INDIGENOUS WHOLISTIC THEORY FOR HEALTH: ENHANCING TRADITIONAL-BASED INDIGENOUS HEALTH SERVICES IN VANCOUVER

By

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Abstract

How traditional healing can be enhanced in cities, has been the subject of discussion between myself and Indigenous Elders, and between many others, for over 15 years. This project was initiated and completed through the recommendations of Indigenous Elders, through prayer and dreaming, and through increasingly specific factors:

1. Two to four hundred years of unequal relations between colonizing and Indigenous peoples, resulting in
2. Significant and persistent inequalities in the health and educational status of Indigenous peoples, leading to
3. Indigenous calls for more culturally appropriate health services, as reflected in the Royal Commission on Aboriginal Peoples (RCAP), instigating
4. Canadian government strategies for implementing the RCAP recommendations, entitled Gathering Strengths, which prompted a
5. Vancouver/Richmond Health Board review of local Aboriginal health and services, entitled Healing Ways, which led to
6. A Strategic Plan to Develop an Aboriginal Healing Centre in Vancouver, in which traditional healing was emphasized

This dissertation affirms and extends prior research, including the National Aboriginal Health Organization document *Traditional Medicine in Contemporary Contexts* by asking how the access and provision of traditional-based health services (traditional healing) can be enhanced, by and for Indigenous peoples in a specific location (Greater Vancouver Regional District; Indigenous pop: 77,500), and by designing, implementing and analyzing this research, using Indigenous wholistic theory, storywork, and talking circle methodologies, protocols, and processes of analysis (prayer, dreaming, reflection, dialogue).

Collective storywork, confirms and extends prior research, by providing locally-specific and detailed strategies for societal, institutional and community enhancements, including the establishment of a cohesive governance framework, educational campaigns, establishment of integrated health teams, establishment of a traditional-based Indigenous practitioner’s council, establishment of liaison positions, and the establishment of traditional-based Indigenous healing centres.

In addition, the research process has resulted in an affirmation and extension of: Indigenous wholistic theory, storywork and talking circle methodologies, Indigenous protocols and processes, a model for Indigenous research entitled a Wampum Research Model, a discussion of the inextricability of health and education, a need to prioritize worldview in the non-medical determinants of health, and Graham Hingangaroa and Linda Tuhiwai Smith’s criteria for Indigenous theorizing and Indigenous projects.
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Dedication

The Medicine Basket
(copied with permission of Lynn Henry, 2004)

Strips of cedar bark, pulled from the tree, All of the ancestors sharing their prayers with me. We pull up long roots, peel off the skin, Wait for it to dry, then we can begin. The bark has been soaking many days in the sea, Soft and pliable now, it is waiting for me. We pull up long roots, peel off the skin, Wait for it to dry, then we can begin. The bark has been soaking seven days in the sea, Soft and pliable now, it is waiting for me.

The cedar is prepped, the bannock is baked, The tea is ready along with cookies and cake. We all come together, the young and the old, To share all the stories that will be told. With family around us and full baskets of cedar, She lays down the first strip saying, “this is for the Creator”. For the two legged ones she crosses one over the other, It’s to include all our human family, sisters and brothers.

Now crossing the others a third strip she lays down To thank the four legged ones for the teachings we found. The fourth strips laid down for the winged ones that fly. The eagle watches over us and guides us when we die. The fifth is laid down for the life in the sea, For all of the seafood that feeds you and me. Now all are laid out, giving thanks to the tree, She picks up the root and begins to show me.

With the root of the cedar she weaves round and round, The strips that are laid out will be tightly bound. In and out in their order she weaves them together, The two and four legged, the swimming, the feathered.

The base of the basket, it has formed now, you see, It’s the base of our people’s life on this land by the sea. Now the strips must be raised up, the sides to be formed. We must add the prayer songs, as our ancestors warned.

The sides as they form create the space to hold prayers, To help and guide us through lessons, worries and cares. In a circle around the center our ancestors’ crests are done, Each crest with a family story, to be shared one by one.

To the top of the basket we have now come to time, To finish off the rim, the strips she’s entwined. Left and then right she folds them to bind. Joining all of our teachings, our life and our times.

The basket’s now formed, its story has been told. The history of our people, both young and old. Basket’s shape and its weave tell us of our clan. So the teachings of our people stay close at hand.

This dissertation is dedicated to all those ancestors who have worked so hard to live good lives, to teach the next generations in good ways, so that our connections to our origins as spiritual beings can continue to work within us, to create better lives for us now, and for our future generations.

I especially dedicate this dissertation to those Elders in my life, who’ve passed on to other worlds, and who’ve given me so much; may your hopes, dreams and prayers come to fruition in these next generations: George Charles, Marjorie George, Val Edgar, Joyce & George Douglas, Shirley Sterling, Ken Schramm, Laura & Lodore Leduc, Florence Shilling, Jim St. Germaine, Jim St. Germaine Jr.
Chapter 1 Hawk-eye’s View and Motivating Influences: Self, Community, Academia

Overview

After 25 years of schooling, and after only 28 years of returning to my relations, I am just now starting to test what I’ve learned, for the benefit of all our relations. In that way, it’s appropriate for me to begin with my childhood name, Hawk-eye, given to me by my father, for spying out where everything was in our house. If anything was out of place, I knew where it was, or what had happened. That talent has not been well received during my forays into student or community politics, where I used it to view inadequacies in the status quo, but it came in very handy when connecting with family, listening to Elders and learning our stories. I have attempted to apply my “hawk-eye” in this more proactive way, beyond conventional research practices and the re-examination of health service inadequacies, to discern ways of doing research, and ways of enhancing health services, with Indigenous peoples, by examining the enhancement of traditional-based health services in Vancouver, British Columbia. Alannah Young alludes to the complexities of traditional-based health practices in Vancouver, in her statement.

A: I worked at the FNHL as a counselor and so I know that in that particular space we are lucky to be able to practice a number of traditional ceremonies and so in that context it is much easier to do this kind of work where we are balancing our traditional knowledge with our contemporary knowledge (Research Gathering 1, December 12, 2003).

Traditional-based education is inextricably intertwined with traditional-based knowledge holders and practitioners, and thereby traditional-based health services. In the sense that both traditional-based education and traditional-based health services are predominately about teaching people to lead good and healthy lives, you could say that they are synonymous in meaning and practice. The onus is upon the teacher/practitioner to transmit teachings about living well, and the onus is upon the student/practitioner to incorporate and practice those teachings. To make discussions simpler, and to reflect the intertwining of traditional-based education and health services, I will use the phrases traditional-based health services or simply traditional-based practices. Because of a focus on the importance of relationship, balance and interconnectedness, the proof of effectiveness or outcome of traditional-based Indigenous health education processes is in the well-being of the particular community as a whole.

As traditional-based education has been predominately excluded in Vancouver, so have traditional-based health services, but to a much greater degree. People have been trying, seriously, to deliver biomedically-based health services and career-based education in more culturally appropriate ways, for at least two decades. This has created small improvements in the health and educational status of Indigenous peoples, but it’s not been enough to eradicate inequities in health between Indigenous and non-Indigenous peoples in urban areas. According to Tjekema (2002), off-reserve Indigenous peoples face a higher prevalence of poor health, depression, inactivity, chronic conditions, and unmet health care needs (20%), compared to the non-Indigenous population.

Educational and health services are disproportionately provided by non-Indigenous people in non-Indigenous ways to non-Indigenous people. The educational needs of Indigenous people in Vancouver are not proportionately represented by the number of Indigenous teachers, facilities or resources, at any level. Traditional-based education or health services are not well recognized at the institutional level and have been marginalized nearly to the point of non-existence: that is, not proportionately representative of the Indigenous population in Vancouver.
There has been some effort to reduce the inequities in Mainstream institutions, by creating affirmative action programs to hire Indigenous employees, by creating cultural advisor positions; by hiring people knowledgeable about Indigenous issues and practices, and by creating cultural-based programs; but this doesn’t go far enough. The funding for such projects is usually short term and is usually pulled according to the political climate towards Indigenous peoples. What this says to Indigenous people, is that the consideration of their needs and ways, is a luxury.

Health services, it seems, are clearly driven not by demand, but by supply. Any attempt to put responsibility for cost control in the hands of those who profit from delivery [Government, Health Insurance] is doomed to failure (Kermode, 2004, p. 12).

The political will to date has predominately been supportive of only services that conform to Westernized health or educational services criteria, parameters, policies and practices. This could be viewed as a “my way, or the highway” approach to diversity. Add-on projects, constrained by Euro-Canadian parameters are indicative of a reactive approach which is akin to the illness-care approach to health; symptoms can be ameliorated but the issues will continuously resurface unless the roots of the issues are addressed. How deep must we dig? What are the roots of more wholistic health and educational services for Indigenous peoples in Vancouver? To know about enhancing health services for Indigenous people, we must be able to look beyond the constraints of Euro-Canadian biomedically-based health services. With a more macroscopic view, we can begin to implement new directions for Indigenous health services in Vancouver.

A transformative approach (Smith, 2003) requires that research move beyond the problem, through conscientization⁹, to solutions, and beyond theorizing to the implementation of real changes. To do this, there needs to be a transition from knowing what the problems are, to implementing changes for the better. What the problems are, have been well documented: health services in Canada have been inadequate for the task of eradicating health disparities for Indigenous peoples (Tjekema, 2002). What the solutions are, have been equally documented: more culturally-based health services must be provided (Canada/RCAP, 1996b, 1996c; Canada/Gathering Strengths, 1997, INAC, 1996 & 1997; Vancouver/Richmond Health Board, 1999 & Leach & Associates, 2000). In light of the fact that long-term calls for more culturally appropriate health services, within Mainstream health services, have not resulted in adequate outcomes, it is logical to consider the recommendations for enhancement of health services for Indigenous peoples, by Indigenous peoples. The decision to focus on traditional-based health services for Indigenous peoples, rather than on services for Indigenous peoples, based in other worldviews, comes from a combination of personal, community and academically motivated convictions that traditional-based health services are the missing ingredient for the closure of health gaps for Indigenous peoples. Hence, it follows that the nature and position of traditional-based health services in Vancouver, must be considered in more depth. To circumvent corruption or assimilation of Indigenous goals and processes, it’s also logical to consider how traditional-based health services may need to be enhanced, designed and implemented, at least initially, outside of the status quo, using Indigenous frameworks. If these considerations are addressed through this research project and through consequent community actions, then both Indigenous and non-Indigenous individuals and groups can work to align and/or to integrate health service goals and processes, through appropriate dialogue and decision-making. In a land of co-existing peoples, the establishment of co-existing health services may lead to radical and positive transformations in the status quo, and eventual creations of complementary and egalitarian health service teams and partnerships, with far reaching implications.
Theoretically, in-depth community-based discussions of how to create changes, with key stakeholders, through a process of conscientization and the inspiration of commitments to act, will instigate change (Smith, 2003). Hence, this research project was designed, using Indigenous theories and methodologies, to instigate a proactive and transformative transition from health service problematizing to health service solutions, by initiating community-based discussions about how to enhance traditional-based health services in Vancouver, by and for Indigenous peoples.

Beginning this project was relatively easy, as was talking with people, but how do you tell or write-up a story that is incomprehensible without a basic understanding of its epistemological foundations? I'll give away the punch-line right now: traditional-based health services can be enhanced by re-instituting traditional-based processes: ways of being, knowing and doing. Western biomedical and traditional-based health processes are often fundamentally antagonistic: the former tend to have material-objective-linear-individual orientations, and the latter tend to have spiritual-subjective-associative-collective orientations (Airhihenbuwa, 1995; deBono, 1970; de Bono, 1967; Krippner, 1995; Malloch, 1993; McCormick, 1997; Mehl-Madrona, 2003; Mihesuah, 1998; Ouellette, 2002, Waters, 2004). In effect, it's not as important what you do, as much as how you do it.

There are many stories intertwined in this dissertation. Writing to prove competence in the academic realm has often required that the researcher's voice be louder than others. To challenge this bias, this dissertation has been designed with more inclusive methodologies, and written from the perspective of a narrator-as-character-in-reflection, to give more weight to the contexts and analyses of the participants. I have chosen to write three stories: one, a beginning story that details the journey that brought me to focus on traditional-based health services in Vancouver, next, a collective story, of how these services can be enhanced, and finally a story about lessons learned. The first will be useful for others who want to do similar research; the second will be useful for making space for traditional-based health services, and the last will provide food for thought for those who wish to build on the work of this dissertation project.

To create a relational validity (see Appendix E), to facilitate a good flow, and to create a sense of the intertwining influences, perspectives, and shifting temporal references, I have included selections of dialogue, selections from documents, a narrative commentary, and some footnotes. Each quotation, whether from myself, the research community or academia is separated out, by indented paragraph, as a reminder of the equality of the knowledge sources. This form of triangulation and tangent will help to portray the larger context. Points of relationship, commonality and diversity, and will help to build a sense of reliability for conclusions and recommendations (Miles & Huberman, 1994). Such connections serve to illuminate and confirm the traditional-based Indigenous epistemological principles of relationship, balance and interdependence.

What are traditional-based Indigenous health services?

While the bulk of the answer to this question may be found in the following sections, both explicitly and implicitly, I will start with my original understandings, which have since been shaped and modified by the research process. Traditions are those principles and practices which have been developed, honed and stabilized through time, through wholistic processes and by application, reflection and modification, to maintain balanced relationships. Traditions are embedded in the contexts in which they arise; they are contextualized. Contexts include specific lands, waters, beings and the activities, tools and language of the people in that land. Traditions are also embedded within worldviews, which inform our ways of being, knowing and doing. Activities, tools and language, which collectively could be called culture, have the
primary role of communicating about the relationships between the land, water and beings. Tradition emerges from worldview, culture and context, to promote unifying operating principles and practices - which in the case of Indigenous peoples, is the maintenance of balanced relationships - which in turn provides a form of stability. A diagram of these terms and relationships can be found in Figure 1.

When traditional principles and practices are carried away from original contexts, and adapted to new contexts, they are decontextualized and neocontextualized (see Figure 2). There are always difficulties or imbalances that arise when things are transplanted, which requires a shifting and rebalancing to create new relationships, languages, tools and activities. The bane of westernized existence has been the disconnections and discontinuities created by the transplantation of traditional principles and practices, beliefs and values, activities, tools and languages without the shifting and rebalancing required to maintain balanced relationships in the new contexts. The imbalances created by neocontextualization become evident in the detrimental consequences of inadequate relationship-building and irresponsible decision-making: pollution, waste, alienation, unmet needs and conflict. The proof of imbalance is in the consequent destabilization, or contamination of local lands, waters, and peoples.

In urban contexts, people are from diverse Nations with diverse traditions. In Vancouver, only the Coast Salish peoples can be said to be living in their traditional context, albeit greatly impacted by the influences of colonization and immigration. For peoples who are descended from other Nations, Vancouver is a new context; our cultures, worldviews and traditions have been decontextualized and neocontextualized. For these reasons, I have chosen to join the words “traditional” and “based”, to emphasis that while health services may be based on original contexts, the traditional principles and practices...
To this point, the phrasing "traditional-based health services" could still be applied to Euro-Canadian biomedically-based health services, which are based on the adapted and modified (neocontextualized) traditional principles and practices of European peoples. In fact, in most health service documents, the phrase "traditional medicine" is usually used to refer to biomedical systems. This is confirmation, by itself, that Euro-Canadian worldviews dominate the fields of health and medicine. The phrase "traditional medicine" is commonly used, by Indigenous people, to refer to traditional-based Indigenous practices throughout Canada and abroad, with the understanding that the practices come from specific territories and peoples. On several occasions during this research project, it was necessary to rephrase or transform my English language usage from a Euro-Canadian academic patois, to an Indigenous academic patois, to an Indigenous community patois. An example of such language choices is given in Figure 3.
Health services in Vancouver could be as diverse as the ancestries of Vancouver peoples. In reality, Euro-Canadian biomedically-based health services dominate, and health services from other Nations are relegated to the margins. I placed the term “Indigenous” in the centre of this phrase for two reasons. It’s good that the placement is ambiguous, because it begs a question that can stimulate discussions about the status quo of health service relationships, which is at the crux of this project. The phrase could be read traditional-based Indigenous health services, or traditional-based Indigenous health services. The first emphasis refers to traditional-based health services by Indigenous peoples, and the second emphasis refers to traditional-based health services for Indigenous peoples. In this research project, I wanted to focus on traditional-based health services by and for Indigenous peoples in Vancouver. An easy way to demonstrate the focus of this research, and the reasoning behind the phrasing, is by diagram (see Figure 4). Consider each oval as an identification of populations with increasingly specific characteristics; the size of each oval is irrelevant; it does not reflect the size or population of health services providers or clients.

Figure 4. Relationships between general and specific health services

It’s now important to discuss what constitutes the “health services” aspect of the phrase traditional-based health services. “Health services” is a phrase borrowed from the Euro-Canadian biomedical establishment, to indicate equivalent fields. It’s well understood by both Indigenous and non-Indigenous peoples in Vancouver, to refer to those biomedically-based services which facilitate aspects of physical, emotional and mental health, with the goal of “getting people back on their feet”, at least metaphorically. If we consider traditional-based Indigenous tenets of wholism - which focus on relationship, balance and interconnectedness in all domains of being, knowing and doing - including spirituality, then “health services” traditional-based Indigenous-style, means all those services which contribute to balanced and interconnected relationships, in all domains. This includes systems of justice, governance, trade, education, employment, religion, entertainment, aesthetics and resource management; essentially all the systems of contemporary society.

Hence, this dissertation is about traditional-based Indigenous-style health services, by and for Indigenous peoples in Vancouver, which hereafter will be shortened to traditional-based
health services, and which includes traditional health knowledges and practices, and their practitioners, carriers, Elders, medicine people or healers, and their helpers and facilitators.

**Who's involved or excluded from the research group?**

Nothing invites a more heated debate than the ideas of sharing what is considered sacred information, such as religious ceremonies, or sharing information about the medicine ways. My response has always been that I was taught to use these plants on sick people, not red people or white people. God gave these plants to all people (Tis Mal Crow, 2001).

B: And one asked me ‘how did your people celebrate Christmas before the coming of the white man?’ They were serious about the question. I said ‘real sacred.’ You’d be surprised how many people don’t have a sense... they said ‘where you from?’ and I said ‘right here...’ And they say ‘no, no, no, like where are you from?’ I said ‘this is our traditional land.’ ‘What? Nah, there’s no Indians around here... four city blocks of teepees or wickiups.’ Right. ‘People selling beads or blankets and stuff? We never see that, only in the movies...’ Tourists go, ‘where’s all the Indians?’ ‘This is all the people, here. Yeah, those are all Indians.’ No, they want to see horses and feathers. ‘Two blocks more that way.’ This is all to do with education. (Research Gathering 1, December 12, 2003).

At the same time as I was narrowing my research to focus on traditional-based Indigenous health services by and for Indigenous peoples, I was consequently narrowing who would be the most appropriate people to include in a discussion of those services. The quotes above have been included here to demonstrate some of the issues around selecting participants for safety, ability to dialogue and relevancy to the research agenda. When considering how traditional-based Indigenous health services, by and for Indigenous people are usually accessed and delivered, that is, through a facilitator, from a practitioner to a client; I decided that it was most appropriate to invite people from these groups to discuss how such services can be enhanced (see Appendix C).

Because of the nature of traditional-based health services, whereby one regains a healthy or balanced life through the receipt and application of traditional teachings, most of the participants said that they had been in several of the designated roles – facilitator/client/practitioner – during their lifetime, and expected to continue to do so. In the end, none of the research participants wanted to be identified as healers, though they would refer to others, doing similar work, as healers. This seeming contradiction points to the values of humility, truth, and respect which in turn refer to beliefs in the multiple influences and interconnections in the genesis and transmission of knowledge. The teachings may be great, but we just carry them and do not own them. Through inference, non-Indigenous peoples may have radically different traditions, worldviews and cultural inheritances, that may clash with those of Indigenous peoples. With such considerations, I decided to facilitate an environment of greater safety, and thereby, a potentially greater depth of sharing, by excluding non-Indigenous traditional-based practitioners, clients and facilitators at the gatherings. To acknowledge and retain the perspective of non-Indigenous traditional-based Indigenous health service facilitators and clients in Vancouver, I included the only three non-Indigenous people, a couple, who responded to my calls for participants, and a man who was a husband and helper to a healer in the group. In hindsight, the number and diversity of research participants was most likely limited by the way the call was distributed; that is, by flyer to all the educational institutions and
agencies that serve Indigenous people in Vancouver (Vancouver Aboriginal Council, 2001). Thereafter, invitations were expected to be circulated by photocopy or by word-of-mouth, which may have added more gate-keeping qualities to the selection process. This latter process is also known informally as the “moccasin telegraph” or “Indian hotline”, which is similar to what is described in literature as opportunistic snowballing (Miles & Huberman, 1994).

Twenty-two Indigenous community members and traditional-based health service facilitators consented to, and participated in this study, after a selection process which depended upon their interest and ability to discuss and share stories about the enhancement of traditional-based health practices in Vancouver.

B: I said, ‘you know... I looked at the four colours of [humanity] one day and...that’s just not the four colours of the Nations of the people on the planet, that’s the four colours of our Nation, our whole Nation, because we got white Indians we got blonde Indians, we got red-headed Indians, we got black Indians, we got Asian Indians’. And then it hit me. I said ‘that’s our greatest weapon.’ Right, because in the old days we used to put, like deerskins on, coyote skins, wolf skins and sneak up on the buffalo and stuff. Right, ‘now’ I said... ‘now we can go anywhere.’ ‘And if they talk bad about you... They would never suspect that person - red-haired, freckles and stuff - to be an aboriginal person.’ We gotta hold them up, to not feel bad about this; they’re our leaders. Man they can go anywhere, right? Cuz, ‘be quiet, cuz there’s one now, see?’ (Research Gathering 1, December 12, 2003).

It’s important to emphasize here that even within this specific research group, there was great diversity among the genealogies, traditional knowledges, experiences with traditional-based health services, ages, education, traditions, worldviews, cultures, traditional contexts and health service standpoints. In a previous course paper, I undertook an exercise to represent a hierarchy of belonging, using a variety of terms used to categorize Indigenous people in Vancouver. In such hierarchies, the status and position of power one holds is relative to one’s stance, and to how one is viewed by members of both the Indigenous and larger Vancouver communities; it changes according to the status and position of power of the viewer. As field-based research, such power dynamics have inevitably played a role in this project. Rather than interfering with, or detracting from the study, a consideration of such dynamics, as played out within the research group, was instrumental in the illumination of issues and processes arising around traditional-based health services in Vancouver.

In his course lectures, Graham Smith (2003), has discussed a more inclusive model (Figure 5) for considering diverse positioning within Maori society, which may be useful in the consideration of diverse positioning within the field of traditional-based Indigenous health services in Vancouver. Any Indigenous person could plot themselves, and their actions on this diagram, by asking themselves what actions they are taking within their particular contexts. For example, a person getting angry at a person discriminating against them is an act of resistance. Someone else learning about the history of their people could be undergoing conscientization, while a group of youth occupying an office might shift policy enough to make things better. All of us continuously go through cycles of resistance, conscientization and transformative action as we are faced with unacceptable conditions or events. By our inherent drive to overcome adversity, we are working together to make a better world for ourselves.

The term “Indigenous” will be used in the plural form, rather than in the singular, homogenizing form. Congruent with the concept of multiple sites of resistance and their connection to common goals, the participant stories and ideas indicated that while there were
Fig. 5. Graham Hingangaroa Smith’s Multiple sites of Resistance

many differences, there was also great synchronicity among the participant perspectives, about appropriate strategies for enhancing traditional-based health services.

It’s understood that there are traditional-based Indigenous practitioners, based in Vancouver, that are providing services outside of Vancouver, and that Indigenous people from Vancouver may seek assistance from Indigenous traditional healers from the surrounding communities, or from their traditional territories. Wherever possible, questions and discussions were focussed to discuss the Vancouver context for access and provision of traditional-based health services. Notable exceptions were those references to the importance of reconnecting with traditional territories or lands, waters and beings outside of Vancouver. For this study, I use the name Vancouver to refer to the community of peoples that regularly interact in the Greater Vancouver Regional District, which has its boundaries between Maple Ridge and Mission on the north side of the Fraser River/Sto:lo; and Surrey and Langley on the south side of the Fraser River/Sto:lo. Including additional populations or geographic locations and terminologies in this study would have expanded this project beyond my capacity as a student-researcher and the benefits of doing focused, in-depth story (narrative) research.

Community members and traditional-based health service facilitators were invited to participate in this study by flyer invitation through community agencies that serve Indigenous peoples and through word-of-mouth. I wanted to include up to thirty participants, and tried to select an equal number of people for each participant group (eg. 10 practitioners, 10 facilitators, 10 clients) based on their orientation to traditional-based health services, but threw the idea away once it became apparent that most healers considered themselves to be clients and facilitators and visa versa. While I was aware of the need to facilitate a gender balance in the research findings, my need to influence this outcome was superceded by the fact that an approximate gender balance (12 women, 10 men) was formed naturally. Once volunteered, each participant was given more details about the research process at informal, individual meetings: verbally and by handout (see Appendix D), which included a list of pre-study issues, research questions, and an excerpt on talking circle methodology. Handouts were given with the specific purpose of rooting the focus of this project onto the topic, questions, and issues that had arisen from the prior concerns of traditional-based health service practitioners, facilitators and clients. In these ways, and by initiating traditional-based protocols around the research, the research process can
be said to be contextually grounded\textsuperscript{13}, community-based (Alexander et al, 1997), and participatory action (Barnsley & Ellis, 1992) in standpoint\textsuperscript{14}.

**From closet schizophrenic to Indigenous health researcher**

While the phrase “from the ground up” is usually used by most Canadians to refer to processes that start with “people in the community” and is often synonymous with “grass-roots”, I’d like to take it back to its more literal meaning, adopted by many Indigenous people, of connecting to the ground, or grass, or more commonly, “the land”. All human beings, or should I say earth beings, have long genealogies with specific lands, waters and other beings. These genealogies of experiences and choices have made us who we are today. If we don’t connect with those genealogies, in specific lands, then we are disconnected from a great source of knowledge and the root of our responsibilities. A belief in the importance of connecting with our ancestral lands and genealogies is rooted in the sayings “getting grounded”, “history is today”, “the personal is political”, “if we forget the past, then we are doomed to repeat it”, and more recently “if you kill the trees, then you are killing us and our children”. We are physical, spiritual, emotional and mental beings and rely directly on the earth, waters and other beings, to give us birth, nourish us, protect us and give us good lives. In any important endeavour, we have to begin with ourselves, rooted in and inextricably connected to the earth, and related in specific ways to those lands and the waters and beings that dwell within them; which in this case, means “where we come from”. When we share ourselves, and where we come from, then our responsibilities, commitments and agendas are made clear. This honesty is a requirement for the creation of good relationships and good research relationships in particular. As such, I have tried to document the beginning influences on this project, and to share with you those same beginnings, so that you can enter into those honest and responsible relationships with us as a research group of people from specific lands and genealogies.

Everything I know emerges from the interrelationships between my physical, emotional, intellectual and spiritual experiences and aspects of being, in conjunction with the world and beings around me. What I know is continually evolving, with retrospect, into more complex understandings of my reality. Rather than seeking to know some-thing, I seek to know the relationships between things, which are constantly changing. Hence, I can never know something entirely, because knowing something requires knowing its relationships, and all relationships are dynamic. In research, this perspective ensures that all conclusions are tentative and means that all statements should be taken “with a grain of salt”. The difficulty that many people have is with applying non-dynamic judgments to dynamic situations; this knowledge is not invalid because it is tentative, it is more valid because it is both dynamic and relational, which is the true state of reality. Decisions can be made, for now, with the understanding that new knowledge may effect different decisions in the future. We all know this is true, in reality, we just have to acknowledge it in our writings, actions and decisions.

The knowledge carried by this dissertation arises from deliberate interactions between personal, community and academic domains of knowledge. Knowledge arises directly from the relationships between lands, waters and beings. Human beings carry these knowledges that arise directly. When these knowledges are communicated and shared with others, a community is created; when that community seeks to create positive changes, through thoughtful actions, then institutions are created for this purpose. Indigenous peoples have had their own institutions of knowledge, for tens of thousands of years. The Euro-Canadians situated in Vancouver have had their institutions of learning for over a hundred years, and are connected by genealogy to European institutions which are also thousands of years old. In this document, I will expand the term academia to refer to that shared domain of knowledge that arises from all communities and
which includes hierarchies of knowledge according to perspective, and to the relationships between those communities. As such “academia” in Vancouver refers to the knowledge arising from primarily, but not exclusively, Westernized (Western Euro-American) communities, or using Westernized filters.

My life is very relevant to why I’m doing this research and will have specific influences on how and what is written up, and where it goes from there. My Indigenous community, which for me is comprised of all the Indigenous beings in my life – past, present and future - has shaped what I know, and how and why I do things. My academic influences, which are made up of both the people and concepts I’ve encountered during my Euro-Canadian education at elementary, secondary and post-secondary levels, have a great influence on what I think I know and how I should be doing things. I have examined some of these influences and will expose them for you to consider, as a prelude to reading what was shared by the research group.

I’m not a traditional healer or in training to become one. I’m a student at the University of British Columbia and looking at enhancing the position of traditional Indigenous health services in Vancouver as a step towards supporting traditional knowledge holders in the passing on of their knowledge. It’s an extremely precarious undertaking because in a city with traditional knowledge holders from so many Nations, I need to be careful that I’m following proper protocols, and not being disrespectful.

To be honest and succinct, this dissertation is inevitably about me, my healing journey, and my desire to give back to those who’ve helped me. My genealogical history, along with my life experiences have provided me with a resilient way of perceiving and responding to the world that has both Indigenous (worldview co-evolved with the natural world) components and non-Indigenous (worldview separated from the natural world) components. I attribute the Indigenous teachings (beliefs, values, ethics) as arising from my Anishnaabek15 father and from my personal experiences. My father was raised by his grandmother, the local midwife and healer until he was nabbed by the RCMP and forced to attend residential school, at 14 years of age. Running away from residential school, joining the Canadian Armed Forces and marrying a French-Anishnaabe girl meant that he could have citizenship, more education, some rights, some status, and a financially stable family. Though he was separated from his relations, reserve, and traditional ceremonies during his work with the forces, the teachings that he carries were passed onto our family in subtle ways.

Not so long ago, my French-Anishnaabe Grandmother and I used to play psychic training games, like Ouija and cat’s cradle. While she was knitting endless supplies of sweaters and socks, she’d tell me stories about ghosts, about the special abilities of human beings, and taught me to read tea leaves.

Outside of the disapproving eyes of my mother - who was trying to turn me into a lady - my father encouraged me to follow my interests in the natural world. Like many, we skated downhill in the backyard during winter, went fishing in turtle, tick and mud-swallow infested rivers and got chased by tumbleweeds and dust-devils in the summer. I have many fond memories of spending months at the cabin on Clearwater Lake in northern Manitoba, at the lake with wild strawberries, purple and black sands, minnows, black flies, chipmunks, ladyslippers and black bears. My grandfather was always slightly out of sight and saying “awis michimoose”, which I found out later meant go away little darling. I grew up thinking that being sensitive to the natural world, and seeing on a psychic level, was normal, until I went to school and realized that other people didn’t think or see the world like me.

Unfortunately, I knew too well that my metaphysical experiences were no-no’s in Canadian society. The contrast between who I was and what was considered normal, made me read a lot of science fiction and philosophy before I was ten; perhaps I was looking for examples where my ways of knowing were accepted. Like my father, I learned to act-as-if, to fit in. But I
could not speak because my real voice was silenced. I saw where exposing one’s real self, where speaking one’s real thoughts, feelings and experiences got you, and I didn’t want to end up the same way...

My twin brother was diagnosed as schizophrenic at 16 years of age. Watching my twin brother’s diagnosis, incarceration in both mainstream and forensic jails, his torture, marginalization and drugged existence was too big of a reminder and deterrent to exposing my sense of reality. Thinking back to my out-of-body traveling, to my psychic training, and to the many strange things I’d experienced and seen, I realized that there was a fine line between my twin and I. It was fortunate that I’d learned to keep much of my life secret. If I hadn’t played normal, I’m pretty sure I would have ended up incarcerated, drugged and tortured like him!

At fourteen, after leaving the Catholic school, I rebelled against the hypocrisy I was seeing between the teachings of Christianity and the behaviour of Christians. I decided that dogma was for the dogs, and set out to find a faith that resonated with me personally.

At the same time, around my 14th birthday, my father revealed the secret that my darker siblings already knew: we were Indian. Suddenly, all those years of not fitting in made sense. I was determined to find out more about what being Indian meant and watched closely as my father regained the Indian Status he had lost when he joined the Canadian Armed Forces. I was the next to apply and learned more about institutionalized racism, as the government stalled my process, in patronizing ways, for another two years.

The first thing that helped me to survive my existential angst came in the form of a near-death experience, just after it was revealed that my father was Native. During a road-trip to the Okanagan, where I was supposed to chaperone my older brother, I ended up being shipped off to hang out with his girlfriend’s brother and other local teenagers. I ended up swimming in a fish-ladder pool, under a dam.

A few seconds after noticing that everyone had gotten out, both upriver and below, I was hit by tons of water. My first instinct was to panic, but I found myself forced against a cement wall so strongly that I couldn’t even close my eyes, let alone flail my arms. It felt like the water was breathing me. Relaxing, I left my body, to visit a place I’d never been before, a place filled with light, which simultaneously felt like love and belonging and God. The amazing thing was that I could see other spirits who made up this light, who were working with beings on earth, and on other planets. I could go anywhere, know anything, and see through the eyes of any being in the blink of an eye.

It’s sufficient to say that I had returned to my life; it wasn’t my time to die. Though I buried that experience during my years of partying, I realize now that it had given me, besides a scar, a clear will to live and had eradicated any desire for, or fear of death. I forgot most of what I learned during that drowning, for a long time.

I decided to pursue a career in the health field. I took courses in kinesiology, psychology, biology, statistics, environmental health and first aid. I became a public health inspector and learned about the civil service and the distance between a political ideal and the political will to implement. I watched as the health of a local Native community was passed between the Feds and the Province and back again, no one wanting to engage with the people, fearful of the quagmire of problems that might come with a direct discussion. Given my disillusion, a Scotsman easily wooed me away from my lucrative career, with his talk of truth, integrity, Pictish roots and metaphysical experiences. His confidence gave power to my own investigations into things Indigenous and released the hold I had on my own metaphysical abilities. Perhaps it was the relationship or perhaps it was the call of the land, but I was soon back in North America, driving back and forth across it, looking for a good path to travel.
My earliest travels were back to the land of my birth, Manitoba, and further back, to the lands of my ancestors, southeastern Ontario and the southwest corner of Lake Superior. In my reconnection with cousins, aunts and uncles, I was moved by their complete acceptance of me and by their enthusiasm in introducing me to all of our kin (over 400 and still counting). According to these extended kin, what I was doing with my life was interesting, but it was who I was related to, and our family stories that were more important. While what I’m doing always changes, my relations and stories are always there to explore and learn from. I understood then that belonging isn’t just about reconnecting, it’s about being deeply connected to a collective history and to specific lands, waters and beings; it’s about a sense of family-community that extends geographically and temporally.

Alongside my personal journeys, I aspired to expand my understandings of health, and to explore the knowledge of other Indigenous peoples and their relationships with lands, waters and other beings. I figured that if I could understand my family and history in the context of the larger world, I would be able to make better decisions when it came to living a good life and being a good person. I decided to pursue my childhood dream of becoming a doctor, and to explore my identity, 3000 miles away from our ancestral homelands.

After attending Native student union meetings for a long time, I realized I’d found my place, at least mentally and emotionally; a place where people thought and laughed like I did. It really helped to feel like I belonged, as my dream of being a biomedical doctor slipped away (memorizing pathways of organic synthesis, and my brain, don’t mix!) By my fourth year of studying First Nations issues, through anthropology, biology and environmental studies, I was starting to realize that I had a legitimate place in the world, that I wasn’t as fraudulent as I felt. By connecting with other Native people at the university and in the community, and by exploring Native issues through courses in anthropology, environmental studies, ethnobotany, botany and counseling, my sense of self grew deeper and wider.

After being able to extricate myself out of an unhealthy lifestyle, and after challenging myself mentally, I found myself returning more and more to thoughts and feelings about my near-death experience, and about the other “abnormal” experiences that I’d kept secret for so long. In my third year of undergraduate studies, I was being pestered so much by these protruding thoughts that I had to share them. I tried seeing a counselor at the university but was interrogated by a loud receptionist; “what’s your problem?” she asked in a crowded waiting room with prying eyes. I walked away with a brochure on mini-courses. I tried community counseling but got tired of hearing “and how do you feel about that?” I was looking for answers; I wanted to find out how to live with myself, with all my strange secrets. When I found myself becoming unhealthy again, I realized that regardless of the potential for hospitalization or ridicule, I had to share my secrets with someone. I started to write down my experiences.

I found some courage and disclosed my documented tales with a man I knew was connected with traditional knowledge holders in the community. He set up a meeting for me with a Coast Salish healer and her husband. It helped that she was also of mixed ancestry. I sat in circle with them and a few others, learning traditional teachings, for a couple of years. Her most welcome teaching was that the things I’d experienced were normal gifts, we all have different gifts and that some of them are to walk in other worlds. When I talked about my brother, she explained that the task of people with these gifts (schizophrenia), is to learn to differentiate between worlds, and to walk mostly in this one; those that don’t learn, get lost, and often end up in trouble and institutionalized. She explained that in the past, people would learn to use these gifts properly while they were very young, they would be given the opportunity to use their gifts in the community, and often became respected healers and Elders. With the help of traditional knowledge holders like these, and the important teachings they carry, I’ve kept myself out of mental institutions and the somnambulistic fate of my brother.
My growing identification with my First Nations ancestry and traditional-based beliefs, was checked by a tragic incident. In hindsight, my young “schizophrenic” Native friend showed all the warning signs of suicide, but I just kept hoping she’d be inspired by something or someone, as I was being. I even tried to arrange a meeting for her with my healer-mentor. I knew what it was like to have weird experiences and to try and integrate them into your life without help. Her death came as a shock. The suffering and loss of such a beautiful, talented young woman, when traditional teachers might have been able to help her, has stuck a thorn of anger in my side. I continue to think about how inadequate or detrimental mental health services have been for my Indigenous friends, family and community. My resolve to address the status quo regarding the acknowledgement of human gifts began to grow, but with a call for caution.

Today, I look back on the anguish of my journey to myself, as resulting from a clash between Indigenous ways of being and the entrenched and institutionalized Euro-Canadian status quo, as represented internally by my experiences in my family, and in the greater community by the historical and contemporary relationships between Indigenous and Euro-Canadian peoples. It’s not what we’ve experienced that indicates illness, it’s what we do, how we react or how we categorize what we’ve experienced that influences our mental, emotional, and spiritual well-being. That one culture sees walking in other worlds as a normal gift, while other’s see it as hallucinatory or delusional, is one culture’s gain and another’s loss. In the extreme, health services based on addressing the specific illnesses of individuals, are on the opposite end of the spectrum from health services based on addressing illness as a symptom of deeper, wholistic (and societal) imbalances. As an example, Canadian health services tend to address the needs of those who embrace the biomedical model of health, while underserving those who embrace more wholistic models.

I want to support traditional healers because I am grateful, for the friendship, guidance and gifts that healers have given me. I’ve seen and heard of them doing the same for many others. Each of them have talked to me about some of the issues that they face in this modernized world, and have expressed concerns that their knowledge may not be passed on. I believe that traditional healers are knowledge holders that are integral to our strength as Indigenous peoples. The sacredness of their knowledge is the cornerstone of who we are as Indigenous people. I am committed and urge others to take the time to ensure that our traditional healers are well cared for, that their needs are being met, and that proper protocols are being followed.

I’ve always been interested and concerned with the state of, and impending threats to our freshwater supplies. I had determined to turn the direction of my Ph.D. pursuing gaze, to serve water. To do so, I wrote steadily, even obsessively for two months on a graduate studies proposal. I had the background, the motivation and a good direction, but found my writing ability crippled and going nowhere. I prayed for guidance.

That night I was given the answer in the form of a powerful and detailed dream of a traditional-based healing centre in Vancouver. I saw it in full swing, with a head speaker, healers from many Nations, planted medicines, practice rooms, apprentice-helpers, a kitchen, sweatlodges, sunken fire-pit, common area, silence room, bunk rooms, herbarium, families & individuals, forest & meadow. I even saw the budget and duty roster. I don’t usually write my dreams down, but there was so much detail that I didn’t want to forget anything.

After about a week of letting the dream sink in, I realized that focusing my research in the direction of my dream would bring together many aspects, interests and goals in my life. I’d always been interested in health, in First Nations issues, and more recently in critical theory.
My personal beliefs and experiences, along with the suggestions of traditional knowledge holders, could finally be acknowledged and addressed. I could bring together both my career interests and personal interests.

There are no coincidences. Motherhood gave me lots of time to think about what was important in life, and about the future of my children. Because of the familial and cultural disconnections in my life, and because of a recent course on post-positivist realism, I was determined to ensure that my new child knew where she came from: Aotearoa and Turtle Island. I wanted her to have the knowledge and teachings that would have benefited me, so that she didn’t have to spend her life struggling with identity, conflicting beliefs or values. This orientation turned my gaze towards all things Maori. I travelled the land, met many people and learned many things. I made many connections between families, genealogies, histories and experiences. I was not surprised to hear of common ancestors and migration stories.

Two important things, so far, have come from my Maori studies. On some marae, the Tohunga, or traditional knowledge holders, work on teams alongside biomedical physicians and other health care professionals. This led me to study the Treaty of Waitangi, which outlines a partnership between the Maori and British Nations. It reminded me of the Two Row Wampum which details a partnership between the Iroquois and British Nations. The fulfillment of both treaties has been problematic. Even so, the honouring of such relationships would seem to hold much more promise for Indigenous people, than the current focus on colonial institutions and processes. The second gift came from Graham Smith, a leading Indigenous theorist - who gave me the language to express my new understandings and refocused intent:

Traditional-based health services should be a legitimate option amongst a range of health services, for Indigenous people (direct communication, 2003).

I had been so busy reacting to a normalized, colonized reality, that I had not seen the more proactive and transformative approach, applicable to both my life, education and research. After a year of struggling to write up a proposal, the help of Graham Smith, and the guidance of my supervisor Jo-Ann Archibald, gave me the edge I needed to write a more focused and cogent research proposal entitled “an examination of the access to, and provision of traditional-based health services by and for Indigenous peoples in Vancouver: creating balance with stories”. It was accepted with few changes, by both my research committee and ethics review board. I was on my way!

**Indigenous Community: Someone should do this**

For a long time I have felt blessed with good fortune and protection in my life. I’ve managed to avoid most hardships, and I’ve had many opportunities to meet respected First Nations leaders and knowledge holders. Sometimes I’ve even had the courage to talk with them.

The most cherished times have been when I’ve found myself unexpectedly listening to the traditional-based stories of Elders from my Nation, and others. Each held a piece of wisdom, regarding our histories, and the best ways to think about, live and relate in this world, and in others. Often these stories were shared informally while cooking or eating, while picking and preparing medicines, or making drums, sweatlodges or medicine wheels, or when learning songs or dances.

The following statements are some of the teachings that these Elders taught me, that have informed and influenced the theories, methodologies, methods, findings and representations related to this research project.
From what I’ve learned, traditional healers practice healing traditions that have arisen within intimate relationships with specific lands, waters, and other beings. Traditional healers, that I’ve gotten to know, heal by recognizing and assisting people to remember that we’re all spiritual beings, complex and connected with everything. I’ve had many conversations with traditional healers, mostly from Ojibway, Lakota or Salish traditions. They all say similar things about our abilities, our gifts as human beings. We can become aware of our connections, and enhance our abilities by undergoing quests, ceremonies, hardships, daily rituals, herbal regimens, healing rites and a number of other processes, depending on what traditions you come from. They key is to remember these gifts, or get assistance to remember when we forget, and to use them well in our own personal healing journeys. I’d like to acknowledge and share the importance of traditional healers in my life, by talking about some of their teachings, about the gifts given to all human beings, that we can use to heal ourselves.

One of our most important gifts is the gift of awareness as sentient beings. By expanding our awareness, we can become more aware of our human abilities and gifts. Awareness can be expanded by paying attention to three aspects of being: inspiration (which brings a sense of connection or relationship), intuition (which brings a sense of knowing) and perception (which brings meaning to experience). These aspects of being are interrelated and arise during both ordinary and special human experiences. As human beings, we also possess abilities to higher and lower degrees, many of which aren’t recognized in western society. When our ability is naturally high, or has been trained to a high degree, those abilities are called gifts. We are all familiar with gifts that are predominately physical, like “gifted athletes”, or with mental-emotional gifts like the ability to do complicated mathematics, music or science. There are also other gifts which have been denied for centuries, by scientific rationalists, because they aren’t understood yet; these are the gifts of out-of-body travel, of “walking in different worlds”, of shapeshifting, of “tapping in” to knowledge through dreams, ceremony, or spiritual guidance. In Westernized world views these experiences are often categorized as mental illness, or dismissed as flaky indulgences. In many Indigenous worldviews, these are considered normal experiences and those who don’t use these other human abilities are often termed “blind”. Common phrases referring to people who don’t look beyond logical scientism, or in more wholistic ways, are: “they can’t see”, or “they’re not listening” or “they don’t understand”.

This research belongs to the traditional knowledge holders in my past, as much as to me and the current participants. They were the ones who kept suggesting that the traditional ways needed to be acknowledged and reinstuted, that they should be legitimized and given status. They thought that someone should find a way to raise the profile of healers and other knowledge holders, so that their work could be recognized and supported in today’s world. Not for the benefit of the healers or traditional knowledge holders, but for the benefit of our people, our children, other beings, our world, and all Nations, for many generations to come. The prophecies, like the Seven Fires and the Hopi prophecies say that we need to do these things. Someone should do these things. I listened, but I never thought that I would ever play a part in having these suggestions addressed.

The table below (Table 1) contains a list of some of the issues raised by these traditional knowledge holders. This list can be considered the results of a fifteen year informal pre-study, generated by reflections on discussions with traditional knowledge holders prior to this study. In the last part of this dissertation, I have categorized a few of the relevant stories, ideas and dialogues shared by the research participant group, to show congruence, relevance, relationship and continuity between what traditional knowledge holders were saying and what they’re saying now, in the Vancouver context. In addition to showing a continuity between what people were saying before and during this study, these categories and comments form the primary operating
assumptions used for the development of the research questions. They all “beg the question” of what can be done to address these issues, and legitimize a deeper analysis.

Table 1. List of Pre-study Issues

- Working with non-traditional based health service providers
- Working with people from diverse Nations & cultural backgrounds
- Sharing & protecting knowledge
- Working outside of traditional territories, and specifically, in cities
- Ethics & protocols in traditional-based practice
- Balancing traditional-based practice with the need to make a living
- Organizing for support
- Passing on knowledge
- Processes & protocols for accessing appropriate healers
- Protecting and maintaining places for traditional-based practices

Academia: Competing perspectives and Indigenous health education services

Historical Relationships

...the origin myths [of Indigenous people] expressed the idea that illness and death were natural parts of the process of life. What was important was to understand the role of these processes, to accept them and to deal with them in traditional education. There is a direct relationship between Indigenous community, the learning process therein, and the quest for health and wholeness (Cajete, 1994; pp. 109 & 178).

The result of the alliance between bioreductionism and medicine has been to fragment medical knowledge on the one hand, while narrowing the scope of health education on the other (Laura & Heaney, 1990; p. 10).

When we consider First Nations health education, we have to examine it within the contexts of history: the history of relationships between First Nations people and Euro-Canadians, the history of Indigenous and European education systems, and the intertwined histories of health and medicine.

Already in the first part of the 17th century Descartes had effectively killed the life systems of the planet by his division of the universe into mind and matter. What was not mind was mechanism. With this background it is little wonder then that when they arrived in America the incoming peoples had no deep feelings for the natural world; they had none of the reverence or even aesthetic appreciation due to the continent. Above all they had no awareness that humans form a single integral community with the other components of the continent, with planet Earth and ultimately with the universe (Berry, 1996).

Until present day, these histories have focused on tensions, areas of conflict and areas of accommodation, from primarily Euro-Canadian perspectives, caused by the colonization of Indigenous people, lands and resources. Through a slow process of invasion, enforced
legislation and Indigenous population decline (through many factors), Euro-Canadians have become the majority within the Canadian borders of North America.

By the early twentieth century, officials' perceptions of the people's healing rites had changed: those rites were no longer demonstrations of savagery and indolence, but rather manifestations of the people's disregard for human health (Lux, 2001; p. 85).

Euro-Canadian and Indigenous perspectives on health, health education and health care have often been portrayed as competing or oppositional. If we see the imposition of Eurocentric health practices, or the eradication of Indigenous practice (aka superstition or placebo) as good for First Nations people, then the retention of Indigenous practice or reluctance to use Euro-Canadian health systems could be seen as competing (Priest) or resistant. In effect, the more appropriate term might be clashing. The end goal of both systems is the same, but the means to get there is and has been primarily different in epistemological foundations. Where Euro-Canadian health services have arisen out of several centuries of critical responses to epidemics by an increasingly entrenched reductionistic biomedical profession, Indigenous health services have arisen out of a wholistic complex of intimate relationships and understandings between First Nations people and their local environments, over thousands of years. In this section, I'd like to outline some of the greatest areas of tension within these diverse health systems and discuss how emerging Euro-American paradigms may provide for the creation of more successful health relationships with First Nations people.

Evidence and clashing world views

What we regard as real and how we go about investigating reality are circumscribed by the framework of scientific enquiry within which both the concept of reality and the procedures for its appropriate investigation are implicitly defined (Laura & Heaney, 1990; p. 5).

Since the colonization of North America began, there has been an influx of primarily western European beliefs about the nature of reality and how health is conceptualized. Western Europe, in the last four centuries, has been characterized by what is called a period of enlightenment. At the same time as massive epidemics were going on all over Europe, governmental systems were making their transitions from feudal to industrial states. An important part of this process, the division between church and state, emerged out of the heretical philosophies of rationalism and scientific method (Kermode, 2004). Reality was no longer that which was preached from the government-church pulpits; it was personally evident via the logical analysis of our sensory perceptions of the material world.

The growing separation of religious and scientific paradigms was hailed as a release from the dogmatic interventions of church into everyday life. Health was no longer a reward for appropriate behaviour, according to God's law, but was the result of careful attention to the process of cause and effect, and applications of those observations, by changes in behaviour, to ameliorate those consequences in the future. On the other hand, illness was no longer a punishment meted out by God, but an impartial effect of a combination of bio-physical events.

The defining characteristic used to separate God from science, or fiction from fact, has to do with the nature of evidence. Where evidence was found previously in Biblical texts, and in the judgments by men of the church, it was now to be found only in the rigid documentation and mental analyses of a material world supposedly divorced from emotion and spirituality. When viewed together, these perspectives seem worlds apart, until we examine the whole concept of
criteria. Thoughts and even physical responses arise within systems of belief. If we do not accept the idea that there can be several equally valid systems of belief, then our judgments tend to be bounded by our beliefs about reality. If we consider the scientific paradigm for example,

We cannot establish evidentially that our senses are not deceiving us, since our reliance upon our senses is itself a condition of evidence (Laura & Heaney, 1990; p. 82).

The nature of evidence is bounded and inextricable from belief systems and cannot be used to judge a perspective of reality outside its boundaries. Hence, as Laura and Heaney put it,

The foundations of science rest not upon such things as evidence and proof, but upon the constellation of beliefs, themselves neither evidenced nor proven (1990; p. 83).

With colonization and attempts at assimilation, European scientific paradigms have clashed with those of Indigenous populations in several ways. Indigenous paradigms, arising out of intimate socio-physical co-evolution with local environments, emphasize wholistic integrations of the physical, spiritual, mental and emotional realms of being. Science clashes with Indigenous epistemology because it has, for the most part, excluded the realms of spirituality (or God) and emotion, and has not considered (until recently) the concept of wholism as it affects reality. Indigenous ways of being have mostly been characterized as outdated or not keeping up with reality, which is a reflection of the material orientation inherent in scientific bias; once again, one paradigm is being used to judge another.

What Indigenous and scientific paradigms have in common, is the belief in empirical understanding. The more often reality is experienced as it is, whatever the socio-cultural context, the more reliable are the predictions based on those experiences. I can't refrain from reminding that Indigenous empiricism is based upon tens of thousands of years of experience, whereas scientific empiricism is based primarily upon a couple hundred years of artificially and decontextualized experimental experience. Laura & Heaney allude to the dangers of reliance on superficial empirical evidence in the following statement: “the traditional [Western] theory of knowledge, and the value orientation which undergirds it, has brought us to the brink of extinction (1990; p. 99).” The next section will expand more on the link between worldview and societal consequences.

**Newton and the entrenchment of bioreductionism**

Not unlike an engineer repairing a faulty structure, conventional medicine is geared to intervene on behalf of the patient to repair the faulty machine. On the bioreductionist model the concept of health was thereby construed as the absence of disease, and thus the thrust of medical research came to focus on the extirpation and control of the microorganisms which cause disease (Laura & Heaney, 1990; p. 6).

One of the most influential scientists of our times was Sir Isaac Newton. His mechanistic theories, which portray the world as “a kind of machine which consists of independent and separate parts into which it can be exhaustively analyzed (Ibid; p. 5)”, have revolutionized industry, technology and human perception. By conceiving of ‘parts’, Newton has created a rationale for reductionistic methodology, where the whole of nature can be analyzed, by examination of those parts. When reductionistic methodology is applied to the examination of bio-physical constituents, it is called bioreductionism.
The impact of reductionistic thinking has heavily influenced the philosophical orientations of successive generations through its promotion in North American education systems.

Conventional science has been institutionalized as the science of reductionism, and the most significant single institutional vehicle for its expression and propagation has been our schools... (Laura & Heaney, 1990; p. 10).

The imposition of this conventional science on generations of First Nations people has had varying effects on the perception of Indigenous health practices.

By the early twentieth century, officials' perceptions of the people's healing rites had changed: those rites were no longer demonstrations of savagery and indolence, but rather manifestations of the people's disregard for human health (Lux, 2001; p. 85).

As a response to the epidemics of the 18th and 19th centuries, the Canadian government instituted measures to protect human health through 'hygienic' practices including sanitation, pest control and disinfection practices. As schools are always embedded within their social contexts, these practices were quickly transferred into schools in the form of school hygiene or health education programs:

Throughout the nineteenth century health education in most western countries was incorporated into school programs (Laura & Heaney, 1990; p. 181).

While religion was being marginalized in the government arena, it continued to have great influence in the education of First Nations children. With the Christian Women's Temperance movement of the 1800's, and the introduction of public health measures in the form of school hygiene education, God, morality and health education became linked. James Rogers highlights the strength of this movement in his words: "no wave of legislation having to do with school hygiene and sanitation has so swept the country as that accompanying the temperance movement (Ibid; p. 181)."

Though initiated in crisis, health education, became entrenched within the school systems. Increasing developments in reductionistic biomedicine and increasing monopolization of health services by physicians have created a status quo of health education based on a disease-cure model of intervention. Torrance attests to monopoly in his statement:

At the same time as disease patterns were changing, a unified medical profession was being forged, attaining professional autonomy and achieving dominance over competing healing occupations (Torrance, 1998; p. 4).

In the United States, the rationale for health education was equally contingent:

Two centuries after formal health instruction began and eleven years before the goal of Health For All needs to be realized, there is still no coherent and well-articulated philosophical basis of health education (Laura & Heaney, 1990; p. 182).

Educated in the supposedly superior scientific paradigm, Indigenous people were expected to conform to Euro-Canadian beliefs and practices of healing.
In schools the ‘facts’ of health science are taught in as dogmatic a manner as were the ‘facts’ of religion (1990; p. 88).

Considering its speculative foundation, health education vis a health science should be considered with a grain of salt. What is ironic, according to Laura & Heaney, is that the religion of Christ was usurped, or perhaps co-opted, by the religion of science.

Where science was once a force against authoritarianism, helping to break the spell of oppressive religious dogma, it has come ironically to cast an authoritarian spell of its own in the form of scientism (Laura & Heaney, 1990; p. 87).

Through the observation of consequences, cause and effect, inherent in both Indigenous and Western perspectives of reality, the limits of the dominant reductionistic paradigm have become apparent. According to Dr. Janice-Ann Priest the consequences of a reductionistic medical monopoly are consistent across Westernized countries. The following is an example of U.S. statistics for the year 2000:

- 12,000 deaths each year occur from unnecessary surgery.
- 7,000 deaths each year occur from medication errors in hospitals.
- 20,000 deaths each year occur from other errors in hospitals.
- 80,000 deaths each year occur from infections caught in hospitals.
- 106,000 deaths each year occur from adverse reactions to medication.
- 225,000 deaths each year occur from iatrogenic causes, which places iatrogeny as the third leading cause of death in the United States, not counting medical disability or misadventure disorders (Priest).

If we remember that this is just one arena, and consider the non-medical effects of an economically entrenched system of biomedicine, the consequences are multiplied and confounded. Attention to detail, to the exclusion of the whole, has resulted in crises in the human-environmental context, in the form of pollution, environment-related illnesses, and more and more virulent pathogens. Science, as reduction, no longer functions to address these more chronic problems, and so the parent paradigm must expand and shift to accommodate the wider reality.

While the value of a more wholistic approach has been voiced continuously since the 1970’s (e.g., by the World Health Organization), the grip of the biomedical monopoly has ensured that change is slow. To our detriment, the disease-cure system of health care is too entrenched and too lucrative to give up easily. Billions of dollars are spent upon the examination, production and dissemination of disease ameliorating substances, employing thousands in the fields of laboratory science, resource extraction and manufacturing, business, health promotion and general health practices.

Unless the extending gap between public intuition for self-care and medical science with its surgical and drug preferences start to meet more in the middle, further public rejections of the present medical model health system will occur... In March 2000, according to NZ Doctor News, a 30 percent drop in patient levels had occurred in most general practices throughout the country. New Zealand attendance statistics reflect what is happening in the rest of the Western world (Priest).
While preventive philosophies are growing, they still tend to focus on eliminating causal factors identified in disease categories, rather than promoting health in more encompassing ways. The reliance on biomedicine continuously returns to blind faith, based in the reductionistic paradigm, and the need for its particular proofs of evidence. The complexity of this system, as well as being self-limiting, has created reluctance towards wholism based on an economically reinforced dependency:

The mystification of medicine serves to foster institutional structures and behavioral patterns which make people dependent and disempowered. They are deprived of the responsibility of their own health, along with ability to make informed choices as to which behavioral patterns are healthy and which are not (Laura & Heaney, 1990; p. 196).

We are constantly inundated by advertisements in magazines and newspapers, in movies, on television and now on the internet, that promote symptomatic relief for scary conditions. While infant mortality rates and death due to infection have declined in the past two hundred years, chronic disease is on the rise. Declining mortality and morbidity due to infectious disease has primarily been attributed to public health measures which limit the communicability of pathogens (Ibid; p. 58). Conversely, the effect of reductionist-biomedical treatments on chronic degenerative ailments has been poor (Ibid; p. 69). Health education in schools and communities reinforce the dependence upon biomedical institutions and biomedical knowledge by providing people with lists of symptoms and continuous warnings to seek medical attention “if you suspect anything”. We have become a land of uncertainty, with both fear and morbid curiosity towards imbalances in health, where the creation of categories of disease are limited only by our imaginations.

Reductionist medicine has proved to be a valuable but incomplete foundation upon which to erect the edifice of health education… (Laura & Heaney, 1990; p. 11).

Where is the logic in perpetuating such a system, through health education, when the more efficacious model, wholistic health care, is staring us in the face? Imagine a world where illness and death were acknowledged for their important roles in our lives, where the ill and dying were treated with integrity, warm consideration, and even with celebration or ceremony. Imagine a world without constant, lucrative, fear-mongering.

Complementary and Alternative Health Services

The relationship between traditional-based Indigenous health services and complementary or alternative health services is similar to the relationship between Indigenous peoples, minority immigrants and the Canadian state. The needs of immigrant minority groups are often considered addressed under the banner of multiculturalism; money is designated for the “celebration” of diverse cultures. The rights to land, resources and opportunities are addressed under the Constitutional rights of all Canadians. Peace, order and good governance, for the greater good, does not mean peace, order and good governance, only for the dominating majority population. A truly equitable society (meaning equal opportunity for diverse peoples) would ensure that the structures, processes, laws, principles and practices reflect all of its citizens, not just the dominant majority.

Politicians have been trying to erase the “special status” of Indigenous people in Canada, under the guise of ensuring “equal” (meaning same) treatment, for very enduring, lucrative reasons. All attempts to eradicate the special status of Indigenous peoples, in effect, erodes the a
priori rights and title to North American lands, waters and resources. While many would agree that the Indian Act and related legislation is problematic and deserves an overhaul, doing so without ensuring the continuing status of Indigenous peoples would be worse than writing out the "founding father" rights of British and French peoples in Canada.

Likewise, complementary and alternative health services are currently, and variously supported as minority interests, with respect to dominant Euro-Canadian biomedical health systems. In response to the increasing public use of such services, the government and medical professions have worked to streamline the structures, conditions and legislation under which such services and products can exist (Papp, 2000). Categorizing traditional-based Indigenous health practices under the banner of complementary or alternative medicine erodes and marginalizes the rights and title of Indigenous peoples to determine their own life ways (self-determination). In contrast, Sakej Youngblood-Henderson portrays the restoration of traditional-based practices in a much less fragmented context:

As Aboriginal people, we must reclaim our worldviews, knowledge, languages, and order to find the path ahead. We must sustain our relationship with our environment and follow our elders' advice. We must rebuild our nations on our worldviews and our good values. We must be patient and thorough, because there are no shortcuts in rebuilding ourselves, our families, our relationships, our spiritual ceremonies, and our solidarity (2000).

The rights of Indigenous peoples to traditional-based Indigenous health practices in Canada should be structurally supported, maintained and enhanced, because they are:

- a priori rights (Creation, Migration & Good-Life Stories, Royal Proclamation)
- negotiated rights (Treaties, Two Row Wampum)
- imposed rights (Indian Act, War Measures Act, Enfranchisement Act)
- constitutionally embedded, self-determining rights (Constitution Act),
- culturally protected rights (Constitution and Multiculturalism Acts),
- globally sanctioned human rights (Charter of Rights and Freedoms, United Nations, World Indigenous Peoples Organization)
- recommended by various Royal Commissions and research (Canada, Indian & Northern Affairs Canada)
- demanded by various Indigenous peoples (Union of BC Indian Chiefs, Assembly of First Nations)
- logically follow from humanitarian redress of historical atrocities and social and health inequities for Indigenous peoples (UN, WHO, Statistics Canada), are
- an option demanded by a large and significant portion of the Canadian population (Canada/RCAP, INAC, Vancouver/Richmond Health), and are
- integral to the continuity and resilience of traditional-based Indigenous ways of being, knowing and doing.

Culturally-appropriate health services

Recently published data of the social determinants of health indicate that culturally appropriate health services may have potential in intervening in the poor health of Indigenous populations in Canada (Cunningham-Sabo & Davis, 1993; Evans, 1994; Green & Ottoson, 1999; LeMaster & Connell, 1994). Australian health service theorists suggest that:
Culturally appropriate care in any aboriginal setting anywhere involves presenting, in a way that these communities can understand and respecting their traditions, what modern medicine can offer (The Lancet, 1998).

While presenting biomedicine in culturally appropriate ways is an improvement on biased Euro-Canadian services, the development of traditional-based health services would be even more responsible and responsive to the health needs and desires of Indigenous people and communities:

After more than a century of well-funded dominance by bio-medicine of the institutions of health and healing in our societies, the western world is now beginning to evaluate the potential contributions of other approaches. The World Health Organization’s goal of health for all is still far out of reach. Traditional medicine and healing practices are a source of ideas that may ultimately benefit not just Aboriginal peoples, but all peoples (INAC, 1996).

... if traditional healers are to offer their services more widely, participate in the redesign of Aboriginal health and social services, and attract apprentices, the matter of ensuring adequate income becomes a public policy concern (INAC, 1996).

A significant example of traditional-based health services are the services provided by Indigenous healers. Historically, ‘traditional-based’ health services, as part of Indigenous cultural traditions, have been oppressed through legislation, and consequently, have been significantly marginalized and even driven under ground (Barman et al, 1986; Hopper, 1999; Lux, 2001; INAC, 1996; Waldram et al, 1995). In 1951, the 1884 Indian Act amendment, that prohibited the Potlatch and Sundance ceremonies, was rescinded. Since then, traditional-based practices have had a resurgence.

A list of health service options and themes being used by Indigenous people in B.C. is detailed in Table 2. The table was derived by reviewing Rod McCormick’s Ph.D. thesis, entitled *The Facilitation of Healing for the First Nations People of British Columbia*, and which was published in its entirety by the Canadian Journal of Native Education (1995). The frequency of incidents, out of a possible 437, is indicated by number. While these categories may be enacted within any cultural context, the four italicized categories seem particularly relevant to traditional-based practices (171/437 incidents). The document clearly supports the assertion that traditional-based options are still being used in Vancouver and in the rest of the province. This is echoed in a poll conducted by The First Nations Centre in 2004, in which 53% of First Nations people in B.C. reported that they had used traditional care. In the same poll, 68% of the respondents said that they would use traditional medicines or healing practices more often if they were available through local health centres. This suggests an unmet need for traditional-based health services, for 15% of the First Nations people in B.C.

<table>
<thead>
<tr>
<th>Table 2: McCormick’s Healing Categories and Incidents</th>
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<tr>
<td>Established Social Connection (16)</td>
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<tr>
<td>Exercise (20)</td>
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<tr>
<td>Involvement in Challenging Activities (7)</td>
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<tr>
<td>Obtaining Help/Support From Others (91)</td>
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<tr>
<td>Setting Goals (15)</td>
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<tr>
<td>Gaining an Understanding of the Problem (22)</td>
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<tr>
<td>Learning From a Role Model (16)</td>
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<td>Anchoring Oneself in Tradition (32)</td>
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<tr>
<td>Self-Care (3)</td>
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<td>Expressing Oneself (55)</td>
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<tr>
<td>Participation in Ceremony (33)</td>
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<tr>
<td>Helping Others (21)</td>
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<tr>
<td>Establishing a Spiritual Connection (34)</td>
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<tr>
<td>Establishing a Connection with Nature (72)</td>
</tr>
</tbody>
</table>
To meet health, education and employment needs that can’t adequately be met on reserves or in rural areas, Indigenous peoples have increasingly migrated to the cities (Frideres, 1998). According to Statistics Canada, off-reserve Aboriginal people represent 1.4 percent of the Canadian population (Tjekema, 2002), out of a possible 3.3% of the Canadian population (Statistics Canada, 2003). Almost one-half (49%) of all Aboriginal people in Canada live in urban areas (Statistics Canada, 2003). Urban-based Indigenous people, as a generalized cohort, experience higher and disproportionate rates of both morbidity and mortality, relative to the urban non-Indigenous population (Chandler & Lalonde, 1998; Frideres, 1998; Tjekema, 2002). Up to 70% of urban Indigenous people still seek out traditional healing processes (Buchwald et al, 2000; Krippner, 1995; Waldram, 1990a; Waldram, 1990b).

With 20% of off-reserve Aboriginal people reporting un-met health needs (Tjekema, 2002), and calls for more culturally appropriate services, the re-establishment of traditional-based health services, including those provided by traditional healers, seems timely. Because Indigenous medicine is traditionally land-based, traditional-based healers may not be present in urban populations in the same proportions as in rural areas. This may have added barriers to the access and provision of culturally appropriate, and especially traditional-based health services in the city, particularly for Indigenous newcomers who would have to seek those services through informal channels.

What is ironic to me is how the clash of Indigenous and Euro-Canadian paradigms has come full circle. Where First Nations ways of being were repressed by law, to the point of going underground, they are now being tentatively explored and even celebrated.

...there was a time when many details of healing were freely provided to inquisitive outsiders, to the point where some were allowed to witness and document various healing activities. By the end of the first quarter of the twentieth century, there appears to have been a shift in this attitude of Aboriginal healers, and a period commenced in which the traditions went underground, shielded from the watchful eye of government administrators and others. Only since the 1980’s has a degree of cautious openness emerged regarding healing (Waldram et al, 1995; p. 97).

The idea of integrating Indigenous health services within or alongside existing health systems, is not new. The World Health Organization has been recommending the utilization of traditional systems of medicine, as a way of ensuring primary health care, since the 1970’s (WHA30.49; 1977). Recently, the World Health Organization created a strategic initiative to develop a framework for the integration of traditional medicine into national health systems (Green & Ottoson, 2000).

Maori health providers on the north island of New Zealand have already implemented a ten year strategy (He Korowai Oranga) and a two year action plan (Whakatataka) to implement health policy that acknowledges and respects the paradigms of Tangata Whenua, the Maori people, and specifically promotes the development of a Maori health workforce, including the recognition and integration of Whanau health workers, who advocate Whanau ora, a Tangata Whenua paradigm of health (NZ Ministry of Health, 2002). The Maori words Tangata, Whenua and Whanau, are core principles in the Maori world view, which roughly translate to people, land and family, respectively (Te Kuratini o Nga Waka, 2002).

In Canada, though not well known, the Medical Services Branch provides financial contributions for patients to see traditional healers, and to take traditional healers into First Nations communities (Gregory, 1991). In 1991, the Federal government established a Royal Commission with a mandate to “examine all issues which it deemed relevant to any or all of the aboriginal peoples of Canada” (UBCIC, 2005). After four years of consultations, the
commission produced five volumes of text and recommendations, including _Gathering Strength_, the volume relevant to health and social issues. The appendix on Traditional Healing is particularly relevant:

Even those who are sympathetic to Aboriginal perspectives often see traditional Aboriginal healing methods as unsophisticated or 'primitive' versions of bio-medical principles. Apart from being paternalistic, this view ignores fundamental philosophical differences between the two systems, including the essential dimension of spirituality in Aboriginal healing and its much more comprehensive goal of restoring balance to individuals and communities (INAC, 1996).

Many who spoke to us argued that strategies for health that originate from within Aboriginal cultures are the key to restoring well-being among Aboriginal people.

Values and practices adopted or adapted from Aboriginal healing traditions offer immediate and long-term positive benefits to health status. These benefits are accessible through direct collective participation in ceremonies, one-to-one client consultation with elders and other healers, and the participation of traditional elders and healers in new program design (INAC, 1996).

In response to the Royal Commission on Aboriginal Peoples, the Canadian government (INAC, 1997) issued an action plan, entitled _Gathering Strength_. Within this document, a commitment was made that is inclusive of traditional-based health services:

Moving to new solutions means ensuring that the authority, accountability and responsibility of each of the parties are established. It means recognizing traditional customs, including their role in governance; celebrating Aboriginal languages, heritage, and culture; assisting to build the capacity of Aboriginal institutions to handle new responsibilities; and working to establish mechanisms to recognize sustainable and accountable Aboriginal governments and institutions.

As a result of federal documents regarding the challenges, recommendations and commitments, strategies for implementation had to be developed at provincial and local levels. The Ontario government has been a leader in recognizing the benefit of traditional healing.

Traditional Aboriginal approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system (Ontario Ministry of Health, 1994, p. 15).

In the year 2000, the Ontario government initiated the Aboriginal Healing and Wellness Strategy to follow through with its acknowledgements, and specifically, to address the issues of family violence in Indigenous communities and to create a provincial, Indigenous-specific health policy (Ontario Ministry of Health, 2000).

In B.C., the Ministry of Health with the Aboriginal Health Association of B.C. initiated Aboriginal Governor's positions on regional health boards: responsible for representing the health needs of Indigenous communities in their region and for creating Aboriginal health plans.
for incorporation into each regional health plan (Aboriginal Governors Working Group (AGWG), 1999).

