creation of new frameworks and lens for measuring success, defining health and wellness, hiring staff and developing and monitoring competencies. Going forward, we hope our report will motivate knowledge mobilizers and knowledge animators as well as decision makers to identify the key choices required to improve the health and wellness of Aboriginal people. We hope to persuade these individuals that things need to be done differently – not just written about, analyzed and debated – but implemented in the form of concrete processes, mechanisms and protocols. We urge them to listen attentively and respectfully to the Aboriginal voices and perspectives that flow from strong traditional values and a profound intimate knowledge of local circumstances validated by a tradition of empirical testing and analysis of results. Throughout our time together, the Sts’ailes perspective and narrative has been consistent and coherent. There is something to be said about the simplicity and power of sitting down together, in an egalitarian, equitable fashion, and learning from each other, breaking down the old practices and old ways of thinking about and doing things.

Although, in the report, our recommendations are directed to decision makers – our CIHR funding mandate requires a focus on knowledge transfer from researchers to decision makers – our advice is also intended to assist on the ground knowledge mobilizers and knowledge animators including frontline health care workers who are strategically positioned to create real change at vital locations within the health and wellness care delivery system. Policies and procedures mandated from high level decision makers are unlikely to be effective without internalized support and buy-in from frontline health care workers. Therefore, it is important for health care providers to understand and value the historical, social, cultural, political, geographic, and economic contexts of Aboriginal individuals and communities. Moreover, such insight and understanding cannot be achieved through one-off courses and seminars but require experiential learning of adequate duration best expressed in the words of our community decision maker, Virginia Peters, “you’ve got to see us, you’ve got to hear us, you’ve got to feel us.”

By following community values and protocols (e.g., 7 Laws of Life [laws governing program partnership]: health, happiness, generations, generosity, humility, forgiveness, understanding; and Circle of Courage [core values governing programming and community development]: belonging, mastery, independence, generosity), Sts’ailes is making great progress on a range of community programs including child and family support programs (Snowoyelh) and economic development initiatives. This report will assist the community as it moves forward with plans for the location, design and operation of a new community primary health centre. We encourage other organizations and communities examining and planning for local health and wellness care initiatives to consider our report as a resource to assist with their planning activities.

1. INTRODUCTION

1.1 Background

In 2007, representatives from Sts'ailes, Fraser Health Authority (FHA), and academic researchers at the University of Victoria (UVic) and University of British Columbia (UBC), have formed the Health Integration Project Planning (HIPP) Committee to explore ways to enhance health services for the Sts'ailes people and other FHA clients who reside in the region.¹ This partnership can be seen as part of a broader FHA response to the Transformative Change Accord (2006) intended to support the health of Aboriginal people and communities in BC. It also operates within and is guided by concurrent activities of Sts'ailes in support of the development of a community health centre. As a result of this collaboration, the partners have jointly developed and implemented the Sts'ailes Primary Health Care Project, a knowledge synthesis/exchange initiative funded by the Canadian Institutes of Health Research (CIHR) and grounded in principles of participatory action research (PAR). The purpose of the Sts'ailes Primary Health Care Project (hereafter, the Project) is to produce a knowledge synthesis of Aboriginal community health centre models that responds to the needs of Sts'ailes and the FHA.

This report summarizes the new knowledge legacy created as a result of the Sts'ailes Primary Health Care Project as well as joint work of the HIPP partnership over the last 5 years. The specific objectives of this report are to: (1) outline the activities of the Sts'ailes Primary Health Care Project; (2) describe the partnership process and the research methodology; (3) report on the research findings; (4) discuss knowledge transfer activities; and (5) summarize key lessons learned to guide recommendations.

¹ The region is defined as the area bordered by Hemlock Valley to the north, Fraser River to the south, Mount Woodside to the east, and Lake Errock to the west.

1.2 Context

The collaboration arose from a confluence of knowledge needs to support the decisions of Sts'ailes and the Fraser Health Authority with respect to health service development. A guiding principle of the collaboration is that health service delivery must be developed so that "Indigenous knowledge, both traditional and contemporary, can complement Western 'mainstream' science in developing strategies to improve health" (HIPP, 2008).

The objective of Sts'ailes is to develop and provide primary health care services to clients living on and off reserve; with diverse values, beliefs, behaviours and health needs (Sts'ailes, 2012). The guiding philosophy is a collaborative, interdisciplinary model of providing integrated health services based on the belief that the model of care is collaborative, participatory, and holistic (Ibid). The role of Sts'ailes members on HIPP Committee was to act on behalf of the Sts'ailes community, with linkages to the Sts'ailes Health Department and the Band Council, oversee all phases of the research process, set direction for research questions and process, and interpret findings. Sts'ailes is the guardians and custodian of the traditional knowledge and new knowledge legacy.

A strategic imperative of the Fraser Health Aboriginal Health Department is to improve access to culturally appropriate services, including primary care. Activities to achieve this goal include partnerships with First Nations health centres in the delivery of integrated primary care services. These services are available to on- and off-reserve Aboriginal people, delivered collaboratively by Fraser Health and Aboriginal communities and organizations. The role of FHA staff on the Committee was to provide their perspective to the Project, interpret findings with their lens, and facilitate knowledge translation of the

project results to FHA Clinical Program Leadership. Fraser Health Aboriginal Health will use the findings to inform the model of primary health care which they deliver to Aboriginal communities. Fraser Health will also use the findings to inform the way the health authority builds partnerships with general practitioners (GPs) in the region.

The activities of the academic partners from UVic and UBC were guided by the goals of the Project while ensuring its scientific integrity. Key overarching obligations of the academic researchers were to: maintain a long-term relationship of trust, ensure that the research is relevant and beneficial to the community and in agreement with the standards of competent research, and ensure that the community has opportunities to actively participate in all aspects of the research. More detailed information on the roles and responsibilities of all partners are described in the Research Agreement (HIPPA, 2009).

1.3 Objectives

The overarching objectives of the Project were as follows:

1. Produce a knowledge synthesis of Aboriginal community health centre models that responds to the needs of Sts'ailes and the FHA;
2. Inform the development of a community health centre that ensures continuity of care through different levels of care to Sts'ailes community members and neighbouring Aboriginal and non-Aboriginal communities; and
3. Facilitate and evaluate translation of Indigenous health services knowledge into policy and practice.

These objectives were guided by the following research questions: (1) What are the Aboriginal community health models currently in existence in Canada and internationally? (2) Which models best reflect the core values and principles identified by the decision-makers? (3) How well do the existing models: (a) integrate Indigenous and scientific knowledge; (b) filter community health centre best and promising practices through the lens of Aboriginal knowledge; and (c) meet the conditions needed to create a level playing field between science and Indigenous knowledge in order to maximize effective knowledge translation? (4) What do we know about

effective strategies for improving the health of Aboriginal communities? (5) How does one implement these models within a Western science dominated system of funding, policy and health services provision founded upon a different set of priorities and values?

1.4 How did the original objectives evolve?

During the course of the Project, the original objectives evolved in line with the needs of the decision makers and as key findings emerged. The primary area where objectives evolved related to the integration of Indigenous knowledge (both traditional and contemporary) and Western primary health care models; in particular, the goal of developing evaluative criteria to assess each health model's capacity to translate Indigenous knowledge. While this point is discussed in greater detail in section 3.1.3, in short, the research showed that Aboriginal culture and knowledge are paramount to the development of the primary health centre, and not something that can be integrated into or with other models. As a result, the Project objectives evolved to researching existing examples of integration of knowledge and practices from different traditions across health and social programs in the community. Further, the decision-makers identified a number of research questions regarding healing and healers (e.g., identification, recognition, remuneration, practice models in centre settings) as a primary topic of focus. Consequently, four main areas of research emerged and were carried out over the course of the Project:

Research Area 1: Health centre and service models

Objectives: (a) Summarize existing literature on Aboriginal community health centre and service models in Canada and abroad; and (b) Summarize characteristics (governance, vision, guiding principles, services) of select Aboriginal community health centres that combine Western and Indigenous approaches to health and healing.

Research Area 2: Non-Aboriginal providers working with Aboriginal communities

Objective: Summarize existing research literature regarding health and healing in the context of non-Aboriginal providers working with Aboriginal communities.

Research Area 3: Health and healing

Objective: Gain wisdom from Sts'ailes elders and community members regarding health and healing.

Research Area 4: Sts'ailes services

Objective: Identify and summarize existing strengths, practices, and lessons learned from the Sts'ailes health and community services.

1.5 Structure of the Report

This document reports on the findings from the four research areas to inform the decisions of Sts'ailes and the FHA in the development of a community health centre in Sts'ailes to serve its people and the surrounding communities. Chapter 2 discusses methodology and the process of gathering knowledge. Chapter 3 summarizes the literature reviews on (a) *health centre, service models, and health centre characteristics* (area 1) and (b) *Non-Aboriginal providers working with Aboriginal communities* (area 2). Chapter 4 discusses the findings from the interviews and focus groups with elders and community members regarding *health and healing* (area 3). Chapter 5 discusses how community capacity was strengthened as a result of the Project. Chapter 6 provides a summary of the collected knowledge (area 4). Recommendations are contained in chapter 7, with a focus on implications for practice. Chapter 8 outlines knowledge transfer and exchange (KTE) activities; these are expected to continue beyond the completion of the Project.

Over the years, the Project yielded countless summaries, process documents, and field notes, all of which form the new knowledge legacy of Sts'ailes to guide development of health and wellness services, as well as future projects. Additional resources and more detailed information can be found in Appendices and in separate documents attached to this Report (see *Appendix 1*).

2. GATHERING KNOWLEDGE (METHODOLOGY)

2.1 Description of the Research Process

The research process rested on a variety of formal and informal mechanisms established by HIPP committee members over the course of the Project, utilizing both Indigenous and academic approaches.

Engagement in partnership entailed years of relationship building, with HIPP members attending teams meetings, retreats, academic events, community events and ceremonies, and spending time in Sts'ailes to get to know people and places. The process of exchanging knowledge was based in iterative, ongoing dialogue, with partners bringing issues and questions to the Committee, discussed and guided by Sts'ailes community protocols and principles, including:

- *Snowoyelh* (Traditional law of everything)
- *Eyem Mestiyexw Kwo:l Te Shxweli Temexw* (Strong People from Birth to Spirit Life)
- *Letsemot* (One mind, one heart)
- *Ey Chap Te Sqwalewel* (Doing things with a good heart and a good mind promises good results)
- Open with a prayer (If we take care of the spirit first, then the spirit takes care of us)
- We all have gifts that we bring to the Project

The research process also rested on academic mechanisms, including:

- Terms of Reference (HIPP, 2008)
- Letter of Agreement between community and researchers (HIPP, 2009)
- Band Council Resolution and letters of support
- UVic Human Research Ethics Board (Approval August 18, 2010; Renewal July 20, 2011)
- CIHR Guidelines for Health Research Involving Aboriginal People
- Ownership, Control, Access, and Possession (OCAP) principles

The formal and informal cultural and ethical protocols, values and behaviours that guided the research process were built explicitly into all phases of the research and were thought about reflexively (Smith, 1999; Wilson, 2008). For example, Sts'ailes protocols were closely followed when approaching, speaking to, and thanking community members for participation in the research. Academic protocols were secondary to this, and were frequently adapted. The principle of relationality, that is, "we are always accountable to all our relations," was central in the way the HIPP members and researchers conducted their activities. Another guiding principle was that both the research process and outcomes must make a difference in people's lives.

The HIPP methodological process is further described in *Appendix 2* and in a paper outlining the partnership (Anderson et al., 2011).

2.2 Gathering and interpreting knowledge

Data collection in the four research areas involved both Indigenous and academic ways of gathering knowledge that included the following (Note. the four research areas – health centre and service models, non-Aboriginal providers working with Aboriginal communities, health and healing, and Sts’ailes services – are noted in the bracket):

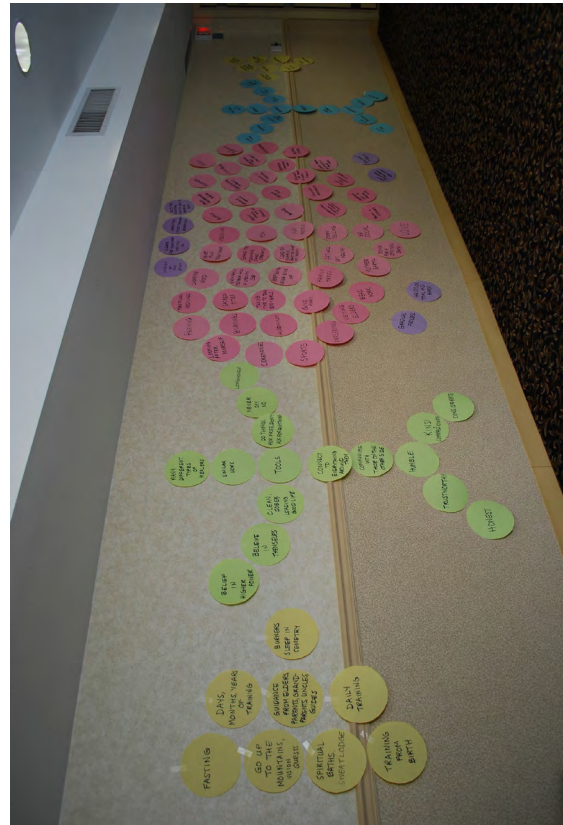
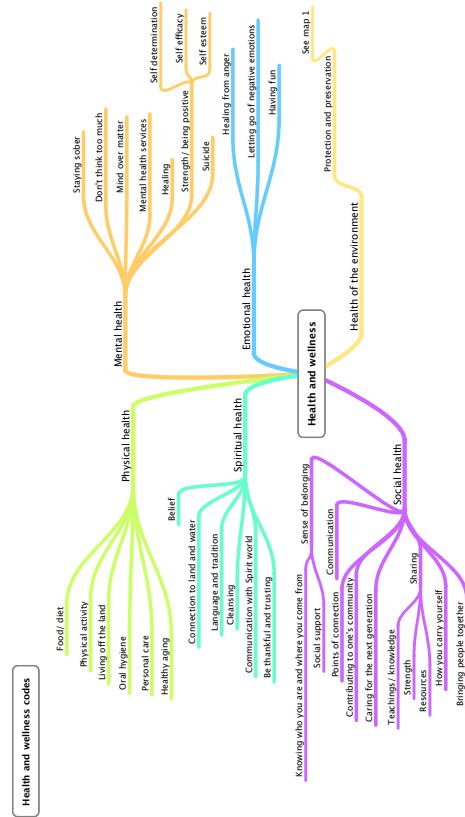
- HIPP Committee meeting notes (1,2,3,4);
- Reviews of the grey and peer-reviewed literature (1,2)
- Interviews with community elders (3)
- Focus groups with community members and key stakeholders, such as staff, Band Council, Youth and the Cultural Committee (3,4)
- Site visits to other community health centres, such as the Southcentral Foundation (3)
- Review of community health centre websites and online documents (3)
- Informal consultations with staff and community members (4)
- Review of documents regarding existing Sts’ailes health and social services (4)
- Stories (1,2,3,4)
- Ceremonies and community events (1,2,3,4)
- Field notes and reflective journals (1,2,3,4)
- HIPP research retreats (1,2,3,4)

The research process of gathering and interpreting knowledge was ongoing, iterative in nature. Information was brought forward to the HIPP committee on ongoing basis, and discussed and interpreted through the lenses of the partners. In this way, our process broadly followed the Indigenous knowledge system described by Smylie (2003), whereby “the generation of knowledge starts with stories as the base units of knowledge; proceeds to knowledge, an integration of the values and processes described in the stories; and culminates in wisdom, an experiential distillation of knowledge (...) Wisdom keepers in turn generate new ‘stories’ as a way of disseminating what they know” (p. 141). Three researchers, representing the community (community researcher), academic (research associate) and bi-cultural perspectives (research assistant), discussed individual articles and documents, and prepared research instruments, under the purview of the HIPP committee and guided by community protocols and principles discussed above.

Figure 1 below shows examples of the use of traditional and academic methods of gathering and presenting knowledge over the course this Project. The first row of pictures show the contrast between gathering knowledge through stories and spending time in the community, and conducting an academic search of the literature. The second row of pictures shows a snapshot of interview findings analyzed and presented using traditional and academic approaches.

A detailed description of the way the knowledge was gathered and interpreted is included in *Appendix 3*. Additional information on data analysis can also be found in the CIHR Research Proposal (2009).

Figure 1: Traditional and Academic Methods of Gathering and Presenting Knowledge



2.3 Validation of Findings

The validation of findings rested on the iterative nature of the research process. The three researchers worked together to prepare presentations and written summaries of preliminary findings for discussions at the HIPP committee meetings. The meetings took a talking circle format whereby everyone had a chance to speak and provide their perspectives. Sts'ailes members brought feedback on the research from the community using informal conversations with staff and community members, and formal presentations to the Chief and Council, meetings and community events. FHA staff brought feedback regarding the practical implications and interpretation of the findings from the health authority perspective. Knowledge gathered from interviews was triangulated with the research literature, focus groups with youth and the cultural committee, and lessons learned from existing community health and social services. Knowledge was further validated using protocols and principles described earlier. Further details on the validation of findings specific to each data source can be found in *Appendix 3*. A summary from a community event to share the results of the research can be found in *Appendix 7*.

3. LITERATURE REVIEW

3.1 Health centre and service models

The purpose of this section is to summarize existing literature on Aboriginal community health centre and service models in Canada and abroad. A total of 90 articles were selected based on a review of abstracts, meeting pre-specified criteria (see *Appendix 3*). The article abstracts, along with summaries, key findings, and principles, can be found in a separate data repository accompanying this Report (Attachment 1). The findings from the literature are summarized using thematic analysis. Three topics emerged from this analysis: 1) Key factors in the development of health models, services, and programming; 2) Traditional healing, medicine, and protocols; and 3) Integration of Indigenous and Western models in Primary Health Care. Themes are discussed under each topic area.

3.1.1 Key factors in development of health models, services, and programming

The first overarching topic identified in the literature was that of key factors and/or best and promising practices that have been found critical in the development and provision of health models, services, and programming to Aboriginal communities. The key themes in this topic area are summarized below.

Indigenous frameworks, methods, and knowledge

While the majority studies discussed models or programs that incorporated both Western and Aboriginal approaches to care, the literature emphasized the need for Aboriginal philosophy, frameworks, methods and knowledge to underlie and guide programming. Programs used Indigenous frameworks, methods and knowledge in different ways and contexts:

- *Medicine wheel* underlying program philosophy and vision
- *Community and cultural protocols* to guide program delivery and staff interactions
- Hiring and training of *Aboriginal health workers*
- Development and use of *traditional wellness indicators* that capture cultural and local conception of health
- *Traditional healing and medicines* (used both as primary and complementary care)
- Prominent role of *elders* (e.g., in program design, delivery or as advisories)
- Acknowledgement of *history* in programming

A review by Awo Taan Healing Lodge Society of Aboriginal models of wellness based on a series of Canadian facilities identified best practices that accounted for the effectiveness of programs delivering care to Aboriginal people (2007). Best practice models were those based on an Aboriginal worldview of healing and wellness, where traditional teachings and practices provided “a framework from which all programs and services are developed and delivered.” Another key factor to the programs’ success was to acknowledge the impact of Aboriginal peoples history on individuals, families and communities, with the view to empower people to find community-driven solutions.