At a slightly earlier time, the Vancouver/Richmond Health Board published an Aboriginal Health and Service Review, entitled Healing Ways, which included recommendations regarding culturally sensitive and appropriate health services:

Care must include traditional practices while accepted healers must be compensated and given due respect by mainstream health care practitioners (1999).

In turn, this review led to the development of a Strategic Plan to Develop an Aboriginal Healing Centre in Vancouver (Leach & Associates, 2000), in which traditional-based health services were prioritized:

Recommendation #5 That traditional healing approaches be an integral part of healing at the Healing Centre. This includes the use of Elders, Spiritual Leaders, and Traditional Healers, as well as sweatlodges, talking circles, water purifications, and the use of traditional plants and medicines.

I am inspired by the current focus on the non-medical determinants of health, but realize that it doesn’t go far enough to address cross-cultural inequities. Culture, worldviews, traditions, or ways of being, knowing and doing, must be prioritized in the scheme of non-medical determinants of health. If this is done, health service policies can make the leap from services that inadequately serve Indigenous peoples (and others), to services that understand, respect and give space to Indigenous (and non-Euro-Canadian) health perspectives, processes and practitioners.

Imbalanced Relationships: Regional representation and cultural appropriateness

The aim of education for health is to raise the level of public consciousness sufficiently that people not only accept the responsibility for their personal health, but are sufficiently aware of the range of factors affecting personal health that they can, and know how to, do something about them (Laura & Heaney, 1990; p. 198).

Health-education services aimed at radical or even moderate health system change requires ratification and participation by motivated individuals, who are effective at representing the interests of diverse and large numbers of people. At first glance, this seems simple. In reality, it is much more complex, and even daunting. As an example, I will outline some of the factors influencing health education reform in British Columbia. Since the early 1990’s, B.C., through the Ministry of Health, has moved to make health services more responsive and more effective by ensuring that there is greater representation and direction by members of community (AGWG, 1999; p. 1). During subsequent reviews and in recognition of the need for greater representation by Aboriginal people in B.C., there were strong recommendations for each health authority (regional health board, community health council and/or community health service society) to have at least one Aboriginal member, and to require the addressing of Aboriginal health (Ibid; p. 1). In effect, because ‘strong recommendation” does not always end in action, and to ‘address’ does not always indicate to what extent, significant issues have arisen that impede participation.

In a 1999 review by the Aboriginal Governors Working Group, it was recommended that representation be required and adequate (connected to the communities), that training, resources, and communication be enhanced and standardized, and that Aboriginal wellness plans be
required. If we continue with B.C's example, to include Aboriginal representation in health education reform, we must also take a detailed look at the relationships between the B.C. Ministry of Education, the Federal departments of Indian Affairs & Northern Development, Aboriginal Health and Aboriginal Education, and the numerous First Nations governments, territorial organizations for health and education, and community identified health practitioners. B.C. 's example provides just one warning about some of the complexities involved in creating change in schools and health systems. Creating new relationships take time; making wholistic changes to health education will take even longer.

One of the biggest constraints to forging new relationships between the descendents of Euro-Canadian settlers/colonizers and Indigenous peoples is distrust based on years of inadequate representation and outright deception or theft of Indigenous lands, resources and knowledge. Indigenous health practices, as embedded as they are in Indigenous spirituality, are still strongly protected. And it seems, protection is still needed from researchers who seek to turn a profit at the expense of Indigenous individuals and communities. Every few days I am informed in the news and on the internet of new transgressions in the use of Indigenous blood and tissue samples, the patenting of ancient tribal remedies and other forms of biopiracy. Some recognition of Indigenous rights is being taken into consideration in the construction of new laws regarding the harvesting, processing and sale of herbal products; but generally, because of its communal domain, Indigenous knowledge is still mostly unprotected:

Instead of receiving proper and due recognition for the areas in which they are known to be efficient and effective, healers are encouraged to surrender their herbal lore for the advancement of science... there is a lack of systematic protection of ownership of orally transmitted information, which is a vital form of intellectual and creative property in traditional medicine. ...traditional healers ought to organize themselves and seek professional status, in order not only to survive but to get their share of government support (Airhihenbuwa, 1995; pp. 56, 58, & 60).

As Airihenbuwa indicates, Indigenous representation within a colonizing nation requires utilization of the strategies recognized by that colony. In the case of participation in health education reform, Indigenous peoples must utilize both the avenues offered them, government and organizational representation, as well as take more proactive approaches to secure representation via legislative and institutional recognition of both Indigenous health practices and practitioners. Creating connections between Indigenous systems and Euro-Canadian systems, via respectful transformations around entrenched processes will ensure the active growth of healthier relationships, which in turn will effect healthier consequences upon the lives of all Canadian individuals and communities.

Questions Generated from the Influences of Self, Community and Academia

True cooperation, in any field, requires a deep understanding of the perspectives, aims and processes of each participant, and an understanding of existing or potential factors that can be used to facilitate mutually agreed-upon courses of action. Zubek applies this idea to health services, by focusing on Indigenous people:

Cooperation between traditional Native and modern health care systems requires greater awareness of different healing strategies, governmental support, and research to determine views of Native patients and healers (1994).
The issue of government support is particularly relevant to the current status of traditional-based health services in Vancouver, and leads naturally to specific questions like: is there support, if there's support, what are the parameters, if there aren't any, why not? Campbell and Gregor (2002) remind us that, to make institutional analyses understandable, researchers must

...explicate[s] ruling relations that organize the situation studied, exposing how ruling texts are activated by those involved. When the presentation of the analysis is sufficiently clear, we can all see how things have happened as they did.

After a short reading of historical relations between Indigenous and non-Indigenous peoples in Canada, the status quo is understood. Collins Airhihenbuwa problematizes cooperation and research between traditional Indigenous and "modern" (allopathic) health care systems, in his admonition that

Instead of receiving proper and due recognition for the areas in which they are known to be efficient and effective, healers are encouraged to surrender their herbal lore for the advancement of science (1995; p. 56).

Maureen Lux corroborates Indigenous dispossession in a Canadian context in her statement:

By the early twentieth century, officials' perceptions of the people's healing rites had changed: those rites were no longer demonstrations of savagery and indolence, but rather manifestations of the people's disregard for human health (2001, p. 85).

Elizabeth Cook-Lynn urges a critical response:

...the essential nature of intellectual work and critical reflection for American Indians is to challenge the politics of dispossession inherent in public policy toward Indian nationhood (1998, p. 130).

In the Basic Call to Consciousness, the Haudenosaunee remind us not to dispossess ourselves:

We must all consciously and continuously challenge every model, every program, and every process that the West tries to force upon us. Paulo Friere wrote, in his book, the PEDAGOGY OF THE OPPRESSED, that it is the nature of the oppressed to imitate the oppressor, and by such actions try to gain relief from the oppressive condition. We must learn to resist that response to oppression (Akwesasne Notes, 1981).

With challenge comes the responsibility of working towards real-life solutions, to make the old ideals, or new ones a reality in current contexts. Graham Smith speaks to this responsibility in his comments on transformative process:

My message to the institute members is that we have the option to set our own courses with respect to realizing our dreams and aspirations, and therefore we ought to be considering developing resistance initiatives around that kind of philosophy, initiatives that are positive and proactive (2000, p. 211).

This study has an inevitable agenda to challenge the politics of dispossession. This theme became underlying by choosing to focus the research in a way that illuminated the gaps between
the status quo and more egalitarian health service practices, by choosing to focus on addressing the gaps by expounding the practicalities of Indigenous worldviews, traditions, theories, methodologies and methods. The efficacy of this approach is echoed in the following statement:

The examination of traditional medicine includes articulating an Indigenous knowledge approach to understanding what traditional medicine is and why it historically existed outside dominant institutions, biomedical models, and Eurocentric paradigms (Hill, 2003).

The challenges given by Cook-Lynn, the Haudenosaunee, Smith and Hill, were taken-up in this research project, by focusing more comprehensively and proactively on how a more inclusive health services framework - which includes the recognition, support and validation of traditional Indigenous healers - might be facilitated. While transformative in stance, this study was not intended to position traditional-based health services as a total alternative to Western forms of health provision. Rather, this study has stated such provision as being important as a legitimate option for Indigenous people amongst a range of services. Such a proposal is congruent with a political science of health model in which health policy:

...should provide a framework for understanding inequalities in health within a broad political context, and for addressing the underlying structural issues, using community development and empowerment strategies (Sargent, 1996, in Kermode, 2004).

Hence, rather than focusing on conflicts regarding legitimacy, which could easily overshadow the transformative aims of this project, I have operated from a stance that Indigenous people are already entitled to access, and to provide traditional-based health services. This transformative approach has been implemented by utilizing theories of Indigenous wholism, story telling and talking circle methodologies, and Indigenous ethics in the conduction of the study. Gregory Cajete alludes to and summarizes the processes and benefits of proactive research in his comments:

Indigenous people have demonstrated a way of knowing and relating that must be regained and adapted to a contemporary setting – not only for the benefits of those cultures themselves, but for all human kind. Learning and becoming whole are, at every level of expression, intimately intertwined (1994; pp 79 & 180).

This study incorporated a number of theoretical tools and understandings, chosen in relation to the Indigenous perspectives of myself, the author. Linda Smith expresses this stance well:

Decolonization, however, does not mean and has not meant a total rejection of all theory or research or Western knowledge. Rather it is about centring our concerns and world views and then coming to know and understand theory and research from our own perspectives and for our own ways (1999, p. 39).

Given all the influences on this research project, from myself, community and academia, I constructed the following main question.

How can the access to, and provision of ‘traditional-based’ health services be enhanced for urban-based Indigenous peoples?
Since this question could have been answered in many ways, further questions were needed to streamline the focus of this study. The following questions, when asked among the Indigenous community members and relevant agency facilitators in Vancouver, provide a deep, qualitative, and community-based avenue for answering the primary question.

1. What counts or should count as 'traditional-based health service provision?'
2. What barriers or constraints get in the way of traditional-based health service access and provision in Vancouver?
3. What facilitates or supports the access and provision of traditional-based health services in Vancouver?
4. What would be the ideal, traditional-based health service situation in Vancouver?
5. What is necessary to create this ideal situation in Vancouver?
Chapter 2  Indigenous Wholism: Theories, Methodologies, Methods, Meaning Making and Appropriate Use

Theories/Thinking

Re-emerging Forms of Wholistic Theory: Sites for Alliance

Hippocratic principles were directly opposed to magic and ritual. However, the continuing success throughout antiquity of the cult of Asclepius shows very clearly that medicine was never fully divorced from its religious connections. Beginning in the sixth century BCE (at the time of the Hippocratic Oath), health resorts, or sanctuaries, known as Asklepia (because they were presided over by the god of healing Asclepius) sprang up all over the Mediterranean. The cult of Asclepius was at the same time a religion and a system of therapeutics. His sanctuaries, such as those at Tricca, Epidauros, Cos and Pergamon, were built outside the towns on particularly healthy sites (University of Virginia, 2003).

The term cult carries a negative connotation that portrays cultists as blind, irrational followers; this term has often been used to refer to the traditional-based practices of Indigenous peoples. This stems partially from the persistent impact of Hippocrates, who has been credited with separating medicine from religion, towards rational medicine. The above quote gives example to pre-Hippocrates forms of medicine, which seem similar to traditional-based Indigenous health services in their inclusion of ritual, fasting, baths, religion, dreaming and interpretation, purification, healthy environments, and therapeutics (University of Virginia, 2003b). If we consider the divorce between spirituality and the body (mind, emotions, body) as the birth of modern medicine, then the move away from medical wholism is only around 2610 years old, less than the oldest trees (Figure 6).

It’s not surprising that remnants of Western wholism have survived and are making a resurgence in the medical professions, and bringing contemporary thoughts full circle.17

It is the poor results achieved by these conventional health-education programs born out of ‘crisis’ which demands the implementation of a new model of education for health, based not only on health issues but the relevant social, political, and environmental concerns of the global community (Laura & Heaney, 1990; p. 182).

The health education/promotion discipline has failed to ground its professional (both philosophical and practical) praxis adequately in such areas of humanities as philosophy, history and cultural studies. The result has been the absence of meaningful participation of people and their cultures in positive behavioral transformation where appropriate (Airhihenbuwa, 1995; p. x).

Retired deputy director general of the World Health Organization, T. A. Lambo, faults the Western medical practitioner as being ...invariably preoccupied with immediate natural causes, almost to the exclusion of the causal relations between conflicts and irregularities in the field of social relations on the one hand and disease or misfortune on the other’ (Airhihenbuwa, 1995; p. 50).
Figure 6. Interactions between Indigenous and European histories of Wholism

Other global level policy makers have reiterated this need for a less reductionistic focus, and have called for an expanded definition of health. In 1978, members of the World Health Organization passed a resolution to thereafter define health as “a state of complete physical, mental and social wellbeing, and not merely the absence of disease (Laura & Heaney, 1990; p. 2).

One of the first shifts following this new definition, was to borrow from anthropology; if the concept of ‘illness’ could not be dethroned, at least its context could be expanded: “what constitutes an illness differs from society to society (with intrasocietal variation as well), and it is best to think of ‘illness’ as socially and culturally defined (Waldrum, 1995; p. 216).” Since the 70’s, despite the domination of health by biomedical institutions and practitioners, there has been a growing cadre of wholistic health proponents who have been theorizing in more courageous ways. Though usually under-funded, health promotion and health prevention practices have begun to step away from disease or biomedical models of health care towards more complex models.

The roots of mainstream wholistic medicine have their roots in the hardest of physical sciences. A contemporary of Einstein, Bohr contended that
The behavior of any specific quantum phenomenon depended upon the logic of its interconnections with the whole of quantum reality (Laura & Heaney, 1990; p. 89).

Though cutting edge, such quantum theory has been confirmed empirically, with the use of elaborate machines, and built upon by other theorists. In 1964, J. Bell published his theory that.

It is the whole, the organizational pattern of the entire system that is, which determines the patterns of its components and the properties and behavior of its parts (Laura & Heaney, 1990; p. 90).

In social science, Heisenberg is credited with revolutionizing philosophy with his assertion that

...every quantum event is ultimately influenced by every other event, including our attempts to record and monitor those influences (Laura & Heaney, 1990; p. 100).

David Bohm provided a convincing experiment to demonstrate his concepts of enfolding, where by placing a droplet of insoluble ink onto the surface of glycerin, which has filled the space between one concentric cylinder and another; if the larger cylinder is rotated clockwise, the ink is enfolded into the glycerin; if then rotated counterclockwise, the droplet will reconstitute itself (1983).

So, whatever part, element, or aspect we may abstract in thought, this still enfolds the whole and is therefore intrinsically related to the totality from which it has been abstracted (Bohm, 1983).

This statement is further illuminated by Bohm’s concepts of a nonmanifest implicate order, which is interdependent with the world of ordinary consciousness, which he calls the explicate order. What is exciting about these theories, is that while they propose a wholistic order or interconnectedness within the universe, they also allow for nonmanifest realms of reality, such as mind, emotions and spirituality.

Adapting these physical theories to theorizing for health education, Laura and Heaney have coined the phrase Epistemic Holism.

The concept of reality unencumbered by description is displaced by the concept of realities which are versions of it, and the value of reduction, biological or otherwise, is proportional to the extent to which it contributes to the integration of parts into wholes. The effect of Epistemic Holism is thus to counter fragmentation, and in so doing, to synthesize diversity where possible, and to explain the failure of synthesis, where not (Ibid; p. 101). The aim is not to exploit human consciousness to achieve control but rather to achieve connection, relationship, and balance through consciousness (Laura & Heaney, 1990; p. 98).

Another wholistic theory to emerge out of Feminist thought is the concept, Gaia, that postulates the Earth as a “…self-organizing, self-regulating, self sustaining system (Ibid; p. 96).” Some have taken this ecologically based theory into more cutting edge discussions, by postulating that the earth, by all definitions of life and sentience, is a living, breathing entity; it’s alive: it moves, responds to stimulus and acts in intelligent, interconnected and meaningful ways. Humans are just a small aspect of this greater consciousness, to which we are inextricably
connected. The challenge and enormity of bringing wholism into our lives is expressed clearly in the words of Ron Miller:

We are entering a historic period of transition from one dominant worldview to another and it is my belief that the new, emerging culture is going to be radically different. Therefore, those of you who are working in this fledgling holistic education movement are pioneers on a rough and uncharted frontier. ...we will need many different tools, many different approaches in order to help make this transformation of culture happen (1999).

Interconnections between Epistemic and Indigenous Wholistic Theory.

Wholistic (or holistic) theory, as it relates to health and ways of living, is the most encompassing and relevant theory for this study. Wholistic theory explains knowledge as multidimensional in aspect, where knowledge is dependent upon multiple points of view; the greater the points of view that can be included, the closer one gets to a more comprehensive sense, or understanding of the whole (Laura & Heaney, 1990).

Perspectivist theory, and for that matter, all theories, can be subsumed within wholistic theory. At first glance, wholistic theory might seem like another term for cultural relativity, which acknowledges legitimacies in different perspectives. For example, some may legitimately focus on the clash between reductionistic and wholistic perspectives:

The holistic integration and internal consistency of the Native world view is not easily reconciled with the compartmentalized world view of bureaucratic institutions (Kirkness & Barnhardt, 1991, p. 7).

The most important consideration, for proactive research, is how different perspectives function within a wholistic model. The difference between wholistic theory and any one theory or perspective on knowledge, besides inclusiveness, is the criteria of complex relationship and reciprocal influence. Indigenous wholism ratifies the relative in relativity by acknowledging that it is not so much the difference that is important, as it is the relationships and mutual influences between these perspectives.

Western knowledge is beginning to explore these orientations to wholism in some of its more recent publications.

Recent ground-breaking discoveries, particularly in the field of psychoneuroimmunology, lend credence to the insights of eastern and traditional medicine. Complex bio-chemical links among body, mind, emotions and spirit, for example, can now be demonstrated (INAC, 1996).

Physics has had a growing influence on social science theory, with its growing explication of the relationship between matter and point of view (Laura & Heaney, 1990). Post-positivist realism, which provides a firm ground for examining these relationships and Systems theory, which explains paradigmatic shifts, come closest to wholistic theory.

The spider's web is a common analogy in both Indigenous and non-Indigenous wholistic traditions: when one strand of the web is moved, all other strands are affected. One of the greatest paradigm shifts that occurred in this century, was instigated by a book by Rachel
Carson, who discussed a similar analogy in her ground-breaking work entitled *Silent Spring* (Rachel Carson.org, 2005). Her wholistic viewpoint is suggested by the following quote:

> The more clearly we can focus our attention on the wonders and realities of the universe about us, the less taste we shall have for destruction (Carson, 1998).

Her work has had a great impact on the development of other wholistic theories, within the scientific world (e.g. ecological theories), and upon the contemporary importance placed upon the relationship between environmental practices and human health.

Another Western analogy, the (eclectic) tool-kit, is also useful as a metaphor for wholistic theory: any one or several theories may be appropriate, in approaching knowledge from multiple perspectives, depending upon one’s needs or goals of the moment.

**Whole Beings: Spiritual realities and the logic of Indigenous wholism**

As an exercise in applying Western logic to Indigenous realities, I’ve included a discussion of Indigenous wholism from a philosophical-logical perspective. Everything that is, is simultaneously, spiritual (“of or concerned with the spirit, divine, inspired”), mental, emotional, and physical in being. By the word “being”, I mean “to exist, to have a place in reality”. For human beings, spiritual aspects correspond with mental, emotional, and physical aspects in the human body. These aspects are translated into meaningful states and actions through human cognitions. Translation is a matter of perspective, or more simply, we see what we’ve decided to, or have been trained to look at. As an analogy, we can consider the phenomena of light. We see light, and under scientific analysis we conclude either wave form or particle form as simultaneous forms (“mode in which a thing exists”; Oxford, 1991). We see human beings and under scientific analysis we conclude matter that is highly organized, cohesive and complex in physical aspect; but we know that this perspective is insufficient. We know that using scientific analysis to analyze non-material aspects of humanness would be like using spectral analysis to see beauty. Through spiritual, mental and emotional analyses, we could conclude (and have concluded) conscious, moralizing, and motivated aspects of being.

In all aspects of being, we are capable of decision-making. Although, it is only by non-physical, mental, emotional and spiritual direction, that we are moved to behave in non-instinctual or non-inculcated ways. As human beings, we are synchronously physical and non-physical at the same time. As such, we can be said to contain both body states and what Descartes referred to as “immaterial substances”. I use body states instead of “brain states” because of my belief in cutting edge physics, physiology and metaphysics which verifies that while the brain may play a central role in the organization of the body’s systems, decisions are made at a cellular and even a sub-atomic level (Capra, 1975; Chopra, 1991). A good analogy for extending reality beyond the physical, is the sun, where what we see is a bright ball of light. Under scientific scrutiny, the sun is made up of the same atoms and molecules that make up our own bodies, but in much greater amounts and densities. My body is just a denser location for all aspects of my self. In actuality, there are no discrete physical boundaries between myself and the atoms that circulate between me and the sun. Correspondingly, the spiritual, mental and emotional aspects of my self are not limited by my body.

Acknowledging our wholistic nature as human beings requires acknowledging the legitimacy of all synchronous, corresponding, simultaneous aspects of human being, not just the observable, physical aspects of being. Ignoring knowledge derived from non-physical aspects of being, can create an imbalance between our perceptions of reality and our experiences of reality,
which can be described as illness. In philosophical terms, the principle of physical determinism is not transgressed, it is merely accompanied by a principle of spiritual determinism, which may follow other, non-physical laws.

**Personal responsibility and the inclusion of Indigenous wholism: medical pluralism**

Learning and becoming whole are, at every level of expression, intimately intertwined (Cajete, 1994; p. 180).

‘Medical pluralism’ refers to the practice of utilizing the medical services of more than one medical system. ...medical pluralism allows the patient to retain both control and the cultural context of healing (Waldram, 1995; pp. 209 & 211).

In an era of health reform, with emergent wholism and increasing dissatisfaction with entrenched health care systems, Canadian society is entering into the more liberal (consumerism based on demand and supply) practice of medical pluralism.

Alternative or complementary therapies, most with complex histories of their own, are increasingly utilized and recognized for their contributions to health; Chinese herbalism and acupuncture, midwifery, chiropractics and homeopathy, various forms of massage or manipulation, psychological and spiritual counseling and nutritional regimes form the bulk of these practices. Informally, the use of these therapies is no longer considered a sign of poor reasoning, but rather, a more personally responsible approach to looking out for one’s health.

Many of these practices have professional organizations and licensing bodies, which help to standardize and legitimize them within mainstream institutions. With legitimization comes inclusion in medical service plans and other financial schemes. What is missing is a comprehensive philosophical framework for health, which can be used to rationalize personal responsibility for health and health care choices, beyond finding cures for ailments. Medical pluralism is a step in the right direction, but much more needs to be done in the way of promoting and educating for epistemic holism and wholistic health in the mainstream.

**Enduring Indigenous Wholism and leadership**

Since this paper is about Indigenous health education, I feel compelled to point out at this point, the case I have been making. Though Indigenous epistemologies, health practices and forms of transmission have been oppressed by colonizing forces, they have survived, adapted and thrived to present day in many forms of locally specific practice. Lux confirms this observation:

This viable and culturally appropriate medical/healing complex was not abandoned when the people settled on reserves... the people’s healing complex continued to change and adapt to altered circumstances and evolving needs, despite the best efforts of the missionaries, physicians and government to discredit healers and repress their practice (Lux, 2001; p. 71).

Given the emerging forms of wholistic theory in mainstream, Indigenous wholistic theory, concepts and practices can be developed as an extension of entrenched forms of wholism; in this way, proponents of Indigenous wholistic theory can play an important
leadership position in the development of Indigenous theories. Though primarily unrecognized or undocumented, Indigenous health concepts and practices can provide an empirically tested template for health education in contemporary society. One recent example of the growing recognition of Indigenous health practices can be found in statements made by the Ontario government, in their efforts to make health care services more culturally appropriate:

Traditional Aboriginal approaches to wellness, including the use of traditional resources, traditional healers, medicine people, midwives and elders, are recognized, respected and protected from government regulation. They enhance and complement healing, as well as programs and services throughout the health system (Ontario, 1994; p. 15).

Spiritual foundations of Indigenous wholism

Ours is a Way of Life. We believe that all living things are spiritual beings. Spirits can be expressed as energy forms manifested in matter. A blade of grass is an energy form manifested in matter – grass matter. The spirit of grass is that unseen force which produces the species of grass, and it is manifest to us in the form of real grass (Akwesasne Notes, 1981).

Most of the concepts of emergent wholism are embedded (enfolded) within Indigenous cultures, worldviews and traditions, which incorporate principles of interconnectedness and balance among social, mental, physical and emotional realms. Possibly because of its roots in the physical sciences and ecology, emergent wholism is timid when faced with spirituality. Indigenous wholism is much bolder. Gregory Cajete provides a bridge to encourage spiritual inclusion, in his statement: "ecological education, wherever found, revolves around the issues that are essentially ethical, religious, and sacred (1994; p. 76)." Airhihenbuwa does likewise in his normalizing statements:

In all forms of traditional healing, religion and shared cultural values and beliefs are at the core of preventive and curative health practices. Religion is critical to an understanding of the spiritual dimension of health, which in turn is pivotal to the maintenance of the psychosocial dimension of health (1995; pp. 48 & 50).

If wholistic health education was based on Indigenous wholistic frameworks, spiritual aspects of being could be acknowledged in the status quo and incorporated into the web of health-education understandings.

Balanced health-education practice

Instead of replacing mainstream health-education services, or adding on to them, the most appropriate action, in a wholistic paradigm, is to integrate wholistic health-education services into all components of daily life and opportunities for learning. Lux, from her anthropological perspective, gives an example of such wholistic principles in her assertion that to some Indigenous plains people:

Illness was a manifestation of the body and soul in search of harmony or balance... disease and medicine was framed... in a world view that placed people and their ills in a
much larger circle of life that was populated by the animate and inanimate, the natural and supernatural (Lux, 2001; p. 18).

Cajete, from an Indigenous perspective, echoes Lux, with practical examples:

Health, wholeness, and harmony of the individual, family, clan, and Tribal community were the ideal state of life, and therefore the ideal goal of life in community. To reach this ideal state, the tools of ritual, medicine, art, sport and other formal and informal teaching were used in the context of Indigenous community (Cajete, 1994; p. 178).

North American Indigenous peoples have been using wholistic paradigms, principles and processes in their daily lives for thousands and thousands of years, and, since contact with Western European civilizations, to interact with non-Indigenous newcomers. A key principle of Indigenous wholism is inherent in the theme of interconnectedness. This theme, which is evident in many Indigenous traditions, emphasizes that aspects of being – mental, physical, emotional and spiritual – are components of relationships between all things (Antone, 2000; Hampton, 1995; Kirkness & Barnhart, 1991; Toulouse, 2001; Weenie, 1998; Young, 2002). One of the most well known visual models for Indigenous wholism is the circle, popularly labeled the Medicine Wheel. In this wheel, all of existence, all the relationships, directions, beings and cycles are represented within a circular hoop (Benton-Banai, 1988). In a good (optimal or healthy) life (see bimadziwin: Toulouse, 2001), these relationships are in balance. When relationships are out of balance, the whole of reality is affected, usually with detrimental effects. As such, a core element of healing, in an Indigenous sense, is the remediation of imbalanced (optimal or healthy) relationships. Alannah Young puts it more eloquently:

Healing involves reconnecting with the interconnections between, and restoring balance to, relationships that have become disconnected. Well-being comes with harmonious relationships between all aspects of creation (2002a).

Balance in a research context, therefore, means documenting knowledge that may provide a foundation for creating better relationships.

Summary

To summarize, wholism is a common way of being, knowing and doing, amongst Indigenous peoples. As such, Indigenous theory, and Indigenous wholistic theory in particular is the most appropriate theory to consider when doing research with First Nations communities. When using non-wholistic theory, difference or reduction tends to be the foci for academic investigation. When using Indigenous wholistic theory, relationship is the key focus for academic investigation. While Western academic theorizing is supposed to be non-political, and non-moral, Indigenous wholistic theorizing, by its epistemological foundations and considerations of relationship, is inherently political and moral. Examining imbalanced relationships for potentials to restore balance inevitably leads to a questioning of the status quo. The tricky part is to do this in a “good way”, a way that reflects the principles and values of Indigenous wholism.
Methodologies/Thinking about Doing

Storywork

The *storywork* methodology used in this dissertation is a modification of the storywork framework coined and used by Jo-ann Archibald, in her thesis, entitled *Coyote Learns To Make A Storybasket: The Place of First Nations Stories in Education* (1997), which discusses the important location of First Nation stories in the education of First Nations peoples. Archibald’s work was an excellent model for applying Indigenous wholistic theory, because of its focus on the principles of respect, responsibility, reciprocity, reverence, wholism, inter-relatedness, and synergy related to using stories and storytelling for educational purposes. Storywork seemed to be an appropriate methodological framework for researching traditional-based health-education services in Vancouver, because such principles are assumed to be compatible, by definition, with the worldviews of traditional-based Indigenous health practitioners, their facilitators and clients.

In Vancouver, the word narrative has connotations of stories made up, of being fictional; subsequently, inquiries after such tales, create a fictional orientation to the finished product. While truth may be in the eye of the beholder, narrative truths may never even be looked at. There is a wide spectrum between being informed by and writing from imagination, to being informed by and writing from lived experiences, upon which all qualitative accounts can lay.

Storywork, is a more appropriate term for working with Indigenous stories, because the term is more closely and culturally aligned with Indigenous terms, concepts and methodologies; oral teaching, learning and documentation in particular. We aren’t working to create stories, we are working to convey them. The emphasis shifts from the creation of a narrative, to the sources of the narrative. Considering the research goal of writing up some concrete conclusions and recommendations, for use by both policy makers and curriculum developers, this shift in emphasis, via terminology, is also strategic.

In doing Indigenous wholistic research, congruency between theory and methodology requires that relationships become the most appropriate focus for identifying, exploring and/or stimulating balance (Hampton, 1995; Weenie, 1998). The balance required to be healthy can be supported by the principles of respect, relevance, reciprocity and responsibility, in relationships: “respect for who they are...relevant to their view of the world...that offers reciprocity in their relationships with others, and that helps... exercise responsibility over their own lives (Kirkness & Barnhardt, 1991, p. 14).” While these principles were originally discussed in the context of First Nations students attending university, they are increasingly being applied, through the influence of the BC ACADRE and the First Nations House of Learning at the University of British Columbia, to Indigenous research in general (Young, 2002; Pidgeon, 2002).

The methodology of collecting stories, like the theoretical base, reflects a wholistic framework and was adjusted to ensure cultural appropriateness and consideration of cultural contexts when working with research participants in Vancouver. Linda Tuhuiwai Smith makes reference to the appropriateness of using stories in contemporary societies:

Intrinsic in story telling is a focus on dialogue and conversations amongst ourselves as indigenous peoples, to ourselves and for ourselves. Such approaches fit well with the oral traditions which are still a reality in day-to-day realities (1999, p. 144).

Shirley Sterling commented on the ethics of using story telling in research, in her dissertation statement:
Oral traditions restore humanity to scientific research and provide models for inquiry which are holistic not dichotomous and/or adversarial (1997, p. 242).

For many Indigenous peoples, good and healthy relationships are modeled through both traditional stories and life stories. Jo-ann Archibald attests to this connection between relationships and stories in her statement:

...the common goal has been to attain a mutual balance and harmony among animals, people, elements of nature, and the Spirit World. To attain this goal, ways of acquiring knowledge and codes of behaviour, are of course essential and are embedded in cultural practices; one which plays a key role in the oral tradition is storytelling. Some stories remind us about being whole and healthy and remind us of traditional teachings that have relevance in our lives (1997, p. 14).

Shirley Sterling echoed the connections in her reflection upon Nlakapamux stories:

The grandmothers, through the stories, are the teachings, showing through example, story, and voice what it means to live successfully and happily as members of the Nlakapamux society (1997, p. 236).

In his book called A Yupiaq Worldview: A Pathway to Ecology and Spirit, Oscar Kawagley legitimizes using story as a knowledge source in his statement:

As I contemplate this question and reflect back to the stories my grandmother told me, I begin to see that the tools for teaching a culture, a science, a way of knowing have always been with us (Kawagley, 1995, p. 31).

Marlene Atleo attests to the transformative processes inherent in storytelling in her following statements:

Storywork provides a means of educating by passing down the beliefs and values of a culture in the positive expectation that the next generation will treasure them and pass them on. Beliefs and values encoded in stories orient learning in a variety of ways... Story telling thus provides a pool of knowledge about learning, which has deep cultural survival strategies that have sustained a People for millennia (2000).

And finally, we must remember that stories are shared differently with different people, in different contexts. Knowing that the stories were to be shared publically, probably influenced participants to share stories that were appropriate for such an audience. Private or informal stories, were probably selected out. Sheema Saeed demonstrates such selection out in her own thesis:

I cannot write down these informal narratives that I have been told of my own ancestors, since they were meant for my ears only, not any one else's. I recognize the importance of these narratives as they are written in my mind's eye in indelible ink and make me be who I am (Saeed, 2003).

Again and again, First Nations academics have written about story telling and its legitimate role as a conveyer of knowledge. When we consider Indigenous wholistic theory,
inviting the telling of stories becomes the logical and most congruent choice for examining
issues of relationship and balance in traditional-based health services in Vancouver.

From a narrative perspective, stories provide us with a plot or theme around which a
variety of characters interact, to the conclusion of the story. In real life, stories are never ending
and are tailored to the questions, or cast of listeners of the moment. Rob VanWynsberghe
describes the unfinished story method as involving “the researcher narrating an open-ended,
‘hypothetical situation’ that is offered in exchange for the interviewee’s help in its completion
(2001, p. 733).” He points to the possibilities of such unfinished stories “to explore the roots of
grievances, explanations and opposition, and the emergence of collective activity (p. 735)”, and
its ability to “foster expansive, imaginative, reflective and especially projective thinking (p.
724)”. In the case of this study, the unfinished story was the story of the researcher’s journey
towards asking the research questions (discussed previously), and included elements derived
from the pre-study issues raised by traditional healers and knowledge holders. In the Indigenous
contexts of this study, it was more appropriate to refer to my (as the researcher) story as the
beginning story; participants were asked to add their own stories and ideas, toward the creation
of a collective story about enhancing traditional-based health services in Vancouver.

Talking Circles

The process that seemed most appropriate for supporting and facilitating a storywork
process, and the one I am most familiar with, was a talking circle methodology, best discussed
by Graveline (2000) and Hagey & MacKay (1998). Circle methodology is a modern adaptation
of the historical decision making styles of many mainland First Nations people. Essentially,
everyone sits in a circle; everyone gets an opportunity to speak; and there are as many “rounds”
as needed to come to a consensus (win-win-win, not compromise), or to table issues for further
discussion at another time. The purpose is to share about and decide on important issues, or
issues that can’t be resolved individually. The goal is to meet the needs of the whole
community, not just those of the loudest, most persuasive or most charismatic.

For the spiritually inclined, circle methodology is based on the premise that we are all
related and interdependent in many ways. The spider web is the most common analogy used to
represent the far-reaching consequences of specific actions: moving one strand affects all the
strands. A related principle is that whatever is shared in the circle will not be used against that
person later, or shared irresponsibility (e.g., for entertainment or personal gain). Traditionally,
First Nations circles start and close with a prayer and held-hands, reminding us of our spiritual
nature, connectedness with all creation and therefore sacred obligation to be responsible and
generous in our thoughts and actions. After each person has finished speaking, it’s common for
that person to say “all my relations” or “that is all I have to say for now”. It’s considered
appropriate to be respectful towards the person speaking (which means no commenting under
your breath, talking to neighbours, or the like); empathy, encouragement or agreement is often
conveyed through quiet sounds like “mmmm” or “ah ho”.

Talking circle methodology is beautifully described in the following excerpt:

...Talking Circle as Methodology Enacted.
Traditionally a Sacred ceremony
    a Gift from the Ancestors.
A physical reality
    a Metaphysical experience.
An egalitarian structure
    each voice acknowledged
heard in turn.
To choose words with care and thoughtfulness
is to speak in a Sacred manner.
We can each have our own Voice
speak our own Truth...(Graveline, 2000, p. 364).

In talking circles, where more associative and inclusive spaces can be created for speaking, the discussion can evolve at a quicker rate by building on knowledge from perspectives that are diverse, not just from an opposing or controversial stance, but from a wholistic ground that includes emotions, spirituality and intuition. Relationship is enhanced by wholistic forms of communication protocol; each consecutive speaker, while speaking for themselves, is speaking in responsive relationship to previous speakers. Regardless of the number of discussants, or duration, the conversation deepens with each consecutive speaker.

Dialogue

Dialogue here is not the threshold of action, it is the action itself (Mikhail Bakhtin, 1929, in Anderson, 2005).

This quote, found on the Morris J. Wosk Centre for Dialogue Website, exemplifies the goal of using dialogue in this research project. Far from casual and unimportant discussions, I view dialogue as a form of active engagement between people with diverse connections and networks, as a form of mutual conscientization, for both myself and the research participants, and as a testing ground for collectively derived recommendations and conclusions.

...dialogue begins with the assumption that “truth” or “meaning” is not the monopoly of any single person or group... The listening process leads each side to question its own truth claims in the light of what is heard or examined. ...through cooperative learning and decision making, the stakeholders can collaborate in a project with higher productivity than otherwise possible (Anderson, 2005).

The facilitation of dialogue in this project was designed to add strength to the storywork process initiated during the information meetings and research gatherings. By beginning with the primary research question, and following with secondary questions – when appropriate - the dialogues built upon, expanded, exemplified, or contested the ideas already shared through previous meetings and gatherings. The interconnectedness between dialogue and community impacts must be acknowledged. When utilizing dialogue for research purposes, the ethics of respect and responsibility requires a consideration of the possible far-reaching consequences of any statements being made during dialogue or included within the dissertation. It becomes important not only to consider what will be shared, but how it will be shared. This is especially important in communities with strong kinship ties, where actions and words can have impacts over great distances. As the dissertation neared completion, the collective story became a participant-influenced, complex and strategic weaving of all the stories shared during meetings, gatherings and dialogues.

Since questions are at the root of dialogue, I thought it was appropriate to consider how I was questioning. During my studies, I have often experienced situations where people are asking questions that I consider rude; they are “none of their business”. Rudeness, like other ethics, is based upon our worldviews and traditions around behaviour. Dialogue questions should follow the same protocol of relationship required by proper Indigenous etiquette.
A good way to understand the complexities of questioning among some Indigenous people, is to consider the questioning of Indigenous people in classroom settings. As a person of mixed ancestry, as a First Nations community member, and as a former First Nations academic advisor, I've found the same difficulty keeps being encountered by people of Indigenous ancestry; they are invariably expected by non-Natives to speak on behalf of all or at least a large number of Indigenous people. “Why do your people...” – fill in the blank. Or more personally, “tell me about your tradition of this or that”. There are several issues here. My knowing about something does not give anyone the automatic right to ask about it. If I consider the relationship a respectful one, I may share certain knowledge. Asking to know specifics is like prying and precludes the judgment of appropriateness and offering by the knowledge holder.

On the other hand, questions may be answered without rudeness or forcing, by presenting one’s ignorance and need to know; if the need is seen as valid then the knowledge may be offered. While any Indigenous person can choose, or be trained to take on the role, formal or informal, of educating non-Indigenous people about Indigenous issues, not all Indigenous people have the right or authority to speak for their Indigenous Nations; those not authorized can only speak for themselves.

In a dialogic context, these issues of questioning or asking emphasize the requirement of informed volunteerism when soliciting participants for a study. The researcher’s ignorance and need to know can be presented to individuals, or authorized speakers (for example, through a beginning story), alongside opportunities for offering knowledge (e.g. through self-questioning, conversational pauses, etc); thereafter the researcher can wait, resist the temptation to coerce, and pray for knowledge to come their way. In a private research context, where an enduring relationship has already been established, more in-depth questioning may be invited. With this intimacy, comes the intensified consideration of with whom, and what kinds of knowledge, are to be shared: when and under what conditions.

**Indigenous Protocols**

**Creating Good Settings**

One of the most important considerations for both applying Indigenous wholistic theory, and the 4 R’s in particular, is the consideration of appropriate settings for research. The creation of good settings for research, should reflect the worldview, and traditions of the people who are being included in the research, to allow identification and trust-building around the appropriateness of their participation.

Creating good settings, in multiple domains (physical, emotional, mental and spiritual), also means attending to Indigenous etiquette around food. This is akin to being hospitable, or a “good host” in most cultures, which inevitably means ensuring that there is good food available, especially for long-term encounters. Creating good settings for research with Indigenous people, also means creating settings where people feel welcome.

**Introducing Who You Are**

After acknowledgement of our connections through prayer, introductions are one of the most important practices in Indigenous communities. How people introduce themselves enables the building of a community of individuals with intersecting lives and histories, and enables people to understand a person’s standpoint as an Indigenous person.
Gifting and Witnessing

From what I have learned from traditional teachings, Ojibway and others, gifting is an integral process for the establishment and maintenance of good relationships, and for the distribution of resources among Indigenous people. For many Indigenous people, the exchange of knowledge during a research project requires the creation of a relationship of mutual understanding and respect, which includes understandings of the origins of the knowledge, agreements about how it is to be applied, passed on or documented, and recognitions of the sacredness or importance of that knowledge. While the specific types of gifts may have changed (food, clothing, tools, shelter, service and intangibles), the underlying rationale remains the same. While they aren’t required, gifts can be given on any occasion, and are often used to formally signify or solidify the importance of relationships, transactions, events and agreements. The more important that event or relationship, the more formal the gifting process. A lack of gifting might indicate a lack of understanding of protocol, a lack of good character, or a disrespect of the relationship or transactions being entered into. For me, it was important to include the giving of tobacco and cloth, as a way of paying my respect to traditional-based Ojibway traditions, as a way of restoring those traditions in the Mainstream, and as a way of signifying the sacredness of the relationships and knowledge being shared. During my stay in Coast Salish territory, I’ve come to know more about the practice and importance of formal witnessing, through my attendance at Vancouver and Coast Salish community gatherings and events. Through witnessing, knowledge is orally recorded by credible people, who then pass on, or confirm that knowledge with others. It is an integral part of oral recording and oral history on the west coast, and provides a high level of validity and credibility to the knowledge being shared, by ensuring public accountability and integrity. Not having witnesses might suggest that the event was not relevant to the larger community, or that participants were ignorant of Coast Salish protocols. Under the guidance of participants, formal witnessing was incorporated into the gatherings of this project.

Methods/Doing

Prior to consenting to being involved in the research group, the participants were informed of an expected participation duration of a minimum of 9 hours over 23 months (September 2003 to July 2005). Participation was voluntary and participants were informed of their right to withdraw at any time. The community gatherings and interviews were conducted at public locations most conducive to telling stories about traditional-based health services in Vancouver. Refreshments were provided. At the time of recruitment there was to be no monetary compensation; however, funding in May, by the B.C. ACADRE supported the presentation of food, gifts and honorariums ($20/hour). Unless participants wished to be identified, names were removed from all documents, except consent or permission forms, and identified by code. Only the researcher and research participants had access to the code-names, audiotapes, notes and consent forms, which were kept in a locked facility for the duration of the study. Individual audiotapes and notes were to be destroyed or returned to interviewees, unless there was unanimous consent, initiated by participants to store them and the group audiotapes, at an appropriate location.

During summary, analysis and write-up of the information gathered, all participants were given opportunities for editing, and additional feedback through email or mail distribution of excerpts, communication at the last gathering, and during the thesis defense.
Beginning-Collective Story

The story technique that I used was a modification of Rob VanWynsberghe’s “unfinished story” method, which culminated in a “collective action frame”. In both the gatherings and dialogues, I began with a “beginning story”, which detailed the origins and progression of the research, and how the research questions were derived. Participants were asked to add to a collective story by sharing their own stories and ideas. Once complete, the “collective story” incorporates the depth and breadth of knowledge and stories of all the research participants.

The first gathering was organized as a 4-hour informal exploratory workshop, where the background, rationale, sensitizing issues and arising questions were presented briefly as a beginning story during the researcher’s contribution to an introductory circle. For example:

My interest in doing research in this area rose out of a background in First Nations issues, combined with my growing understanding of the issues around traditional medicine in Vancouver... traditional healers told me of their difficulties around not being recognized or supported, about not having committed apprentices...friends and family talked about not being able to find the right healers when they needed one...my original intent was to do a Ph.D. on freshwater management ethics, but I had difficulty writing up an application proposal...a dream about an international traditional healing centre in the city inspired me to do something about supporting traditional-based healing in the city...soul searching about the meaning of my life led to a decision to start giving back to the community by focusing on more practical issues... I spent over a year talking with different people, including my thesis committees, about asking the right questions, in the right way... I would like to invite you to help me create a more complete picture of traditional-based health services in Vancouver, by sharing your stories and ideas related to the research questions that have emerged from previous talks.

The beginning story was designed to lead naturally into an invitation to others to share their stories and ideas. Participants were asked to expand on my, the researcher’s, story, by providing their own stories and ideas, relevant to the research questions. This workshop was recorded by audiotape and written notes. Participants were informed that they could withdraw any part of their transcripts being used.

Talking Circle

As you may have surmised, I am a strong believer in wholistic research, or getting as many perspectives as possible, to inform about things in question. This mind-set comes both from what I consider Indigenous valuing of communality and relatedness, and from the [Canadian] intellectual understanding that issues are always complex (more than meets the eye) and comprised of many arguments. Both of these approaches may be taken in doing wholistic (a la perspectivist) research. Interestingly, these orientations allude to some of the difficulties encountered with communication methods, in multi-cultural academic settings.

Similar to issues of respect and questioning, issues of rudeness and speaking are complex and related to genealogies and relationships between speakers and listeners. With its history in intimate communal living arrangements, Indigenous protocol tends to create respectful space for both speaking and declining to speak, for the good of everyone concerned. A common example of this, is the use of a talking circle or talking stick; everyone is given the opportunity to be heard in the first round, without interruption or comment; more complex responses take place in the second round. The same context has provided for an ethic of privacy that transcends personal
gain; you do not share what has been said, unless the speaker has allowed it and only to certain people under certain conditions; the well-being of everyone must be considered before sharing. Sharing given knowledge with inappropriate people, who may act upon it inappropriately, is unethical.

In the research settings, I tended to wait until everyone had spoken; if my perspective had not been presented, then time willing, I presented it. Where there was pressure to perform, and comments were expected to be linear, individually-owned chunks; not speaking may be seen as dysfunctional and un-academic, or as withholding or not contributing to the conversation. In my mind, not speaking in a competitive arena may show several things: an acknowledgement that "everything's been said" (which has more to do with a collective sense of completion rather than exhaustion of a topic), a discomfort with non-relational assertions, a respect for what's been said, or that what's been said is still being processed. In an atmosphere of competition, my adaptation is better than nothing, but not always satisfying when carrying an ideal of wholistic communication.

The issues of speaking protocol and relationships are critical when considering sharing research or ideas in public settings, whether in a classroom, at a conference or community event. As mentioned before, situational identities require the assessment of context so that appropriate action can be taken. This assessment requires knowledge of the potential relationships between speakers and listeners so that appropriate knowledge can be offered. In large settings it is difficult to determine one's relationship to individuals who are present; assumptions have to be made. In doing so, combined with the ethics around questioning, I find it is very uncomfortable to speak appropriately, whether as a presenter or questioner: difficult to situate my identity, ascertain appropriate behaviour, or adjust what I am sharing appropriately.

Academia exists, ideally, to explore the world in both theoretical and practical ways, to add to human knowledge. Altruistically, public speaking is seen as a formal way of sharing this knowledge with large numbers of people; it is also seen as a validifying process whereby one exposes oneself to potential challengers. In a less aggressive and more appropriate way, knowledge can be shared and tested in smaller groups, where a relationship can be developed with the participants and where true communication, rather than dissociated statements, can be made. The consequent informal sharing of such group communication, in a ripple effect, creates a larger, more complex and more accurate dissemination of information.

The research gatherings were designed to encourage the story-telling or storywork methodology (see above, and Archibald, 1997; Atleo, 2000; VanWyensbergh, 2001; Kawagley, 1995), using a talking circle. Circle methodology works best when there are no time pressures; people can come and go (and eat throughout), but all perspectives are witnessed (and thereby recorded). If children attended with participants, they were invited to participate or witness (and therefore learn) as long as they were not disruptive. A key principle was that each person got to speak on the issues in question, without interruption. This meant that regardless of their words or emotions shared, or challenges raised, there was no attempt to respond verbally with suggestions, consolements or counter-arguments. People were encouraged to speak or refrain, as was appropriate, by indicating they would pass during a round. An equally important principle was that those not speaking were expected to listen very carefully, so they could add understandings to their own perspective. Each consecutive speaker could have built on what was already said. Theoretically, the discussion deepened each round to a point where the best solutions had been suggested and decided upon, to meet all the needs and goals of the group. For those of us who weren't used to using our memory, flip chart paper was taped up to record and remind us of key words and suggestions.

Following individual interviews, another gathering of the participants was held, using the talking circle methodology. Prior to the gathering, the initial draft of the complete dissertation
was mailed to each research participant. Attached to each dissertation was a letter of permission to use their whole names, or use pseudonyms in the final document (see appendix). On the same letter was a question whether group audiotapes should be destroyed, and whether individual audiotapes should be returned or destroyed. Also attached was a letter inviting participants to the gathering, with a request that they review the document and either send their comments and suggestions for revision in written form, or bring them to the talking circle (see appendix). An overview of the dissertation, and invitation for comments and suggestions, was presented at the beginning of the talking circle. This second gathering was also recorded by audiotape and written notes. Participants were reminded of their right to withdraw or modify their names or contributions at any time.

Dialogue

After the first gathering, all of the research participants were invited to participate in more in-depth individual interviews (approximately 1 hour in length, each), using the same beginning story method. Selection was supposed to include considerations of each participant’s ability and aptitude to elaborate on the depth, relevance, uniqueness and diversity of knowledge gained from the first gathering, but this was thrown out upon realization that every participant had different, deepening and broadening perspectives. Rather than a strict question-and-answer format, the interviews conducted in this study took the form of dialogue, with questions providing a rough guideline or focus for more in-depth exploration.

As per the research gathering, my plan to select an equal number of people for interviewing, from each participant group (eg. 5-5-5), to a maximum of 15 people, was also thrown out. By the end of the interview and gathering stage, I had completed dialogues, taped and untaped, with all 22 participants. During each interview, I began with a shortened form of the beginning story which included an interest in focusing on areas that may have been only briefly touched on during the first gathering. After the beginning story, participants were asked to respond to the research questions and sensitizing issues, when it seemed appropriate. Beyond occasionally returning to the research questions, the “interview” took on the form of natural, associative dialogues.

Indigenous Protocols

Creating Good Settings

In a practical sense, for this project, creating good settings meant meeting with individual participants at the locations that were most convenient and comfortable for them: workplaces, restaurants, and homes. Group settings were also chosen for their comfort and convenience: the first gathering was held downtown, at the Roundhouse, and the second gathering was held on the west-side, at the Wondertree Learning Centre. The gatherings were held at different times of the week, at different times, and at different locations, to accommodate different schedules and travel time.

The physical set-ups of gatherings, were designed to be conducive to a more egalitarian sense of process, and to storytelling and talking circle methodologies, by placing comfortable chairs and couches in circular formations.

At workplaces and homes, I made sure that I brought food and/or refreshments, and at restaurants I offered to pay for meals or snacks. During the gatherings I provided meals of sandwiches, stew, raw fruits and vegetables, bannock, desserts, juices, teas and coffee.
At all times, I tried to provide encouragement and connections to ensure that participants felt that their perspectives were relevant and important to the goals of the research. During the selection process, one potential participant used intimidating and invasive body language and constantly interrupted and dominated the conversation. I felt that it would be inappropriate, unsafe, unwelcoming and discouraging to include this person in the research project, so with gratitude for their interest, I informed them of my decision not to work with them.

Introducing Who You Are

After acknowledgement of our connections through prayer, introductions are one of the most important practices in Indigenous communities. How people introduce themselves enables the building of a community of individuals with intersecting lives and histories, and enables people to understand a person's standpoint as an Indigenous person. Time for introductions was facilitated in each gathering. The following excerpts from the first research gathering (December 12, 2003), are examples of how participants introduce themselves, in English, among other Indigenous people with interests in traditional-based practices in Vancouver.

A: Ok, so welcome everyone. Thank you for coming to this good project. I am really honoured to be able to take part in this good work. My name is A, my traditional name is A, I’m from the beaver clan, that’s on my mother’s side. I grew up in Winnipeg and I’ve been living here in Coast Salish territory since 1990.

Amelia McComber: My name is Amelia McComber and I’m Ojibway and Mohawk. I come from Sudbury, Ontario and been here for nearly 10 years now.”

Oldhands: My name is Oldhands and I’m a Shoshone and I’ve been living in the Vancouver area and New Year’s day will be 13 years.

Dawn Marsden: My name is Dawn Marsden. I’m Anishnabe from eastern Ontario. My mother is French and... that’s always been the hardest question because I have a real long story about who I am and I could go on and on. My father retired out here so our family came out one winter and we’re all living here now in BC.

Sharifah Marsden: My name is Sharifah Marsden. Dawn is [my relation] and I’m here to help her today putting my input in as a young Native woman.

E: My name is E and I’m going back to my birth name. I still like to be called E I’m Metis and Cree and French.

B: My name is B. I’m from Alberta. I’m Cree Iroquois blood. I’ve been here also since 1990, about November of 1990.

I: Thank you for inviting me. I’m K, Coast Salish and Nez Perce (Gathering Tape 1).

Besides giving examples of introductions, these quotes provide a partial example of the cultural diversity represented by the participants in this research project.
Gifting and Witnessing

As per my ancestral traditions (Ojibway), I gave gifts and tobacco to the participants, after consenting to the project, and later, during the gatherings and dialogues, I added honorariums. With some words about the sincerity of my intent and need for assistance, each bundle was given as a demonstration of my respect for the knowledge about to be shared, and of the seriousness of entering into such relationships, for the good of all our relations. Each of these processes was accepted by participants, with nods of acknowledgement, and seemed to facilitate more warmer, inviting and appropriate settings for doing research with the people in this research group.

A: And before we begin talking about the study I thought we would practice or acknowledge your good intentions your good work to the study by offering people to witness what’s been said, so Dawn maybe you will want to call up people. We’ll do this in the best way we know how (Gathering Tape 1).

Witnessing was incorporated by calling four participant-witnesses to stand, who were then given gifts of cloth and money, to signify their role. They were then instructed to remember the events that took place, and the words shared, in case they were called upon later. At the closing, they were called again to stand and recount what they had witnessed, and what they would share with others.

Meaning Making/Thinking, Sensing, Feeling, Being Aware

...making sense answers the question, “How can I understand what I have been through?” Making meaning, a term associated with Mezirow’s (1991) theory of transformative learning, is “to construe or interpret experience – in other words, to give it coherence” (Bray, 2000).

When participants were asked to comment on the issues relevant to the access and provision of traditional-based health services in Vancouver, we were given stories in response that carried themes of meaning around which a variety of real-life people interact. By analogy, an understanding of interacting characters, or relationships, gives us an understanding of important processes operating upon the question. For example, if I am repeatedly told stories by people who have undergone years of counseling and drug therapy, who finally find relief after meeting traditional-based healers by accident, then I can surmise a structural theme that front-line health workers are unaware of both the potential successes and availability of such traditional-based health services.

Only stories that related to the primary and secondary questions were included in the analysis phase of this study. Stories that related specifically to traditional-based health teachings, or to specific ceremonies were not analyzed, but may have been referred to during discussions of healer and/or client goals. For example, while it may be appropriate to include stories of frustration around trying to find a Sweat Lodge Ceremony to participate in, stories about the ceremonial details will not be included.

The process of analysis used in this study, Indigenous wholistic meaning making, is a subjective and interconnected process whereby knowledge from all aspects of being - mental, physical, spiritual and emotional – and knowledge from other beings, influences understandings about what’s important, common or thematic. Mentally, logic upon reflection suggests that if the meaning of a story is repeated many times, from diverse people, it may be important,
common or thematic. Physically, specific responses to stories, such as racing pulse, or a sick-to-the-stomach feeling, may indicate level of importance, commonality or theme. From an emotional aspect, importance, commonality or theme, similarity or dissimilarity may be identified by paying attention to the intensity of feelings. Spiritually, metaphysical processes may guide the physical, mental or emotional experiences towards specific conclusions. When viewed from a Western eye, these processes aren’t dissimilar from the qualitative data analysis discussed by Miles and Huberman (1994). D’Arcy Ishpeming’enzaabid Rheault puts such considerations another way:

The sensing of the ‘self’ and one’s cultural intuition are what necessitate a different approach because in various Aboriginal cultures this method is a fundamental way of knowing; a fundamental epistemology, the absence of which would render one’s study invalid. This method is about coming to objective truths through a subjective method of inquiry and analysis not explicitly characteristic of any Western systems, but of various Aboriginal cultures (2000, p. 4).

What makes Indigenous meaning making, Indigenous? While there is no formula, meaning making is Indigenous when it incorporates and makes use of Indigenous embedded, Indigenous sanctioned and Indigenous promoted tools for knowledge generation, which will vary according to each person, their cultural origins and their current context. For myself, praying, dreaming, visual arts and reflection are the most congruent with my worldview (primarily Indigenous), origins (Anishnaabe and French), and current context (in Vancouver, researching traditional-based health services), and meet the criteria of being embedded, sanctioned and promoted by members of the traditional-based research group, and members of the Vancouver Indigenous Community, as appropriate knowledge generating tools. There is a tension here; where Western frameworks predominate, Indigenous people in Vancouver may choose to not be explicit about their Indigenous meaning making practices, or may choose Western tools over Indigenous tools for interaction. In a sense, Indigenous people in the city must become multicultural, and will respond differently in different situations. The important thing to remember is that these different epistemologies don’t detract from determining truths, they provide complementary ways of knowing, describing and analyzing the same issues, in ways that contribute, more and more, to the whole picture.

Prayer

When starting this Ph.D., I realized that, to start sharing what I’d learned, I would have to “come out” in a way that people would begin to know who I was and what I believed in. Even though I felt exposed, I knew it was important to do things in a good way and to maintain my integrity, regardless of my fears of being in the stage light. After I spoke with the first person to join my research group, I realized the immensity of the journey that I had set myself on. Here I was, overwhelmed by the stories and teachings of one person during an information session, how was I going to deal with sitting in the same room and speaking with 20 traditional knowledge holders? After meeting with everyone in the research group and speaking with everyone individually, my anxiety increased. How could I possibly create a collective story that was both understandable and true to what had been shared with me? The responsibility of carrying that knowledge, and representing it in a good way was daunting. Beginning to write was complicated by where to start and what to include. I decided to start with my story of initiating and carrying out the research. When thinking about relevant influences, there were too many
variables, spanning from my early childhood, from experiences to people I'd met or read. I prayed for guidance.

At the same time, I was working on another community based project (see Appendix K), during which, there was a lot of talk about beading belts. The decoration of clothing and other materials with beads, to represent stories, relationships, vision, or identity is a tradition that predates colonization. Beading as a form of communication, called Wampum in the northeastern woodlands, was done to represent relationships, agreements, important events, treaties and public accounts. Like other traditional-based practices that have been impacted negatively by colonization, beads have retained a stigma of betrayal through their use in the co-option of lands & resources, and in stereotyping. In a natural process of healing, Indigenous peoples are working to reclaim these practices, to dissolve the stigma and to regenerate cultural practices.

**Dreaming**

... special rites were observed. After purificatory preparation, baths, fasting and sacrifices, the patient would spend the night in the god's precinct or temple, a process known as "sleeping in" (enkoimesis, incubatio). Thus, we have rational and thaumaturgic medicine, i.e. dream therapy, developing together through the Hellenistic period pari passu, i.e. in equal steps, rather in the manner of astronomy and astrology [one after the other]. During the night as the patient slept, Asclepius would appear to the patient in a dream and give him advice. In the morning the priests would interpret the dream and explain the god's precepts. Patients would thank Asclepius by tossing gold into the sacred fountain and by hanging ex-votos on the walls of the temple (University of Virginia, 2003).

According to the Encyclopedia Mythica, Asclepius was a Greek hero who later became the Greek god (son of Apollo) of medicine and healing (2005). He is especially attributed with prioritizing dreamwork in the diagnosis and treatment of disease. Since the divorce of wholistic medicine from Hippocratic medicine, dreams have continued to play important roles in peoples lives.

Dreams have always played an important part in my life, but until recently I kept them separate from my professional life. When I think about it, dreaming is a normal aspect of being, a way of knowing that all humans possess, but something that we’ve been conditioned to discount in this Westernized society. If we can’t touch it, it’s not real. Why should physical foundations to research be validated more than non-physical foundations to research? Isn’t it true that our psyche can’t tell the difference between what we see awake and what we see during dreaming? Isn’t it true that we respond emotionally, mentally, spiritually and even physically to dreams in the same ways as we do waking experiences?

I’ve had all kinds of dreams, some ordinary and some with deep significance. Some made instant sense and others have required years of experiences and teachings to make sense. Time is different in dream, where we can spend many years in a dream-world, while only hours pass in this waking world. Sometimes dreams are reenactments of our waking lives and sometimes they are prophetic. Sometimes dreams are guiding us about what we should do, can teach us things, or let us know that things are as they should be. My dreams used to trick me, waking from one dream into another until I questioned reality; in hindsight, this was good training and preparation for a conscious, critically questioning adult and academic life. What were most stable were the physical, emotional, mental and spiritual impressions that dreams left me with. While ordinary details varied or even shifted mid-dream, these impressions, along with
important animals or symbols, continued to resurface in different dreams, to provide continuity and a sense of connectedness.

To validate dreaming as a research tool, we must remember that dreaming is where we symbolically process, synthesize and resolve the information, questions and experiences that we have had each day, with the knowledge we have accrued so far, to produce knowledge "new-to-us". Some dreams, which we may call visions or gifts, are especially helpful in answering our questions, guiding our actions, or making sense of the world.

Dreaming is a fact of human existence. Everyone has dreams, whether we remember them or not. We can train ourselves to remember them, just as we train ourselves to do interviews, create surveys or design laboratory experiments. It just takes practice. Dreams can be inspired by our intent or need to learn something, whether through prayer or through specific thoughts. In turn, dreams can give us visual answers or models for what we are trying to understand. These can be diagrammed, written down, painted, or represented in any number of ways. You don't have to be an artist. The important thing is that what you record reminds you of your dream, so that you can analyze the details later.

The shift required to make dreaming a useful tool for research, is to accept your dreams as a valid way of obtaining knowledge. Because we may not understand how dreaming works, doesn't negate the information they are conveying. Just call them gifts. Dreams are valid according to the sense they make to you, in the symbols that are important to you. A "how to" book on dream interpretation will only be as helpful as the similarity between your and the author’s world view. All dreams can be analyzed for the subconscious messages they contain. If you're lucky, your dreams will provide the specific answers you are looking for, in a way that is easy for you to understand.

Whether to act on dreams or not requires careful consideration which I haven’t gone into here. The only suggestion I will make is that if harm to people, other creatures or plants is involved, then do not act. If disturbing, sick or terrifying dreams keep coming to you, then you may want to seek counsel from an appropriate Elder or counselor, who can help you to put your dreams into perspective.

Dreaming provides insight into mental, emotional and spiritual processes that are beyond our current comprehension, and can thereby provide cutting edge templates for the analysis of our research processes and findings.

Visual Arts

For me, one of the easiest ways to remember my dreams, is to draw or paint them out. Once complete, we can use these representations to inspire new avenues of thought, and analyze thoughts, logic, explicit and implicit concepts. Before I could put any words down, I had to paint what I’d seen.

Painting is just one of the ways that dreams can be expressed, but as a visual, is especially effective as a communication tool, or starting point for designing, analyses or discussions. I would recommend that more academics incorporate both dreaming and visual arts into both their research and presentations, because dreaming is able to process, and visual arts are able to communicate so much more than written words.

Over the 6 months following my field research, I had decided to get some more practice presenting my ideas, as a prelude to defending my dissertation, and to test my ideas. In the fields of education and health, people usually use Power Point to present their ideas, with the occasional photograph. Not being proficient yet with Power Point, I decided to use the Wampum Research Model and paintings that I had been using during my brainstorming work. I was a little worried about how my presentations would be received, but aside from the
statements “you’re in education, aren’t you”, and “this is really radical”, the feedback was about resonance and acceptance.

My work has never generated the amount of attention and interest I received after those presentations. In my case, the picture really was worth a thousand words (this paper a case in point). The Wampum Research Model poster and paintings provided a visual model of my ideas which enabled a quick transition from discussions of general ideas, to more in-depth discussions of relationships, theory and process, specific to my research. For myself, painting provides a comfortable form of communication that far surpasses my speaking abilities, in its ability to convey my ideas.

Reflection

The individual attains reflective distance from his own life history only within the horizon of forms of life that he shares with others and that themselves constitute the context for different individual life projects. Those who belong to a shared life-world are potential participants who can assume the catalyzing role of impartial critics in processes of self-clarification.

Ethical-political discourses have as their goal the clarification of a collective identity that must leave room for the pursuit of diverse individual life projects (Habermas, 2003).

These statements of Jurgen Habermas, come closest to the kind of reflection that I am undertaking within this project. The reason that is employed transits through pragmatic, ethical and moral questions centred around the enhancement of traditional-based health services in the city, from a traditional-based Indigenous perspective and using traditional-based tools for knowledge generation. As such, the commentary, strategies, recommendations and conclusions are contextually embedded within the presupposition that such services ought to be provided, and in design, are inseparable from my personal identity, history and preferences. Conversely, those participants that shared my life-world, at least in the support of traditional-based services, provided the catalysis and critique necessary for the transition of ideas from a personal identity reinforcing project, towards a collective identity reinforcing project. Likewise the academic community, primarily represented by my supervising committee and literature, provided catalysis and critique to enable reflections within another community context, that of UBC, the Vancouver community, and the Mainstream.

As mentioned previously, this project has been undertaken, not only to reinforce a collective traditional-based identity, but also to assist in the transformation of the larger society, towards the integration of a larger collective identity which includes diverse Indigenous peoples and their rights to traditional-based health and educational options in Vancouver. In summary, the reflections within this dissertation are purposefully selected and expressed to illuminate and address the themes, commonalities, differences, strategies, recommendations and conclusions of Self, Community and Academia, towards a collective vision of restoring traditional-based practices as an option, for several audiences (traditional-based Vancouver Indigenous community, UBC, Greater Vancouver Regional community, Mainstream).
Appropriate Use

Writing and Publishing

Situational Identities

The phrase situational identities arose from a personalized understanding that how I identify myself differs in different contexts, based on immediate appraisals of expectations and norms. An examination of this concept is useful for considering the complexities and biases involved in writing to represent multiple contexts and multiple identities, for multiple audiences.

The most predominant context that I have been in, in the last ten years, has been in a western Canadian university setting, where most of the individuals are of non-Native ancestry. This situation has enabled me to take a unique look at my own values around respectful behaviour, by contrasting my responses with the most common protocols encountered within academic settings. While non-Native individuals may have similar responses, I attribute mine to having a different world-view and value set, acquired by the Indigenous influence of my mixed ancestral past. What this unique view provides, is a preliminary reflection and critique of some of the implicit ethics involved in acquiring and maintaining academic credentials, and alludes to some of the meaning behind Aboriginal calls for more respectful behaviour.

To say that identity is dynamic and contextual is one thing; to know and act appropriately from and upon that knowledge is another. From a context of mixed ancestry, I would like to propose that we are all dynamic and complex beings, who make decisions based on the actual situations we are in, more than upon the ideals we are supposed to meet or carry out. This is relevant to both learning situations and teaching situations, where our own identities impact upon the diverse identities of those we are interacting with.

For years it seems, I have been learning about different ways to think about my own identity. At first, I didn’t know I had one; other than mild discomfort and a sense of not belonging in most situations, didn’t realize that this concept had real effects in my day to day life. At fourteen, with Bill C-31, I was given to digest, and understand, that my father could now be called a Status Indian. Supposedly, he lost his identity as an Indian when he joined the Canadian Armed Forces to go to war; it was something to do with the contradictory times of “serving” while not being a legal citizen or able to vote. The consequences of those times have played out. At fourteen, I was now eligible to register and call myself a Status Indian. What did that mean?

As a person of light skin colour, born on a military base, English and French speaking, raised off-reserve, with both French and Anishnabe ancestry, I was an anomaly in the world I was born into; not totally Indian and not totally White. Since I thought I knew everything about being White, having been raised in Canadian communities, I set out to learn about what it was to be Indian. In hindsight, considering all the unspoken questions, given stereotypes and assumptions, it was a painful but necessary journey. Fortunately, in searching for an Indigenous and mixed identity, I have come out fairly unscathed, and full circle. I am not a this or that, as essentialists might promote or judge, and I am not an amorphous being, subject to the whims of imagination, as some cultural relativists might suggest. I am a whole being, dynamic and complex, grounded within my genealogical history and situational choices.

This personal confession is relevant here, to examine the concept of situational identities. What I have described is a brief template upon which issues of identity play out: what my ancestries are, where I’m from, what I speak, the primary conflicts, consequences and conclusions. Though the description may change in detail, it is primarily factual, stable and mostly unchangeable. This genealogical history forms the foundation for diverse, dynamic,
changeable, perspectives of my identity, based upon the potential relationships and understandings of self with the people, location, materials and other beings at hand. I am who I am, in relationship with you.

Identifying oneself according to each situation is adaptive and required for behaving appropriately. Rather than seeing this as creating new or fraudulent identities for opportunistic reasons, these shifts can be seen as presentations of different aspects of identity, for better relationship and communication within the assessed situations. For example, if I find myself at a political rally in support of Aboriginal rights and title, I may emphasize my Anishnaabe ancestry and belief in sovereignty. If I am at a conference that seeks to build bridges between peoples, I may emphasize my mixed ancestry and understanding of the complexities that may be involved. In an all-Native situation, I may identify myself formally, by my Nation and Band membership, depending upon how formal the situation is. In a predominately non-Native situation, I may just give my name and occupation. If there are a few Native people, I may give some of my heritage. Each decision to self-identify revolves around adapting and assessing each particular situation for its political ramifications. Situational identity involves a statement of identity that will externally situate oneself within a group, with respect to ones beliefs and allegiances, in relationship to those of the others. To say that I am Native, as a pale person of mixed ancestry means that I am stating my support of Aboriginal people, rights and title, and am affirming the right of people of mixed ancestry to claim that identity.

I happen to love writing; I find it provides an opportunity to express my thoughts and feelings with a clarity that I cannot reach with my deficient verbal skills. Initially, I just wrote for myself; later I learned to enjoy writing as a way of communicating to professors. Writing, for me, has always been about reflecting upon what I think I know. If I can share my writing with others, where there is a chance for feedback or discussion, then it can be called communication.

As a reflection on knowledge, in communication with specific individuals, the most appropriate form of writing is passive. An ethic I've grown up with is that tooting your own horn is inappropriate and disrespectful. Writing in active voice with definitive statements and conclusions, borders on tooting your own horn. Everything I know is in a dynamic process of change and is situationally relevant and valid. I don't know anything definitively; to act as if I do is presumptuous. Though I've been able to express myself in passive voice, the academic pressure is to write in active voice, to present things confidently, as if I know extensively about what is being presented. From my perspective, perhaps as a person of mixed ancestry, active voice borders on arrogance; hence, most of my writings will display a struggled mix of both active and passive voice, in the attempt to be both academically clear as well as ethically congruent.

In ways similar to speaking, writing in an academic context creates difficulties. There is a great pressure to write for publication, to become known in one's field and to subject one's ideas to public testing. Academic success demands it. While the opportunity to become known in wider circles is tempting to the ego, and probably professionally beneficial, it is not strong enough, so far, to alleviate my concerns with sharing knowledge in indiscriminate and inappropriate ways. Conversely, I am grateful that others have shared their work, because it feels like I've learned so much. Sometimes the concepts I read about inspire me to creative thoughts and actions. Often, reflection upon classroom discussions of assigned readings brings clarity to concepts and terminologies in the field. When it comes down to it, though, most of what I've learned has not been through what I've read, but through what has affected me as an individual, directly. When I think about publishing, or writing for an unknown public, I am stymied by the inability to assess my audience, and hence communicate appropriately. Though I pride myself on my writing ability, how can anyone really understand what I'm saying, unless
they know me in context, unless they have a relationship with me? I cannot determine or control
my audience in publication, so I cannot determine what is most appropriate to share or control
whether that information will be used appropriately.

Referencing

I learned along time ago, that one should give credit where credit is due. People who
share what they know by writing are stepping out and taking a chance that people will be moved
in some way. They may have been thinking about their ideas for a long time, or they may even
think that they are the only ones who’ve thought about them. When I think about how we all
exist in relationship, to each other, to the world and influences in our lives, I am humbled and
forwarned about presenting anything as new to anyone. When someone tells me something, I
am interested in both the concepts and what they were influenced by: the natural development of
the knowledge. If I can understand a little about who the authors are and what they have
experienced directly, then I can acknowledge and honour the whole process and all the
relationships. By looking at knowledge as a relational and wholistic process, rather than as ideas
that can be claimed by individuals, referencing takes on a whole new meaning. With such
thinking, I am resistant to the importance imparted to individual authors. It is the genealogy of
the concept, developed by many, that should be honoured, while considering, acknowledging
and respecting the credibility and authority required to impart that concept appropriately, or
through proper protocol. I attribute my orientation towards academic referencing to a (possibly
Indigenous) ethic that, what was said, how it was said, and in what context, is at least as
important, if not more important as who said it. This seems especially true in Indigenous oral
storytelling, where details may be slightly changed, according to who is listening and why the
story is being shared.

I am also insulted by the implied assumption that I cannot arrive at ideas or conclusions
without reference to a published author. I am ashamed by how many times I have written a
paper and gone through my books at the end to find authors who’ve said similar things, just so
that I have references; it detracts from the whole process. From what I hear from many
Indigenous and non-Indigenous colleagues, I’m not alone in this transgression. My ideas are a
product of my experiences, relationships, (situational) identities, and historical genealogy. If I
was to truly reference where my ideas come from, then my experiences with my whole family,
history and friends would be included, and the guidance and gifts of the Creator, Mother Earth,
Ancestors, Spirits and All My Relations would have to be acknowledged.

The attempt in this dissertation was to use my own ethical responses to academic
pressures to ascertain difference, conflict and relationship between the desires of the academy
and my integrity as an Indigenous graduate student. As a person of mixed ancestry, I considered
personal ethics outside of the mainstream and congruent with the Indigenous teachings and
beliefs that I already held, to be Indigenous ethics; but only if they had been reflected in
discussions with other people of Indigenous ancestry regarding these issues, or in writings by
Indigenous authors. A point of confusion may be drawn where Indigenous ethics overlap with
those of other non-Indigenous individuals. The ethics discussed may be considered Indigenous
ethics, but they may also be the ethics of others, who are also experiencing similar difficulties
with academic pressures, protocols and constraints.

In a nutshell, and in hindsight, this paper promotes another, perhaps Indigenous,
methodology for doing coursework and research. Identity is dynamic and situational, knowledge
is wholistic and rooted in genealogies connected to the land, and the questioning and sharing of
ideas through speaking, writing and publishing can be accomplished more appropriately by
greater attention to etiquette, or the ethics of personal relationship. If we can get beyond
polarization and competitiveness, acknowledge the dynamic nature of both identity and
knowledge, and take to heart the concept of relationship, then we are better empowered to seek knowledge, in relationship, with respect.

I have discussed these ethical issues with many of my Indigenous colleagues and many seem to have similar concerns. How do we develop professionally if we don’t publish or present our ideas in formally academic ways? How can we live and work, in a good (appropriate) way, within academic settings, when these ethical concerns are encountered on a daily basis? The admonishment that we are no longer Indigenous if we stay too long in an academic setting, hits close to home. If we disregard our Indigenous ethics and take on conflicting academic protocols, we are in danger of losing our integrity as Indigenous people. Though many Indigenous individuals have walked the path, the ethics around respect and remaining Indigenous in academic settings remain to be resolved.

**UBC Dissertation**

The dissertation document will be written up as three collective stories. The research story and lessons learned story will centre around the community-based story, which will be a reflection upon, or portrait of the themes and commonalities described by the participants’ stories, relevant to the research questions. The reflection will include the integration of individual stories, in as complete a form as possible, into the text of each chapter. Jo-ann Archibald speaks to the importance of attending to the process of incorporating stories, in the following statement:

Transforming the orally told stories to another language and another form of representation so that the power and integrity of the stories remain requires that one know the essential characteristics of the stories (1997, p. 33).

Framing participants’ stories alongside my stories as a researcher (reflection, portraiture or analysis), and being explicit about my agendas within the context of the research, will help readers to understand and examine the limitations, gaps, strengths and standpoints, relevant to the traditional-based stories being shared and incorporated.

In addition to including the participants’ stories with a consideration of respect, reverence, reciprocity and responsibility, the stories will be included in a way and in such numbers that “participants’ roles and voices hold at least as much weight as those of the principal researcher (Haig-Brown & Archibald, 1996, p. 249)”. This goal was facilitated by ensuring continuous opportunities for participants to change or remove themselves or their contributions from the dissertation. In the end, while my supervising committee was essential and important in the development of the dissertation, the final dissertation would not have been created without the participation, guidance and diverse approvals of the participant research group. The specific contributions of participants have been acknowledged in a special section, to provide additional insight into their contributions and influence on the dissertation, unless anonymity was desired.

**Knowledge Translation and Transfer**

This whole dissertation has been designed to provide a translation and transfer of Indigenous knowledge from Indigenous perspectives, for the specific purpose of creating understanding and allies for the ideas and strategies contained within. However, dissertations are never really accessible to all community members, in part because of their academic jargon and sheer size. As part of ensuring relevance, respect, responsibility and reciprocity, a version
of this dissertation will be designed as an information booklet, for guiding access to traditional-based health services in Vancouver, for use by Indigenous community individuals, and referring health professionals. Ideally, this booklet will be available in time to be given away at a community gathering after the dissertation defense. Members of the research group and the Vancouver Indigenous community will be invited to this gathering to celebrate, witness, engage and disseminate dissertation findings to the larger Vancouver Indigenous community.
Chapter 3 Creating a Collective Story, From the Beginning, And the End

J: And they judge each other and what they do to each other in the name of God is horrifying. And this is what we have to be careful of because if we are not...
Dawn Marsden: We can go the same way.
J: Exactly. And history has shown that. Which is why - in that way - we do need to be careful about how we join the rest of the world. We have to be careful not to become a part of that as well. And keep our traditional health based services, our provisions... And we’re meeting our own needs and we’re always reminded of who we are and where we came from. I have to appreciate and value the sacrifices our ancestors gave up. They had that vision of not putting any blood on my hands, or your hands; we have to keep that. If we do that then everything that they gave up and suffered, wouldn’t have been for nothing (Tape J).

Lee Brown: So... to bring sacredness into a system, a sacred approach to healing, into a system which just believes in money, is a very difficult thing to do. But someday, someway, we’ll figure it all out (Lee Brown’s Tape).

Introduction

In Canada, at a time when social determinants of health are becoming the prime focus in the health field, there is no precedent for studying the context and social relationships around traditional-based health services. From a wholistic perspective, social context includes a consideration of diverse aspects of society: social, political, legal, spiritual, educative, and administrative. As such, the contributions of this study to research in these diverse fields will be groundbreaking and by necessity, interdisciplinary and complex. At the very least, this study will provide a baseline of knowledge on relationships around accessing and providing traditional-based healing in Vancouver, towards implementing a more inclusive health service framework, which in turn will address the Royal Commission on Aboriginal Peoples’ recommendation to include more traditional healers in health services for Aboriginal people (INAC, 1996).

Hypothetically, a wider array of health services can be provided to Indigenous people in urban areas, by expanding to include more traditional-based health services. Sharing and recording stories around traditional-based healing, in community gatherings and written documents, will help more people to gain a better understanding of Indigenous perspectives on health services in Vancouver, of the contemporary value of traditional-based healing, and of the complexities that might arise when considering the integration of traditional-based health services with non-Indigenous health services. For the participants, sharing and hearing stories may increase awareness of issues and recommendations relevant to the inclusion of traditional-based health services in Vancouver, which may influence personal empowerment and activism around providing, using or facilitating ‘traditional-based’ health services in the city.

Greater understandings of traditional health services will foster better cross-cultural relationships, and will stimulate more discussion about the possibilities of networking, organizing and/or planning for enhanced traditional-based practices in Vancouver, with consequent influences on health outcomes for Aboriginal people.

The question asked of the research group participants - how can the access to, and provision of, traditional-based health services, be enhanced, by and for Indigenous peoples, in Vancouver – while specific enough, resulted in too much information for comprehensive short
term analysis, even with poor quality tapes. While only about ½ of the audiotaped stories and ideas could be quoted directly, unrecorded participant ideas have been incorporated as generalized ideas, within the non-transcript text, through memory, and through follow-up dialogues and confirmations.

This section will provide a greater understanding of the complexities of using storywork and talking circle methodologies within Indigenous communities. What becomes apparent is that both the process and content of participant storywork, was about the development and deepening of relationships, which is appropriate if we consider that the goal is to produce a collective story. Talking circles and dialogues were particularly appropriate for storywork in this project, because of the opportunity of participants to include, build upon and synthesize the knowledge and recommendations of prior speakers. In this way, participants did their own “working of stories” to reflect group consensus. The participants held such wholistic, deep and sophisticated understandings of relevant issues and strategies, that innumerable interacting factors, at all levels of society, were touched upon in the talking circles and dialogues. Such is the nature, purpose and gift of stories.

Documenting an orally created collective story, by translating it into text, is problematic because of the filtration that occurs in the writing process, which is individualistic. Over a year of brainstorming, modelling (primarily visual), testing (through public forum), and participant feedback was necessary to hone, transfer and write up the knowledge shared into a representation of the collective story (300 pages). Unfortunately, this written account was inadvertently, or perhaps necessarily lost during a break-in at the UBC Educational Studies department.

This section then – at the cost of lengthy detail - has been given the advantage of secondary analysis, which has enabled the writing of a more succinct, focused and participant-guided version of a collective story. A revised framework for storywork analysis was devised by reflecting on the original transcripts and the format of the lost account. To separate and categorize perspectives that are, in reality, wholistic and inseparable, is difficult. To make the research findings relevant to the proactive orientation of the research question (“how can .... be enhanced... in Vancouver”) I separated discussions into levels where decision-making might be most influenced: societal, institutional, or community. These general categories proved easy to use and enabled a quick re-writing of this section (one month versus four).

Overview

Lee Brown: I would say there is a tremendous lack of understanding. I would say - more than a lack of understanding - there is a positive will not to understand, not to have anything to do with [Indigenous ways](Lee Brown’s Tape).

There are some in the Canadian population - at all levels of influence – that understand and assert that dominant institutions should have enough health service options to address the diverse needs of all its citizens, including Indigenous peoples; this is a social justice perspective. Some may even embrace diversity and its potential for providing options beyond monopoly. The following diagram (Figure 7) is a visual representation of diversity (left) and potential options (right). The centre lens represents the official worldviews from which options are designed and decided upon. The white line is a representation of reduced influences on societal options; for some, this line represents the status quo.

An even smaller number of people understand that regardless of humanitarian ethics, Indigenous people have a constitutional right to appropriate health service options, as prior long-term occupants of North America, as self determining peoples within diverse Nations, following
J: So one of the things that I would like to see come out of this interview and your research and things, is just having the ability to reach the policy makers and have the understanding that we can meet our own needs. It’s a right to be supported. We’re not asking for permission to do this work, or we’re not going to apologize for being where we are at. They have a responsibility to change, to help, to help create an enlightened community, a community, a society that evolves... (Tape J).

These knowledgeable and assertive groups, along side or independent of Indigenous groups, have had a strong enough influence, over the last 200 to 400 years, to create a large body of research (from primarily non-Indigenous, but some Indigenous perspectives) about, and recommendations for addressing the general health needs of Indigenous peoples in Canada.

The funding, infrastructure, and political will in Canada, so far, has been insufficient for creating the necessary shifts needed to implement the recommendations already made (more culturally sensitive services, more culturally-based services, more Indigenous service providers and decision makers) on a large enough scale to effect radical outcomes at the community level, or for supporting the research needed to hone the generalized recommendations into locally specific recommendations.

Dawn Marsden: Perhaps the resurgence, also, has to do with all the healing initiatives that have come up, residential school healing projects that have kind of opened the door?

Lee Brown: I think the healing was reviving before then. I actually think the residential school stuff came out of the healing, not vice-versa. A lot of healing has happening at places like Alkali Lake, where tremendous healing has happened. I think that the strengthening or the healing started first and then the residential school stuff came later because there had to be, when the healing stuff started to re-emerge in 1969.
When the Hopi prophecy [was fulfilled], when people landed on the moon - that was supposed to be the end of our hard time, and the beginning of our getting better - just shortly thereafter, a treatment centre was started on one of the Apache reservations in Arizona. I believe it was the first alcohol and drug treatment centre and then within a year or two, they had spread all across North America. In 1978/79, Round Lake was started in B.C., which is where I came to work, and it was in those centres that the healing really started. The way I see it is that... having the healing path, as we have as a people, started to strengthen in treatment centres and in prisons. That’s where it really started happening. Once that started going, and once a critical mass of people started to get well, or at least started to deal with our issues, the stuff that we had been through, we started to deal with that, and started to get a little healthier, then it was possible for us to deal with some of these other issues like the residential school abuse, and other kinds of things (Lee Brown’s Tape).

By asking a specific question, in a specific locale (Vancouver), this research project has answered many of the: who, what, why, where and when questions around enhancing traditional-based Indigenous health services in Vancouver. In this study, Vancouver has been used geographically to refer to the Greater Vancouver Regional District (GVRD), and interpersonally to refer to all those people who live, work or otherwise contribute to the communities within the GVRD. This is appropriate if we consider that the providers of traditional-based health services may travel large distances to assist people in Vancouver. It may serve to substantiate locally relevant rationales and strategies for transforming limiting pre-existing structures (status quo) into more Indigenous (and diversity) responsive structures, at both institutional and community levels, in both top-down and bottom-up directions. Real, sustainable change requires shifts at all levels.

Doreen Sinclair/White Cloud Woman (Anishnaabe): What barriers or constraints... traditional based health services access and provision? Exactly what we were talking about... a lack of support and adequate funding for those services (Doreen Sinclair/White Cloud Woman’s Tape).

Influence at the institutional level has the potential to shift the dominant political will to create and support services that will meet the needs of all its citizens.

O: It will probably take someone in political office whose family is renewed, renewed by Aboriginal types of practices; they could turn around in their lives and actually see a value, and say ‘yeah we need something like that’ (Tape O).

Influence at the community level has the potential to shift the Vancouver Indigenous political will towards a cohesive vision and strategy for sustainable change.

Doreen Sinclair/White Cloud Woman (Anishnaabe): You know, that’s where it starts. It starts with a dream and then you work with manifesting in reality, our waking reality (Doreen Sinclair/White Cloud Woman’s Tape).

If Indigenous people are to be self-determining, then Indigenous ways of knowing and being and, hence, traditional knowledge holders, must be supported in today’s society. I am using the phrase “traditional knowledge” and “traditional knowledge holders”, in this study, to mean teachings, and those people who carry them, that reflect the beliefs, principles, knowledge
and practices of a particular community, that reflect a multi-millenial, intimate, and knowledgable relationship with the animals, plants, other beings, lands and waters of a particular territory.

The fact that the teachings may be dislocated from the territories, or carried by people not related to that community, does not detract from the knowledge, but does create a responsibility to consider where the teachings come from and how they have been traditionally taught, for a more complete, contextual understanding. Learning traditional teachings by choosing to work with traditional knowledge holders that are from the same or related community may make contextualizing and understanding the teachings easier, but does not negate the possibility of learning in decontextualized situations.

Doreen Sinclair/White Cloud Woman (Anishnaabe): What facilitates or supports access like right now today? What’s working today? People don’t advertise, it’s all word of mouth. There are a couple of places I would say - and they are few and far between - that do support the access to traditional based health services. But the majority of the places don’t. One is Urban First Nations; they have two elders there. And I’m thinking of the prisons you know they’ve always had elders and healers working there; they’ve always had more services than they do out on the street. Those are the two areas that I was thinking of. I know a few others have elders, but that [can be] different than healers and spiritual people.

Dawn Marsden: Yeah, would you say the constraints would be around perceived ability to heal? There might be a perception that it is not really worth anything or…

Doreen Sinclair/White Cloud Woman: Or they don’t believe in the person. Yeah, I think that there is that, there is that suspicion of somebody, suspicious of the healer, or lack of trust. I find that kind of sad because - 10 years ago - they brought in a group of people on the north shore, in Squamish. Were you there? Did you go and visit them? The majority of them were non-Native, they were from the states, somewhere in the states. Yeah, all these non-Native healers there. And I went over there and I was looking for a Native person to work on me and I think maybe there was one. There may have been, there was quite a few. I was so disappointed. So that’s a prime example of trying to find money, to bring other people, to do healing. And yet, look in your own back yard, there’s a lot of people there, that are talented and can do that work. But then we refuse to support them, or put our trust in them. Yeah, that’s kinda sad. That’s sadness.

The relationship between “modern science” and traditional ways of knowing provide a good example of learning from decontextualized situations. The difference between using the word “traditional” and the word “recent” is like the difference between an old friend and a new acquaintance. The difference is a matter of time and relationship. The thousands of years behind traditional knowledge provides for a trial-and-error deepening of relationship that creates knowledge that is very different from that created from short-term or transient relationships. Traditional health knowledge arose from these multi-millenial relationships and so, includes a vast pool of knowledge about healthy relationships. This knowledge remains contextualized when passed on to the younger generation in the same or similar context. The teachings are decontextualized when applying them in a new territory or situation, until they are adapted and integrated into the new community of beings.

Modern science has quickened the creation of knowledge artificially by looking at the minute and repeatable aspects of decontextualized situations. The knowledge created remains decontextualized until it passes from the realm of documentation to the realm of human being
and is carried as a teaching relevant to the new context or becomes common knowledge. Along this line of reasoning, the word decontextualized becomes almost interchangeable with the word dehumanized.

An old test for new knowledge is time and balance. Over time, if the new knowledge does not find a niche that is in balance with the older knowledge, then either it is thrown out, or a paradigm shift occurs. Biomedicine is a product of modern science, which has immensely advanced our knowledge of the details of the human body, in a very short period of time. The knowledge holders in this case are the scientists and biomedical practitioners. The strengths, and differences between both systems of medicine - traditional and biomedical - are represented well by the words relationship and fact. Where traditional relationships may not have provided knowledge for addressing newly encountered conditions (eg smallpox); biomedical facts may likewise find their limits when exploring aspects of relationships (eg the mind-emotions-spirit-body-environment interactions). In this sense, these systems are complementary, providing strengths where the other has yet to follow.

Lee Brown: Yeah, I think there will be a shift some day or, I've thought a lot about this. I don't know how we can integrate a total, a spiritual approach to healing into the current hospital system. I think there will have to be a huge shift in consciousness for that to happen. I think that the people that believe in the physical path of healing will have to undergo a great change to make room for the spiritual to be there, even as much as just, again, in the case of the Vernon hospital, where we've asked, where we've had meetings with administrators of the hospital and just asked for a room where we could do a smudge or a ceremony or something like that. They have not been able to accommodate that, let alone the everyday presence of the elders and traditional healers.

Dawn Marsden: Not even temporary space?
Lee Brown: That would be beyond... Yeah they can't even give us a temporary space. A real integration of the two systems would be beyond anybody's comprehension right now. I don't know of anywhere it's happened in Vancouver. If there is anywhere it's happened, I haven't heard of it (Lee Brown's Tape).

As always, to read this section, the onus will be on the reader – based on their own backgrounds, assumptions and intents - to examine the emergent framework and factors for analysis, and the supporting evidence (based on the oral testimony of participants), to create and contextualize their own conclusions and applications.

Through the privilege of research, readers have been given instant access to the knowledge shared by participants. Ordinarily, in talking circles, the information and stories shared are cathartic: from the heart, at the moment, within trusting relationships; as such, they are to be kept within the circle, and not to be used against anyone. As a reader, good relationships can still be entered into with participants, by treating the excerpts carefully, with respect, in a way that acknowledges the private conditions and contexts under which stories and ideas were shared, and by using the information responsibly, and without detriment to Indigenous peoples in Vancouver.

The difference with this talking circle, is that the stories included in this section have been shared specifically and publically to address issues of access and provision for traditional-based health services, by and for Indigenous peoples, in Vancouver. The results of this project, therefore, are represented as a specific and enduring vision for the restoration and re-integration of an Indigenous institution into the main-stream of life, with specific strategies for creating change in existing Vancouver community, institutional, and societal structures.
Visioning the Next Destinations

The ideal situation for traditional-based health services in Vancouver, in a nutshell, is to operate in an environment where traditional-based Indigenous world views are understood, respected, supported and included within all existing institutions, agencies, policies and most importantly, processes.

B: We not only need to have our own healthcare, our own dental clinics, we need to have a place where our people can possibly be treated respectfully. But we don’t have that. We don’t have our medicines, we don’t have our Elders, and ...we need to have a gentle place to heal (Tape B).

Culturally, this vision would mean the respect and support of diverse traditional-based Indigenous rites, rituals, ceremonies and processes. Specifically, this might include the support of beliefs and processes around birth, puberty, marriage, illness and death. Fundamentally, this will mean supporting and transmitting Indigenous beliefs and teachings about human relationships with others, ancestors, spirits and the natural world, in English and Indigenous languages. Inevitably supporting these processes, beliefs and teachings will support the ability of traditional-based practitioners and other traditional knowledge holders to assist in the regeneration of Indigenous identities, languages and ways of being. Regenerating these identities, languages and ways of being is inextricably connected to building capacity for self-care and healthy lifestyles; which addresses the primary and non-medical determinants of health.

Lee Brown: So... a centre where we could go where the healing was available, where there would be counseling for the emotional realm, where there would be able healers and that kind of thing for the physical body, where there would be counselors and advisors for mental problems and possibly even teachers for people who wanted to learn about these sorts of things - whether it be a program or an apprenticeship - so people could be studying and working with Elders, because, you know, there’s a few Elders with lots of knowledge. A lot of people could study there and some people would go on their spiritual healing journeys. A centre that would be congruent to our traditional beliefs and by that, I mean couldn’t function on a 9-to-5 kind of setting. It wouldn’t have the kind of paperwork that most institutions have (Lee Brown’s Tape).

For Indigenous individuals, families or groups, this would mean that any agency, clinic or hospital could be approached for referral, with protocols, to appropriate traditional-based health services and/or practitioners. Protocol might involve doing service or providing resources for the functioning of a health centre. Traditional-based health services and practitioners could be approached and engaged with in respectful, safe, ethical and efficient ways.

E: That’s what I put down, the point. When I read it [the research question], I thought “location.” That barrier and constraint to access and provision in Vancouver could be location, and then qualified people, practitioners who would... you go to when you go there. You’d want to make sure that some criteria was followed. To make sure just like the public halls that they had training for certain people... for this person or that, and accept you as someone who can help me.

Dawn Marsden: Like a couple of guidelines for community healers?
E: Exactly, exactly.
Dawn Marsden: And also community referrals?
E: Yes, different people who you could talk to and... yes. I can’t imagine a place in Vancouver that would have that. It would have to be... if was close to Vancouver or in Vancouver proper you’d have, I imagine, a place that’s protected inside so that you’d at least have some barriers from all the other energy. A lot of natural plants and...

Dawn Marsden: Reconnect with the natural land?
E: Yeah (Tape E).

For agencies, clinics and hospitals, this would mean that information would be readily available regarding existing traditional-based health services, ethics, standards, categories and levels of care, protocols and processes.

On a service level, the ideal would be to have teams of health care professionals and agencies, including traditional-based practitioners, available to work together with individuals, families and groups; cross referring, and consulting with each other to provide the most appropriate and informed care possible.

E: Yeah, I took a course - I’m [creating] a training module for Aboriginal medical systems - and they did a little piece on Aboriginal traditional systems and I came across a lot in Africa. The World Health Organization is now into this community based knowledge for traditional health because they are finding it impossible, budget-wise, to provide European based medicine in communities that there already is a medical system there, a traditional medical system. So what you need is to bring the two together so that in the same building, the same practitioners talking to each other. So that was really exciting to see that there’s a global acceptance of traditional health and the World Health Organization is really promoting it very highly (Tape E).

Environmentally, the inclusion of traditional-based health services would mean that places of historical, medicinal and spiritual importance would be legally and spiritually protected and maintained, and made accessible for the continuance of traditional-based practices.

Lee Brown: We need those places here. That’s exactly why we need them. We need a place to regenerate ourselves, even just one day out of seven. Even here at the longhouse - like coming to a sweat - it’s regenerating because it’s kind of in a sacred space, and it can really help, you know, to maintain that power (Lee Brown’s Tape).

Spatially, there would be a central health centre, with outreach clinics, that provided spaces for screened traditional-based health service practice, information, referral, with protocols, to practitioners with appropriate categories and levels of care, and guidance. Ideally this health centre would support residential and extended care of clients, their families, and attending practitioners and helpers, through the establishment of volunteer-served accomodations, a kitchen, a herbarium, a resource centre, and licensed daycare services.

Doreen Sinclair/White Cloud Woman (Anishnaabe): I think having say like a what do you call it, a co-op, of people from different disciplines. You know like some people would only work on dreams, others are good on masks, others are good working with energy, others are good with ceremonies. And I think an ideal situation... having a consortium or co-op of people that can be drawn upon and well supported (Doreen Sinclair/White Cloud Woman’s Tape).
Organizationally and professionally, traditional-based health practitioners would belong to a cooperative council, based in the centre, which would provide screening interviews, background and criminal record checks, create ethics, standards, categories and levels of practice and training, create protocols for accessing traditional-based practitioners, and guidance and liaison for the centre, council, and greater community. For traditional-based practitioners, this would mean that respectful, ethical, safe and economically viable protocols, processes and spaces would be established for serving Indigenous individuals, families or groups, according to their own categories and levels of practice. Traditional-based practitioners that did not pass the screening process, or ascribe to the ethics or standards of practice and training would be excluded from membership on the council, and practice at, or referral by, the centre.

A: So... some kind of provision where, if a person is requesting a certain kind of traditional health practitioner, that, that be funded in some way, whether it’s travel, or fees, or to help with what people need. So that’s the biggest thing: around payment, fees and recognition (Tape A).

Economically, it would follow that referral and team-based information and processes would be generated and maintained by inclusion in the budget of relevant agencies, clinics and hospitals. It would also follow that traditional-based health practitioners and services would be supported economically by local, provincial, First Nation and national health service budgets. Ideally, the latter would be implemented by the creation of a fund, controlled by budget, to meet the basic living, professional development and practice needs of the traditional-based cooperative council, their trainees and administrative assistants. Access policies and reviews would be set up to ensure appropriate use and designation of funds.

Socially, such a situation would instigate the transformation of participating Indigenous individuals, families and groups, towards more culturally resilient, healthy, economically and politically viable relationships within the Vancouver community.

J: I’ve been so stuck in what the barrier is and where we are at now that I haven’t even thought about what is ideal. Ideal would be, of course, all of our needs being met by health services. The holistic picture, our spirit, our hearts, our minds and bodies, mental health, emotional health, physical health, spiritual health its not there.

And the children, teaching them how to be good people. Teach those children. It’s up to us to teach these children. It’s our responsibility. I know my grandsons, my sons, they’ve been taught to not hit one another, and I know it’s not happening in other homes. I know it’s not happening, because I see it. There are not secrets about it, there’s only silence, denial, justifying. An ideal would be to get rid of all those poor qualities or whatever of humanity. Ideally, we have the ability to meet those needs, realistically. But then my lifetime... you know who... and what we once were can be restored. I think it is possible. I know it’s possible you just have to want it. Sticking together.

I know it could and it would. We just developed a new program cause we have new criteria with working with families. It’s not our first choice but we did choose to go with it. We are going to work with the entire family unit. And we are going to teach people how to weave cedar, how to make drums, sing songs, speak their language, go canoeing, go up the mountain for cold water baths and use these traditionally health based teachings to recover their self esteem. To feel better about who they are as people, to recognize their ancestral qualities, or what is unique about them. But at the same time we are going to deliver what we refer to as a psychoeducational component; every session we’ll deal with the behavioural issues, addictions whatever...
Yeah. Relationship skills, communication skills, conflict resolution skills. All the while, enhancing their own self-esteem, and learning traditional skills. Like with cedar bark weaving: they are going to go out and peel the cedar tree themselves. Usually when a cedar bark class is offered, the cedar is there, it is peeled, it’s all prepared, and then they weave. That’s a half measure; we are going to teach them everything from scratch.

Dawn Marsden: Then you get the whole connection.

J: Yeah, so in that way I mean, I’m excited about it (Tape J).

Politically, these conditions would necessitate the establishment of a community created, cohesive and culturally appropriate government framework for representing and addressing the needs of all off-reserve or landless Indigenous peoples in Vancouver (GVRD), and for establishing good relationships with both land-based Indigenous peoples and Canadian peoples.
Chapter 4 Strategizing at the Societal Level: Greater Vancouver Regional District

Creating Space for Indigenous Realities

How can traditional-based health-education services be enhanced at the societal level?

Oldhands: They’re slowing thinking that. Remember that Western medicine comes from England and a European kind of science. And that these are the meds Aboriginal people gave to them; they started to enhance it and all of a sudden… ‘Synthesize this’ and ‘I’ll make money’. ‘I’ll go here, and you pay me’… and that opened the drug industry, right? Still, close to natural medicine, we are going now. ‘Cause people are understanding that it works; ‘well that’s where medicine originated’. Go back to that old good way, of waiting, of more natural scientific [processes]. But the thing is, that our systems aren’t the same as other peoples systems. Our [systems] stay clean because we believe. Slowly, people try to.

I do a lot of work in Langley, because it’s like a bible belt over there, because they still teach them, that what we do is wrong, and evil. That would be like telling an Italian guy ‘you speak Italian, it’s wrong, it’s evil.’ But they still do that, so I tell them, ‘nah, nah, we’re special; that’s why there are so few of us’ (Oldhand’s Tape).

Educating for Anti-Racist Action

J: To come in contact with Native knowledge is also coming in contact with colonialism and oppression and it’s very painful for people have been on the oppressive end of things, to deal with that knowledge. They don’t have to and they don’t want to (Tape J).

Daisy Heisler: We had known this specific Dr. for many years, and that she had been open to alternative medicine along with allopathic medicine in years past. So we thought she might be a good physician to refer a person to, when Ken was asked to help. A woman who had heard about Ken phoned to see us. I told this person that a referral to us was necessary, from another physician, first. She phoned back to say that her doctor [the same one] had refused to give a referral to Ken because ‘Ken is a devil worshipper because he is involved with Native people’ (Email addition to dissertation by Daisy Heisler).

Beyond good intentions or even deceptions, the clash between imported European worldviews and Indigenous worldviews in North America, were made worse by deliberate creation of assimilation policies, which were intended to weaken Indigenous peoples claims to specific lands and resources. If people are, by the manipulation of definitions, no longer Indian, then their lands and resources are up for grabs, and the federal indebtedness for the use of lands and resources will have been fulfilled. Today, the rights of Canada and the United States to use lands and resources in North America hinge on the ambiguous wording within the treaties, and other Eurocentric documents, and not upon the relationships agreed upon by Indigenous peoples in the Two Row Wampum (see Appendix A, Kahnawake Mohawk Territory, 2005).

The speaker below alludes to the dishonesty inherent in manipulations of both the spoken and written word, in her references to the treatment of John Graham and Leonard Peltier, and in her closer-to-home example of the treatment of bullying in the schoolyard. Dishonesty and redirection of responsibility serves in the continued control of Indigenous people through
misplaced authority, fear and criminalization. The challenge is to become a warrior for our people, to find the courage to challenge those practices, for ourselves, for our children and for others who can’t speak for themselves.

B: You’ve got people who stand up and are on the front lines, others sat on them, to fight a war of purpose; to lead one end of the country. Even now when we look and see our brother John Graham being arrested for a murder that was very clearly... And the officer, the FBI agent who found her, had arrested her a multitude of times prior to finding her body, then hadn’t known she was shot in the head. They said that she had frozen to death, they chopped her hands off! I had never heard of those kinds of occurrences—the kinds of things they did, and you know, arresting them twenty years later. Now it’s like, it’s blatant. Those are the kinds of injustices that we have to deal with. Still we have to deal with. You know what Leonard Peltier has been sitting in jail for... I don’t know how many years, and all he was doing was protecting these people. And so without those warriors without those kinds of stands, and sacrifices... They sacrificed their life so that we can move forward and say it is our inherent right to have education, to have health, to have good shelter. And so we have the other kinds of warriors who go to school and learn, like yourself, who are doing research and say ‘get people together and ask’.

Dawn Marsden: Yeah-pushy warrior (laugh)

B: Pushy warrior (laugh). A warrior nonetheless. I see myself as a warrior. I see myself as being a voice for people that I serve. There’s some rights that are being violated, so if those rights are being violated, then we need to be able to speak up about it. I’m always up against the school system but you have to stand up and you have to say to the principal or whoever I’m speaking to, ‘not all of our Aboriginal people have voices, or are willing to speak up.’ I would like to stand up to them and say ‘you know what, you may think you’re right but I don’t think you’re right, so we need to talk about this.’ But some people don’t have that ability to do that.

I don’t know if I told you the story of my son getting assaulted it happened a couple of years ago when he was fourteen years old, by an Asian guy. There’s witnesses so my son’s best friend’s mom calls me at work says ‘what should I do’ and I said ‘phone the police get it all recorded and get a file number and everything and I’ll see you when I get back’. I go home at 2 and she said ‘they didn’t even spend 5 minutes with Jon, they didn’t take any of the accounts from the witnesses, but you know he comes from a rich family so, you know.’ And I said ‘what?’ So I said ‘what’s the file number’. So I’m talking to the constable you know, and I tell him ‘as soon as I found out that this young man had money I knew this was going to happen’ and he said ‘maam, this has nothing to do with it’. I said ‘BS’ and ‘it has everything to do with money’ and I told him ‘my name is Dixon and I work with the urban youth association and the City of Van and I can tell you that this is not going to stop here. What is your supervisor’s name?’ And he said ‘pardon me?’ He said ‘you don’t want to talk to me anymore?’ and I said ‘no, our conversation is over; you don’t think there’s reason to pursue charges, I want your supervisor’s name.’ So I took it right up to the corporal, and the inspector, and finally got an audience. And so the corporal said ‘maam what do you want from us?’ And I said ‘I’ve got my son there and I’ve the best friend there and the best friend’s mom there and myself’. I says ‘I am a youth worker and I do not want - in no way, shape, or form - want this young man charged. What I do want, is a red flag.’ But the constable had also said that ‘this boy has no charges and if you don’t charge him, he’s not going to.’ ‘I want a red flag on his file so if it happens again you know that it’s a pattern because he was
very aggressive with his mom. So he’s volatile. And over and above that, my son is sitting there and he knows that no matter what, I will fight for his rights.’ And he listened to my story and it got acknowledged it and I got a ‘thank you very much’ and it took me three months and I documented everything and kept in contact with them (Tape B).

The relationships in our society can be examined, at the micro level, in our schoolyards. Unfortunately, it’s no coincidence that the violence of our world is being reflected in the lives of our children. While every one of us is modeling, teaching and providing opportunities for our children to learn in good, autonomous ways, if we aren’t making efforts to change the unhealthy aspects of the society we live in, then we are complicit in the maintenance of those unhealthy influences. Far from shifting the blame around, or giving up in despair, it’s our responsibility to model, teach and provide chances to learn healthier approaches to conflict, and to challenge the status quo, at all levels. We, as individuals, as warriors for good relationship, can affect positive changes in the world around us. The speaker below demonstrates these convictions in both her words and her actions.

B: Years ago my daughter was bullied, was always being bullied. A group of Asian girls were bullying her and finally one day - she was at 8 rinks - the leader was there. ‘Oh there’s just you and me’, and they got into a fight and my daughter assaulted her. I was working and didn’t even get a call but this young lady had a cell phone and called her dad and he called the police and my daughter got charged. Now how many times did my daughter get assaulted by this girl and her friends? Numerous. My girl got charged and ended up having a file. And how many stories do I hear from Aboriginal youth that that happens to? It’s high, high numbers. And so those are some other things that have to stop in the educational system.

I actually had a healing circle with my daughter’s school with my young son, my daughter, myself the principal of the school, and the head counselor. The counselor was in tears after the circle. She said ‘thank you’ and ‘this is the way you do it’. And I believe that my children need to be accountable and I bring them up to be accountable and responsible. Doesn’t mean that they’re always respectful, they’re learning, they’re growing, but I said ‘it is my job’. But no matter what, I am there for my kids. I will believe my kids first, so I’ll fight for my kids (Tape B).

One-on-one we are good people, but in groups, our authority to make good decisions is often given or taken away. Some of the most important traditional-based principles around relationship, are to speak from the heart, and to ensure, through action, that words do not become empty. Getting together and speaking together then, becomes an act of integrity and courage, where heart, mind and actions can address conflicts with relevance and responsibility.

B: I’ve gone as far as talking to the teacher and the counselor and the principal and thank you very much. It’s just, everywhere that we went, the situations that we’re dealing with - just because of our ancestry - and I’m not seeing or gaining anything other than what other people are going through. I just know as Aboriginal people there are issues that come out, just about that. They set up barriers. It’s really difficult. So one of the things I say is, I want to start instigating conversations, not instigating but getting those kinds of conversations going like what’s happening in school, like tell your story why did you not make it in school what happened there, did you get involved in drugs in school or after school (Tape B)?
It takes courage to do what’s right, in a world gone crazy with disconnections. It takes challenging the dehumanizing processes that we have created, that we maintain, or that has been imposed upon us. These processes may have had good goals in the beginning, but like a runaway horse, these processes need to be reigned in and gentled; we need to remind each other of the good relationships that these processes were designed to facilitate. Rehumanizing the status quo is daunting but can be done, by relating to people as responsible, interconnected human beings, and by challenging those principles and practices that don’t serve people, or other beings, well.

The next table (Table 3) is designed to portray a personal reflection on the historical clashes between traditional-based Indigenous worldviews, traditional Westernized state propaganda, and traditional-based Christian residential school doctrines. It is a personal reflection on my own experiences, the experiences of relations, participants, friends and acquaintances, and upon the literature I’ve read. As such it is a personal construct about how the world has been, and is designed only as a tool for beginning a discussion about the very real intersections, conflicts and consequences of European colonization in North America.

Table 3: Doctrinal Clashes about Living a Good Life

<table>
<thead>
<tr>
<th>Traditional-Based Indigenous Worldviews</th>
<th>Sites for Conflict</th>
<th>Westernized State Propaganda</th>
<th>Traditional-based Christian Residential School Doctrines</th>
</tr>
</thead>
<tbody>
<tr>
<td>The will of the Creator is already accessible within us</td>
<td>Internal vs external sites of spiritual authority</td>
<td>Citizens elect leaders to follow</td>
<td>Humans must submit to will of God, as interpreted by priests</td>
</tr>
<tr>
<td>Fulfill desire and instinct in healthy and balanced ways</td>
<td>Positive vs negative value judgement regarding state of humanity</td>
<td>Human weaknesses must be regulated for the good of all</td>
<td>Suppress desire and instinct</td>
</tr>
<tr>
<td>Care for yourself so that you can care for others</td>
<td>Bottom-up vs top-down responsibility orientation</td>
<td>Authority knows best</td>
<td>Put others before yourself</td>
</tr>
<tr>
<td>Humans as one of many beings living in balance</td>
<td>Egalitarian vs authoritarian decision making; being vs human centred</td>
<td>Government as most appropriate managers of people and other resources</td>
<td>Humans as children of God, in dominion over the earth and its beings</td>
</tr>
<tr>
<td>Humans are essentially good/spiritually oriented</td>
<td>Positive vs negative value judgement regarding state of humanity</td>
<td>Citizens expect their needs to be supplied</td>
<td>Humans are essentially bad/materially oriented</td>
</tr>
<tr>
<td>Everyone is personally responsible for maintaining their relationship to the Creator and other beings</td>
<td>Internal vs external sites of responsibility</td>
<td>The state enforces laws and policies</td>
<td>The father/priest is the keeper/enforcer of the faith; the mother/nun is the keeper/enforcer of purity</td>
</tr>
<tr>
<td>Knowledge is to be generated, obtained and assessed relevant to ones life</td>
<td>Internal vs external sites of knowledge generation and acquisition</td>
<td>Knowledge is to be generated, obtained and assessed relevant to accepted standards</td>
<td>Knowledge is to be generated, obtained and assessed relevant to God’s law</td>
</tr>
<tr>
<td>Knowledge, land and resources belong to those who have maintained and protected good relationships with them.</td>
<td>Communal vs individual orientation to property</td>
<td>Knowledge, land and resources belong to those who claim them</td>
<td>Knowledge, land and resources belong to God and are gifted to specific individuals for God’s purposes</td>
</tr>
</tbody>
</table>
Indigenous peoples are disadvantaged by the imposition and enforcement of immigrant worldviews, institutions and processes, upon Indigenous worldviews, institutions and processes. One should enter into all relationships with a consideration of the need to maintain balance and respect.

Mistakes are expected in the process of living and learning. Positive reinforcement vs negative reinforcement orientation to human fallibility.

Both men and women are expected to be loving providers and guides for their children and other relations. Egalitarian vs authoritarian sites of responsibility.

If we look closely at the hypothesized principles of State and Christian doctrines in this table, it becomes apparent that they are closely aligned and mutually supportive; which is no surprise if we look at the history of Western Europe and the close, ongoing and cooperative relationships between the church and the state. For these reasons, I've decided to group State propaganda and traditional-based Christian residential school doctrines as a group, to enable a more effective view of the potential conflicts between traditional-based Indigenous people and dominant institutions (see Sites for Conflict in Table 3).

While these categories aren't absolute, and can overlap on a person-to-person basis, they demonstrate how radically different worldviews and traditions, like those of traditional-based Indigenous peoples, can challenge the status quo enough to result in legislative sanctions. When we consider that Christian residential school doctrine was legally enforced and thereby coercively imposed upon generations of Indigenous people by the Canadian state, one can hypothesize a wide variety of both immediate and long-term effects upon the psyches of Indigenous peoples (see Table 4).

The following two quotes speak to some of the impacts of such doctrinal conflict in the lives of real people.

M: Before my Mom passed away, she always said, 'don't do any of that funny dance either.' I asked her, 'what funny dance are you talking about?' And she says, 'you know.' So when she was on her death bed I asked her, 'that funny dance you're talking about, Mom, is that the longhouse?' She didn't have a voice to talk with anymore; she just went like this [nodded]. I was like, 'my God, Mom, what's the matter with the
longhouse?’ So she didn’t want to talk about it anymore. It must have been a really devastating time for all of them, for all that to be taken away, eh? (Tape M).

Table 4: Hypothesized Effects of Doctrinal Conflicts

| Rejection of traditional-based principles and embracement of both State and Christian doctrines; |
| Rejection of both State and Christian doctrines and embracement of traditional-based doctrine; |
| Rejection of one of State or Christian doctrines and embracement of traditional-based doctrine; |
| Rejection of any of these doctrines; |
| Embracement of one of State or Christian doctrines |
| Embracement of Traditional-based, State and Christian doctrines |

K: ...barriers in the system, in the medical system. There is also barriers in the native community in the sense that there’s some people that no longer believe in our system. There’s some people that don’t have any awareness of it. There is lots of Aboriginal people that consciously choose the non-Aboriginal system even though there is -- time after time after time, there’s displays of how that system does not work well for us and still people seem to have more faith in that system than our traditional healing system. Our traditional healing system may not be as technological, but I think it is -- even as disabled as it is, even as discriminated against as it is and hobbled by general society, it still is very effective in a lot of kinds of treatment and more and more people are turning to it. So I think people are coming back to it, but for quite a while now there’s been a. even in the aboriginal community there’s been very productive using that system, because there’s large parts of the community that don’t want to and then there’s the whole influence of Christianity which usually views our traditional kinds of healing as... words I’ve heard are “hocus-pocus” and “smoke and mirrors” and, you know, “trickery” and “foolery” and fooling the people and tricking the people (Tape K).

The conditions under which one learns or embraces a teaching often affects the impacts of those teachings. The more advantageous the contexts and opportunities, the more likely people can make decisions that effect positive outcomes. If one is invited, encouraged and positively reinforced in considering new ideas, they may be incorporated into ones worldview, with positive outcomes. If teachings are gained under conflicting conditions, the teachings will be associated with those conditions, with adverse outcomes. Teachings that are acquired in conflict make it necessary for a person to discern and rationalize, to make choices about what is to be denied, embraced or modified to fit into ones worldview. Conscientization about historical, social and economic contexts, through education or lifelong learning, assist in this process of discernment.

I: There’s something I wanted to talk about in terms of healing. It’s been an issue for me, like the issue of control, and the time thing, and something’s that been bothering me lately. Like say for example my house, my residential school regimentation. I think I talked to you before about the regimentation of our spirituality, the regimentation of... like the taking off the hat thing. Whereas traditionally - and traditionally to me is cliché now - traditionally just means how we used to do things, but it wasn’t our tradition. It’s like if I got up at 6:00 every morning, or my Grandmother got up at 6:00 every morning, that would be - so called – ‘our tradition’. But that’s just what she used to do, therefore that’s what my mom does.

Dawn Marsden: It’s not the rule.
I: Yeah. And so that regimentation of our spirituality and traditions is annoying to me. Like for example, even at powwows or wherever, they even do it in the longhouse now. A couple of the guys they’ve been sort of talked to about that, over regimenting our longhouse. You know ‘stand up, sit down, stand up, sit down, take off your hat’, you know.

Dawn Marsden: Sounds like church.
I: Yeah, exactly, that’s what it is. Years ago you wouldn’t see that. They wouldn’t tell their Elders ‘sit up, stand down’, you know. You’d just do your praying and people would watch and they’d do it if they wanted to.

The other issue that I have is the cleanliness issue. In residential school, I understand - I went through it, my mom went through it - the regimentation of cleanliness. So therefore our life was heavily regimented in terms of cleanliness, to where as an adult I hate it, I hate doing dishes, I hate vacuuming, I hate it, but I do it because I have to. But where you see my issue is in my room. We have two bathrooms and one bathroom for some reason, I’ll close that door when people come over because I have clothes on the floor, it’s like toothpaste on the mirror, the garbage is all torn. In my room, clothes, I’ve got a Safeway garbage bag...

Yeah, I have stuff under my bed, my closet, I’ve got stuff stuffed. It sounds neater than it is. I think that’s part of why I like sleeping on the couch, especially if I’m not feeling... if things are going on, the house starts to get sort of stifling. And in the meantime I’ve told my sons, ‘I want you to - especially when you have your own place - do the dishes right away, put the laundry in a...don’t pile it like I do’. I said ‘I thought I’d better tell you that’, I had to tell them, if we didn’t do something right we’d get made to, pushed around, and shown how to do it right. If we didn’t move fast enough we would get pulled, you know, smacked, things would get thrown all over the place and we’d start all over again, and that’s what we went through in residential school. So I said ‘I have a big issue around it, that’s part of my sick things and you don’t have to deal with that, but I want you to know what should be done is: eat you do the dishes, I cook, you do the dishes, you guys I need your help’. I said ‘if there’s anything that I has to deal with it’s the regimentation’. I call it the regimentation of cleanliness. Regimentation of spirituality.

Dawn Marsden: It’s like a revolt too.
I: Yeah. A lot of our people are - I know that I’m cluttery - but you walk past some of our people’s doors and it’s...ugh. I sat at place and one of our men was there and he was like ‘oh my God’. Some of our people are like hyper clean.

Dawn Marsden: It’s an issue.
I: It’s an issue. But no one’s talked about it, and so I want to be someone who can talk about it. Over years just notice the odor, it’s time and again, an issue with landlords, which is why a lot of our people don’t get [apartments], it’s not just because of alcohol, it’s because when the people move... you know.

Dawn Marsden: Total mess.
I: Yeah, So, I feel cleansed now having said that. But that’s something that’s not talked about.

Dawn Marsden: Yeah, It’s one of those core issues again, core issues around all that history
I: Yeah, our history, control, cause that’s one of the ways that we were controlled. I had to do the toothbrush in the bathroom thing. You know I had to do the floors, a lot of times I had to do the dorms, do the beds, everything. We’d all have our rags and do squares. When that was done, then soap on the floor, we’d have to get down on our
hands and knees, one square, two squares, all of them, from there to here. Scrub, scrub, scrub, scrub, we’d do the scrub thing. Then we’d have to take our rags and squeeze the water into the bucket and spill it out, and then another bucket, we’d go rinsing, then we’d have to dry it up. And then, oh my goodness.

Dawn Marsden: Wow, yeah, it’s not just about cleaning, it’s about...
I: intergenerational regimentation.

What complicates things is that most of our choices and decisions about principles for living, are made unconsciously, at important moments, under specific conditions. Unconsciously made, these choices and decisions are integrated, or “hard wired” into our psyches, and continue to operate long into our futures. Changing our internal concepts requires a similar process of important moments, under specific conditions (as in traditional-based practices), and is a dynamic process that continues throughout our lives. If one decides, or is influenced to incorporate conflicting beliefs, that can’t be rationalized or modified, then the resulting principles can cause fragmentation within a person’s concept of themselves and their external realities: fragmented worldview, fragmented life. Denial, anger, confusion, and depression are common descriptors for people suffering from “residential school syndrome”, from “post-traumatic stress disorder” or from “ethnostress”, which are often attributed to Indigenous peoples in North America.

J: Our people are deeply traumatized. We continue to see the affects, although the Residential Schools are now closed, we see how the rest of society continues the oppression. It’s still there, we know its still there. We see teachers; schoolteachers actively sabotage our young peoples’ education you know and this really disturbs me as I see these teachers as having a responsibility to teach. And to actively sabotage a young person’s life what does that say for that teacher? How poor they are in their values and beliefs, spirituality... that is one of the poorest... and it’s not about strength. Some of the weakest things that a person can do, an adult person, you know, who takes on the responsibility of teaching... that really hurts. It hurts. (Tape J).

A whole section could be written here about the power relationships between Westernized men and women, the different positioning of relational knowledge and factual knowledge, the power relationships between Westernized societies and Indigenous peoples. The following quote by Edward Curtis, is an example of a stereotype of Indigenous people, which, in effect, details the perceived difference between Indigenous people as “the Other” and Euro-Americans as the standard.

‘The Indians could have given us physical vigour which must be one of the foundations of any lasting and important strength; they could have helped us in the creation of literature, for they were marvelous in the beauty of their free, poetic thoughts, full of imagery such as white men have never known. Their souls were those of poets. They could have helped us in our music, for their’s was a real part of their lives, a genuine expression of emotion. They could have aided us vastly in our decorative art. And in a broad sense, they could have helped us in our morals, for in all their dealings they were fair until we taught them theft and lying (Hutchens, 1973).’

While stereotyping is inappropriate because of the potential limitations they place (through discrimination) on the place of people in society, they are the result and indicator of a natural (though faulty) human disposition to discern, to enable decision-making. The statement
above displays a discernment of differences in worldview and culture. The same theme of
different and marginalized forms of expression, is present in the next statement.

Traditional western arts education and practice has a history of marginalizing and
stereotyping both women and minority groups in the arts. The arts works of marginalized
groups have been documented, appraised and categorized within a hierarchy of male art
practice (Grierson & Mansfield, 2003).

The same process of male-centred documentation, appraisal and categorization could be
said to be operating at other levels of society, like health service settings. Through such
hierarchies, many Westernized men have inherited, and reproduced competitive worlds where
relational, expressive processes are marginalized, and where they reap the benefits of such
positioning. Through facetiousness, Paula Gunn Allen describes the consequences of such male-
centred positioning upon the lives of Indigenous men and women:

The plot that we all know doesn't exist has been contrived to convince Indians and
everyone else that Indians are doomed to extinction, to throw to the ground every
woman's heart. It has been carried out by the simple process of subjecting our cultures,
lives, traditions, rituals, philosophies, and customs to Christian patriarchal scrutiny,
seeing only the male in them, putting male bias into systems that never had it, interpreting
rituals, customs philosophies, and attitudes in male-biased terms, and generally creating
out of whole cloth the present male-dominating view about the tribes and their

Through resistance, assertion and proaction, many Indigenous people continue to inherit
and create worlds where relational knowledge is prioritized, and where everyone is designed to
reap the benefits. Even so, gender-based and cultural-based imbalances in power, continue to
influence and result in conflicts, tensions and inequalities.

One battle ground for balancing these relationships, is in the field of education.
Education is the one field that crosses all domains, and affects the character and understanding of
all future generations. Education is where our epistemologies are encouraged/discouraged,
nurtured/neglected, guided, facilitated, inculcated or dictated. The saying "education is our
future" is so true that we must pay special attention to how it is being done, and to who is doing
it, to ensure more inclusive and egalitarian relationships in the future. This is especially true for
Indigenous people, where people with colonizing attitudes persist in their determination to
control and influence the epistemologies of future Indigenous generations.

The prioritization of relational knowledge has some specific consequences in public
practice. It has occasionally been said that Indigenous people have the characteristics of women
in general, that they are concerned with good relationships, children, intuition, empathy,
compassion, and all the aspects that contribute to our whole being. Consequently, as the ways of
women have been marginalized, so have the ways of Indigenous people. These ways have been
seen as noble, quaint, passionate, martyr-like, altruistic and more; always on the edge, never
fully able to integrate into the mainstream. Likewise, the abuses against women: rape, physical,
sexual, emotional abuse and harassment, undervalued work, marginalized or stolen knowledge or
processes, lack of representation, lack of space, freedom, or care, are similar to the abuses
against Indigenous people.

The power relationships between men and women need to be brought into complementary
balance, where ways of knowing and being are given equal status, where the knowledge of both
relationship and fact are integrated into a more wholistically balanced society. Until
Westernized men start to value the importance of relationships in society, and until Westernized
women become successful at asserting the importance of relationships in public as well as private domains, all Westernized relationships will remain marginalized and out of balance. At the same time, Indigenous people must become successful at asserting the importance of relationships in both public and private domains, to ensure more balanced relationships and outcomes for the future.

In addition to discerning between doctrines, resolution can occur by deconstructing misapplication of original doctrines. In Christianity, for example, while there has been a lot of importance given to man’s dominion over the world and its beings, the text which is cited as the source (The Bible) provides some contradiction between the philosophy and the actual practice. For example, in 1 Corinthians. 12:20-26, it states:

God hath tempored the body together that there should be no schism in the body but that the members should have the same care one for another, and whether one member suffer, all members suffer with (Hutchens, 1973).

This statement suggests an interconnectedness between body, mind and spirit, and between all beings. Herein lies a bridge between the wholism of Christianity and the wholism of Indigenous peoples. While many have acquired positive coping behaviours for dealing with the influences of colonization, some still cope in more self destructive ways, with drugs, alcohol, suicide, abuse and other forms of violence. Participation in healing activities, like ceremony or counselling, assists us to work through emotional and physical responses to our lives, and to support the healthier choices we make.

The above comparisons are just a few of the many important examples of the intersections or relationships between Indigenous and non-Indigenous peoples, since contact. Besides government, church, doctrinal and gender comparisons - which could be said to be driving forces - there are education, legal, health and social service comparisons, which could be called supportive, reinforcing, or maintaining forces. The impact of colonization, by its interconnected influences on Indigenous contexts, cultures, worldviews and traditions has been, and continues to be immense. Any legislation, policy or practice which excludes considerations of the contexts, cultures, worldviews and traditions of the people they serve, is amoral and will have reactive consequences that will inevitably impact upon the decision makers and those they serve. The assimilation experiment continues to this day in new forms, by the omission or marginalization of Indigenous perspectives, processes and representation in institutions (education, law, medicine, social services) and in resources (pamphlets, booklets, magazines, textbooks, television, internet, radio, information centres, agencies...). The negative impacts upon Indigenous people have been well documented.

What has not been well documented, are the impacts of exclusionary politics upon the non-Indigenous peoples of North America. What has Mainstream society lost by excluding Indigenous peoples from full participation? Perhaps this kind of research would create more wholistic and less myopic responses to the consequences of Indigenous/non-Indigenous relations. To circumvent more negative impacts, for all peoples in North America, good (inclusive) relationships, at the levels of legislation, policy and practice must be created, firmly established and maintained.

Oldhands: I don’t know and you know it’s quite funny. Like I tell people “you know Aboriginal people, traditional ways, are respected through out the world except where we live.” You can go to Germany and all that... I have a man he comes to our circle, he travels up to like, Yugoslavia and he goes “oh” he says “we have so much praise for the noble red man” he says that there “cause they are still connected to the
earth.” “Well did you hear about all the struggles with alcoholism?” and he says he never heard of that. He said “if those [Yugoslavian] people came here they’d be crushed.” He said “because they have this picture of some hope still up in the world of something right.

Dawn Marsden: Like an ideal, I used to work at the House of Learning and we’d get lots of Germans and other people looking for Indians right you know they’d walk by about 20 of us...

Oldhands: Cause they want to see buckskin and feathers

Dawn Marsden: Yeah, like it’s such a powerful vision that they have that they can’t see...

Oldhands: I think that in their vision that they are seeking is they want to know that there are still people in this planet that are actually free. Because that’s what the Indian on horseback with feathers that represents freedom to them.

Dawn Marsden: Freedom of the heart...

Oldhands: When I do story telling with little kids - they can be all Aboriginal kids - and I’d go in there with all my regalia, my buckskins and feathers and stuff, and they’d go “a real Indian!” I go “you’re an Indian” and they go “but your a real Indian.” I start laughing, “I don’t wear these all the time”. Yeah, it’s quite funny. That’s the way society is and sometimes I wonder about Western medicine, is that they kinda, almost like they protect, they’re very protective cause they don’t understand something. I told them, like you said, “the Chinese medicine goes back thousands of years and so does ours. We only kept what worked.” If it didn’t work scrap it right. If it works, it works, same with theirs, eh. But they try to protect: “now our money’s going to leave us” right. People are going to be going to an acupuncturist, sticking needles in... Well let me tell you when I was a young man I broke my ankle, my foot spun around the opposite way, right. I didn’t know of any Indian medicine I could put on to kill that pain cause I never felt pain and that was a release right and my doctor he was responsible for bringing acupuncture into the states there and making it a legitimate medicine to them. He sapped me a couple of times with those needles and the pain was instantly gone. He grabbed my foot, spun it around and snapped it back in place. Well, I thought I could just walk out of here, run out of there, it felt so good. “Naw”, he said “I still gotta put a cast on it,” but when he did that I said he sold me on acupuncture, “that worked” (Oldhand’s Tape).

In the context of Vancouver, where Indigenous peoples have been trying to live in good relationship with non-Indigenous people, Indigenous people are at a historically created, contemporarily maintained, Euro-Canadian-dominated disadvantage. While it’s definitely not a game, being Indigenous in Vancouver is something like trying to play a game where the biggest person makes all the rules. While the rules of fair play are still espoused, they’re often set aside when the game gets competitive. The playing field would be a lot fairer if Indigenous people and their worldviews were acknowledged, understood, accepted and included in societal decision-making.

Drugs, or anything that will relieve without removing cause, is a questionable good, and certainly an outrage and a crime where the remedy blinds the physician as well as the patient to the need of searching for cause and removing the same (J. H. Tilden, 1921).

The healing philosophy that states that the root of the cure can be found in the root of the cause (Tilden, 1921), is very applicable to today’s world. Vancouver is less than two hundred
years old, yet the changes that have occurred for Indigenous people have been immense, and greatly detrimental. If health is a state of balance - emotionally, spiritually, physically and mentally - then the root of the cure for the unhealthy relationships between Indigenous and Euro-Canadian peoples, is in the re-balancing of those relationships and in re-centering of health services in spiritually-based, and balanced wholism. The re-balancing of health service relationships is especially relevant to the health of Indigenous peoples. We are all connected, and we all have hearts. We know what to do, and how to do it, we just have to do it, for all of our children, now and into the future.

Understanding Rights to Self Determining Actions

J: Look at how things were when I was a child, most of the adults in Native communities were abusing themselves and each other. Now it’s still prevailing, but it’s a lot more common for people to be sober, free of alcohol and drugs, tens of thousands of us now. So that’s changed. Barriers or constraints? What we put there, what society puts there, for myself personally. Professionally, as a men’s domestic violence counselor, the policy makers the bureaucrats, the ministers, both Provincial and Federal, determining what our needs are without consulting us... When I find out that the decision was made on our behalf, that in order to facilitate the domestic violence group I have to be accredited, or I can’t, or I won’t be funded, or supported financially to do that kind of work... But I know and I’m doing it. I continue to do it. I continue to host men’s domestic violence groups: Aboriginal, Native, men’s domestic groups, I’m an expert at it, I’m good at it. In terms of Aboriginal men’s domestic violence groups, we’re (Change of Seasons, Warriors Against Violence) the best in the world, and we know what we are doing, and we don’t need someone coming from outside our community, who never sets foot in our community, does not live with our community, and doesn’t have to live with the effects, the impacts on our communities. They don’t have to live with it, and yet they can make the decisions. I have concerns and issues with that (Tape J).

This speaker addresses a fundamental issue relevant to the access and provision of traditional-based health services in Vancouver. There is a discrepancy between the right of Indigenous peoples to determine best avenues and options for Indigenous health care, and the available avenues for implementing these determinations in Vancouver. According to most of the research participants, consultations have been inadequate for the effective design of Indigenous-specific, traditional-based health services, for Indigenous peoples in Vancouver. The current emphasis on evidence-based practice has not included a discussion of traditional-based practices, to any effective degree.

Self-determination is a wide open term, used to express human rights to autonomous decision-making and self-efficacy. We have the right to determine the course of our individual lives, as long as we don’t infringe upon the self-determining rights of others. According to the Canadian Charter of Rights and Freedoms, self-determination in this sense, is guaranteed and monitored by local, provincial, federal and international human rights tribunals. What this means at a societal level, is that opportunities for self-determination must be accessible by all citizens, regardless of gender, age, infirmity, sexual orientation, religion or ancestry. In Canada, with people of such diverse worldviews and backgrounds, accessibility necessitates the design of diverse options for, and avenues to access. Unfortunately, budget constraints have always ensured that options and access have been designed to meet the needs of the majority of Canadians, who have primarily European ancestries and worldviews, to the detriment of minorities, and specifically Indigenous peoples.
As the prior long-term inhabitants of North America, with long-standing relationships and treaties with the Crown and Canada, the rights of Indigenous peoples to self-determination is explicitly recognized in Canada (see Appendix B).

J: And so, at ____ we’ve been resistant to changing our primary focus of working with men, men working with men, with all of [the new] criteria over the past 7 years or so, where criteria has shifted - and it shifts every year - working with the entire family unit. Men, women, children, mother, father, parents with children, or youth and whatever programs. I mean their criteria is culturally based. I can appreciate that and I can see where working with the family is important, there are needs. Men have needs that are unique.

Yeah, needs for women and men that are unique and gender specific; they need to be addressed in a special way. Men’s domestic violence is one of them and it is acknowledged that men’s domestic violence is a major societal issue, whether it’s First Nations or mainstream society (how we refer to the rest of the population of Canada and the United States, Europe). Men’s domestic violence is a major issue and in Canada, there is no Provincial ministry or Federal ministry that has a mandate, and yet every year, especially around election time, the Ministry of Attorney General, Justice Canada... ‘you know that we’re taking violence seriously’. We’ve heard it time and again. And so one of the things that I would like to see come out of this interview and your research and things is just having the ability to reach the policy makers and have the understanding that we can meet our own needs. It’s a right to be supported. We’re not asking for permission to do this work, or we’re not going to apologize for being where we’re at. They have a responsibility to change, to help, to help create an enlightened community, a society that evolves. And this goes back to my original statement, ‘has humanity stopped evolving?’ Are they going to be a part of it, or are they going to be a part of where it’s at, being stuck?

Well, we see how the rest of Mainstream... they continue to abuse each other. So what does that say for us. We realize and understand the way things are. We can’t look to them for all of our needs, because its not going to be there. And those are barriers and so for me it’s a matter of being able to reach the policy makers but also having the ability to convince them to hear and address what our needs are and that they are adequately met.

J: I resent this Mainstream society making the decision that I won’t be funded for doing my domestic violence groups. They are saying that I can’t do it.

They are saying that I don’t have the ability or the skills, that’s the way I see it. It’s paternal and negative in every sense of the word that you can think of. And yet none of these policy makers have ever come into our community to see them. The alternative would be for me to go back to college or UBC or....

Dawn Marsden: To get the paper.

J: Yeah. I do see the benefits of these of institutions of learning, I respect them, but at the same time there are other ways to learn. It’s not always about college or university based teaching or learning. This is where mainstream society needs to back off and support our own decisions, our own directions that we decide to take. Like I said before, mainstream society has a responsibility to support us in our healing, growth and coming back into mainstream society. Assimilation was not a choice that we made, it was imposed; it was legislated. We weren’t even, in their eyes, human beings; we were savages, heathens and all that stuff.
Creating Space for Indigenous Wholistic practices in Vancouver

Arguments for inclusiveness

Lee Brown: I think that society in general is afraid of our ways, afraid of the spirituality. The dominant society doesn’t understand spirituality, doesn’t understand the power of it. Western society has very little knowledge of the spirit and in the spiritual realm; you’re dealing with the spirit. There’s mechanics of that. There’s laws, there’s spiritual laws, and there’s spiritual mechanics that you have to know and understand to be able to deal with it and there’s a lot of the traditional people who know these things and can deal these things and can make amazing and unusual things happen. The dominant society is very afraid of that. They’re very sceptical (Lee Brown’s Tape).

There are many arguments for creating space for Indigenous wholism. One of the strongest is the right of Indigenous peoples to practice their spiritual beliefs. Because spirituality and health are so combined in traditional-based practices, Indigenous wholism must be given space because it may reduce some of the inequities in the health status of Indigenous peoples.

Lee Brown: I believe, myself, after listening to countless Elders and also some influence from books, that there was no major illness in North America when Columbus landed here. There was no widespread endemic illness. We had rare cases of illnesses, but the illnesses were treatable and they were healable. There was no illness that could not be healed (Lee Brown’s Tape).

The memory of Indigenous peoples, through oral traditions, are long. While Indigenous people’s weren’t disease free prior to colonization, their immune systems were unprepared for the number of diverse and virulent pathogens and lifestyles, arriving with immigrating peoples. Some responsibility for the decimation of Indigenous peoples by disease and illness, must be held by contemporary societies, in a way that is inclusive of tradition-based wholistic practices, which have cured or alleviated conditions for tens of thousands of years.

Lee Brown: The type of system that we’re involved with now is good at cutting things out, very good at doing surgeries, but really can heal almost nothing. They can’t heal arthritis. They can’t heal diabetes. They can’t heal cancer. Cancer rates have gone up one-half percent for the last 100 years, per year. It’s up to almost 50 percent of the human population now is getting cancer. It was one-half of one percent in 1900. Up until about 1940, almost no Indians got cancer. It was almost unheard of for a Native person to have cancer. Now 30 to 40 percent of our population is getting cancer. So we seem to be getting sicker as a human species and I think that the Elders have a tremendous wealth of knowledge about health that if it was to come together, it would -- with the dominant system, would make all human beings healthier. As a matter of fact, I spent quite a bit of time with an Elder from Lummi, in Washington State. He said, “only when the two systems come together will we be healthy again.” The word that Isasador used was “limping.” Human beings will be limping along until the spiritual system and the physical system that Europeans understand come together, then we’ll have health. So I think that we’re positively excluded from the system. I’ve witnessed some exceptions to that and I’d like to talk about one of those, but for the most part we’re excluded from the system and that is a detraction for everybody (Lee Brown’s Tape).
Indigenous wholistic practices, like traditional-based health practices, should also be given space, for their potential to add to contemporary knowledge about health and wellness, and consequently, for their potential to cure or alleviate the pain and suffering of all peoples.

Ken Schramm: But the underlying reason for that, which has never been discussed, is biomedicine has no place to go. They have various theories on disease, but they have no theory on getting better. They always think in terms of time-limited, system-oriented, of specific interventions, and creating huge problems for community, problems that they don’t know what to do with (Ken Schramm & Daisy Heisler’s Tape).

The inclusion of Indigenous Wholism and traditional-based practices has the potential to reduce the load on the biomedically-based health care system, by providing time-tested, preventative and non-invasive health services for people in need.

Ken Schramm: The other system, the biomedical system has a monopoly by claiming that it has it all covered. People know the herbs and know the medicines, it’s just a mythology that you got to have a medical degree. It’s just something that’s been imposed, because that’s the way these guys are trained. It’s a whole religion, as a science. The other religions are much more flexible and much more interesting and much more dancing and singing. And money is more a matter of support. Just having one center like the Chinese... but if you can provide from that center, outreach groups that have their own little thing going... Just the same as Chinatown, the Chinese don’t ask you what they can do down there (Ken Schramm & Daisy Heisler’s Tape).

Indigenous wholistic practices should be given greater space in Vancouver because they are in demand, they require less resources to establish and maintain, and because biomedical institutions don’t have all the answers; maybe traditional-based practices can provide a few more answers, in ways that biomedicine has not yet understood.

Indigenous wholistic practices should be given space in Vancouver, because biomedical practices don’t always provide culturally sensitive or appropriate care. Traditional-based practices can facilitate health benefits through wholistic interventions and a greater focus on non-medical determinants of health.

E: No, they don’t ask me how I feel, they don’t ask me what’s been happening in my life, they don’t ask me...there’s no context for it. It’s just immediate. It’s just at this moment, ‘this is what we are going to do’ and they don’t connect with you. And I feel if they can’t connect with you, I can’t help them. So I knew that a traditional health system environment would actually help (Tape E).

Greater space should be given to Indigenous wholistic practices because they are comprised of entire cultural-based medical systems. The repository for both the terminology and the application of these systems is within Indigenous languages. Supporting Indigenous languages has the potential to support both Indigenous wholistic practices, and the retention of a great wealth of medical knowledge that is relatively unknown in the Mainstream.

E: Language could be part of it. We had a dream, when I was in New Westminster. Everything was percolating really well there for a while, and I was ‘ok, our next thing will be Aboriginal multicultural language centres’, so if you lived in the city and you wanted to learn or practice, or keep up on your language you could go in, put a
headphone on, and listen and talk in your language, or learn about it. I thought that would be a lot of fun. And really needed because that’s one of the needs that came out was language. I would like to learn my language, I used to speak it but I don’t speak it anymore, my Mom spoke it and I know I can understand it, but I can’t speak it. All different kinds of stories connected with [language]; as I realized that, I learn and acknowledge that this way of looking also has a language, and maybe that’s why it’s difficult to say things.

Dawn Marsden: We’re waiting for the English society, the English speaking society to come up with the terms.

E: Yes, exactly, exactly, yeah.

Dawn Marsden: System theory touches on wholism, and wholistic theory kinda touches on Indigenous holism, but it’s still not there.

E: Because... I think it’s because of the experiential thing, it’s just that you need to experience it. You need to feel... go down there, and know that there’s something that you don’t learn from a book. Sit and listen to stories...