A First Nations Health Society's BC environmental scan of best practices of traditional models of wellness provided a series of examples of how traditional medicine practices are successfully incorporated into health services and programs (FNHS, 2010). These included the use of the medicine wheel into programs, prominent role of elders and healers in meetings and gatherings, incorporating traditional gatherings, ceremonies and prayers into programming, and linking clients with elders to address specific their needs. Traditional models of wellness were defined by First Nations community respondents as "having a healthy mind, body and spirit," where wellness encompassed a person feeling well emotionally, physically and spiritually and leading a healthy lifestyle, which in turn involved connection to the land and one's culture and beliefs (Ibid).

In a study of a substance abuse treatment centre in the Canadian north (Gone, 2011), Western and Aboriginal approaches were consolidated "into a coherent therapeutic endeavor through the subsuming of these diverse modalities within the overarching philosophy of the medicine wheel." Similarly, in a review of the literature regarding traditional knowledge and medicine, Martin Hill (2009) suggested that the success of strategies for Aboriginal communities relies on an integrated approach to community health services that support traditional medicines and practices within culturally sensitive environments, where "the interconnection of land, language and culture are the foundation of wellness strategies." Multiple other papers (e.g., Anderson, 2006a&b; Ratima et al., 2006; FNHS, 2010) discussed the need for culturally and locally relevant understandings of health, and with it – the importance of traditional wellness indicators – as a base for health planning and delivery.

In summary, the use Aboriginal frameworks, methods, and knowledge, is a critical factor in development of successful health models, services, and programming for Aboriginal people and communities.

Community building, control and ownership

Programs that strengthened community building, control and ownership over health services was another best practice theme identified in the literature. Key factors to the programs' success were that programs are developed by Aboriginal people for Aboriginal people (Awo Taan, 2007), rest in culturally and locally relevant understandings of health (Anderson 2006a&b), and increase community capacity in terms of workforce

education and training (Jackson et al., 1999; Wilson, 2007). In a study of effectiveness of a community-directed healthy lifestyle program in a remote Australian Aboriginal community, Rowley (2006) concluded that community control and ownership is needed for effective strategies. There, community control and ownership enabled embedding and sustainability of the program, in association with social environmental policy changes and long-term improvements in important risk factors for chronic disease. Finally, community capacity building is identified as one of the key guiding principles of the FHA in building partnerships with Aboriginal communities in the region (FHA, 2006 & 2011).

Integrated care – the complete Circle of Life

The theme, broadly classified as integrated care, encompasses a series of practices and approaches to the successful design and delivery of health models and programs in Aboriginal communities. In a report summarizing the recommendations of the Aboriginal Mental Health Committee and best practices in the area of Aboriginal mental health, Smye and Mussel (2001) concluded that services must be integrated, that is "complete the 'Circle of Life'." This theme was reinforced in the literature in a variety of health areas and implemented in variety of ways, including:

- *Integrated care, governance, teams, models, and service provision – across lifespan* (e.g., Kyba, 2010; Maar, 2004; Maar & Shawande, 2010; St. Pierre-Hansen et al., 2010)
- *Holistic, wholistic, and inclusive approaches* (e.g., Awo Taan, 2007; Gottlieb et al., 2008; Martin Hill, 2009)
- *Inter- and multi- disciplinary care, teams, and collaboration* (Benoit et al., 2003; Purden, 2005; Dobbelsty, 2006; Maar & Shawande, 2010; Walker et al., 2010)
- *Integration of traditional Indigenous and Western medical practice, and integrative medicine* (e.g., Napoli, 2002; Cook, 2005; Walker et al., 2010)
- *Non-verbal communication, taking time, openness and informal service delivery* (e.g., Benoit et al., 2003; Shahid et al., 2003; Purden, 2005)
- *Non-hierarchical staff structure, and participatory approaches* (e.g., Macauley, 1997; Benoit et al., 2003; Petrucka et al., 2007; Smylie, 2001b)
- *Partnerships of empowerment in restoration of culture and wellness strategies* (e.g., Martin Hill, 2009).

For example, in an examination of Noojmowin Teg – an Aboriginal Health Access Centre in Rural North Central Ontario – integrated service provision based in Aboriginal and non-Aboriginal methods and providers offered seamless, holistic, community based care, and strengthened community health empowerment (Maar, 2004). The success of the Sheway program in Vancouver has been attributed to factors, such as: a multi-disciplinary team; a non-task-oriented philosophy of care; provision of food and opportunity to socialize; establishment of trust with staff and volunteers; provision of a safe, encouraging and supportive environment; a fluid and informal service delivery model; a collective, non-hierarchical staff structure; and horizontal relationships between staff and clients (Benoit et al., 2003). In this and other studies, Aboriginal people expressed a desire for models of care that address their concerns in an integrated manner, and where they are given the opportunity to shape and influence decision-making about services (Ibid). Such an approach has been implemented on a large scale in the case of the Alaska Native Health Corporation, which is customer owned and managed. The principles underlying its health service operations are based in integrated primary care teams, relationship building, whole-system approach, and are customer driven (Gottlieb et al., 2008).

Approaches to integrated care described in the literature were both formal and informal. Formal approaches include governance models that take an integrative lens to service provision and team structure, including interdisciplinary protocols and training (St Pierre Hansen et al., 2010; Walker et al., 2010). Informal approaches included a culture of listening and taking time (Levin & Hervert, 2004), openness and inclusiveness (Purden, 2005), and using ceremony as a foundation for discussion (Indigenous Physicians Association of Canada, 2009). The key recommendation across the literature is to build-in adequate formal and informal mechanisms, so that relationships between staff, and between health practitioners and patients from different cultures and traditions are equitable, participatory, and grounded in the understanding and respect for each others' roles and strengths (e.g., Shahid et al., 2003; Smylie, 2001b).

Holistic care, cultural safety and competence

The theme of holistic care, cultural safety and competence was one of the most prominent best practice themes in the literature, encompassing aspects, such as:

- Holistic conceptions of health, with a strong focus on spiritual healing
- Holistic approaches to care and healing
- Importance of culture and cultural identity in healing
- Access to culturally-appropriate and culturally-relevant services
- Cultural safety and competence training
- Inter-cultural communication and cultural awareness (by non-Aboriginal practitioners)

Multiple studies identified the need for holistic healing and programs that address spiritual, physical, mental and emotional components of health as an essential component of providing care to Aboriginal people. Awo Taan Healing Lodge Society review of best practice models of wellness discussed the importance of working with the whole person, and considering all aspects of their personal development – spiritual, mental, physical and emotional – but also environmental factors (Awo Taan, 2007). This notion is perhaps best described in a 2002 study of integrated care models for native women by Napoli, who states:

“An understanding of Native traditions, such as prayer, storytelling, and ceremonies, along with an understanding of the importance of body, mind and spirit, are integral components of treatment. We cannot separate ourselves into parts; we are part of a whole and, from a health perspective, need to be treated as a whole person.”

Importantly, the literature describes holistic care as inseparable from culturally relevant care, recognizing the importance of culture and cultural identity to healing (e.g., Sinclair, 2006; Smye & Mussel, 2001). In the BC environmental scan of traditional models of wellness, holistic health care is defined as an integrative approach that balances, the mind, spirit and body, and rests in traditional ways, practices and culture (Kyba, 2010). Culturally relevant care is also seen as key to knowledge translation in Aboriginal communities (Hanson & Smylie, 2005).

Improving access to culturally appropriate services remains a top priority of the Fraser Health Authority (FHA, 2006 & 2011). It also represents the second prominent aspect of this broad theme in the literature, with key concepts of cultural safety and competence. The term “cultural competence” is often used interchangeably with terms such as cultural sensitivity, cultural awareness, and cultural safety. Petrucka et al. (2007) provided a summary of the literature on cultural competence in the context of providing care in Aboriginal communities. They borrowed a definition from Campinha-Bacote (1988), where cultural competence refers to an ongoing process of “seeking cultural awareness, cultural knowledge, cultural skill, and cultural experiences,” a definition that has since been extended to behaviours, attitudes, and policies adopted by the system, agencies or professionals. When applied to working in Aboriginal communities, culturally competent care has three attributes: cultural appropriateness, cultural accessibility, and cultural acceptability (Petrucka et al., 2007).

The literature discussed cultural competency in a number of ways, but frequently focused on providing adequate training for non-Aboriginal health practitioners to provide effective care to Aboriginal people (e.g., Coffin, 2007; Van Wagener et al., 2007; St. Pierre Hansen et al., 2010). In this context, discussions often focused on cross-cultural patient safety, with practice guidelines for non-Aboriginal physicians and health practitioners. These included:

- Communicating in a culturally sensitive and empathetic manner; acknowledgement and respect for Aboriginal family structures, culture and life circumstances; an understanding of the significant role of non-verbal communication; and the importance of history, land and community (Shahid et al., 2003)
- Speaking less, taking more time, and being comfortable with silence (Kelly & Brown, 2002)
- Taking time and listening to patients; understanding the Aboriginal worldview (Levin & Hervert, 2004)
- Improving communication with Aboriginal patients by learning about their history, building trust and giving time (Towle et al., 2006)

In other studies, communication style, while important, constituted only a part of culturally competent care. For example, in a study of sources of miscommunication between physicians and Aboriginal patients in the Yolngu

language group in a suburban Australian community, Cass et al. (2002) found a series of systemic barriers to communication, including: lack of patient control over the language, timing, content and circumstances of interactions; differing modes of discourse dominance of biomedical knowledge and marginalization of Yolngu knowledge; absence of opportunities and resources to construct a body of shared understanding; cultural and linguistic distance; lack of staff training in intercultural communication. For Napoli (2002), holistic, culturally competent care is “the path of transformation for both/ provider-patient relations,” pointing to the importance of addressing the underlying power relations.

Similarly, Walker et al. (2009) described cross-cultural patient safety as needing a broader, systems-based policies and practices, where cross-cultural patient safety occurs through: building a culturally-integrated organization; developing culturally-congruent staff; requiring and supporting culturally competent practice; the effective delivery of health care services; across barriers to understanding and identifying patient or client needs; by surmounting obstacles to implementing prescribed remedial or supportive actions. As aptly put in a later article, “genuine cross-cultural competency in health requires the effective integration of traditional and contemporary knowledge and practices” (Walker et al., 2010).

In sum, the literature described holistic, culturally competent care as one of the cornerstones of best practices in providing care to Aboriginal people and communities, with many authors challenging practitioners and organizations to change the underlying structures and models of care. Many of the proposed solutions lie in utilizing Indigenous frameworks, models and knowledge, and providing integrated care, as discussed above. Dr. Kyba’s 2010 review of traditional models of wellness in BC provides numerous examples of ways in which traditional medicines and practices can be successfully integrated into health programs to provide holistic, culturally competent care, including:

- The medicine wheel being integrated into all programs
- Healers and elders attending important meetings or gatherings (especially where they were able to have funded roles in their health centers)
- Opening and closing prayers

- Incorporating traditional medicines, feasts and ceremonies
- Holding a sweat at least once a week
- Having gatherings where they shared and gave people a chance to talk and teach
- Having sessions with community members and staff to learn about traditional medicines in the health center
- Promoting use of traditional medicine, and linking clients with elders that had appropriate skills to address their needs.

Addressing the underlying causes of health and wellness

Another theme identified in the literature was that health models and services should address the underlying causes of health and wellness, and improve the health outcomes of Aboriginal people (e.g., Awo Taan, 2007; Petrucka et al., 2007; FHA, 2006 & 2010; OAHAC, 2010). Some of the key factors in addressing the underlying causes of health and wellness included community resilience (Kirmayer et al., 2009), economic self-determination and education (BC PHO, 2010; FHA, 2010), historical and intergenerational trauma (Martin Hill, 2009), and cultural congruity (OAHAC, 2010). In many studies, the interconnection of land, language and culture was seen as the foundation of wellness (e.g., Martin Hill, 2009), pointing to the need for inter-sectoral approaches to address the underlying causes of wellness, such as environmental health and education.

Other guiding principles

A series of additional guiding principles in the development and provision of health models, services, and programming were identified throughout the literature, including:

- Strength-based (i.e., recognizing strength as the foundation for healing)
- Safe and sustainable
- Responsive (e.g., same day access)
- Community governed and driven
- Community and family oriented

In conclusion, the five themes that emerged in this topic area provide guidance as to the key factors, and best and promising practices that are critical in the development and provision of Aboriginal health models, services, and programming.

3.1.2 Traditional healing, medicine, and protocols

Background

Over the course of the research, the prominent topic of traditional healing, medicine, and protocols emerged. Sts'ailes and FHA decision-makers indicated a series of research questions to guide thinking and decision-making regarding the development of a health centre in Sts'ailes, including: How are healers recognized and selected? What are the models of remuneration and ongoing support for healers? How do healers work within a collaborative health provider team setting? What are the strengths and weaknesses of healing protocols? These questions guided a focused literature review, which is summarized below. Additional information regarding traditional healing was gathered in interviews with Sts'ailes elders, and can be found in chapter 4 of this Report. In both instances, the project team conducted a thematic analysis of the information gathered, verified through iterative discussions with HIPP members.

Traditional healing and medicine as a means to restoring health

In recent years there has been a growing recognition of and movement towards the development of health care models that utilize Indigenous knowledge and traditional medicine as a means to restoring health (see Journal of Aboriginal Health Special Issue on Traditional Medicine, Vol. 6, Issue 1, 2010). One key resource on traditional medicine in Canada is Martin Hill's 2003 report, which discussed contemporary issues in traditional medicine, and clarified terminology. Traditional healing has been described as a path of transformation for both the client and the health practitioner and an ongoing journey (Napoli, 2002; Martin Hill, 2009). Traditional medicine and knowledge cannot be isolated from a way of life, as intervention and prevention are not based in curative medicine, but are an integral part of one's life:

"Traditional medicine is connected to all spheres of human activity; it is a way of life. Traditional medicine should not be reduced to a moment of interaction between healer and individual and a "treatment". Rather, healing is an ongoing journey" (Martin Hill, 2003).

Importantly, traditional medicine has an intricate relationship to land, language, and culture reflects the geographic and cultural diversity within Indigenous knowledge (Ibid).

A number of studies investigated traditional healing practices in clinical settings and health services in Aboriginal communities in Canada (e.g., Maar & Shawande, 2010; Skye, 2010; Walker et al., 2010). In BC, the 2010 environmental scan of traditional wellness models found that the majority of community respondents incorporated traditional medicines and practices into their health programs in a variety of ways. As many as 66% stated that they have traditional healers practicing in their communities and 33% stated that the traditional healers operate through their health centres (Kyba, 2010). Respondents defined a traditional healer is somebody with knowledge in traditional ways, practices and culture (Ibid).

An environmental scan of the First Nations Health Society (2010) found that the majority of First Nations community respondents view wellness from a traditional perspective, meaning “having a healthy mind, body, and spirit” and being connected to the land, and one’s culture and beliefs. Respondents said that maintaining wellness involved carrying out traditional practices, such as fishing, hunting, berry gathering and participating in healing circles, sweats, drumming and learning the language. Identity and connection to culture were seen as integral to maintaining wellness from a traditional perspective (Ibid). This theme was reinforced in a review of traditional medicine and restoration of wellness strategies, with traditional medicine acting as a pathway to both empowerment and health for communities, and culture and language seen as central components to its practice (Martin Hill, 2009).

Traditional healing and medicine in health care settings

A prominent theme identified in the literature on traditional healing and medicine provided in primary health care settings was that of a tension between providing safe and high standard care, and the fear of appropriation of traditional knowledge and practices (NAHO, 2006). On the one hand, many studies discussed comprehensive integration of traditional practices, spanning governance, patient and client supports, and protocols, among others, as foundational to the success of programs and services. In fact, Maar and Shawande (2010) suggested that integration of biomedical and Indigenous healing practices can deepen providers’ understanding of their clients and enhance the wholistic approach to client care. On the other hand, many emphasized the need to protect traditional knowledge from exploitation

and appropriation, recognizing that certain aspects of traditional knowledge are sacred and should be protected.

The 2010 report of the First Nations Health Society provided a series of examples of how traditional medicine practices can be incorporated into health services and programs. It also identified key issues and barriers to sharing traditional knowledge. These included:

- Trust and communication: being able to review research before it is published
- Some feel medicines should be private and protected
- Concern about commercializing knowledge
- How the information will be used by the funders
- Getting information returned to the communities.

Similarly, the 2008 paper by NAHO presented three case studies from Canada, illustrating unique approaches to traditional knowledge and medicine. The authors concluded that “respect for, and use of, Indigenous knowledge and practices in the development and implementation of public health programs can only hope to succeed if the holders of that knowledge are allowed to define the how, when, where, who, what and why of its utilization in the best service of Aboriginal peoples.” In general, recognition, monitoring, and credibility of traditional healers are determined by the community (Maar & Shawande, 2010).

The literature identifies the need to educate non-Aboriginal health care providers about Indigenous healing in order to foster respect of it and to establish trust between Indigenous patient, non-Aboriginal practitioners from the Western biomedical tradition and Indigenous healers (e.g., Struthers et al., 2008). In a study of traditional Mi’kmaq medicine, the majority of Mi’kmaq patients surveyed have used traditional medicine in addition to Western medicine; however, they did not discuss this with their physicians (Cook, 2005). Aboriginal clients may feel uncomfortable discussing traditional healing options with non-Aboriginal providers (Maar & Shawande, 2010) or feel the physician will not understand or will disapprove (Cook, 2005). In a study of Anishinabe men healers, healers felt that non-Aboriginal practitioners often did not understand or respect the efforts of traditional healers (Struthers et al., 2008). They felt that non-Aboriginal practitioners are good at what they do, and have the ability to “touch on the mind... touch on the body... but very, very seldom do they understand the

spirit” (Ibid). The study suggested that non-Aboriginal practitioners should be aware of traditional healing to facilitate the use of traditional healing practices as part of the health care regimen. Maar and Shawande (2010) proposed an integrated interdisciplinary approach to care, which includes coordination between interdisciplinary team members, allows shared responsibility, and ensures that healers are not working in crisis mode in response to their clients’ needs.