Dawn Marsden: And have someone say, “did you hear the eagles wings?”

E: Yes.

Dawn Marsden: And have that way of seeing acknowledged.

E: Exactly. And having opportunities to be in ceremonies because in ceremonies... One time the lead dancers were coming out of Squamish Longhouse and there was this most amazing experience, and I was thinking ‘this is how we lived all the time.’ It was amazing and time changed. Connection and communication; I felt connection that you can’t put into words. And when I came home to North Van, I got in the bath and I could still smell all the smoke around me, and plus, all of a sudden I was home. I phoned up... and said ‘did you get home really quick too?’ Because it was like, it was so incredible.

Dawn Marsden: Distortion of time seems to be... well, real time is different than institutionalized time.

E: Yes. So you have to experience that to know, you need to experience... that’s what it is, traditional health.

Dawn Marsden: Yeah, places where we can acknowledge that and work with that.

Indigenous wholistic practices should be given space in Vancouver, because they reflect the worldviews of up to 77,500 people. Facilitating a sense of belonging, a sense of acceptance of all perspectives of reality is an inclusive and egalitarian stance, one that Vancouverites have espoused for generations.

**Understanding How Indigenous Wholism Works as a Healthy Worldview**

What entered into every discussion of traditional-based health services, in this project, were the words spirit, spiritual or spirituality. In all cases, spirit was used to refer to an animate and sentient force. I am confident in saying that any discussion of traditional-based health services must not only include a consideration of spirituality, but also centre on it. Talk of spirit was also associated with talk of the Creator or ancestors, but often it was discussed by itself and commonly as the unifying force behind reality.

O: I believe that it should be a universal entity force that guides us because mankind cannot do it on its own because our, on our own, when they start doing something good,
then their egos get in the way. And my ego gets in the way if I done something good, and I don’t want my ego to get in the way.

That’s the other thing, like, even, when its involving us, its seems to be, pretty much we think the same way, we can still acknowledge where traditions come from, and most of the people like you, are doing the work, are saying, and this is from our tradition, and I know you not are going to write the tradition, for my nation, but I’ll offer you this teaching and you can take it or leave it, and people, as long as they remember it, where it comes from, ancestors, teachings, and just remembering those important things, teachings, and the ego, the ego always gets in the way, fortunately that higher power has a way of pushing through our egos, reminding us (Tape O).

With the understanding of wholism, on emotional, spiritual, physical and mental levels, there comes an understanding of balance. When humans forget the importance of one or more of these aspects they tend to become unhealthy. In Indigenous wholism, the phrase “knowing who you are” is more than a discussion of your name or position in society, it refers to knowing who you are emotionally, physically, spiritually and mentally, in relationships with others. If we take care of these four domains of being, then we will “walk in balance”. This is relevant to discussions of spirit because, if we’re not in balance, then it’s harder to know who we are. The forces of spirit, or spirits or spirituality, as a core and unifying force within and around us, provide us with knowledge, teachings and insights into what’s going on around us. If we are out of balance, as the discussion about ego, above, relates, then we become less aware of those knowledges, teachings and insights. Unlike mental, physical and emotional forces around us, which are temporary and are the domain of human beings, spiritual forces are the source of our identity and reality. Walking in balance, then, means clearing the way for spiritual knowledge, teachings and insights, which in turn helps us to walk in more and more balanced and healthy ways.

Lee Brown: My sweathouse teacher, who is a Puyallup Indian, said that all healing occurs through circulation: on a physical level through the blood stream, and the emotional level through our feelings. Sickness occur when there’s a blockage in one of these areas. If there’s an emotional trauma that’s stuck in the emotional self [it will] manifest as a physical sickness. Then there’s our spiritual healing, our spiritual circulation which has to do with smudging and things that keep our spirit focused in, on moving throughout our body. And so in the mental realm, it’s being able to clear thoughts, not having secrets or things you can’t talk about, or terrible abuse that you can’t tell anybody about. That blocks the mental circulation and eventually makes a sickness in four parts of ourselves, of the medicine wheel. So healing always occurs in one of these circulations and what we need, we need a place, we need to move towards a healing centre to heal these as much as we can, which we have been doing to an amazing extent.

We have treatment centres all across the land. You know, Round Lake alone has had 7 - 8, thousand clients in the last 25 years and that’s just one of many centres. There’s been thousands of Native people that have at least attempted to enter a healing situation where they were healing themselves, so it’s actually an amazing thing that is happening already. I think there are tremendous forces moving towards this kind of thing, but it’s already started. I think we’ll get to that moment of crystallization get to that point where enough has occurred and there’ll be a huge change.

Dawn Marsden: I’m inspired. Yeah, I think things are happening pretty fast. Yeah. You just reminded me of when a pile of these healing centres -- they’ve been so
powerful amongst the communities, these people come back from the healing centres and, you know, they effect the people around them, but, also, there’s that opposite effect which is sometimes a lot of that healing is undone or, I don’t know, people are re-wounded, I guess, in their vulnerabilities. Yeah.

Lee Brown: Yeah, once that wound is there, it can always be retouched or stimulated and it’s a point of weakness and vulnerability, but the more that it’s healed, the less vulnerability there is.

Dawn Marsden: And the more the communities are healed, the more support there is for that healing?

Lee Brown: Yeah. There are some really sick people in our communities - that have been hurt or traumatized, or have hurt or traumatized others - that hold the healing back. You know, but the more the community heals, just like you said, the more healing will occur (Lee Brown’s Tape).

Knowing who we are, and thereby connecting with spirit brings us knowledge of the afterlife. As spirit operates in the physical domain, so does it operate in the non-physical domains. Some traditions, including traditional-based practices have the saying “as above, so below”. Knowing who we are, as fundamentally spiritual beings, liberates us from fears of death. While it may be the end of our physical bodies, death is not the end of who we are. On the contrary, without the distractions of living in the material world, with all its problems, we are left with an enhanced awareness of who we are, how we belong and are connected to all other beings, and how spirit interacts with physical beings and worlds.

J: When we have that strong mind and we have that focus and discipline of living a good life, a strong life, caring, kindness, sensitivity, love all those qualities that I talk about, those good thoughts, those good feelings go out into the universe and it finds who is hurting, who is sick, finds who is vulnerable, and we become healers, we become healers and it’s the same thing – thought, feeling, action. If we are strong in that way then we won’t ever hurt each other. We won’t even hurt ourselves. That is power. So when spirituality, when I hear that spirituality has no power, with the policy makers, with government, with ministers then it just tells us how poor they are. The universal truth of humanity is all the same. It’s all the same. It’s all the same. So its about denying it... Forgetting it, losing it. And that’s a very poor existence, that’s living on borrowed time. And it’s only a matter of time and they can’t see it. We see it coming. I think that reminds me of a barrier. When you can’t help but know, but it becomes too painful to look again, at what you should be doing because of the mess (Tape J).

Walking in balance and knowing who you are, as an Indigenous person in Vancouver, can be very difficult. The Vancouver mainstream, in general, does not recognize the role of spirituality in day to day functioning; it’s relegated to the churches, temples or synagogues, once or twice a week at best, or at the worst, at holiday times or never. While individuals may try to carry their teachings throughout the day, and may even enter into spiritual discussions with others, it never seriously enters the “realities” of work, business, education, policy or governance. Charters of human rights and freedoms in the western world, dictate that we cannot discriminate on the basis of gender, colour, disadvantage, political orientation, culture or religion. These have been translated to mean that we cannot create barriers or difficulties for people based on those attributes, that people have the right to equitable treatment in partaking in the opportunities of society, and that people have the freedom to pursue their own political,
cultural and religious agendas. Unfortunately, to honour these principles, to protect or prevent discrimination between religions, within policy and practice, decision makers tend to deny or ignore religion or spirituality, in any place. As the speaker infers below, this is a dangerous path.

J: ...what you were saying about spirit, about spiritual values and beliefs, as being core... but it’s not integrated into mainstream life. And so it’s speaking to that difficulty because officially, spirituality plays no role and so that’s the difficulty I see in communicating without losing integrity (Tape J).

If most religions in Vancouver are based on an identification with a sacred source, then the commonalities that arise between these religions must be integrated into the mainstream. Removing the spiritual from public life is like removing moral education from public schools. Why don’t we see the removal of political orientation in the public realm? Devoid of spiritual, mental or emotional consciousness, theories of economy and trade dominate our existence, our relationships become “just business” and our world is left, like a ship, to the winds of amoral change (more commonly referred to as “big business”). That people in positions of power are often “informally” associated with, and supported by the larger religions (Christianity, Judaism, Muslim), may prejudice decisions in favour of these major religions, but do not allow for the integration of common spiritual principles and practices.

As a wholistic “religion”, Indigenous spirituality permeates every aspect of life. Bringing discussions of spirit into day to day events, in the mainstream, is often seen as a sign of mental or emotional illness. If we, as traditional-based Indigenous people, cannot reference a major source of our knowledge and reality, without discrimination or stigma, then our knowledge and reality are being marginalized.

J: As I walk this line between because research is often in that position communicating, needs and aspirations and beliefs and the one of the critical things comes back to what you were saying about spirit, about spiritual values and beliefs and as being a core and I know you connect to that with our ceremonies and that its there and in the churches and... but it’s not integrated into mainstream life. And so it’s speaking to that difficulty because officially, spirituality plays no role and so that’s the difficulty I see in communicating without loosing integrity. You know to translate in a language even in English that has no place for spirituality. There’s a little bit of movement in health and ecological and they are saying yeah mental health is important but it is still yeah so I that’s where I am at right now even with writing, writing stories just communicating is a barrier.

Here’s a story: In terms of political, global, status, we as a First Nations people we have no political clout, globally we have no, we are without our own nation, our own land-base, or access to benefits of its resources, so we are seen as a weak people and that speaks to values and beliefs. When we talk about what our beliefs are and its effects and when we understand where in parts of the world and even here in Canada where people are tortured and beaten: not only from citizen to citizen, but we know that the police... I mean there are cases in Vancouver where police are beating people to death. Executions and torture in other parts of the world are seen as power. How far can that go when it is unchecked and unchallenged and it’s unquestioned. It’s only a matter of time before humanity just destroys itself or humanity carries on in a way that mother earth can no longer sustain life. And that’s the way humanity is going and it always comes back to beliefs and values because people behave or relate with one another according to what their value and beliefs are (Tape J).
What we do in our daily lives is intimately connected to who we think we are, how we see reality and an understanding of consequences. If we see ourselves as disconnected from the land and water, disconnected from other humans and the other beings that inhabit this planet, if we see individualized existence in this world as the pinnacle of who we are as human beings, then we are doomed to lives of isolation, irresponsibility and consequently, fear. Disconnection leads human beings to atrocious acts. In reality, we, the planet and all the other beings here are connected physically, emotionally, mentally and fundamentally, through spirit. Spirit, like our bodies, minds and emotions can influence action in the world around us, and beyond. One analogy is to view spirit like a pool of water; each of us represents a droplet within that pool. One drop can disturb the whole pool. If many drops are in movement, then we can have currents and waves that can carry other droplets along. If we can see everything as an extension of ourselves, and if we strive for balance and health in all things, then it follows that we will act responsibly and with consideration, towards those extensions of ourselves. Responsible action creates good sustainable relationships. Common sense dictates that the preservation, protection and creation of good relationships with lands, waters, plants and other beings, will facilitate the preservation of and protection of our own lives, and create good relationships within our personal contexts.

A discussion of spirit, from a traditional-based perspective, leads naturally to a discussion of relationships. Everyone knows what a relationship is. Where we differ is in the definition of a good relationship. If we consider the previous discussion, about responsible and connected actions, then we will be getting to the crux of both the strengths and challenges of intercultural relationship-building. The word “responsibility” is understood from within culturally-based contexts and is loaded with meaning. For many, responsibility means to live a life where you go to work daily, provide for dependents, protect what you’ve worked for, and try not to get into trouble. Those who don’t follow this course of action are seen as irresponsible, and often negligent or criminal. Responsibility from a traditional-based perspective means to act appropriately, now, with a consideration of all extended relationships, past, present and future. How well we do that depends upon our knowledge and our balance emotionally, spiritually, mentally and physically. To reflect these extended considerations and contexts, we can modify the above statement of a responsible life to mean a life where you work when you need to, take care of dependents when they need you to, protect what needs protecting and try not to get into trouble, unless you have to. The authority to be responsible and lead good lives is within each of us, not something to be imposed on us by others, who may not have an understanding of our specific contexts.

Understanding the Diversity of the GVRD Indigenous Population

Diversity among Indigenous peoples takes on a whole new meaning when we move beyond stereotyping, to specific Nations or Indigenous groups and beyond those, to a consideration of primary contexts, where worldviews arise. Each of us has a unique genealogy of ancestry, ancestral decisions, ancestral values and historical contexts that influence us until today. With contemporary travels and global influences, even within First Nation communities there is great diversity. Understandings of the diversity and complexity of origins, migrations and effects, within Vancouver, was reflected in the responses of the research participants. Also reflected in the responses was an understanding of the lack of this knowledge among the general population. Within an urban population of 77,500 Indigenous people, Vancouver is comprised of people from 100’s of language groups and 100’s of tribal groups. While the population may be skewed towards a greater number of British Columbian and northwest coast Indigenous
peoples, there are great numbers of people who have relocated from the central plains, the eastern woodlands and as far away as Mexico, Florida and the east coast. Within this research group alone, there were people with coastal and interior Salishan ancestries, Cherokee, Cree, Metis, Ojibway, Lakota and Mohawk ancestries.

How Indigenous people self-identify can cause more confusion among people trying to understand the diversity of Indigenous peoples in Vancouver. Factors may include whether people are from Treaty or non-Treaty First Nations, ceded or unceded territories, “Status” or “non-Status Indians”, Bill C-31 “Status Indians”, “traditional” or “non-traditional”, on-reserve or off-reserve backgrounds. All of these categories have been applied via Canadian public institutions, and are often rejected by Indigenous individuals and groups, who may prefer using Indigenous names for themselves and their Nations, or may reject any official categorization. Considering the divisive and detrimental effects of such labelling, and the lack of education about the historical and contemporary antecedents, it’s not surprising that there’s confusion.

If we look at the diversity of traditions within which people have been raised, through migrations, relocations and other influences, the breadth and depth of diversity among Indigenous peoples in Vancouver, becomes magnified. Understated in this research project, was a prevailing theory that ignorance of this diversity is a contributing factor to continuing racism and inappropriate, divisive or detrimental service design in Vancouver. Hypothetically then, the creation of greater awareness of the diversity of the Vancouver Indigenous population, among the general population, will ameliorate some of the confusion, racism and discriminatory practices within Vancouver.

**Addressing Basic Health Needs**

While chronic diseases have become the number one cause of mortality, for Canadians as a whole, accidental or violent deaths are still primary causes of mortality for Indigenous Canadians, as a whole. The effects of historical racism and assimilationist policies have been confounding influences on such statistics. Without specific amelioration, the extensive intergenerational effects of racism and assimilationist policies will continue to impact the health and educational status of Indigenous peoples in Canada, and more specifically, in Vancouver, for a long time to come.

In addition, poverty ranks as one of the strongest contributing factors to the documented inequalities in the health and education status between Canadians in general, and Indigenous peoples in particular. While we have to remember that there is great diversity within Vancouver - that there are high income, middle income and low income Indigenous people, living within every neighbourhood - we still have to take care of the group with the greatest life-threatening needs. Because of cheaper costs of living and opportunities to congregate with other Indigenous peoples, many of these at-risk, or disadvantaged people live or interact on a regular basis within the downtown core of Vancouver, and within east Vancouver neighbourhoods. Even so, with such an interconnected Indigenous community – where individuals are often related to, or interact with Indigenous people from diverse sectors of Vancouver - the chances are great that the impacts of disadvantage and inequality will affect most if not all Indigenous peoples in Vancouver, across income groups and neighbourhoods.

J When you look at the needs of the family, the needs of the community, a certain focus on the needs of the whole, and the needs of the individuals, or gender based issues for women, issues for men, and issues for youth - be it behavioural, addictions - we have needs for that and they are being met on a extreme minimal basis. You know that we have a population of First Nations people that can be anywhere from 50,000 to 70,000 at any given time and yet there are only two men’s domestic violence groups. In time, the
most that we can be dealing with is 24 men, tops, out of a potential base of 10 to 15 thousand men. And that doesn’t even begin to scratch the surface. There’s not even a bucket.

And with government shutting down women’s support services in terms of women as victims, it’s actually sickening, it’s disgusting. I look at this government... the (very minimal) support services for women as victims, it wasn’t enough to begin with, and now they are closing what little is there. It is very scary. You look at the fear that women live with, it’s overwhelming. It’s overwhelming that sense of hopelessness that women have.

I have a daughter, she’s a young woman, she’s 27 and she’s pregnant. The baby is due any day and the man just left her. And she’s been hurt by every man that she has ever been with. And I look at my baby girl and I just say ‘she wasn’t brought into this world to be hurt like that’. And soon I have to look at my sons and other men. And other parents should look at their sons and teach them how to be husbands: how to be gentle towards women. And that’s the ideal, that’s the vision is where men do not hurt women, men do not terrorize women and women don’t live in that fear. I look at my granddaughters and I wonder - the other boys that are growing up in this community - who will become their future husbands? Are they being brought up to be beaters of women? What beliefs and values are they being taught? That’s what I work for. It’s the ideal, so that my baby girls do not live in fear, grow up in fear. It doesn’t have to happen. All we have to do is support 100 more men’s groups: fully funded, fully supported, so that we could work with thousands of men a year (Tape J).

The inequalities in the health and education statuses of Indigenous peoples may seem to indicate an inherent disability, or inability to adapt to “modern” life, but this is a fallacy. Indigenous peoples have always adapted to new conditions, for tens of thousands of years. The difference now, is that Indigenous peoples are greatly disadvantaged by a lack of entry points into full participation (which means respecting, acknowledging and incorporating Indigenous worldviews, principles and practices), and a legacy of intergenerational effects of racism, assimilationist contexts and residential school abuses. Not only have the tools for healthy self-sufficiency (hunting, gathering, self-governance, self-educating, self-rationalizing, self-medicating, self-determination) been attacked for generations, but also, when Indigenous peoples are making strides to regain those tools, the intergeneration impacts of such losses, have ensured a reduced capacity to make use of them.

The basic health needs of Indigenous peoples in Vancouver are greatly confounded, maintained and reproduced by intergenerational trauma, poverty, and continuing racism and discriminatory practices. Basic health needs need to be addressed and designed specifically, with these conditions and factors in mind. Meeting the basic health needs of Indigenous peoples in Vancouver should not have the same priorities and processes as meeting the basic health needs of other Canadians. To do so is to ignore the factors that continue to maintain the inequalities between Indigenous peoples and other Canadians. Treating the same, in this case, is treating unequally.

Respecting Local First Nations

The territory that Vancouver (GVRD) has been built upon, is the territory of the Coastal Salishan Nations: The Musqueam, the Squamish, the Tsleil Waututh, the Kwikwetlem, the Katzie, the Kwantlen, the Tsawassen, and the Semiahmoo. If we don’t belong to those Nations, or if we haven’t established good relationships with the people of those Nations, then we are
strangers, and will be treated accordingly. Imagine strange people coming into your house, using your resources, deciding to stay and telling you how to live your life. After many years, a few good relationships may result naturally, by working side by side. Alternatively, after many years, there may be much misunderstanding and hostility. Misunderstanding and hostility can create further fragmentation and barriers to the well-being of everyone.

A: Yeah, so from the plains there’s Sundancers. And I know when I worked in the downtown eastside, there were people who were trying to claim their identity, to get some strength, and address some inequities. So one of the things that they were willing to do was to go to local sweats up closer to the city. But in other places, having access to a sweat lodge is a kind of overall wellness model. That could be a weekly or monthly thing, but sooner or later people would want to use that ceremony as part of the bigger ceremony, wellness, and keeping the tradition going: like Sundancing. And those are usually farther away, so people don’t usually have money to get there. So if there was a bus going, or some sort of provision if people wanted to go. But that would take four years, generally, so you would have to have options to go to other places, or to even have one sponsored. And start to develop relations with the Squamish people. That would be ideal so that there is more connection to urban North Vancouver (Tape A).

The onus is on the newcomers to understand their status in this land, to initiate new relationships on better foundations, on foundations that acknowledge and respect the long-standing sovereignty of Coast Salish peoples in this territory. For both Indigenous and non-Indigenous newcomers, this is vital to the establishment of more beneficial relationships, projects and services, because it ensures that any new actions are under the guidance of local traditional knowledge keepers, who have great wisdom about the potential consequences and benefits of change, to all the peoples, lands, waters and beings in this territory. While newcomers may have new ideas, new roles and new gifts to offer, these must be integrated harmoniously. Creating good relationships, between agencies, projects or peoples, and the peoples of the Coast Salish Nations, is a right, an obligation, is respectful, wise and a powerful force for proactive change, for Indigenous peoples in Vancouver. If all 77,500 urban Indigenous people (GVRD: Statistics Canada, 2005a, b; Fraser Health Authority, 1996) worked together to support and create good relationships with Coast Salish peoples, as the caretakers and hosts of this land, then it would follow, through obligation and responsibility, that the health needs of both Coast Salish and urban Indigenous peoples would be taken care of, without competition or fragmentation. Figure 8 represents the recognition of Coast Salish sovereignty in the GVRD.

Figure 8. Recognizing Coast Salish Sovereignty

force for proactive change, for Indigenous peoples in Vancouver. If all 77,500 urban Indigenous people (GVRD: Statistics Canada, 2005a, b; Fraser Health Authority, 1996) worked together to support and create good relationships with Coast Salish peoples, as the caretakers and hosts of this land, then it would follow, through obligation and responsibility, that the health needs of both Coast Salish and urban Indigenous peoples would be taken care of, without competition or fragmentation. Figure 8 represents the recognition of Coast Salish sovereignty in the GVRD.
Strengthening Urban Indigenous Governance

J: Yeah, those are some barriers, constraints that are put there by other people: the effects of oppression, past and present. And also what we as Native people put out there in isolating ourselves: not going out in the world, and not only challenging the world, but challenging ourselves. You know... the life's obstacles and barriers and challenges that we put, or that we allow to defeat us, or where our people just give up too easily. We need to be stronger in that way. I would always look at answers within, and people do need to support each other, and work together and what we refer to as (not-sumat) which is one mind, one heart. And you know we had that at one time: where we worked as a community and everyone supported one another, everyone had a role. And everyone’s role was valued. No one’s role was seen as more important than the other or superior or inferior or whatever. Every role was crucial to the well being of the community of the people so...

And that’s what we need to go back to. Our uniqueness as a people, staying together as a people, growing as a people, doing it together. We’ve been spinning our wheels for such a long, long time now that it’s time for us to start to accept that we are a part of a global community now, and learn to become a part of it, or take or use the best qualities of it, and use it to help our people. I’m always reminded of what the late Chief Dan George said, that ‘our people will pick up the tools of the rest of the world, like a rising thunderbird out of the ocean we’ll stand up once in a while’, that always inspires me (Tape J).

What the Indigenous community in Vancouver needs is a collaborative, cohesively organized and streamlined Indigenous framework for the governance, management, and distribution of services for Indigenous peoples in the GVRD. Without such a framework, services continue to be fragmented, duplicated, short-term, competitive, and porous; providing for no services in some areas, inappropriate ones in some, and over-servicing in others. A cohesive framework would require a unifying vision that the community could commit to, and a dynamic and flexible process for implementing strategies and services, appropriately, as determined by the both the agencies that provide services, in collaboration with the greater Indigenous community.

This is controversial because the bulk of funding and services for off-reserve Indigenous peoples in Vancouver remain predominately under the control of non-Indigenous institutions, are applied without much consultation, and use non-Indigenous frameworks, which do not differentiate between the needs of Indigenous peoples and the needs of other Canadians. While devolution has been considered and attempted in Vancouver on a service level (e.g. Vancouver Native Health) there has been no cohesive framework in place, or greater community involvement, or adequate commitment, to enable its implementation on a wide scale. In the past, the imposition of such frameworks by non-Indigenous agencies, or by partisan groups have never succeeded, because they have not been inclusive, nor representative, of the diverse needs and backgrounds of Indigenous peoples in Vancouver. The development of such a framework will only succeed if given the flexibility for lengthy respectful deliberation, to ensure the participation and inclusion of all Indigenous peoples within Vancouver, and to enable identification with the framework as Indigenous-appropriate.

J: Who’s gonna guide us? Who’s gonna direct us? The Elders of today training the Elders of tomorrow, but the Elders of tomorrow, learning to stick together that is when we will be able to...
Dawn Marsden: Recognizing each other.

J: Yeah, and being able to identify the people's needs. But how about identifying the people who can meet those needs? We need our healers. We need our educators. We need our hunters. We need our artists. We need you know, traditional-based. We also need our doctors. We need our lawyers. We need our engineers. We need our educators. We need our construction workers. So you know, we have two roles in life that we need to take on: traditional, and modern. And people's qualities or strengths need to be identified as they grow....

For myself, don't even think about giving me a hammer and saw, I'll wreck anything I try to build right. I'm a people person, I can work with people, I can talk, I can heal in certain ways. But those are my qualities. Another person can just love working with their hands, they love constructing or whatever. But identifying those duel roles: traditional way and modern world, identifying those needs, but also identifying those qualities. Those needs are only going to be met by the people who have those qualities, and enhance those qualities, support them. I look at my grandchildren and I see one loves writing. The other one just loves numbers and the other is into sports, another plays music. Those are their qualities. And they are going to be raised according to those but they are also going to be challenged in other ways. They are not just going to be limited to certain things. So it's not only about enhancing qualities but challenging them on others.

I've mentioned that we are born with gifts, and identifying them in both worlds... There's a story about that was passed on to me about an old Siem, which is an old chief; even that word 'chief' to my understanding was a military ranking of the Roman Empire, and so how appropriate is that? We have an old Siem who was doing what we talked about, looking for the qualities in his children; and he found that quality through a test. So that quality came out, and the people who were tested didn't realize the qualities that they had. So we look at the qualities.

It's like what I said, understanding and knowing what the people's needs are and seeing that those people's needs are met and that the people learn to work together and value each other and not in terms of hierarchy or power or esteem or whatever but that everyone is valued equally. And so the gift of leadership...

Even that word leadership... what is a leader? Is a leader someone who has a group of people following them? That's one, that's a definition but there are other [definitions of leadership]: the prime minister, the premier, the mayor, a council member whatever, but we also look at ourselves as individuals. I'm the leader of my own life. I've made choices that have helped me in the life that I lead and I've made choices that have hurt me. I used to abuse myself with alcohol and drugs; that was a choice. I led myself to that, and then I got tired of it and chose to lead my life in another way, free of alcohol and drugs and my life has improved, to say the least. At least I know what I am feeling is real. And I'm a leader of my own life and there is nothing stopping me from leading my way back into a bar or liquor store or finding a drug dealer or whatever. I could find a drug dealer within 15 minutes if I want, but I choose to lead my life in a different way.

The speaker above has given us a great example of an Indigenous-appropriate framework for the organization and inclusion of diverse community capacities. It is an egalitarian framework, where each person has a voice, where gifts and wisdom are acknowledged, where each person can contribute their strengths, and which exemplifies a belief in the internal versus external locus of responsibility in decision making.
This is a model of leadership where, instead of leading from above – as in most Canadian institutions – leadership is supported or denied from below, at the level of community. Leaders are the chosen voices for community-based decisions; the locus of control remains within the hands and hearts of the people, whom the leaders choose to serve. Under such a framework, people aren’t isolated or excluded with categories and criteria, people involve themselves in whatever projects they are passionate about, according to their own abilities and interests. While funding might be slim, the skills and talents of Indigenous Vancouverites are many and underutilized. Many people are ready and willing to contribute their time, skills and services, regardless of the level or presence of a salary, but are stymied by existing frameworks.

Once an enabling framework is in place, many leaders can emerge or can be chosen by the community to lead. Focused changes, and distribution of funding and resources, would naturally follow the inclusion, organization and development of this skilled and motivated workforce, where everyone’s contributions would be rewarded, and where each family’s needs would be provided for, as appropriate. The most effective way of setting this up, as the Ojibway/Mohawk visionary, Millie McComber, has challenged, would be to restore systems that are still functioning strongly in Vancouver: family networks, clans and historical relationships. This would be a contemporary version of a traditional-based Indigenous governance system, situated under new conditions, but based on thousands of years of experience. It’s a system that is sustainable, time tested and most importantly, it works. How such a framework might exist within Coast Salish territory is represented in Figure 9.

Figure 9. Urban Indigenous Governance Framework, in Alignment with Coast Salish Nations

Establishing Sacred Sites

Lee Brown: I remember talking to one Elder woman, I can’t remember her name. That was many years ago when I was young and she was a healer. I was going to see her and not for myself but for someone else who was seeking healing and she was just getting ready to go into the mountains and she, herself, said that she healed for three months and then she went into the mountains for three months, and it was that tie to the land. When she came down out of the mountains and did healing, it was very strong at first, but the longer she stayed away from the land, living in a house kind of setting, the weaker it felt, you know.
So you see how people that live in the city for 15 years and they’ve never been out of the city, you know, how...
Dawn Marsden: Totally disconnected.
Lee Brown: They become disconnected (Lee Brown’s Tape).

Considerations for doing traditional-based healing work in Vancouver, often involved discussions of the lack of healthy or sacred sites for practice. For some, traditional-based practices – in the city – is an oxymoron, and one of the biggest critiques regarding traditional-based practices in the cities. How can you provide traditional-based services in the city when traditional-based requires connecting with specific lands, waters and other beings? The response by some, is that people get out of the city, periodically, to connect with these sacred sites and beings.

Lee Brown: There’s two - there’s many things - but two main things that make healing in an urban area difficult. One is that it’s not a wide-based community of support. Although, sometimes there’s community organisations, like clubs and associations and friendship centres, that almost recreate a tribal community setting, where you can get support. The other thing that makes it different is that all our traditional healing systems are tied to the land and they’re tied to the land of where they come from originally. And sometimes people in urban centres are not where they’re from originally, so they have to make adaptations. And these adaptations, I think, can weaken the process (Lee Brown’s Tape).

Another response to the critique of ineffectuality, is that, while they may be trampled, buried or unprotected, there are and will always be sacred sites and beings in Vancouver. Known ceremonial sites at Jericho and Stanley Park, on the North Shore, at various lakes, inlets and waterways are a testament to our reliance upon and relationship with the lands, waters and beings of these territories. Rather than making adaptations to unhealthy city structures and processes, people can heal in traditional ways, in a bigger sense, by cleansing and reestablishing those connections, relationships and responsibilities to local lands, waters and beings within the boundaries of the Greater Vancouver Regional District.

Dawn Marsden: Do you think that there’s anything about being in the city that’s different than in the country?”
Doreen Sinclair/White Cloud Woman (Anishnaabe): Well I find working in the city is harder to have private sessions. You go into an apartment, [with other] apartment dwellers, so it’s hard to have private sessions unless you have an office base or someplace where you can do private work, and I find that hard. Especially if you want somebody to start crying and screaming and carrying on and getting rid of something. Yeah, or even singing. Yeah, I find that hard. So I guess that’s the difference between being in a house and all by yourself, or in the country. You can make all the noise you want.
‘Cause when I worked in the Cariboo, I remember working with this one woman. What I had her do… She had a pillow, and she was screaming into it and that was so powerful. I’ll never forget that. And I can’t remember how that came about but I remember the incident. You can’t see us doing that in the city (laughter).
Dawn Marsden: Yeah, Yeah I haven’t done a whole lot of singing for that reason cause I don’t want to bother my neighbors, or get the cops called on me.”
Doreen Sinclair/White Cloud Woman: That’s right, yeah. And when I do my pipe - I live in a condo down by the Fraser River - when I sing my songs, and drum, you know I don’t sing as loud as if I’m out at UBC or out at the sweat, or in a house. You don’t sing as loud, because of that. And you know we shouldn’t be like that when I’m thinking of that, because we’re not disturbing anybody really. It’s our own, it’s our own…

Dawn Marsden: Care of others’ beliefs?
Doreen Sinclair/White Cloud Woman: Yeah, somebody else’s beliefs, yeah.
Dawn Marsden: Well… and with good reason.
Doreen Sinclair/White Cloud Woman: Yeah otherwise we’ll have 10 complaints (laughs). So that’s one of the downsides (Doreen Sinclair/White Cloud Woman’s Tape).

Indigenous traditional-based health services, centred on spirituality, require the same kinds of sites for facilitating the healing and re-balancing of individuals and, more commonly, groups, as those historically used by Euro-Canadians (sacred groves, bodies of water, temples, caves, churches). In cities, with such high population densities and such diverse criteria for good relationship, it has been difficult for Indigenous peoples to practice outside, or even inside, without upsetting the neighbours or the status quo, or legislation around acceptable practices. While the tolerance of Indigenous practices is low at best, it may be enhanced through increased awareness and advocacy within public institutions (eg police, health, parks and educational institutions). Regardless of the processes, these self-determining processes must be supported by Canadian citizens and institutions, as has been promised through treaty, law and constitution.

While many sites for healing have been buried under the cement, or pollution of Vancouver, many, especially in the surrounding areas, are still intact. As the above speakers suggest, traditional healing practices are tied to the lands from which we and our ancestors have come from. These considerations make it especially important to establish relationships with the caretakers of Vancouver spaces, the peoples of the Coast Salish Nations, to ensure that the integrity of sacred places are maintained, and, through good relationship, facilitate the connections necessary for traditional-based healing practices.

E: Yes, it’s so different, I just keep looking, trying to find that place I go to that… White Rock beach, ’cause that never changes. All the beautiful houses up on the bluff and everything, but it’s one of the few places that’s not changing. I walk down there and my sons we walk down there, and the ones that live in Alberta, they come and we walk down there. It’s so, it reminds me how things used to be, because… and I was thinking about that relationship with certain places that never change. There might be a storm, trees might fall down and different things or there might be a flood, the river might have a little bit different route, but our memories were connected with things that were in the land and that’s really difficult now because you go back and see that it’s all developed. It’s changed. New houses, and it’s hard to find anything that was there before.

C: It’s kind of like a symptom of barriers, constraints that get in the way of traditional based health services: places, sacred places, sacred journeys.

E: Exactly, that’s what I put down, the point. When I read it [the research question], I thought “location.” That barrier and constraint to access and provision in Vancouver could be location (E’s Tape).

Both common sense and tradition suggest that if a place is in turmoil, physically, mentally, emotionally and especially spiritually, then it would not be a good place to practice traditionally-based health services. Contemporary biomedicine has confirmed the effects of stressors like noise, pollution, pathogens and the numerous behaviours and chemicals that
humans exude when excited, aggressive, angry, scared, in pain and a host of other conditions. If what both tradition and science say is true, then parts of Vancouver, where the population and stressors are high, must be particularly unhealthy places to live or work. If spirituality is the appropriate base for traditional-based health services in Vancouver, then space has to be “made healthy” or “cleansed” on a regular basis to protect it from unbalancing influences, and to provide space for sacred or traditional-based practices. The ideal would be to establish sites outside of the downtown core, with lots of green space, but accessible by bus or local transport.

Some consideration was given to how to ensure that a space is protected. As the speakers below discuss, having title, or owning the land you wish to practice on, is the best way to protect sacred spaces from toxic influences.

Daisy Heisler: Well there’s that sort of thing, if given land, it’s yours to do, rather than rented land.
Ken Schramm: You have the right to keep people away who aren’t ready to deal with sacred spaces (Ken Schramm & Daisy Heisler’s Tape).

With this in mind, supporting or assisting Coast Salish claims to surrounding territories, or to sacred spaces might enable the respectful establishment and protection of sites for practice. If lands not under contention can be purchased, for the establishment of traditional-based practices, then these too can be incorporated into a cohesive system of urban governance and relationship.

While it may be hard to re-establish, create, maintain or protect sacred sites, they must be established, maintained and protected, for the well-being of the Vancouver Indigenous population, as well as the non-Indigenous population.

Lee Brown: It’s all connected to some land, somewhere. I know in Oklahoma, there are certain ceremonies... people travel hundreds of miles to get just the earth of where that ceremony comes from, take it to the ceremony and when the ceremony’s over, take the earth back and put it where it was before. So it’s tied to the earth. You know, the ceremonies are tied to the earth. They’re tied to herbs or plants or medicines that come from the earth, and that tie is very important. So in an urban area, which is covered with concrete - the Hopis call cities ‘prairies of stone’ - when it’s ‘prairies of stone’, it’s very hard to maintain that connection to the land.
Dawn Marsden: Some people have talked about the creation of sacred space or the reclamation of sacred areas within and around urban areas.
Lee Brown: Yeah.
Dawn Marsden: Do you think that’s ...
Lee Brown: Very important. That’s very important. We need those places here. That’s exactly why we need them. We need a place to regenerate ourselves, even just one day out of... Even here at the longhouse, like coming to a sweat. It’s regenerating because it’s kind of in a sacred space, and it can really help, you know, to maintain that power [that connection with] the mountains.
Dawn Marsden: Right, so maintaining the relationships?
Lee Brown: Relationship with the land, and the water, air and fire. There’s four things that bring healing into a ceremony, earth, water, air and fire. Every person that does healing has to use at least one of those elements. There’s something that comes from all of them.
Dawn Marsden: Right, so all those things would have to be considered in the creation of a space?
Lee Brown: I think so, yeah. I think that thing, at Manitoulin Island, that we were talking about earlier, that they had an actual fire going, that’s really important. The meaning of a fire is a big part of it and you need a fire if you are doing something (Lee Brown’s Tape).

Establishing sacred space, or space for traditional-based practices then, means establishing space for re-connecting with all domains of our reality, and our being: earth, air, fire, water; mental, emotional, physical and spiritual. Keeping these spaces healthy and balanced requires the establishment of good protections and good relationships with and around these spaces, and with the Coast Salish peoples whose territories they are located in.

Respecting Intellectual Property

E: Now I’m thinking “what is the difference between traditional and traditional-based” so I got to thinking about that and traditional is about original and in my mind I got that traditional is the way that things have always been done and it’s knowledge that ... connected like that, and that people have learnt, have been shared, taught it by someone who knew it before. So they are Aboriginal health systems that had those knowledgeable people, taught in that traditional way (Tape E).

Knowledge always comes from somewhere, and to be respectful, responsible and accountable about that fact, we are obligated to reference that knowledge when we use it publicly. Where knowledge comes from is intimately tied to specific people, under specific conditions, in specific communities, in specific territories.

Knowledge arises from the direct experience of individuals in community. When it is shared, it enters community awareness, where it is acknowledged, tested, modified, rejected, accepted, and/or instituted. How that plays out depends upon the territory, culture, worldview and traditions. Rules around communally shared knowledge determine who can carry it, who can apply it and who can pass it on, to whom. In the next few paragraphs, some of the intricacies of the rules around communal knowledges are exemplified, by using an example of singing and drumming, which is often used in traditional-based practices.

Besides bringing us together, in many senses, singing and drumming plays historical, documentary and formal roles. People sing and play the songs that have come to them in their dreams or ceremonies, or that have been passed on to them by their relations, for specific reasons and for specific purposes, and according to specific rules. Songs inhabit private, communal and public domains and must be treated accordingly. Individuals, families, clans and Nations have their own songs. In the communal domain, songs can be sung and/or drummed, at appropriate occasions, by anyone in that specific community. Other communal songs can be sung and/or drummed by anyone in a specific Nation, and still others can be sung and/or drummed by people from other Nations. The principle here is that if one obtained the right to sing and/or drum a song, it must be done in a way that is appropriate and that is respectful of the songs’ lineage. Beyond “singing to one’s self”, a person can’t just decide to use someone else’s song in a public way, or worse, to claim it as their own; it would be inappropriate, disrespectful and show ignorance of the importance of relationship (Marsden, 2003 course paper).

A convenient illusion in today’s world, in a world where knowledge means power, wealth and privilege, is that communally held knowledge, once it enters the public domain, is up for
grabs. People, or the businesses they run, can claim knowledge, develop it, change it, patent it, and make money of it, as long as there are no prior, official claims, by individuals or companies, until the patent expires. While many beneficial things have been developed through both responsible and irresponsible uses of traditional knowledge, the fact remains that the protections aren’t yet strong enough to ensure that Indigenous peoples maintain control over their communal knowledge, for the benefit of future generations. Hence, this current system of temporary ownership is unethical and socially irresponsible towards people with collective knowledge systems, because it doesn’t address the concept of communally-held, shared and developed knowledges, or intergenerational inheritances of those knowledges.

Traditional-based Indigenous knowledges are especially threatened by current intellectual property practices, which are based in a worldview that revere the individual. Documenting or displaying traditional-based practices is especially dangerous because of the potential for theft and patenting of ideas. As an example, the use of herbal remedies may be witnessed and later developed or patented for individual profit; it’s then within the right of the new owner to initiate sanctions, fines or punishments on a traditional-based practitioner, or the person they learned from, for applying the herbal remedy. While this may seem ludicrous, it’s already being attempted within the regulation of “food supplements”, and within the pharmaceutical industry (Volpe, 1998; Department of Health, 2003).

Another danger, is that sacred items, practices or processes can be profaned by their inappropriate use, by unscrupulous people. While such profanement may not have any impact on the spiritual domain – like racism – it may have very real impacts on Indigenous peoples, in the physical, emotional and mental domains. Imagine the impact of patenting ‘holy communion bread’, or ‘sacramental wine’ upon practicing Christians. Knowledges that are directly related to the well-being of people - like concepts of identity, religion or health practices – have the potential for highly negative impacts upon people.

As well as emotionally and mentally, we have already seen the economic impact of the appropriation of cultural art forms by sports teams, t-shirt companies, and other designers, upon the well-being of Indigenous artists. Where some countries are combating these forms of capitalizing on intellectual property, by creating ‘authentic’ labeling systems, or by bringing law suits to the table, the damage continues.

Cognizant of these dangers to traditional knowledge, many of the participants in this research project expressed that it “was time” to bring traditional-based health practices into the public domain, that it was time to move from secrecy, to healing our relationships within mainstream society, to create more health service options for Indigenous peoples in Vancouver. How this can be done, in a way that protects traditional knowledge, has been implied elsewhere in this document, through participant discussions of the establishment of appropriate understandings, relationships, agreements, protocols, structures and processes.
Chapter 5 Strategizing at the Institutional Level: Health-Education Services

How can traditional-based health-education services be enhanced at the institutional level?

Making Institutions Indigenous-Friendly

Dawn Marsden: That gets into our next one, which is ‘what facilitates or supports access and provision of traditional based health services?’ You mentioned creating a space where you feel comfortable. We talked about finding sacred places, places that don’t change...

E: Right and places that are run by Aboriginal people. I was just thinking about the Native Education Centre and how wonderful... I loved it there, when ___ was there, and when it was really being managed by Aboriginal people and the struggle. Aboriginal organizations... I think they provide, and the people in them provide the access... I’m thinking of the Institute of Indigenous Governance... And so, you go into those places and ‘oh, Aboriginal, ok, this is great.’ Like the Native Education Centre, but I don’t go there anymore; I used to. And I was hoping that the Institute for Aboriginal Health will eventually be something like that. And the [UBC] Longhouse, that’s another wonderful place. That’s a very small number of places isn’t it?

We worked so hard in New Westminster to start that center there. There just needed to be a place that... If you lived in an apartment in an urban setting, when you walked out of your apartment, and you needed to go somewhere: at least one place where you could go and just be: ‘this is me’. Everything, what’s on the wall, how people are interacting, ‘this is me’ because everywhere else you went reflected a different way, reflected a European base, perspective and value system. Every urban community should have a place where Aboriginal people can go.

[Funding] had never been used for Aboriginal programs because it kept being filtered into non-Aboriginal programs: saying that ‘we’re providing these programs’. And so we said ‘I’m sorry but when an Aboriginal person goes by into the office, and there’s nothing in there that reflects, not the staff, not the programs, not the setting, nothing reflects who they are so they’re not going to stay’. So for me, it’s Aboriginal ways (Tape E).

As this speaker suggests, making health-education services Indigenous-friendly means creating processes for appropriate application of funding, the hiring of Indigenous personnel, the facilitation of Indigenous identification with the space, services and personnel, the creation of a sense of community, and the inclusion of Indigenous people at the design and management level. Some of these ideas were and are expanded upon further, in the following sections.

Being of Good Service

B: Downtown I have one person I know who has an eagle feather and it just sits on her desk and I’ve said to her, ‘you know, you need to take care of that eagle feather, it’s medicine. You leave it out and it picks up everyone’s energy’. She hasn’t been around it, so I said ‘I’ll make you an eagle feather case and show you how to cleanse it and to take care of it’. It sits there, and she works with our Aboriginal people and there’s no honour anymore. No acknowledgement of how we are as a people and what those eagle feathers mean to us. What medicines mean to us.
I'm constantly calling on people down at Oppenheimer Park. They'll get donations for food and they'll put it out, just in boxes, just outside the door, and I'll say 'have a bun, would you like a bun?' And I'll ask the staff members and say 'what makes you think the people want to eat that? You take some time and wrap it and set it out in an honouring way, respectfully, right? (Gathering Tape 3).

What is culturally sensitive, or culturally appropriate? In an international setting like Vancouver, it comes down to common values of respect and good relationship. This means taking the time to recognize and make space for different ways of doing things, and for treating people like valuable members of the community, even if it shaves a few minutes, or hours off the schedule.

B: As the years pass, there's so many things that come up. Within the Young Bear's Lodge, I always call in someone that I really respect and I sit with them. Robert Nahanee from the Change of Seasons Society and I, we talk. He helps me with spiritual protocols. We have workshops with the staff members called “One Heart One Mind” because I have a lot of non-Aboriginal staff members. And to be able to get them to a place of cultural sensitivity. I feel as though it's all of our responsibilities, sort of, to bring people's attention to cultural sensitivity (Gathering Tape 3).

If that's too ambiguous, and if in doubt about how to proceed; ask for guidance from traditional-based Indigenous health practitioners, or other traditional knowledge holders. For example, when asking “how can I make these meetings more comfortable”, you might get the response “sit in a circle, invite everyone to introduce themselves, provide food, and have breaks”, or maybe “invite people to bring their families for support”. The most important distinction between welcoming and unwelcoming services, is how services are implemented. You could have identical services, but the agency that pays attention to clients as people first, then as having diverse histories and cultures, will be the most effective.

Oldhands: Why does it have to be so quiet? To me, we had a young man here who was given the wrong meds over at the hospital and went into a diabetic coma. And I went over there, and they said 'he can't hear you'. But I knew he could hear me, because when I started talking to him – ‘don’t worry about it, we’re going to help you’ - and tears started coming out, and I knew he was there. So we brought the big drum in. I had to carry it in. And they said they’d give us ‘one room, there’. And ‘naw’. We sang, we reverberated through the halls, there. Nurses came in and said ‘keep it down’. ‘Ok we will.’ But we didn’t, cause we wanted him to hear it. And I’m sure the nurses weren’t too happy with us that day. But everybody... when we came through there, all the other people in critical condition said they thought it was the most powerful thing that they’d experienced. I thought they were going to start yelling at us: ‘oh you don’t know how much that helped my daughter... my son over here.’ It just lifted them right up. Sure, because it was total quiet, like ‘what’s going on?’ They need that aspect to... Dawn Marsden: Wake up their spirit?

Oldhands: Wake up their spirit, yeah, so when he finally did pass, in his passing he performed a miracle. He brought that big Sundance drum into the hospital. I said maybe he went, but for someone in there, it might have been just enough to bring him back. So I said ‘someone who’s out there in that death experience... be out there!’ I think it’s part of honouring human life, right. Some dignity to passing over rather than just... like when my mother wanted to punish me ‘go to your room’: no radio, no T.V. And you’re
just sitting there in total silence; that’s a killer. But if you’re gonna die, why do you have
to have total silence? It’s like you’re being punished. ‘You’re being punished for being
sick, right? ‘That’s bad.’ Gotta change that, gotta feel alive, like you had a purpose.
Gonna be anxious to go home, to meet with your relatives. At least they’d go in a good
way (Oldhand’s Tape).

For many Indigenous people, the transition from the spiritual realm to this one – at birth –
and the transition from this realm to the spiritual one – at death – is an important time for the
well-being of the person making the journey, and the people that surround them. For some, both
are about leaving things behind, and embarking on a new journey, in a good way. The
involvement of family and those who can help in the transition, through ceremony, songs or
prayers, is especially important, for the continuing well-being of all. Acknowledging the
importance of such transitions, and making room for such practices is critical in making health
services more Indigenous friendly.

**Prioritizing Relationships over Rules**

B: As long as we can continue with that same base that we have with Native Health,
where you don’t have to worry about having a heart, then you can have that, you can sell
the system (Tape B).

In a society where standardized procedure “is akin to godliness”, Indigenous values of
respect and good relationship, are sometimes undervalued or trivialized next to the officious
workings of big institutions like clinics, hospitals, and universities. People are “lost in the
shuffle”. The need for accountability has been well documented. Unfortunately, the flip side of
accounting for every minute, action, or word, is that it can result in the dehumanization of
agency processes. There’s a fine balance between meeting the needs of the people, and ensuring
that everything is transparent and above board.

Ken Schramm: And having worked with _____, I mean that was just a building
with cement around it, and rows of chairs for people to sit on, not even a place to have a
cup of tea.

Dawn Marsden: more like a welfare office.

Daisy Heisler: Oh, it’s awful, I had to get out of there. I was told. I got up from
my desk to open a door, a very heavy door for someone in a wheelchair. The other
person at the other desk complained that I had left the front desk. When I tried to
explain to the administration, I was told ‘you’re not here to be a good samaritan’. ‘Oh,
that’s clear, I’m leaving now’. That was it, they just did too much. And that was the
crowning; ‘I’ve gotta get out of here, I’m with the wrong people’.

Dawn Marsden: Yeah, yeah, I’ve seen that happen; and people who are working
in that environment get sicker, get bitter, if it’s a sick place.

Daisy Heisler: I don’t know how they will ever fix it.

Ken Schramm: It was called a community health centre clinic, but I didn’t see
anything community. ...built on a grand idea (Ken Schramm & Daisy Heisler’s Tape).

While there’s a need to follow laws, regulations, policies, and guidelines, to ensure good
and focused practice, sometimes situations have not been accounted for. Adaptations which
stretch the policies and guidelines must be incorporated, until that time that the policies and
guidelines, or even regulations and laws are updated. This is particularly the case in Vancouver,
where laws, regulations, policies, and guidelines have been designed, primarily, without the involvement of Indigenous peoples. Until that time that policies and guidelines can be updated, there must be some flexibility to allow for Indigenous-specific enhancements to the status quo.

**Getting Away From Experts**

Oldhands: That’s like... Here we have - how many programs throughout Canada that are researching residential abuse? Right. What about helping them in the releasing part of it? Why spend all the money on [finding out what happened]. You know it happened. How many research [projects] do you have to have, to get the same information? Ok, we know it happened, it’s still happening in other ways. Right. What are we going to do about it?

Dawn Marsden: Yeah, I see that a lot. Ok, let’s talk about residential schools. It would be ‘good for us’. But does the group stay there? And there’s no assistance, no guidance no direction to move out of that. And I think that that’s making some people even sicker. People already know.

Oldhands: Yeah, because what happens is, if you went to therapy for counseling for 20 years to get over what happened to you, then all of a sudden we got this money to find out what happened to you, and you know you got people coming, and you got to tell it all over again; it comes all flooding right back and the next thing you know ‘oh jeez, I’m still hurt’. And when that person leaves they feel like a scab came off and there’s no part after that. Let’s put the money to the after part; we already know what happened. It’s correctable. I know people say, ‘is there any amount of money?’ ‘Ok, here’s a cheque for you.’ ‘Wow, you know it doesn’t bother me anymore.’ I don’t think so. Right. Cause you could burn up all this money and [not be healed]. I’m old school (Oldhand’s Tape).

For generations, Indigenous people have been studied or approached by so-called experts, who have been mandated with documenting or addressing the concerns of mainstream Canadians. While some documentation and interventions have been beneficial for Indigenous peoples, or at least had good motives, some has contributed to the misrepresentation or appropriation of traditional knowledge, and to the continuing oppression of Indigenous peoples through the imposition of inappropriate policies, funding, programs, processes, categories or stereotypes.

In a post-modern world, the very concept of experts is being questioned by community members and academics alike. How can someone understand anything about Indigenous people, unless they have a good understanding of relevant locally specific, historical and contemporary contexts, issues and innovations? While border workers and Indigenous allies may fall into this category, the quality of the work is still suspect, without the understanding that comes with identification and lived experience. In the end, people are only experts of their own experiences and perspectives, and it becomes inappropriate to deem anyone, especially an outsider, an expert.

B: So again, about processes in relationships, that’s what keeps coming up. It’s not about somebody who does this or that, it’s about someone who does things, in this way. And getting away from the idea of being the expert. I believe we are all the experts, of our own. You know at the end of the day, I’m by myself with the decisions I’ve made, with the interactions I’ve had, and with the direction my life has gone. At the end of the day I have only myself to sit with, and my Creator to say ‘okay, am I on the right track?’ And if I don’t believe in nothing else, and I believe you have the answer, then I’m going
to be lost because you're not always going to be there. And if I'm looking at you to be the expert and it's not working I think ah...

Dawn Marsden: It's my fault.

B: And so we have to really get out of that mindset that there are experts. People are getting rich at being the experts. All they are experts of, is their own experiences, and what’s worked for themselves, so they can give suggestions right? And those are awesome suggestions, but there’s other ways of doing stuff. Maybe I can take a little bit of that, and a little bit of this, and put my own stuff in there, and get something. But getting people to that place that’s empowering them, letting them be.

Dawn Marsden: Not all on your shoulders.

B: Not all alone. And there’s safety in numbers, but there’s a larger voice. When someone says, ‘she’s the expert’, I think, ‘oh my god I’m not the expert on anything, I know a little bit about a lot of things.’

As the above speaker mentions, the maintenance of a hierarchy of knowledge, through the establishment of “experts”, can be disempowering. If we are taught that only the experts, or the authorities have all the answers, then we are being taught to become dependent. The locus of control and responsibility is placed outside ourselves, and we can become as complacent, or as irritable as unhappy children. Empowering research recognizes that everyone is an expert, and places the locus of control and responsibility back into the hands of individuals, families and communities.

M: When I shared my story at the Edmonton conference, I said, ‘oh, my God, all these Elders are sitting in the front. I wonder what kind of story they're waiting for.’ And the kind of story they were waiting for is ‘what’s it like for you to live in the modern days? How many of you just get lost in the system?’ I went up to one elder at the naming, and she was sitting there all by herself, and I saw that her eyes just travelled far away and I went up to her and I said, ‘lots of big changes, eh?’ And that almost made her cry. And I said, ‘I have a hard time with new changes too.’ And she says, ‘but you are so young, how do you know all that?’ And I said, ‘you know, I am going onto 50 years old and I seen the changes. It’s really hard.’

And I said, ‘my great Grandfather was a Chief and he was also a medicine doctor and he had gatherings every October, every year, and all the old people of Canada came every year for two weeks and told old stories and teased each other, and it’s not like that anymore.’ She says, ‘oh, it’s a good thing there’s somebody else sharing that.’ She just grabbed my hand right away and the tears were just welling up in my eyes. I was able to know how she was feeling inside because that’s the way I felt, and it's hard. It’s not easy.

And I started with my story last Wednesday. I said so many people see Elders and ask them ‘how are they’. I said,‘they’ll probably give you a bit of a story, and maybe you might not even get one, but if they feel, if they know that you are a very compassionate person, and able to see where they come from, they will tell you the whole story, but probably a little at a time.’ By the time I finished my story, I just said, ‘All My Relations,’ and was going to sit down, [but] all these elders were lined up to give me a big hug. Yeah. They said, ‘thank you for sharing that story. It helps me to heal inside, too.’ And I said, ‘it helps me to heal a little bit more too.’ I said, ‘I get really lonely too, you know,’ and they say ‘we can see that,’ and their eyes were just full of tears. I was, ‘oh, my God.’ Yeah, it’s hard (Tape M).
In Indigenous communities, Elders are the people identified with carrying advanced levels of knowledge. This term is particularly misleading, because of the dynamic conditions under which Elders are designated. While Elders are often stereotyped, or equated with people deemed experts, in many Indigenous communities, Elders can be anyone who carry knowledge or who have skills that are more advanced, or older, than one’s own.

J: In terms of Elders, councils, for me I hear ‘what is an Elder?’ To me, there is a person who lives a certain way, whatever their age. You can have a person who is 75 or 90 years old and hasn’t healed, is abusive, controlled by addictions, it doesn’t make them an Elder, they’re just an old unhealthy person; that is not an Elder. To me an Elder is a person - whether they 90, 100 or 6 months old - who live a certain way of life. Someone who has something that they can teach me. I know I can learn from a 6 month old person, I know I can learn from a 16 year old person; if they can teach me something then they are an Elder. So to me an Elder is defined by the way of life that they live. An Elder will always tell you, the first thing, that they don’t know anything, and that they are here to learn. And that’s the first thing an Elder will always tell you. Then you know you are talking to an Elder. I wouldn’t be too concerned with the age of the person. I know there are a lot of young people who grew up with their Grandparents. You know the way they carry themselves that they were raised with their Grandparents, their ways are so old. They look beyond their years, they speak their language, they know their medicines, to me, they are Elders (Tape J).

In this sense, the term Elder becomes situationally relative, and people of all ages can be designated Elders. In a community extension of this, and in consideration of the ethic of humility, Elders usually don’t self-identify as Elders, they are invited to lead or participate in specific gatherings, according to their relative knowledge or skill. These ethics are also applied to traditional-based practitioners, as knowledge and skilled people; they may do healing work or carry good medicine, but won’t call themselves healers; others may address them, or their work in that way, in appropriate situations.

While being old doesn’t necessarily make someone an Elder, there is a strong correlation, if that person has developed a way of living according to traditional-based ethics (respect, interconnectedness, balance, responsibility...). If the term expert was applied in these ways, as situationally relative, the negative connotations that the term carries in Indigenous country, might dissipate.

This discussion of experts is particularly relevant to traditional-based health-education services, because it positions all health-education service providers at the same level as the people they serve. Rather than experts bestowing the wisdom or skills of their accumulated knowledge upon supplicants, each individual can play a role in the health and education of others. Under such perspectives, health-education services become less competitive, and Indigenous peoples become responsible for their own health decision-making, among multiple options for well-being.

Today, many Indigenous agencies, communities and allies are working towards better control of research, to protect Indigenous interests and to create mutually beneficial and respectful relationships between researchers and communities. Even so, the lessons of history are pervasive, and the status quo is not yet free from racism and discrimination; it’s still prudent to examine the motives and processes of “experts” and their projects. Until a history of beneficial research is established, a wariness of experts will also prevail.
Creating Integrated Health Teams

Oldhands: You said something that was quite interesting now. I do see a beginning of some sort of change. Like at this cancer forum, many people came up afterward and wanted to know more about... 'cause some of them have been around. Well another approach that they have been working at... sometimes they work so hard that they just stay in that one room. I was telling them - when I started Eldering for HIV Aids network - I said ‘well I want to know more about this disease’. So once I started learning what they were telling me and I said ‘well jeez how can I help?’ Kind of a new thing for us (Oldhand’s Tape).

While integrated health and education teams may be a reality in New Zealand between Maori and Pakeha (non-Maori) peoples, Canadians and Vancouverites have a long way to go to firmly establish such partnerships. The first place to start is in the establishment of respectful relationships. As mentioned previously, there are many societal barriers to the enhancement of traditional-based health-education services. These same barriers have prevented the establishment of integrated networks, exchanges, referrals and team-based practices, between Indigenous and non-Indigenous peoples in Vancouver. As the speakers below discuss, contemporary contexts for health-education team-building in Vancouver may be starting to open up.

Lee Brown: I think there is an emerging group of doctors who are more open to this kind of stuff. In my own lifespan here in British Columbia, I’ve had a number of doctors that practice [alternative medicine]; I’ve been to about six different doctors over the years. One of them was very open to hearing about, you know, if something was wrong with me, I’d say, ‘well, I’m going to try this kind of tea,’ and he’d say, ‘okay, try that’. And then there was another doctor where, if I said that to him, he’d say, ‘oh, that’s nothing, forget about that, don’t even do it, it’s worthless,’ and totally put down and disrespected traditional healing.

So I think that there’s some institutions such as treatment centres and institutions on reserves that have kept it going. I think that there are some doctors that are even more open to that, and I think there’s beginning to be more legal and political support for it, not much, but some (Lee Brown’s Tape).

Some of the most important factors in the development of integrated health-education teams, as these speakers suggest, are openness to Indigenous practices, patient-focused care, altruistic service orientation (rather than materialistic orientation), an understanding of wholistic interactions in health and wellness, mutual advocacy, and a willingness to support team-based decision making.

Oldhands: Well, I know that a lot of our newer doctors they are more open minded. They are more open minded, and they’re getting to the point where they’re searching for whatever it is that can help the patients. The newer ones are coming in, and they want to help people. There are some of those that just want to make money. The difference here, is - where I come from - the people who are becoming doctors are all specialists, because of the money. And the ones that are general practitioners just want to help people in my community. ‘I don’t want to be a $500,000 an hour plastic surgeon, or something; I want to help people who are sick, old people’. So their hearts are more into helping the people than the ones who just want to be the most expensive plastic surgeon.
in the world. They are looking for fame and money and not just the healing. So there are people out there that would care for people’s concerns more than their own. I can see them really moving if they had a healing counsel, because one can work with the other. If I go on in there and work on your spiritual aspect to make your thinking strong, giving you that hope, and this person over here is giving you some type of meds to help you. It’s better than just one person, and one part of you lacking. So a counsel like that is good.

Dawn Marsden: So team based provision of medicine, you can see that working?

Oldhands: Yeah. It’s different aspects. Then the healing work that I do, that would enhance the western style. But then, they are also enhancing what I do, so it works together for that one person. And when, if you are a patient and you know that these two forces are concerned for your heath, then you feel better about yourself, you feel ‘hey I got some self-worth’. And even that feeling of good self worth helps fight back a lot of the illness, strengthening the person (Oldhand’s Tape).

Integrated teams have the potential to provide a more comprehensive support of patient goals for health and wellness, than alienated or fragmented services. As O mentions, working with teams on an egalitarian basis (see section on experts, above), can provide the inspiration and support needed to activate individual resources for healing and self-efficacy.

Establishing Advocates for Indigenous Peoples

B: So many things have come up for me just listening in the circle and you know the healing, the healing that needs to be done within our communities is so vast, right, I mean I’ve gone to so many funerals, so many of our people are dying. And you go into these cold red rooms, and people sitting around, they don’t even know what to do, they’ve got pictures of the last supper, none of the traditional medicines are there, and they don’t know if they can go into the room to pay respects to their loved ones (Tape B).

Alongside the establishment of integrated health-education teams, Indigenous peoples in Vancouver have been indicating a need for advocacy, especially around incorporating traditional-based health and education practices into mainstream services. The most important roles of such advocates, would be to negotiate appropriate space for traditional-based practices, and to liaise between patients, their families, and health or education personnel.

Lee Brown: I have done a lot of -- I don’t really see myself as I healer or anything like that, but have been called on by a lot of families, especially in the interior. I lived in the interior for the last 23 years and did that kind of thing. I was called into hospitals many times. Some of the experiences I have had, there was an elder that was hit by a car in Vernon and she had damaged her spleen. She happened to be from a family that knew quite a bit about medicines and they wanted to bring her some tea and she was unconscious, so it would have been an intravenous feed and the hospital refused to do that until they got an attorney and actually had to threaten to sue the hospital, at which time they met with the administrator of the Vernon Jubilee Hospital. I know this is not Vancouver, but I think the situation is similar everywhere.

And the administrator promised the Native community, this was set to be a big protest at the hospital, all kinds of promises that there was going to be a committee and native stuff was going to be included, but as soon as the threat of protest was gone, they never heard from them again. And I called them, they didn’t want us there (the family),
so there’s a real exclusionary factor. I did a smudge in a hospital in Kamloops and both
the fire department and the police department were called and when I came out of the
room, I was nearly arrested just for doing a smudge. I think if there hadn’t been 20 or 30
members of the guy’s family there, I probably would have been arrested. I’ve done
countless smudges in institutions and never set off the fire alarm, but they always say,
“Well, you’ll set the fire alarm off,” and this is their excuse for not doing the smudge.
But in reality, they just don’t want the smudge to happen (Lee Brown’s Tape).

While the public education system has added on the services of First Nations resource
workers, which often play advocacy roles, the public health system has yet to follow suit, as
consistently. People in this research group estimated that there were only a couple people in
Vancouver, who were designated advocates for Indigenous peoples, in institutional health-
service settings. Several others shared disheartening or heart-wrenching stories of inappropriate
and disrespectful responses to requests to incorporate traditional-based care and grieving
processes. It was suggested that the greatest need for advocates was in hospitals, where
Indigenous people are often more vulnerable, by being isolated from extended family by
schedules, procedures, and issues of consent.

Recognizing the Importance of Traditional-Based Practices

Contrary to popular beliefs, due to the suggestion of out-dated text-books, which
notoriously write about traditional-based practices in the past tense, traditional-based health and
education practices are alive and well, and of continuing importance in the lives of Vancouver
Indigenous peoples. Many might argue that traditional-based health and education practices are
at the heart of defining who we are as Indigenous peoples. While who’s who, is hotly debated,
the reality is that Indigenous Vancouverites still make use of traditional-based practices, along
with a wide variety of health and education services.

Because of prior prohibitions, restrictions, sanctions, and criminalization of traditional
Indigenous health and education practices – like questing, Sundances, powwows, potlatches,
feasting, ceremonies, or basically, any gathering of Indigenous people - many practices went
underground. They didn’t suddenly and mysteriously disappear, as the history and anthropology
books might inform us.

While protecting traditional practices – in secrecy – during a time of residential schools
and other assimilative practices may have resulted in a loss or fragmentation of traditional
knowledge and processes, traditional knowledges and practices continue to be maintained,
passed on, restored and applied in the undercurrents of Indigenous communities, through the
efforts of staunch individuals, families and communities. The following speaker presents some
of the ways in which these practices have continued in and around Vancouver.

Lee Brown: ...the treatment centres, basically, and different kinds of centres that have
occurred in different reserves around the area, that either started the healing or kept it
going... reserves in and around Vancouver that have traditional kinds of healing: the
sweathouse, the smokehouse, the spirit dancing, the different kinds of [practices] that
exist in this area... the people that have kept those going, they have supported the
access, and kept the door open. The door to our traditional ways were never completely
closed because our key families did maintain these traditions (Lee Brown’s Tape).

If traditional-based practices are to be enhanced in Vancouver, the presence, strengths and
challenges of traditional-based practices must be brought into the light, in appropriate ways.
The need for secrecy is growing weaker, as caution, safeguards and protections are built to maintain the integrity of Indigenous peoples and their knowledge, as the emancipation and cultural resilience of Indigenous peoples grows, and as the potential for mutually beneficial relationships become more possible in the Vancouver society. If one suggestion can be deduced from this project, it would be to protect where protection is due, and to strengthen and restore, where strengthening and restoration are needed.

Recognizing Existing Traditional-Based Health Services

The Invisible Profession

M: So the other one that’s really lost and long gone now… It’s not really long gone anymore, is the longhouse. In B.C., there were longhouses all over and a lot of people will deny that. They will deny it just like the way… like a client. He wanted to get his status back, and his Grandmother would have been able to get it back but she won’t help him. That’s sad. So the genocide that shut somebody down like this, some of them promised themselves they are not going to [practice longhouse traditions] anymore. And that’s the way it is in my area too, but I’m mostly the last one. In that longhouse at the barn - everybody called it the barn - when my Sister and I went in there, we walked around and I was asking her, ‘does that look like a kitchen to you, over there? Does that look like bleachers up along there?’ And she says, ‘yeah.’ And then the other end was a pantry house, because… it didn’t look like there were stalls in there for horses or cows, there were just bleachers (Tape M).

Unfortunately, and perhaps through residual distrust, or lack of precedence, the continuing maintenance of secrecy around traditional-based practices has had some unexpected and detrimental effects. Because traditional-based health practitioners aren’t officially recognized for the health services they provide, in the Mainstream health care system, they are, in effect, invisible. While this invisibility has played an important historical, protective role, against attacks or appropriation of traditional knowledge, it has enabled the employment abuse of traditional-based practitioners.

B: So many of them go without. They don’t have the free time to go out and get a job because they are called upon so often to help people. So how do your regular 9 to 5 jobs help when so many of them are at the poverty level: they have their cigarettes, cars, gasoline [to consider]. Definitely honouring their status, their knowledge... I so want to hear those words spoken. I know that within the program that I’m involved in, I know that within the proposal there was no money set aside for cultural, and yet the whole program is based on cultural teachings, yet it is a constant taking from this, this to pay for people to come in, and be respectful around, you know, knowing that they have gas money, time that they have taken away from other things (Gathering Tape 3).

Once again, I am drawn to compare the historical abuses of women, this time in the workplace, who were expected to do double duty as maids, housekeepers, errand girls and companions; their work was expected, but invisible and unpaid. In the case of traditional-based practitioners, they may be hired as counsellors, advisors, consultants, social workers, nurses, or in a wide variety of roles, while being expected to provide traditional-based services. How many traditional knowledge holders, or traditional-based practitioners have been asked to act as Elders, to do prayer, to provide protocol advice, to “talk to” clients, during the course of their work in
other roles? As with women, who were expected to be nurturers and caregivers, the invisible roles and expertise of traditional-based practitioners are co-opted through long-standing obligations to provide service to those who ask.

M: When I work for old people, they always say, 'that person’s not qualified like the way you are M.' I said, 'just hush about that, okay. They’ll learn that on their own. You don’t need to tell them that.’ So I practice that at my job; some of the clients would ask for it (Tape M).

Another parallel is in the coercion inherent in the contract of services. Historically for women, they either accepted their extra duties, or they ran the risk of social stigma, or of losing their jobs. For traditional-based practitioners, the coercion is much less visible; I can’t imagine a practitioner saying no to such requests for service, since it is also an opportunity to provide culturally-based services to Indigenous people and to bring such services into the Mainstream. Whether they’d lose their job if they refused, is uncertain. It would probably depend upon whether or not “knowledge of, or experience with Aboriginal people” was a condition of their hiring. The social stigma for refusing traditional-based service may not come from within the agency, but from the wider Indigenous community. The point here is not that people may be agreeable to doing extra duties, but that such duties are invisible, not compensated for or may be coerced through hiring practices, or social stigma.

Doreen Sinclair/White Cloud Woman (Anishnaabe): So, what barriers or constraints? Exactly what we were talking about: lack of support and adequate funding for those services. And that’s directly related to the funders. I think there would be a great deal of demand because right where I am now, I’ve received permission to work with two clients. I was hired to work with groups, not one-to-one, and so when the other staff heard that I was doing one-to-one, it was ohhh, wooo, ohhh. I know and expect to be busy. They can do the counselling, and I’ll do the healing (Doreen Sinclair’s Tape).

A consideration of employment ethics is particularly important when we consider the well-being of traditional-based practitioners or traditional knowledge holders. While traditional-based services may be initiated at the work-place, the actual practices may require hours, days, months or even years of time commitments, outside of regular work hours, and incur the use of large amounts of personal resources on the part of the employee. In the worst case, it is the equivalent of doing two jobs. Since traditional-based practices can be intense (emotionally, mentally, physically and spiritually), double-duty can circumvent recuperation time, and lead to burnout.

A: And then when they get to a point where there is more accessibility, that the ones who are being worked with don’t get burned out. ‘Cause they need to do certain things, and I’m also thinking about pension. I guess people would need to know that in the summer we do the ceremony, or maybe it’s the winters. So that people aren’t expected to be around you at this time. So that if there’s some way... if its a yearly fee, maybe. Dealing with it administratively, equitably, to look at it like it’s a year lump sum and then the long term. What happens if they get sick or something like that.

Traditionally you’re expected to deal with it responding to every need, every request for service but in an internationally city context it’s unreasonable, you’d be going, going, going (Tape A).
If traditional-based practitioners or knowledge holders are being hired for their knowledge and expertise in traditional-based areas, it becomes ethical for the employer to recognize their knowledge and skills, their commitments and contributions, and to compensate or accommodate them accordingly. Accommodation in this sense, means the support of such practices through the provision of space, supplies, scheduling, transportation or other resources.

Doreen Sinclair/White Cloud Woman (Anishnaabe): I think how I’d answer is, the ceremonies should be supported from... say from VACFASS. If I’m there as traditional Elder or healer then the organization should be willing to support the ceremonies, the pipe ceremonies: support in all manner of ways. Like the sweat: help to provide the money for tobacco, cloth and wood, and even provide for going out, getting all the supplies, the willows and that. Then with pipe ceremonies it should be the same thing. Is that what you are thinking of? (Yeah) And also if somebody is doing a sweat, quite often they should be able, allowed to have the next day off to recuperate. Because, I find when I’m working, especially if it’s a healing sweat or you are doing something specific and stuff is going on, it can take a lot out of the person doing the sweat. So if they can provide something to compensate for the sweat: one day [for the sweat], and a day to recuperate, something like that eh? So that person doing the sweat can recuperate their energies so that they don’t get burnt out ‘cause its easy to get burnt out in this area (Doreen Sinclair/White Cloud’s Tape).

This raises several problematic issues. There is little precedent for officially recognizing traditional-based practitioners or knowledge holders in the Vancouver workplace. Notable exceptions include the incorporation of traditional-based practitioners through the Residential School Healing Project (Aboriginal Healing Foundation), through the reserve-based healing centres at Musqueam and Squamish First Nations and through various Indigenous-specific programs (UBC Longhouse, Ts’elk, First Nations Law and Social Work Programs, Pacific Association of First Nations’ Women, Native Education Centre, etc). Even so, traditional-based roles are homogenized under one title – Elder – because of their common attribute of carrying traditional knowledge. To do otherwise, to differentiate and label the profession of traditional Aboriginal medicine, would stimulate all kinds of barriers and dangers.

The first barrier, is in the ambiguous status of traditional-based practitioners as providers of health services. While they may be seen as on par or even more skilled than westernized biomedical doctors, and while they may use various traditional-based diagnostics, treatments and therapies, the profession, and the specific practices are not recognized. This is especially difficult when we consider that most traditional-based practices are spiritually based; in the mainstream, such practices are usually relegated to religions or cults, and considered inappropriate for the workplace, or evidence-based health services.

Oldhands: That kind of stuff in medicine, it’s that way because they don’t understand what we do. And they realize that they may not be able to do what we do. It scares them. What happens is, the ones that aren’t scared, are the ones whose sole interest is in helping the person. Anyone who has that purpose - just want to help - will want to do anything just to help. Money wise they get protective. ‘I might lose money here’ (Oldhand’s Tape).

At the same time that traditional-based and biomedical practices are clashing about how reality works, there is an element of competition or threat that enters into the discussion, when considering raising the profile of traditional-based services. The Canadian medical system has
ensured that only accredited, biomedically trained individuals can practice as either medical doctors (MD’s) or drugless practitioners (naturopaths, acupuncturists, nurse-physicians, chiropractors, physiotherapists, traditional Chinese medical doctors, etc), without criminalization and penalization under both federal and provincial laws. In effect, biomedically-based health services dominate the health care scene in Canada, and dictate what will be considered efficacious, or not. While some may scoff at the idea of competition, the example below gives us an idea of how competitive health services really are.

Lee Brown: One of the things that stops this integration from happening, and it’s come up in discussions I’ve had with hospital administrators before, is the whole issue of money. How much will traditional healers be paid, as opposed to medical doctors? How much education do they have? And how much training do they have and what are they worth and what do they charge? And since money is something that is a reluctant part of the traditional healing, and people are not always happy to receive it... But on the other hand, it’s a necessary part these days; it’s needed to survive, but it’s an issue and it’s a huge issue with hospital administrators. I’ve talked to them in the past and one of the first things they ask is, ‘well, if you bring this traditional healer in, how much is he going to charge?’ I said, ‘well, he will come for gas money from Alberta to here.’ And he said, ‘well, what’s gas money?’ And then they overpay this guy so much for doing this. And ‘what are doctors going to say’, and this kind of stuff.

And there’s a tremendous turf war. One of the things I’ve done in hospitals, is deliveries. I’ve done a number of births, delivering children, and the only way that I can do it in the hospital is if the doctor and the woman agrees, and they will only agree, as I understand it - and this is what I’ve been told by women in the past - is that if the doctor is the first one touch the baby when the baby’s been born, then the doctor gets paid for that birth. And usually what happens, if I’m doing a birth in a hospital, the doctor will touch the head when it starts to come out, and let’s me take over after that. As long as he touches the head, he can get paid for the birth. No doctor has ever said, ‘what’s the birth ceremony about?’ No doctor has ever said, ‘can I be a part of it?’ No doctor has ever said, ‘why do you want to do this?’ The only thing doctors have ever said is, ‘well, will I get paid for this delivery?’

I was once doing a birth where there were two doctors and both doctors should have been paid for the birth. One was a doctor-on-call and one was a family doctor. The woman’s usual doctor was actually out of town, so she had a substitute doctor who thought he should get paid, but because it was a substitute doctor, the doctor-on-call thought he should get the birth. And the woman was in labour and the baby was starting to come, dilation was complete, and the baby was coming and the doctors were just having a furious argument. They were turning red and finally the one doctor stomped out of the room.

Dawn Marsden: In the room?

Lee Brown: And I told the women’s husband, who was there, to light the sweetgrass, and smudge the area where they had been arguing and fighting. They have no comprehension whatsoever of the sacredness of what was happening. It was totally about them. It’s not about birth. It’s not about life. It’s not about the coming of a life to the people, and it’s not about sacredness in any way, whatsoever. It was about, ‘am I getting paid?’

To me, it would be a real embarrassment to doctors to see these Elders working; someone living next to absolute poverty, just for the privilege of healing, then we have these medical doctors who are making a fortune, seeing you for five minutes and not
even answering all the questions you have, about what’s wrong with you, and hurrying out of the room for the next patient, so they can see 50 or more in a day, or something.

So the contrast between the two systems has become more and more stark (Lee Brown’s Tape).

The other danger is that, while naturopaths and traditional Chinese medical practitioners have led the way in bringing credibility to wholistic practices, official recognition brings with it re-definitions and restrictions that reflect biomedical worldviews, more than wholistic ones: the proverbial hands are tied, and biomedicine remains secure. The other alternative, which amounts to learning two whole systems of medicine, is to acquire recognition as both a practicing physician and as a traditional-based practitioner; the parameters around practice in this case, may be even more restrictive than working as drugless practitioners.

Bringing traditional-based practices into the mainstream, may be socially just, but will require much deliberation. The counsel of this research group has been to raise the credibility, acknowledgement, standards and protections for traditional-based practice, by creating a cooperative council of traditional-based Indigenous practitioners; similar to a college of medicine. Thereafter, on terms that are appropriate to traditional-based practitioners, recognition and integration can be represented and initiated.

Just What are Traditional-Based Health Services?

Lee Brown: I think doctors need to be educated. I think the whole attitude towards Native healing and concepts of health need to change. I think that as long as we are treating just parts of the person and not treating the whole person, we’re doing a disservice to the patients. As a matter of fact, they say one in five illnesses now are iatrogenic, which as I understand, means illness that is caused by the doctor’s care, and one in five people in the hospital are there because their medication is causing problems in parts of the body or usually It’s because the whole person is not taken into account (Lee Brown’s Tape).

Traditional-based health services are just that, health services based on traditions that originate in specific lands and relationships. Where traditional health practices might be learned through traditional processes, traditional-based health practices are often learned and shared through processes that may have some basis in tradition but not always.

These ideas speak to some very important areas of concern in traditional-based practices, around the adaptation of traditional knowledge to city environments. The quick judgement, connected to the need for caution and resistance to change, is that traditional-based is not good enough: traditions can’t be practiced out of context. The reasoning behind this is appropriate if we consider that traditional Indigenous health services focus on holistic relationships between people, land, water and other beings. Whereas the surgical room may be the appropriate place for surgery, only certain contexts may be appropriate for traditional practices. If we extend this discussion to travelling out of traditional territories, then we can see how traditional-based practices work in new contexts. If we use the same example, many surgeries can be accomplished safely outside of hospital environments, if the need arises: for example, during warfare, during travel into remote areas, during disasters. The location may not be ideal, but it’s the best at a critical time. Likewise, traditional-based practices in Vancouver may be operating the best they can, under the circumstances.

Implied in most of the interviews was a sense that people were referring to Indigenous principles and practices from within North America. Traditional-based North American
Indigenous peoples, principles and practices are connected by a common sense of spirituality. It’s not the tools or the techniques of what’s being done that connects health traditions; diversity reigns and is respected here. It is the core understandings, like spirituality, balance and consequent relationships and behaviour that lay the foundation for that sense of connection.

Oldhands: Well what counts or should count as traditional medicine in the local area it gets kinda touchy cause we have west coast culture, we have plains culture and you got woodland, we got arctic culture and you have all the different aboriginal tribal customs coming together and so, as myself working with people there’s a core that’s exactly the same with variations within them But, the first part we should do, what should count as traditional medicine we need, it should be... we need the tradition herbal medicine from the different locals cause they each have their own healing properties from the different groups because west coast might use this plant, plains might use this other plant and they bring them together so you have that but I think what’s missing today in health services is there, there’s no spiritual aspect to the healing (Oldhand’s Tape).

Traditional-based health services are also diverse in how they are used, alongside any of the approaches that have immigrated from elsewhere: European Biomedicine, Hawaiian Huna, Chinese Acupuncture, European Herbalism, British Wiccanism, Christian Laying-on-of-hands, Indian Ayurveda, and many others. How much these other systems are practiced or utilized, alongside traditional-based health services, depends upon when each particular group of Indigenous peoples first received these immigrant peoples, the nature and number of those encounters and relationships, and the time between then and now. Timelines between first encounters and today, are estimated to vary between 25 years and 500 years (not including small groups of travelers who ended up intermarrying). As reflected above, the diversity within traditional-based practices, between traditional-based health services, is almost as diverse as the traditions from outside of North America. Each of these diverse health services are valued as offering unique approaches and practices that may aid in re-creating balance for Indigenous peoples seeking help.

J: In terms of traditional based health service and I’m sure you are aware of this but defining tradition, defining traditional ways and you’ve spoken about that in the unique differences even between First Nations people and there’s thousands of different ways because there are thousands of different nations between the First Nations people. But also along a timeline of how it once was and how it is. That needs to be defined and that word you mentioned balance, balance the difference with the unique distinctions of First Nations people with balancing of our history and the modern days with because I believe this modern world has a lot of approaches or practices that can help us because we need to recover from the trauma of assimilation and oppression (Tape J).

While diversity may be valued for the consequent repertoire of influences and approaches available for healing, there are also cautions. The common adage “you don’t mix medicines” is as prevalent among those using or providing traditional-based health services, as it is among biomedical health services. Again, the caution is around balances and relationships. If you value your health, you don’t mix medicines or medical practices that may work against each other. Each relationship between medical traditions must be examined, within the context of the specific healing relationship. A series of cold water baths may prepare a person mentally and emotionally for the next stage of healing, but may not be compatible with drugs that are dangerous for people who are physically weak. Alternatively, illness-cure principles, that
suggest treating symptoms with homeopathics, may be totally appropriate, if symptoms are getting in the way of other processes (eg participation in ceremony).

Understanding Traditional-Based Practitioner Roles

A: [traditional-based health services are] healing modalities that are hard to be measured in terms of the [dominant] system, in the way categories are set up. And it’s not just health, it’s education and all kinds of disciplines (Tape AY).”

So there’s a number of traditions within traditions that I’ve been involved with and [I] realize the multi-tasking that we have in our relationships and our extended relationships, on our journey (Gathering Tape 1).

O: What gets in the way of the healing, the healer, and doing the work? Well, there isn’t a base for a traditional-base: their life and their work. A lot of time it’s just talking to people, listening to people and helping them find their own answers. ‘Cause they have their own answers within them, but they don’t realize that when you’re saying it. And it’s just a matter of pointing it out to people. It’s like waking them up and making them realize that they have what it takes to, you know, to take on the world (Tape O).

Traditional-based health services, as a system addressing health from Indigenous perspectives, are fundamentally holistic. In this sense, anything that facilitates the re-creation of balance or harmony in any relationship, in any or all of the domains of being, is a health service. To this end, people can learn or acquire gifts, according to their interests and aptitudes.

M: And my Great Grandfather, he ran a sweat lodge and he carried the pipe, too, but I never really got to learn too much about either. Well, everybody knows how to run the lodge, but the way he did it, he really healed a lot of people. He was gifted to heal people (Tape M).

Once again, it’s not what you do, or the tools that you choose, that’s important, as much as how, or within what worldview you do it. Traditional-based practitioners utilize specific healing modalities, inherent or acquired, that have been trained and honed within specific worldviews and which reflect specific traditions.

Doreen Sinclair/White Cloud Woman (Anishnaabe): One of the ways that I use my healing abilities is through dreams. I record my dreams and do dream work with people. So there’s working through dreams, and the physical healing work we can do with our ceremonies, and physical, emotional, mental and spiritual covers all of that level with our ceremonies. And I was thinking about my Metis side, honouring my father’s people. When I was very young I remember seeing a fiddle, a banjo and guitar on the wall. My Mom used to win jigging contests so I honour that part of my father’s part in ah... I play music you know, I play rhythm guitar, and piano and I sing (Gathering Tape 3).

Some specialized role examples may include working with dreams, working with stories, working with emotions, working with ancestors or other spirits, working with plant, animal or mineral medicines, working with personal journeys, working with the elements: fire, water, wind or earth, working in the spiritual realm, working with musical instruments, working out-of-body, working with rituals and ceremonies, working as a helper or supporter, working as a teacher, working as a carrier of specific knowledge or items, and/or combinations of these.
Each Nation has Indigenous terms for these roles. While in some Nations these roles are taken on by many members of the community (e.g., certain family members, anyone with aptitude, etc), in others, the roles are formalized specialties that usually require special training, or a high amount of experience or skill (e.g., Anishinaabe shaking tent practitioners, singers and dancers, Midewiwin, etc). Variations in terminology, categorization and formalization are extremely diverse, both between Indigenous Nations and within Indigenous Nations. The complexities involved with communicating these wholistic concepts of traditional-based health-education roles, within a biomedical framework, is expressed by the participants, below.

Lee Brown: Traditional-based health service provision. Well, it should include all the different kinds of traditional medicines of healing that exist. In the physical realm, there should be access to herbs and access to tea, to medicines and the people who have that knowledge, either have that knowledge or are supported in that -- supported by the system instead of not supported. In the spiritual realm, the ceremonies that are used to interact with the spiritual realm should be given credence and should be available to people whether they’re in a regular hospital or wherever they are at. Emotionally, traditional kinds of counseling services and ceremonies that deal with the emotional aspects of the human being should be available. And mentally, we should -- have access to elders and advisors that can share with us knowledge and wisdom and how to have a good life, and the teaching (Lee Brown’s Tape).

A: I’m a counselor I work with trauma. I’ve been trained in expressive arts as well as sexual abuse and trauma from residential schools so that’s my background. I’m also an initiate into the Mide Medicine Society, as well as a Sundancer in Lakota; I’ve been adopted into that tradition. So there’s a number of traditions within traditions that I’ve been involved with and realize the multi-tasking that we have in our relationships and our extended relationships on our journey so it is really an honour to be able to listen and hear what’s guided through me, the stories that will come today, and to also hear your stories as well so I know that’s healing and medicine on all levels: mind, body, spirit (Gathering Tape 1).

Amelia McComber: I’m working on my Bachelor of Social Work with the intention of practicing holistic healing medicines and cultural avenues for the future. I haven’t closed the door to education because everyday that I live, I learn and that I must be here (Gathering Tape 1).

B: I currently work at the Young Bear’s Lodge. It’s a treatment facility for Aboriginal youth 13 – 20. I also work the front lines downtown, downtown eastside where we have a street outreach. I’ve been working with our people for the last seven years in both arenas probably with Urban Native Youth Association and the City of Vancouver. I choose to stay on the downtown eastside to be a voice because many of the services that are provided are very power based, very set up as us/them when we’re here to heal you, what can I do to help you and I believe that we all have our own medicines and we have the strength. We just have to be able to be in a place where we can nurture that and to be able to feel and to grow in a good way. I feel like such a baby when it comes to the medicines; I feel like I grew up within, within all of the policies and within all of the lies that were set up by the government (Gathering Tape 1).
If we look at the roles of traditional-based practitioners from a developmental perspective, we can begin to understand the relationships between Indigenous realities, Indigenous aptitudes and varying levels of ability and skill. As these speakers convey, everyone is born with, or acquires specific abilities and skills; when these abilities and skills are pronounced, we call them gifts. The first step is to recognize, and to acknowledge these gifts within ourselves, with or without the assistance of family members, community Elders or other practitioners. The next step is to develop these gifts, ideally with the help of others who have knowledge or experience with those kinds of gifts.

Doreen Sinclair/White Cloud Woman (Anishnaabe): I got my education at UBC and UVIC and through that, just like a lot of education, it was a personal journey. So learning about who I was and where I fit in the world and how I can contribute and it took me a lot of years to actually get out from hiding in education and this is my first coming out, is doing something like this (Gathering Tape 1).

The most critical step, and one which can be used to differentiate between a traditional-based practitioner and someone who’s not, is the decision to share and apply those gifts appropriately, responsibly, and for the benefit of others: “to be of good service”. Commitments are powerful determinants of how and what we will be doing in the future. As traditional-based practitioners become known for their commitment to service, they are assessed and guided by the feedback of their communities: premature judgements of practitioner ability, ethics or approach, are changed with time, as the practitioner’s skills mature, as new skills are acquired, and as the community comes to consensus. With commitment and experience comes more exacting application of these gifts within a specific community (eg. Vancouver). Co-incident with this greater application of skills, comes a greater status in the community as a traditional-based practitioner. After years of reflection, practitioners are able to conceptualize their processes easily, and may take on additional roles to pass them on to others through mentoring, apprenticeship, or specific instruction.

If this developmental example of traditional-based practice seems familiar, or similar to the development of any profession, then I’ve done my job conveying how traditional-based practice is a profession, as it has been conveyed to me.

Recognizing & Exploring the Processes, Outcomes and Efficacy of Traditional-Based practices

efficacious a. producing or able to produce the desired effect; efficacy, n. (Oxford University, 1984).

Healing Overview

B: So to me, traditional medicines are wholistic. I mean, I’m not saying that there aren’t times when western medicines are needed and should be taken; that’s part of where the partnership comes in. But to be really treated, like for depression... You know... [people are] postponed: ‘here’s a prescription for the gym; go there and work out four times a week and come back and see me in a month’. There are kinds of balance [that need to be maintained], rather than just seeing [that] there’s sixty patients out there (Tape B).

An underlying theme of this collective story has been to emphasize that it’s not as important what’s being done, as much as how it’s being done or said. This orientation to
process, rather than to content, is specifically applicable to a discussion of the processes, outcomes and efficacy of traditional-based health-education services. What traditional-based practitioners specifically do, changes from practitioner to practitioner, and is less important than how they do it. Hypothetically, even biomedicine could be used as tools for traditional-based healing, by using traditional-based processes, from traditional-based worldviews (e.g. Indigenous wholism). The active ingredients, treatments or therapies, in traditional-based Indigenous health services, are wholistic, respectful, and process oriented. To make a discussion of efficacy relevant, then, the search for evidence must be shifted from examining the consequences of using specific tools, to examining the consequences of how those tools were used.

J: what counts is we count, what counts is keeping our humanity, maintaining our humanity, enhancing our humanity so that we continue to grow, to evolve. I question, I wonder, if this is as far as we will ever go as a human being, can we evolve to be more: to travel to a higher plain of being....

Dawn Marsden: You know that those things are possible?

J: Yeah, I believe, I agree it’s possible. I know it’s possible because when we go into ceremony whether it’s in our longhouses or going up the mountain for our cold water baths, fasting for four days, dance, sweat-lodge, we go into the spirit world and we discover who we are, where we’ve come from sometimes even where we are going. And we relieve ourselves. We lift all that heaviness that we accumulate all our life. So this is what our ceremony does, it lifts all that heavy stuff. I really go for my cold-water baths, go up the mountain at four or five in the morning and walk into those beautiful streams and rivers and I let that water clean all that heaviness off of me. And that’s what keeps me from acting out with violent thoughts, or acting out in a hurtful or destructive way to other people, and even towards myself. That’s what helps me hang on to my humanity. And that’s what counts, traditional based health services that helps us to hang on to who, and what we are as human beings. And when we can identify that as a strength - where that strength is being kind, caring, sensitive, with empathy - those are the strengths of humanity that should be held to the highest (Tape J).

Hence, traditional-based healing produces the desired effects, not because of the material tools of the practitioners, but because of their specific, Indigenous, wholistic, spiritually-based, service orientations to providing health-education services, and because of client beliefs in, engagement with, support of, and commitment to those healing practices, processes, and relationships.

Oldhands: Yeah, I know for a fact that a lot of stuff that we do in Aboriginal medicine has to do with not just the healing process but the mental process. It would take a burden off the hospital units, from people who are going into emergency for a cut on the finger, or, ‘I just don’t feel good’. They just want the doctor to spend five minutes - like old people - just feel that somebody cares. Or they could come in a circle and talk and feel good. It would alleviate their [ailments] and be very cost efficient. ‘Cause there’s some people out there that just need somebody to listen to them. If they feel like you’re hard, they’ll just jam up. And so he’s in there – ‘my neck hurts’ – ‘cause they want human contact and stuff (Oldhand’s Tape).

Bedside manner is extremely important in traditional-based practices. What is even more important, is a belief in a reality that may work in mysterious ways. While mainstream
biomedicine is young and still concerned with proving itself, traditional-based practices have been honed for more than tens of thousands of years. After testing healing processes for such a long time, it’s not always necessary (to the cure) to provide explanations for how those processes work, and in fact the impact of explanations may impede the healing process, through preconceived ideas, over-analysis, and self-fulfilling prophecy (auto-suggestion). As human beings, we’re all made up of the same physical components, and we’re wired (emotionally, mentally), basically, the same. The X-factor here is spirituality, or one’s orientation to the universe.

As integrated beings, healing in one aspect of being has the potential for healing in other aspects. If we consent to being treated for depression with drugs or electric shock - which affect us physically – and believe in the process, it may have beneficial effects mentally and emotionally. Conversely, if we have trouble adjusting to mainstream life, because we are having visions, or hallucinations, we could be shown a different, spiritual framework, that accounts for our experiences (normalization). If we accept the premises – believe in it - then we can be taught to interact with those visions and hallucinations in more balanced and functional ways. Were we mentally ill, or was our conception of the universe inadequate for making sense of our lived experience?

Oldhands: The doctor from the forensic hospital here, he was asking what I could do to help the men in the hospital there. I said, ‘are there criminally insane in there?’ He said, ‘oh no, you’re not going to be working with criminally insane. You’ll be talking to people who are mostly on medication because they hear things and they see things.’ And I go ‘just because they hear things and see things, that you don’t see, you put them on meds?’ ‘Oh yeah.’ I said, ‘I tell you what, you come down to the sweatlodge, and when you come out of that ceremony’ I said ‘things will talk to you, rocks will talk to you, you’ll hear things and see things; when you come out, am I gonna put you on meds?’ He started laughing, he goes, ‘I understand now.’ Just because somebody sees something...

The doctor said, ‘at the end of their lives, in palliative care, the patients start to hallucinate; they see things, they see people they used to know.’ And he says ‘and that’s just part of the mind processing.’ I go ‘excuse me, let me tell you something’. I said, ‘for thousands of years, people who are dying see a relative, a grandma, grandfather, an uncle, an auntie. Even uncles or aunts they don’t even know.’ ‘Children, maybe a mother had a child that died in infancy; she knows that’s her child.’ And I go, ‘look, they’re not hallucinating; they’re not going ‘oh I saw Barney, or Big Bird, or Jimmy Carter.’ That’s hallucination. When you think of hallucinations, this is part of who we are. It’s not a stranger, it’s always a loved one. That light at the end of the tunnel: seen it. It’s not the light on overhead It’s about process (Oldhand’s Tape).

In the next few pages, stories about specific traditional-based practices have been grouped together, to give a basic understanding of what kinds of tools are being used by Indigenous practitioners, and more importantly, how they are being used. To determine efficacy, examine both the outcomes and how the practices are applied. For the purposes of this examination, try and set aside any compulsion to find a plausible link. The fact that traditional-based health-education services work, is all that’s important. The fact that a plausible link isn’t found doesn’t deny the existence of a process, it denies the usefulness of the applied rationale, and suggests a road for future study.

Oldhands: I go ‘you’re scientific; we don’t know nothing about science.’ ‘Our ancestors do know about law, the law of nature.’ I said ‘there’s up, there’s gotta be down.’
‘There’s right, there’s gotta be a left.’ ‘If there is living, there’s gotta be death.’ ‘And if there is death then there’s gotta be an ending.’ ‘If there’s a physical body, there has to be a spiritual body.’ I said ‘you guys, you wanna measure, how the spirit is 22 grams at the point of death.’ The spirit doesn’t weigh 22 grams. And you know they may have dehydrated that last second, something is moving within that person right. Spirit. You don’t know that yet, till it happens to you. Yeah right. The law says there’s physical then there’s gotta be spiritual. So we have to work on all those aspects. Right. There’s illness then there has to be wellness. There’s wellness, there’s illness. Whichever way you work at it right. Somebody’s healed they can be well. Use the law of nature to work on it (Oldhand’s Tape).

Working with Spirits, Spirit and the Spiritual Realm

spiritual, 1 a. of or concerned with the spirit; religious, divine, inspired. 3 spirituality, n.; spiritually, adv. (Oxford University, 1984).

M: At the longhouse, my husband,...I put him in. There’s this woman, I don’t remember who she was, but I was sitting there, I was busy writing notes down, and this woman, I guess her back got injured by a car accident. And she says, ‘M, I know you touch people.’ And I said, ‘excuse me, I didn’t say nothing to you,’ I told her. I’m sitting here minding my own business. I’ve got my business to do, to do with my husband. I’m writing down my grocery list. And I said, ‘is there something wrong with that?’ She says, ‘M, I know you have it. Can you please touch my back?’ And I could hear, she could hardly get up from the table. Finally, I told her, I said, ‘number one rule,’ I said, ‘I’m not the one that’s healing you. It’s the Creator, God, Christ or whatever you want to call him. He’s the one that’s touching my hands.’ And all of a sudden I seen that light coming right out of my hands and my hands was guided right up her back and I had to do that four times, and the next thing you know, it just went. It was loud and I didn’t even know other people were watching. And I just told her, ‘please, do not tell anybody this.’ And I turned around. ‘You didn’t say nothing, did you?’ ‘Yes, we did.’ ‘Oh my God, that’s all I need,’ I said. And she went for her x-rays and her back was good. So that was one of my experiences (Tape M).

Indigenous peoples have had tens of thousands of years to hone the science of spiritual-based practice, whereby knowledge of reality, or gifts of healing are inspired, acquired or communicated through divine experiences. We can know about the spiritual realm, and by connection, about other manifestations of spirit (physical realm), by following certain preparations, protocols and ceremonies. Sometimes the gifts acquired through the tools of preparation, protocol and ceremony, are duplicated through traumatic life experiences (eg. near-death-experiences), or through spontaneous events (visioning/dreaming).

Over our lifespan, or probably over a few, we learn to become aware of, and work with other spirit-beings, spiritual laws, and the spiritual realm. These spirit-beings may have living physical manifestations (the bear you run into), or they may be wholly in the spiritual realm (ghosts, guides, angels). These spirit-beings may have been connected to us through genealogy (eg. ancestors), through historical communal relationships (eg. crane clan), or through personal relationships with specific animals, lands, waters or plants. What is important to remember, is that in the sense that we are all spiritual beings, we can always connect to the knowledge of other spirit-beings; we will never be alone, and we are never without available guidance. We can know what we need to know; we just have to ask, in a good or right way.
Oldhands: Myself, I try to work with stuff that works with western medicine, kind of side by side because there’s a lot of diseases we have now, a lot of them we’re not traditionally set up for. I mean there’s a lot of times where somebody like yourself comes in and has a certain problem - my ancestor, my grandfather taught me the medicines; that disease like HIV, he wouldn’t know what that was - then I go into our little lodge and ask the ancestors ‘help me, clarify to me what it’s actually doing to somebody, and then tell me how I can help them.’ And then they pretty much answer me, there. Or sometimes it’s kind of like they’ll say ‘well, I’ll get back to you on that’ and then they’ll come back to me at night, and then they tell me. It’s quite interesting because I’ve had, I’ve talked with doctors and they’ll tell me they’re studying the research on this for 14 years, you know. And I go ‘you know what they told me?’ And the guy will, like ‘what?’ Just sitting in my lodge with my pipe and they told me in five minutes (laughs). ‘Well you didn’t ask right? You just look, you’re searching but you’re not asking.’ So, that’s quite funny (Oldhand’s Tape).

Besides questing for and receiving knowledge, spiritual guidance can be given at a mundane level, by reminding people that we are more than machines that need to be fixed occasionally, that there is more happening in our reality than physical cause and effect. What this reminder does, is give us hope, a sense of self-determination and a renewed faith that we are still connected, that we are not alone, and that there is meaning in our lives, and to our deaths. Nowhere more than in the presence of sick people is this teaching more important. When we present the world as predictable, inevitable or predetermined, we remove not only hope, but a person’s own ability to transcend their physical experiences, to reconnect with who they are as spiritual beings, and to create miracles.

Oldhands: I think what’s missing today in health services is, there’s no spiritual aspect to the healing. I was working with a young woman at St. Paul’s. And she was quite upset because the doctor came in the middle of night, she said, and just woke her up and said ‘you are going to die’ and left. Right. I could see she was quite distraught after that and I said ‘you should have told him we’re all going to die’. Right, nobody knows when; you can’t say ‘tomorrow or in three days’, I said. But there’s no spiritual aspect; they work on the physical parts of disease... Not even the mental part; they kind of break that down. That eliminates the hope aspect, and the spiritual part that makes you strong so you can fight it off. Say like when you go into the doctor and he says you got cancer you walk out of there all depressed and stuff and your immune system goes down and it attacks even more. So when you work with spiritual based you got the hope part in there and that releases part of the brain; that’s more attack on your disease. And even if a person is not going to be cured they can be healed. In other words, they can come to a good aspect of the disease or whatever illness they have and accept it and move toward a good way of leaving, rather than going in a fearful manner. Because sometime you might not be able to cure someone but you can heal them so that they accept their outcome and do the best until their final moment rather than get depressed and grieve and lose that last part of their life which can be very... Sometimes somebody’s last week of life, more living goes on there than it did in their whole lifetime. And sometimes I tell people that’s because you failed to understand what life was about. This comes so you can really know what life was (Oldhand’s Tape).

Spiritual processes are about guidance communicated through multiple domains of being (mental, physical, emotional and spiritual), about knowing what life is, about our place in it, and
how to go about it. This is a fundamental concept to the well-being of traditional-based Indigenous individuals. If we know who we are as spiritual beings, then we know where we are going, and what we are capable of; responsible and healthy decision-making follows naturally.

There is a difference between curing and healing in that one is about eradicating an unhealthy condition, while the other is about moving us towards balanced wholeness; that is the desired effect. Spiritual guidance can be called upon to learn cures, but those answers aren’t always given; sometimes it’s more important to learn how to heal, in more wholistic ways, to mobilize our healing resources and to heal who we are as complex physical, emotional, mental and spiritual beings.

Oldhands: When I gave her the medicine and told her to do this, she went off all her pain medicines, just by using that, and the next thing you know the doctor came in and he was blown away. He said ‘what happened?’ …there is something in our medicines that they don’t understand so they are open to it. They are still kinda skeptical but when they see the actual turnaround in a patient that makes them more open (Oldhand’s Tape).

Finally, the magical or miraculous effects of spiritual awareness or influences in healing are not exclusive to traditional-based Indigenous practices, they are universal. At the highest levels of faith, there is no difference. The speaker below gives an example of this idea. Where practices and terminology may differ, the core concepts and the source of healing are the same.

J: With the beliefs of other people, when they speak their ultimate truth, Christianity, Muslim, Buddhist, whatever; that truth of humanity is the same. It’s exactly the same, I have taught with Christians and Buddhists, Muslims and Sikhs. When they speak their truth they can walk into our longhouse and say the same thing, no different. Or I could walk into their temple or place of ceremony and speak my truth and it would be no different from what they talk about, what they believe, what they practice. It’s all these other manmade rules that get in the way. But…it’s the ceremony, it’s the cleansing, the coldwater bath, the sweat, the sundance, the longhouse season, that lifts all that heaviness off so that I don’t have to carry on, and act out; and its my humanity.

Dawn Marsden: Connection.

J: Yeah, reconnect, reconnect and in that small way. I’m keeping what our ancestors passed on, ‘cause, what counts as well, is honouring their sacrifice. Cause they realized, to keep their humanity, to keep those qualities of strength alive, that they had to (Tape J).

Prayer

Throughout this research project, people spoke about the power of prayer and how important it was in the practice of their daily lives. Interestingly enough, only two sections of dialogue about prayer, among all the dialogues, were audible on the tapes. The following story was shared during an interview, by two people with European ancestry, who have expressed a wholistic and spiritual understanding of extended interconnections, with the world and the beings in it. It exemplifies both the previous discussion about the central and universal role of spirituality, and demonstrates the role of prayer as a specific practice for mobilizing spiritual resources. This story has been shared with the same matter-of-factness that I see repeated in the telling of traditional-based Indigenous stories about prayer. Prayer works, and it produces desired effects.
This story gives example to the Rolling Stones song that says, “we don’t always get what we want”, but “we get what we need”. While the results can seem (from a scientific perspective) as almost coincidental (based on probability), from a traditional-based perspective, the miracles obtained through prayer are the natural and co-incident (based on interconnectedness) mobilization of spiritual forces.

Daisy Heisler: I was one of the founders of the Dharma Centre, a Buddhist meditation centre in Kinmount, Ontario. We bought four hundred acres of beautiful rolling land with forest and a small lake, two log cabins needing a lot of repair, and a stone well that was dry with dead porcupines in it. The well was cleaned and the log houses were restored to a livable fashion. My husband and I were chosen to live in the main house with our four children, on just a tiney baby in cloth diapers. Besies looking after my own family, my duties were to look after hundreds of people, and Buddhist monks from Tibet and Thailand, making sure they all were fed and looked after.

The well remained dry. Our only water source for household use, cooking and washing, was a sparkling, pretty little stream that came out of the ground like a tiny fountain between some rocks on our land. To get water meant a long walk hauling the water in jugs or pails far down the road, over a large hill.

One of the meditators suggested a solution to water storage as he watched me in the kitchen. He was able to get oak whisky barrels from the brewery he worked in. So the barrels arrived and were filled with water from the stream. Life seemed easier with large barrels of water sitting in my kitchen.

Then came the weekend a few weeks later, when a lot of people arrived and I cooked for them as usual. I thought it had been a successful weekend until I was told during the week by our Teacher that many people had become ill after the weekend and I was blamed. I was told that I had probably cooked their meals with an improper frame of mind. I knew this was not true and water tests revealed mold in the barrels. Then I did become desperate.

I went to the dry well and talked to it. I asked for water.

My family slept in the top floor of the cabin and I was in the habit of looking out the window to view the fields first thing in the morning. The very next morning I went to the window as usual, looked out, and saw the well filled with water.

I ran out to the well filled with so much water that it overflowed, covering the ground for several feet around. I could not get close. I thanked the well for the water. I talked to the well about too much water. I told the well I wanted the water to be about a foot below the top of the stone wall and not all over the ground.

The very next morning I looked out the window again and saw that the ground was dry around the well. I ran out to the well and sure enough, the ground was dry around the well and the water level was exactly as I had requested. But I looked at the water and it looked a little dirty with dry leaves and bits of dirt floating on top. I thanked the well for giving me water to the measurement that I had requested and for the dry ground around the well. Then I asked the well for clean water.

The very next morning I looked out the window at the well and it looked good. I ran out to the well and it was sparkling clean, to the level I had requested and the ground around was dry. I thanked the well and started to use the water that day. It tasted really good and clean. The level of water maintained itself as I had requested. We did send a bottle of water for testing and the test came back clean.

Then I found that I could get water but not everyone could get water. Certain people were not allowed to take water from the well. Their pail would not turn over and
fill with water, no matter how they tried. I had one fellow go hysterical over it and one woman called me a witch. I heard that when I left the meditation centre, the well went dry.

Ironically, my father was a water diviner, a very good one who nevr took a cent for what he called his ‘gift’ (This story, from Ken Schramm & Daisy Heisler’s Tape, was rewritten as is, by Daisy Heisler. It is copyrighted and may be reproduced only by the permission of Daisy Heisler).

Prayer was of such importance to participants in this research group, that it was understated. Besides direct references, prayer was implied in references to smudging, ritual, ceremony, ancestors and spirits. What goes hand-in-hand with these processes is the will to prayer, to give gratitude for things in ones life, and to request assistance in the leading of ones life, and for the good of others. If we understand that everything is connected by spirit, then we must be responsible with every thought, every word, and every action. The way we live our lives becomes a process of prayer through the creation of good relationships with others.

M: You know what can happen? This is my vision: 200 of these tobacco ties can be done, maybe 450, one for each direction. All have one mind and one body and one soul, and pray into these. And have one special leader to do the healing. And the one I know, that would be good for that, is that Charlie. I don’t know if you ever met him or not, but he’s really powerful. He was trained by seven elders. I know two of them passed away, but I don’t know if the others did or not. And he has really powerful teachers, this one. His dream, too, is to gather one person out of each society, pray over one area, pray over everything. Pray that some societies will be okay, but society [in general] also. I think that’s one good way of doing it (Tape M).

Far from wishful thinking, prayer is the willful activation of our very real connections to spirit and thereby, to all other beings. There is a grain of truth to the phrase “self-fulfilling prophecy”, or to concepts of “auto-suggestion”. Similar to the field of “mind-body” medicine, where the discounted “placebo effect” was revisited and given new status, autosuggestion and prayer will be revisited and celebrated for their “magical” or “miraculous” effects.

Another anonymous philosopher summed up these related concepts of prayer, mindfulness and intent, and the interactions of mind and body, in the phrase “what the mind conceives, the body creates”. To extend this phrase more appropriately, I would say “what the spirit, mind, and emotions conceive, the body creates”. If we intend harm, then, through our relationships, our thoughts and words, we can effect harm. Likewise, if we intend good, our thoughts and words can effect good. The caveat, or warning, is that we must always be careful about what we pray for, because it can happen. Again, like the song, our prayers may not result in exactly what we ask for, but may be answered in ways that address the needs implied in our prayers. We may think we need a new car to fill that void, but perhaps a new friend would fill it better. The operating principle is that our relationships (physical and non-physical) around us will continuously affect changes towards a dynamic state of balance, and in effect, facilitate the answering of our prayers. The more aware we are of our spiritual nature, and thereby our connections, the more we will be open to, and realize our ability to effect change through our intentions and prayer. The more we are aware of the rebalancing nature of the universe, the less inclined we will be towards harmful thoughts, words, actions or prayer, which may return to us with increased force. This is not superstition, it’s common sense.
Dreaming and Visions

Doreen Sinclair/White Cloud Woman’s Tape (Anishnaabe): People are always talking about well this can’t be considered traditional and that’s not traditional. So, I guess I’ll go on how my development was. Traditional is studying about dreams and interpreting dreams and visions. That’s where, for myself, that’s where the grandfathers and grandmothers came to me and I was prompted, through those visions, to go home to my own people. And so I would take my dreams and visions to somebody, like a medicine person or a spiritual person, and so they would do ceremony and work with me and tell me why I was dreaming, and what the grandfathers and grandmothers were saying (Doreen Sinclair/White Cloud Woman’s Tape).

One of the most commonly understood traditional-based practices, is the practice and experience of dreaming. Human beings can dream, if the conditions are right, or if there is a need to dream. Dreams provide us with all kinds of information and guidance about how we live, or how we should or will live our lives. While most ignore or discount their dreams, traditional-based Indigenous people acknowledge dreaming as an important part of their lives.

M: I still go for my baths, sometimes I stay in that water for two hours. Another good teaching that was given to me was... I was told if you ever want to go, let go of old emotions that comes out, sit by the cedar tree and let it all go. Just holler and holler, then go to the water and bathe and sometimes you see a vision. Lots of people pray for visions to come to them right away, but mine just comes just like that. Some people would ask me, ‘how long does it take you to see a vision?’ I said ‘everyday.’ And I would ask them, ‘why, do you see visions all day?’ And they said, ‘sometimes.’ I said, ‘oh, really, now what do you see all day then.’ This is a challenge I give them. So they don’t know what to say after; and I said, ‘to be honest with you,’ I said, ‘I’m not supposed to even tell you how many times I see a vision’ (Tape M).

As in the traditional hunting practices of some knowledge holders, the creation of visual representations of our dreams can help to make the information in our dreams relevant and influential in the physical world. The speaker talks about this symbolic and active connection in her discussions of contemporary dreams and contexts.

Doreen Sinclair/White Cloud Woman (Anishnaabe): When I was on the island I did this one collage; I had never ever thought of moving to Vancouver, it was the farthest from my mind. I was 12 years on the Island and in the collage I put on there that I had a white car and at that time I was driving a blue car and these great big buildings just like in Vancouver and I had that on, and, lo and behold, three years later here I was living in Vancouver and driving a white car. And I still have that on my collage and I thought wow this stuff is powerful. You know what we want we have to be careful what we think because it manifests (Doreen Sinclair/White Cloud Woman’s Tape).

When starting my Ph.D. studies, I realized that, to start sharing what I’d learned, I would have to “come out” in a way that people would begin to know who I was and what I believed in. Even though I felt exposed, I knew it was important for me to do things in a good way and to maintain my integrity, regardless of my fears of being in the stage light. For me, prayer and dreaming are intimately connected. When I pray for guidance, the answers often come in visually detailed dreams. I’d also like to interject that as a phenomenon that connects spirits and beings, dreams are also a collective process. While I say that I pray and my prayers are
answered in dream, I'd like to acknowledge that many other people are praying and some are praying specifically to assist me and this research process. Where the knowledge actually comes from then, is from a complex of myself in relationship with other beings and the universe. I'm not always the best listener and don't always learn from experience, so I figure that my spiritual guides must have decided to communicate in the way that's easiest for me: visually. Prayer and dreaming are integral to the processing of this dissertation. For example, the following is a list of some of the questions asked in prayer and answers given in dream:

- What should I focus my research on? Dream: a traditional-based healing centre in operation in Vancouver. Interpretation: focus on supporting traditional medicine.
- How can I make sense of what I've learned from my research process? Dream: a beaded belt with the research process outlined on each bead (Figure 10). Interpretation: create a visual beading model for my research.

Figure 10. Wampum Research Model, without text

- Should I exclude a discussion of spirituality, as recommended? Dream: a view of the fabric of reality and the intersections of spirit with life on earth and Indigenous worldviews. Interpretation: a discussion of spirituality is inextricable from discussions of traditional-based health services.
- How can I respectfully include a discussion of the role of Christianity? Dream: a story of a woman, hiding from her husband, ashamed and afraid to go for help. Interpretation: the power of our beliefs can affect unhealthy responses to real situations, the root of our healing is in questioning those beliefs.

Dreams and dreaming are important human abilities that inform ways of being, knowing and doing. Dreaming is one of the most important traditional-based processes for knowledge generation or acquisition. While dreams may be considered relevant to some psychologists or counselors, dreaming is primarily treated in Canadian society as unreal, and the imaginative workings of our unconscious desires and fears. To date, texts that include discussions of dreaming have been marginalized as flaky, whimsical or as imaginative fiction at best. For many Indigenous people, dreams aren't just imagination, they are the visual manifestations of real life situations: past, present, future and conditional.

M: It’s just like this one, I got to tell you this one... At the conference, when they did that naming, there was 200 people that made that circle and I saw this four times: three layers of circles. What is it? A mother and a daughter holding a pipe and a buffalo robe and this man that was carrying this white eagle, and this young man was receiving a name, but I didn’t see their heads. And this man, he was a Sundancer, and he had a red bandana around him, and one of those, what do you call those? It’s a medicine wheel. It’s cut like a medicine wheel, with the four directions. He had that tied up in his hair, and then I
said, 'jeez, this looks so familiar.' Then the circle started going like this. The one would go around this way, and the other one would go around this way or the opposite way.

I said, 'oh my God, I've seen that circle at Lethbridge.'

We stopped there, and there was a picture. I was looking, but I looked on the side. I saw the Sundance. They were doing the same thing. But it switched to me, it switched to that time at the conference, on Friday. Friday morning, I said, 'that's where I seen it.'

Then I also saw it again, back in 1994. The first time I saw it was when I was six years old. The Creator told me, this is how it's going to tell you that you really are on your healing path. The torment that your people have suffered will come to pass, and you're going to witness all these people going into healing, and it's going to be like that all across the country that you're living in.' I said, 'oh my God, that is familiar.' So I was trying to remember way back when I was six years old when I seen that. So it's come to pass now (Tape M).

Many of the books, papers and resources created by Indigenous people have been treated in the same way – as unreal, imaginative workings of our unconscious - because of their references to dreaming, prayer, and other Indigenous ways of knowing, being and doing. Once again, the marginalization of traditional-based worldviews are directly related to the marginalization of traditional-based health services in particular, and culturally appropriate services, in general. Imagine moving to a society where another of our human abilities was denied, like hearing or sight; we'd find a way to adapt, but either we'd think the society was crazy, or we'd start to question our own ways of knowing.

**Singing and Drumming**

Singing and drumming, like prayer, was also understated in this research project. While many tradition-based people still sing and drum, to express honour, humour, grief, strength, welcome, etc, and to bring relationships, body, mind, spirit and emotions into balance, it has been constrained in Vancouver because of its marginalization by the non-Indigenous status quo. Singing to express oneself is still accepted in family or private functions, but sharing it with the outside urban world – loudly, in the streets, on the bus, at work, during public or formal functions - is looked at as an oddity at best, or, embarrassingly, as a sign of mental illness (someone who expresses themselves too loudly or inappropriately). Adding the sound of a beating drum, with its many tones and reverberations, can carry the sounds of the singer far into the distance. In some areas of Vancouver, such singing and drumming could be constrained and penalized, ironically, through the Health Act and other “noise” regulations or by-laws, at the discretion of health and by-law officers.

At Indigenous functions or workplaces, singing and drumming is expected, and often used as an indicator of how Indigenous the function or workplace is: “no singing, no drums, no food: must be a non-Indigenous event or place”. As soon as the drum or rattle is heard, people gather. As soon as those deep notes sound from the singers’ bodies, the listeners’ bodies shiver, hairs stands up, and hearts swell. Like a tuning fork, the sound of the drum and accompanying singers, can create a focal point for people to centre themselves, emotionally, mentally, physically and spiritually, both consciously and unconsciously. As the drum and voice echo and synchronize, or accompany the rhythms of our body’s systems, our health is influenced and we can be made whole. The resonance and connection we feel with song and drum are undeniable; we feel it in our mind, body and soul. As such, drumming and singing are often the starting place for people’s return to better understandings of who they are.
Singing and drumming play integral roles in maintaining or re-creating our connections to who we are as holistic beings. Space must be created in Vancouver for the re-acceptance of singing and drumming as healthy and essential activities, without sanction. The fact that singing and drumming might intrude into the isolated and exclusive lives of Vancouver citizens, might be a good thing, as it calls all people into relationship and balance. Facetiousness aside, singing and drumming can be re-established through the creation of respectful relationships (forewarnings, invitation to participate, consideration of sleep requirements, acoustics, etc).

Singing and drumming plays another role. The beneficial effects of these practices upon individuals are replicated outwards in community, to enhance and reinforce the self determination of both. Healing in its holistic sense moves from the individual, into the community and out into the bigger world, and visa versa, like ripples or waves in a pond. Singing and drumming require a conscious effort to be heard, to use ones voice and body to express and communicate.

For people who have been victimized, oppressed, discriminated against, or otherwise marginalized in today’s society, speaking out can be a very difficult thing to do. It requires using your voice and words in a way that gets a response from people. Even today, many Indigenous people have been silenced for so long, or so many generations, that they can’t get the words out, and are barely audible. I’m not talking about people who are quiet spoken, or choose their words carefully; I’m talking about people who experience a wide variety of physical, emotional, mental and spiritual difficulties when they try to speak up, to be heard, in a public context. While Indigenous people are regaining their speaking voices, and affecting change by ensuring they are heard, singing requires the breaking of stronger barriers. Singing and drumming in Indigenous ways, requires the courage to embrace, display and hold up, Indigenous histories, traditions, and ways of being, in the context of a society where Indigenous people are still being marginalized.

M: That’s Aunty. What she did was… She did a ceremony with all of our families; they put us in a circle. And I was about two years old when this started and I was always hanging onto my dad, and my great auntie was at the head of the circle there and she started singing this song. But this song has to do with our people must suffer far away from each other in order for our family to keep going and that as long as the earth is changing or as long as the people are changing, we must continue to go on our own journey and that our families will always live together. And she pointed us, with all of us that were kids, and she said, “I’m cutting my hair before you to show you that we are in mourning for the old ways that are gone because this new world is coming ahead and that our culture is not going to be the same anymore.” And they way she used her hands, it was always like far away. When it is time to bring the family back together, some of you will run into all the families and this song will come out to you. One of you kids, it’ll come out to you.” And I thought, “Well, I don’t think it will be me.” At that time I was like, “that’s going to be a long time from now.” And then I would ask my dad, “What’s the matter? Why is he crying?” And he says, “Because the old times is gone now and the new ways is coming in... but he basically said they going to force themselves on us. So that song is very powerful and it’s really tearful. I sang that one day and it was really sad. I even sang that when I went for my water bath. But that’s all a part of it. My great grandfather, he bathed us twice a day in the cold water and we had to stay in that water for one hour every morning; one hour, seven o’clock in the evening. And he says the reason why he bathed us in the evening is that when the times get rough our spirit will always remain strong. And he said, “you’re the one that’s going to be telling this story...
about how our people are far away and how they’re going to come and gather together (Tape M).

Songs can be like the threads that binds together the fabric of families, and whole Nations. Because songs are so contextually-specific, singing them reinforces the contexts and worldviews they are linked to. Like the embracement of other Indigenous traditions (dress, food systems, ceremonies, etc), singing and drumming tell the world that we, as Indigenous people, are still here, still strong, and here to stay. Singing and drumming then, and the creation and maintenance of places to sing, are self-determining behaviours, and are political acts, towards the emancipation of Indigenous peoples in Vancouver. Singing and drumming then, are efficacious, because they produce desireable wholistic outcomes for both individuals and communities.

Ceremony & Ritual

J: They can’t take away this. They can’t take away this or this or this. Right. We ask for it, and it’ll come back, it’s just sitting above us right here. You just have to know how to pull it back down and let it settle. Try going for a bath up in the mountain every day for a month, and you’ll have visions, plain. I’ve done that; I’ve gone for my cold water baths, and I’d be sitting here just like this and I’d have a vision. I’ve seen things. I know who I am now. I know what my spirit is. It came to me while I was awake. And it was shown to me. But going for a cold water bath everyday for a month, took off all those layers and layers of stuff that was on me, ‘till I was finally open to receiving, right here; and it came down. So if you sweat everyday for a month, or if you fast every month for 4 days, or what we used to do: fall, spring, summer, winter, at the beginning of each season; we would fast for 4 days. Some people would fast at the beginning of the season, some would fast at the end of the season: beginning, end, beginning end. So it’s about that. We gotta have that strength to find out who we are, and that’s what facilitates and supports access (Tape J).

As in the healing processes of singing and drumming, ceremony and ritual mobilize healing processes on many levels. Where singing and drumming are usually practiced by one or a few individuals, for themselves, or for the group, ceremony and ritual can be entered into by large numbers of people, for themselves, for the group, and/or for absent others.

M: While that gathering was happening, he makes a really big bonfire and he says, ‘the reason why that big bonfire was there, it was to represent the spirit of the people’. So the fire keeps the spirit alive. So in the evening most of the Elders go out by the fire, and they tell stories around that fire too, and the fire’s not allowed to go out. He always said when the fire goes out, another soul leaves us. So the fire was basically... it’s probably the same story all over. I’ve heard lots of people talk about that (Tape M).

Traditional-based ceremonies and rituals are those practices which actively connect and remind people of the interconnected nature of this world, our connections as spiritual beings, to spiritual forces, and to our need to be balanced, harmonious and responsible in all domains of being: mental, physical, emotional and spiritual.

Doreen Sinclair/White Cloud Woman (Anishnaabe): And then fasting is another one where we were given experiences, visions and dreams. Not fasting just for spiritual [effects], for every day living. And it’s part of who we are. We should be supported to
go on fasts, because it’s part of - should be a part of - our natural way of healing. It should be (Doreen Sinclair/White Cloud Woman’s Tape).

Fasting, smudging, and cold water baths, are just a few traditional-based rituals that can be done as part of a healthy routine, and can be done individually or in groups. Participating in these rituals helps us to symbolically cleanse ourselves, or to give us a good orientation or outlook for the rest of the day. The desired effect produced here, is to remind us of our commitments to health, to good ways of living, and to our interdependence with other plants, lands, waters and other beings, for our survival, nourishment and well-being. These activities have also been shown to produce beneficial effects, from a biomedical standpoint (detoxification, cardiovascular stimulation, stress reduction, elevated endorphins, etc).

Lee Brown: In my interaction with psychiatrists in the past, I’ve been very disappointed and I think a lot of the stuff that they do is way off the deep end as far as our needs go, and it’s so disconnected from our culture. I’ll give you an example of that. There was a guy who was assessed by a psychiatrist - and there’s lots of articles that have been written about how assessment is not very accurate, if there’s no cultural knowledge involved in the assessment - and the guy was assessed as having some kind of schizophrenia or something and believed that four or five years of treatment, possibly being institutionalized. Then an Elder came and looked at the same guy and said that he needed to fast, and this guy did go up to a fast, a four day fast, and has been fine ever since; I’ve been working with the family. So to me, the Elder’s diagnosis seemed much more accurate than the psychiatrist’s (Lee Brown’s Tape).

Where ritual could be equated to integrating healthy biomedical-based public health routines (teeth brushing, bathing, sanitation, etc), ceremony could be equated with major diagnostics, treatments, therapies and surgery; they have moderate to profound effects on the wellbeing of individuals, and in the case of ceremonies, on whole groups of people.

Lee Brown: Another part of this process of our systems of healing really becoming fractured and oppressed, is that at one time, the wholeness of the healing would have been supported by the wholeness of the community. When the healer was working, he would not be working alone, or she would not be working alone, the whole community would be focused on praying together and everyone believing the same thing. Today, in our communities, there’s all different kinds of beliefs. There’s some people who believe in it, there’s some people who don’t believe in it and there’s some people that are positively against it. And generally, the healer, often times, works alone. It’s one person, one man or one woman doing a ceremony, maybe with a few relatives helping or some singers helping or something like that, but very limited compared to what it once was. So the system is fractured. We’re still able to accomplish a lot (Lee Brown’s Tape).

Ceremonies, like biomedical processes, are extremely diverse, and dependent upon the needs and desires of the individual (or group). People who are feeling ill, or imbalanced, or disharmonious, may initiate ceremony to find out what’s wrong (exploratory or diagnostic practices) with individuals, groups, or a particular imbalance. The speaker below shares an example of applying a traditional-based ceremony (a pipe ceremony), to ascertain the imbalances of a particular ailment, during collaborative work with a cancer problem-solving biomedical team. The conversation is between him and spiritual guides or forces. Whether the traditional-
based diagnosis was put to use, is uncertain. Logically, the opportunity to focus research into specific areas, and to thereby save millions of dollars, and lives, should be welcomed and readily applied.

Oldhands: So I went in and sat with my pipe and I asked them ‘what is it?’ ‘Tell me in a way, so I can understand it.’ They told me, and I said ‘oh yeah, I can understand that. What can we do about it? How can we cure it?’ And the answer that they gave me, they said - they didn’t say you can change it - and this is exactly what they told me, ‘the cure is in our marrow’. And I said ‘what do you mean the marrow?’ They said, ‘the disease is in the blood’. ‘Blood is in our system only for so long and then our marrow makes new blood.’ ‘And then the old blood goes through the liver and cleansed out.’ And this is what they told me, ‘did you ever notice that it doesn’t attack the factory?’ [I said] ‘there’s something in the factory?’ ‘There’s something.’ So, I said ‘it must be some kind of enzyme or protein or something that it stays away from.’ ‘It waits till it’s out of the factory.’ ‘So there’s something in there. That’s where the key is, and that’s where the cure is.

And I started thinking later on, about cancer, bone marrow, and there is bone marrow cancer, and leukaemia, and there’s something in that bone marrow that counteracts, so there’s something within. So I asked them ‘so cancer hits our body, there’s parts of our body that never gets cancer, why?’ ‘Because there’s something in there that it doesn’t like and stays away like a dog.’ ‘There’s something about a certain animal, like bears don’t go near a snake, cougars won’t go by a skunk, there’s something in there that they don’t like. And it stays away.’ ‘So, you find out.’ So the logical thing is, you find out. What is it in our body that doesn’t get cancer, and what is it that’s in there, that the rest of the body doesn’t have.

Dawn Marsden: Uh-hum, seems simple.

Oldhands: Very simple but they are always going towards... they spend millions of dollars on...

Dawn Marsden: Examining blood and platelets and taking people apart (Oldhand’s Tape).

The idea of focusing on the root cause of an imbalance, rather than on the people exhibiting symptoms, is particularly profound. I am reminded here, of the relationships between the structural or historical causes of abuse, the people engaging in abuse, and the abuse itself. Because the latter two are dependent upon the former, or specifically, poor relationships between Indigenous and non-Indigenous peoples, an appropriate ceremony – from a traditional-based perspective - might focus on the healing of those relationships. This is very different from mainstream responses that focus on the problem, rather than its cause. For example, in the case of abuse, the focus is on punishment or prevention of abuse, and amelioration of the effects on victims. For the short term, focusing on prevention and amelioration is essential, but for the long-term, it would seem more efficacious to focus on the root cause, the eradication of the problem, in both traditional-based and biomedical systems.

Another type of ceremony that was discussed, is designed to bring about health, wholeness or healing, when a cause, or the progress of the illness is already known. In this case, individuals or groups will initiate ceremony to bring about a rebalancing, or readjustment to the illness or its progress, and/or to eradicate it entirely. As the participants in this study have echoed, a return to balance or wholeness is often more important than the complete removal of the illness. In many instances, which reflects a worldview of interconnectedness, illness is seen
as a necessary process for the rebalancing or growth (mental, emotional, physical, spiritual) of an individual, or group.

Other types of ceremonies, are designed to address recurrent issues, where both the root cause, the symptoms, and the therapy are known. For example, it is expected that tensions and challenges will arise during certain life processes (birth, maturation, death, etc). If these processes aren’t put into a good perspective, or are ignored or marginalized, then often, maladjustment, imbalances, and inappropriate responses can occur (unwanted pregnancy, high risk-taking, selfishness, abuse, etc). Ceremony, in this case, reminds people of healthy relationships, responsibilities, roles and places in the universe. For example, naming, questing, and rites of passage, were so important among Indigenous peoples, that they became institutions: large numbers of people supported them, and went through them, as focal individuals.

Rituals and ceremonies are effective traditional-based processes for achieving wholistic health goals and outcomes, because they facilitate desired changes in individuals and groups, in both superficial and profound ways. It’s only at the point of conflict, where traditional-based practices are undervalued and marginalized, that it becomes necessary to examine and translate such practices. With understanding comes better relationships, and an increased ability to address the health of Indigenous peoples. The effectiveness of these practices has been honed and established through tens of thousands of years of application, to the point of unconscious competency; because of this, few feel it necessary to examine how they work. From a traditional-based perspective, rituals and ceremonies have worked for a very, very long time, because they incorporate in-depth knowledge of wholistic health processes. If applied properly, with an understanding of necessary preparation, protocols and contexts, they will continue to be effective in the maintenance of good health, and in the eradication, prevention and amelioration of unbalanced or unhealthy conditions.

Communal Gatherings

B: And the way I see that happening, is that the community take the responsibility of having a feast, whether it be one organization that does it a month, or everyone bringing stuff to the feast. So that the community is there, the Elders are there, and you sit them in a big circle, so they’re able to feast together. And sit in the circle and introduce yourselves, and you know have like a ceremony together, whatever it is that we do together, to bring us together, right. We’re community right; the spirit of moving forward. And they’ve done it with Six Nations, the Iroquois Confederacy; that’s how it should really be built (Tape B).

From where I’m standing, Indigenous communal or community activities are an extension of ritual and ceremony: acceptable behaviour is proscribed and prescribed, and specific formalized activities are expected to occur, for the well-being of both individuals and groups. In Vancouver, the role of Indigenous gatherings is still not entirely recognized. The example below demonstrates the oppressive effects of such oversight.

During the writing of a grant proposal, it became obvious that individuals in the group were coming from two different perspectives. One person said strongly that we shouldn’t include a request to fund gatherings, because the funders would think we wanted to spend budget money on partying. Others in the group were shocked by this obvious ignorance and stereotyping of the importance of gatherings to Indigenous people. In the end, even though people were visibly upset, they deferred to the first person because they were afraid of her authority, education and position (author’s experience).
To address such issues, I've included a discussion of gatherings as a traditional-based practice, to draw attention to their importance in effecting well-being among Indigenous people.

B: So there are some good teachings from old people, who have learned a lot about the medicines, and a lot about ceremony, but for whatever reason haven’t made the changes in their lives that would help them to be really powerful, and I always think of those people. It’s a great feeling, they’re not healing as fast as we think they should be healing, but they are healing. They definitely can’t sit in ceremony without their grandfathers and grandmothers coming to be with them.

We have to get rid of the mentality, this segregation and separation from community, and from the people. It’s working, it’s hard, it’s driving us deeper, it’s separating, and then you come back and you don’t feel like you fit...

It’s especially problematic in cities, everyone is completely enclosed; ‘this is our counsellor, this is our occupation’, and then if you’re not working, then you’re categorized according to other criteria: ‘I’m mentally ill’ or... (Tape B).

The gathering of groups of people, or people within a community is about communing with others, and is fundamental to maintaining the cohesion of a society. Communal gatherings are another one of those ubiquitous practices; every culture, within every Nation has communal gatherings. Some of the most visible gatherings of Indigenous peoples, include powwows, longhouse gatherings, potlatches, feasts, and councils or meetings. The gatherings that aren’t as visible, are those designed for specific training, or the gathering or processing of resources.

M: Yeah, it’s really neat how the fishing started. Everyday it was like a same routine. It was a really good day. The whole community was involved, and what I mean by the community is mostly the Aunties, Uncles and maybe the Cousins if they’re way older, and then the Grandparents.

And right at birth, the Grandparents were the ones that look after the kids, the babies after they’re born. And the parents, it’s up to them to gather berries, gather food and make sure the shelter is good, is really on a strong foundation, and the hunting. What he used to do is he used to put all the kids on the mules and they travelled by horse and they went up through four-mountains to gather berries and roots. Apparently that’s where all the good roots were. And they made their own flour, too. They ground it; I don’t know what they used to grind it.

And they would stay in the mountains for two weeks at a time just gathering food.

Dawn Marsden: That’s a lot of food.

M: Yeah, it is. My mom was saying that my Grandmother used to make these big baskets, and I guess all the old people used to make all these baskets, and that’s what they carried the food in. And sometimes, if they wanted to can it way up there, what they used to do, I guess, on the mule, they used to put that big tub on them. That’s how they cooked all the food or how they used to preserve the food. And then dry it out up there. And I guess my Mom was telling me, too, that way up there, there’s lots of cedar boughs. So they made lots of baskets up there, too, and I thought that was pretty amazing (Tape M).

In urban settings, where many can become isolated, communal gatherings become particularly important. For traditional-based Indigenous peoples, gatherings aren’t designed only for socializing or networking, they are important in the maintenance of a way of being, a way of knowing and a way of doing.
B: And when you start building on that relationship, where you get that information all the time, and it’s building that relationship and community, then I think it all goes hand in hand with having that council. Where we have the community feasts, and we start coming together. And it’s not just our elders, and it’s not just our young people; it’s people in between the adults, the ones that are lost. They are feeling lost, they have no place to go, they’re being abused by their families, they’re out there using; then, you have that sense of family and community: ‘there’s a feast today!’ (Tape B).

As discussed previously, traditional-based practices are based on concepts of interconnectedness, relationship, balance or harmony, and spirituality. As such, they are fundamentally democratic and egalitarian; the needs of the many are met by the voices and the actions of the many. Even in hierarchical systems of Indigenous governance, the focus is to provide for the whole community: each community member has a voice, and can use familial networks and alliances to ensure that leadership is fulfilling their roles.

M: The potlatch was every October. It was called the potlatch; other times it was called Harvest Time. What happens is, all the hunting is done, all the produce is done - it’s been preserved - and all the berries have been picked, all the roots have been prepared, and all the fishing is done. You name it, it’s all done. And what they usually hunt for is moose, elk and deer. Those are the three main ones, and once in a while it would be bear or even cougar. I couldn’t imagine a cougar. And then, he raised an awful lot of cattle. Most of the cattle were quite wild, so my Dad always brought them home and they even raised wild horses. So what he did was - I think my Mom told me - that he slaughtered 12 cows and then he chopped them up and he had it ready.

So what they did was, the people gathered from all over North America and that little house that we stayed in was just a little green house. Hundreds of Elders sat right around the corner, making a nice big square; they called it a circle anyway. And there must have been at least four circles of elders all squished up together. And my Mom told me that it took two weeks for each one to tell a story, to share how they used to live and share funny stories. And in the meantime, all the food would be put in the middle. This is where we started sharing all the food that was prepared and gathered, they put that in the middle for the people that haven’t been able to hunt for themselves. So lots of people went home with full hands, where they were able to eat for the whole winter (Tape M).

With such mandates, Indigenous gatherings should be looked at as self-determining opportunities to voice specific needs, to provide knowledge, to provide resources, to assist in decision-making, to witness public transactions and processes, and to provide sanctions, towards the rebalancing and healthy functioning of the whole community.

M: My Mom - before she passed away - she says, ‘you better bring it back.’ I said, ‘how am I supposed to do that?’ I said, ‘I don’t get support from my brothers and sisters.’ And she says, ‘well, you make them.’ I said, ‘they’re not going to listen. They already told me that they didn’t want anything to do with me because apparently I wasn’t home for them, or whatever.’ So after that, it’s like I have a dream of bringing them back, but it’s going to take lots of work. And she says, ‘all you have to do, is do it by mocassin trail’ (Tape M).

In suggesting strategies for enhancing the access and provision of traditional-based practices, participants were particularly vocal about reinstating communal gatherings in
Vancouver. This makes sense if we consider the role of Indigenous processes for teaching and learning in the well-being of Indigenous people. Communal gatherings are where Indigenous worldviews are reinforced, revitalized, restored and passed onto the next generations. As the speaker below suggests, creating barriers to communal gatherings is akin to practicing genocide.

M: They need to get well with that because the genocide has to stop, because genocide is really practiced, everywhere. Even though some people say, ‘I don’t need to go, I already dealt with what I went through’. But, how did she deal with it, is my question. What did you do with your culture? Do you allow culture to come into your working area or do you say, ‘no, how about if we talk about that four months from now?’ And I would say, ‘well, how about right now?’ A lot of the people must be totally hurt from their lack of culture.

Dawn Marsden: Yeah. It’s that overwhelming urge, or this voice that says, ‘well, you can’t do that.’ We’re always thinking about what we can’t do. ‘We can’t do that. How can you do that?’ Rather than ‘let’s do it’.

M: They always say “everything costs money.” Sometimes it doesn’t have to cost money, and then there’s always the dollar store, right?

Yeah. It’s like we’re facing a dilemma right now. The dilemma of healing. Some communities are ready, and some just aren’t ready or willing (Tape M).

To restore Indigenous gatherings, all we need to do, is to be willing, and to have them.

M: I think in the city it can be possible, but we need the freedom to do that. We need the support of every society there is, in the Lower Mainland. Every executive director or supervisor needs to support that. I believe it’s possible, like, maybe once a month our societies can take turns to do a gathering, or maybe four societies. Just have four days for that, and go back to work for 10 days. I think that’s possible. Do you think it’s possible?

Dawn Marsden: I think so.

M: I think so, too. We all just have to be educated. I really believe that. A lot of people ask me how do you think we can do it? I said it’s easy. You just got to keep it simple. I said there’s no such thing as not being flexible. I said the old people were quite flexible with us. But, they always told us, ‘this is the time that we need to do the gathering.’ It’s like, with the squi-squi; the Sto:lo people, they hold their squi-squi at their big office. They hold it every season - summer-time, fall-time, winter-time and spring-time - the four seasons. And I can’t see why that can’t happen in the Lower Mainland here. So I believe it’s possible, but the societies need to agree with that (Tape M).

Traditional Medicines

Oldhands: The only barriers I see within the system are the scientific parts of medicine. Some of them still believe it’s mumbo jumbo, even though they’ve forgotten that western medicine is derived from Aboriginal medicine. They try to look at fighting the symptoms. Aboriginal medicine finds the source. I think right now... not all medical professions though, because I’m talking more and more to doctors and they are open to that part. They see where somebody, all of a sudden...

I’ll give you an example of a friend of ours. His wife was in hospital with severe heart problems. Her heart was very, very weak. And I said ‘oh I got some good medicine for that’. And I gave her some medicine and put it in a pouch for her, ‘put it on
your neck and when you feel really lousy, just smash it up and breath it in’. The doctors told her husband that it didn’t look good so that’s when I gave her the medicine and told her to do this. She went off all her pain medicines, just by using that. And the next thing you know, the doctor came in and he was blown away. He said ‘what happened?’ She said ‘I’m ready to go’. He just couldn’t believe it, that her heart got strong again. And then he gave me his card and wanted to know what I put in there, and he wanted 100 bundles; ‘how much would I sell?’ He could give it to all his patients, right. I go ‘yeah sure’. But he was quite amazed at the turnaround, and that there is something in our medicines that they don’t understand. So they are open to it. They are still kind of skeptical but when they see the actual turnaround in a patient that makes them more open (Oldhand’s Tape).

The most accepted traditional-based practice, is the use of traditional-based medicines. Mainstream scientists have had a great interest in Indigenous medicines, since biomedicine began; in fact, as the speaker above reiterates, modern pharmaceuticals have been derived (~500/800) from the practices of Indigenous practitioners. Traditional-based medicines include partial or whole plants, animals, and minerals, earth, water, fire and air, by themselves or in combinations. Even in ancient cultures, people methodically and scientifically collected information on herbs and developed well-defined herbal pharmacopoeias. Indeed, well into the 20th century much of the pharmacopoeia of scientific medicine was derived from the herbal lore of native peoples.

This acceptance in the mainstream, while marginal, is based on the superficial similarity between traditional-based medicines and the biomedicines and herbs accepted by the mainstream; each are derived from the natural environment, and each are used as treatments or therapies for specific ailments. The biggest critique and schism appears when, after laboratory analysis, there seems to be no active ingredient. How can a medicine work if there’s no active ingredient? Based on this biomedical criterium, many traditional medicines being used by traditional-based practitioners are considered inactive, and thereby, are considered to have no therapeutic value. By association, traditional-based practitioners are seen as ineffective and perhaps even deceptive.