In order to facilitate the use of traditional healing and medicine, and increase collaboration between non-Aboriginal practitioners and traditional healers, the Indigenous Physicians Association of Canada (2009) made a number of recommendations:

- Place equal value on Indigenous knowledge and traditional medicines in statements and policies
- Provide support for environmental work of elders and healers (i.e., non-health)
- Recognize Indigenous understandings of health
- Doctors should build personal relationships with elders and healers
- Make referrals to elders and healers as much as possible, and make an effort to be aware and informed on their patients openness to, and use of, traditional healing practices or medicines
- Utilize ceremony as a basis for discussions and relationship building
- Commit to learning the language of their nation or of the communities that they serve
- Provide training and professional development on Indigenous knowledge and traditional medicines for medical students and physicians

The literature identified a number of other issues that need to be taken into account and considered for the successful use of traditional healing and medicines in health care settings. It is recommended that these be discussed at a community level, with input from elders and healers, and in line with community protocols (Martin Hill, 2003; Maar & Shawande, 2010):

- Authenticity and authority of healers
- Recognition, monitoring and credibility of healers
- Funding and remuneration for healers
- Impact of policy on traditional medicine
- Protection traditional medicine, and intellectual property rights

“Provision of traditional healing services in the new cultural setting of a health centre requires much groundwork, because traditional healing practices have evolved based on Aboriginal cultural frameworks, not Western primary care models. It is important to understand that each community and each individual is unique with respect to their expectations, familiarity and level of comfort with traditional Aboriginal medicine. Community consultations may be held to develop guidelines for service provision. Challenges include strain on staff and high staff turn over rates; fitting intergenerational trauma, cultural identity, and language loss into a biomedical model of illness; some staff being unfamiliar with the community and the culture; demand for Aboriginal health professionals heavily outweighing their availability; unrealistically high community expectations of Aboriginal staff; regulation of traditional healers.”

—Maar, 2004

In sum, “an educational space must be created for Western biomedicine and traditional medicine to learn together. The key is to continue the dialogue with Elders and healers and act on their recommendations and continue to seek their expertise and wisdom” (Martin Hill, 2003).

Healing protocols and guidelines

The tension between providing a safe and high standard care and protection of Indigenous knowledge and practices was also present in discussions of healing protocols and guidelines. On the one hand, the development of traditional healing guidelines was seen as an essential element for the successful integration of Aboriginal and Western models in health services (Maar & Shawande, 2010). On the other hand, some examples from New Zealand warned against the appropriation of Indigenous practices into biomedical systems, whereby traditional healers and practitioners may become accountable to external parties and requirements rather than their own people and communities (Mara Andrews, 2011, Retreat Presentation). Drawing on lessons from native communities around the world (e.g., Amazon, New Zealand, the Philippines), studies from Canada recommended that guidelines for healing programs are developed by individual organizations in local contexts, with discussions with elders, respecting local healing practices, and taking into account contemporary contexts (Aboriginal Healing and Wellness Strategy (AHWS), 2002; NAHO, 2006).

The literature recommended (AHWS, 2002; NAHO, 2006; Maar & Shawande, 2010) that the following issues be addressed in traditional healing guidelines and protocols:

- Guiding principles of a traditional healing program
- Recognition of traditional people and medicines
- Acknowledgement and recognition of traditional healing
- Appropriate and respectful ways and protocols of accessing a traditional healer
- The appropriate offerings and/or payment for the healer and helpers, including gifts
- Storage and handling of medicine
- Protocols for dealing with inappropriate behaviour, practice, and abuse
- Standards and ethics, including protocols for breach of ethical conduct
- The roles and responsibilities of all people involved in the patients care
- Protection of traditional healing practices
- Relationship between traditional and Western medicine

- Use of traditional language
- Expectations of those seeking traditional healing
- Complaints resolution processes
- Development of a traditional healing committee
- Protocols for revision of traditional healing program guidelines
- Considerations for establishing traditional healing services in health delivery organizations (e.g., safety and security of clients; ongoing educational opportunities; traditional role of healer; staff roles and relationships)

Two key documents provided guidance on addressing many of the above issues. First, the Aboriginal Healing and Wellness Strategy (2002) released draft guidelines for traditional healing programs, including an example of guidelines of a local health centre. Second, the NAHO Haudenosaunee Code of Behaviour for Traditional Medicine Healers (2006) discussed codes of behaviour, including a series of guiding principles, drawing from international examples. The Haudenosaunee Code of Behaviour can be found in *Appendix 4*. Importantly, these documents should be viewed as frameworks for discussions at a community level to develop community-appropriate guidelines in discussions with elders and traditional people (AHWS, 2002).

3.1.3 Integration of Indigenous and Western Models in Primary Health Care

The issue of whether and, if yes, how Indigenous and Western models can work together represents the third overarching topic identified in the literature. Many studies discussed the importance of collaboration between Indigenous and Western approaches to health as “best of both worlds”; however different authors proposed different means to this end. Some focused on trust and relationship building, as well as the importance of the concept of ethical space – “a space of possibility that emerges when two groups with distinct worldviews engage with one another in mutual collaboration and respect, creating new channels for dialogue between the groups” (Smylie, 2006). Others viewed respect and recognition for traditional knowledge as key to its integration with other knowledge systems (Turner, 2009). On the other hand, some authors discussed the dichotomy of values between the two systems, and the differences in approaches between traditional medicine and biomedicine

(e.g., Gurley et al., 2001; Cook, 2005; Sinclair, 2006; Martin Hill, 2009). Still, for them the two systems have different strengths and weaknesses: rather than choosing “one or the other,” they perceived the different systems of care to address different problems.

Studies by Walker et al. (2010) and Skye (2010) provide examples of the successful integration of Indigenous and Western biomedical approaches to improve the health of communities. In both cases, integration of the two systems was based in an explicit recognition and validation of Indigenous knowledge and epistemologies of health in providing health services, rather than integration “into” another system. As explained by Skye (2010), what the article advocates is “not a fusion of modern science and Indigenous knowledge, but systems that acknowledge both knowledge systems for their strengths, and utilize those qualities to best meet the holistic health care needs of Aboriginal peoples.” Similarly, Lavalle and Poole (2010) warned against programs that are based on Western knowledge “with some modifications made for Indigenous peoples.” They argued that health models should recognize that Indigenous peoples have their own knowledge systems that can augment, extend and ultimately strengthen the Western approach.

The research literature provided a series of recommendations and guiding principles for the integration of Indigenous practices and traditional medicine in primary healthcare settings (Jackson et al., 1999; Ahuriri-Driscoll et al., 2008; Indigenous Physicians Association of Canada, 2009; Kyba, 2010). Recommendations included: place traditional medicine and healing at the centre of interventions; acknowledge Aboriginal health workers for the unique role they play; provide moral and practical support for the role development of Aboriginal health workers; view Aboriginal health as a discipline area in its own right, and one that must be placed firmly under the care and control of Aboriginal people; provide a prominent role to healers and elders in meetings and gathering (funded if possible); open and close with prayers; hold sweats and gatherings;

and provide learning opportunities about traditional medicine, and promote its use. Guiding principles are summarized below:

- Traditional basis for healing activity
- Relevance to current day
- Accessibility
- Demand
- Development of an integrated body of knowledge to rationalize treatment
- Training of practitioners
- Establishment of internal arrangements for maintaining excellence
- Openness to other approaches
- Guarantee of no harm, accountability, and liaison with the other parts of the sector
- There must be acknowledgement and acceptance of the validity of Indigenous knowledge by the dominant culture

After reviewing the literature, the HIPP committee held focused discussions as to whether and how Indigenous and Western models can be integrated into a new primary health service model. The result of these discussions were multiple discourses with respect to the blending of various traditions: some advocated the “best of both worlds” approach, and others argued that Sts’ailes culture and traditional knowledge are predominant, with other knowledge systems complementing model and program development. The group reviewed various documents on Sts’ailes health and social services, and discussed existing examples of integration in the community to understand how it is already occurring, including how different ways of knowing are being used, and what protocols and stories are used to support it. This experience suggests that the process of bringing together various knowledge and cultural traditions occurs in different forms depending on issue or context. The lessons learned from the strengths and knowledge within existing community structures are summarized in in chapter 5 of this Report.

“Making integrated services feasible took initiative, dedication, desire, and a commitment on the part of boards, staff and partner agencies to collaborate through a process of consensus to make things work for everyone involved (...). A formal approach to community capacity building is needed. Benefits of integrated services include seamless, holistic and community-based services for the clients; better access to specialized services at the community-level; and improved team process and capacity building for health centre staff. A key component of integrated services is the clients’ choice between Western and traditional Aboriginal health services, or a combination of both.”

— Maar, 2004

3.2 Non-Aboriginal providers working with Aboriginal communities

The purpose of this section is to summarize existing research literature regarding health and healing in the context of non-Aboriginal providers working with Aboriginal communities. The search of peer-reviewed literature found 32 relevant articles based on titles, of which 18 were relevant based on abstracts. The literature review was conducted with an Aboriginal wellness lens, with the findings are grouped into key themes below.

You’ve got to see us, you’ve got to hear us, you’ve got to feel us

A key theme consistent across the literature (Cunningham & Wollin, 1998; Dobbeltstyn, 2006; Foster, 2006; Towle et al., 2006; Shahid et al., 2009) was the importance for health care providers to understand and value the historical, social, cultural, political, geographic, and economic contexts of Aboriginal individuals and communities (see Appendix 5). This was also closely linked to the health provider’s willingness of working in Aboriginal communities. For example, in a cross-sectional survey of an urban cohort of family medicine residents, Larson et

al. (2011) found that inadequate knowledge of Aboriginal culture was the primary barrier to residents working with Aboriginal peoples. In contrast, residents with some exposure to Aboriginal issues were more likely to intend to work in Aboriginal settings. Nursing students, too, can benefit from clinical practice in Aboriginal communities by increasing their understanding of the cultural, historical, geographic and socio-economic contexts, strengthening cross-cultural skills, and experiencing a positive shift in attitude toward Aboriginal people (Cunningham & Wollin, 1998). Levin and Herbert (2004) found that for many health care providers the only interactions with Aboriginal patients were in difficult situations when the patients were in distress, which served to reinforce the providers’ negative attitudes. However, providers with experience of working in Aboriginal communities were able to challenge these views and witnessed the strength and well-being of Aboriginal peoples. In sum, living and working in Aboriginal communities can help providers develop a deeper understanding of the contexts of their practice in providing care to Aboriginal people (Browne, 2007).

Training in cultural awareness, cultural competency, cultural safety and cross-cultural communications was one of the top recommendations by and for health care providers in Canada and Australia working with Aboriginal patients (Cass et al., 2002; Browne, 2005; Coffin, 2007; Castleden et al., 2010). Foster (2006) recommended that employers increase their focus on culture in the hiring and management processes. While health care providers can benefit from training opportunities provided by employers (e.g., online packages and workshops), possibly the most important

learning occurs through experience in the community. By being involved in the community (e.g., attending cultural gatherings), health care providers can not only build better relationships with their patients, but also increase their own understandings of the local Aboriginal culture (Foster, 2006). Cultural training and

“Unfortunately, many health care providers have encountered Aboriginal people only when they are in the most difficult situations and are most vulnerable. As a result, negative stereotypes have become firm attitudes. Others, who have actually worked in Aboriginal communities, may have had the opportunity to know many health and happy Aboriginal people, so will bring a somewhat different perspective.”

— Levin & Herbert, 2004

community-based learning can enhance non-Aboriginal practitioners’ knowledge of, respect for, and perceptions

"If health care is to be accessible, then it must be culturally appropriate. In Aboriginal communities, culturally appropriate care means that nurses must not isolate physical and mental issues but consider the entire picture of a person, including spirituality, emotions, culture and history."

—Foster, 2006

of Indigenous peoples, knowledge, practices, medicines, and cultures. This theme, which has been written about by many researchers throughout many peer-reviewed articles, can be expressed in one simple yet powerful teaching from Virginia Peters, Health Director of Sts'ailes: "You've got

to see us, you've got to hear us, you've got to feel us." It is critical for health care providers to know the community they work with, to understand who they are and where they come from, and to take the time to build trusting relationships.

Everyone has a gift

The theme that "everyone has a gift" highlights the need to acknowledge and address conflicting worldviews underlying Indigenous and Western approaches to

"Achieving cultural security is about the meeting of two different approaches in health, the Western definition and the Aboriginal definition, to achieve the desired outcome of improved health status."

—Coffin, 2007

health and well-being. Researchers have acknowledged that non-Aboriginal health care providers are subject to widespread (and often negative) assumptions about Aboriginal peoples that exist in mainstream society (Browne, 2005; Foster, 2006). Within the health care setting, multiple

power differentials exist that disadvantage Aboriginal peoples: the biomedical model is valued over Indigenous knowledge and methods of healing (Browne, 2007), and non-Aboriginal health care providers assert dominance over Aboriginal patients (Tang & Browne, 2008). Power differentials and devaluing of Aboriginal knowledge and culture creates a barrier for Aboriginal patients to receive culturally competent and safe care (Petrucka et al., 2007), as shown in Appendix 6. Tang and Browne (2008) reflected on the predominant belief in the Canadian

health care system that "everyone is treated equally" and question whether this approach is appropriate to respond to inequities and racism within the health care setting. Rather, the teaching "everyone has a gift" can empower health care providers and patients to confront conflicting worldviews and beliefs, and come to understand and respect everyone's gifts they bring to the health care setting.

One mind, one heart

While the theme of 'everyone has a gift' celebrates the unique knowledge and perspectives that Aboriginal and non-Aboriginal worldviews and epistemologies

"Aboriginal health workers and elders in the communities are the health system's greatest resource."

—Coffin, 2007

have to offer, the theme of "one mind, one heart" acknowledges the strength of uniting those different perspectives together in the health care setting. Across the relevant literature, there was a common theme of the importance and benefit of inter-

professional interactions and multi-disciplinary teams within the Aboriginal health care setting. For example, non-Aboriginal nursing students in Australia increased their knowledge and culturally safe practice by working on teams with Aboriginal health workers (Cunningham & Wollin, 1998). Through these interactions, nursing students developed cross-cultural skills and experienced a positive change in attitude toward Aboriginal people, and benefited from improved professional relationships with Aboriginal health workers (Jackson et al., 1999). These improved professional relationships were achieved through learning more about one another's roles, deconstructing power differentials, and promoting skill sharing through which Aboriginal health workers learned more clinical skills from the nurses while nurses gained understanding of the cultural and spiritual contexts of Aboriginal health care practice.

Employing more Aboriginal health workers in the care setting has been found to improve access for Aboriginal patients (Shahid et al., 2009). Findings from Canada also support the approach of fostering inter-professional collaborations. Levin and Herbert (2004) surveyed Aboriginal Canadians accessing care in an urban setting and found an unanimous support for increasing the number of Aboriginal health care professionals and

promoting designated spots for Aboriginal students in training programs to promote more interactions and learning between Aboriginal and non-Aboriginal health care professionals. Purden (2005) found that non-Aboriginal health students benefited from classroom and clinical opportunities to work with and learn from Aboriginal health professionals. Purden recommended promoting culturally competent practice through bringing Aboriginal and non-Aboriginal practitioners together to collaborate and blend ideas and perspectives, suggesting that this reciprocal learning is beneficial to the health care professionals, but also the patients and communities receiving care.

Lifelong learning

The final theme that emerged from the literature was the significance of non-Aboriginal health care providers recognizing their practice with Aboriginal individuals and

communities as a personal journey of lifelong learning. To optimize the learning along this journey, researchers have recommended that health care providers develop

“Developing cross-cultural communication was difficult and took years, if not forever. Understanding Native communities changed physicians. They described a journey of self-examination, development of personal relationships, and rewards and frustrations.”

—Kelly and Brown, 2002

strategies to reflect on their own beliefs and assumptions, as well as the new perspectives they develop through their practice and interactions with Aboriginal patients (Browne, 2005; Foster, 2006). Smylie (2001) encouraged ongoing self-education and assessment for providers to better meet the needs of their Aboriginal patients. Cunningham and Wollin (1998) suggested that the earlier the health care provider starts training and working with Aboriginal communities, the better recruitment and retention of providers. By embracing the journey of ongoing learning, health care providers can experience fulfillment through their own personal growth, the personal friendships they form, sharing in the successes of their patients, and their acceptance within the community where they practice (Kelly & Brown, 2002).

In conclusion, non-Aboriginal health care providers who provide care to Aboriginal patients and communities can experience greater learning and fulfillment and provide better care to Aboriginal people and communities if they follow and respect four basic teachings: *You’ve got to see us, you’ve got to hear us, you’ve got to feel us; Everyone has a gift; One mind, one heart; and Lifelong learning.*

3.3 Health centres summary

This section summarizes information on select health centres, which were reviewed part of the Project. In total, online information for 11 centres was reviewed: 10 from across Canada and 1 from Alaska, USA. Websites for two additional centres, Anderson Creek Health Centre (BC) and Inuulitsivik (QB) were reviewed, but were not included in the Report due to limited online information available. In general, the health centre summaries are limited by the type and amount of information available on the centres’ websites, and have not been validated with other sources.

The centres described varied in size, type of services provided, size of population served, location (including rural/ urban), and funding arrangements. The summary provides a general overview, focusing on types of services and examples of integration of Western and traditional practices and programming. More detailed descriptions of the centres and their services, including centre vision, mission, and guiding principles, can be found in a separate document accompanying the Report (Attachment 2).

Nisga’a Valley Health Authority (New Aiyansh, BC)

Overview

The Nisga’a Valley Health Authority (NVHA) operates a diagnostic centre at New Aiyansh, BC, and satellite clinics in the other villages providing physician services, home care, cultural community health representatives, and the administration of non-insured health benefits to meet the needs of clients in K’alii-Aksim Lisims (the Nass Valley). The NVHA is responsible for creating and maintaining facilities and promoting medical and public healthcare programs. The NVHA is “built on Nisga’a culture, and traditional healing practices teaching that listening, learning, and choosing healthy lifestyles result in health of mind, body, and spirit” and is “committed to collecting and sharing the traditional wisdom of Nisga’a

Elders pertaining to overall health and vitality, striving to integrate these traditional ways with present day practices.”

Programs and services

The NVHA offers primary health clinical services, including physician services, public health services, dental services, and psychology services. In total, six doctors are on staff and a visiting psychologist, with three doctors working rotation shifts. In addition to primary health clinical services, the NHHA provides community health and preventative services in a range of areas: Public Health, Home Support & Resident Care, Cultural and Community Health, Mental Health and Wellness, and Youth Enrichment.

Integration of Indigenous and Western approaches to health and healing

The NVHA philosophy states that in keeping with the vision of “healthy minds, healthy bodies, healthy spirits,” the NVHA collects and shares traditional knowledge from hereditary leaders and elders, and upholds a vision of health that integrates traditional healing with current health practices. Based on the documents reviewed, examples of integration were present in the department of Cultural and Community Health. The department hires Cultural and Community Health Representatives (CCHRs) whose key role is to increase accessibility to health care by bridging the cultural gap between health care professionals and their clients to promote wellness and health, and prevent injury and illness.

The CCHRs work closely with members of the health care team to help improve and maintain the spiritual, physical, intellectual, social and emotional well being of individuals, families and communities. They work “under the direction of health care professionals” to provide services in areas of health promotion and education, client care, health protection, community advocacy, cultural liaison, and administration. Their activities may be to: design or help create culturally appropriate education resources; refer clients and families to appropriate resources and services, and help them overcome any access barriers; act as a liaison and collaborate with community leaders, agencies and service providers; and translate or describe routine medical processes and procedures for clients or interpret cultural practices or beliefs for health care professionals.