There are two responses to these critiques. The one used by both herbologists and traditional-based practitioners is that herbal medicines don’t work in isolation, that it’s the interactive qualities of the elements within a compound that produce the desired effects. While there is a strong pharmaceutical tradition of recording adverse effects, beneficial effects haven’t been examined as much. Whether this argument proves, through scientific experimentation, to be inadequate doesn’t matter, if we consider again the foundation of traditional-based practices on process, on the interactive qualities of relationships and conditions outside of a compound.

The efficacy of traditional-based medicines – their ability to create the desired effect – depends upon how the medicines are identified, acquired, processed, and applied. This doesn’t mean that the natural qualities of a medicine are ignored, or aren’t known. To the contrary, the establishment of good process, or good relationship with medicines requires a deep knowledge of their qualities, particularities, strengths, variations, weaknesses and historical interactions with human beings.

Appropriate identification may mean the use of medicines that a practitioner is familiar with, or may mean the identification of new medicines through ceremony, dreaming, prayer or other processes. Appropriate acquisition means using specific protocols (eg tobacco, prayer, song, smudging, seasonal timing, gender, responsible harvesting) and specific intents and motivations (to assist in healing, to trade for other medicines for healing, to prepare oneself or others). Appropriate processing also requires specific protocols and procedures, to ensure that
the medicine is at its most appropriate strength, in the most appropriate combinations, and to ensure that it is stored and handled with respect of its relationships with other plants, animals, minerals, earth, water, fire and air.

A: I guess the danger is knowing what the protocols are and where it [traditional-based practice] comes from and then you know what the dangers are... and what are the considerations for the people because [knowing] that contributes to peoples’ well being (Tape A).

In addition to appropriate processes between a practitioner and a medicine, specific protocols and procedures must be followed when using the medicine to assist in healing work with others. The terminology gets a little convoluted here because of the difference between the concept of medicine, which wholistically, could be anything that assists in health and wellness, and the term medicine, which refers to a physically-based substance. While medicines can be used, as medicine, they are just tools, like prayer, song, gatherings, ritual and ceremony, for facilitating the processes of healing, which are fundamentally spiritual in nature. If the processes are right, then healing will take place, regardless of the absence or presence of active, or even toxic, ingredients.

J: Any medicine... you take tobacco - you just offered me tobacco as a gift - it’s tobacco, it’s a healer, it’s a medicine to me, and your prayers that went into it will help me. But this medicine of tobacco, if abused, can hurt. It’s the same with alcohol; alcohol is not necessarily a bad thing, it’s a medicine; it can help. It’s what people do with it, whether you abuse it. You take a knife, a blade... in the hands of a carver it will create, in the hands of someone else, it can take a life. It’s what we do with the tools. That’s why we have to be aware of what our values and beliefs are; I’ve mentioned earlier the atrocities humanity does to humanity, in other parts of the world. They take these tools and they take these gifts, and turn them into weapons of destruction, where life is cheap (Tape J).

With all this discussion of appropriateness, we are reminded to think of the consequences of improper identification, acquisition, processing and application of medicines; in the wrong hands, these gifts, or tools, can be dangerous. One of the most important cross-over between western and Indigenous traditions of thought, is the concept of moderation. Too little, or too much of a good thing, can be detrimental to our well-being.

The speaker above mentions a few of the medicines most abused in contemporary society (tobacco and alcohol), because of their improper identification, acquisition, processing and application. With addictive or toxic substances, intents, motivations and relationships play particularly important process-roles. It’s not the substance that’s addicting us, it’s us that’s addicting to the substance. If this wasn’t the case, beyond genetics, we wouldn’t be seeing such different physical, emotional, mental and spiritual responses to alcohol and tobacco. The common adage that “we all react differently”, is true but not because we’re all genetically different, but because we all have different orientations to ourselves, to the world around us, and to spirit. Hallucinogens are another example of substance use where process can instigate the difference between spiritual connection, illness or death. We see this in the amazing feats of those who deliberately engage in dangerous practices (initiating snake bites, bee swarm-stinging, ingestion of poisons, piercing, etc) with no ill effects. Medicines are simply tools that must be used wisely (through good process), to initiate proper wholistic positioning for our realignment with our healthy, spiritually-based selves.
Chapter 6 Strategizing at the Community Level

J: When we go into ceremony whether its in our longhouses with Siaowin, or going up the mountain for our cold water baths, fasting for four days, dance, sweat-lodge, we go into the spirit world and we discover who we are, where we’ve come from sometimes even where we are going and we relieve ourselves, we lift all that heaviness that we accumulate all our life (Tape J).

How can traditional-based health-education services be enhanced at the community level?

Creating Guidelines for Accessing Traditional-Based Practices

Lee Brown: I think that this is that time that was prophesied long ago and we will arise to do something good.
Dawn Marsden: Seventh fire?
Lee Brown: I think it’s time for us to awake and to realize that it’s a new day for us (Lee Brown’s Tape).

What has been prophecized, among many Indigenous Nations, is that Indigenous people will pick up the trail of their ancestors, will return to the teachings, and heal the disconnections and fragmentations that have been made, to remake our world in good relationship. While it may seem difficult, or even impossible, our urban communities are in particular need of a makeover. Awakening, returning to the teachings and healing our disconnections, in an urban setting has its own peculiar difficulties. Fortunately, much thought, for many years, has already gone into instigating the transformation of our cities. Some of these strategies are made explicit and practical, on a personal level, in the paragraphs that follow.

The Importance of Protocol

B: It’s like, sharing your story, and ‘come on over to this ceremony’. And we take care of each other. And there is no room for violence, because we stand up to it. There’s laughter... well, just setting the tone. We went to that ceremony where it was all youth and [attitudes] so I walk in, my kids are like ‘hmm’ and I say ‘no, not here!’ ‘It’s time for ceremony, that energy is for ceremony’. So when they come through, I nod at them and smile at them, and so they realize they didn’t get spanked or anything; it was just to be respectful. So it’s just building on that relationship, so when we’re in ceremony, when were together, and we’re feasting, there is no room for that energy. I mean there is healing. Because then, we get to know someone in a different context; we say okay! That’s a heavy load to have to be violent and angry. The ones that are carrying that energy are the ones that are really in need of healing. That’s draining. It’s way harder to be angry than it is to be not angry. It seems to always enter into ceremony because there are so many people that are angry. It would be like having those strong leaders who are angry, sit outside and support us out there (Tape B).

Ideally, learning and applying traditional teachings, or entering into healing relationships requires a shift, or transformation of the self into specific, facilitative states, through the temporary or long-term setting aside of unhealthy, mood-altering, excessive or obsessive practices (drugs, alcohol, junk food, personal grudges), by ‘leaving them outside’ and through enhanced attentiveness and awareness. Most protocols around accessing traditional-based
health-education services have to do with this transformation, which carries with it active, tangible and intangible commitments to healing, learning and good relationships. For example, giving tobacco to a traditional-based practitioner, carries with it the connotations of healthy engagement, an understanding of protocol, a desire to enter into a good relationship, a desire to be healthier, or to learn, and denotes an underlying faith in the processes being initiated. This orientation to a healthier, more focused way of being, along with displays of commitment, knowledge and faith, are instrumental and conducive to the activation of traditional-based healing processes.

M: So there’s lots of really old rules. Like, a lot of people always say, ‘I wish we could live in the old ways.’ I don’t think they’d want to do that because in the old days, the Elders were very strict. I said ‘they’ll stand you up, right there’. I said ‘if you don’t listen to them, your parents get stood up with you on the floor’. That was really... I did that to my Mom and Dad. They were mad at me. I tell you, they were mad at me. But I had my way with my Dad. I used to squeeze his leg up to here, and I’d put my arms around his calf there. I wouldn’t even let him go, and give him that little puppy look, ‘don’t be mad at me’ (Tape M).

On a community level, protocols and implied commitments to being healthy will focus guiding, supporting and censoring community eyes (and resources) onto the person in question, as a way of integrating that person and their skills into the community. As the speaker above notes, this isn’t always a comfortable position to be in, but a necessary transition to being an accepted and contributing member. No news is not always good news, and may indicate the status of persona non grata (invisibility).

Lee Brown: Another really important dynamic, and this is where the training comes in, is the years and years of training that people once had. Part of the training was to deal with the human ego. You know, just to overcome that ego ‘to overcome my greatest enemy, myself’, and to achieve to some extent, humility. When a person becomes a healer and they haven’t had the years of training, and they still have a strong ego, they’re dangerous, not only to themselves, but to others. Because the ego is attached to the lower self, whereas the healing ways are attached to the higher self. The person has to overcome and subdue the ego or they’re always going to be attached to the lower self, and lower self desires. And that could get them into big trouble, and it takes a long time for someone to overcome their ego, and that’s where the training comes in. And much of the training is just a process of humbling, to become a humble person, to become a servant to others this is what is missing these days. They learn how to do a ceremony, they can have a ceremony every week if they want to, but without having 30 or 40 years of training.

Dawn Marsden: To practice without ego?
Lee Brown: Yes, anybody can do a ceremony, but only a rare person can do a ceremony without ego involvement, where they’re really truthful, (unclear) taking everything out of your inner self to the point where the creator’s power can flow totally through you easily, and that’s what the years of training are for.

Dawn Marsden: I see a lot of people who are on the verge of leadership and developing themselves, not take those steps because they’re afraid of their ego.
Lee Brown: Yes, because there’s a fine line. It’s like, ‘now I have some skills, some abilities where I can help my people, but I’m afraid of what it’ll do to me’; whether they can control it.
Dawn Marsden: Yeah.

Lee Brown: And the people who are really successful being a helper they can have a hard time, a really hard time. One of the things my teacher taught me, is to never expect thanks-giving, or never expect the people to appreciate what you do because they don’t. If you do a thousand good things here, that’s good. But you do one bad thing, and that’s what the people will be talking about forever (Lee Brown’s Tape).

On a personal level, protocols and implied commitments reinforce our sense of self-efficacy. The enhancement of self-efficacy ensures that the interactions and processes between individuals, are at their most proactive, influential and effective. If we are committed to the healing relationship and to healing, then we will heal. On a spiritual level, these orientations, commitments and faith can “clear the road” (of mental, physical and emotional “baggage”), for the mobilization of spiritual processes in healing and learning: to enable processes and influences outside of ourselves to connect and interact with us. Another way of visualizing this, is to imagine a dam on a river, or blockages on a train track; if the dam or barriers are removed, then we, as the river or train, can connect with our extended selves, and move freely, over great distances, as we were designed to do.

Enhancing and Applying Identity, Knowledge and Resonance to Engaging in Traditional-based Health Services

E: Yes, I think it’s really okay, I think it’s very okay, and I’m thinking for myself that [to make mistakes] means to go forward, that it’s all a learning process. When I go, somebody will tell me not to go a certain way, ‘don’t go that way, don’t see this person, do this and this, and expect this and this’, but that’s their journey. And I need to find my journey and I need to make my mistakes along the way, and I’ve been listening too. ‘Yeah I see that, but I don’t think I need to do that.’ So I will take some of it, what feels right for me, and I do that. And you know, I think traditional healing systems and being an Aboriginal person has never been about ‘this is how you...’ (Tape E).

We all start on the path of integrating traditional-based practices and services, with differing amounts of knowledge, skills and experiences, primarily because of the disruptive impact that colonization has had on our ancestors, our families, and our lives. Like targets of other forms of violence, we may feel ashamed or embarrassed by our current conditions. We are not to blame for our ancestors’ inability to protect themselves, from their aggressors; how could they have known their cautious but welcoming hands would be chained by disease, stronger weapons, deceptions, impoverishment, and the imprisonment of their children? The question is, will we allow the abuses of others to interfere with our right, and our children’s right to have healthy, fulfilling and self-determining lives? As the old adages say “we have to start somewhere”.

B: I always say ‘when I started crying, I thought it would stop after three or four days’. It’s just giving them... that it’s okay; it’s part of who you are right now: being human. ‘And this will give you more responsibility’ and bring it back down to humanity. So if you don’t start addressing it, don’t start saying - ‘it’s okay to be angry, it’s not okay to hit, that hurts’ - it keeps things going, and things get bigger and bigger and bigger (Tape B).
If traditional-based practices seem a good way to go, the best place to start, according to many practitioners, is with yourself. Who are you, where are you from, what do you know, or not know, about traditional-based practices and what are you willing to do with your life? The first two questions are about our specific identities and histories as Indigenous people, and are critical to providing us with a strong base for the development of personal efficacy. If we know how we came to be born, and under what conditions our ancestor made their decisions, then we will know what is interfering with the fulfilment of our present lives, and we can take steps to move through those barriers. Asking ourselves these questions, deeply, doesn’t only prepare us for traditional-based practices, it is a process of traditional-based practice. Knowing who we are, and where we came from (see discussion on spirituality, above) is the key to understanding and integrating the traditional-based principles of interconnectedness, relationship, spirituality, balance and consequently, responsibility.

A: Because of the transient nature of the people in the city, they are going to come from different traditions and different circumstances: whether they know who their parents are... It does take ongoing encouragement. Maybe those are the themes that would help indicate wellness, or traditional wellness: their connection to their family tree and stuff. But somehow connecting with their history and their traditions... this whole education thing is really important (Tape A).

For traditional-based Indigenous people, knowing who you are, eventually means reckoning to more than one’s Grandparents or Great Grandparents. It usually means learning the whole history of one’s family, back to the creation stories. From a beginning perspective, it’s an intimidating task, but an important one to take up. Knowing one’s ancestry, for at least 7 generations, creates awareness of the agreements and relationships that were entered into previously, for survival, and to create better lives for our families and others. This kind of knowledge is essential for placing our lives in the context of ongoing relationships and changing conditions, and for understanding our values and the teachings that we carry or don’t carry. Not knowing our histories - where we came from - helps to maintain fragmentation and disconnection from who we are as interconnected human beings, and from our responsibilities to all our relations.

Because it is so important, connecting to who we are as Indigenous peoples, with unique traditions and histories, can be scary. As the speaker below suggests, we can reduce the anxiety of reaching out for assistance on this journey, by taking a deep breath. If we are kind to ourselves and aware of our own processes, then we can trust ourselves to proceed appropriately, at our own pace.

B: I think that in my work both here and the city I find that the very first connection with an Aboriginal healer or someone else who connects to ceremony [is important]. I know that there’s a few people downtown who will come to me, and ask me about sweet grass, or sage or tobacco. And it’s from that first connection, when they’re scattered, when they’re starting to feel anxious, or scared, or fearful at something that’s going on with them. It’s like ‘okay breathe, sit’. And it’s that first encounter (Tape B).

Once we are on the path to knowing who we are, and where we’re from, we can start to learn how much knowledge we have acquired, or are still carrying, from our ancestors, and then value and uphold it. What is surprising to many is that, while specific traditions and principles aren’t named or recognized as such, they have continued to operate in our lives as beliefs and values for living.
E: I find I haven’t had a lot of teachings, traditional teachings, but I remember I was reading somewhere that one of the things that was done was putting yourself in cold water as part of healing and I remember I’ve done that all my life. And it sorta like builds up inside you have to go and find a creek or someplace and go in the water and the people I’d be with would go “What are you doing?” I have to, I have to do this. Its absolutely necessary and I don’t do it as much now and but I used to do it often before so I was thinking well just that traditional health systems are more in sync with who we are as human beings. And so, just that’s what I want to find, something that’s in sync with who I am. As a human being and who I am mother and grandmother.

C: Sounds like there’s more traditional teachings that you have, that you don’t see as traditional teachings: values, and principles, and things that you do, are so a part of you that you don’t consider them traditional teachings (Tape E).

One traditional-based concept - ancestral memory – accounts for that nagging familiarity, identification or skill, with traditional-based practices, that we’ve had no prior encounters with. Ancestral memories feel like resonance, belonging or connection on a deeply personal level: something “feels right”, or “feels wrong”, or “your body remembers”. Ancestral memories are thought to include biological, social and spiritual ways of knowing about things in one’s genealogical past. We know about our past (mentally, emotionally, physically and spiritually), because we are the cumulative, extended and focused result of our ancestors actions. The resonance that ancestral memories provide, can play a particularly useful role when deciding about paths to knowledge, by helping us to identify personalized “best fits” with practitioners and practices.

J: I’d imagine sometimes our needs are specific and certain backgrounds are... ancestral origins can meet those needs in certain times (Tape J).

Advanced biological studies have discovered a form of cellular memory, which might provide a western insight into applying the ancient and worldwide principle of ancestral memory. The logic is akin to genetic inheritance, where, if you know what genetic predispositions for talent you may have, you can nourish them; if you don’t know, you may spend your life in occupations that “don’t fit”, and not live life to its fullest potential. If used appropriately, ancestral memories can guide you to fulfill not only your fullest genetic potential, but also provide you with a prior knowledge, a wisdom beyond your experience, that can guide you in both fulfilling ancestral legacies and creating new ones.

That many non-Indigenous people claim a “deep feeling” or resonance with Indigenous traditions, while claiming distant Indigenous ancestors, or that many Indigenous people who are adopted out as babies feel like they’re “coming home” when they connect with ancestral lands and traditions, may not be so far fetched. Even contemporary Euro-Canadians are only separated from their Indigenous roots by about 1000 years (50 generations). The Scottish people have a saying that says it all: “the blood is strong!”

We can find ways to reconnect by combining what we can learn from family stories, historical documents, visions and traditional teachings about our migrations and creation as a people. With the knowledge of our ancestors behind us, we can step more confidently into the future. Once we know what we know, and don’t know about our ancestry and knowledge of traditional-based practices, and about what seems to fit best with ourselves on a personal level, we are better equipped to ask questions, and to learn from new encounters in traditional-based relationships and practices.
Sharifah Marsden: You would have to have guidelines for what kind of healing you would want, or what kind of healing is done, and traditional support you would have, and what you’re looking for, and you’d have to know exactly what kind of person you were looking for (Sharifah Marsden’s Tape).

To facilitate the processes discussed above – learning about who we are, where we come from, what we know and don’t know, where we want to go – several participants suggested that a workbook be developed, for the guidance of both individuals and groups around preparing for and engaging with traditional-based practices. The speaker below suggests the inclusion of proactive exercises in such a workbook, using a self-help model for learning.

Dawn Marsden: Like a workbook on preparing for wellness, outlining some of those different levels that are required.

A: Yeah that’s helpful, coming from [Indigenous] people, about that process. Some way to gauge, or some measurement thing, even for the people, they can do on their own. And then there’s all kinds of provisions around what those lines would look like. So having an educational component: making ceremonies based on going home, name giving, or things that enhance their identities. So it could be more experiential, rather than school, and feasts… (Tape A).

Deciding on, and Entering into, Traditional-based Relationships

While personal or family designed processes and self-help workbooks can be transformative, sometimes their effect is limited by obstacles that we’re not even aware of. If we suspect this is the case, that our efforts aren’t getting us anywhere, then perhaps we could use the assistance of people who have “fresh eyes” for viewing our challenges, and who can facilitate engagement with traditional-based practices. Finding the appropriate practitioners to work with in Vancouver, requires some investigative skills, some luck and a lot of patience. Without an organized referral system, potential clients are left to ask Indigenous community members, or Indigenous advocates or counselors, if they know of anyone. One of the best ways to find traditional-based practitioners in Vancouver, is to refer to the Vancouver Aboriginal Council directory of Indigenous-specific agencies; for some agencies, a small note is included, that mentions whether or not they do referrals to traditional practitioners. In some agencies, there are people who can give more than referrals; some can facilitate the process of creating a good match and entering into a traditional-based health-education service relationship.

Facilitators of traditional-based health services are catalysts for the creation of good relationships between those needing assistance and those providing assistance.

A: Its good to get people knowing what counseling is. I think it happens just by people talking to people. And trying to blend one to one, and group. I think that group is quite a bit more effective, although one to one is sometimes about learning how to be appropriate in communication skills, what your rights are in terms of what a counseling thing is. I guess I’m in the training mode or something, around creating some sort of literacy around how to use the system, traditional-based. I talked a bit about what would be the ideal, right. Well I guess some sort of easy speaking about the supports, or access to provisions. Like referral: I think that there’s kind of an ideology about not knowing what is traditional-based. So how do you know? I guess that would have to be developed (Tape A).
Facilitators often take on the role of traditional-based counselors, and will often work with people, to move from individual work, into group work, which is understood to instigate transformations in more wholistic ways.

For facilitators, referral requires a special consideration of client needs and backgrounds, and knowledge of practitioner specialties and parameters for practice. This is relevant to the prior discussion, of knowing who you are, and what your needs are, because practitioners are also aware of their criteria for best fit. Some practitioners can work with some people, in some ways, but not in the same way, or at all, with others. The idea of matching for “best fit” in this case means considering the best fit criteria of both the potential client, and the potential practitioner. Because this requires a wholistic assessment of specific individuals, creating a standardized formula for creating relationships is not appropriate, but guidelines may be helpful. Unlike Mainstream services, where standardized relationships (same duration, availability, timing, approach, responses) are often equated with good service, in traditional-based services good services are often equated with the ability to engage specifically: in specific practices with specific people.

A: We tried to build [a standard process] with the Elders, but we didn’t really want to give that out, because it was a personal thing. Like my interaction with one traditional-based person. I know that she only wants to work with certain kinds of people, and so I can’t put her with such and such, because maybe she only works that way with me. And so I really don’t know that, but I do know there’s consideration around people’s intentions about misappropriating the teaching, around thinking that it’s free for the taking in some sense. So I guess guidelines around, if it’s an Indigenous focus, that other people who aren’t Indigenous can be supports. That’s how I see it. So that’s important: the hiring and training for capacity building. A lot of people don’t have basic professional skills so there needs to be capacity building with that (Tape A).

As a specific, but touchy example, some traditional-based Indigenous practitioners won’t or can’t work with non-Indigenous people, or even “white-looking” Indigenous people, for a variety of historically, spiritually or practically, relevant reasons. For others, it’s no problem. If a practitioner recognizes that they can’t enter into a good relationship with a potential client, then ethically, they shouldn’t; if they do, then the efficacy of the relationship and practices, will be undermined, and a potential is created for harm to either the client, practitioner or helpers.

The speaker below alludes to another example of applying best fit criteria, but in this case, to the potential problems of creating a directory of traditional-based practitioners.

Oldhands: That’s a little touchy too because if they come up with a resource book or directory kind of thing... It’s usually word of mouth. In most of my work, [in the tradition] that I come from, it’s... somebody who came, got worked on and their lives turned around, and then they go tell somebody: ‘say I had the same problem, and this guy did this, and...’ It’s more word of mouth than a directory. Because there’s some parts of medicines or the healing process that I don’t do; it’s beyond me. Like, I’m not a bone fixer or stuff like that, so you need to find someone else. I think in the community it’s mostly just word of mouth.

If they heard about me and they don’t know where I live, they just ask different organizations ‘oh can you give us his number?’ ‘Give us your number and we’ll call him’ (Oldhand’s Tape).
When we consider issues of best fit, directories don’t seem appropriate. This means that there needs to be a greater reliance on the role of traditional-based facilitators, who are knowledgeable and experienced about, and have access to both potential clients and potential practitioners. Currently, many of these facilitators may be found at the agency level—working as contacts, or formally and informally at the community level, working in leadership roles, and through personal networks and word-of-mouth.

E: And I’d love to go to a sweat lodge but I’ve never been to one. And I just don’t know why.

Dawn Marsden: do you hear of sweat lodges?
E: Yes, I hear, I’m invited, but I just don’t go. I guess it’s just that I’ve been asking myself that one thing. Well I don’t like mixed so I’d just go to a women’s, and I just wonder about why everybody had to wear these big dresses. I’m thinking, well I used to go in saunas [which were] very spiritual to me; just go in there with fire and I didn’t have to wear clothes, and be by myself. This other thing, its like trusting like the people that are running it, and people tell you stories. ‘Oh yeah we had people come to our sweat lodge.’ They allowed this person to come but they really shouldn’t have come because they were... and I don’t need that (Tape E).

Often, community or agency-based facilitators are “helpers”, or practitioners in training, and like nurses, are able to provide a high level of assistance. In a community like Vancouver, where the ratio of specialized practitioners, to community members is extremely low, helper-facilitators provide a form of triage, providing basic traditional-based services so that more specialized practitioners are able to attend to the more serious conditions or situations.

When it comes to the final decision making about working with a traditional-based practitioner, facilitators can make suggestions, and offer leads, but it’s up to the potential clients to decide whose services to engage, and up to both client and practitioner to create the relationships necessary for good (traditional-based) work. In the context of a city, where peoples’ backgrounds, training and motivations are often unknown, or questionable, the establishment of an essential quality – trust – is difficult. Best fit then – without an organized referral system, is left to rely on word of mouth, resonance, personal assessment, facilitation, and perhaps in the near future, guidelines for accessing traditional-based services.

Engaging in Diverse Practices

Lee Brown: Traditional-based health service provision. Well, it should include all the different kinds of traditional medicines of healing that exist (Lee Brown’s Tape).

The Vancouver Indigenous community includes people who self-identify as Indigenous, Native, Metis, Indian, Aboriginal, Inuit, or as belonging to one or more of thousands of Indigenous Nations in North America and abroad. Indigenous people in the city may be one to three, or even four generations removed from their ancestral communities, from all parts of the globe. To add to this diversity, Indigenous people have been intermarrying, or creating children, with non-Indigenous people from around the world, for generations. The resulting diversity of ancestries and traditions that the Vancouver Indigenous community embody, carry, practice or are willing to engage with, is wide-ranging, very complex and can create dilemmas and tensions. The treasure in such diversity is that people with diverse ancestries can choose from several traditions that may resonate with their genealogical context, and that through the practices of people from different (to one’s own) Nations, we can heal and reconnect with our own ancestral
traditions. “Best fit” then, entails a process of deciding to enter into relationships with practitioners and practices that are congruent and resonant with who we are as spiritual beings with specific genealogies. The caveat, as the next speaker demonstrates, is in differentiating between the tools of a traditional health system – which may change – and the principles of a traditional health system, which endure over time (eg emphasis on curing symptoms, relationships, environment, etc).

J: There was a carver, a west coast Native carver and he was working on a totem pole, and a white man came along and he was watching him carve. He had steel blades, and a steel adze, using saws and sandpaper, using non-traditional tools and the white man said to the carver, ‘how come you are using these tools, that’s not your tradition.’ ‘How come you can’t use what you used to use?’ And the carver just looked at the man and said, ‘traditionally, we’ve always used the best tools available to us’. And that’s what we have to do today, always use the best tools available to us (Tape J).

One of the biggest critiques about engaging in traditional-based practices in the city, surrounds the ethic of following practices that are “traditional” which means following practices that are based on locally specific, multi-millennial, interdependent relationships. While the concept of ancestral resonance plays a role in this ethic, some people go beyond the consideration of best fit, to make evaluations of people’s characters. For example, when people follow traditional practices that “aren’t their own”, I’ve often heard the pitying comment “they don’t know who they are”. This is akin to saying they’re incompetent human beings. This kind of superficial judgment can spread extremely quickly in a small Indigenous community like Vancouver (~40,000 people), and can detrimentally affect the health, employment and socio-economic status of the individuals being judged. This kind of stigma, or consequence, influences people to keep quiet about what they know and don’t know, or even to be deceptive, and just makes the cycle of harmful judgment, deception and silence continue. Once again, if people remember the history of why our traditions have become fragmented, the active position is to assist all Indigenous people (if not all people) to regain that sense of who they are, by whatever respectful means possible, and to support the enhancement of all Indigenous health practices.

Dawn Marsden: Yeah, and other times there’s people from different Nations can provide good ways.

J: My line of thinking on that is that we’re so thinned out with what we once had - in our history, traditionally - any chance, any opportunity we have to keep anything alive, we should support; use what is given or provided or offered.

I don’t see it too much anymore but as an example, like someone who is west coaster, BC born, BC raised, a west coaster - Coast Salish or Haida or Tsimshian or whatever - they’d be offered the opportunity to smudge, which is stereotypically known as a Plains tradition. And they’ll say ‘oh, I don’t smudge that’s not my way.’ We always counter that with ‘in our [Coast Salish] history we did smudge, and we did purify, but it was with cedar, and either it was burned or we just took a cedar bough and brushed ourselves off, which is the same thing.

And also, we are taught - and it’s the very first thing that we are taught - is to respect all other people’s ways. So when we are invited to participate, a part of respecting is to participate, it is also to learn and to grow with it. So, there are a lot of teachings that go with the statement ‘respecting people’s ways’. And so when someone says ‘I don’t smudge’, I’m hearing two things. I’m hearing this person say that ‘I’m not
spiritual’, and the other is ‘I question the teachings’, question their ancestors, and at least their community. ‘Where did you learn this?’ ‘What were you taught, or why weren’t you taught to respect other people’s ways?’

When someone says ‘I don’t smudge, that’s not my way’, well there might be a certain amount of reality or truth to that, but it’s also about declining in a respectful way. There might be reasons for not participating in another way; it’s just about respect, saying ‘no thank you’. So we can respectfully decline. Because our way is not to force anything on anyone either, so it’s about inviting a person to participate, but its also about either accepting it or declining it respectfully. And that to me is very, very basic. That was my first teaching. I remember hearing as a child, ‘we always respect other people’s ways’ (Tape J).

For someone new to traditional-based practices, adopting the practices of other Nations can be a good first step towards becoming whole. As the speaker above suggests, participating in diverse traditions can help us to grow and to learn more about ourselves and our own ancestrally resonant traditions. The important thing to learn is that while health practices and systems may have similarities, they must be differentiated to maintain their integrity, and to prevent adding to their fragmentation or homogenization.

Labeling and socio-economic consequences also occur when traditional-based practitioners incorporate practices into their repertoire that aren’t in line with their ancestries; in hushed tones, people talk about the dangers of practitioners who “mix medicines”. While there is a need to be cautious, to understand and separate traditional-based processes on many levels (physical, mental, emotional and/or spiritual), it’s good to remember that being personally responsible for ones health (from a traditional-based perspective) means using “what works”. The speaker below offers a humorous perspective and reminder about discerning between the tools of traditional-based practices, and processes of healing which are universal and go beyond cultural boundaries.

Oldhands: Well, in my teachings, my Grandfather taught me ‘you take the medicine that heals you’. I’ve had people say ‘well you know, those sweat lodges, that’s not part of our tradition. We don’t do that.’ I say ‘well, do you take your appendix out?’ ‘Oh yeah.’ ‘Well surgery is not part of your people; dental, that’s not traditional’. Whether it’s acupuncture or acupressure or surgery, you take what heals you. Right. I go ‘if you are a non-Native and Native medicine will heal you, you’d take it. Right?’ ‘If you are from Africa, and you don’t know anything about the sweat lodge, and it will heal you, go in there.’ ‘I’m sure you don’t go to the drugstore when you got a tooth ache or belly ache, and pick up something off the shelf, and think whether it’s traditional or not. Right. You pick the medicine that heals you.’ So we have to be open to whatever it is (Oldhand’s Tape).

The key to engaging in diverse practices respectfully, regardless of the origins of the client or practice, is to remain cognizant of those origins, to differentiate between practices, and usually, to keep the practices separate. If the protocols of specific practices are followed, and ideally, believed in, then those practices can potentially help anyone, regardless of their ancestry. The ability of people to engage in the practices of people from Nations different than their own, has always, and will continue to depend upon their behaviour and attitudes, and how those are received.
B: There’s so many awesome ideas but we just have to get out of that mindset that ‘this is mine, this is yours, my teachings are better than your teachings’. It’s all the same, we just have a different way of doing things. When you look at the core of what we’re doing its about respect, honesty, responsibility, humbleness. We’ve got those same teachings; it’s a common thread, right through. And it doesn’t matter if we’re white, black, yellow, or red. Remember them, bring them back into our world, our institutions. I mean all of our institutions used to have those as core principles. Institutions lost sight of that power and control (Tape B).

In the city, as discussed previously, the types and ways of carrying out traditional-based practices are extremely diverse. Without an organized referral system, people must develop their own capacity for locating practitioners and discerning best fit between themselves and the available practices and practitioners. At the same time, a diverse population of practitioners means that – with little available guidance - learning the appropriate protocols for approaching and working with a practitioner, in a good way, can be difficult to impossible. While many practitioners are willing to overlook a lack of proper protocol, until the client/student can learn them, some practitioners consider those protocols essential to creating relationships that are efficacious. A suggestion for accessing diverse practices more easily, given by participants throughout this dissertation, is to create a cooperative practitioner council. The representatives of this council, or delegated liaison people, could be given the responsibility to assist in the facilitation of, referral to and representation of traditional-based practitioners and their practices.

**Economic Considerations**

**Freeing Practitioners to Focus on the Profession**

B: A few years ago I was an administrator of a health centre in Nanaimo and we negotiated and accessed $93,000 for a medical doctor and she wasn’t even working full time; she was only working part-time. I forget how many hours but anyway, at that time I was involved in guidelines provincially. In that program there was a core group of us working provincially and I was a part of this and subject came up about just what we are talking about. How do traditional people and the medicine people fit in, in the work that we are doing in the province and then we started talking about healing and how people, different people do their healing and how it’s done and how its offered and then somebody brought up money: “how do we pay for that, how do you pay for your healer, how do you pay for your medicine person?” There was one woman, I don’t remember where she was from, but anyway, she said “well, so and so from our tribal area is happy with a blanket and some tobacco”. And so I spoke up and said “you know I feel sorry for that person that gets that blanket and tobacco”, I said, “because it’s hard to make a stew out of a blanket, it’s hard to run your car on tobacco”, and I said “I’m sorry for being so blunt” you know cuz I could see she was visibly upset. I said “I’m sorry to be so blunt about this” I said “but we do need to talk about it (Gathering Tape 3).

Under different headings, participants discussed the need to raise the status of traditional knowledge holders and practitioners, and to compensate them accordingly. This is particularly relevant to the freeing of practitioners from the dilemma of deciding between a need to make a living, and the desire to practice, develop and pass on traditional-based knowledge, skills and teachings.
Dawn Marsden: If you are going to train someone, then how do you work and make a living, and how is this person going to do that, and that whole issue.

Doreen Sinclair/White Cloud Woman (Anishnaabe): Yeah, there's that whole issue. I've been fortunate while I've been doing this; I've had full time jobs. And what I was doing was always on the side. [It was] hardly ever part of the job, like the mentoring part. Yeah, and the teaching part.

Dawn Marsden: Yeah, did you find any conflict between working and your practices?

Doreen Sinclair/White Cloud Woman: Conflict? No, only with my energy level, sometimes I'm just too tired.

Dawn Marsden: What would it be like if you could have this as a full time job?

Doreen Sinclair/White Cloud Woman: Oh, I'd love that. I dream about that. I dream about doing supportive work, and doing the Creator's work; that's how I term it. Just do the Creator's work, 'cause there's so much work. I receive calls but I know I can't. I can't meet the needs because of my energy level and I really have to look after my body. And if I wasn't working full time... but I need a roof over my head. You know I need to pay for my car and all that. That would be just wonderful; I'd be working with more people. I'd be mentoring more people, you know teaching and I'd also be learning more (Doreen Sinclair/White Cloud Woman's Tape).

Under contemporary Vancouver conditions, the cost of living ensures that traditional-based practitioners must find work outside of their traditional-based practices. Such financial constraints limit the development of the profession as a whole, and ensures that there are never enough practitioners available to meet the demand of a growing population of Indigenous Vancouverites.

Adapting Traditional-Based Support-Service Relationships to Urban Contexts

Doreen Sinclair/White Cloud Woman (Anishnaabe): In ancient times, in villages, when we lived in villages" I said, "our spiritual people, our medicine people didn't have to worry about going out and collecting their food and all of that; they didn't have to worry about a roof over their head; their lodges, their food and everything was taken care of by the village people; so they didn't have to worry about how much wood they needed for the winter, how much meat they needed to put by and their clothes; everything was provided for them because those people were there for the whole village, they were there; it was their gift that they were sharing and they chose to share so then there was that exchange, you know, they shared their healings, their teachings, their knowledge and in turn the village people paid them; so that was the exchange in ancient times (Gathering Tape 3).

There are two major issues around the provision of money for traditional-based practitioners, and they often get confused. One is practical, and the other is sacred. In ancient times, as the speaker reminds us, practitioners or healers were provided for, as a form of generalized exchange for their services. Healing services weren't bought, because it was well understood that healing forces are wholistic, spiritually centred and not reducible to small units of measure. What was also well understood, was that to enable healers to practice, they had to be provided for. In a communal setting, this can be done without the exchange of forms of credit, through the provision of services or goods. In urban settings, people often have to provide for themselves and others, with money: to pay rent and utilities, and to buy equipment,
tools, supplies, food, transportation, insurance, clothes, medical services, furniture, toys and entertainment.

Doreen Sinclair/White Cloud Woman (Anishnaabe): So here we are in 2003 and what we need to work at is changing that mindset because in a lot of places, in a lot of areas, that mindset is still there amongst our own people, amongst the agencies and organizations and communities that medicine people and healers should work for tobacco and a blanket.

During the era when I was working provincially, there was this one friendship centre I was all excited to hear about, that was the first to hire a medicine person. ‘Oh this is wonderful, I can hardly wait to meet and find out where they got the money from’. So I was at a provincial meeting and I got to talk to the guy; I said ‘how did you do it, how did you hire him?’ ‘Oh’ he said, ‘we accessed money from here and here and here’. I said ‘good for you’ ‘cause what he did was he took money off programs to create position and wages. And I says ‘good for you’ because this guy that they hired was very powerful and very much in demand and a powerful person.

So the next question I asked was ‘well, how much do you pay him?’ He said, ‘well, he’s happy with $26,000 a year.’ And I said ‘what?’ And he looked at me and said ‘why?’ And I said ‘well, you know we have a doctor over in Nanaimo and we’re paying her $93000 a year and she doesn’t even work full time and that’s how much money we got from the Ministry of Health’. And I said ‘why I’m bringing this up is… we can turn around and go to the Ministry and they’ll give us money for a doctor who has studied for 7 years and done blah, blah, blah in the hospital. And they can hang their shingle out and all this money starts coming into their pockets right away’.

And I said, ‘our traditional and our spiritual people, usually they are chosen from when they are very little, and they can’t go off the path. They try and go off the path and poof, put right back on again, and the training never stops, the training never stops, and usually they’re on call 24-7’, as _____ was saying. ‘And what do we do with that?’ I said, ‘there has to be a balance here someplace, so we have so start turning that mindset around about that blanket and the tobacco payment, this is 2003, we are in the 21st. I’m so… we need to keep that in mind. And we need to support those people in a good way and a good manner so that they are not hurting, so that they don’t turn around and get sick for the want of food or getting around, having enough gas money or having to drive an old clunker.

And I said, ‘there has to be a balance here someplace, so we have so start turning that mindset around about that blanket and the tobacco payment, this is 2003, we are in the 21st. I’m so… we need to keep that in mind. And we need to support those people in a good way and a good manner so that they are not hurting, so that they don’t turn around and get sick for the want of food or getting around, having enough gas money or having to drive an old clunker.

So these are some of the things that I would like us to take into consideration when we’re talking about this and it needs to be talked about. Not just in the circle, it needs to be taken out into community and promoted (Doreen Sinclair/White Cloud Woman’s Tape).

The rules of good relationship and protocol haven’t changed. Traditional-based healing services still can’t be bought, protocols like the giving of tobacco and cloth must still be followed, and practitioners still need to be provided for. To ignore the practical needs of practitioners is to ignore tens of thousands of years of tradition.

Doreen Sinclair/White Cloud Woman (Anishnaabe): I was thinking of the fasting grounds when we go fasting, we always make sure it is on a long week-end so we have the time off. We would never think of asking you know time off to go fasting and it is very important to us. So I guess it’s another health thing we need to look at.

Dawn Marsden: Professional development.
Doreen Sinclair/White Cloud Woman: Yeah, exactly, professional development. And then with that too... what we need is money to pay other medicine people. We have a really good person who comes into town. Every so often we bring him in, his name is David Blacksmith, and he is very wonderful. He is such a strong healer, and people like him need to be supported, and we would need to be able to access funding for that.

And although a lot of times, sometimes I’m two minds, because I feel that if we take money out of our own pocket to ask for healing that’s more powerful. I’d never think of asking for money to go to a Sundance or that sort of thing. All the spiritual development that I’ve been through, I’ve paid for myself. I think it makes it more yours. So there’s two ways to look at that. I just had a discussion with one of my co-workers and he was saying that he doesn’t believe that our spiritual people should accept money, should charge for a ceremony.

You know I’m not going to try to change this guy’s way of thinking, so I just state ‘this is how I feel, and this is the way we need to go’. I see that currently we don’t take care of our Elders, they’re used as specialists [but they’re] living in poverty. And sometimes their phone gets cut off because their phone bill’s 2 thousand dollars, from people all across Quebec. They get calls from all across Canada. But the thing is, that all the work he does, he doesn’t get compensated enough to support himself. So there’s a lot of work to do there (Doreen Sinclair/White Cloud Woman’s Tape).

In the next few pages, participants share ideas around providing for practitioner needs, without profaning the sacred, and in ways that honour the lifelong training and status of healers.

Supporting Traditional-Based Practitioners Economically

Fee-for-service is an inappropriate practice for services that are spiritually based. People are called to the profession of traditional-based health practice, and through in-depth processes, commit to the application of their gifts, knowledge and training for the benefit and service of others. Traditional-based practitioners care for people, on a long-term basis, without considerations of payment.

Oldhands: It’s kinda hard, you need to find people who know what they are doing, or people that would like to think they know what they are doing, so that puts a damper, but the thing is: money, right? They don’t understand that any type of spiritual healing, that there is never any cost involved. That usually makes a lot of people [mad]. That’s where I make most of my enemies. They say ‘well how do you live?’ And I say ‘well I got a job’. Its’ like anything you learn; you go learn Reiki, you go work on two, three people a week and make 65 bucks an hour. And that’s not what it’s for because I have affection for people and I want them to be better and I want to know them… When I leave this world [I want to know that] somebody benefited from me being here. I don’t ‘I did this, I did that.’ Nah. I just open myself to the Creator to use me as a tool and that’s it. That could be one of our barriers and constraint: people that come out of woodwork right.

Dawn Marsden: Yeah, and then I guess one of the ideas is, if you are working full time you don’t have time to focus and develop your skills as a traditional healer. So there should be some kind of support for traditional healers as it was in the past.

Oldhands: I could see if they told me like ‘ok, we’re opening up a healing centre over there, and we want you to work over there; they’re going to pay you this much.’ But it would never be for… It would be for my facilitation, not actually doing it to
somebody. I won’t have somebody come and say ‘we need this ceremony’, and say ‘it’s gonna cost you this much money’. No. There are people that do that, that’s not the way. People that do that, they’re just b-s-ing them. That’s the way I look at it (Oldhand’s Tape).

The first idea presented here, for providing for traditional-based practitioners without establishing fee-for-service, is to hire practitioners to facilitate traditional-based health services, without paying for specific services. The next idea, given below, is to create an expense account for practice related costs.

A: That’s the problem; how do you employ people? Because traveling costs a lot, it costs a lot to bring people in. Then the question of fees. It’s hard for people to be able to live on… So some kind of provision where it’s not government regulated - we don’t want that either: White style. It’s getting harder and harder to practice. Then you are caught in guidelines and technicalities, on how they would measure, so that doesn’t work either. So if some kind of provision, where if a person is requesting a certain kind of health practitioner, traditional heath practitioner, that that be funded in some way, whether it’s travel or fees or to help with that what people need. So that’s the biggest thing: around payment, fees and recognition (Tape A).

The best recommendation made by participants, was to establish a practitioners’ fund, managed by a cooperative council, and used by practitioners for practice and training expenses (including honorariums for apprentices and helpers), and for living expenses. It was suggested that this system could be set up and drawn from, according to the amount of time or events logged by each practitioner, and according to their training and experience, to a maximum per practitioner.

While money, resources and a stable location aren’t always necessary for doing things that are really important to people, they can facilitate movement in more committed and identifiable ways, and in ways that don’t drain the resources of people who may not be able to afford it. The latter consideration is even more important in large urban areas like Vancouver, where people don’t always have extended family or community members to draw resources from, and where practitioners may be isolated from each other. For the participants in this project, having a centralized space, and supportive resources would be the ideal situation for enhancing the access and provision of traditional-based health practices in Vancouver.

Supporting the Development of a Traditional-Based Health Profession

Doreen Sinclair/White Cloud Woman (Anishnaabe): And that way [a co-op], people can start right from where they are or work out of where they are, or go to deliver their services on site. ‘Cause, right now I do both. I’ve been doing that at work, or I can do it in their homes.

Dawn Marsden: Oh wow, excellent, Mainstream services are coming around.

Doreen Sinclair/White Cloud Woman: Slowly, slowly.

Dawn Marsden: If we can get beyond the short term.

Doreen Sinclair/White Cloud Woman: Yeah, we’re still battling; it’s a battle with attitude, and a battle with history. But it’s a start.

You know, change starts with a few people that believe in something, that do the best they can from where they work. They just keep on working, working, working.
People know people, by what they do, what they are all about. And the good people don’t have to go out and knock on doors; it is word of mouth.

Dawn Marsden: In the bigger cities, it’s harder to find unless you know where to go, and talk to the right people. And it’s a very slow process if you are new to the city.

Doreen Sinclair/White Cloud Woman: Yeah, people tend to be more suspicious, and they wonder where you are coming from, what you’re all about, and sometimes you’ll find people will protect a person. Have you run into that? Yeah, I have too (Doreen Sinclair/White Cloud Woman’s Tape).

The biggest reminder, in the professionalization of traditional-based Indigenous health practices, is that while there are principles of professionality that can extend across cultural boundaries, the structures and processes for contemporary traditional-based Indigenous professions will probably look very different than Mainstream health professions; in the sense that – to be congruent - they must arise from Indigenous worldviews, Indigenous traditions and Indigenous peoples. Doing otherwise would result in the duplication of current services that are working under the constraints of incongruent structures, processes, worldviews, traditions and peoples. Throughout this dissertation, I have borrowed terminology from the academic Mainstream, as a way of translating the importance and equivalence of Indigenous institutions, principles and practices. In a similar way, I have borrowed the term professionalization, as the most equivalent term for the reputable organizing of a highly esteemed, intensely specialized, and integral health service for the well-being of diverse peoples. The caveat is to remember that the professionalization of traditional-based Indigenous health practices can only be done by traditional-based Indigenous health practitioners, in self-determining ways. How this can be done, in good ways, in Indigenous ways, and respecting multiple Indigenous traditions, is reiterated in the following sections.

**Developing a Cooperative Council**

B: It would nice if what they came up with is a co-op and that you always had a certain number of people available who could come if you’re tired. If we have enough healers and Elders that are sitting there, there’s going to be enough compassion in that room to deal with it [the anger] ‘cause that’s what the medicines are. And when you start building on that [community] relationship, where you get that information all the time, I think it all goes hand in hand with having that council (Tape B).

While the need for change at societal and institutional levels has been discussed in detail, what those changes might look like at the traditional-based practice level have been more convoluted, and even more controversial. Traditional-based health services in Vancouver are at a turning point, where many practitioners, facilitators and clients desire to move beyond marginalized and isolated practices. To this end, the suggestion of participants - creating a cooperative council - becomes the vehicle for enhancing the access and provision of traditional-based health services at the practice level, and becomes synonymous with the development of a traditional-based Indigenous health profession.

Dawn Marsden: One of the things that a lot of the other people, who are involved in this, have been talking about is having an Elder’s council. To provide some kind of a screening process and just say, ‘you know, we’ve talked to this person and this person is learning about or is doing these kinds of things’. ‘People in the community support this person.’ So having some kind of a counsel that people can go to for advice.
Lee Brown: That’s a really good idea if it could be done in a way that’s not political.

It’s very hard. If you get people that are traditional enough that are strong enough so that they can stay out of politics, then I think it’s a really good thing. One of the things that we observe with many really strong traditional healers is that they tend to move away from the people, to maintain an independence. They stay out of the politics and they separate themselves from the people. A guy that I knew, said that he moved away from the people three times. He moved further and further into the more remote areas of the reservation, and he said the further he moved out, the more people came to see him. But he had to move away from the people to maintain the integrity of his spirituality. People would compromise it. A council like that would be a really good thing, as long as it wasn’t political, because as soon as it became political, then it’s relatively useless for traditional people. The idea itself would be really good.

Dawn Marsden: By political, you mean people trying to impress their agendas?

Lee Brown: Yeah. There’s a certain power that goes with being a traditional healer, believe it or not, and - there’s divisions in a lot of our communities - and it’s very hard for a traditional person to stay out of those divisions, and not get involved in that, and be able to be of service to everybody in the community, no matter which side they’re on. And if you get, you know, for instance, too many people on one side, on this Elder’s council, then it can make it really hard for some people. Not only hard for some people to be identified, as who can do the healing, it would make it harder for some people to get the healing, because of the politics that would be involved in the situation. It could be a real non-political [council], if you could get people that were so esteemed, that they were beyond that sort of thing, then it would be a great thing (Lee Brown’s Tape).

In any profession, there are factions that want things to go in certain ways. One of the most egalitarian processes for guiding community actions, present in many traditional-based societies, is the concept of traditional-based councils. Like modern day cooperatives, where everyone has a voice, members work together respectfully to meet the diverse needs of its membership. This might sound like representative democracies, where a few elites try to represent the needs of the majority, but it’s not; the needs of the minority are also addressed. Traditional-based councils are made up of a whole community, in this case, traditional-based health practitioners, who agree to participate in a traditional-based council system of guidance. One of the major differences between a traditional-based council and a representative form of democracy, is that there’s no executive decision making. Where some decisions can be delegated by the council, important decisions are made by all participating members, for as long as it takes, until all issues are resolved. While time consuming, this ensures issues are addressed deeply, from all perspectives, for the good of all.

Dawn Marsden: Something that came up at the gathering was having an Elder’s counsel, that could do screening, talking about protocols, ethics, what do you think of that idea?

Oldhands: Good, I mean a counsel like that would be good, to do screening and protocols and ethics. You need that right, like finding the right group.

Dawn Marsden: Building the right group.

Oldhands: Yeah, it’s hard. Even last night I went to a meeting; I left at midnight, it started at 7:00, and they weren’t even half way through. The question was put before everybody and they talked about everything other than what the question was. They all wanted some sort of control, but they didn’t even know what they were asking about, or
anything. I was there all evening, and it never got settled. Everybody walked away with, probably, bad feelings. They probably weren’t even being listened to, or heard. I can see the same thing happening here: finding the right people for the counsel, ‘cause everybody thinks their way is the right way. There will be people out there that say ‘this is a traditional land, of so and so; they should have the most input’. But most of the people downtown are plains Indians, right? So what are you gonna say? Because most of them are plains, that we should hire somebody from over there? You’d have to find, you’ll have to do a screening just to find the elders that think alike, that would put the people’s interest first, not their own. That’s the hard part (Oldhand’s Tape).

The caveat here, as suggested by the speakers above, is that the council system will only work if members agree to its basic premise: to work respectfully towards community consensus in guiding traditional-based practices in the city. In a community like Vancouver, where people are diverse, and where many people are still recuperating and finding ways to be resilient to colonization, in competitive environments (socio-economically), the ability to rise above difference is a rare quality. The embodiment of traditional values in the city may not always come easy, and may have to be worked at.

Oldhands: A counsel like that... it would be good to do screening and protocols and ethics, you need that, right (Oldhand’s Tape)?

A: Yeah, I guess there could be something developed around a screening process, depending on the questions. But you’d do that informally, to have a sit down, not quite an interview, but just ask where did they learn their medicine from? Is it okay to contact these people? And to always have and encourage that the ending works out the best. Without all of that, it’s just a statement (Tape A).

The recommendations for creating a council membership, are very specific. To ensure that a traditional-based health practitioner council gets off to a good start, a cooperative screening process has to be set up, whereby each potential member of the council submits to a criminal record check, makes an in-council presentation about their training background, specialties and experience level, and submits contact information for teachers, witnesses and clients.

A: I guess the administrators, who would be looking at the administration part of these provisions would get a sense of who does what kind of medicine and what kind of way they can help us out. Some kind of board to review, or council to look at how we can best do service: to take care of the medicine people and provisions around how to monitor safety. I know at the Longhouse we do criminal record checks. And often people who have been involved in the law when they’re younger don’t know the system that well. So if they had something that could be wiped off the records, I mean that’s just one way but I mean if there were other ways to figure out how to manage practicing agendas and that kind of concern (Tape A).

To prevent the disrespect of Elders, all Elders that are coming from a sacred space should be welcomed into the council (Wendy Nelson, West Coast Salish, Yakima, Mohawk; June 19, 2005 conversation).
As the above speaker cautions, we must take care to be inclusive, and to ensure that, if any screening is being done, that it be done appropriately, and respectfully. For example, if an Elder wanted to join the council, their background check and interview would be done by Elder members of the council.

It’s also been suggested that this screening should be gender specific, to prevent breaches of protocol or ethics. After presentations, references will be checked and the potential council member will be invited in, under the conditions that they practice according to their confirmed training, specialities and experience levels, and according to council guidelines. If their backgrounds or references can’t be checked, or if potential members are unwilling to abide by council guidelines, at their training level, then avenues may be set up for community members-at-large to contribute to or otherwise support the council.

Doreen Sinclair/White Cloud Woman (Anishnaabe): When I heard there’s already a healing center in the architectural phase, I was totally shocked. That’s going to be a major step, consulting and territory and ownership.
Dawn Marsden: How do we do a healing center that’s supposed to be about balance and good relationship? And how do you do that in such an international forum?
Doreen Sinclair/White Cloud Woman: What I see, that has to be worked on, is the love and respect for each other, where it doesn’t matter what tribal group: respect for each tribal group, and the support we can give each other. That’s where it has to start. And if we respect and care and support each other, then we will support a healing center, it doesn’t matter what tribe you come from. But it will have to be on-going because sometimes old animosities that stem from the church and residential school, suspicion and... Compassion (Doreen Sinclair/White Cloud Woman’s Tape).

One of the most important functions of a profession, is to provide a network of professionals who can confer and provide guidance about what to value in traditional-based health practices, about ethical principles for action, and about the different applications and outcomes for specific practices. One of the ways this has been done, for thousands of years, is to have periodic gatherings of people interested in discussing and resolving the same challenges. While a popular, contemporary form of this is the hosting of conferences, a traditional-based form of networking might incorporate considerations of appropriate timing, protocol and ceremony. The speaker below gives some examples.

A: I guess camp site times where a lot of business got done ceremonial wise, and so the different healers would come, a gathering, and so there will be different medicine people, and then the medicine people could confer as well with each other, you know professional development.
Dawn Marsden: Annual conference
A: Yeah, so a seasonal thing too. Right. So it’s in each season (Tape A).

Another important consideration, for the provision of traditional-based health services, is mentioned below.

O: We don’t have a medical centre for Traditional-based healers. A place for traditional-based healers to go and heal themselves (Tape O).

It’s well understood that anyone providing front-line health services are in danger of becoming overwhelmed or drained of their energy - mentally, emotionally, physically and
spiritually - if they don’t keep their own lives in healthy balance. To provide a well-functioning health service, practitioners are obligated to keep themselves healthy. Having a community of practitioners to assist in this process, can be particularly empowering.

B: I’m thinking, just listening and thank the Creator that I don’t take that on. I just listen and am there for that person. And sit there and give comfort and I can provide some suggestions. ‘I don’t know what the answers are for you, I can provide some suggestions’ and give them some names ‘and be there for you when I can be, but you have to start moving forward, you can’t stay in that.’

To be able to do that, I have to be able to take care of myself, that’s why I weight train. That’s why I like to do ceremony. That’s why I go to school. You know, in my life there’s a lot of things that I do that I can’t very well say, ‘well, I do it so you can do it’, because I’m highly functioning. I do a lot of things and my life is really full, but I know that it works for me, to be able to keep my medicine balanced right. It’s important that I keep my medicine in balance but if you have provisions built into jobs... Right. Traditionally-based. Right.

You can’t give anything that you don’t have. And so if I’m saying to ‘you be here, come on, you need to exercise, you need to start getting those feel goods happening in your brain.’ If I’m not practicing that, and I’m sitting here and I’m out of shape, and I’m drinking coffee, and having a smoke outside, they’re going to be like ‘ok then’. But they know that I practice what I say, and I never say anything that I’m not willing to do myself. And that’s part and parcel of what we need to do here. The staff do ‘boot camp’ recreational development, so I’m going, am able to do a whole lot, and push our staff. Sometimes the staff get a really good work out. We’re always exercising everyday, about an hour a half - it’s part of wellness - and then we do ceremony, workshops and life skills. It’s all built in.

But they still need to be able to have a safe place to be able to say ‘grrrr’, and this happened, and I don’t know if I dealt with it properly, maybe I was inappropriate here.’ You know what I mean: be able to bounce a lot off and see it. (Tape B).

At the same time as inspiring and strengthening the profession as a whole, networking can assist practitioners individually: to become inspired, to feel supported, and to acquire the strength and healing they need to continue good practices.

B: I’m thinking we really need a healing circle that provides for the service provider because we don’t have a place to go, and sort of bounce around ethical dilemmas, right? You know ‘this happened, you know, like I just need a safe place to be around people and know that it’s not just something I’m experiencing by myself’. Be able to grow and heal and to be able to... not get high burnout; it’s extremely high.

You know we’ve had meetings right - AA meetings, and AC meetings NAC, all kinds of meetings - but I’m thinking we really need a healing circle that provides for the service provider, because we don’t have a place to go and bounce around ethical dilemmas. You know, ‘this happened’. I just need a safe place to be around people and know that it’s not just something I’m experiencing by myself, and that I can go and get people.

To be able to grow and heal, and to be able to not get high burnout - extremely high – it’s because people don’t have the idea. Here I am working, taking care of kids, but I’m not taking caring of me. They’re not taking care of themselves. They can’t do anything for anyone else if they’re not taking care of themselves. They call in sick, and
call in more and more, and pretty soon it's stress leave. And I would just as soon say 'you know what, let's build a wellness plan right into this job so that, it's part and parcel of everything you do'. Without that provision - because the issues are so huge, there's such a great deal of pain and suffering, and we're going to see more of it - we're sitting with people who are dealing with people, whose situations seem insurmountable even to my ears.

Yeah, there's other boundaries that have to be set up around safety. But for sure, there's two things I've been asking for here. And it's sort of gotten to the broader image, before the circle, 'cause he comes to do 'One Mind' workshops here; and we started out by saying 'you need to have an elders council here'. And now it's expanded into all organizations: one council that you can go to and say... like I could say 'I have a Nishgaa youth...'. So they would direct me to go to teachings from the Nishgas; so I would go there and bring that person there, and then if something happened you know where people don't understand the teachings, or something happens, you go back to the counsel and you say, 'oh, this is what happened, so that you understand', rather than, all of a sudden, there's all kind of conversations going around about this person, and it's just a misunderstanding. If there is inappropriateness then the elders would no longer direct people to that person (Tape B).

A place for traditional-based practitioners to congregate would also enable the development of teams for traditional-based healing events and therapies, for both individuals and groups. Practitioners would no longer have to work alone, and their services would be strengthened by the additional resources of team members. Working as a cooperative, a traditional-based practitioners' council would enable continuous, reliable, enhanced and safe avenues for both accessing, and providing, traditional-based services.

Lee Brown: A few years ago, in B.C. there was a big effort to identify all the traditional healers, I received a letter in the mail saying that they want to identify all the traditional healers and that we were going to have little cards. You know, I'm not saying I'm a traditional healer, but traditional healers were going to have little cards and they asked me to reply to this. I sent them back a short letter and I said my authority for anything that I do is the tobacco that people give me and that's the only authority I'll ever accept or ever respect. And so I never heard from them again, and I think the effort to do that fizzled, but on the other hand, it would be a good thing to have some way of knowing who was real and who was real and legitimate in the sense that they have had actual training (Lee Brown's Tape).

By creating a network of traditional-based health practitioners, a collective vision can be created, and guidelines proposed for the development of the profession, towards the provision of best practices for the wellbeing of both practitioners and potential clients. If we consider these ideas, and connect them with recommendations for respecting local First Nations, and for creating a cohesive governance framework, a traditional-based practitioner council in Vancouver might be represented by the diagram in Figure 11 (next page). The black circles represent the diverse Nations within a cooperative council; within a larger red circle which represents the GVRD Indigenous governance framework; within a brown frame representing alignment with and guidance by local First Nations.
Developing Cooperative Spaces for Traditional-Based Practices

Lee Brown: The Ideal would be a place where we could go where we could access traditional healing, where we could be totally confident, an institution that was supported, where the people that worked in that institution were supported, where it was reliable and open to people, possibly affiliated with the hospital or medical doctors, as well as psychiatrists.

So, anyway, a centre where we could go where the healing was available, where there would be counseling for the emotional realm, where there would be able healers and that kind of thing for the physical body, where there would be counselors and advisors for mental problems...

...and possibly even teachers for people who wanted to learn about these sorts of things, whether it be a program with an apprenticeship so people could be studying and working with elders, because, you know, there's a few Elders with lots of knowledge...

...and some people would go on their spiritual healing, follow their spiritual ways. A centre that would be congruent to our traditional beliefs, and by that I mean, couldn't function on a 9-to-5 kind of setting. It wouldn't have the kind of paperwork that most institutions have.

So it would have to be something congruent with our ways and the ways of traditional people and how they do that, but at the same time, have the integrity of an institutional structure to it. So that would take a lot of work and a lot of thought, but it could be done and there's no doubt that it could be done. And not only could it be done, I think, eventually, it will be done. I think our ways are getting stronger and there's no way of stopping them, now, of becoming stronger. I think it will take a couple generations, but you know, the people are getting stronger. There's no doubt about it (Lee Brown's Tape).
M: I've seen these questions before. Where I saw them was in Lytton, where I was originally from. And what they wanted... They wanted to use traditional healing and traditional medicines in the new hospital that was going to be built, but I guess it's not going to be built now. And the people that told me this, I asked them, ‘so if you’re going to put traditional healers in there, and traditional medicines, how are you going to run the hospital? Who’s going to have the hearsay? Are you going to have the hearsay, or is the government going to have the hearsay?’ It was like an automatic question that everybody would ask. Or, ‘how are you going to know that this person is really traditional? Or, is this person really a healer? Is this person a gifted healer or is this person been trained as a healer’ (Tape M)?

The first consideration in creating appropriate spaces for traditional-based health services - in a country that has historically oppressed traditional-based Indigenous laws, institutions and policies by imposing Euro-Canadian laws, institutions and policies – is to examine who will be designing, owning and running the centres. Providing traditional-based practices in Euro-Canadian settings, under Euro-Canadian ownership and management, is not the best case scenario. If we flip it around, and provide Euro-Canadian health services, in traditional-based Indigenous settings, under traditional-based Indigenous ownership and management, we can see in another way how it doesn’t work.

Daisy Heisler: It’s so hard to get enough land in Vancouver, to even give people a piece of grass: a place to chop a piece of wood. When you think of places in Vancouver that we could have a health centre, it’s usually a building rather than a plot of land, right? And I, for Native people, can’t see a building without land, I just can’t. But that’s maybe part of my background, too. I’m not Native, but I need land. Values and principles that are Indigenous, that are shared with other people who are connected with their Indigenous roots.

Dawn Marsden: I think that’s why there is so much interest now in leadership sometimes places can be transformed by how people, the right kind, work. I’ve seen it happen (Ken Schramm & Daisy Heisler’s Tape).

The setting that can facilitate the best-situated services, is a setting that is designed, owned, and run in congruence with the ethics, protocols, people and practices that are being hosted. Space considerations, as the above speaker urges, must include more than just building; if we are to incorporate traditional-based worldviews, space must be inclusive of emotional, mental, physical and spiritual domains of being. The next few paragraphs detail participant ideas about inclusive space considerations.

E: There’s so much easiness in accepting other people and their ways that I love, I just love. Wouldn’t it be wonderful to have a resource in an urban setting, a place where you could go, to find an advisor, you could go to this person and ‘ok, this is how they conduct their sweats and this is who goes to them’ (Tape E).

The most appropriate people to design, run and own a place for traditional-based Indigenous practices, are traditional-based practitioners. If we take to heart the prior recommendations, then a traditional-based health council becomes the most appropriate group to design, own and run such a place, in congruence with traditional-based ethics, protocols, people and practices.
In the discussions about the role of facilitators and traditional-based practitioners, the establishment of an organized referral system was recommended as a way of enhancing access to traditional-based health practices. If this to be done in a good way, in a way that reflects and facilitates traditional-based ethics and practices, appropriate space will need to be made available, for the facilitation of best fit, through traditional-based counselling or diagnostic practices.

Lee Brown: It would be nice if we had a traditional healing centre where... One thing you’ll know for sure is that the real tribal communities know themselves very well. There is a very accurate understanding of who’s capable of doing what. When you come to an urban area and you’re not really in a tribal community and you’re just meeting someone who says somebody can do a certain kind of ceremony, it’s really difficult. It’s like being in the dark.

So it would be nice if there was some kind of centre where people could go, depending on the kind of health need they had, they could be directed to the kind of person that did that kind of thing. My understanding is at one time, when tribal healing systems were intact, there were certain people... That’s what they did, they diagnosed a person; they didn’t do the healing. You would go to them first, whether it was a man or a woman, you would go to them first and then they would do a ceremony to determine who you saw next. So you were directed to the person who could handle what it was that was bothering you (Lee Brown’s Tape).

These same diagnostic and matching services can be provided in urban settings, with a few modifications. In lieu of a tribal understandings about who’s qualified to do what, a traditional-based health council, in combination with in-person facilitation, can ensure that urban clients are properly diagnosed, referred to appropriate practitioners, and are prepared and committed to the specific healing processes being proposed.

A: Yeah, so in thinking about [the needs of] medicine people... They have their family or a crew of helpers. So there is a consideration about those kinds of relationships where it’s not just them, it’s their helpers. Everybody has a different kind of role. Like, if there was a training session for the people who are in the space, they know they’re going to be dealing with more than just the person; that it’s probably ten people. So they have to have a place for that; so it’s not just one hotel room, or something like that. It’s got to be a bigger space because often, there’s an interview process to it as well (Tape A).

If we remember that many traditional-based practices are best done with the support of family or community, we must consider spaces that will accommodate large numbers of people. While a single room might be adequate for one-on-one counselling, it would be inadequate to meet the space needs of a traditional-based health council and practitioner services, which may include large numbers of people.

Lee Brown: I was back at Manitoulin Island and they took me to the hospital there where they have a traditional healing room, and this is leading into your fourth question, but they have a fire in the hospital, they have a circular room where a number of Elders each have their own little cubicles where they work and keep their medicines and to me that’s an ideal situation. There’s a back and forth, according to what they told me at that time, there’s a back and forth between the Elders and the doctors, and that’s how it should be (Lee Brown’s Tape).
While many services can be done at practitioner’s homes, or at outdoor or sacred sites, some might be facilitated by providing a variety of spaces for individuals, groups or gender specific activities.

Sharifah Marsden: The ideal situation is individuals having their separate offices. You know, almost like doctor’s offices, when you go and see them. Or it can be something of Hey Way Noqu, where they have counselling services. They have one reception and they have like 11 different people. And then within that, those 11 people create their own groups: one’s a men’s group and then they have a women’s group, and then they have a co-ed group, and then they also have different workshops. Something like that would be pretty good, too. So, I guess, having the services available, like, within an office kind of perspective and then also having the healers come together and doing classes or doing workshops with the people, with larger groups, I guess. So if they wanted to do a sweat, they could do a sweat with a whole group of people, instead of one-on-one (Sharifah Marsden’s Tape).

As suggested, these spaces could be booked according to practitioner needs and availability, on a 24 hour basis.

Doreen Sinclair/White Cloud Woman (Anishnaabe): And of course an ideal situation would be having a healing center where you can go for one stop shopping and have the different disciplines and different talents all working there in one place (Doreen Sinclair/White Cloud Woman’s Tape).

One of the most interesting themes, with the most varying suggestions, had to do with what kind of traditional-based practices a traditional-based health centre would include. The difference in responses again indicates the ambiguity of the phrase traditional-based Indigenous health services, which can range from very exclusive, to very inclusive ranges of people.

The first speaker cautions that a centre for practice must be inclusive of all people of Aboriginal ancestry, regardless of divisive labelling practices. She continues to discuss the inclusion of Aboriginal doctors and dentists, Elders, councils and networks. In this sense, it seems that the phrase traditional-based is the most emphasized, meaning that what makes something traditional-based, is how [respectfully] something is done.

B: It’s the part people don’t understand: the Aboriginal community is so small because they try to keep us separated with status, non-status, on-reserve, off-reserve, Metis, Inuit; so that keeps us separated. [Otherwise], we’re so large. So, if the aboriginal organization, doesn’t step into this in a respectful way, it’ll separate us. We can’t afford to do that anymore. We have to come together and heal in a powerful way ‘cause that’s the only way we are going to grow. You know where we are. It is time people know that we need to do this. So that’s the exciting thing about it. The fact that we won’t get any new money for it doesn’t matter because we never had it anyways, and we’ve still been successful the way we are now. So it’s just joining hands and going another step further and having Aboriginal dentists, Aboriginal doctors, and Elder’s councils and networking. Because once we start doing that and once we start to evolve with that, we are going to have access, the ones that have those gifts, because the medicines are so powerful. I’ve seen what badness, and I’ve seen what goodness can do so there’s no one there that can tell me it’s not powerful (Tape B).
The next two speakers discuss a centre in a similar way, but emphasize the multicultural aspects of Aboriginal people. This emphasizes seems to indicate a need to be inclusive of people from diverse Indigenous Nations, in North America.

E: Yeah, this is what I wrote down. Multicultural Aboriginal Health Centre. And it would be all the different cultures. Cree, everyone. Multicultural Indigenous, so that people could go there, Metis people even (Tape E).

Sharifah Marsden: Yeah. Like, say you have one healer from Alberta and one healer from B.C., or like a couple from different areas in B.C. and a couple from the different areas across Canada and some from the states, just giving a variety, and then female, male, so that there’s a lot of options so that if someone is looking for a certain kind of help... Or, if they’re comfortable with a certain way of doing things (Sharifah Marsden’s Tape).

The next speaker expands the meaning of traditional-based inclusiveness even further, to include traditional-based Indigenous practices from around the world, for the benefit of all people.

Oldhands: I’ve actually thought about that for the past 4 years. Myself, the ideal traditional based healing place would be a multicultural healing centre because we have a large group of Punjab people, and they have a spiritual aspect close to ours; I’ve worked with a lot of them. And they’ll say ‘you know, your smudging and your prayer flags, that’s kinda like what we have’. So, if I’m working on somebody who is Asian or Punjabi, and they come and they have the feeling that I can help them, and that’s helping them, that’s good. I don’t want to work just on Aboriginal people, I want to work on anybody who thinks that whatever I can do will help them. But there’s aspects of their spirituality that I don’t know, so if we have a multicultural center that works on each of those - the mind, body and spirit part - I think it would be a very powerful place. And even those healers can learn from each other. So it would be constantly, everybody in there would be constantly upgrading themselves. So I think, not just an Aboriginal healing centre, cause it would bring... people would be going ‘why do they got a center and we don’t got a centre?’ Multicultural [traditional] for anybody; not just Aboriginal. Just like my mother, she went to a doctor - and she did our traditional medicines before she had to go to a doctor - and she always wanted to go to an Asian doctor. I used to say ‘why do you go to an Asian doctor?’ ‘Because they go to school more’, that’s what she said. She goes ‘if someone is going to be working on me, I want them to know what they are doing’. So she believed that because they had education, they would probably be better than somebody from, say Africa. ‘I can be smart too’; that’s what I’m thinking. We have a lot of people go to Aboriginal healers, because they believe they have special magical powers that will heal them. And that belief, it’s like a placebo to them; it helps them. I think a multicultural centre... I would expect it myself (Oldhand’s Tape).

Considerations of who to include, is inevitably connected to considerations of how to include. The principle of people-centred service, can also have different meanings, depending on which words are being emphasized. Where mainstream services may agree that people-centre services are the ideal, practice more often demonstrates an emphasis on attending to good techniques. In traditional-based health services, the emphasis has consistently demonstrated an attendance to people.
Ken Schramm: I can jump right in and tell what I envision; a people place, rather than a doctor-nurse place. A people place. Keep the focus on people; anybody else who provides services in that place should think of it as a people place. You know, someone wants to come in and have coffee, and just have a visit it should be fine sitting in a room waiting for their appointment, a people place. And that, as far as I’m concerned, that could be any traditional medicine: Chinese medicine, Native medicine, Tibetan medicine, whatever; just keep it as a people place and away from the western medicine model. I think that would give you a real good feel for what needs to happen, where a woman and her family would be comfortable and safe in a sacred place, to give birth. So it’s really about creating good environments (Ken Schramm & Daisy Heisler’s Tape).

The last few considerations are just as important as the previous considerations, and are inseparable from who will design, own or run a traditional-based health centre. Healing spaces, for anyone, must include the four most important elements: healthy air, healthy earth, healthy water and healthy fire. These things are the cornerstones, or major physical tools of traditional-based practices, and tie together all the other recommendations for accessing and providing traditional-based health services in the city. Ownership of land, as one speaker suggested, may be vital to ensuring that these elements are designed in, and protected within a traditional-based healing centre.

Oldhands: The centre would have an inner court yard, plaza, so that you could have a lodge in there or whatever. One of my long term dreams would be to have an Aboriginal hospice with an open court yard; that way you could go out at night and see the stars, hear the drums, watch the fire, and hear the music and feel who you are. ‘And you know not, what they are leaving behind, but what they are going to, their ancestors’. I think it would be powerful. You don’t have anything like that here. You could go out at night - two weeks, three weeks or a month - and sit outside, see the stars, smell the fresh air, smell the smoke from the fire, and listen to the drumming and singing, the story telling (Oldhand’s Tape).

While urban areas aren’t always conducive to providing these important elements, there are, as participants suggest, high tech methods for including them.

A: so then I guess maybe a state that’s conducive to having smoke or fire so it might even be a wood stove inside or something like that... and where sound [is acceptable]; that kind of stuff. So, not quite aesthetic, but built in Aboriginal tradition. So that if it’s outside [it doesn’t] bug neighbours or anyone, at all hours (Tape A).

Finally, space for traditional-based practices, must be established at multiple sites, to meet the needs of a diverse and geographically wide Indigenous population (in the GVRD).

B: So an ideal traditional-based health service situation in Vancouver would be, not just downtown. We have Elders who are afraid to go down there, we have drug dealers that are hanging out right in the front, and I’m not afraid of them, but I have a relationship with them. I can walk down there because I’ve walked down those streets before; so I know how to walk in there and take care of myself. Right now, some of our people are robbed and beaten as we speak so we need health services that are in different areas as well. Not just one token one; we need to have outreach (Tape B).
As suggested, spaces could be developed over time, from popular outreach facilities, into more established institutions. Besides creating locally specific practices, multiple sites enable access and provision, for and by those who may not have the funds or the ability to travel longer distances, or for those who may not have the aptitude to travel into certain areas (too rich, too poor, too White, too radical, too fast-paced, too dangerous...).

Sharifah Marsden: Because nobody... They're not advertised and there's not really a list of people you can call up. You just got to go from word of mouth. Yeah, if they were all, I guess, in one centre or if there was, if they were linked to centres, different places that you can call, like the Friendship Centre and say, “you know, we want to talk to somebody”, and if they had connections, and they could give you a number of someone to call. You know what I mean? Instead of just going from what your cousin’s brother said, and actually having a centre that’s reliable, I guess, that you can trust. And I guess a way of getting a hold of and finding the people. And if there was, I don’t even think there’s that many in Vancouver, that I’ve seen or that I’ve heard of. Maybe if there was a way, yeah, just basically a way you could contact somebody or find out how to get a hold of somebody.

Well, first of all, there are a lot of Aboriginal organizations that are already interconnected. So that’s one good thing, that we already have a basis to start from and Aboriginal people have places to go and, you know, word-of-mouth gets around, and if we had another kind of centre that was basically for a call centre or, just to call in and get connections, referrals, that too. Or even have a healing centre with some people already there, or both. Yeah, having both things available, but having something that aboriginal people know they can call, like an Aboriginal Helpline.

Dawn Marsden: Traditional Helpline or something?
Sharifah Marsden: Yeah, Traditional Helpline, even that too. Then again... But people would find people better that way; easier that way.
Dawn Marsden: Rather than the slower word-of-mouth process?
Sharifah Marsden: Yeah. Yeah, and if they were interconnected with... All they would have to do is just get to know people at the other places, other Aboriginal places, centres, and it would just be like a poster or some kind of advertisement. Then everyone would know in no time. Because we have Aboriginal everything, why can’t we have an Aboriginal health centre or even an Aboriginal helpline? We can just keep going from there. We’ve gotten so many things started...
Dawn Marsden: So there isn’t an Aboriginal helpline right now?
Sharifah Marsden: I don’t think so (Sharifah Marsden’s Tape).

Supporting the Training of New Practitioners

Sharifah Marsden: You can’t just get a certificate. You can’t just go to school and get a degree and become a healer. You either gain it from practice or you get it from birth, right. I don’t think you can go to school for that, that’s my personal opinion (Sharifah Marsden’s Tape).

J: I would look at the Elders in training, the Elders of the future. See ourselves - like that vision - how are we going to be 21 years from now? There’s a group of people our age, we’re not kids anymore, we’re not 18 anymore, but we are not Elders either.
We’ve been around the block a few times, we’ve had the benefit of experience and have learned from it. We are the future Elders.

That is the role of an Elder, ‘cause Elders identify those gifts. They used to watch their babies and see which way they lean towards. My wife, Lorraine, she was a baby, they took water and splashed her face and they’d take her sister or whatever and she’d sleep right through it. But you know what that was a test for? A healer. A healer will wake up. And then the next night they’d splash from a little further away.

Dawn Marsden: Sensitivity.

J: Yeah. A little further so they’d get to the point where they’d go from here, to down to the river - which was a mile - and she would wake up; whereas the others would sleep right through it. The Elders have the abilities to recognize those hidden gifts we wouldn’t even know how to look for.

Dawn Marsden: Yeah, finding out early, not when your 60

J: Yeah, exactly. And what is necessary to create this idea? Believing in ourselves and each other. The creator gave us these gifts, he gave us these qualities; we still have them. They can’t be taken away. If we pray on it, the creator will give them back. We just have to keep going to our ceremonies, going to our Sundance, going to our sweatlodges, go up in the mountains, go to the cold water baths, go to our longhouses, pray, and the visions will come. Our visions are coming. We’re being shown who and what we are. We just have to ask. We have to believe. See, we’re putting too much power into these other people. We believe that they can take away who we are. They can try… (Tape J).

The role of traditional-based health-education practitioners is vital to the continuity and resilience of Indigenous people, especially in urban areas, where the environment is especially conducive for fragmenting, disconnecting, isolating and otherwise destroying lives. Because of this, it becomes the most important place for people to retain a strong sense of identification with the universe and with where they have come from; without those principles and practices, people can drift without purpose and are in danger of becoming amoral, to the detriment of themselves and others - lands, waters and beings - in the area.

Establishing a traditional medicine clinic enables the shaman’s clinical skills (including rituals and belief systems) to be preserved in practice and provides an opportunity for apprentices to observe and develop their own clinical skills. This is not dissimilar to the role of the university teaching hospital in undergraduate western medical education (NUFFIC, 2003).

In traditional-based services, health and education become inextricable processes, and consequently, the well-being of practitioners and clients/students, become inseparable from the well-being of the whole community. Traditional-based health services are about passing on teachings that people can use to guide and make sense of themselves, their worlds and their roles within them. In this sense, the long-term relationships established between practitioners and clients become complementary; lifelong learning and lifelong educating become extensions of the same traditional-based processes.

O: I know there’s a few brothers out there that are - what I would consider - ‘a healer’, but they don’t know it; they don’t realize it. There’s a lot of people out there that have a lot of gifts within them, and they’re just wasting them, because there is nowhere to
exercise them, there is no where to exercise in a traditional-based healing centre of any sort, anywhere (Tape O).

As long as there are people interested in and committed to acquiring the knowledge and skills for bringing traditional-based health services into their own and others’ lives, the role of traditional-based practitioners will remain integral, and the cycle of cultural continuity and resilience will be perpetuated.

Doreen Sinclair/White Cloud Woman (Anishnaabe): And also training. I see a need for those of us who are in this field to be training all the time. Training others, younger people that are interested in this way. Training them ‘cause it is a life long thing. And you know when you decide to walk this way, that you never stop learning. And I’ve been working with this one woman I think about 7 years on the island, working with her on dreams. And she’s to a place now where she will call me up and say I need help with this dream. I can’t seem to work my way through it. But, she’ll do healing work on her own dreams and now she’s starting to work with others. So, I mentored her all those years and there’s this other lady in the Cariboo and so that’s ongoing.

And I guess I’m always surprised when somebody comes up and say ‘you know how to mentor’ and I say ‘oh, how do I mentor this person’. So, there needs to be more of that because we just need it.

Dawn Marsden: I’ve talked to some who say they’ve been waiting for years for someone to work with and who’ll stick with them longer than two weeks so I imagine that a month is just a testing ground.

Doreen Sinclair/White Cloud Woman: You know I’d really like to go to one that mentors… to learn more about the plants and medicines. You know, people always think I know a lot about roots and medicines. Maybe I do but I don’t feel I do. And there’s always lots more to learn. And when I go and sit with this elder, I feel like I’m just a little kid. You know the knowledge that’s available.

Dawn Marsden: You can devote a whole life time to just one specialization.

Doreen Sinclair/White Cloud Woman: That’s right, yeah. So what I’ve been concentrating on, in line with that… I’ve been concentrating on working with people’s dreams, helping them with their dreams, doing mine first, working with mine, and then others and then working on their healing.

And I also do clearings, you know like spirits and stuff. And what I’d rather do there, again, I teach people how to do the clearing and keep themselves clean, rather than relying on me all the time. I’ll teach them, this is how you can maintain your energy, this is how you can get rid of other people’s energy, by these exercises. So, actually I do that just about everyday when I stop to think of it. I do a fair amount of that now (Doreen Sinclair/White Cloud Woman’s Tape).

One speaker discussed how it often takes people 30 – 40 years to accumulate the knowledge, skills and experience to start practicing bit-by-bit, with other people, if ever. This is a form of informal apprenticeship, or mentorship, where everyone may be taught or be helped to realize the knowledge and skills they need, or are gifted with, to be responsible for the health of their own lives.

M: I ran into lots of people… This is where I get really scared about lots of people. They come up and they tell me they’re healers and I would ask them, ‘when did you discover your gift?’ ‘What gift?’ You see, when they ask me ‘what gift,’ that tells
me automatically about them, because I’m not going to send anyone to them if they’re going to say, ‘what gift?’

And the only time I really want to hear about it, is if somebody is really denying that gift, and there’s a certain way that they deny that gift, because I know I denied mine for I don’t know how many years. But then _______. He used to work on me a lot. And then at that time, the gifts that I did have, well, I’d been denying it for I don’t know how many years.

When I went to Tsow sen Lelum, I remember I was singing this song. My group sister… Her and I would be playing with each gift, years ago. We both sat down, like she sat on her bed and I sat on mine. We burst out laughing and she asked me, have you ever thought of where you got that from?’ I said, ‘yeah, I can imagine where I got mine from.’ And she says, ‘who do you think you saw that did that?’ I said, ‘my great Grandfather.’ I said, ‘I seen his hand move on top of this person. He’d have a song that goes with it.

And I said, ‘one time I practiced with my sister.’ She was maybe a year, going on two years old. ‘Lay down.’ So I started singing that song and I got done with four verses and I didn’t even know my Dad was watching. ‘Hey, what are you doing?’ And my heart just about jumped right through the ceiling. He had to grab me right away, he said, ‘I’m sorry, you don’t do that until you’re an old woman,’ he said. So that’s when I discovered that I was from my great Grandfather, and I would have it in me to practice what he did.

But then I shoved it down more and more, and it seemed like the more I shoved it down, the worse it got. I could feel it was shaking right inside of me and I could feel it. Like my hands would have that tingling feeling, and my hand would be just shaking like this and I would sit on it right away. I’d say, ‘just quit that right now. Go get somebody else that’s responsible.’ So that’s how badly I didn’t want my gift, and finally I just got beat up for it, meaning that I was sick a lot.

Dawn Marsden: That’s one scary journey.

M: Yeah, it is if you don’t accept it. It’s not only you, you hurt, but you hurt your family members, too; that’s what I found out. So what happened for me, when I was at Native Ed. - this one was a really scary one - I woke up and I was awake when this vision came through for me. A white buffalo came charging through my chest. Its head was about this big and the nostrils had steam coming out. I said, ‘oh my God, what are you doing?’ And it took me four times and I said, ‘I’m not ready. I’m not committed.’ I said, ‘don’t you see how many people are praying to be a healer or whatever?’ And I said, ‘I don’t want it right now.’ And it was like that for me right up until I went to Tsow sen Lelum, about two years ago.

Mind you, I did work on some people, but it wasn’t a full commitment. I said, ‘don’t you even tell anybody that I my hands worked on you.’ And then all of sudden my hand… (begins to sing). Some people tried to get that out of me and I said, ‘don’t even go there with me.’ I said, ‘I am not a responsible person. I do not wish to be accountable to anyone, or to Creator either.’

I said, ‘do you hear, please?’ You know, other people are more responsible, not me. Then all of a sudden in Tsow sen Lelum, I heard, “’why not you?’ ‘why not you? You know your history.’ I said, ‘I don’t want to know any more,’ I said. I curled up on my bed; I said, ‘please choose somebody else. I’m not a responsible person.’ And I was really serious, and I started crying and all of a sudden, I seen that buffalo coming out again. I said, ‘I give up. Here I am. I’m tired of anything coming from my chest. My chest is so tired.’ My hand was just shaking. ‘I give up.’ It was a humbling experience.
I said, 'okay, show me my teachers.' There's this bundle I carry - truth and honesty - that's how it started for me (Tape M).

What differentiates between informal apprenticeships, and formal ones, is a student’s calling and commitment to acquire and use their knowledge, gifts and skills for the service of others. The calling, as mentioned repeatedly, is often ignored; the path of a healer is difficult, and not always welcome. For some, the calling is undeniable, or they are motivated by circumstance or drastic events to apply their knowledge and gifts. Upon acceptance of a calling, commitments are made.

Dawn Marsden: Reminds me of when I talked to this one Elder... He’s in his 80’s. And I asked him how things were going. And he was telling me about how people are still coming to him. He’s been training people all his life, about what he knows about spiritual practices. And he says, instead of them going on, remembering and listening, they just keep coming back. And so he’s very disappointed that he’s done all this work and training, and trying to teach people, and either they don’t have the confidence or they just don’t have the skills to, or the will to remember. It’s just easier to go to the Elders. And he says he’s just about burnt out, but he keeps on working with people because they ask him. Like he would like to retire and let new people come in and work. And he would help them (Doreen Sinclair/White Cloud Woman’s Tape).

Sometimes commitments are made on a personal level, whereby a student acquires more knowledge, skills and experience, and grows into increasingly recognized roles as a healer or practitioner. The caveat here, as the speaker above shares, is that sooner or later, people need to move beyond learning, and to shoulder the responsibilities of bringing ones teachings into real life; without guidance, role models or challenges, it may be easier to stay in the learner role. Moving beyond isolated roles is an especially difficult step in a city where neither the status of, nor confidence in traditional-based practices has been openly supported.

To avoid the credibility issues of the solitary path, some students seek out and make agreements with and commit to working with, learning from, and assisting, an established healer or practitioner. Occasionally, though rare in urban settings, a person’s apprenticeship will be made formal, by declaring the teaching-learning relationship at public events; this provides additional guidance and recognition of the services of both the practitioner and the student.

A: Then, the people who are working with [the medicine people], ideally... it would be good to have the staff, or people training from them informally. It would be nice if it was formally, but if people are all for it then they’d come in and talk about it. You know, the process and how they do it, and get paid for that. So yeah, training, mentorship... so that it’s easier, so we get more understanding (Tape A).

In any recruitment program, the best advertisements and encouragements are opportunities to “job-shadow”, or to work as volunteers. The profound, wholistic efficacy of traditional-based health services have a way of involving and inspiring people, on very deep levels. If the gifts and aptitudes are there, the calling to learn and become a practitioner will come. With the development of a traditional-based health practitioner council, and the establishment of spaces to meet and practice, the opportunities for young people to become inspired by the profession would increase. With the establishment of additional supports for both practitioners and apprentices, the profession would grow in both numbers and ability to both train the next generation, and to continue to serve people in need.
Ensuring Standards of Training and Care

Lee Brown: There’s a lot of abuses happening. There’s a lot of abuses of people saying they can do things they really can’t. There was a man that I met who tried to do a ceremony. He went to a tribal area where nobody knew him and he had a very small knowledge of this, and he said he could do a ceremony. He actually did four or five ceremonies for people and he had no authority to do it, whatsoever. None, absolutely none. Just totally, absolutely, totally phoney. And what he did, was make a lot of people not believe in it. He disappointed a lot of people.

Dawn Marsden: It’s dangerous.

Lee Brown: It’s very dangerous. He could have hurt somebody, I don’t know if he did or not, but there are different kinds of abuses like that. So there needs to be something, but it’s hard to say what, because of the nature of traditional healing, you can’t. If a man or a woman has the healing gift, and the Creator is gonna make them hear, they can use it, you can’t say whether it’s traditional or not. There’s nothing that can stop you and me from going to somebody, if we believe that they can help us. But for a person that’s really sick, that is new in the city, who’s kind of good, and has the power to do something… It would be nice to have a counsel that said, ‘these are the men and women that can do ceremonies, for sure.’ It would be nice to have something like that (Lee Brown’s Tape).

Doreen Sinclair/White Cloud Woman (Anishnaabe): The bottom line is that there are people out there who come along and do ceremonies, and they are not real. I heard of one guy who was run out of his community, actually two guys, two different guys, one from the States and one from up north that were literally run out of their communities because of their abuses. And so what do they do? [They start] plying their trade around elsewhere. So there has to be some measures you know, checks, because you can do a criminal record check, but then a lot of these abuses wouldn’t come up in a criminal record check. So you have to be very in touch with communities or where they come from (Doreen Sinclair/White Cloud Woman’s Tape).

Standards of care are dependent upon standards of training. Developing and adhering to standards of care and training is dependent upon codes of ethics, guidelines and protocols around practice. Development of a traditional-based profession, through the development of a traditional-based health practitioner council, would facilitate the development of codes of ethics, guidelines and protocols, and ensure standards of training and care by council members. The goal, as the speaker below mentions, is to provide the opportunity for practitioners to limit and provide their services, according to their ability, training and skill level.

Lee Brown: But traditionally - I was told by one of my teachers - if a Native doctor claimed they could do a healing and they did not accomplish that healing, they were in real big trouble. And if the patient died, a lot of times they died too. So according to my teacher, if a traditional healer said he could heal something, then he’d better be sure that he could heal it and knew what he was doing. I think that there was a lot more certitude in Aboriginal healing. By that I mean, along with the story that my teacher told, that when a person said they could heal something, it was healed (Lee Brown’s Tape).
In Vancouver, without a guiding council, practitioners are susceptible to the winds of unfounded gossip, and clients are left to decide by themselves whether a practitioner is legitimate, or skilled at specific levels, in certain areas.

Doreen Sinclair/White Cloud Woman (Anishnaabe): Yeah [background checks], and then on the other end, I hear people doing a lot of damage with gossip. And taking a disliking to that guy over there, because ‘we were hitting on him and he didn’t answer’. So then, they turn around and start gossiping and saying not-nice things. And unfortunately, people believe the bad stuff without checking it out. So there’s a lot of unrest. A co-op, that’s a good place to start (Doreen Sinclair/White Cloud Woman’s Tape).

How can ability, training and skill level be gauged?

Lee Brown: My understanding is, is that at one time the training to become a traditional kind of helper, I like the word “helper” better than healer, was 30 to 40 years. I mean, you apprenticed for a long, long time. There was so much to know. I remember this statement and I believe it was of an Ojibwa man that had become a medical doctor. I remember reading his statement that he became a doctor in four or five years, but it would take 30 or 40 years to become a traditional doctor.

But on the other hand, when you move into an urban area, especially if you don’t know anybody, it’s really easy to get connected with someone who’s not for real. I think there’s a lot of people, not just in traditional Native medicine, but in all aspects of the new age kinds of healing and the stuff that’s going on, that maybe studied something for a year or so, and then they put out a shingle that they can do it. Whereas, all these practices, whether it’s ancient practice or any other kind of practice - of traditional healing rooted in past times - the apprenticeship would have been almost a lifetime. If you got to do some healing the last 10 or 15 years of your life after [training] your whole entire lifetime, you’d be doing good. So there is a need to identify who’s for real and there is a need to provide more access. I don’t know how that would be done. I know that there are some places in the States now where there are traditional people who have cards stating that they are certified, able to do certain kinds of things, which is kind of funny in a way, but it’s difficult (Lee Brown’s Tape).

Card-carrying council members may seem a little far-fetched at this point, but it’s in line with the suggestions for council member screening. The assessment of ability ‘to do certain kinds of things’ is one of the goals of screening. Once a way of determining ability, training and skill can be developed, practitioners can be held accountable and clients can rest assured that they aren’t being deceived, or in danger of malpractice.

Sharifah Marsden: Or guidelines for what kind of person would be allowed to do this work. And, like, there would have to be criteria, reference record checks and background checks. You have to find out if that person’s very credible or not. How would you do that? I don’t know. You’d have to do your investigations (Sharifah MarsdenTape).

Ensuring the Safety of Traditional-Based Clients

Lee Brown: One of the things that really helped me when I was studying for my Master’s degree, I had a wonderful teacher and he talked about the different kinds of
competencies that existed in human beings: the technological, the physical, cognitive competency, emotional competency - which is what I’m studying - spiritual competency, and also, moral competency. Now spiritual competency is our ability to interact with the spiritual world in such a way that, sometimes very positive things happen. Moral competency is our ability to interact with other human beings in such a way that the more competent we are morally, the more we’re able to think about the potential of the human beings around us. So you see here that there’s a difference between moral competency and spiritual competency. Some people are very spiritually competent and can do powerful ceremonies, but don’t have a good development of moral competency and so sometimes do harm to the people around them; there’s a difference. It is possible for somebody to have great powers and be a bad person, and be immoral. [By] immoral, I mean harm the human beings around them. And it doesn’t really lessen their spirituality, because moral competence and spiritual competence are two different things.

Dawn Marsden: But possibly, both are necessary for doing good work as traditional health practitioners?

Lee Brown: It’s really good that we have both. You could do great spiritual feats and not be a very moral person, if those safeguards were in place, so that people around them made sure that they didn’t harm others. That’s why those safeguards are needed. Even people that are fairly morally competent, if the safeguards aren’t there, they’re going to have the temptation that all human beings have. And they might be a very good person, but... once or twice, every now and then, because that’s the way it is. That’s why those safeguards are there: to not only protect the people, but to protect the healer, also. Sometimes people are spiritually gifted and then do bad things and then it makes the Native way look bad. But it’s not that the Native way is bad, it’s just that there’s a difference between spiritual competence and moral competence. If a person has a really high level of moral competency and a really high level of spiritual competency then they are very sacred. There’s a person like that in every tribe from time to time, but there are some times when we have no one like that.

Dawn Marsden: So you have to work with what you have?

Lee Brown: You have to work with what you have.

Dawn Marsden: That’s a really good discernment. Yeah, I like that because I’ve always mixed the two up, myself. Like, to me it’s almost like if you attain these spiritual connections and do ceremony and like -- yes, that’s a good discernment because often I’ve judged people’s ability to do good work by their moral actions. Yeah.

Lee Brown: Yeah, and those are two different things (Lee Brown’s Tape).

As discussed above, any screening of council members would require an examination and differentiation of practitioner competencies in several domains: technological, physical, cognitive, emotional, moral, and spiritual. While the ideal practitioner would be someone who was highly competent in all these domains, the reality is that we are all fallible human beings, with differing abilities and interests. Any screening of potential council members could require a consideration of competency in each of these domains.

Lee Brown: Some traditional healers might not pass a criminal record check.

Dawn Marsden: Yeah. I think, well, specifically around abuse, like sexual abuse and...

Lee Brown: Certainly. Abuses do happen; it’s unfortunate. I know in the interior there was a guy that was doing bad things in a sweat and he just put off a whole lot of people. It’s a really sad thing, because people wake up to our spirituality, and they
become involved in something, and they meet one bad person and then they get turned off it. They get turned off of it and are badmouthing it for the rest of their lives. It’s a bad thing.

Dawn Marsdn: Yeah. I’ve met a lot of people who really would like to connect with healers that they can build trust with, but are afraid, are doubting everyone. Because everyone, no matter if they seem like good people to work with, have been badmouthed. So it’s complicated (Lee Brown’s Tape).

Those practitioners that were found to be morally incompetent in specific areas could be excluded, and those with lower levels of moral competence in certain areas could be restricted to non-endangering practices.

A: Any person that you have reference checked, if it’s related to endangering, or related to sexual abuse, that’s related to the job... So, site things that are considered high level, like sexual assaults.

Some people are not quite clear on appropriate behaviour. [Another suggestion] is to have someone on staff, or that’s always present. Well you don’t want someone standing like a policemen, but who can... And it works both ways: safety for the medicine people and for the client, especially people that are mentally ill around that stuff. They have that [sexual assault] in detox, different places like that... You know it’s pretty hard: ‘he said she said’. You have to have someone who is somewhat coherent (Tape A).

While human beings are fallible, the bottom line is that traditional-based health services must provide a measure of prevention against abuses, by either practitioners or clients. The suggestion above, to have an official witness and protector at every healing event, would provide for a measure of safety for everyone, and protect against the slander of legitimate practitioners.

With the development of a traditional-based health profession, council and spaces for practice, traditional-based safeguards can be re-instituted, with modifications for urban settings:

Lee Brown: That’s why a community process is a really important thing and traditionally, we understood that people are like that, so there were safeguards. There were safeguards in the way that we did things so that those abuses did not happen. And what happened when Christianity came into our communities and harmed the traditional way, they removed all the safeguards.

And some of the safeguards are not involved in traditional healing. Like the fact that you don’t talk to your wife’s sisters; that’s a traditional safeguard to stop things from happening because of sickness. And when those safeguards were removed by Christianity, all manners of abuse came up. And a lot of the so-called priests and nuns that came to our communities did not have any concept of traditional safeguards and they just had a field day, and all kinds of abuse got started. And so what we really need to do is re-institute the safeguards and...

Dawn Marsden: Practicing in community versus practicing in isolation?

Lee Brown: Don’t allow people to heal one-on-one. You know, like a man doesn’t heal a woman without other people present because it just should never be done. That’s why it’s a group ceremonial process because we are human beings, and because of our human nature.

First of all, because of our human nature, we need ceremony. We have ceremonies because we’re human. We don’t have ceremonies because we’re saints or
because we’re really spiritual people. If we were saints or really spiritual people we wouldn’t need the ceremonies. We have the ceremonies because we need them, when we need them. We have traditional healers who are also human beings, because we’re not perfect. And you can look at anybody’s life, living in the world today - anybody’s - and find something wrong with it. And when the person becomes a public person, there are people that will spend their days and nights badmouthing that person. You know, Bahaullah said that whenever a human being raises a cry of truth, someone else raises a cry of denial. And so whenever you try to do something good, there’s always someone that [responds] with something bad. It can’t possibly not be that way, that’s the way the universe works. But that’s why we have the senses - and we do need them - and we also need the safeguards. We need the process because we’re human beings, because human beings will do all manner of things, given a chance (Lee Brown’s Tape).

When the dangers are known, it becomes easier to protect against them. Health service practitioners and their clients are particularly vulnerable to predation and abuse, because of the vulnerability associated with needs for assistance. Protecting both clients and practitioners then, is linked to the establishment of an in-depth screening process, and the creation of both safeguarding roles and community processes. Given the right guidance and opportunity, human beings will refrain from, or be prevented from behaving amorally, and aspire to higher levels of competency.

**Protecting Traditional-Based Practices, Processes and Products**

Because of its invisible and historically marginalized status, the profession of traditional-based health practitioners is especially susceptible to predation by amoral opportunists or capitalists. In Vancouver, there aren’t any safeguards for protecting traditional-based knowledge, processes or products, other than the voluntary commitment to research or developmental ethics prescribed by universities, companies or community agencies. Ethical guidelines are good for guiding behaviour and for keeping people accountable, but because they are voluntary, they are inadequate for the protection of traditional-based practices, processes or products.

E: We were just talking about that at the staff meeting, and we were talking about the program and the curriculum that’s being developed. Who owns that? And student papers? And I was just drafting a letter, asking them about knowledge, because when an Aboriginal talks about their knowledge some of it is... We need to be careful about where some of it [goes/is used]. It may be just knowledge that is kept in the community, and some of it may be knowledge that’s okay for other people: other Aboriginal people or non-Aboriginal people, to access for their research or their inquiries. So it was a really good discussion about that. So we all thought as an institute “we need to be aware of that”. When we do develop a database, there may be a restricted area of the data base, or there may be a data base strictly for Aboriginal people, or groups of Aboriginal people. It could be... a writer would stipulate... you know, “you can share my paper, but it needs to be shared in this way. This part of the paper is just for Nuu-chah-nulth people. This part of the paper is for other aboriginal people, and this part of the paper can be for everybody.” I don’t know... That might be overly restrictive. But I think protecting knowledge is really important, because so much has been taken, to be used in any old way. That keeps coming up, often, now. So you have to have an advisory council [to decide] how a data base would be (Tape E).
Traditional medicines are particularly susceptible to bioprospectors; all that’s needed is the identity of a plant, used as a traditional medicine. The following chart (Figure 10) shows a recommended process for developing traditional medicines, which may be useful when considering how to protect traditional medicines from appropriation. An additional and related threat or barrier to the protection of traditional medicines by Indigenous peoples, is the governmental regulation of the manufacturing, distribution and sale of natural health products (Department of Health, 2003). While the protection of Canadian citizens from harm or fraud is a noble and possibly essential effort, without a special clause to recognize the a priori Indigenous rights to resources and self-determination, the regulation of natural health products (which include traditional medicine) adds up to another form of legislative, bureaucratic and Constitutionally negating form of oppression. Hypothetically, such legislation will protect the theft or appropriation of traditional knowledge, if regulations are followed correctly.

Figure 12. Flow chart of sequence for the study of plants used in traditional medicine (Fabricant and Farnsworth, 2001)

What needs to be developed, in addition to ethical guidelines, is a comprehensive strategy for the prevention of appropriation, misapplication and misuse of traditional-based practices and products. If traditional-based knowledge is protected by traditional-based practitioners, then how traditional-based practices and products are used or developed, are also under a measure of control.

Dawn Marsden: In Zimbabwe, there is a traditional healer’s society that is parallel to government, it’s a parallel agency. So any referrals having to do with traditional-based
knowledge are sent to those people. Whether it’s pharmaceutical companies, individuals, or that traditional healer’s agency it’s a big deal. They take that request for information to the whole collective. They regulate who is involved, you have to meet certain criteria to be considered a professional healer, and they decide as a group ‘we will give them this information, about this, for this purpose’. And they’ve also got their own company so that they can develop their own pharmaceuticals the way they want to, and in ways that they want to, and then they sell them to people. They can control all the knowledge and production of traditional knowledge and medicines and so it’s maintaining traditional medicine in that country. They also control the ethics around traditional medicine; it’s like a regulatory agency.

E: Yes, that makes perfect sense and I think that the ACADRE [Aboriginal Capacity and Developmental Research Environments]... one of its objectives is to determine how that’s going to work (Tape E).

As mentioned above, one way to protect knowledge, is to control what kinds of information are shared with particular individuals or groups of people. We see this process in current applications of the “Freedom of Information” legislation, whereby certain information is censured, due to its possible endangerment of individuals or groups. This process is contingent upon the subjective discernments of the people who are custodians of the knowledge (Boyle, 2001). Partnerships for knowledge and benefit sharing could still be made, but under specific conditions determined by the traditional-based practitioner council (Bierer & Carlson, 2001).

Dawn Marsden: The problem with data bases is that they can be always be turned over. They can be built with certain ethics and protocols, but they can always be opened.
E: So some things may not go into a data base, or be part of that
Dawn Marsden: The reference could be, ‘you can go and ask this person’.
E: Right, yes, that makes sense. It’s a big responsibility (Tape E).

Besides limiting access, some knowledge, processes and products can be protected by ensuring that they are never documented, and by ensuring that safeguards are in place for maintaining the secrecy of those practices. Some of the suggested avenues for providing safeguards and maintaining secrecy are through certificates of origin, low-cost patenting, innovation registers and the transformation of traditional medicines and practices into trade secrets (Posey, 2005).

Doreen Sinclair/White Cloud Woman (Anishnaabe): And I don’t think they should be... They shouldn’t be expected to do a file on, like the results of the sweat; I see that as very untraditional. You know it’s very governmental, beaurocratic.
Dawn Marsden: The tricky one is meeting those stats, so you have to record something.
Doreen Sinclair/White Cloud Woman: Oh, You can record the numbers or the issues but not go into details. Yeah. You can still record the ages and gender and things like that but not the specifics: like an issue, and how you treat it. How you treat would be off limits because when the Grandfathers and Grandmothers... That wouldn’t be traditional at all. I would really resent that, if they tried to make us do that.
Dawn Marsden: Have you found that there’s been any kind of pressure that way?
Doreen Sinclair/White Cloud Woman: No, No, when I used to do the sweats and pipes for Tillicicum House they never, that wasn’t required. But I can see the way the money is: the crunch of the dollar now. Where we have to really justify what we are
doing, and yeah I can see that that might become an issue. But you know, as I’m saying that, I am thinking what would probably happen is - the way the Grandfathers work - we would probably be guided on how to word it, to satisfy those guys with money. And not really go into specific details or treatment plan so to speak.

Dawn Marsden: Goals and general outcomes.

Doreen Sinclair/White Cloud Woman: Uh hmm. And what is achieved can be worked out, but I certainly wouldn’t describe all the minute details of how a treatment would go (Doreen Sinclair/White Cloud Woman’s Tape).

Record-keeping is a particularly insidious avenue for knowledge appropriation and especially, knowledge misuse or misapplication. Just as the behaviours of amoral agents can be controlled or limited through the censorship and secrecy of traditional-based documents, the behaviour of traditional-based practitioners can be controlled or limited by the misuse or misapplication of traditional-based documents.

Ken Schramm: So I said, it’s really important that you guys own the building; when you own the building, you have a say in what happens. [In a different scenario] different rules applied; they could not access the money to buy the building. So, they were constantly having to go to the provincial government. They were always running out of money, never had a grant to do a proper health centre.

Daisy Heisler: If you are going to build an actual site, you need private money rather than government money. That’s clear (Ken Schramm & Daisy Heisler’s Tape).

If traditional-based practitioners become dependent upon the funding of incongruent agencies, special care would have to be taken to protect everyone involved, the profession in general, and the practices and products in particular. Knowledge can be used for, or with people, or against them. The warning here, is not to succumb to record-keeping agreements that compromise the ethics, protocols, processes or products of traditional-based practitioners, or their clients.

Ken Schramm: My view of the existing medicare service, is that it’s a system of surveillance, with the facility of testing, of scientific drug testing, and all. So a hospital is the most dangerous place to go to because of all the testing that’s going on. So it would be better to keep everything pretty low key, stay away from government funding or trying to be part of existing community health centres.

Since we started working together, we have tried to provide counseling for couples and families in their homes rather than seeing them in an office or hospital setting. There is something very precious and special about seeing people in their own homes. By being invited into the intimacy of their home, it is also more essential to keep confidentiality about what goes on in the privacy of their home, it is also more essential to keep confidentiality about what goes on in the privacy of their home. The government uses the billing system as a surveillance system. Therefore, it is best to keep the written information about psychotherapy on the charts to an absolute minimum.

Daisy Heisler: Oh god, because Ken is a psychiatrist, the government, in audit gave a list of things they wanted to know about the patients. They wanted every patient to be labeled with a psychiatric label (DSM IV code) for every three months, and wanted to know who was on drugs, who drank, sexual habits, absolutely everything, the most personal things. Ken had promised all his clients confidentiality and he would never go back on his promise to keep whatever they told him secret. He used only ‘adjustment
reaction’ for billing purposes. Everyone can have an adjustment reaction. He never labeled anybody. And if they were on drugs, it was because of another doctor, not because of Ken; so he didn’t have to write it down, cause we didn’t know if they were telling the truth about what they were taking or not. It was the other doctor’s responsibility. However, he would have discussions on the telephone with the other doctors. Ken would work along with the other doctor to help the patient get off or reduce prescription drugs.

Well this auditing psychiatrist wasn’t happy about any of that; he wanted everybody labeled. He wanted to know all the details of their lives. He was a forensic psychiatrist and bragged about his ‘getting the goods’ on people for court. L worked a totally different kind of psychiatry, and refused to go along with it. And that caused him to lose his health because it was a two year audit. He did the research for his arguments and came up with an interesting bit of information. The [DSM] codes are being written out of psychiatry and there will be a whole new way of looking at patients in the near future. So the auditor was out of date with what is happening in his own profession. There was a two hour fight between Victoria and our lawyer’s office, because our audit hadn’t been completed. And the auditors, who were not medical people, but simply numbers people, wanted to see the details of these peoples’ lives. And he wanted all this other stuff and L just absolutely, totally refused. So it was the end of the practice, and the end of Ken’s health. They even tried to starve us before the practice ended by not paying us for the work we were doing (Ken Schramm & Daisy Heisler’s Tape).

Whether for greed, for competition or for oppression, the dangers of such insidious [record-keeping] processes, that aim to control knowledge and practices, are very real and very dangerous. During the completion of this dissertation, Ken lost his battle for his health and for his clients, against the stress-inducing, mainstream forces, and passed away.

Daisy Heisler: In Ken’s case, he always thought he was in his own private practice, self employed, living by his Hippocratic Oath. When the audit happened, the government in the form of Medical Services Commission and the government lawyers informed L that he was an employee of the government because he was paid by the government, and that all his charts actually belonged to the government. This is why L stated to you over and over that to take government money had a deeper threat and danger than just taking money. L kept his Hippocratic Oath and died with it and his patients’ secrets. I am the only person alive who knows all and I will never betray L and his patients. I am the legal keeper of the charts for seven years and I will burn them before I let anyone have them, even though L did not write down any real secrets. He listened and talked. That was all. In this province, there is in writing by the College of Physicians and Surgeons, that medical records are confidential except in audit. Therefore, L kept his writing about patients to an absolute bare minimum, so that nothing could escape (Ken Schramm & Daisy Heisler’s Tape).

In any effort to record or document their knowledge, due consideration has to be given to intellectual property rights, and protecting the interests of the indigenous peoples against charlatans, pirates, and the like. The knowledge contained within texts or utilized in the traditional medicine clinic belongs exclusively to the shamans and tribes of Kwamalasamutu and access to such texts will thus be restricted. ACT does not engage in bioprospecting (NUFFIC, 2003).
Legal protections for communally-based knowledge systems, like traditional-based knowledge systems, are still being figured out (eg sui generus law). It'll probably be some time yet until such safeguards are implemented on a large enough scale to protect traditional-based community-derived knowledge. Until that time, awareness of knowledge related dangers, and control of knowledge sharing practices becomes the best protection. Creation of the council mentioned previously, would be an ideal host for the preventions and protections of traditional-based knowledge, processes and products.

Summary of Research Group Recommendations

Participant stories and ideas detailed many recommendations for the enhancement of traditional-based Indigenous health services in Vancouver. According to Stout and Kipling, in reference to fostering resilience and promoting healing, the following recommendation was made:

For those hoping to address the Legacy of residential school abuse, efforts must be focused instead on implementing programs that address key risk and protective factors and are themselves the subject of on-going evaluation to test their effectiveness in responding to the needs of individuals (2003).

After consideration of the many recommendations of this research project, it seems appropriate to draw out key risk and protective factors for the implementation of programs for Vancouver Indigenous peoples. The following recommendations (Table 5) can be protective factors, towards fostering resilience and promoting healing. They have been chosen from participant discussions, because of their potential for immediate proposal, application or intervention, and for their potential to ameliorate or remove barriers and facilitate strategies for enhancing traditional-based Indigenous health services, in the long-term.

- Establishment of a cooperative, self-screening practitioner council for the development of guidelines, ethics, protocols, and standards of practice, and for the training of new practitioners
- Understanding of the need to be initially independent of, but engaging in negotiations towards egalitarian integration of traditional-based health services alongside existing services.
- Establishment of a cooperatively managed, fund of contributions, to meet the living, practice and professional development needs of practitioners and apprentices
- Creation of appropriate, multiple and cooperatively used and maintained spaces for traditional-based health practices, including the creation of land-use agreements.
- Creation of co-referring and team-based relationships between traditional-based practitioners and other health professionals
- Creation, collection and dissemination of public documents, workshops, courses, conferences, and gatherings, for the enhancement of traditional-based health services, and reduction of barriers due to ignorance or racism.
- Creation of positions for advocacy and public liaison between traditional-based health practitioners, other health professionals, Indigenous peoples, and the general public
• Promotion of a cohesive and inclusive governance framework for off-reserve Indigenous peoples in Vancouver, in alignment with local land-based First Nations.

Table 5  Recommendations for the immediate enhancement of traditional-based Indigenous health services in Vancouver

A hypothetical example of how these recommendations might be facilitated, is given in Appendix N.
Chapter 7 Lessons Learned from Indigenous theorizing, methodology and method

Let a man once begin to think about the mystery of his life and the links which connect him with the life that fills the world, and he cannot but bring to bear upon his own life and all other life that comes within his reach the principle of Reverence for Life, and manifest this principle by ethical affirmation of life (Albert Schweitzer, 1960).

The greatest gift of working directly with people, and those working with traditional-based practices in particular, is that the examination of theory, methodology and method becomes simplified. Applying theories, methodologies and methods that aren't relevant, appropriate or adequate to specific research contexts becomes as obvious as the proverbial pink elephant, which many participants and community members are willing to point out. This doesn't mean that those same theories, methodologies and methods aren't valuable, or cannot be used in other contexts; it adds to knowledge about the specificity of those particular theories, methodologies and methods.

Besides examining the applicability and specificity of theories, methodologies and methods, research contexts can enable expansions or modifications of applied theories, methodologies and methods. The theories, methodologies and methods used in this research project were: Indigenous wholism, storywork, talking circles, Indigenous protocol, prayer & dreaming, unfinished story method, dialogue, audiotaping, Ojibway & Coast Salish practices, and visual arts.

In the next few paragraphs, I will provide a reflective examination of the applicability, specificity, and suggested expansions or modifications of the theories, methodologies and methods used in this research project.

Continuity between pre-study issues and research stories

This section has been designed to demonstrate the congruence, relevance, relationship and continuity between what traditional knowledge holders were saying informally across Canada, and what they've said in this research project, in the Vancouver context. I consider this critical to the validation of using informal, community derived, pre-study knowledge, as a way of informing the design of research, and to prevent duplication of what is already known. To this end, I have selected a few of the relevant stories, ideas and dialogues shared by the research participant group, under each pre-study category (see Table 6), as examples. The lengthier amount of quotations, about the first issue, is appropriate when we consider that the relationship between Indigenous and non-Indigenous peoples, in Indigenous lands, is at the crux of why

Table 6. List of Pre-study Issues

| Working with non-traditional based health service providers |
| Working with people from diverse Nations & cultural backgrounds |
| Sharing & protecting knowledge |
| Working outside of traditional territories, and specifically, in cities |
| Ethics & protocols in traditional-based practice |
| Balancing traditional-based practice with the need to make a living |
| Organizing for support |
| Passing on knowledge |
| Processes & protocols for accessing appropriate healers |
| Protecting and maintaining places for traditional-based practices |
traditional-based health services, and Indigenous people in general, are marginalized today; it’s about relationships.

**Working with non-traditional-based health service providers and agencies**

The quotes below have been chosen as an example of some of the challenges of bringing traditional-based practices into existing institutions. The first quote exemplifies the fears that our ways of being will be co-opted through mainstream processes, in ways that reproduce assimilative effects and inequities in resource distribution.

B: I was doing some funding stuff that’s..., you know, they’re sneaky; they’re trying to get us to assimilate our own people, right? We just got to get smarter. It’s like, you know, when we get funding from these agencies; they give us this much funding, to do the same thing that their people get this much to do, and... ‘let’s see you do it’ (Gathering Tape 3).

The next quote displays some of the discrimination encountered by Indigenous peoples in existing institutions, which is an important challenge to legitimizing the integration Indigenous practices.

B: You know we had a write-up in the newspaper about going to the dentist and... Dawn Marsden: I saw that--I was shocked.

B: The one daughter, she’s status, so my question to the dental clinic I was at was, ‘do you want the status card?’ ‘No we don’t, we don’t take people who are on social assistance either its just too much paperwork’ and I went ‘what?’ I said ‘well let’s hold up here on any kind of treatment you’re going to do on my family, because I’m not going to sink a lot of money into your clinic if you’re not honouring the status card or people who are at poverty levels’.

Dawn Marsden: And then there’s no monitor. Who’s monitoring the work that they’re doing?

B: There’s people that I know who have had atrocious things done to their mouths. Because it’s almost like they’re guinea pigs now, and they’re allowed to do whatever they want and experiment, right, and if we documented all of those it would be like (B’s Tape).

The next quote gives another example of the continuing fear, distrust and clashes between people with traditional-based world-views and mainstream worldviews, based on a history of experimentation and human rights abuses against Indigenous peoples.

Lee Brown: By that I mean, along with the story that my teacher told, that when a person said they could heal someone, they were healed. Whereas today, you go to a doctor and the doctor says, “Well, we’ll try this, you know, and if these pills don’t work or if you have some kind of negative reaction to them, you know, come back next week. And not only is it experimental, but it’s much more experimental on Native people than on anybody else. I think we’re experimented on a lot. I think there’s a whole lot of cases across Canada coming out now of different kinds of experimentations that were done on Aboriginal populations. Experimentations, also, in the States; there was a widespread sterilization program of Native women in the 60s and 70s unknown to us. This system that all of the people had so much faith in was actually sterilizing our young people at the same time and not even telling us that...
they were doing that. So the system, as far as I’m concerned, doesn’t have our best interests at heart. There’s no light in the system. There’s no kindness. There’s no caring and it’s a system very much based, much more, on money than ours is.

Dawn Marsden: It’s interesting that you said one of the fundamental issues for the non-Native society is they don’t want to accept traditional medicine because they have to look at colonization and oppression. Maybe that’s also operating with the Native people on the reserves, or elsewhere, who, like you say, have been inculcated.

Lee Brown: Yeah, they’ve internalized, a lot of the oppression, and...

Dawn Marsden: So they also have to, it’s painful, they don’t want to have to look at all those issues?

Lee Brown: Yeah, I think that’s true. I think there’s a lot of truth to that (Lee Brown’s Tape).

Working with people from diverse Nations & cultural backgrounds

E: So I think... ‘why do we have to search so extensively [for traditional knowledge]’ but I guess it’s cause my parents took on, took on all the modern system. And they were removed from their parents. They moved to the coast and everybody, all the family were in Saskatchewan, and so they were out here trying to be good urban people. Working and...

Dawn Marsden: That was the feeling at the time, that was the norm, eh. My parents did the same, trying to fit in and war was going on (Tape E).

For generations there has been a strong migration of Indigenous people from traditional territories, to the cities, in the pursuit of employment, education, health care and other services or opportunities unavailable back home. This migration has meant that large numbers of Indigenous peoples, end up interacting in the city with people from increasingly diverse cultural backgrounds. This diversity, in turn creates a challenge to maintaining the integrity of traditional-based practitioner ethics and protocols, while respecting the ways of others.

Working outside of traditional territories, and specifically, in cities

B: There is a lot more to be done, but it’s beginning. I see so much change, even with the fact that one of the things that the Native Urban Youth Association is working on is... a place. Youth drop-in centre for Aboriginal youth, I walk in there. I swore it was a club house, east L.A. gangbangers, right? I walked in there, I go ‘is there anything in here that is Aboriginal?’ A couple of dream catchers. All the posters on the wall were like Toupoc, Emenem and... ‘where’s our Aboriginal heroes man? You got black rapper gangster posters on the wall (Gathering Tape 3).

The influences of pop culture, materialism and high powered marketing are felt globally through television, radio, print and now, the internet. In cities, these influences are magnified by greater numbers of radio and television stations, moving and stationary billboards and storefronts. Such high energy competition for people’s attention, can distract people away from activities like identity reinforcing traditional-based practices, which have to be sought out. In addition, finding spaces that are appropriate or conducive to traditional-based practices, like ceremony, singing or prayer, can be difficult.
Ethics and protocols in traditional-based practice

When I was speaking with Dawn the other day she was mentioning safety for people who wanted to use traditional methods and that was one of our concerns when we first opened the centre, was to make sure that anyone we brought in as a traditional healer was happy and clean. That did prove a little difficult so I’m really glad that you are doing this, that you honour traditional healing not only from the west coast but throughout Canada because we are all together here and being family, and we welcome together in this beautiful country here in BC and we honour all traditions at the centre (Gathering Tape 1; anonymous).

In her brief statement, this speaker gives recognition to the importance of ethics and protocols around traditional-based practice, specific to issues of safety, practitioner self-care and professionality, accessibility, diversity and connectedness.

Balancing traditional-based practice with the need to make a living

Lee Brown: As in the old days, the traditional person, a traditional healer would have been supported and would have been living among the people and would have been on basically the same economic realm as everybody else, if not a little poorer, because sometimes there was an aspect of poverty required to be a healer. But today, doctors are making 250, 350, 400,000 a year, you know, 10, 15, 20 times as much as some people make, you know, and still complaining about not getting enough. So that’s a huge disparity. So I think that’s another barrier (Lee Brown’s Tape).

One of the most consistent recommendations, in line with pre-study recommendations, was the need to address the misperceptions around the economic support of healers on par with other health care practitioners. Because traditional-based practices are sacred and invaluable, they cannot be purchased on a fee-for-service basis. However, in order for practitioners to continue their sacred practices, their living and well-being must be supported.

Organizing for support

E: I’m grateful for the circle. I believe also that there’s a tremendous need for us to come together and to learn each others work and be able to network and call for help when we need it and to be able to know that we have places to call and where, you know, names to ask for (Gathering Tape 1).

This issue has two meanings. The first is the importance of support for practitioners; the second, support for people seeking traditional-based practitioners. For both, networking is discussed as essential to meeting the need to learn traditional-based practices.

Passing on knowledge

E: I’m so interested in traditional medicines and practices. I touched on it a little bit but I haven’t gone there totally and I really want to, and feel like I need to and I want to share that knowledge with my grandchildren but I just don’t know how to go about doing it and so I’m here to learn, continue my journey. I really would love to see traditional medicine as being part of… have available, just a natural thing, just a part of
your life, from someone perhaps, someone in the community that you can talk with and
who can talk to you (Gathering Tape 1).

Traditional-based practices are about life long learning, through the use of specific tools,
like the use of herbal medicines, daily rituals, and the counsel of Elders. To pass on traditional-
based health practices to our grandchildren, we have to learn and embody those processes
ourselves.

Processes and protocols for accessing appropriate healers

Doreen Sinclair/White Cloud Woman (Anishnaabe): I have a lot of motivation to see and
support more traditional based health services in the city because I hear, keep hearing our
people talking about “I’m looking for this person or that person...I need this help or that
help” and there’s a lot of help out there but there’s room for a lot more. (Gathering Tape
1).

Sharifah Marsden: I don’t have that much information, but I know I’m looking. I’ve
looked for help in different ways but there’s not much out there that I’ve seen and it’s
hard to find for the average person, especially for young people who don’t know that
many older people (Gathering Tape 1).

A: I moved here in 1990 and I was coming to go to school at UBC and it took quite
awhile for me to find my medicine people or community and so by that I meant I was
interested in looking for people who practiced my way and I realized that there was a lot
of protocol that is more practiced out here and I was really happy to see that. I should
really be working with people where I’m from and also to acknowledge what’s
happening whereever I am in that context and that’s been a really, really big help to me
(Gathering Tape 1).

Protecting and maintaining places for traditional-based practices

J: You know I was talking with an elder who has knowledge of traditional medicines
herbs and things like that, she’s in her 90s this woman who is from Chase, which is just
outside of Kamloops, she remembers as a young girl going up into the Alpine, up in the
mountains, a higher plateau and seeing unlimited medicines and herbs that would grow
10-12 feet high, just as far as you could see. There was never any concern or shortage,
but now, even her, she goes up there and she sees nothing; but when she does find a plant
that is a medicine it’s only 4 inches high and she’s scared to take it because she’s scared
that it may be the last. Even what’s available, what’s out there in terms of our medicines,
-physically - our medicines, like plants and herbs, are literally disappearing.

And even if we do recover to the point of being able to go up there, what’s going
to be left? In terms of the traditional based health service provision, we need to be able
to preserve what is out there. You just mentioned about the Asian people in maintaining
their herbs and medicines, they have that and we don’t. And I believe that the way the
people of the earth are going, its all going to just disappear anyway, I don’t feel
optimistic about that, honestly I don’t have much hope with that, to continue to believe
that it can recover (Tape J).
One of the most serious crises facing traditional-based practitioners, is the protection of lands for traditional-based practices, like the harvesting of herbs. In single lifetimes, traditional knowledge holders have seen a drastic decline in quantity, quality and types of medicines available in traditional harvest places. These places must be protected from pollution, overharvesting, destruction, and for non-herbal practices, pollution and destruction in the domains of spirituality, mind and emotions.

In addition to showing continuity between what people were saying before and during this study, these categories and comments formed the primary operating assumptions for the development of the research questions, and were used to sensitize participants to the kinds of issues that have already been raised, regarding the enhancement of traditional-based practices in the city. While this could have had some limiting impacts on the direction of participant responses, the use of sensitizing issues seems to have been more beneficial to this study, than not. Rather than denying or disagreeing with the pre-study issues, research participants confirmed them in such depth and detail that it became obvious that participants were greatly aware of the issues prior to the study. At the least, these pre-study categories helped to influence the breadth of participant responses, by being general enough to prompt extensive storytelling.

Consequently, I would highly recommend the inclusion of informally derived pre-study categories in both designing research questions, and in applying them as both sensitizing and evaluative tools (congruence, relevance, relationship and continuity).

Research Process Challenges and Complications

One aspect of this research that may have been improved, is that while the project was motivated by and designed to explore issues raised by pre-study acquaintances, it wasn’t designed by them; it was only suggested by each that “somebody should” address certain issues. The design came out of prestudy issues, and traditional-based processes of prayer, ritual, dreaming and ceremony, which influenced my decision to use Indigenous wholistic theory and Indigenous methodologies. In the end, the continuity between pre-study and research group concerns and recommendations demonstrated the efficacy of using informal pre-study knowledge for theorizing and research design. Even so, I’m sure that it would have been more effective, and had more impact, as a community-controlled theorizing and design process.

Designing the research with new traditional-based participants would have also been effective, but would have needed to be initiated at the same time as graduate coursework and doctoral exams, or prior to entering the Ph.D. program, to complete in the usual 4 years. As it was, even with background research being conducted during the first two years, the field research took three years to design, implement, test and write-up. Timelines for graduate research, or for any research with or for Indigenous peoples must always be flexible or extended to ensure appropriate involvement by Indigenous communities. Like a formula for time considerations, the more people (n) involved at each decision point, the greater the length of time (t) of the research project, the greater the credibility (c) of the final conclusions and recommendations.

\[ n = \uparrow t = \uparrow c \]

Another challenge was that I had intended to obtain guidance and raise the profile of traditional knowledge holders by including Elders on my committee. Knowledgable and skilled Elders should be given a similar status to university faculty, to ensure that research by and for Indigenous peoples is undertaken, guided, and approved in ways appropriate to Indigenous worldviews and methodologies. In addition, while Elders have often guided students in their research and been credited through acknowledgements, there has been little acknowledgement of
this guidance in formalized ways, in ways that would raise the intellectual capital of Indigenous peoples. The requirement to make a persuasive case for the inclusion of non-academic people on committees, prevented me from involving Elders, because of the length of time already used during completion of courses, exams and research proposal; I didn’t think building a case would have been successful, quickly enough, to include Elders on my committee, in a full and respectful way, given the short time remaining for completion of the research. It is heartening to hear that other graduate students have had the time to successfully build cases for having Elders on their committee. Institutional structures should be modified, to ensure that they facilitate clearly mandated, budgeted, publicized, easy-to-access, efficient, and successful avenues for the inclusion of Elders on Indigenous graduate student committees. In the end, I realized that I had elected to work with 22 traditional knowledge holders, who, in their greater experience, were Elders to me; inclusion of Elders on the committee became a non-issue, except for the lost opportunity to raise the academic status of Elders.

One over-riding complication of this research process was that, because of a commitment to give veto power over the dissertation and products, to participants, the completion and presentation of this dissertation was only made possible by their individual and collective approvals and permissions. While this has rightfully given control over this thesis to participants, it has produced a certain level of anxiety around the possibility of extensive revisions or total veto.

As a single parent with two young children, another issue that entered into the relationship building process, was a limit, both financial and familial, on the time available to delve deeper and gain more feedback, in person, with the research participants. Research in Indigenous communities is never “9 to 5”, and requires participation in community events, at all times of the day and week. Entering into relationships with traditional knowledge holders is also a privilege; it would have been more respectful to engage more often with participants; considerations of childcare precluded this. Engaging with 22 Elders in more appropriate ways, would have extended this research project beyond the limits of both university constraints and my student finances.

Finally, one of the greatest limitations to this dissertation is that, while Indigenous wholism is a multi-millenial living theory, and the principles have been written about in many publications about Indigenous peoples in North America, the concepts are fairly unrecognized in academic institutions and academic publications, beyond folklore, myth or fairy-tale. To create space in academia (the root of policy making) for Indigenous peoples, there has been a strong need for the transfer and translation of Indigenous knowledge across paradigms. This movement, to validate, promote and utilize Indigenous ways of being, knowing and doing, sometimes called The New Aboriginal Paradigm is being facilitated by national funding agencies like CIHR and SSHRC (primarily through ethical requirements and strategic initiatives), provincial agencies such as ACADRE (Aboriginal Capacity and Developmental Research Environments) and Indigenous organizations (through mandates and policies), by traditional-based departments within Indigenous organizations, academic institutions and businesses, and at the grass-roots level, by empassioned community members. The advantage to working within this genre, is that the field is wide open for development; the disadvantage is that appropriate criteria for judging rigour, beyond Eurocentric biases regarding evidence, are just starting to be developed.

**Indigenous Wholism and the Five R’s**

The assumption underlying the design of this research project was that the best way to do qualitative research with urban people working with traditional-based Indigenous health services
was to use theories, methodologies and methods that were congruent with - incorporated the same ways of being (ontologies) ways of knowing (epistemologies) and ways of doing (methodologies) - as those same services. To determine congruency, I called on the knowledge obtained as a person of Ojibway and French ancestry living in Vancouver, the knowledge gleaned from my prior education and literature review, the knowledge gained through prayer and dreaming, and the knowledge acquired by interactions with and feedback by individuals from both the pre-study and research groups of people. These locations and processes enabled a combination of both insider and outsider perspectives of the chosen Indigenous ontologies, epistemologies and methodologies.

Of the selected participants (volunteered willingness and ability to participate respectfully in talking circles and discussions about traditional-based health services), only one person withdrew from the study, after mentioning a conflict between supporting the development of urban Indigenous resources and supporting land-based Indigenous resources. Whether this withdrawal had anything to do with the appropriateness or specificity of the chosen theories, methodologies and methods is unknown.

At face value, from multiple perspectives, both the design and processes of this research process were congruent with the Indigenous ways of being, knowing and doing, of the research participants, in Vancouver.

While relatively undeveloped as an academic theory, Indigenous wholism has been well established as a living theory, in various forms, for tens of thousands of years. Naming, describing and applying such theory in Vancouver research contexts seems particularly appropriate if we consider the population of Indigenous people in Vancouver (GVRD: 77,500), and the persistent inequities between Indigenous and non-Indigenous people in Vancouver.

In a synthesis of both the preliminary concepts of the chosen theories, methodologies and methods, with the concepts derived from the storywork, dialogues, protocols, prayers and dreaming, the following statements can be made. Indigenous wholism is a culturally-based grand theory, like epistemic, scientific, or other forms of wholism, which postulate that the universe operates and/or is designed to work towards a unifying and harmonious or homeostatic whole. As such it is all encompassing, and relevant to human intervention to greater or lesser degrees, provides for the examination of issues from multiple, contextually specific and integrated (aka eclectic) standpoints, and is, by extension theoretically inclusive. That is, all theories can be understood as contributing to a wholistic process of knowledge generation, analysis or documentation, towards explaining reality from multiple standpoints, towards creating multiple interventions and applications.

Indigenous wholistic theory is differentiated from other forms of wholism, by the consistent emphasis on key ways of being (ontologies), knowing (epistemologies) and doing (methodologies), toward specific effects. Briefly, Indigenous wholistic theory is an organic theory in that it reflects the consistently-emphasized traditional-based components within Indigenous worldviews, as represented in the informal discussions, interviews, gatherings, writings, presentations and products of Indigenous peoples. As mentioned previously, traditional-based in this sense means arising from sustainable, multi-millenial relationships between specific people and specific lands, waters and other beings. Some of the consistent principles of Indigenous wholism, are as follows:

Ways of being

- within a unified and self-regulating universe
- that is self-aware in increasingly encompassing levels of organization, and
- inclusive of mental, physical, emotional and spiritual domains of being,
• that are interconnected, with
• physical realities as the physical manifestations of aspects of the universe

Ways of knowing
• through relevant interacting mental, physical, spiritual and emotional processes, that are:
• theoretically and methodologically inclusive

Ways of doing
• through methods that attend to respectful, relevant, reciprocal and responsible relationships and processes, that are:
• inclusive of considerations of interacting mental, physical, spiritual and emotional domains of being, which are:
• inclusive of considerations of human beings, and the beings of earth, water, and air, which necessitates
• methodical eclecticism, towards

Specific effects
• contributing to changes towards a unified and self-organizing, multi-dimensional, dynamically balanced whole, at varying levels of specificity:
• inclusive of change at individual, family, community, national, international, global and universal levels.
• inclusive of change in mental, physical, spiritual and emotional domains, and
• inclusive of change affecting human beings, and the beings of the earth, water, and air

Because of an emphasis on change towards beneficial effects, Indigenous wholistic theory can be said to be a transformative theory, with a transformative praxis. Theories, methodologies and methods of Indigenous wholism have consistently been represented by circles, spheres and spirals. The following cyclic representation (Figure 13) may help to facilitate an understanding and exploration of the transformative relationships between Indigenous wholistic ways of being, knowing, doing, and effects, and about Indigenous wholistic theorizing, as a whole. Read the diagram by starting with Indigenous wholistic theorizing, as a response to a questioning of the status quo, and follow the arrows in a clockwise direction. Research is designed with transformative praxis, which utilizes Indigenous wholistic methodologies to generate specific knowledge relevant to balancing the status quo. Research projects can be evaluated, or new research directions can be generated by examining whether or how the status quo has changed since the onset of the research project.

If we represent the effects of multiple applications of Indigenous wholistic theorizing, as epistemology plus methodology (ways of knowing + ways of doing), and incorporate Indigenous wholistic ontology (ways of being), we come up with a familiar image (Figure 14), that facilitates an understanding and exploration of how Indigenous wholistic theory is a grounded theory. In the diagram, the violet petals represent applications of Indigenous wholistic theorizing, praxis and effects; the black represents the physical, mental and emotional aspects of reality, and the green represents the spiritual aspect of reality. This diagram also illustrates how Indigenous wholistic theorizing is different from other grounded theories, in that Indigenous wholistic theorizing is also grounded in spiritual realities. Explanations, knowledge and
Balancing Effects

Status quo/Reality

Indigenous Wholistic theorizing

Transformative Praxis

Figure 13. Reflexive relationship between theory, praxis, effects & reality

Figure 14. Flower metaphor for Indigenous wholistic theorizing
interventions then, are likewise liberated from grounding in physical, emotional and mental realities, and are expanded into more expansive and inclusive domains of cause and effect; this is particularly relevant to traditional-based Indigenous health services, where decision making is also based on empirically tested spiritual knowledge and practices (theories and methodologies).

How Indigenous wholism applies to traditional-based Indigenous health services in Vancouver is particularly interesting. From the same synthesis of personal, community and literature sources of knowledge, the following diagram (Figure 15) was created to portray how ways of being, knowing and doing interact on a pragmatic level.

A summarizing statement for this model of human experience, is that we are spiritually-based beings transiting between physical and spiritual aspects of reality. If we accept or embrace the concepts of spiritual based existence, then specific principles and practices will arise. Within this view of reality, the paradigm of health and illness are intimately tied to self-identification as spiritual beings within a spiritual universe. People transit through physical manifestation (birth), through self awareness as a spiritual being (adulthood), and through physical demanifestation (death) to spirituality. From the arising principles of interconnectedness through spirit, it follows that we must be respectful and responsible in our actions, as they ultimately impact upon ourselves. If you know that you are connected to everything else (mentally, emotionally, physically and spiritually) then it follows that motivations of self-preservation or altruism will have reverberating consequences upon the other beings of earth, water, sky and fire. Hence, learning ways to maintain or create balance in one’s life (mental, physical, emotional and spiritual), becomes fundamental to living a good life and being in good relationship.

Figure 15. Relationship between physical and spiritual aspects of reality

Development of self-awareness and spiritual worldviews can be facilitated through ceremonies and rituals like birthing ceremonies, questing rituals, naming ceremonies, coming of age ceremonies, purification rituals, healing ceremonies, teaching rituals, death ceremonies and other rites of passage. These are especially helpful for assisting individuals who are lost, confused, depressed, or disconnected in other ways, from themselves, and society. A common phrase for the process of traditional-based Indigenous healing is “remembering who you are”. Within an Indigenous wholistic paradigm, remembering who you are results in responsible, respectful, relevant and reciprocal behaviours which assist in the maintenance of a balanced
whole universe. Some of the conclusions that arise from Indigenous wholistic theory, relevant to traditional-based Indigenous health services are as follows:

- Spirit slows and thickens to manifest as physical reality.
- Illness is the non-resilient state of disconnection or dislocation from cultural competence (e.g. forgetting who we are).
- Health is a resilient & balanced state of cultural-based competence (spiritual, physical, emotional & mental), which can be facilitated by traditional-based health practitioners (e.g. through ritual, ceremony and rites of passage).
- The purpose of life is to experience & learn from material existence; the challenge is to remember who we are.
- Plants & other beings of land, water, air & fire can be powerful symbols, gateways and tools for healing, through recognition & respect of their spiritual ties to us.
- Ancestral connections & journeys are ongoing, long-term, and shared experiences between ancestors & other spiritually-based beings like humans, animals, other beings, land, water & air (e.g. facilitation through naming ceremonies).
- Reproduction is the sacred union of two spirits and their two ancestral lines.
- Spirit is the sentient light form of all states of being, which can be transformed from one form to another.
- Love is the experience & feeling of intense belonging created by reconnecting with spiritual states of being.

These explorations of the findings of this project confirm, ratify and extend the preliminary hypotheses of this project about Indigenous wholistic theory, and the principles and methodologies embedded within Jo-ann Archibald's *storywork* (1997) and the four R's described by Barnhardt & Kirkness: responsibility, respect, relevance and reciprocity (1991). Collectively, these four R's make up principles for action, which have been described by many people as fundamental for the establishment of good relationship, which, in turn, is integral to the principles of Indigenous wholistic theory, and by reflection, a balanced whole reality.

In reading these statements (and diagram) of a synthesized version of Indigenous wholistic theory, applied to traditional-based Indigenous health services in Vancouver, it's important to remember that they are inclusive of, and not necessarily representative of the perspectives of the individuals who participated in this research project. As such, while Indigenous wholistic theory may be a grand theory, the versions will always be specific to the people and contexts in which the theories are applied.

A good way to examine Indigenous wholistic theory, as discussed in this paper, is to query how this theory meets Prof. Graham Hingangaroa Smith's “minimal set of conditions that ought to inform a claim to ‘indigenous theorizing’ (see Appendix O)”. The statements that follow attempt to qualify Indigenous wholism as a theory, using Smith’s criteria.

i. Indigenous wholistic theory, in this project, is both connected to and tested within the urban traditional-based Aboriginal communities of Vancouver and Victoria, and within my community of Anishnabek relations. It may also be relevant to other traditional-based Indigenous communities.

ii. Indigenous wholistic theory was made with people within these communities.

iii. I, as the person putting forward the theory, have some cultural skills and am able to connect with the epistemological foundations of the knowledge, language and culture related to the people involved.

iv. Indigenous wholistic theory is transformative in its reflexive orientation to
proactive change, towards a balanced whole.

v. Indigenous wholistic theory is portable in that it can be used to theorize diverse situations relevant to states of balance, harmony, relationship and responsibility. It is universal only in its inclusiveness of other theoretical perspectives as part of a whole.

vi. Indigenous wholistic theory has the flexibility to critique and renew itself, by continuous re-grounding in lived, community experience.

vii. Indigenous wholistic theory can be identified in relationship to other theories, and in particular, as extensions of epistemic and scientific wholistic theories, Kaupapa Maori theories, ecological theories, systems theories, cultural resilience and continuity theories, phenomenological theories, hermeneutic theories, post-positivist realist theories, and others.

viii. Indigenous wholistic theory has a fundamental orientation to critique new and traditional forms of colonization, by reference to imbalances in relationships, to imbalances in multiple domains: mental, physical, emotional and spiritual, and by reference to the connections between irresponsible or unjust decision making and imbalanced consequences.

ix. Indigenous wholistic theory is responsive to multiple sites of struggle and engagement by the ability to locate such struggles in reference to wholistic engagement towards specific balancing effects.

x. While Indigenous wholistic theory could be complicated by the use of academic terminologies, it is easy to understand through traditional-based metaphors, stories, principles and practices.

Collective Storywork

At the beginning of this project, I decided to use *storywork*, rather than using narrative inquiry or critical ethnography, because the ontology, epistemology, terminology and processes are more congruent and culturally aligned with the methodologies used in traditional-based Indigenous health services. Even though the collective story is a shortened, written representation of the actual stories and ideas shared, it clearly demonstrates the value of using storywork as an appropriate research process, by the sheer volume and depth of the stories shared; participants wouldn’t have shared as much if it wasn’t an appropriate methodology. In addition, using storywork in this project promoted Indigenous tools for examining the Indigenous collective, which is self-determining, rather than using Western tools for Western-determining, which can place Indigenous people in the role of curious, exotic, culturally relative or marginalized other. This is congruent with the statements of Linda Smith (1999), Shirley Sterling (1997) and Oscar Kawagley (1995) regarding the contemporary importance of oral traditions, the importance of stories for teaching, and the legitimization of stories as knowledge sources (respectively).

The storywork methodology used in this project is based on the framework for storytelling described by Archibald (1997), which incorporates principles of wholism, respect, reverence, reciprocity, responsibility, interconnectedness and synergy, for educational purposes. Storywork differed from the original in this research project because Archibald’s framework is designed to be a way of storytelling for education, and in this project, the framework is applied as a way of eliciting wholistic, respectful, reverent, reciprocal, responsible, interconnected and synergistic stories, for knowledge generation and translation. The ability to apply storywork successfully to researching, in addition to educating, demonstrates the flexibility of this methodological framework. In a sense, storywork for research is the reciprocal of storywork for
education, in that they are interconnected: traditional-based practitioners, facilitators, and clients applied storywork to educate me, while I was applying storywork to research what was being shared.