Eskasoni Community Health Centre (Eskasoni, NS)

Overview

The Eskasoni Community Health Center provides a wide range of primary care and community services to the people of Eskasoni (population ~3400). The Primary Care Unit provides basic emergency services, home care visits, blood collection 2 days per week, well woman clinics for early detection of breast and uterine cancer and a women’s breast screening unit, and includes a Pharmacy.

Programs and services

The goal of the Primary Care Clinic is to provide a holistic approach to health care. The clinic is staffed by family physicians, a nurse practitioner, support staff, and visiting specialists. Two full-time pharmacists and two technicians staff the Pharmacy. In addition to Primary Care services, the Eskasoni Health Centre provides care in the following areas: Home Care; Diabetic Clinic; Pre/ Post Natal Care; Medical Transport; Community Health; Dietitian; Mental Health and Social Work Services; and the Headstart Program. These services are supported by Community Health Nurses, Home Care Nurses, Community Health Representatives and other support staff. In order to overcome language barriers, the centre has 2 Mi’Kmaq liaison workers on staff, who work within the Cape Breton Regional Hospital and serve all Mi’Kmaq patients.

Integration of Indigenous and Western approaches to health and healing

The integration of Western and Indigenous practices is limited to online descriptions of the holistic approach, the conception of health, and some use of the Mi’Kmaq language. For example, the department of Mental Health and Social Work Services describes their philosophy: “We are committed to helping one another (“mawi apoqnimatimk”) as we are all in this world together and working towards a healthy sense of self and self worth. Health involves the total person and it is only by nourishing all four aspects of health that a Community can attain true growth.” In addition to 2 Mi’Kmaq liaison workers, the community health representatives also act as community liaisons. Finally, special cultural and community-based events are organized.

Anishnawbe Mushkiki Thunder Bay Aboriginal Health Centre (Thunder Bay, ON)

Overview

Anishnawbe Mushkiki is an Aboriginal Community Health Centre, which has been established as a primary health care facility within the District of Thunder Bay. The Centre's mandate is to improve the health of Aboriginal people by means of a wholistic approach combining Western traditional and alternative medicine. Programs and services are provided to Aboriginal individuals, families and communities.

Programs and services

Primary health care is provided by a team of nurse practitioners and doctors, who provide a range of clinical services, including pre/ post natal care, immunizations, sexual health, and chronic disease management. In addition, the following programs are offered: Health Promotion (includes fitness and nutrition programming); Healthy Eating, Active Living (covers areas such as diabetes, smoking and healthy eating); Diabetes Program; Community Access Program (provides internet access and training); FASD/ child nutrition; and Traditional Healing Program, which uses traditional and cultural teachings.

Integration of Indigenous and Western approaches to health and healing

The Centre incorporates traditional and cultural services both into and alongside mainstream medical programs, including special events such as sweats, ceremonies and elder presentations. The Traditional Healing Program offers seasonal feasting ceremonies, sweat lodge ceremonies, drum teachings, traditional crafts, regalia making, and Anishnawbe language and culture teachings. There is a Traditional Coordinator on staff, who invites elders for spiritual guidance and consultation, naming ceremonies, grieving ceremonies and provides access to Traditional Healers. The Traditional Coordinator also provides individual and community cultural education on the following: Medicine Wheel Teachings; Seven Grandfather Teachings; Clan Teachings; Traditional Child Rearing; Women's Teachings; and Fours Sacred Medicines. Finally, the program is "culturally-based" in that traditional healing approaches and healers are placed at the centre of the organization; however, funding arrangements are not always reflective of this commitment (Smye & Musell, 2001).

Anishnawbe Health (Toronto, ON)

Overview

Anishnawbe Health Toronto (AHT) is a fully accredited community health centre that offers access to health care practitioners from many disciplines including traditional healers, elders and medicine people. The AHT promotes traditional Aboriginal practices, and has affirmed and placed them at its core. The AHT mission is to improve the health and well being of Aboriginal People in spirit, mind, emotion and body through both traditional and Western healing approaches. The programs and services offered are based on Anishnawbe culture and traditions through a multi-disciplinary team of healthcare professionals and service providers.

Programs and services

The programs and services offered at the centre include: (1) Primary Health Care Services (a multi-disciplinary team, which includes medical support, nurse practitioners, registered nurses, physicians, a chiroprapist, counselor and health promoter, and provides holistic healthcare); (2) Diabetic Education and Management; (3) Diabetes Prevention and Management for Seniors Program; (4) Traditional Family Services; (5) Aboriginal Mental Health and Addiction Services; (6) FASD Services; (7) FASD Diagnostic Clinic; (8) Mental Health Services; three homelessness programs – (9) Babishkhan: Circle of Care Workers; (10) Nmakaandjiiwin: Finding My Way; and (11) O Ta Ti Baen Program; (12) Community Health Worker Training Program; (13) Chiropody Services; (14) Naturopathic Services; (15) Chiropractic Services; (16) Healthy Smiles Ontario Program; (17) Dental & Oral Health Services; (18) Psychiatric Service; (19) Psychology Service; (20) Traditional Counseling; and (21) Enaadamedg Kwe (Women's Helper) Program.

Integration of Indigenous and Western approaches to health and healing

Based in Circle of Care and Traditional Teachings, the Anishnawbe model of care is grounded in traditional practices and approaches, which are reflected in the design of its programs and services. Rather than being part of a separate department or program, traditional and cultural care are provided as part of regular care throughout the health centre's programs and services.

For example, the Diabetes program and the Traditional Family Services program both provide access to biomedical as well as traditional and culturally-based

services providing diabetes care and youth support, respectively. The Aboriginal Mental Health and Addictions program and the Mental Health Services work within a strength-based model, integrating Western and Indigenous approaches “to assess, diagnose and treat mental health issues across the life cycle.” The Enaadamged Kwe Women’s Helper Program, which provides pre- and post- natal care to women until their child is 12-months old, offers a blend of Western and Indigenous services, including education, nutritional counseling, lactation supports and infant development groups, as well as traditional pre-natal circles, traditional teaching circles, traditional parenting circles, welcoming ceremonies, and naming ceremonies.

The Traditional Counseling Services team uses both Western and Indigenous approaches to healing, and includes Traditional Healers, Elders and Medicine People. These approaches include: Traditional Doctoring, Traditional Medicine, Guidance and Counseling, Teaching Circles, Healing Circle, and Spiritual Ceremonies, such as Sweat Lodge, Shaking Tent, Full Moon Ceremony, Naming Ceremony, Clan Feasts, Pipe Ceremony, and Vision Quests. Finally, the Community Health Worker Training Program provides participants with culturally-based training in community health work, building community capacity in four main subject areas: Traditional Health, Community Development, Communication and Presentation Skills, and Health Promotion, Advocacy and Counseling.

Noojmowin Teg Health Centre (Manitoulin Island, ON)

Overview

The Noojmowin Teg Health Access Centre is one of ten Aboriginal Health Access Centres found across Ontario. The primary health care services include physician, nurse practitioners and traditional healing providing a wide range of services. The Centre policy, which recognizes that the Anishinabe live in a bi-cultural social environment, is intended to solidify cultural revivalism through Aboriginal healing ways while maintaining an integrated health model.

Programs and services

The Centre provides a wide range of services delivered including of pre and postnatal care, nutrition, health education, health promotion, disease prevention, counseling, traditional healing and treatment. The following programs are offered: (1) Nurse Practitioner Services; (2) Community Nutrition; (3) Psychologist

Services; (4) Traditional Medicine (including traditional healing and residential school support services; (5) FASD Program; (6) Child Nutrition Program; (7) Children’s Recreation; (8) Diabetes Wellness; (9) Aging At Home; and (10) Aging at Home Van Transportation Service.

Integration of Indigenous and Western approaches to health and healing

As stated in the Centre policy, the Noojmowin Teg Health Centre places a high value in cultural revivalism and the use of traditional and cultural approaches whilst maintaining an integrated health model. The Centre provides an extensive Traditional Medicine Program for individuals and families, which includes: a) referrals by other health care providers or self-requests for traditional teaching, supportive counseling; traditional healing; b) consultation, protocol teachings, intake assessment; c) referral to traditional healer or other health care provider; d) helper duties involved in ceremonial preparation, documentation, and filling herbal prescription; and e) follow-up appointment, referrals, case management as required.

The program is administered by a traditional coordinator, overseen by a traditional advisory committee representative of Elders and members from all Manitoulin Island First Nations. Program operations are guided by a bi-cultural program and policy manual. The traditional program employs a coordinator, healers and helpers. The components of the program are: Anishinabe Therapy (support), Healing Circles, Doctoring, Herbal Medicines, Specific Cultural Healing Practices (ceremonies), General Ceremonial Healing Events (naming, rites of passage), Advisory (advice, guidance). Aside from providing traditional healing, program members engage in a variety of activities, such as harvesting medicines, providing workshops and teachings, research support, program support and advice for other sectors of the Centre (Manitowabi, 2009). In particular, the role of the coordinator is multi-faceted: a herbalist and trained nurse, the coordinator is a liaison between the Executive Director and other Centre sectors, supervisor of healers and helpers, program secretary, liaison between Manitoulin Island First Nations and Noojmowin Teg, harvester of medicines, research associate of various project, associate of Mnaamodzawin Health Services, healer and most importantly, “cultural mediator” – balancing clinical accountability and the integrity of Ojibwa/Anishinabe traditional healing (Ibid).

Awo Taan Healing Society (Calgary, AB)

Overview

The Awo Taan Healing Lodge Society is a 27-bed, full service emergency shelter that provides services to women and children from all cultures, who have suffered from family violence and all forms of abuse. The shelter operates 24 hours a day, 7 days per week, and is run by 33 staff. There is a minimum of 2 on-site counselors at the shelter 24 hours a day, and emergency counselors on-call 24 hours a day. Women and children can stay at the shelter for a period of up to three weeks. If shelter is required beyond the 3-week period, clients may arrange for an extended stay or are referred to other agencies. The shelter 'Awo Taan,' which means 'shield' in the Blackfoot language, is "blanketed in a unique atmosphere where the traditional wholistic and spiritual teachings of the Aboriginal people's Medicine Wheel are practiced."

Programs and services

The shelter offers a full range of in-house crisis and outreach crisis, healing, and prevention programs. Components of the program include: (1) Shelter services; (2) Aboriginal Support; (3) Outreach; (4) Family Violence Prevention; (5) Volunteer; (6) Child Support; (7) Peace (educational anti-bullying program); and (8) Parent link.

Integration of Indigenous and Western approaches to health and healing

The Society's website states that programs and services are provided from an "Aboriginal worldview," incorporating traditional knowledge and practices of healing and wellness. The shelter operates from a strength-based perspective, linking clients to elder services, and organizing various events and celebrations, including storytelling and healing circles. The Aboriginal Support Program is guided by the Seven Sacred Teachings and other spiritual teachings. The Programs' activities and services include elder support, counseling and advice, daily smudge and prayer, community cultural awareness workshops, and traditional teachings.

Ma Mawi Wi Chi Itata Centre (Winnipeg, MB)

Overview

Ma Mawi Wi Chi Itata Centre (Ma Mawi) is one of the largest urban Native child and family support programs in the country, established in 1984 to reclaim control over family and community support services available to

Aboriginal people in Winnipeg. Today Ma Mawi has over 50 programs, 9 sites, and 200+ staff and volunteers. Ma Mawi is Aboriginal directed and supported human service organization, delivering children in care and community based programs and services to Aboriginal families. The Centre uses a neighbourhood based practice model aimed at identifying innovative policy and practice initiatives to create and sustain family supported neighbourhoods. It is governed by a Board of Directors elected by the community.

Programs and services

Programs serve self-identified Aboriginal families. Most programs require no formal referral process, however some programs only accept referrals from mandated child and family service agencies or agencies in partnership with Ma Mawi. All of Ma Mawi's Youth Department programming offers free healthy snacks and transportation. The following programs are offered: (1) Community Care Programs (drop-in groups, individual and parent support, crisis and emergency services, and Internet access); (2) Youth Programs (Cultural Programs; Cubs and Scouts; Positive Adolescent Sexuality Support); and (3) Children in Care Program (short-term and long-term housing and supports).

Integration of Indigenous and Western approaches to health and healing

The Ma Mawi model of healing and wellness focuses on and builds on individual strengths, creates opportunities for community and family involvement, and aims to provide culturally relevant programs and supports. Educational sessions on Aboriginal culture as well as a series of traditional and cultural activities (e.g., Pow Wow clubs, drum groups, traditional arts and crafts, sacred ceremonies, Aboriginal language workshops, regalia making, and traditional teachings are offered as part of youth programs. In addition, the Cultural Program is a separate year round program that offers cultural teachings and sacred ceremonies, such as sweats and pipe ceremonies, community medicine picking, and teachings about Aboriginal culture, traditions and perspectives through the importance of the medicines and the Seven Sacred Teachings.

Wabano Centre (Ottawa, ON)

Overview

The Wabano Centre for Aboriginal Health is an award-winning charity that is a leader in community-based, holistic health care, and bridging Native cultural practices with Western medicine. Each year, Wabano provides professional services and cultural events to over 10,000 Aboriginal and non-Aboriginal people. The Centre's mission is to provide quality, holistic, culturally relevant health services to First Nations, Inuit and Métis communities of Ottawa. The Centre's guiding principles are based in a belief that "Good Medicine" is characterized by:

- The reclamation of culture as a pillar of healing;
- The teaching and healing practices of First Nation, Inuit and Métis peoples;
- A contemporary model of quality, primary healthcare;
- Focus on the individual in the context of family and community;
- A belief in the wisdom of our Elders, Traditional Healers and Teachers; and
- A belief in the importance of ceremony and celebration.

Programs and services

The program and service delivery model key ingredients are:

- A philosophy based on traditional teachings and practices related to healing and wellness;
- Inclusion of ceremonies, traditional teachings, circles, referrals to Elders, traditional healers, and sessions on native identity and culture reclamation; and
- Ensuring the ongoing development and delivery of culturally appropriate and sensitive services and programs to the Aboriginal people in their catchment areas.

The programs and services offered at Wabano are: (1) Clinic (staffed by a team of health practitioners, including physicians, nurse practitioners, chiropractor, dietitian, and gynecologist); (2) Health Programs (wide range of programming, including FASD, HIV/AIDS, pre-natal care, parenting, diabetes, seniors programming, healthy living); (3) Mental Health; (4) Community Programs (including community garden and kitchen, parenting supports,

culture programming, and an inter-generational bridging program); (5) Homelessness (medical care, outreach and referrals to those at high risk of homelessness); and (6) Youth Programs (after school programming, supports for youth involved with the justice system, education and advocacy).

Integration of Indigenous and Western approaches to health and healing

The central role of traditional and cultural knowledge and practices and teachings is evident in the mission and guiding principles of the Centre, which are incorporated throughout Wabano's programs and services. Many health programs, such as the pre-natal and parenting programs, use the teachings of the Medicine Wheel at the core of their services, with activities such as the Sacred Mothers Circle, traditional crafts, and cultural teachings. In addition to the Medicine Wheel, the program's cornerstone are teachings from Elders and knowledge systems, such as the Good Mind, Four Directions and the Sacred Hoop of Life teachings. Similarly, activities of the Healthy Living Program include a blend of Western and traditional activities, such as fitness and recreation, as well as Sacred Smoke, traditional medicines and knowledge (including Tobacco teachings), traditional food cooking, canoeing and traditional games. Finally, the Medicine Wheel Make-Over program provides access to health professionals such as dietitian, personal trainers, and cultural teachers to support individuals to achieve balance, and meet new goals.

Similarly, the community programs offer an array of Western and Indigenous programs and services. For example, the Inter-generational Bridging Program provides a common platform for Aboriginal seniors and youth to come together and undertake culturally based activities (e.g., elder teachings, healing and educational circles, traditional ceremonies and craft workshops), which help promote mutual support and build a strong sense of community. The program also provides physical activities, life skills and employment training for youth, with strong partnerships with high schools and community service providers. Additional culture programming includes talking circles, cedar lodge, and elder consultations.

Aboriginal Health & Wellness Centre of Winnipeg (Winnipeg, MB)

Overview

The Aboriginal Health and Wellness Centre is a community-based health and wellness resource centre committed to serving the Aboriginal community of Winnipeg. The philosophy of the program is founded on traditional values and perspectives, where services and programs are parts of a continuum of resources made available to identify and support the aspirations, needs and goals of individuals, families, and thus, the community through access to both traditional and Western resources. The Centre is funded through a contract with the Winnipeg Health Authority. There is no charge for services.

Programs and services

Programs and services are offered in the areas of primary health, community development, outreach and education, and health promotion and prevention, and include: (1) Wellness Centre (Primary Care Clinic, with the services of physicians, nurses, community health workers, and access to Traditional Healers); (2) Traditional Services and Programs (with a traditional healer on staff working 5 days a week); (3) Stop FAS; (4) Abinotci Mino-Ayawin: Children's Healing (includes parenting groups and supports); (5) Head Start Program; (6) Women's Healing Program; (7) Men's Healing Program; and (8) Indian Residential School Program.

Integration of Indigenous and Western approaches to health and healing

Integration of *Indigenous and Western* practices appears to be present to varied degrees across programs. For example, the services of the Wellness Clinic are based in biomedical approaches; however, Medicine Wheel Assessments are provided. On the other hand, the Women's and Men's Healing Programs offer a blended approach of contemporary and traditional methods of healing. Traditional and cultural services are largely offered through the Wellness Centre's Traditional Program, which provides access to a traditional healer, Elders, and teachers. The Traditional Program offers guidance and ceremonies through spiritual direction and knowledge. A summer Medicine picking program is also available.

Sioux Lookout Meno Ya Win Health Centre (Sioux Lookout, ON)

Overview

Sioux Lookout is a fully accredited facility with 41 acute care beds, 8 complex continuing care beds, and 5 medical withdrawal management beds; and a 20-bed extended care facility. The centre provides health services to all residents within Sioux Lookout and the surrounding area, including the Nishnawbe-Aski communities north of Sioux Lookout, the Treaty #3 community of Lac Seul First Nation, and residents of Pickle Lake and Savant Lake. "Meno Ya Win" means health, wellness, well being – a state of mental, emotional, physical and spiritual wholeness. All services and programs are designed on this understanding. The Meno Ya Win hospital service agreement underlines the need for culturally responsive programming in almost every section from the preamble through philosophy and principles to operational and capital funding, planning, service definitions, and special requirements and exemptions (see Walker et al., 2010).

Programs and services

The following programs and services are available: (1) Internal Health Services (including hospital programs, long term care, emergency, obstetrics and maternity, and ambulatory care); (2) Community Counseling and Addiction Services (includes outreach, referrals, assessments, and needle exchange); (3) Traditional healing, medicine, foods, and support services; (4) Odotsemag (Healthy Choices for Healthy Babies); (5) Admitting Department; (6) Diagnostic Imaging; (7) Health records; (8) Laboratory; (9) Pharmacy Services; (10) Population Health Infection Control; (11) Rehabilitation Services; and (12) Medical Withdrawal Support Service.

Integration of Indigenous and Western approaches to health and healing

The merging of *Indigenous and Western* traditional and modern healing practices at Sioux Lookout occurred through the development of the Traditional Healing, Medicines, Foods and Client Support Services program. The program was designed to be fully integrated as an element of virtually all clinical programs, rather than a separate, stand-alone program, conforming to the principles of integrative medicine (see Walker et al., 2010). The program has the following components:

1. Choice in Healing Pathways: Patients, residents, and clients and their caregivers will be able to choose to access the services available through the

THMF program as an adjunct or alternative to other conventional clinical services and supports.

2. **Ceremonial Practices:** In addition to birth and palliative practices, vigils, smudging, healing circles, and possibly other ceremonial practices will be introduced on-site prior to the construction of the new hospital. Sweat lodge ceremonies will be available for clients.
3. **Ceremonial Spaces:** ceremonial practices are currently provided in temporary structures. A new facility is being planned that will incorporate dedicated ceremonial, healing and related gathering and support spaces, which will be fully integrated into the conventional hospital space.
4. **Traditional Healers:** Traditional healing practices are supported by healers with several types of skills and training. Meno Ya Win is working to develop a roster of healers who will be available to patients and clients who want to access their services. A process of “certifying” healers will ensure that healers will be reviewed and “credentialed” to ensure appropriate qualifications and standards are in place. Traditional healers will work collaboratively with members of medical staff, other professionals and health care givers, as well as in conjunction with northern community, Sioux Lookout and other Northern Ontario healers.
5. **Mashkiki (*Traditional Medicines*):** The four sacred traditional medicines of cedar, sage, sweetgrass and tobacco are used in ceremonial healing. Under supervision of the care givers Meno Ya Win allows patients and families to use a limited range of other medicines that they bring with them. Work is underway to develop an expanded range of approved medications. Storage and preparation areas for these medicines will be included in the new facility.
6. **Traditional Foods:** At Meno Ya Win traditional foods have thus far been used on a very limited basis. A broad range of traditional foods is being added to the menu selections available.

Southcentral Foundation (Anchorage, Alaska)

Overview

The Southcentral Foundation has partnered with its customer-owners to develop an award-winning health care system made up of a wide range of programs to address physical, mental, emotional and spiritual wellness. The Southcentral Foundation provides services for over 50,000 Alaska Native and American Indian people in the Anchorage Service Unit area, totaling over 100,000 square miles. The key ideas that drive the organization are: a) The customer drives everything; b) All customers deserve to have a health care team they know and trust; c) Customers should face no barriers when seeking care; and d) Staff members and supporting infrastructure are vital to success (Gottlieb et al., 2008). The Alaska Native Medical Centre is a 150-bed regional community hospital, providing local primary care and tertiary care, with over 400,00 visits last year.

Programs and services

Services are offered through small, integrated care teams that do not only deliver care to customers, but also seek to develop relationships with them. Each team includes a primary care physician, 1-2 medical assistants, a nurse, an administrative assistant and, often, a behaviourist. A comprehensive array of services is offered through the following programs: (1) Medical Services (including primary care, complementary medicine clinic, emergency, family health, immunizations, laboratory, optometry, obstetrics and gynecology, pediatrics, pharmacy and radiology); (2) Dental Services; (3) Behavioural Health Services (including mental health services, residential and outpatient addiction treatment, family and social support services, residential programming for adolescent males, and a safe home program for women); (4) Executive and Tribal Services (including an Elder Program and a Traditional Healing Clinic); and (5) Office of the President, which runs the Family Wellness Warriors Initiative to address family violence.

Integration of Indigenous and Western approaches to health and healing

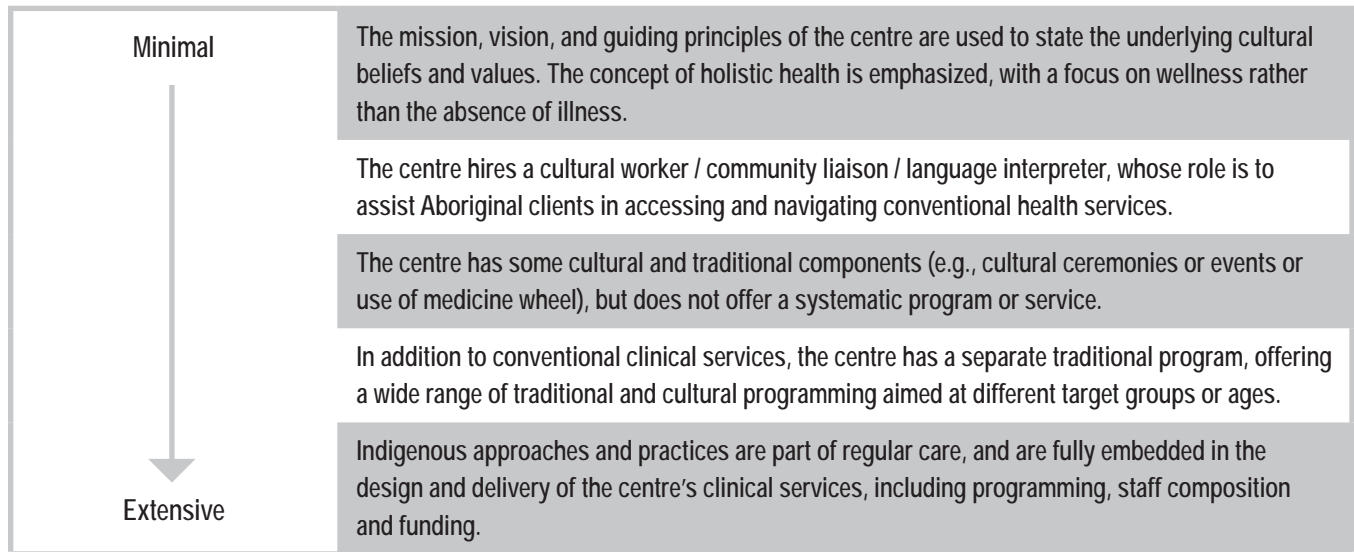
The integration of *Indigenous and Western* practices is reflected in various components of the organization (e.g., design of spaces, guiding philosophy, service delivery). For example, extensive time and resources are spent on training to help staff understand roles, protocols, processes, philosophy and culture. In providing health services, health care teams focus on building relationships

with customers and their families. In conjunction with the other services of the Southcentral Foundation, the Traditional Healing Clinic provides traditional Alaska Native approaches to health in an outpatient setting. Tribal doctors provide customers with practices such as healing hands, culturally-sensitive supportive counseling, cleansing, healing touch, talking circles prayer, songs, dances and consultations with Elders. There is also an Alaska Native Healing Garden, which is a teaching place. Other programs and services, such as the Family Wellness Warriors Initiative and the Pathway Home, incorporate the Alaska Native beliefs and cultural practices, focusing on the strengths of Alaska native culture and traditions.

Summary

The Aboriginal health centres bring together Indigenous and Western knowledge and approaches to provide health and healing services. Based on the online information reviewed, centres combine Indigenous and Western approaches in different ways and to varied extents. The ability to integrate and provide Indigenous services and programming may be a reflection of the underlying service agreements, the funding systems available, and/or other socio-economic or historical factors. The study of these was beyond the scope of this broad overview. Additional information of note, such as centre space design, staff training and relationships, other aspects of program and service delivery, as well as protocols, may be available in other forms, but was limited on centre websites. Figure 2 below summarizes the extent to which Indigenous approaches and practices are reflected in Aboriginal health centres, from minimal to extensive.

Figure 2: Extent of Indigenous approaches to health and healing in Aboriginal health centres



4. HEALTH AND HEALING IN STS'AILES (FINDINGS)

This section reports on the findings regarding health and healing in Sts'ailes from interviews with community elders, and focus groups with community members and key stakeholders. The interviews and focus groups covered questions in three key topics areas: 1) being healthy and what it means; 2) traditional healing; and 3) the community health centre. A number of questions focused on participants' views of the ways in which their own and community perspectives on health, wellness, and traditional healing could be reflected in the operations of a community health centre. The results of the thematic analysis are discussed, identifying common themes as well as interpretative differences, with exemplars for each theme.

A description of how the knowledge was gathered and analyzed can be found in *Appendix 3* of this Report. Other information is included as separate attachments, including the interview guide (Attachment 4), summary of themes and codes (Attachment 5), interview quotes bank (Attachment 6), and visual maps of themes (Attachment 7).

4.1 Health and Healing Themes

4.1.1 Pathways to Health and Healing

Pathways to Health and Healing was a prominent theme discussed by all respondents, describing many dimensions of health and healing on both the individual, family and community levels. The first dimension of health and healing discussed was **holism**, which participants spoke of in terms of balance between physical, emotional, mental and spiritual health, protection and preservation of land, environment, sacred knowledge and practices, as well as connectedness and interconnectedness of communities and generations. Many participants provided examples

of how “everything is connected,” telling stories of the interrelation between the spirit world, nature, land, water and the community. Two participants explain:

“I couldn't sleep. And my spirit was stronger than my body. That's what they told me. So that's why they say you need to be balanced. See my spirit was stronger than my body and I was getting run down, tired, and I remember them telling me, you'd better go home for awhile (...). So, I came home and then I just slept and slept and slept. I thought, now I understand what they mean, we're supposed to be balanced, well balanced, physically, mental, spiritually, and emotionally. When I thought, and I wasn't balanced, and I'm still not really balanced.”

“Everything you need that's in the soil. It's gone. Everything's been destroyed. And so now the sun is going to be beating down, it's going to dry up everything so a lot of the Elders are saying (...) where this building is now, this used to be all wild strawberries. And just out by the school there, that was all, uh, huckleberries, blueberries, wild, they'd just grow there. There's not a plant there now. You don't see it. It's been destroyed. So now we've got to find maybe a crop here a crop there, but they're clear cutting the mountains now and then we're going to run into that problem again (...). Once you start destroying soil there's not too much, well, the Earth can give back to us, it's gone, it's been destroyed. It'd be a hard, hard thing to get back and you'll end up (...) having to go to like Superstore or places.”

Culture and spirituality were identified as a key component of pathways to health and healing. In particular, participants talked about the role of traditional medicine (collecting and preparing medicines from the land), culture and traditions, as well as the longhouse. Culture and traditions were spoken of as a source of cultural pride, and a source of traditional knowledge. They

highlighted the importance of the longhouse as the place of teaching, connection, and medicine, where protocols for life are learned, and practices are passed on. In sharing their stories about health and healings, the significance of water and connection to the land emerged:

“We go for spiritual baths and we get rid of anything that’s bad. We send it downstream and we turn around and take the clean water and that’s what I have to do because in here, in this institution, like I have a lot of confidential things, and I can’t hold it myself either. So I have to go out and just brush down and through it in the water. Or I get filled up too. So that’s what I’m teaching here. If they’re angry or anything just go into the water, holler it out and get rid of it.”

“You talk about health and that right there, that smokehouse, to our younger people and our other generation, is medicine. Hunted all my life. That’s medicine too, you know. Hunting. Fishing. All our traditional stuff, that’s medicine (...) for our people. Our own people, our people that do that. Cause you go fishing and hunting for the Elders (...), that’s medicine. Cause you know deep down in your heart that you’ve done something good for your people. And that lifts you up. Makes you realize that you’re wanted on this reserve or you’re cared for on this reserve, you’re not just a nobody that roams around drinking and doing pot and stuff like that (...). You’re somebody, go out there and help them out (...). My medicine was my wife and my kids and my brother, yeah. That’s how I turned around.”

“The one thing we have going is our smokehouse. That’s active. It became, it was a canoe shed behind our house, and that was there maybe 15 years or more and we used it as a smokehouse, and um, that was, so that, we can bring our his dad’s teachings (...). And then it got too small so we had to build a bigger one. Now, that’s one of the, I think the strongest thing that we have going for us. Is our smokehouse, we made it bigger. Where you have to welcome your people in to share your strengths and your teachings.”

Intergenerational teaching and learning was described as another pathway to health and healing, and was closely tied to practicing cultural ways and the role of elders in the community. Participants spoke about teaching and learning occurring in the longhouse, in nature, in schools, and within a family. They told stories of learning about sacred medicines and foods by spending time on the land,

and learning the lessons of Mother Earth and Father Sky. Another pathway to health and healing was described as *living well*, that is, living in accordance with community values and laws of the land passed through generations, keeping strong, honoring one’s roots, and keeping a positive attitude. Many participants expressed concern that young people are losing the knowledge of culture and traditions, and the need to teach those values to young people to keep the community healthy:

“For the next generation that’s coming up, right now, as most of us can see, to this day our younger people have no idea as to what this plant will do, what this plant will do. And if we keep an area that’s always storing this type of plant, we will for generations, generations and generations know that these are sacred plants. They’re not to be destroyed like they’re destroying all our crops, our trees, and some of those places where the trees are those, are put there for a reason, they’re our fertilization with the needles off the trees, the bark off the trees, (...), without those trees around there’s our fertilization for everything else, it’s gonna be gone. The strength and potency of all, of each tree around, they give that nourishment for whatever we’re going to need it for.”

When asked to talk about their understanding of the work and role of healers, participants emphasized that there are different types of healers, who use different tools for health and healing. Participants spoke about healers who do burnings, smudges, brushing, or work the longhouse, explaining that their work “to keep our balance” is also different for different phases of life, from birth to spirit life:

“A traditional healer (...) is somebody that has a belief in a higher power and he’s - he or she - is connecting themselves to everything around them. Cause we, as xwélmexw people (...), we have to understand everything around us to be able to help somebody else (...). That’s what a healer is. You have to connect yourselves to the people on the other side or the higher power. And to make sure your heart is open.”

“But right now we need healers, the ones for the burnings. Ones to brush people off. Ones for doing initiations in the long home. Ones, uh, for young families that need to hear those words, now that you’re going to begin a family well this is what has to be taken care of before the child arrives. You’ve got all these different phases of healers that keep our balance (...). The healer that does the burnings, reconnects, passes the messages on to the family so they have to keep that balance spirit to spirit (...).”

Healers were described as “chosen,” whose gifts come in various ways – from the spirit and ancestors, taught by elders and other healers, or passed down through names. Healers must lead their life in accordance with their gift and the teachings they received. However, the “authenticity” of a healer comes from the people:

“[There are] different ways of receiving these gifts. Some people don’t even have the choice. The gift is passed on from generation to generation and they have to be taught how to control it and how to handle it. Some of it is carried out through our names. If you listen to some of our shxwelméxwelh skwí:x, some of those names, those names who are medicine people, and they say if you receive that name you will eventually start to follow that line.”

“These gifts come from the spirit and not everybody can have those. So you’re more or less classified as the chosen one when you’re bestowed a gift like this and there’s some in every community, and that’s all learned through the spirit mostly and from your Elders.”

“Everybody has the power. It’s just that they don’t know and they use it without knowing. If everybody knew what they could do, we’d probably be a powerful people again.”

“That siyá:m needs you, that siyá:m needs people to believe in. Therefore you have to be humble. You have to be a real trustworthy siyá:m, you have to be Indian doctor, you gotta be real trustworthy to people (...).”

“The chosen ones are just that. They’re looked upon as being chosen by the spirit or what some people might call God (...), and they’re chosen cause somewhere along the line in their life, maybe even before they’re born, their spirit says this one is going to be a chosen one and he’s gonna help the people and he’s going to bestow them the gift. It could be healing with the hands, or it could be what some people term as fortune telling, or being a shxwólá:m, an Indian doctor, there’s sort of three different classifications of Indian doctor in itself. And it’s just that, the people get chosen to be a healer, a traditional healer they call them, but, people just are able to heal and that’s not without, being a gift, you’re expected to lead a real fine line in your life, where you have to stay clean in order for this gift to help the people successfully. You have to be leading the right path, you have to be leading the right life and staying that path and there’s all types of traditional healers, but this is the main one that comes with um, with our people.”

While discussing how the work and practice of healers has evolved over time, participants talked about the need to preserve and revive the work of healers as a way to maintain the wellness and strength of the people.

4.1.2 Ways of Knowing

Another prominent theme apparent in the stories and descriptions of the participants related to the many Ways of Knowing, gathering and passing knowledge and wisdom. Biomedical practices were described as both effective and ineffective for different people and in different contexts. In general, participants felt there was an important role to play by Western and Indigenous approaches, as they have different roles to play in health and healing, as illustrated below:

“Cause a lot of times when people go in the hospital and that, they can’t find what’s wrong with him and then they go and see an Indian doctor and they find out what’s wrong with them. A lot of times it’s spiritual, it’s not physical.”

[Speaking about a spiritual healer] “That’s the one that, she’s real you know. She’s, um, I’ve had her come here when I first found out I had breast cancer. [Someone] invited her to come talk to me. And uh, she just took away all the fear. I was so scared. You know, I was so scared I was gonna die right now, you know, and um, she just grabbed my hand and held my hand. Tell me what she needed to do. And I wasn’t afraid any more. And I thought I’m going to go through this and I’m coming out of it. Which I did. I had to go under twice, two surgeries. They didn’t take the lymph nodes out, they took a couple out of here but they found it was full of cancer there so I had to go under again and they took them all out.”

“I think that it’s time that we all work together. The natives and the non-natives. Cause we all live in the same territory and we’re all (...) going to be sick at a certain time and what not, you know, its time we, we mingle together.”

Many participants described the need for cross-cultural respect, and for non-Aboriginal practitioners working in the community to be open, to learn about the traditional healing and Sts’ailes culture, and be supportive of traditional approaches to wellness. Traditional knowledge and practices described included traditional activities such as hunting, fishing, canning, burnings, dancing, mask, sweats, crafts, basket making, and weaving, to name a few, as well as traditional medicine, healing, story

telling, and cultural approaches to wellness, including language, land, and water. Some participants felt that a lot of work combining Western and Indigenous approaches is already happening in the community, and that patience is required in this work.

Another aspect of different ways of knowing was the theme of **intergenerational teaching and learning**. Participants described the many ways in which learning takes place over the course of one's life: listening, observing, taking the time to teach and learn, oral traditions, story telling, hands on learning, and leading by example:

“Mainly there was a lot of Elders that were training us young to be adults, whether it'd be canning, whether it'd be hunting, whether it be fishing, whether it be out gathering the medicines for what ails either our young ones, young adults, or Elders (...) they were teaching us the leaves, the types that would work with some stomach ailments or rashes or what types of herbs that we have to go and pick at certain seasons. So that will help us through the ordeals that we had to go through cause it was a long, long ways to our doctors. Our Elders taught us to make our healing salves and our herbal teas for like arthritis or upset stomachs or couldn't sleep, needed extra energy, the additives that were placed in each type of herbal tea, like stinging nettles, one of the well used plants that's used for like, similar to aspirin ingredient and it was used for quite a few of the Elders. A lot of them were busy with their hands and always aching and this is what they used for arthritis. That's one of the main ingredients that we had, we really keep an eye out for what seasons to pick and just to keep us on the go or keep our health (...) very balanced.”

Finally, **spirituality** emerged as a unique way of knowing, with participants describing multiple examples of activities and practices of connecting to the spirit world.

4.1.3 History of Our People

In sharing their experiences growing up and recalling examples of health and wellness, the theme of History of Our People emerged. Closely embedded in Sts'ailes traditions and stories, they described the life of a strong and healthy nation. Many then shared stories of dislocation and generational effects of colonial process and practices, such as loss of traditional practices, language, and a teaching/ knowledge gaps between generations:

“When we were growing up we pretty well lived in a poverty state, so there wasn't too much teachings along that line, in health and looking after yourself and wellness.”

“They went to residential school. That's why they didn't teach us our language too. Uh, like our generation and the generation before us, we were not, we didn't know how to be parents. And the residential school all we know was punishing and hitting and all that, we didn't know how to be caressed or loved so we didn't do that with our children (...).”

“Every family has people that are chosen to carry out this work. Same in the old days (...) it sort of went by the way side when the Europeans came over here and outlawed all of it, they outlawed all of this stuff for us to do, and it started with the anti-potlatch law in 1884, and we were forbid to dance right from 84 right up until 1952 when they allowed us to dance again. So, all of this medicine and the dancing all sort of went by the way side, it was almost lost. And the Indian dancing and traditional healing all started to come back as recently as 1969-70, when it started coming back.”

In fact, descriptions of **returning to the longhouse** was a strong sub-theme of History of Our People, and a large component of bringing health and healing to the community: *“Everything they teach you in that longhouse is what they're teaching you everyday life. So you can carry on in your life in a proper way.”*

4.1.4 Relationality (Relationships in Context)

The final theme that arose from the interviews and focus groups was that of Relationality (Relationships in Context), which was noted across all responses to questions. Relationality was evident in a multitude of ways:

- With nature, family and community
- Between the mind, body, and spirit, and dimensions of health
- Between past, present, and future
- In teachings and learning between elders and youth
- In interconnectedness and interdependence of the land, water, plants, animals and people
- Between Western and traditional practitioners

The quotes below are examples of relationality, its importance in Sts'ailes way of life and cultural traditions, and its role in health and healing:

“Dad used to tell us stories too, like Th’ówxeyya, Th’ówxeyya would come down from the mountains and she had a basket made of sticks and she had pitch there, and she’s put the bad kids in her basket and put pitch in their eyes so they can’t see where they’re going and she’d take them up and then make a fire. So he was telling that story and he made a fire and my sister said, where’d you get he matches Dad? [Laughter] Cause she was questioning him. Did he have an axe? [Laughter] They taught us by telling stories... That’s why we do four hours at the smokehouse, we’re teaching our kids by example.”

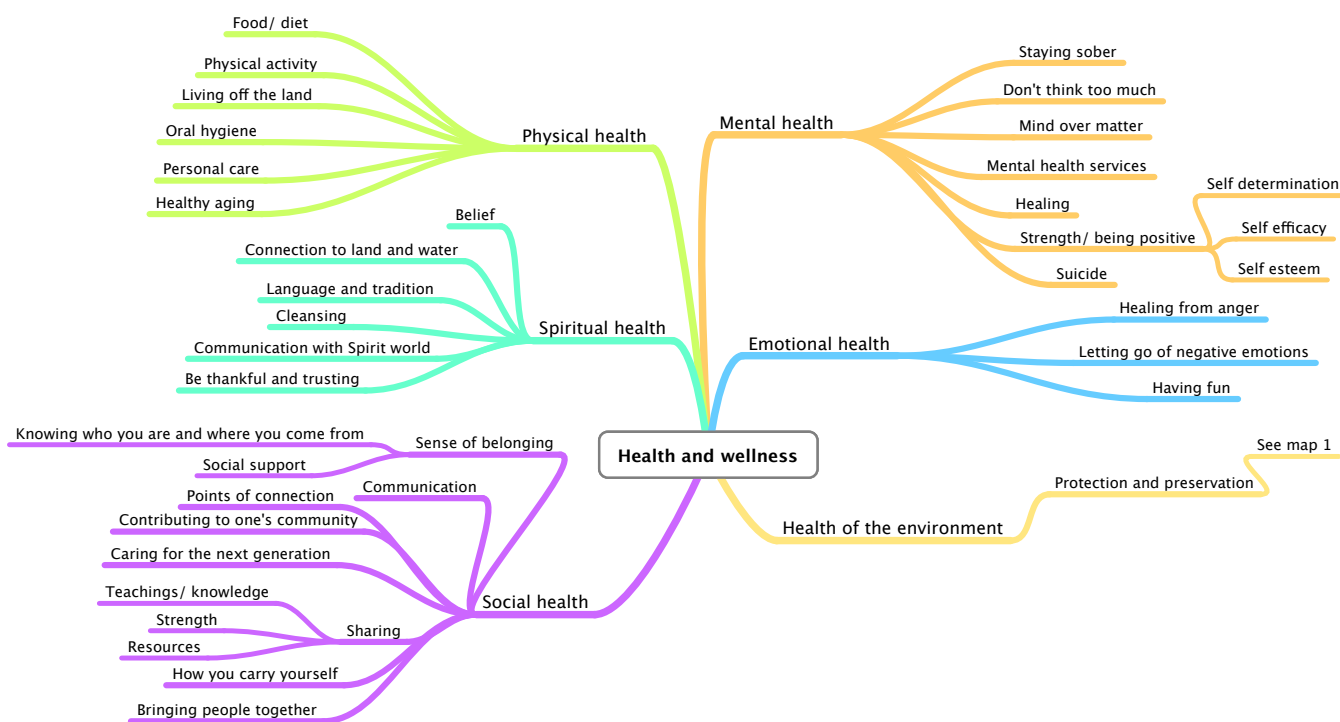
“I have seen the changes throughout my (...) years of existence. I’ve been a canoe puller since I was eleven years old. Played soccer all my life. Played baseball. And I had a

chance to participate with the Elders throughout my life, going up to the Elders camp in the Fraser Canyon and learning, learning different things from some of the Elders up there. I had a chance to look after my uncle.”

“She had me as an Elder and every time she’d do something she’d come and get me and I’d be the elder for the young moms. So I sort of knew what she was doing. Right from gathering wild herbs from the riverside and through the woods and gathering cedar, cedar roots, she’d come and get me and I’d go with the young people. And that’s fun. That’s where the young and the Elders should be sort of put together (...). The Elders are the carriers of the language, the knowledge of life, and what’s right and wrong (...).”

Figure 3 below summarizes the various dimensions of health and wellness as described by elders and community members in interviews and focus groups. Additional visual maps of emerging themes can be found in Appendix 7.

Figure 3: Dimensions of Health and Wellness



4.2 Interpretative Differences

Overall, there was close congruity in themes across participants, and between interviews and the focus groups. However, two interpretative differences emerged in the focus group with the Cultural Committee members, and are discussed below.

4.2.1 Traditional and spiritual healers

Similar to the accounts gathered in interviews, members of the Cultural Committee discussed the various types of healers and their roles. However, they placed an emphasis on the difference between traditional and spiritual healers. For them, traditional healers are those “who know how to bring forward our traditions for healing,” such as working with cedar or knowing the language. Traditional healers have to be from the land (i.e., from Sts’ailes), because “they know what comes alive from teachings and medicine.” They work with their hands to teach others about traditional ways. The committee members went on to describe various traditional ways and how they are practiced, and these accounts were consistent with those described in other focus groups and interviews. However, they made a distinction in describing spiritual healers, who are *recognized* by the people for their work (i.e., “credentialing comes from the people), and may be from other communities. The return of the gifts of spiritual healing was noted as a sign that the community is healing, and becoming stronger. The work of spiritual healers is sacred and should remain unwritten.

This is an important distinction that is often obscured in descriptions of healing services offered by community health centres summarized in this report. Often, the work of cultural workers, traditional healers, and spiritual people is described under the umbrella of traditional services, with the terms “traditional,” “cultural” and “spiritual” practices used interchangeably.

4.2.2 Traditional and novel technologies to promote health and wellness

The second thematic difference was in Cultural Committee members’ discussion of the use of traditional and novel technologies in promoting health and wellness. They recommended that online and visual technologies be used as part of the community health centre as an important way to communicate and teach youth about health and their culture. For example, they suggested

building an interactive website about the longhouse and various traditional activities, or creating educational videos on the life of Sts’ailes families. Some members pointed out that the school already has some educational videos, and suggested that these be reviewed, revised, and posted on an interactive site for youth and others to access. In making these recommendations, however, committee members emphasized the need to preserve and promote the use of traditional approaches to teaching and learning, as they play a unique role that cannot be replaced. For example, they discussed the importance of face-to-face interactions with elders and other groups of community members.

4.3 Building a Community Health Centre

During the course of the interviews and focus groups, participants identified a series of recommendations and strategies for the building and design of the community health centre and its services. The sections below summarize their perspectives.

4.3.1 Programs and services

Participants identified a wide range of programs, services, and amenities they would like to see be part of or closely linked to the community health centre:

- Ambulance Services
- Child development (traditional life cycle)
- Chronic Disease Management
- Cultural programs
- Detox
- Diabetes management and information
- Dialysis
- Dietitian
- Doctors, including eye doctors
- First Nations Policing
- First Nations workers
- Fitness program and nutrition
- Grief & Loss support
- Halq’emeylem Language classes/ language immersion
- Healthy sexuality (including programs addressing sexual abuse)

- Healthy Food and Supply Store
- Justice Office (Restorative Justice)
- Laboratory Services
- Massage therapy/ physiotherapy/ rehabilitation
- Meditation
- Meeting rooms for workshops
- Mental health services
- MRI/ X-Ray/ Ultrasound
- Naturopath
- Nurse Practitioners/ Nurses
- Nursing home/Assisted living
- Other amenities (e.g., bakery, deli, info centre, laundromat, movie theatre, hair salon, gift shop, clothing exchange) and franchises (e.g., Subway, Booster Juice, restaurants)
- Palliative Care and hospice along with traditional ways for care
- Pharmacy
- Psychologist
- Prayer rooms
- Radiology
- Reiki
- Safety of kids
- Services for staff and caretakers (e.g., support and stress management)
- Speech & Language Pathologist
- Swimming pool/ track and field/ water park/ and outdoor gym
- Traditional Health Foods Café
- Traditional Medicines Programs
- Traditional Practitioners
- Traditional Therapy Program
- Youth training and activities (Bald Eagle – Cultural Boot Camp)

4.3.2 Strategies and considerations in designing the community health centre

After sharing stories and examples of health and healing in Sts'ailes, participants were asked about their views on ways to integrate the described health and wellness practices into the community primary health centre, as well as strategies for designing centre and its programming. Their suggestions were congruent with the best practice themes identified in the literature, including holistic approaches, integrated health, traditional programming, traditional medicines, role of Elders, addressing the underlying causes of health and wellness, and community ownership. These are summarized in select quotes and recommendations below:

"I agree with anything that's holistic. If it's going to look after every part of our life, it's going to be good (...). We have so many unbalanced people that only look after one part."

"Probably what we need [is] a lot of more sacred places."

"Think there could be a lot of healing [in the drug and alcohol world] (...). Once you make up your mind, you know, to quit, then its good to have someone who knows a lot of it. So I think they would, they should have, like, not just him, but an Elder to sit there with them too, so that's kind of the thing he's doing, he calms them down. So they would need an Elder for that. Just like us in here. In the programs they do have Elders in the programs because they bring out a lot of stuff in programs and uh, I think Elders are important for things like that."

"I think you might want to include the link in there, somewhere, cause we talk about the Elders but you might always, always want to have youth involved in this program as well. They'd be our link, strong link to carry on the traditions."

"When you talk about traditional healers too, then we have to include the traditional medicines out there too (...). The Indian doctor who always knew about the mother Earth's medicines out there, and the mother's foods out there, and people (...). And there's a few in the community, in every community, they know a certain amount about Mother Earth's medicines, about how they help us. Take, for example, a little thing like swamp tea, and I'm just learning about that now, how it helps so many of the ailments but you have to stay on it day by day before its going to help

you. You can't just say, I'm going to take it for this little bit of time, like a prescription, you've got to stay on it and it helps and it does wonders. And I think that's the way all Mother Earth's medicines are. And that's another thing that should be a big part of the primary care, is getting back to herbal medicines."

"We need to have healthy families. If we don't have a healthy family it shows in the illness of the people that are getting ill in that family. If you knew a lot more about why people get ill, you'd probably know what goes on in some of the families."

Additional suggestions were as follows:

- Bring back Traditional Games (e.g., Slahal)
- Bring Canoe Races
- Build a program for making paddles and canoes
- Build a new Youth Centre (including Youth Conference and Youth Exchange)
- Connect people to the land
- Employ cultural workers
- Employ our own people who have the knowledge
- Encourage exercise
- Ensure a prominent role for Elders (they know the family and history to support family specific needs)
- Ensure proper planning is done to increase success
- Ensure the centre is community owned
- Ensure it is free to use
- Group ideas according to individual, family, and community, and plan from there
- Have a choice of what programs to take
- Have a Pow Wow
- Have a place to visit and socialize in the new building
- Have a talent show
- Have an indoor walking and running track, and have ore sports equipment
- Have elders and babies close together in the building
- Have music classes and instruments
- Homework Club and Tutoring – different location than at school
- Keep up with current trends
- Learn from neighbouring communities
- Learn how to harvest cedar

- Make sure it is holistic
- More youth programming (including WIFI and Internet access)
- Organize cooking classes with elders
- Respect the four directions
- Teach how to preserve fish and wild meat, and canning
- Teach and live according to the four seasons

4.3.3 Traditional and spiritual healers working in the primary health centre

Participants were asked about their views on whether and, if yes, the ways in which traditional healers might work in the new health centre along other health practitioners. They discussed many potential roles of traditional healers as well as cultural workers, such as Aboriginal liaison, spiritual advisor, and traditional healers, who could be employed as staff at the centre. A number of elders offered this advice in the interviews: start slow, learn from lessons, and allow for this process to be gradual:

"You could get yourself into trouble if you don't do it properly. And you don't know what traditional healers are going to be willing to go there and offer their service like that. Usually a traditional healer is approached by somebody and just goes and does the work, rather than like a doctor who sits in his office and waits for the clients to come there. The people usually go out to the traditional healer and ask for his help. So its going to be a real fine line, I think, to actually get somebody there that's gonna be willing to be a centre like this, is probably going to be hard, I would guess. But I could see it helping, like, um, like I said, just gradual processing. Get 1 or 2 people in that door and then I think it will work."

As mentioned, Cultural Committee members felt strongly that while traditional healers can work as staff at the centre, referrals out should be made to spiritual healers linked to the centre.

Another suggestion pertained to cross-cultural competency and understanding: participants talked about the need for *both* non-Aboriginal doctors and traditional healers to understand "both worlds" in order to work well together, including each other's policies and protocols. Participants talked about the need to build respect between all health professionals and workers at the centre, so that they understand and value each other's roles, and

so that their work does not counteracts together (e.g., prescribed Western and traditional medicines). In general, the suggestions regarding how Aboriginal and non-Aboriginal providers could work together were highly congruent with the themes identified in section 3.2 of the literature review.

Finally, the quotes below summarize both the possible challenges and rewards associated with bringing Western and Indigenous approaches together to the community health centre:

“It made it seem crucial to come up with some sort of money value to this traditional healer and that’s difficult because we do it for free. We’re taught that as traditional healers, you never ask for money to heal somebody, to help somebody, now they want to try to put this money concept into it. Even though, in modern times it might seem like a good thing that’s going to be a real hard concept to try to instill in this, if you offer traditional healing in this primary health care project.”

“It’s starting to go more that way in today’s society where you have an actual doctor and a traditional doctor. In all of these places, um, sometimes with our people, the medical people they can’t figure out what’s wrong with our lost ones and so it’s going to take a more in-depth, spiritual person to go and look for that mistextw about that person, so I think it would be a really good idea to have one in there. Just to have that extra insight, not just for the medical doctor but also for the spiritual side. More and more, I’m finding more and more (...) medical doctors are starting to turn that way. They’re starting to tell our people, or maybe you should go look for spiritual help. I hear that more and more often today amongst our people. And even some of the xwelitem and some of the other ethnic groups are starting to look at it now”

5. STRENGTHENING COMMUNITY CAPACITY

This Project has helped to inform Fraser Health's Aboriginal Health in how they can work to influence Fraser Health to adapt its organizational processes to better fit the needs of Aboriginal health centres. The findings from the Project will be used to make recommendations to the organization around how to adapt services to better meet the needs of the new Sts'ailles Primary Health Centre and other Aboriginal health centres in the region. The findings will be shared with Fraser Health Aboriginal Health's human resources department. Additionally, the Project has helped both Fraser Health and Sts'ailles better understand each other's needs, challenges, and perspectives in delivering primary health care to Aboriginal communities. Following the HIPP methodological paradigm (see *Appendix 2*), community capacity was strengthened through: new relationships; knowledge products; trust building; place-based learning, and problem solving capacity.

New relationships have formed and strengthened under the oversight of the HIPP committee. The working relationship between the researchers (community, student, and academic researchers) was extremely collaborative with each researcher uniquely positioned to provide value-added to the research process. The Aboriginal student researcher is a member of a neighbouring Sto:lo community with close kinship ties to Sts'ailles. During her term with the Project, she completed a Master of Public Health degree followed by a work position in the field of First Nations health. Her contribution to the research project exemplifies the concept of bi-cultural competence, thus assisting the team with the interpretation of data and ideas that bridge two knowledge traditions. The community researcher resided in a neighbouring First Nations community and worked for the Sts'ailles band. She brought a detailed understanding of community customs and protocols, and a local perspective to the selection of research participants, interview protocols and

procedures as well as data analysis and interpretation of results. The academic researchers (principle investigators and research associates) established a close relationship with the decision makers through regular meetings both on and off reserve, attendance at cultural gatherings and healing ceremonies, team retreats, and overnight lodging on reserve. These relationship bonds have nurtured a new research capacity for Sts'ailles that can be applied to additional future analyses of existing interview data and program evaluation.

The new skills can also be applied to other domains beyond health and wellness services to include economic and social services planning activities, thus providing a broad research expertise to the community as it moves forward with its long-term development plan.

In terms of knowledge products, our research data was collected from literature reviews, individual interviews with community elders and healers, focus group interviews with community services staff and youth and other sources. We used a blend of traditional and non-tradition research methods for data analysis and validation of research findings. These methods can be applied to future community projects in the field of health and beyond.

Trust building between the researchers and the decision makers began with formal written research agreements with the Sts'ailles Band Council. The project followed ethical guidelines for conducting research with Aboriginal communities and ethics approval was sought and granted from university ethics boards. Financial trust was established by transferring research grant funding for the community researcher directly to the Sts'ailles band for local oversight and administration. Throughout the research collaboration, resources were pooled among the participants including food, accommodation, meeting

locations, etc., in the spirit of sharing and cooperation. Rather than dominating discussions and imposing an academic perspective, the academic researchers have learned to listen, trust and begin to understand the local community perspective and priorities including the role of Indigenous knowledge as a lens for focusing the deep intimate wisdom of local context and circumstances. The Project reinforced that Sts'ailes does not need to defer to every idea that flows from an academic source (e.g., policy, procedure). Future research collaborations should benefit from this experience.

Finally, problem solving occurred throughout the Project during many meetings both formal and informal involving respectful listening, interpretive and interrogative dialogue and open, frank discussion. In short, the research collaboration exemplifies the key features of a place-based learning community by demonstrating itself as a dialogic network that supports people by responding to their own needs, developing capacity to generate their own research projects, creating supportive relationships through the building of dynamic processes for the co-production of locally relevant knowledge. The problem solving capacity generated within this place-based learning structure and process can now be applied to future projects and challenges as community planning activities continue into the future.

6. SUMMARY OF COLLECTED KNOWLEDGE

This section provides a high-level summary of the lessons learned and knowledge collected through this project. This knowledge will be of use to Sts'ailes, Fraser Health and others engaged in cross-cultural dialogue and action related to primary health care. The knowledge collected could be framed in many ways but is presented here under three headings designed to inform the process of developing the Sts'ailes Primary Health Centre.

6.1 Pre-Existing Knowledge

During the course of the project, the original objectives evolved to recognize the importance of pre-existing bodies of knowledge, ways of knowing, and ways of relating. This pre-existing knowledge base provides the foundation for moving forward.

While the mechanisms for generating, collecting and filtering scientific health care knowledge are articulated in the academic literature, those related to traditional or cultural knowledge are more relationally encoded. That is, the body of knowledge is not so much stored in “books” but in the living memory of the community. Words divorced from their relational context can easily be misinterpreted or lose their real power. The Elders have a central role in terms of evaluating and preserving knowledge in the community. Nonetheless, certain principles have been adopted within Sts'ailes as articulating the core knowledge of the community. These include:

1. **Seven Laws of Life** (health, happiness, generations, generosity, humility, forgiveness, and understanding) to govern program partnerships (e.g., Sts'ailes Lhawathet Lalem Youth Wellness Program, 2001)
2. **Circle of Courage** (belonging, mastery, independence, and generosity) provides core values governing programming and community development

3. **One heart, one mind** (Letse'mot): *“Be strong-balanced: our laws and teachings are for everything and everyone. Everything is sacred to us. We are all one mind and one spirit as Sts'ailes.”*

4. **Snowoyelh**: Teachings from Xals (the Creator) handed down by Ancestors and Respected Elders

This suggests important differences not only in terms of the bodies of knowledge but in terms of the ways of knowing. We need to be careful not to over-state the differences, but, whereas Western education tends to put the emphasis on the validity of the argument, the strength of the evidence and logic, Aboriginal thought puts greater emphasis on the relationships of transmission and on wisdom. This accounts for the central role of intergenerational teaching and learning from Respected Elders the wisdom of the Ancestors.

Community members recognized the value of these different bodies of knowledge and different ways of knowing. They spoke of the need for cross-cultural exchange. Despite many examples in the community's history in which traditional knowledge and practices were not respected, the community has been forging new relationships and has developed a series of guidelines that help ensure a respectful cross-cultural exchange. These include:

1. Culture, spirituality and the teachings are the strength of the people and their way of life and must be the foundation of exchange. Sts'ailes believes that “if we take care of the Spirit, the Spirit will take care of us.”
2. Services and policies must be “made in Sts'ailes” by blending the best of the “two worlds,” (First Nations knowledge and Western knowledge) in a way that honours Sts'ailes tradition and culture.

3. The Halq'emeylem language, especially the old dialect, is important to consider in designing and delivering services.
4. The Elders have a central role in in the community in terms of teaching, evaluating, training, discerning, and oversight. Community elders must work in partnership with program staff and providers and offer ongoing direction and consultation related to day to day operations.
5. It is the process that matters: take time, reflect, and discuss, so that everyone owns the product at the end.

6.2 Multiple Discourses

Any discussion of primary health care must wrestle with the challenges of different definitions of health and the different perspectives embedded within different approaches to care. Within the health services system this diversity can be usefully summarized with reference to the different discourses present. Many of the services we often associate with “health care” focus on disease or injury (i.e., illness model) and seek to cure or repair the damage within a materialist paradigm (e.g., addiction may be presented as a biological disease of the brain or the result of genetic factors). An alternative perspective (and consistent with health promotion) focuses on health as a positive state of physical, mental, emotional and social well-being rather than the absence of disease. In this more holistic view of health, a much broader range of services and supports, including traditional health care services, are seen as contributing to health. In addition, several ‘alternative health’ discourses can be incorporated into a broad bio-psycho-social understanding of health. So, for example, acupuncture and meditation may be practiced alongside cognitive behavioural therapy and pharmacotherapy in treating addiction. A complex ecological understanding of people and communities allows for the respectful coexistence of these multiple discourses.

Likewise, multiple discourses emerged as we explored ideas of health and healing within Aboriginal communities. One of the important distinctions that emerged was with reference to traditional healers who teach traditional ways that provide healing for the community compared to spiritual healers whose sacred work is a gift of the Spirit.

These multiple discourses are helpful in several ways. For one, the existence of multiple discourses within a single tradition helps us avoid the oversimplifications that often emerge when we contrast two traditions. Furthermore, the more holistic discourses within Western health systems share a lot in common with traditional Aboriginal conceptualizations of health and wellness. And finally, the experience of working in an environment in which multiple discourses are in play may offer insight in learning from and using the strengths of different perspectives to serve a common good. Some of the related lessons that emerged during the research project include:

Following community protocols and protecting sacred knowledge and practices is essential to respectful exchange.

A team approach that recognizes and utilizes the gifts represented by people within “both worlds” enriches the process and the outcome.

Having bi-cultural competence within the team (in our case through the work of our Aboriginal student researcher) was invaluable in bridging both cultures and suggesting useful interpretations.

6.3 Ways Forward

There is a general recognition within Sts’ailes that the work and practice of healers has evolved over time. But there is also a recognition that the structures (e.g., offices, appointments, remuneration) in which Western health disciplines operate are radically different than those in which traditional healing has operated. The question is how best to structure primary health care so as to benefit from both traditions.

One method might be called a multi-cultural approach. In this approach, traditional healing might be seen as another discipline alongside other health disciplines. In this approach, the practitioners are usually encouraged to understand and value each other and seek to be as complementary as possible but continue to operate within separate paradigms. Many of the comments of community members assume some version of this model.

A more radical approach might be referred to as cultural evolution. This model begins with a firm commitment to traditional values and principles to which all services must adhere. Insights from other traditions can be incorporated into the culture of the community but only as they are critically assessed and molded to fit the community. Some of the comments received tend to reflect this perspective.

These are not mutually exclusive but are identified because they reflect different perspectives within the community and have important implications for the design and operation of the Primary Health Centre. The need for cross-cultural competency and respect is universally recognized within the community and among the stakeholders. How these concepts are defined and operationalized will depend, to some extent, on how the community views the process of blending “the best of two worlds.”

7. RECOMMENDATIONS

1. Recognizing that indigenous knowledge provides a window to understanding Sts'ailes health and well-being, the Sts'ailes narrative(s) are central to the structure and operation of the new community health centre. The collective knowledge of the Sts'ailes should direct the course of the centre, including assisting in allocation the centre site, naming, and design, as well as informing educational requirements for staff and health providers.
2. The community recognizes the value of different bodies of knowledge and different ways of knowing. There are, however, multiple perspectives with respect to the process of blending various bodies of knowledge and traditions. The decision makers should continue the dialogue on how to structure primary health care as to benefit from those traditions (e.g., define and operationalize the guiding concepts that emerged from this Project, and the process for blending "the best of both worlds").
3. The decision makers should develop a plan to facilitate the partnership of healers from across traditions – traditional and spiritual healers, medical model physicians, nurses and other health providers – to support the health and well-being of the Sts'ailes and other people accessing the new community health centre. The research project has provided insights into traditional health, wellness and healing practices and protocols, but more work is required to operationalize indigenous knowledge into the work of the centre in collaboration with the primary health care model.
4. Community Elders have a key and central role in the new community health centre extending beyond providing a symbolic presence. The decision makers should determine how best to apply the expertise of the Elders to work in partnership with the centre staff and provide ongoing consultation to the direction of the centre and its day-to-day operations.
5. Educational processes should be put in place to support staff education regarding the historical, social, cultural, political, geographical and economic contexts of providing care to the Sts'ailes community and its neighbours. This goal can be achieved by following a key message articulated by the Sts'ailes leadership group: *"You've got to see us, you've got to hear us, you've got to feel us."*
6. The decision makers should develop a framework for evaluating the new community health centre. An application for external funding would help support this initiative. There are examples of several potential frameworks in the literature that might serve as a baseline and help inform the development of a Sts'ailes-specific framework.
7. The new community health centre has the potential to become a centre of excellence for training of health care professionals. The decision makers could consider opening negotiations with health care training organizations to establish training opportunities for multiple level and inter-professional trainees.
8. Sts'ailes has established itself as a place-based learning community. The lessons and skills learned over the past five years within our research collaboration can be applied to future research and management projects both within and outside the realm of health care.
9. The summary of the health centres reviewed as part of this project provides a high level overview of types of services and Western and Aboriginal programming offered. Information available online rarely included details on the hiring and remuneration of traditional workers and healers, the operations of health centres,

and the mechanisms in place to implement stated principles. It is recommended that the decision makers consider contacting the management of health centres of interest to learn from their experiences.

10. The information and data collected from the individual and focus group interviews are very rich and comprehensive. The traditional and non-traditional analyses have uncovered themes that inform both the structure and operation of the community health centre. It is recommended that the decision makers consider conducting additional data analyses with the assistance of academic partners and external research funding to identify additional themes that inform the evolution of the centre.
11. The decision makers continue to work with the CAR-BC Vancouver office to develop and implement knowledge transfer and exchange (KTE) activities that promote the key messages emanating from the research project. These KTE activities should include the development of effective and culturally meaningful communication tools that express the components of the Sts'ailes narrative and local stories and that articulate the vision and purpose of the new community health centre to the relevant stakeholders. The practical applications of the findings of this Project as well as any future analyses of the data gathered over the course of the collaboration will help expand and enrich the existing Sts'ailes narratives.

8. KNOWLEDGE EXCHANGE/TRANSFER

Knowledge exchange and transfer occurred throughout the course of the project in both formal and informal ways. In terms of knowledge products, our research data was collected from literature reviews, individual interviews with community elders and healers, focus group interviews with community services staff and youth and other sources. We used a blend of academic and Indigenous research methods and ways of sharing information.

Implementation of recommendations will continue to be carried out after the completion of the research project with the support of the Knowledge Exchange Unit at the Centre for Addictions Research of BC. The research findings will be shared in a number of formats (e.g., report, presentations, personal communications) with a variety of stakeholders and knowledge mobilizers, including the newly established First Nations Health Authority in BC.

The findings have already informed the work of Sts'ailes leadership and their consultants in feasibility and development planning, and will continue to do so as the planning moves forward to the implementation phase of the project. The findings are being used on an ongoing basis in consultations and meetings with surrounding communities who will be future users of the primary health centre. The findings have informed the work of Fraser Health Aboriginal Health with other Aboriginal communities, in particular in terms of the lessons regarding the process of engaging in community partnerships. The project has also had a number of spill-over effects (e.g., successful CIHR planning grant application entitled "A community-driven approach to improving access to primary health for Aboriginal people").

Sts'ailes and the local health authority will continue to use the findings to develop new policies, guidelines and programs.

9. APPENDICES

Appendix 1: Directory of separate attachments to accompany the Report

Attachment 1: Literature Review Data Repository

Attachment 2: Health Centres Summaries

Attachment 3: Lessons Learned on Community Interviews

Attachment 4: Interview Guide

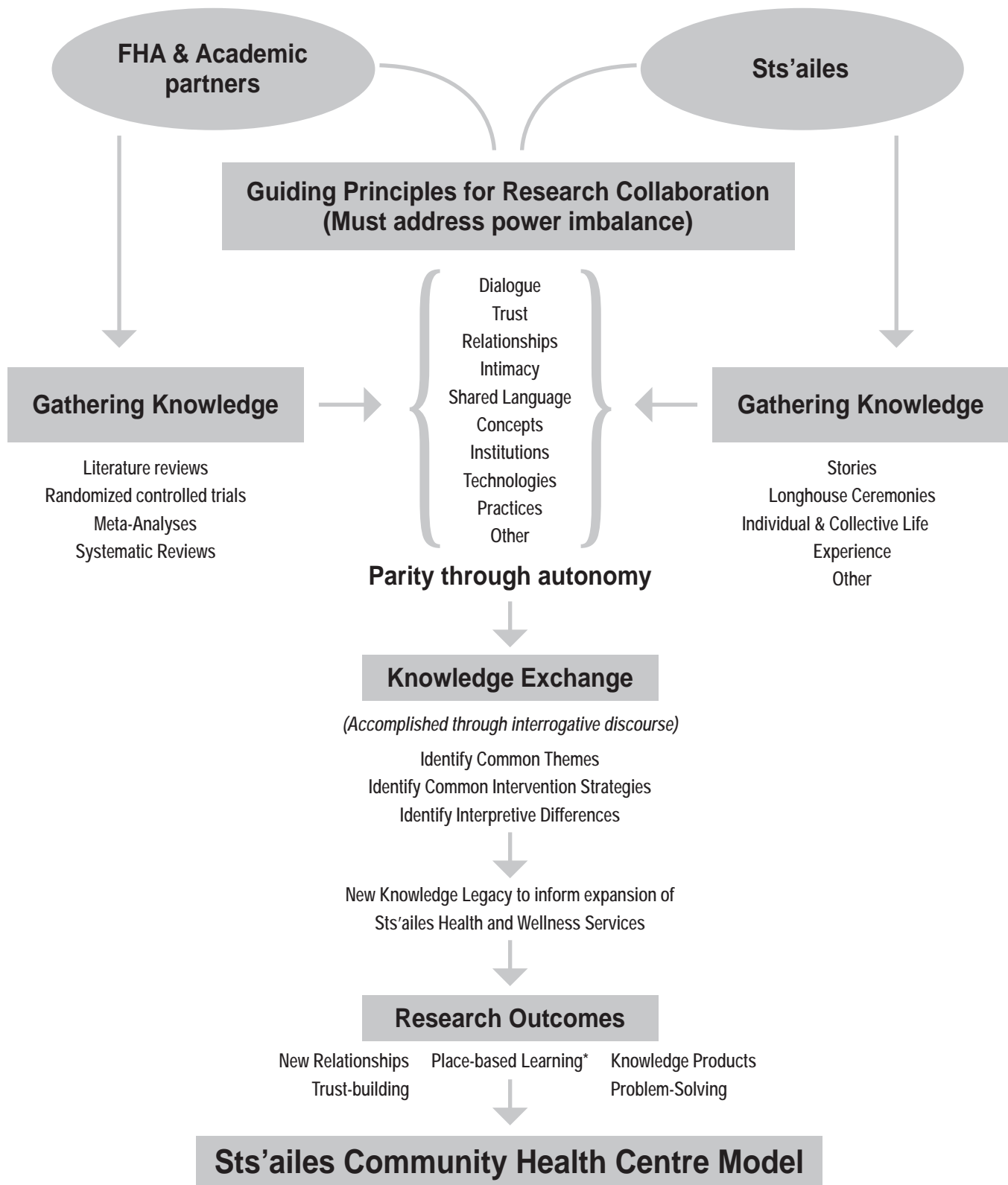
Attachment 5: Summary of Themes and Codes

Attachment 6: Quotes Bank

Attachment 7: Visual Maps of Themes

Attachment 8: HIPP meetings summary

Appendix 2: HIPP Methodological Process



* Place-based learning communities are dialogic networks formed to support people by responding to their own needs, developing a capacity to generate their own research projects, creating supportive relationships with other researchers through the building of dynamic processes for the co-production of locally relevant knowledge.

Appendix 3: Gathering and Interpreting Knowledge

| Source of knowledge | How was it gathered? | How was it analysed? |
|---|---|---|
| <i>HIPP Committee meeting notes</i> | <p>The HIPP committee met regularly (monthly or bi-monthly) to provide updates, set questions and direction, and to comment on and interpret preliminary results, and their application. The meeting notes were recoded by the research associate and sent back for further input. Where possible, the notes captured the underlying guiding principles and perspectives of the decision-makers.</p> | <p>The research associate reviewed the meeting notes to identify themes and inform the interpretation of preliminary findings.</p> |
| <i>Reviews of the grey and peer-reviewed literature</i> | <p>Two research associates conducted independent searches of peer- and non-peer reviewed literature using Medline, Pubmed, and Health Science databases as well as Google Scholar and other online sources such as NAHO (for a complete list, see the Research Proposal). Review articles were included, and citation tracking was used.</p> <p>In research area 1, searches included combinations of keywords: Aboriginal, First Nations, Indian, health services, health centre models, health system, integration, primary healthcare, healthcare delivery, Indigenous knowledge, healing, wellness, traditional knowledge, place-based learning, community health. In research area 2, keywords included: Aboriginal, culture, traditional medicine, Aboriginal patients, health care providers, provider perspectives, Aboriginal health, traditional healing, integrative medicine, medical pluralism, Indigenous health, traditional healers.</p> <p>Additional literature was identified by HIPP members through a variety of informal sources.</p> | <p>Abstracts found were reviewed and selected, with a focus on Aboriginal health centre and service models as well as Aboriginal/ Western knowledge and practice integration. Inclusion expanded to examples of traditional and Western practices and practitioners within a specific health area (i.e., birthing centres, diabetes, mental health).</p> <p>The abstracts for all articles and documents were organized into a data repository. A database was created where two research associates summarized the findings of the literature, drawing out keywords, key considerations, and principles from each document. The keywords were then grouped themes, highlighting key quotes under each theme.</p> |

| Source of knowledge | How was it gathered? | How was it analysed? |
|---|---|---|
| <i>Interviews with community elders</i> | <p>The community researcher conducted 7 interviews with 11 community elders, cultural teachers, mentors and healers. The interviews focused on traditional health and healing, consisting of questions prepared by the researchers, with input from HIPP and Sts'ailes staff. The interviews were audio recorded and transcribed.</p> <p>The community researcher met with 3 well-known Sts'ailes interviewers in order to gain guidance on protocols for conducting interviews with elders, and gain feedback on questions. Included as separate documents are the lessons gained in these meetings (Attachment 3), as well as the interview guide (Attachment 4).</p> | <p>Three researchers, one FHA staff, and one co-principal investigator separately coded each transcript. Coding was based on interviewees' own words. The team met multiple times to review transcripts and codes, combining all codes for each transcript. Then, each person identified themes, which the team discussed in multiple meetings to arrive at grand and sub-themes.</p> <p>The research associate and assistant met separately to organize sub-themes, with codes fitting under each, and prepared visual maps of themes and codes. Key quotes were pulled into a "quotes bank" under each theme. The full team reviewed all themes and visual maps, and which were finalized after a review by the HIPP committee.</p> |
| <i>Focus groups with community members and key stakeholders</i> | <p>The community researcher conducted four focus groups with Sts'ailes health staff (May 20, 2011), Chief and Council (July 26, 2011), the cultural committee (September 26, 2011), and youth (February 22, 2012). The purpose was to identify common and divergent themes from different community voices, and to validate findings.</p> <p>The community researcher made a presentation to fifteen Sts'ailes health staff and health committee members, summarizing the results of the interviews on health and healing. The focus group took a talking circle format following the presentation, using a series of guiding questions (attached in a separate document).</p> <p>The focus group with the Chief and Council took the form of a discussion, following the researchers' brief presentation to update the group on the Project. The Council members responded with comments to the presentation and discussed services they would like to see be part of the community health centre.</p> | <p>The community researcher summarized the information from each focus group, both during and following each group discussion, using a reflective notes format, drawing out broad themes. The themes from all focus groups were organized, identifying common and divergent themes.</p> <p>The research associate analyzed the cultural committee focus group notes by grouping participant comments under each question into categories. From then, broader themes were developed, and cross-checked for similarities and differences with findings from other sources. Similar responses were given the same codes and theme names, as those developed by the research team for the interviews. Unique themes were given a new theme or sub-theme name. The research associate reviewed the participant comments again, and organized them under each theme, either as verbatim quotes or as codes. The final themes were verified and revised by the community researcher.</p> |

| Source of knowledge | How was it gathered? | How was it analysed? |
|---|---|---|
| <i>Focus groups with community members and key stakeholders (continued)</i> | <p>The cultural committee focus group consisted of the same questions that were asked in the interviews with community elders. The committee members took turns answering each question in a talking circle format. The research associate took notes, which were displayed on a screen for the group to see and to make corrections and validations. Detailed information on the cultural committee focus groups, the process, and reflective notes, are included as separate documents.</p> <p>The focus group with 4 youth aged 16, 16, 17, and 31 took an open discussion format about health and healing in the community.</p> | |
| <i>Site visits to other community health centres</i> | <p>Over the course of the Project, various HIPP committee members have visited other community health centres, most notably the Southcentral Foundation in Alaska. The findings and lessons were discussed in HIPP meetings, and summarized as written notes. Additional information was gathered in the form of documents, power point presentations, and reports.</p> | <p>The information gathered from site visits was discussed in HIPP meetings to identify promising principles and models. The research associate reviewed all documents, summarizing operating principles, vision statements, services, populations served, and service models.</p> |
| <i>Review of community health centre websites and online documents</i> | <p>Eleven community centres were selected for review based on their integration and/or use of both traditional and Western health and healing services and approaches, and the amount of online information available. Three researchers and one FHA staff reviewed and collected online documents about selected health centres over the course of the Project. A final review of the centres' current websites was conducted between July and August 2012.</p> | <p>The research team drew out principles and guidelines, focusing on integration of traditional and Western approaches, and how these were implemented (i.e., how do they play out in practice; what protocols and/or stories being used)? The research associate summarized descriptions for each centre in this Report, and in a more detailed, separate document (Attachment 2).</p> |
| <i>Informal consultations with staff and community members</i> | <p>The community researcher met with various staff and community members throughout the Project to seek guidance on protocols, and to gain feedback on preliminary findings (Attachment 3).</p> | <p>The community researcher drew wisdom from these meetings through the traditional research methodologies (e.g., prayer, ceremonies).</p> |

| Source of knowledge | How was it gathered? | How was it analysed? |
|--|---|---|
| <i>Review of documents regarding existing Sts'ailes health and social services</i> | The community and academic researcher gathered information on existing Sts'ailes services in the form of reports, power point presentations, and other written summaries over the course of the Project. This process was guided by feedback from the HIPP committee and the decision-maker's information needs (e.g., integration, protocols). | The team drew out principles and themes, which were discussed and validated in meetings and one-on-one conversations with Sts'ailes staff and HIPP members. |
| <i>Stories, ceremonies, community events</i> | HIPP members gathered information over the course of the Project through stories, ceremonies, and community events. | Through an iterative, circular process, stories, ceremonies, and community events guided protocols and processes, informed questions, and were used to validate findings. |
| <i>Field notes and reflective journals</i> | Over the course of the Project, the research team gathered information through field notes and reflective journals. | Field notes and reflective journals stories were used to review and validate findings. |
| <i>HIPP retreats</i> | Additional information was gathered through interrogative dialogue of researchers and partners, and feedback from various guests and groups at HIPP retreats. | Information gathered through HIPP retreats was used to review processes, discuss and validate findings. |

Appendix 4: The Haudenosaunee Code of Behaviour for Traditional Medicine Healers

A Code of Behaviour

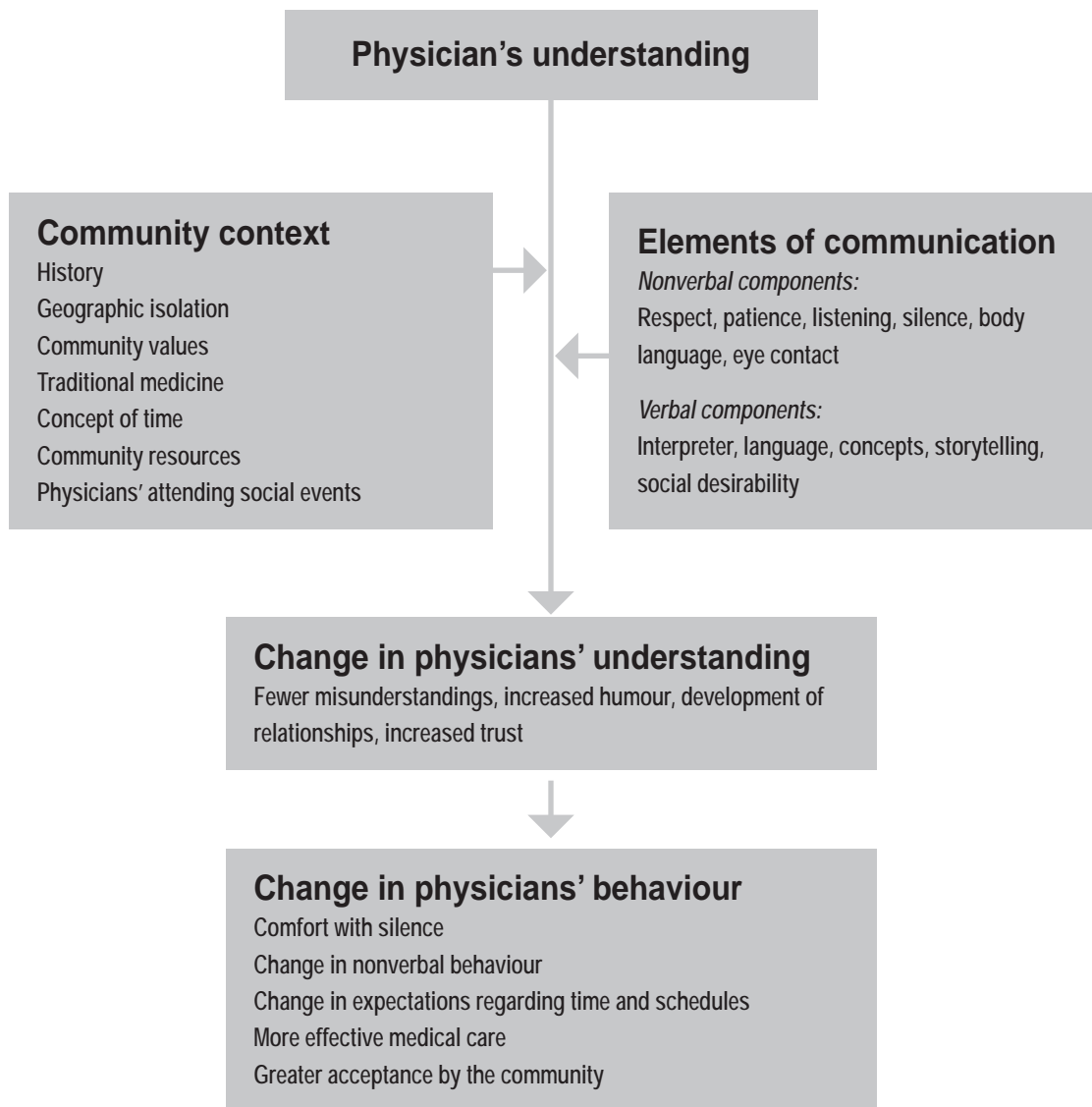
As is the case with other professional people, our traditional medicine healers have a primary responsibility to regulate their profession. One example of such self-regulation is a code of professional conduct, which could be adopted by the nation. A draft code has been developed for discussion by the Haudenosaunee. Other nations will take other approaches to self-regulation. This approach is intended only for Haudenosaunee people and Haudenosaunee healers, to be applied through Haudenosaunee jurisdiction, as is our inherent right.

1. As traditional healers, we commit ourselves to working for, and on behalf of, Sonkwaiatison (the Creator), for it was Sonkwaiatison who appointed certain people and gave them special gifts to assist the healing of our people.
2. As traditional healers, we commit ourselves to understanding the four sacred ceremonies, our responsibilities in each of the four seasons, and the powers of the four directions.
3. As traditional healers, we commit ourselves to developing bonds of trust and respect with other healers. We commit ourselves to working together in the defense and advancement of our cultural heritage and in the enhancement of our knowledge. We renounce division, gossip, and ill will.
4. As traditional healers, we commit ourselves to establishing and maintaining standards of practice for traditional healing.
5. As traditional healers, we commit ourselves to establishing a mechanism for complaints about the failure to adhere to the established standards. This mechanism will allow us to collectively investigate and take appropriate action.
6. As traditional healers, we commit ourselves to following the teachings of Sonkwaiatison.
7. As traditional healers, we commit ourselves to using our medicines wisely and respectfully and prohibiting ourselves from selling our medicines or knowledge for commercial purposes or personal gain.
8. As traditional healers, we commit ourselves to protecting, caring for, conserving, and nurturing our medicinal plants.
9. As traditional healers, we commit ourselves to referring our clientele to other healers, doctors, or practitioners whenever we feel another form of care is required.
10. As traditional healers, we commit ourselves to finding and recruiting apprentices, setting high standards for them, and guiding them in becoming traditional healers of high quality.
11. As traditional healers, we commit ourselves to engaging in continuous learning about the wisdom of the Elders, about our traditional medicines, and about traditional knowledge regarding health and healing.
12. As traditional healers, we commit ourselves to act with respect, accountability, honesty, humbleness, and humility.
13. As traditional healers, we commit ourselves to be role models in our lives, to be followers of our own advice, to maintain confidences faithfully and completely, and to speak positively of others.
14. As traditional healers, we commit ourselves to not seek publicity other than the good news passed on to others by our clientele, Elders, and community.
15. As traditional healers, we commit ourselves to speak out collectively if we encounter unqualified persons practicing our traditional methods without the knowledge to do so safely.

16. As traditional healers, we commit ourselves to be fair, honest, and practical for the services we provide. Financial contributions will be based on the means of the individual, family, or community.
17. As traditional healers, we commit ourselves to having a healthy, non-exploitative attitude, particularly with our clients.
18. As traditional healers, we commit ourselves to the knowledge that human beings are more than just flesh and bone, that they have feelings, memories, and spirituality. We commit ourselves to be concerned with the entire person, the interrelationship of mind, body, spirit, and emotion, and the relationship people have with their family or clan, community, and nation, as well as with the Creator and the spirit world.
19. As traditional healers, we commit ourselves to working for, and on behalf of, what is right and good, and to the defense of life. We seek blessings to keep our hearts and minds pure, without evil, hate, or envy.

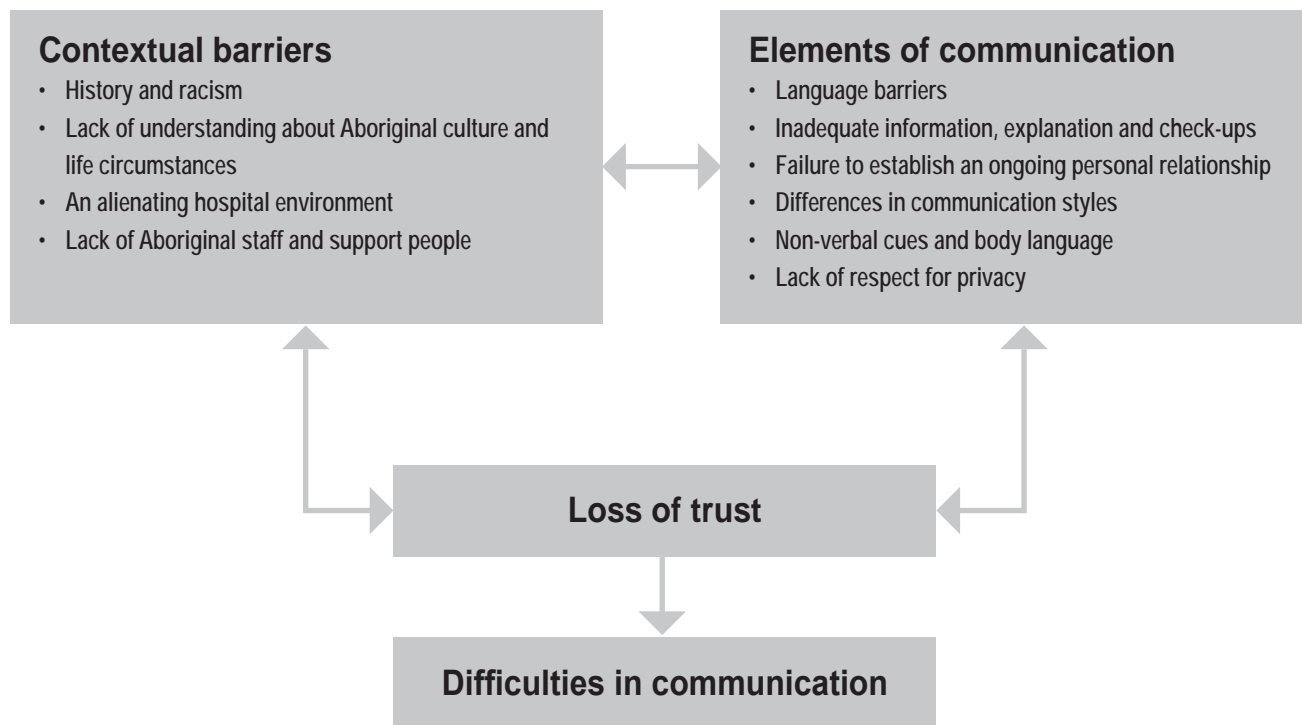
We establish this Code of Behaviour and commit ourselves to it as part of our right to health care in accordance with our own practices, customs, knowledge, and medical traditions.

Appendix 5: Changes in physicians' understanding of Native culture lead to changes in their behaviour and their acceptance by Native communities



Source: Kelly & Brown, 2002

Appendix 6: Barriers to effective communication between Aboriginal patients and health service providers in the hospital setting



Source: Shahid, Finn & Thompson, 2009

Appendix 7: Summary from a community event to share results of the research

As part of sharing the results of the project with the community, an event was held in Sts'ailes on November 8, 2012. We met in the morning at the school library, with about 25 people in attendance. The group was composed of elders, school students, Sts'ailes staff from various departments, and HIPP committee members. It was an opportunity to hear back from some of the people who participated in interviews or focus groups, and to discuss the process and results of the project, and any other ideas with community members.

The day was opened with a prayer and a welcome by Virginia Peters followed by a circle of introductions. Virginia let the community members know that research from the project was brought forward to HIPP committee meetings on an ongoing basis by the research team, thoroughly discussed, and accepted by the decision-makers on the project before going forward. Virginia led the group by sharing her experiences on the project over the 5-year period and providing the Sts'ailes perspective, before inviting others to share their views. Below is a summary of some of the key points of discussion:

- Sts'ailes members emphasized that the grounding of the health centre needs to be in tradition and culture.
- Sts'ailes members talked about the process of bringing various perspectives together to make the centre happen: "Everyone who comes through the door of the centre will be a friend, and will be welcomed."
- HIPP members who were not from Sts'ailes commented on their experiences with Sts'ailes as a very open and welcoming community. Others in the group echoed these comments, stating the importance of the atmosphere of the centre as inviting to reflect this openness.
- FHA representatives explained their role on the project was to bring information back to the health authority with a focus on protocols and changing processes so that they work as best as possible for First Nations communities in the region. FHA had a key role in accessing funding for the business and feasibility plan.
- HIPP members reflected that the research project was a different way of doing business for all sides. Everyone learned from each other and brought different skills and perspectives to the table. The theme of "open minds, open hearts" and the importance of bringing the right people to the table was raised.
- University representatives gave an overview of the findings and themes from the project, and asked for feedback and whether these adequately represent the community's views.
- Sts'ailes members talked about the importance of the spirit to health and healing, and offering holistic services at the centre. In particular, discussion focused on recapturing beliefs in spiritual ways, and bringing back traditional foods and medicines. Many people shared stories and examples from the community of how traditional practices, foods and medicines have helped to improve the health and well-being of people in the community.
- Sts'ailes members expressed concern about writing information down as it can lose its sacredness and may be taken out of context. One member said: "we had 5 years of a learning curve on this project, to understand our words, but those who will read [it] will not have that learning curve." Many Sts'ailes members talked about the importance of bringing context to the written word, and being cautious when sharing information to protect traditional knowledge and practices.
- Sts'ailes members discussed frustrations with not being able to serve traditional foods at community events. Many said there is still a lot of work in having government organizations accept and value traditional ways. Others talked about medical approaches not working for a many people in non-Aboriginal communities, and that those communities are increasingly turning to traditional ways to improve their health, and looking for services for "the whole person."

The discussion was closed by comments from Virginia Peters regarding the next steps in the development of the health centre in Sts'ailes. She talked about the role of the information from the research and consulting groups' reports in terms of design, planning, and funding work that will continue going forward. Virginia Peters said that although there was hope for a bigger turn out for the discussion, the people gathered as part of the group were connected to many others in their families and in the community. She asked everyone to share what they heard with others. The discussion of the group was followed by a lunch gathering and a ceremony honoring Elders and welcoming new babies, with over 200 people in attendance.

Appendix 8: Directory of folders for all electronic files

1. Admin

- a. Contact List
- b. Finances and expense forms
- c. RA and CRA positions

2. Scoping resources (pre grant)

- a. Community based research
- b. Integration proposal
- c. Policy reports and papers
- d. Research literature

3. Pictures

4. Ethics

- a. Background ethics resources
- b. FHA ethics
- c. Research agreement, TOR, resolution
- d. UVic ethics

5. Meetings

6. CIHR grant submissions

- a. CIHR first submission (admin, application, budget, CV files, letters of support)
- b. CIHR second submission (application, CV files, registration)

7. Other grants and funding

8. Communications, papers and power points

- a. Conferences and presentations
- b. Place based learning paper
- c. Reports, bulletins & brochures

9. Project work and data collection

- a. Data collection (focus group, interviews)
- b. Health centres review
- c. Literature review and analysis (complete research literature, literature theme analysis)
- d. Planning tools and resources (charts and models, workplans and templates, resources)

10. Final report

- a. Appendices
- b. Attachments
- c. CIHR reporting
- d. Planning and resources

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