Both the process and the findings of the storywork methodology used in this project confirm and extend the process and findings in Marlene Atleo's work (2000). In her work, Atleo applied Archibald's storywork framework to the analysis of storytelling, which resulted in a detailed account of the ways that people learn from stories to ensure the continuity of both culture and survival: wholistically, respectfully, reverently, reciprocally, responsibly, with interconnectedness and synergy. This work confirms and extends storywork as an analytical tool in its confirmation of the importance of the beliefs and values transmitted through story, and through the transformative potential of storywork-derived, culturally-based strategies for enhancing traditional-based health services in Vancouver.

Archibald's storywork framework is not only flexible in application, it is flexible across Indigenous cultures and geographic location. Through Archibald, Atleo and this project, storywork has been successfully applied in both urban and rural contexts, and with Coast Salish, Nuu-chah-nulth and multicultural Indigenous (Vancouver) contexts.

In addition to applying the storywork framework as a research methodology, this project has applied it as a collective writing methodology. By paying attention to wholism, respect, reciprocity, responsibility, interconnectedness and synergy as principles for methodology, stories have been woven together in as inclusive, respectful, responsible and synergistic a way as possible.

It took months to write a collective story for our research group, that conveyed the answers of research participants to the questions. Over time, I have come closer to understanding what collective storywork is, at least for me. I differentiate between collective storywork and collective stories, in this chapter, by equating them with verbs and nouns, respectively. Collective storywork, as a research methodology is the active process of sharing, telling or engaging with multiple stories, for the purpose of documenting consistent and important themes. Collective stories are the final products or versions of what has just been processed, through reflection, analysis and conclusion.

An individual, writing a collective story, sounds like an oxymoron, until we consider the intent and the processes. Individualistic storywork has as its intent, the representation or transmission of primarily one person's story; collective storywork has at its intent, the representation or transmission of, primarily, many people's stories. Where individualistic storywork may be like irresponsible "consultations" - brief, superficial, and decontextualized engagement with Other's stories - collective storywork moves closer to its name, by being longer term, deeper, and more contextualized in its processes. The reminder here, is to remember that these terms, individualistic and collective, aren't mutually exclusive or discrete, that they are polarized ideals on a spectrum of storywork; no one lives in a vacuum, or can submit their expressions entirely to a collective will. The goal then, for collective storywork, is best immersion, for best analysis, conclusion transmission and expression.

After going through the initiation, facilitation and analysis of storywork within our specific research group, a question arose in my mind, about how to differentiate between stories, ideas and perspectives. I've used all three terms in this project, to refer to what was shared by research participants. How I've used them displays the relational framework I've used to discuss and create the collective story. Stories are wholistic and complete carriers of knowledge, and may have single or multiple interpretations, depending upon the relationship between, and the uniqueness of both the story-teller and the story-listener. These stories may in turn be included and necessary to the completeness of larger stories. In effect, any relayed contextualized experience, of any size may be considered a story; it can be extremely brief (the quick version),
or much longer (the whole story). Each person carries hundreds of them, which, when shared and combined with the stories of others, creates larger stories with increasing integration and complexity. Ideas are unique statements that may underlay, summarize or promote certain aspects of stories. Perspectives are the unique and situationally-synthesized views of individuals, which include stories and ideas. I say situationally-synthesized, because it reflects my observation that during this research project, participants tailored their perspectives and ideas according to what they considered relevant to the people involved (including myself) and to the research focus (as was requested). The same stories, in another context, might contain and promote different ideas and relevance.

Structurally, story writing is about portraying people and ideas, around specific plots or themes, over a period of time, to specific conclusions. The key to differentiating between primarily individualistic and primarily collective storywork, is to examine the relationships, commitments and understandings prior to writing. My own story about getting to the research, represented in the first section of this dissertation, is an individualistic story. While there were many influences, I was the primary decision maker about what was included, or excluded, and this role was set out by research committee agreements, before doing any fieldwork. In Section II, while the writing may have been skewed by my perspectives, knowledge, agendas, and conclusions, the story became collective through the inclusion of, not only different voices, but also different analyses and conclusions.

Getting a grasp on, and integrating what a group of individuals have said, from multiple perspectives, is an extremely painstaking and lengthy process; and it’s definitely work. As someone who utilizes and facilitates traditional-based health-education services, I was a fully participating, and immersed member of the research group. But this didn’t make it any easier. Differentiating between my own thoughts and analyses, and what our research group really wanted to say and conclude, required on-going self-consciousness, dialogues, information sharing, and requests for feedback. My writing decisions and processes were communally censored and guided, through honing of the framework for writing, reintegration and reorganization of the transcripts, and the inclusion of multiple voices, analyses and conclusions, as explained and agreed upon at the information sharing and consent stage of this project.

Was it really appropriate, would I do it again, and would I do it differently? Indigenous wholistic theory, as applied here, requires the creation of good relationships towards specific balancing effects. An analysis of storywork as a method can be focused on the efficacy of the relationship-building process (a la 4 R’s), or on the specific balancing effects. Both analyses could be subcomponents of an entire research process. In hindsight, it would have been good to incorporate more formal mechanisms for analyzing both relationships and effects, to a greater degree. A form of summative evaluation of both relationships and effects will be provided at the end of this chapter, under the heading Evaluating Research by Applying Indigenous Projects.

Storywork is an excellent methodology for deeply and broadly examining contextually specific Indigenous issues. If anything, storywork was difficult to apply with larger numbers of participants (and one researcher) because of the need for continuous researcher self-scrutinizing, and because the amount of the information obtained was so large that it requires lengthy analysis to be respectful (inclusive in a good way) of all perspectives. If the poor quality of the tapes hadn’t precluded the inclusion of half the transcripts, the analysis and writing process required by this storywork process would have taken twice the time. After completing this project, if I were to use storywork again, in projects with short time-frames, I would ensure that I limited the number of participants to less than ten per researcher.
Talking Circles: methodology and method

My assumption that talking circle methodology would be a good methodology for the sharing of stories among Indigenous people interested in traditional-based health services, was correct, at least in this research project. Even though participants were from diverse Indigenous backgrounds, the format seemed to be familiar and comfortable to everyone. This might be attributed to the fact that talking circle or similar circle formats are used widely within Vancouver Indigenous settings, and/or to their wide use outside of Vancouver. In addition, some influence may have been made by providing participants with a small excerpt of Graveline’s writings (2000) on circle work, prior to the gathering; it may have served as a reminder of some of the principles within talking circles (no interruption, consecutive opportunities to speak, respectful word choice and tone, right to not speak, etc). Wherever their understandings of talking circles arose, it seemed apparent that participants had deep familiarity with both the principles and processes.

The talking circle for the first gathering was slightly different than some talking circles I’ve participated in, because of the guidance of one of the participants, and because of the decision to include witnessing protocol, which is a Coast Salish tradition. At the beginning of the talking circle, after prayers and songs and instructions, four participants were invited to stand as witnesses to the day’s events. At the end of the day, they were invited to share their observations.

Talking circles are relatively confidential in that participants are expected to keep what is shared private, unless they obtain permission to share what’s been said. While people can talk about who was there and talk generally about what was said, identities are to be protected, unless the people in the circle agree to open the circle. With research, participant identities are also to be protected, as far as possible. In the end, talking circles are public events and participants decisions to break protocol, to share personal information, cannot be controlled.

In addition, the research process was designed, with participant permission, to be shared with the public through documentation. Throughout the research process, participants were informed of their rights to withdraw, and were asked whether they wanted to attribute their names to the process. Most participants agreed to remain anonymous until the final draft was created, to ensure a fully informed decision about submitting their names for publication. Considering some of the discomfiting stories about the need to change the status quo, it seems appropriate that many participants would not want to be identified.

Breaches of circle protocol can happen when difficult issues arise, when people feel they must speak out of turn. This occurred once during the first gathering when new information was introduced about a plan for an Aboriginal healing centre in Vancouver. When such breaking the circle interruptions occur, the format may be dropped in favour of a verbal competition format (point and counter-point). The resumption of the circle format then often depends upon the willingness of other participants not to breach protocol, until the disrupting individuals decide to rejoin the circle, or upon the ability of the facilitator or other participants to initiate return to circle format. In the case of the first gathering, all three methods were used to return to circle format. Throughout the remainder of the first gathering, and the second gathering, talking circle format was adhered to, to the conclusion of each gathering’s purpose (initiate sharing of stories, feedback on dissertation-in-progress).

One of the most interesting things about doing storywork in talking circles is that the researcher has no control, beyond introducing the research focus and questions, over the contributions that participants will make. The direction of stories shared can be within or deviate widely from researcher expectations. The latter occurred during the first gathering, when the facilitator-participant linked the research to participant journey’s to traditional-based health
service use or practice, and during the second gathering, when participants voluntarily decide to focus on the applicability of, rather than the need for changes in the dissertation.

Because of the consecutive nature of talking circle contributions, earlier contributions "set the stage" for later contributions, as long as consecutive participants felt that it was in line with what they had to say. Rather than being rigid, the direction or focus of the talking circle contributions shifted and changed throughout and across each round. Participants returned to reemphasize previous points, or focus on new or underrepresented areas of consideration. Talking circles, as applied in this project, became indirect dialogues between multiple participants, where conflict was avoided by focusing on the stories and ideas, rather than on who said them, towards an inclusiveness of perspectives, towards the building of consensus.

Figure 16 is a visual representation of the increasing depth and cohesion created by the talking circle processes in this research project, as the focus shifted from establishing relationships, through the communication of ideas and stories, through the generation of new ideas and strategies, to group cohesion, consensus or synergy.

Each phase of the diagram could represent one round, or several, depending upon how well participants knew each other at the beginning, and how willing or able they were to move to different phases. The introduction of each new person, or new idea, had the potential to bring the process back to the previous phases.

Considering the research goal of producing a collective story, the utilization of talking circle methodology in this project became one of the most effective processes for directing the writing in a way that best reflected the consensus around the direction, focus and applicability of the research.

Talking circles are limited by the willingness of participants to attend, and in this project, to share relevant stories. In line with the ethics of the research process, no one was coerced to attend the research gatherings, or to share their stories. As such, only ten of the 22 participants were able to come to the first gathering, and only 6 of the participants were able to come to the second gathering. The first gathering was designed to introduce both the researcher and main research question to the participants, to enable the research group to broaden and deepen understandings about themes and ideas within the research project. The second gathering was designed to encourage attendance by those who wanted to give feedback and direction to the...
dissertation in general, and collective story in particular. In the next paragraphs, I will be talking about the interview-dialogues; everyone participated in this process, which may indicate a consideration of best opportunity for sharing relevant stories. During the whole research process, only one person withdrew themselves entirely from the project, after the first gathering, apparently for reasons separate from the appropriateness of using storywork or talking circle methodologies. It seems reasonable to conclude that attendance at the gatherings may have been limited by their introductory and feedback purposes, as much as by scheduling, availability and other considerations.

**Dialogue, Unfinished Story Method and Virtual Talking Circles**

The use of dialogue, with a consideration of Indigenous etiquette around the asking of questions (see section I), turned out to be the most effective method for encouraging the sharing of stories and ideas relevant to traditional-based health services in Vancouver.

Each dialogue was initiated using a shorter version of the unfinished story, first used at the first gathering. The unfinished story served as a good reminder about the goals of the research project, how the main research question came to be, and led naturally into the asking of more specific questions. On a one-on-one basis, participants seemed more comfortable with asking for clarification of the terms and phrases that I was using, than during the gatherings. On one occasion I was asked to translate my academic language (English), into a more common, Indigenous use of the language (see Figure 5).

When I began the dialogues with the people in my research group, I was inspired to confirm and support stories and statements made, by sharing the stories and statements shared by other members of the group. As the dialogues continued, I realized that we had reproduced a form of a talking circle, a virtual talking circle, where each consecutive person built upon previous ideas, to a point of great detail and great consensus (see Figure 13). It would be interesting to explore how virtual talking circles could be adapted to the internet, with “rounds”, to create and disseminate collectively built-upon stories, relevant to research questions.

Except for one participant, each of the dialogues continued for well over the expected hour. If the tape quality wasn’t so bad, there would have been over 44 hours of transcripts, instead of 22 hours. Conversation flowed well from stories (mine and the participant’s) to the next relevant question, in varying orders. It’s been noted before in this dissertation, that the question that seemed to bring the most surprise, was the question about the ideal situation for traditional-based health services in Vancouver. While it might seem like the most apparent question when considering how to enhance such services, we must remember that a focus on what’s not working is still so important that it has precluded a focus on the ideal, and has done so, for a very long time. With an understanding of the past’s encroachment on today, and an increased focus on creating the ideal, today, perhaps the shift into a better phase of health service options in Vancouver, can be quickened.

**Using Prayer, Dreaming and Visual Arts in Knowledge Generation, Analysis and Presentation**

I can’t overemphasize the importance of prayer, dreaming and visual arts in this research project. The use of these processes liberated and empowered me as a person and as a researcher, and provided me with the skills I needed to do good work. Before I started post-secondary education, these processes were a big part of my life, but were excluded by myself and others thereafter, as inappropriate for academic settings. Prayer and dreaming were the initiation of this research project, so I felt compelled to discuss them as valid in doing research about traditional-
based health services, with interested people, because traditional-based health services include the use of prayer, dreaming and visual arts. In addition, they were congruent with the use of Indigenous wholistic theory, storywork and talking circle methodology, and Indigenous protocols, because they are wholistic in nature. In effect, they enabled me to interact with people, make sense of my research in meaningful ways, and assisted me in presenting and discussing the research processes and findings in more effective and appropriate ways, than previously available (see Figure 17).

Figure 17: Poster presentation of Wampum Research Model and research paintings, at the University of Alberta’s “Listening to the Voices” Conference on Aboriginal Health (June 4, 2004).

Over the last year, I had decided to get some more practice presenting my ideas, as a prelude to defending my dissertation, and to test my ideas. In the fields of education and health, people usually use Power Point to present their ideas, with the occasional photograph. Not being proficient yet with Power Point, I decided to use the Wampum Research Model and paintings that I had been using during my brainstorming work. I was a little worried about how my presentations would be received, but aside from the statements “you’re in education, aren’t you,” and “this is really radical,” the feedback was about resonance, acceptance and even excitement.

My work had never before generated the amount of attention and interest I received after those presentations. In my case, the picture really was worth a thousand words. The Wampum Research Model poster and paintings provided a visual model of my ideas which enabled a quick transition from discussions of general ideas, to more in-depth discussions of relationships, theory and process, specific to my research. For myself, painting provided a comfortable form of communication that far surpassed my speaking abilities, in its ability to convey my ideas.

The painting in Figure 18 was created for the primary funder of this research project, the B.C. ACADRE (Aboriginal Capacity and Developmental Research Environment)\textsuperscript{21}. It contains several Anishnaabe-specific referents: Nanaboozhoo (teacher/trickster), strings of wampum beads (historically used by Anishinaabe, Mohawk and Iroquois peoples, for documenting relationships and events), and the seven grandfathers (representing 7 values: respect, love, knowledge, bravery, truth, honesty, humility). The position that the wampum is being held, is
similar to a position in one ceremonial process, and is intended to remind us of our commitments, for the good of our future generations. It was designed to represent the challenge and the transformative influence of bringing Indigenous wholistic theories and methodologies back into the public realm, and as a representation of my gratitude for enabling me to do research in line with the 4 R's of Indigenous research: respect, reciprocity, responsibility and relevance.

Figure 18. Enabling Indigenous research in the Academy

Indigenous Models for Knowledge Generation and Analysis: Wampum Research

Inevitably, the use of traditional-based processes in this research project, like the use of prayer and Indigenous protocols elsewhere, led to gifts, or leaps in knowledge and understanding, beyond what I usually acquire through mental efforts. As mentioned previously, one of the most profound gifts of this research project, was the dreaming of a beaded representation of the research process (Figure 19); this came after praying for assistance to comprehend all the complex influences and considerations.

Figure 19. Wampum research model, with question numbers.

A way to understand this model, is to view the beads as multiple and interconnected influences and decision points about the research, over time (left to right). The top row represents the influences of academia, in UBC colours. The middle row represents the influences of the Vancouver Indigenous community, in important traditional-based colours. The
bottom row represents the influences of myself, as a graduate student researcher, in my favorite colours. The black beads represent the decision points and reflect the necessity to keep the research grounded in the community. The white spacers represent research questions. In addition, the beads can be viewed from bottom to top, as a representation of the transition of knowledge, from direct experience, to integration into the community through sharing, and into the public domain through documentation and presentation. This latter perspective is particularly relevant to the potential protection of knowledge through the limitation of what is shared, documented or presented.

After representing the Wampum design dream in a large poster-painting, and after detailing the significance of each bead with text (Appendix P), I realized that I had come up with an adaptation of an Indigenous process, that could be used to design, analyze and represent responsible research with Indigenous communities. The questions generated for consecutive column of beads, are as follows:

1. What are the relevant motivations of self, community and academia?
2. What question arises?
3. What is your disciplinary lens?
4. How does this affect the question?
5. What are the relevant theoretical foundations of self, community and academia?
6. What are appropriate theories?
7. How does this affect the question?
8. What are the relevant methodological foundations of self, community and academia?
9. What are appropriate methodologies?
10. How does this affect the question?
11. What are the relevant methodical foundations of self, community and academia?
12. What are appropriate methods?
13. What are the relevant meaning-making foundations of self, community and academia?
14. What is appropriate meaning-making?
15. What are the relevant utilitarian foundations?
16. What is appropriate use?

In one complex, but easy to represent dream, I was given a way of seeing and making sense of the whole research process. It's interesting to note that the processes of dreaming and painting this Wampum research model were all generated during the early part of the "meaning-making" stage represented by the model. By centralizing the traditional-based research group in the centre row of beads, I was able to maintain my focus on community-derived agendas for the research, which helped to mold the direction of the dissertation. If I were to signify this, and the importance of relevant research, in a physical model, I would create a bracelet connected through the centre row. In such a configuration, the model would also represent the theoretical basis of this research: Indigenous wholism.

One the most exciting things about this model is that it can be used to weave together and represent the influences and relationships of more than three relevant groups, and more than 16 considerations, by weaving in more strands of beads. One or more prioritized groups can be placed in the centre strand positions and patterns can change according to the needs of relevant groups, the design, analysis or presentation. As in older forms of Wampum, important symbols
can be woven to deepen the significance of the representation. Visual and physical representations provide avenues for working with knowledge intuitively, emotionally and spiritually, providing knowledge beyond the mental domains, into other realms of human being.

An important thing to consider, is that beads and bracelets and other weavings and patterns have been used for thousands, if not millions of years, by humans, as a way of connecting all our domains of knowledge: mental, physical, emotional and spiritual. Some of the most persistent examples in both Eastern and Western cultures, have been the use of bracelets and beads as religious mnemonics (e.g., Buddhist, Christian, Jewish, Muslim). These, like many other symbolic tools, provide the focus point for very real change. If we can re-integrate Wampum and other beading and weaving tools back into our institutions of knowledge, as metaphors or models for research, we will be well on our way back to rebalancing who we are as Indigenous people.

This Wampum Research Model is a research tool that can be used and modified to represent, design, analyze or present complex influences and relationships in qualitative research and is a rich example of the potential of revived traditions and visual arts for expanding and extending perspectives into other domains of being and knowing.

Naming the Wampum Research Model was difficult until I remembered the role of Wampum in the history of my people and neighbouring Nations. My first concern was that I might be profaning the sacred by bringing Wampum into the academic world. After more research, I realized that Wampum was an important communication tool that was not sacred in itself, but only as sacred as the relationships and events that were being represented. That the Wampum Research Model might be used as a symbol to both represent and strengthen relationships among academia, individuals, communities, and Indigenous peoples, seems resonant, relevant, and related to the integrity of Wampum traditions.

Lastly, as an Indigenous research model rooted in specific histories, traditions and peoples, this Wampum Research Model is not mine. In an effort to represent the collective genesis of this model, I’ve included a chronicle of events, as they related to the process of designing and interpreting this model.

1. Thoughts around beads came from a discussion of beading belts as Olympic souvenirs, as a revival of traditional kinship networks and traditional practices, during work on the Vancouver Aboriginal Community Realignment Proposal with Amelia McComber. The beading dream came from my prayers, and from the prayers of the research group and others.

2. The motivation to name it came from Maori scholar Graham Hingangaroa Smith. As in traditional practices, naming in a research context brings things to life. The choice in name is a continuation of Wampum theory and practice of relationship that predates Confederation. Wampum has already been applied (prior to this project) to a contemporary health context by Joe Jacobs who designed and has carried the Teiakonekwensatsikhe:tare (Our Blood is Sweet) Wampum to communities, to aid in the battle against Diabetes (search Wampum and Diabetes online:

3. When asking for guidance, Elder Lorraine Muehlfarth-Hance reminded me of the teaching of humility, which necessitates an acknowledgement of collective creation and therefore, collective “ownership”. The editor of Pimitisiwin, Laura Botsford, gave me the final push to get this story published and provided the technical expertise to get my research example onto the visual Wampum model.

4. In discussions with Maori scholar Wiremu Doherty Tuhoe, about the similarities between the Wampum model and the Matauranga Tuhoe Framework, he pointed out how the
vertical beads provided a genealogy for Indigenous knowledge – from ourselves as rooted in specific lands – through the domains of our communities, and into the domain of academia. This is particularly relevant to the issues and protections of intellectual and communal property.

5. In looking for an appropriate metaphor for Indigenous leadership, Alannah Young spurred me to remember to acknowledge this Wampum Research Model as a product of the Indigenous community, by sharing it widely. In looking for the reference for the Teiakonekwensatsikhe:tare Wampum, the first article that emerged was written by Alex McComber, of Kahnawake, where that particular Wampum arose. Another circle was completed as the people of Kahnawake (Amelia and Alex McComber) and Mnjikaning (where my relations are) came together again, as in our multigenerational meetings at the summer grounds at Port Carling, and through the gathering of our peoples at the 2004 Elders Summit at Six Nations, Ontario.

6. Finally, during the review process of a paper on the Wampum research model, Ed Bochert reminded me that to ensure balance, we must be explicitly consider the domains of emotion, spirituality, physical and mental. His diagram (Figure 20), which clearly shows balance in-itself, was awe inspiring, it is included here, with a change from text to colour codes.

![Figure 20: Expansion of the Wampum Research Model to ensure consideration of the influences of emotional, spiritual, physical and mental domains](image)

Blue = Academia Turquoise = Community Purple = Researcher
Yellow = Emotional Green = Spiritual Red = Physical White = Mental

The Wampum Research Model can be applied and expanded by anyone with an understanding of its genealogy and principles, along with efforts to maintain that integrity through respectful action, to any Indigenous research context.

The Inextricability of Indigenous Health and Education Services

Indigenous people have demonstrated a way of knowing and relating that must be regained and adapted to a contemporary setting – not only for the benefits of those
cultures themselves, but for all human kind. Learning and becoming whole are, at every level of expression, intimately intertwined (Cajete, 1994).

Like many people, I like to pragmatize my understanding of the world, so that I can make decisions. In this section, I will attempt to summarize and pragmatize some of my reflections on research with a group of traditional-based health-education practitioners (healers, medicine people, traditional knowledge holders), their facilitators and clients in Vancouver. The focus of the research was to create a collective story about how to enhance the access to, and provision of traditional-based health services, by and for Indigenous peoples, in Vancouver. For me, the findings of this research provided deep insight into the inextricable inter-twinning of Indigenous health and Indigenous education.

For me, the phrase Indigenous Education is complex, and deserves much examination. First of all, education in its broadest sense includes all those processes which are designed to maintain, or which naturally maintain, a healthy societal status quo: everyone living in relative harmony with each other, their environment and other beings. More commonly, Indigenous Education is used to refer to provincially standardized systems of education (curricula + procedures) that are delivered to Indigenous peoples. While there are some exceptions, most band-run schools or other K-12 First Nations education programs are constrained to deliver provincially packaged curricula, under strict guidelines. While many are satisfied with the status quo, many are also demanding more choice in schooling. More recently, people are questioning not only who is delivering the curricula to whom, but also from within whose worldview the curricula and processes are being created. In a country where assimilation is supposed to be “in-the-past”, and where legislated Aboriginal-rights and title to land, resources and self-determination are decades old, these questions are not only ethical and just, but urgent and past-due.

Epistemology n. theory of method or grounds of knowledge; a. epistemological [Gk epistēmē knowledge] (Oxford University, 1984).

I like to differentiate between traditional-based Indigenous worldviews and other worldviews by asking myself how connected or derived they are from specific contexts (see Figure 1). For me, traditional-based Indigenous worldviews (as differentiated from non-traditional-based) are those dynamic systems of beliefs and values which have arisen from long-term intimate relationships between and within specific lands, waters and beings. Because of these intimate relationships, traditional-based Indigenous worldviews commonly embrace beliefs around, and values of, wholism - spiritual, physical, mental and emotional - balance, interconnection, interdependence, and thereby, respectful and responsible relationships. Because of the complexities involved, discussions of Indigenous Education usually focus on these common principles, and from there, applications to curriculum delivery processes are made. Considering the history of Indigenous education in Canada, such advances should be held up as indicators of the great socio-political accomplishments and continuing influence of our Indigenous predecessors.

Another step that needs to be taken, and which has driven my research, is to move beyond the preservation of Indigenous artefacts and practices, to move parallel to distinguishing between worldviews (in the creation of culturally sensitive practice) towards restoring Indigenous traditions within protected contexts. Space for multiple epistemologies (and more specifically, Indigenous epistemologies) must be asserted, supported and created within the mainstream domains of health and education (see Figure 7). That is, restoring traditional-based Indigenous principles and practices for health-education would assist in the creation and maintenance of a
healthier, more just, and egalitarian societal status quo. An immediate assertion might be that: “we can’t go back to the way we were”. We don’t have to. Traditional-based Indigenous health-education principles and practices are those traditions, arising from Indigenous worldviews, that educate - remind, model, teach, exercise and reinforce – us to live in relative harmony with each other, our environment and other beings. The restoration of Indigenous traditions in contemporary contexts is a logically sound, health-enhancing, sustainable, and responsible recommendation.

In a relatively homogenous community (language, culture, religious practice, history, context), traditional-based health-education principles and practices can be restored on a larger scale, by their integration into dominant educational and health systems. For example, we can incorporate traditions like rites of passage (Birth, Adulthood, Elderhood, Death), storytelling, ritual, feasting, and ceremony (naming, healing, grieving) to remind us who we are as spiritually connected, physically interdependent and globally responsible beings. How we do that in an international setting, like Vancouver, is tricky but not impossible. In an egalitarian society, there are always choices and creative environments for self-determination. Traditional-based, health-education practices - linked to considerations of respectful and protective protocols - can be offered as options amongst a range of health and educational services, and identified as critical in the creation of an inclusive, pluralistic society. Traditional-based health-education practices can be initiated by creating space for such activities, by creating opportunities for information exchange, and by creating long-term practitioner-client relationships. These relationships can be facilitated, directly or indirectly, towards a “best fit”, by considering ancestry, history, gender, prior knowledge, personality, and potential commitment. Except in medical emergencies, considerations of ailments or conditions are secondary to the establishment of healing relationships, which are the “active ingredient” in lifestyle-oriented, traditional-based Indigenous health-education practices.

Historically, Indigenous health-educators were the Elders, the Aunts, the Uncles, and occasionally, people who had specialized knowledge; which is appropriate if the emphasis is on the message, rather than on the transmitter of that knowledge. Anyone who shares traditional knowledge about who we are, about how to live a good life, or about how to be a good person could be considered a health-educator, at that moment, and the gifts imparted could be considered good medicine. Those who specialized in sharing or applying such knowledge could be considered medicine-people.

Naming a person a healer or medicine man/woman - in the English language – (which tends to focus on the transmitter) is something of a faux pas in many Indigenous circles, because it does not allow for a “thousand year” tradition of sharing where one’s knowledge comes from, over a lifetime of familiarity. In urban areas, where people come and go in one’s life, it’s harder to establish such long-term sharing and healing relationships. Sometimes there aren’t any Elders, Aunties, Uncles or Medicine people to visit. In such cases, people take risks and are willing to find surrogates: friends, strangers or associates who are known to fill the same medicine-sharing roles.

While traditional-based Indigenous health-educators - historical or contemporary – may play key roles in the facilitation of health for individuals, it is the surrounding complex of relationships which ensure, empower and maintain the efficacy of the practices. In a relatively homogenous community this complex would include close and extended family, friends, and important associates. In an urban context, where family may not be as available, close friends and important associates may fill the roles, as surrogate family. In the end, this complex of health-educators, family, friends and associates, becomes an enduring web, not only for the support of one person, but also for the well-being of everyone in that community.
The key to utopia, or a world of healthy sharing and healthy living, reiterated by many (and mentioned by everyone in our research group), is the importance of spirit and spiritual ways of being, knowing and doing. Much ignored, maligned and closeted in the public practices of a westernized world, spirit is the unifying belief behind who we are as human beings (see Figure 21). We are spiritual beings on a physical, mental and emotional journey. This is not news to most Indigenous people, nor to most non-Indigenous people, on a private level. What may be revolutionary is the idea of restoring the centrality of spirit back into our public institutions and public practices. If we know who we are – that all life is connected through spirit – and if we learn how to live good lives, then, by extension, we will act responsibly towards the creation of harmonious and sustainable (healthy) relationships within this world.

![Figure 21. Process of life: from Spirit, through physical manifestation, to Spirit.](image)

While North American history hasn’t been the most honourable in the past few hundred years, there are rumours and prophecies that the time and timing for positive change is around now. People in cutting edge science, policy and philosophy – quantum mechanics, ecological and systems theory, post-positivist critical realism, transformative inquiry, social determinants of health, socially responsible business, New Ageism – are walking in the footsteps of people applying traditional-based Indigenous theories and methodologies (worldviews and traditions). It’s no surprise, or secret that the academic world is turning a serious eye towards traditional-based Indigenous knowledge, as templates or paths to wisdom (or profit). While there are still pirates, there has never been such common ground between Indigenous and non-Indigenous peoples, nor as much potential for radical, positive educational change for the health of Indigenous, and all peoples.

Restoring balance, by restoring the place of spiritually-based traditions in our public institutions is logical and necessary: locally, regionally and globally. Memories might arise of a time of dark ages, when religious oppression reigned. Scientific reasoning is said to have broken the hold of religious dogma over people’s lives. The research findings referenced in this project don’t suggest that we return to the dark ages, but that we expand science beyond reductionism and machine analogies, beyond essentialism and cultural relativity to critical understandings of reality, through the deep examination and restoration of health-enhancing, sustainable epistemologies. Traditional-based Indigenous ways of life were, and still are based on such epistemologies. It’s time for courageous health-educators and allies to take the lead, to promote and restore contemporary forms of traditional-based Indigenous health-education practices, towards breaking the hold of scientific dogma over people’s lives.
For the more pessimistically inclined, the ideas in this section may sound like idealistic grand theory, but they are practical, especially at the local level. These common sense ideals, have been spoken about by our relations for many years. Many are finding new ways to apply these theories, methodologies and goals, within their lives, at home and in the work place, regardless of the constraints of the status quo. At the centre of such ripples of community development, for radical health and educational change, are ordinary people who decide to take their worldviews and traditional principles and practices out of the closet. Such courage inspires others to act with more cultural integrity. The challenge is out: who dares to meet publicly, to move beyond divide and conquer politics, to demand a space for another positive path to health, to design health-educational policies and programs in line with Indigenous worldviews; who dares? Our ancestors and our children’s children are waiting.

Evaluating Research by Applying Indigenous Projects

In Linda Smith’s book, *Decolonizing Methodologies* (1999), there is a section that describes the type of projects that Indigenous people can undertake, towards decolonizing methodologies in research. These ideas entered into the research process at the time of the literature review and have contributed to the directions and approaches of this research. In this section, I have chosen and applied ten out of twenty-five of these project categories and descriptions to evaluate this research project as a whole, to demonstrate the usefulness of applying these projects as evaluative tools. These projects were chosen because their descriptors were the most explicit and quotable. Applying these projects, as questions, is an effective way to evaluate the strengths and shortcomings of doing research in Indigenous communities.

Intervening

The Indigenous intervening project carries with it some working principles. For example, the community itself invites the project in and sets out its parameters (Smith, 1999; p. 147).

How was this research project Intervening? The intervening principles for this project were derived through processes in three domains: personal, community and academic (see Figure 14), by orienting to both Indigenous wholism, and by centralizing the Indigenous community. As such, the primary focus of this research project was to address long-term queries, comments and recommendations for action, made by Indigenous people around accessing and providing traditional-based Indigenous health services in the city.

The parameters and the question were both set by the needs and the themes inherent in these queries, comments and recommendations. The proactive orientation of the question – “how can... be enhanced...” – was designed as an on-going, transformative influence and intervention, on both the processes and products of this research project.

The mode of intervention, through the application of Indigenous wholism, storywork, talking circles and protocols, was an extension of the precedent already set through prior relationships with pre-study individuals. These processes are intervening because of the healing and conscientization that occurs during the sharing of such stories and ideas.

In the end, this project is intervening because the community-derived question has been answered in great detail by the participants, with great potential for immediate application.
Gendering

Gendering contemporary indigenous debate... indigenous women hold an analysis of colonialism as a central tenet of indigenous feminism (Smith, 1999; p. 152).

How was this project Gendering? This project was inherently gendering through the initial and on-going discussions, stories and ideas around the influences of colonialism and westernized gender relationships, upon Indigenous people in general, and upon traditional-based Indigenous health services in particular (see Section I). As the stereotyped domains of the female have been marginalized, ostracized or otherwise oppressed as unimportant, illogical, or hysterical, so have the stereotyped domains of the Indigenous person: connection to the land, spiritual and healing ways of being, knowing and doing.

Within the findings of this project, it’s interesting to note that there were no great gender differences between how the men responded, and how the women responded. Each talked about both their personal challenges, and their desire to assist not only Indigenous people, but all peoples: young, old, men, women. This seems congruent with the expectation that people interested in traditional-based health services, might embody the traditional-based principles of balance or harmony in relationships, and the implied orientation to an altruistic sense of responsibility.

While men and women participated equally during the dialogue sessions, a difference was noted in the rate of participation in the gatherings. In each, only 1 man participated (out of ten and seven); the reason for this discrepancy is unknown. Considering less than half of all participants came to either of the gatherings, the lack of male participation may be somewhat attributed to the suitability of gatherings in general. However, in the first gathering, the only male participant identified himself in relationship to his female partner, and discussed, through humour, his acknowledgement and respect for the power of women-in-circle. These comments-in-circle may refer to some of the traditional-based protocols around gender, and suggest an influence on attendance during co-ed gatherings.

In hindsight, a more in-depth questioning and analysis of gender-specific recommendations, and within gender-specific talking circles, would have enabled a more explicit orientation to Indigenous feminism.

Reframing

Reframing is about taking much greater control over the ways in which Indigenous issues and social problems are discussed and handled (Smith, 1999; p. 153).

How was this project Reframing? The problematization of Indigenous people in Canada is as rampant today as it was 400 years ago, when disagreeable outcomes within relationships between colonizing and Indigenous peoples were entitled “The Indian Problem”. This orientation is challenging for several reasons; it deflects dialogue away from real, specifically located, people, with real needs, supports the view that these “problems” are inherent to Indigenous people, and maintains an inactive status quo. This mind-set has been so enduring and so dominating that it is one of the primary influences on contemporary institutionalized racism, and after generations of application, internalized racism.

We’ve known what the contributing factors have been, for about 400 years. We’ve also known what will solve most of the issues that Indigenous people face in Canada: better and more equitable relationships between Indigenous and non-Indigenous peoples, and the consequent
entitlement or redistribution of power, resources and lands, in support of Indigenous self-determining actions.

What hasn’t been sufficiently addressed, is how these factors and relationships can be realistically transformed, at locally specific and practical levels. This project attempts to reframe Indigenous health-education research, by asking a proactive question, and by focusing on locally specific strategies. According to participants in this project, traditional-based health services can be enhanced in the short-term and in the long-term, by concurrent actions within, and actions outside of the mainstream health system. These effects of these actions, in turn, are congruent with the numerous calls for better and more equitable relationships.

Connecting

...set of relationships... places in universe... connecting to traditional lands through the restoration of specific rituals and practices... about establishing good relations (Smith, 1999; p. 148).

How was this project Connecting? The focus, process and findings of this project are connecting in many ways. Indigenous wholistic theory has, as part of its framework, an orientation to an interconnected and spiritually-based reality. The motivation to establish good relations is a fundamental consequence of accepting the core principles, which has ensured a procedural acknowledgement and inclusion of local Indigenous peoples, and created a link between the generation of Indigenous knowledges and their inextricable connections to direct Indigenous experiences with specific lands, waters, peoples and other beings.

The use of Indigenous ritual protocols was particularly connecting through its ability to communicate and establish specific relationships between myself and the participants of the research group, for specific altruistic purposes (for the good of all our relations).

Storywork and talking circles are about expressing oneself wholistically, in relationship, or in connection with others; what is shared is shaped by who is listening. As a result, this project is about connecting the needs, knowledge and motivation of the traditional-based Indigenous community, with the needs, knowledge and motivation of academia, for specific community-based outcomes.

Traditional-based health services are just that, health services that are connected to traditions arising from specific lands. Asking people how traditional-based health services can be enhanced, therefore, is akin to asking how health services, and consequently people, can be reconnected to the land. An underlying theme within the findings of this project, is that the health of many Indigenous people, is intimately connected to their ability to identify and connect with Indigenous ways of being, knowing and doing.

Networking

Relationships are initiated on a face to face basis and then maintained over many years, often without direct contact. Building networks is about building knowledge and data bases which are based on the principles of relationships and connections. Networking by indigenous peoples is a form of resistance, face to face, about checking out an individuals credentials, not just political... but their personalities and spirit (Smith, 1999; p. 156).

How was this project networking? The screening process, mentioned earlier, was designed to create a strong, respectful foundation for the research. While only volunteers were included in this research project (leads were not followed), the end result of the call for
volunteers was that I knew almost all of the participants, before the project began. This can be attributed to the fact that I was already involved with a network of people in Vancouver, and across Canada, that knew, or knew of each other, and each other’s work. The network of traditional-based practitioners, their facilitators and clients extends across North America and beyond. The fact that people were willing to engage with me in this research means that my intent, credentials and processes were known and acceptable to them. Conversely, I am aware that other traditional-based practitioners decided not to volunteer, and are watching this project and my work, as a prelude to supporting or denying future projects related to me, or the research findings. Because of this awareness, I have been as careful as possible, to ensure that both the research processes, and my relationships are appropriate and respectful.

Networking in the field of traditional-based health services is about lifelong relationships, because the field is based on commitments to specific interconnecting worldviews. As the saying goes, once you’ve started on the path, there’s no turning back. Hence, my role as a researcher in this field was not taken lightly; unlike many research projects, where relationships are terminated with the project, I have committed to maintaining and nurturing these relationships indefinitely. I believe that some of the participants wouldn’t have entered into this project if I hadn’t used Indigenous protocols to signify a commitment to these concepts. In this sense, it’s important to ensure that Indigenous protocols aren’t co-opted to establish relationships that otherwise wouldn’t be entered into.

And we never hear from them again is one of the most damning expressions – directly related to the bad experiences of Indigenous people engaging in research with non-Indigenous peoples. Long-term relationships carry with them an expectation that people will work together, resolve conflicts and combine actions for mutual benefit. Initiating research with Indigenous people is a privileged entrance into a network of Indigenous (and non-Indigenous) relationships, and must be considered carefully. Transgressions or inappropriate behaviours related to these research relationships will ensure difficulty engaging those networks again; conversely, good relationships might ensure the quick activation of those networks.

In short, this project has been networking by its utilization of traditional-based Indigenous networks, by its ongoing censorship by Indigenous networks, and by the initiation and expansion of committed long-term network relationships.

Envisioning

...is a strategy which Indigenous people employ to bind people together politically... is a strategy which asks that people imagine a future, that they rise up above present day situations...dream a new dream... set a new vision (Smith, 1999; p. 152).

This project has been envisioning by its orientation to an activation of ideals relevant to traditional-based health services in Vancouver. I differentiate between the term visioning, as the creation of a vision, by defining the term envisioning, as the activation of a vision. Implicit in the issues raised by both pre-study individuals, and project participants, is a sense of an ideal situation. By making the focus of this research pro-active, I have emphasized both the legitimacy and the need to strategize towards these underlying ideals. The envisioning process began with the sharing of the ideas and questions that became fundamental to this research. In the fall of 2000, I began to share these ideas and questions within Vancouver and elsewhere; by the end of 2003, the research proposal had been shared widely with Vancouver Indigenous agencies (Vancouver Aboriginal Council, Chief Dan George Education Centre, Vancouver Coastal Health, Vancouver Native Health...) and many individuals, with the intent of “getting the ideas out there”.
To make this research even more envisioning, the question has been asked: "what would be the ideal situation for traditional-based health services in Vancouver?" The answers to this question have been incorporated into the prior section as a way of transforming the underlying ideals, into a cohesive vision for collective action. Detailing this vision, by outlining specific areas to address, with specific recommendations, completes the envisioning process, by providing a pathway for the realization of the vision. Whether this pathway is implemented, is somewhat irrelevant to the envisioning of this research, because the goal has been to initiate and legitimate the vision in the minds of many; this has already been accomplished by the engagement of the Vancouver Indigenous community, the University of BC and others, in the research project. Eventually, if the envisioning has been embraced widely enough, the vision will be realized, through the momentum and collective decision-making of like-minded people, by whatever means is appropriate. It is fulfilling to know that the seeds of ideas that were planted through this research (and the work of others) have already grown beyond the scope of this project, within the Vancouver Indigenous community.

Democratizing

Democratizing in indigenous terms is a process of extending participation outward through reinstating indigenous principles of collectivity and public debate (Smith, 1999; p. 156).

This project has been democratizing by its orientation to community initiated and community designed storywork, using methodologies and theories that have already been promoted as appropriate for working with traditional-based Indigenous peoples (Indigenous holism, storywork, talking circles, Indigenous protocols). It is further democratizing by its inclusion of anyone volunteering, appropriate (practitioners, facilitators and clients) and able to engage in relevant dialogue, in respectful ways, across nationalities.

The recommendations of this research group are inherently democratizing by the consistent reference to the need to meet the diverse needs of diverse Indigenous peoples, whether or not that includes traditional-based health services, by making future services inclusive of those diverse needs, peoples and services.

Revitalizing

Revitalization of cultural practices in various states of crisis... (Smith, 1999; p. 147).

This project has been revitalizing, by its proactive focus on traditional-based health services. Traditional-based health services have been in a state of crisis since the beginning of European colonization of North America. With the influx of new pathogens and more sedentary lifestyles and diets, alongside assimilative influences against "heathen" or "unscientific" health processes, traditional-based health practices were marginalized in favour of biomedicine. In various documents, traditional-based health services are considered to be extinct; in effect these services are still being provided across North America, and even in the cities. The survival of these practices are closely aligned to the survival of traditional-based Indigenous ways of being, knowing and doing. The recommendations of the research group aim to revitalize cultural health practices, by supporting the establishment of traditional-based health service networks, through the creation of a council, the creation of space for practice, and through guidelines for both practice and entering into traditional-based health service relationships, towards the restoration of traditional-based health services as legitimate health care options.
Restoring

The restoring of wellbeing spiritually, emotionally, physically and materially has involved social... and health... in a range of initiatives, some of which have been incorporated into mainstream programs... conceived as a holistic approach to problem solving... in terms of the emotional, spiritual and physical nexus and also in terms of the individual and collective, the political and cultural. Restorative programs are based on a model of healing rather than of punishing. Health programs addressing basic health issues have begun to seek ways to connect with indigenous communities through appropriate public health policy and practice models (Smith, 1999; p. 155).

This project has been restoring by its underlying agenda of making space for traditional-based health services, both outside of, and within the mainstream. Many people have been working to restore such services, on both small and large scales within the Vancouver area, and beyond, for generations. This research has been designed to add to this agenda, by creating one collective story about how to restore traditional-based health services, by one research group. Rather than seeking punishments, apologies or atonements for the state of traditional-based health services in Vancouver, this project recommends the healing of current imbalances, towards more equitable, safe, legitimate and effective health service options, through the cooperative creation of stronger networks, explicit visioning, and guidelines for both practitioners, facilitators, clients and associates. If the vision of this research project is realized, then the well-being of Indigenous peoples will be greatly restored within Vancouver, alongside the well-being of non-Indigenous peoples.

Representing

Representation of indigenous peoples by indigenous peoples is about countering the dominant society’s image of indigenous peoples, their lifestyles and belief systems (Smith, 1999; p. 151).

This project has been representing of Indigenous peoples, by Indigenous peoples, by its focus on enhancing traditional-based health services in Vancouver, with an underlying assumption of legitimacy, and by the centrality of Indigenous people in the processes of this research. The greatest critique and stereotyping of Indigenous lifestyles and beliefs has been about the appropriateness of such practices and beliefs for today’s world.

This project and its recommendations counter those critiques and stereotypes by discussing traditional-based health services, in a language that is more accessible to non-Indigenous peoples, and in particular, non-Indigenous policy makers. This is necessary because, to date, documents written using Indigenous terms, concepts, metaphors and language have met with little success in shifting mainstream thinking and practices; on the contrary, such documents have been used to further marginalize Indigenous peoples by applying Euro-centric judgements. The logic goes something like this: I cannot understand it, therefore it doesn’t make sense, which is faulty if we consider ontological or epistemological bias. This enables all parties to engage with traditional-based practices on the most appropriate level: as legitimate health service options.

If we assume a starting point for discussions, beyond the legitimacy of an option that is still practiced, and still in demand, we can get to issues of strengthening the service through public education, professionalization and client safeguards. This project usurps the starting point for discussion, by moving to represent Indigenous perspectives and recommendations
proactively, using Indigenous theories, methodologies and methods, as directed by pre-study individuals and participants. A discussion or examination of efficacy, and more importantly, measures of efficacy, can come later.
Chapter 8 Recommendations

Prioritization of Worldview in Considering the Non-Medical Determinants of Health

The transmission of traditional health knowledge in Vancouver, is inextricably linked with the status of traditional knowledge holders in Vancouver. Traditional knowledge holders who work with the health of people, practice by teaching people how to take care of themselves. Sometimes they are called healers, teachers, Elders or medicine people. In this study I have called such traditional knowledge holders, traditional-based practitioners, to reflect the (mostly) neocontextualized nature of their practice, in the urban Vancouver setting. Practitioners may practice teachings taken from one, or more than one territory, either separately, or blended, but to prevent homogenization, ensure that they are differentiated. If, after historical efforts, there is still a demand for greater numbers of culturally appropriate health services in Vancouver (and there is), then it follows that traditional-based practitioners aren’t being supported adequately in Vancouver; that the transmission of traditional health knowledge is still being marginalized, and thereby, the options for wholistic health care are less than adequate.

How can things change? In the shift and growing emphasis from illness care to health care, there has been an increasing acknowledgement that biomedicine is limited in its ability to keep people healthy and that non-medical determinants of health may play a more important role in the health of Canadians in general, and of Indigenous people in particular. In “The Health of Canadians – The Federal Role Final Report researchers reported that

The remaining 75% of the health of Canadian population is determined by a multiplicity of factors outside of the health care system. These factors, which are often referred to as the ‘non-medical determinants of health,’ include: biology and genetic endowment, income and social support; education and literacy; employment and working conditions; physical environment; personal health practices and skills; early childhood development; gender; and culture.

The shift to more wholistic ways of conceptualizing health is concurrent with statistics and reports on the health of Indigenous people in Canada, which recommend more culturally appropriate health services, including an increase in the number of traditional healers (INAC, 1996).

Culture is listed as one of several non-medical determinants of health under consideration by the health care system (IHPR, 2005):

Culture and ethnicity come from both personal history and wider situational, social, political, geographic, and economic factors. Multicultural health issues demonstrate how necessary it is to consider the interrelationships of physical, mental, spiritual, social, and economic well-being at the same time.

In a recent document by the PAHSS Committee (now called the BC Aboriginal Health Network), it was presented that one of the core functions of the Aboriginal Health Division (under the Provincial Ministry of Health Services, Population Health and Wellness Division)\(^{26}\) was to “provide an Aboriginal lens for health legislation and policy development”.

After completion of the field work portion of this study, I strongly assert that in caring for Indigenous people’s health, worldviews (or ways of being and knowing/ontologies and epistemologies) - not just attributes of culture - must become the prioritized lenses from which all other determinants of health are considered.
If there is truly an agenda to shift from illness care to health care, in deeper and more wholistic ways, then worldviews must be prioritized a) to provide more culturally appropriate health care services for Indigenous peoples, and b) to provide wholistic models for expanding current health care services for all Canadians (see Figure 8).

This project has combined a population-based agenda of addressing the calls for understanding cultural determinants of health, with the Royal Commission on Aboriginal Peoples’ calls for more traditional healers, by researching how the transmission of traditional Indigenous health knowledge can be enhanced in Vancouver. The assumption was that if a dialogue (or multilogue) of the enhancement of access to, and practice of traditional Indigenous health services can be initiated, the transmission of traditional Indigenous health knowledges can be activated and strengthened.

The key to addressing these agendas in this research project, was to look at the relationships and processes which influence the access to and provision of traditional Indigenous health knowledges in Vancouver. A strong conclusion from the collective story (Chapters 4-6) would be that recommendations for enhancing traditional-based health services in Vancouver reiterate the necessity to attend to non-medical determinants of health when providing health services to people from diverse origins; it’s not important what’s being done, as much as how it’s being done, by whom to whom, and under what circumstances. The ideal, would be a pluralistic health care system that included health-service options that were appropriate for people seeking traditional-based Indigenous services or processes. The collective story within this document provide a blueprint for modifying health services in Vancouver, to ensure that Indigenous people have traditional-based options to meet their health needs, and to ensure that non-traditional-based health-services are provided in ways that are more accessible to Indigenous peoples, and potentially non-Indigenous peoples, who embrace traditional-based worldviews.

Establishment of Traditional-based Relationships, Councils, Guidelines and Centres

Issues of client protection, healer protection, healer payment and/or support and the protection of traditional medicines and ceremonial substances must be addressed in a more formal way if traditional healers, midwives and elder-counsellors are to play a significant role in Aboriginal health and social services. For traditional healing to come out of the shadows, issues of professional accountability and public trust must be addressed. It is, in fact, the mark of an established profession to be self-regulating (INAC, 1996).

In the big picture, urban Vancouver is a unique and exciting context for the growth of traditional-based Indigenous health services. The groundwork has been laid by both Indigenous activists, and by cutting edge health service policy makers, who agree that more culturally-based options must be developed, with the Indigenous people of Vancouver. Many health services are already being provided in more culturally appropriate ways, through such agencies as Pacific Association of First Nations Women, Vancouver Native Health, Knowledgable Aboriginal Youth, Urban Native Youth, She-Way, Hey-Way-Noq, Healing Our Spirit, Circle of Eagles, Warriors Against Violence, Squamish Healing Centre, Suslim Lelum, Change of Seasons, Vancouver Aboriginal Friendship Centre, First Nations Chiefs Health Committee, and others. These agencies in turn, are being guided by Elders, Indigenous community members, and institutions of learning, research and governance, at local, regional, provincial and federal levels, in both Indigenous and Canadian streams of governance.
Through this research project, an understanding has been shared, that while these efforts and accomplishments have been great and beneficial, they haven’t been enough. Indigenous people in urban areas still face continuing and urgent health inequities and disadvantages, when compared with Canadians in general (UN Commission on Human Rights, 2002): for example high rates of diabetes, tuberculosis, HIV/AIDS, suicide, incarceration, family violence, substance abuse; and lower rates of employment, housing quality, water quality, graduation from high school and post-secondary education. In Vancouver in particular, Aboriginal people, compared to the general population:

...have a shorter life expectancy, higher rates of cancer and communicable diseases such as TB and HIV/AIDS, greater risk for death by unintentional injury, and a higher incidence of teenage pregnancy and associated complications such as low birth weight babies (Vancouver/Richmond Health Board, 1999).

More culturally appropriate services - traditional-based services in particular – must be developed for the urban Vancouver Indigenous community, to ameliorate these inequitable consequences. Though there is a tension between those who support traditional-based services and those who don’t, there is recognition of the need for diverse options, which will be instrumental in the facilitation of alliances for the enhancement of both biomedical-based and traditional-based health services.

The impetus to create strong alliances for the benefit of all Indigenous peoples in Vancouver, is facilitating a move away from competitive strategies, towards more inclusive and community-focused strategies, regardless of funding barriers. This movement is reminiscent of the actions of the Maori people over the last 15 years, during which community-based alliances enabled radical beneficial changes in educational services for Maori, which in turn influenced similar self-determining Maori movements in the fields of health, economic development and recently, political representation.

While the recommendations of this research group were a direct response to a question of how to enhance the access and provision of traditional-based health services in Vancouver, they are far broader in scope than expected, and provide visions and strategies for enhancing the access and provision of all services, for Indigenous people and other marginalized groups in Vancouver. This is so because the visioning and the strategizing was about the healing of relationships and inequities between Indigenous and non-Indigenous peoples in Vancouver, from an Indigenous wholistic perspective.

The access to, and provision of traditional-based health services can be enhanced by implementing strategies from three positions in the Vancouver community: through initiatives by traditional-based Indigenous practitioners, by people working in health and educational services and institutions, and by people in the wider society that are involved in making decisions for Vancouver communities at the metropolitan, regional, provincial and federal levels. These findings are congruent with both Indigenous wholistic and critical perspectives which assert contextualized or interconnected influences and effects, with transformative theory which asserts the necessity of multiple sites for change in the status quo, and with Indigenous theories in general, which assert the necessity of self-determining actions, for effective changes in the status quo.

At the societal level, decision makers must be influenced to ensure that the unique and urgent needs of Indigenous peoples in Vancouver are prioritized and addressed in appropriate ways. Ignorance of the historical and contemporary agreements between Indigenous and colonizing peoples, and of the intergeneration consequences of colonization and assimilation, is continuing to result in racist or discriminatory practices and must be combatted through
proactive societal-wide educational campaigns and institutional interventions. A recent UN Commission on Indigenous issues in Canada (UN Commission on Human Rights, 2002) reiterated the importance of such campaigns, but warned that

…it be clearly established in the text and spirit of any agreement between an Aboriginal people and a government in Canada that no matter what is negotiated, the inherent constitutional rights of Aboriginal peoples are inalienable and cannot be relinquished, ceded or released...

These educational and institutional campaigns must include a positioning of Coast Salish Nations as the constitutionally acknowledged hosts to Vancouver peoples.

In addition to these campaigns, decision makers must take steps to mobilize and secure finances, resources, land and relationships towards supporting the self-determining establishment of a cohesive urban governance model for the organization and distribution of services for self-identified off-reserve Indigenous peoples in Vancouver. In particular, sacred sites must be secured and protected, under the guidance of Coast Salish Nations, for the well-being of both land-based and off-reserve Indigenous peoples.

Existing policies and procedures that affect Indigenous peoples must be revised to ensure inclusive and equitable treatment of Indigenous peoples and their worldviews and lifeways. In particular, discussions of the role of spirituality and spiritually-based practices must be re-engaged at a public policy level, to ensure that people are not discriminated against, on the basis of religious or cultural practices. Denying the role of such practices in the public health of communities is negligent, especially towards traditional-based Indigenous peoples who may have worldviews and ways of doing things that centre on spirituality. At the same time, intellectual and cultural property safeguards must be created to ensure that the documentation and implementation of such educational campaigns, governance models, services, policies, procedures, worldviews, and lifeways, are not appropriated or used to further oppress and discriminate against Indigenous peoples in Vancouver.

Educational campaigns, radical decision-making, relationship-building and safeguards must also be implemented at the institutional level, to ensure that traditional-based Indigenous principles and practices are both integrated into existing systems of care and education, and supported outside of existing systems, until a cohesive governance framework is established. Thereafter, the onus will be placed upon existing institutions to negotiate, devolve or make space for new practices. In particular, the profile of traditional-based health principles, practitioners and services must be raised to enable greater streamlining and utilization of existing services, and greater team-building and advocacy for Indigenous peoples, within and outside of existing systems.

At the community level, for people who embrace traditional-based health principles and practices, educational campaigns must be initiated to reinforce the relevance, and self-determining right to traditional-based health services in Vancouver, and to initiate discussions about the creation of a council controlled fund for the economic support of traditional practitioners, to alleviate tensions between the sacredness of traditional medicine practices, and contemporary adaptations of historical supports. At the same time, traditional-based Indigenous health services must be developed, by traditional-based Indigenous health practitioners, as a self-guiding cooperative profession, complete with communal screening practices, ethics and guidelines for practice, protection, referral and engagement of approved services and products, and for the training of new practitioners. The screening and guidelines are necessary to raise the credibility of diverse practices and levels of training, and to protect against fraudulent or abusive services or situations. The most consistent and strongest recommendations for enabling the
development of traditional-based health services in Vancouver were the need to establish a cooperative council of traditional-based Indigenous health practitioners, and eventually, the establishment of appropriate sites both within existing institutions and independent of existing institutions, for the delivery of traditional-based services. The Canadian Co-operative Association has echoed this call for more cooperative health service options for Indigenous peoples, in a recent communique (See *Co-op Model Responds to Aboriginal Health Care Needs*):

The Canadian Co-operative Association is calling for a dialogue around the potential of the co-op model to deliver more effective and responsive health care in rural, remote, and northern Aboriginal communities.

Considering the Indigenous wholistic principles of interconnectedness and respectful relationship, such models will be instrumental in the creation of health services for urban Indigenous communities, as well as for rural Indigenous communities.

All of the recommendations of the traditional-based research group echo and make locally relevant the urgings of academics quoted earlier, like Graham and Linda Smith, Marie Battiste, Sakej Youngblood Henderson, Jo-ann Archibald, Shirley Sterling, Jean Barman, Leslie Roman, Gregory Cahete, and Collins Airhihenbuwa, who urge proactive, critical, grounded, and culturally relevant responses to imbalances in the health service status quo.

Applications to Curriculum Development & Community Education

According to some of the research participants, who attended the dissertation-draft feedback gathering, one of the most obvious and important uses for this dissertation was said to be the development of curriculum for workshops and courses. In particular, it was suggested that a curriculum based on these findings would be essential for the education of physicians, nurses and other health care practitioners, about some of the factors that need to be considered when providing appropriate options for diagnosis, care and referral of traditional-based Indigenous peoples. These statements provide a strong counterbalance to the following recommendations:

The Canadian Medical Association (CMA), for example, has called on members to show "openness and respect for traditional medicine and traditional healing practices such as sweat lodges and healing circles". It will take an active program of professional education by organizations such as CMA to achieve this goal (INAC, 1996).

While the CMA may not be the only organization or group to offer such education, embracing the idea is a step in the right direction.

Some of these factors would include an engagement with Indigenous wholistic theory, and its potential influences on knowledge generation, differential diagnoses, differential treatment, and the health of individuals and communities. Another important discussion would be about spiritual-based perspectives and their influences on both individual and community processes of healthy identity formation, resilience, employment aspirations and adjustment to adulthood. An exploration of relational worldviews and health profiles could be facilitated through personalized, contextualized genealogical health research. An understanding of the legitimacy and efficacy of traditional-based practices could be facilitated by delving deeper into some of the discussions in the collective story, and by shadowing traditional-based practitioners
"on-the-job" (under strict protocol). The potential consequences of such learning on building integrated teams with traditional-based practitioners, is promising.

At the same post-secondary level, this dissertation could be used as an example, case study or template for learning about designing qualitative research with traditional-based Indigenous communities. In particular, some of the ethical discussions could be used to influence research that serves community goals, needs and processes, by helping to reposition researchers away from identities as privatized academics, towards identities as collaborators in problem solving, knowledge generation and documentation for the good of All Our Relations.

On the edge, this dissertation could be used to challenge students to design research that challenges the cultural-based boundaries of objectivity and rigour in the academy, to facilitate deeper discussions into non-physical and subjective forms of evidence and validity.

More interestingly, the processes, reflections, stories and discussions in this dissertation can be taken back to the Vancouver Indigenous community, in the form of educational booklets, workshops or courses, to facilitate awareness of this kind of research, as a way of testing, improving, modifying and implementing both the processes and the ideas, in community lived, experience. Specifically, some of the stories and ideas around traditional-based worldviews, the importance of genealogies, rituals, ceremonies and community gatherings in urban settings, the efficacy of traditional-based practices, and strategies for organization and development, might be well received. This is in alignment with the agenda of Indigenous wholistic theory, towards specific balancing effects, through reflection and practice. Creating a community booklet for accessing traditional-based health services – after submission of the dissertation – was one of the specific non-research commitments entered into at the beginning of this project, in an effort to ensure that this project remained connected and relevant to the traditional-based Indigenous communities from where it arose.

Applications to Sustainability

Because of their strong orientation to lifestyle teachings, traditional-based health practices have a great potential to affect the health of Indigenous peoples, and others, in the long-term, if we can connect the political will to more sustainable approaches to influencing health. The Canadian government echoes the potential and the challenge of creating such connections in the following excerpt (Canada, 1997):

Although it is clear that, collectively, the non-medical determinants of health have far greater impact on the health of the population than health care, the fact is that the very positive outcomes from promotion, prevention, protection and population health activities are generally visible only over the longer term, and thus are less newsworthy. Because they are less likely to capture the attention of the general public, they are less attractive politically.

The decisions we make in our daily lives are intimately connected to who we think we are, how we see reality and to our understanding of consequences. If we see ourselves as disconnected from the land and water, disconnected from other humans and the other beings that inhabit this planet, if we see individualized existence in this world as the pinnacle of who we are as human beings, then we are doomed to lives of isolation, irresponsibility and consequently, fear. Disconnection leads human beings to atrocious acts. In reality, we, the planet and all the other beings here are connected physically, emotionally, mentally and fundamentally, through spirit.
Spirit, like our bodies, minds and emotions, can influence action in the world around us, and beyond. One analogy is to view spirit like a pool of water; each of us represents a droplet within that pool. One drop can disturb the whole pool. If many drops are in movement, then we can have currents and waves that can carry other droplets along. If we can see everything as an extension of ourselves, and if we strive for balance and health in all things, then it follows that we will act responsibly and with consideration, towards beneficial consequences. Responsible action creates good sustainable relationships. Common sense dictates that the preservation, protection and creation of good relationships with lands, waters, plants and other beings, will facilitate the preservation of and protection of our own lives, and create good relationships within our personal contexts.

A discussion of spirit, from a traditional-based perspective, leads naturally to a discussion of relationships. Everyone knows what a relationship is. Where we differ is in the definition of a good relationship. If we consider the previous discussion, about responsible and connected actions, then we will be getting to the crux of both the strengths and challenges of intercultural relationship-building. The word “responsibility” is understood from within culturally-based contexts and is loaded with meaning. For many, responsibility means to live a life where you go to work daily, provide for dependents, protect what you’ve worked for, and try not to get into trouble. Those who don’t follow this course of action are seen as irresponsible, and often negligent or criminal. Responsibility from a traditional-based perspective means to act appropriately, now, with a consideration of all extended relationships, past, present and future. How well we do that depends upon our knowledge and our balance emotionally, spiritually, mentally and physically. To reflect these extended considerations and contexts, we can modify the above statement of a responsible life to mean a life where you work when you need to, take care of dependents when they need you to, protect what needs protecting and try not to get into trouble, unless you have to. The authority to be responsible and lead good lives is within each of us, not something to be imposed on us by others, who may not have an understanding of our specific contexts.

Applications to Urban Indigenous Governance

By our connectedness as human beings, it is inevitable that research will be influenced by, and influence events outside of its parameters. Through the networking of this research project, I was invited to work as a Van City grant proposal writer for the Pacific Association of First Nations Women (PAFNW) on a project entitled Urban Aboriginal Community Realignment Project. The proposal was inspired during a Vancouver Aboriginal Council meeting (March 18, 2004), when it was queried what kind of framework could be designed for the devolution of services to Indigenous peoples in Vancouver. One young woman, Millie McComber, a volunteer at the PAFNW, was inspired to respond that we could adapt our time-tested Indigenous frameworks, which were based on traditional kinship networks, to the issue of urban Indigenous governance. These networks could be built in Vancouver, in alignment with the land-based Nations, to provide representation, and the distribution of information, services and opportunities. While the proposal wasn’t successful, and the project was dropped by the PAFNW, it was supported by many agencies and people in the community. If it is to be successful, it’s been suggested that the term realignment will have to be changed because of its community connotation that Indigenous people are out of alignment. It was presented to the Vancouver Indigenous community, using a flag, at the Vancouver Aboriginal Council on June 17, 2004 (see Figure 22). While the Urban Aboriginal Community Realignment Project may be too radical for immediate implementation, the vision is a step in the right direction.

While this project was not designed to discuss governance for Indigenous peoples
in Vancouver, it has inevitably touched on this subject, as necessary to the enhancement of
traditional-based Indigenous health services. While the urban Vancouver Indigenous population
has been acknowledged, to the point where millions of dollars are being budgeted to address the

Figure 22. Urban Aboriginal Community Realignment Project, presented at the Vancouver
Aboriginal Council,

needs of this population group, political representation of this population has been designated to
the good graces of majority-based politicians, and to the leadership of small numbers of
Indigenous agency advocates, within mainstream institutions. Consequently, health services for
Indigenous peoples are also underrepresented and primarily under the control of non-Indigenous
peoples. Because Indigenous-specific services are designed only to supplement the services
available in the mainstream, they tend to be short-term, disconnected, overlapping and lacking in
the coverage of Indigenous health needs. According to the people in this research group, the
equitable and just distribution of health services for Indigenous peoples in Vancouver requires a
more cohesive framework, designed by Indigenous people, to ensure that both medical and non-
medical determinants of health (worldviews, Indigenous health processes) are addressed
appropriately, and effectively. This strongly reflects the conclusions of the Royal Commission
on Aboriginal Peoples, regarding the governance of relationships between traditional-based
practitioners and their clients:

This will require financial assistance from Aboriginal, federal, provincial and territorial
governments so that traditional healers can form national (or several regional)
associations to encourage the exchange of information and build toward more formalized
self-regulation. In the long term, these organizations should become self-financed and
operate under the authority of Aboriginal governments (INAC, 1996).

If we pull together prior recommendations and diagrams for respecting local First Nations, urban
governance, and practitioner models, and orient them alongside existing services, we can see, in
a powerful way (Figure 23), the potential transformative influence of cooperative relationships
on the self-determining capacity of both off-reserve and land-based Indigenous peoples in
Vancouver, and upon the appropriateness and efficacy of services delivered to Indigenous
peoples, by non-Indigenous institutions in Vancouver. Additions to prior models include the gray square, which represents Mainstream institutions in Vancouver; the white oval, which represents new and existing services for Indigenous peoples; and the arrows, representing a stronger voice of Indigenous peoples in the design and delivery of health services for Indigenous peoples in Vancouver.

Working Towards Alignments or Partnerships

B: We can't say "oh our teachings are better than your teachings" because we all have the same teachings. It's about honesty and respect, compassion (Tape B).

This project was never intended to present traditional-based health services as the only or most important option for Indigenous peoples in Vancouver. On the contrary, both the agenda and the research findings strongly indicate a desire to position Indigenous wholism, Indigenous methodologies and traditional-based Indigenous health services as legitimate options for both research and practice in Vancouver. This legitimacy is based on constitutionally embedded rights for Aboriginal peoples, on human rights and issues of social justice for Indigenous peoples in Vancouver, and upon decades of research and community calls for more culturally appropriate services for Indigenous peoples.

The collective story clearly articulates a framework for cooperation between Indigenous and non-Indigenous health care professionals. This framework reflects two of the four possible relationships suggested in the Royal Commission on Aboriginal Peoples (INAC, 1996):

Respectful Independence ... parallel systems whose practitioners have respect for one another, make referrals to one another, and may occasionally co-operate in treating clients or responding to community problems.

New Paradigm Collaboration ... work together to develop techniques and practices to promote and restore health, using the best elements from both systems or recombining those elements into wholly new ways of approaching health and healing [without melding or homogenizing].
The framework recommended in this dissertation strongly suggests that the ideal relationship is *New Paradigm Collaboration*, but that the best way to develop that relationship, is to initiate the establishment of a parallel system, to develop cooperation through *Respectful Independence*. Ideal partnerships can only be developed by supporting the establishment of traditional-based health services as an independent profession, by and for Indigenous people, first.

**Applications to Global Health and Global Citizenship**

J: Well, we are a part of the global scene now. I mean we are not an isolated people anymore and we’ll never go back to what was; that’s not going to happen. And I believe the sooner we accept that... And it goes both ways: I see our people actively isolate themselves from the rest of the world, and I can understand and see the reasons why, as we’ve been hurt so much as a people, and certainly as individuals. There are people in my family, in my community of Squamish who have absolutely no non-Native relationships and by that I mean friendships, acquaintances, professional working relationships of any kind; their whole world is of Native people. And I don’t think that helps us; we do need to branch out and expand our horizons so to speak: learning to get to know other people, and other people’s ways. And again, that goes back to respecting other people’s ways. I can do that, while holding on to who I am, to what is unique about my beliefs: spirituality and whatnot, no one can ever change that; no one can take that away. When we go back to traditional-based health, it’s always about who we are as a people, unique, distinct, what is special about us. We have a lot to offer this world, when we are ready, and when this world is ready to accept it (Tape J).

According to some in the pre-study and research groups, more and more Indigenous people are ready to work beyond differences, to heal and create stronger relationships with peoples in Canada, for the benefit of all. Those who embrace Indigenous wholism eventually go back to the principle of interconnectedness, which means - as difficult as our neighbours are to live with, and with full acknowledgement of the transgressions - we’re in this world together, and have to follow the paths of the heart, to peace.

Indigenous peoples have already been modeling inclusiveness on national and international levels: creating bridges of understanding and cooperation through sincere dialogues and commitments, working through barriers of language, culture and historical tensions. The glues for these relationships are the common goals of fair and equitable treatment for Indigenous peoples, commonalities in experience and worldviews.

While there may be many from diverse backgrounds who might share these commonalities, there is an even stronger bond that can draw diverse interests together: survival as a human species. The warnings of research participants, other Indigenous peoples, and prophets from other cultures have been very clear about the road of individualistic and materialistic pursuit; it does not end well. Conversely, these same prophets talk of a return to understandings of our interconnectedness and interdependence. Global warming, global pollution, the threat of global war, the failure of our ecosystems and the death of millions of species are not just fantasies, they are influencing the health of human beings in more and more obvious and disastrous ways.

The recommendations of the research group are clearly connected to influencing not only the health of individual Indigenous people, but whole communities and the entire world.

If we take these recommendations seriously, then we must embrace a path of inclusive pluralism, at all levels of society: nationally and internationally. We must bank and protect our diverse knowledges, so that we can apply them to the resolution of our longstanding global
inequities and imbalances. What if Canadian society was reshaped to be inclusive of the diverse principles and practices of its Indigenous and immigrant citizenry? How would it look? Would it start with community-based recommendations like the ones in this project? Would it start with cooperative councils and self-determining locations and stances? Would it start with a demand for more equity in the design and distribution of services? I think so.

J: I always go back to what the creator gave us, but also what the Creator gave to the rest of the people of the world: the European, the Asian, the Middle Eastern people, the African people. They all have their gifts as well, and that's what we are taught to respect: the best quality of what they have, their gifts. And that's what the Creator gave them; so who am I to question that? If I question their ways and say Oh, I don't smudge or I don't cross myself then I'm saying I am not spiritual. There are a lot of wonderful and positive qualities about whether a person is Christian, Muslim, and Buddhist, you know; it is about respecting all of that. On the other hand, it's about all those other ways of life respecting us. It is not about asking for their permission to exist. It's not even about apologizing for who and what we are. It's not for them to question. And that's what they have to realize, 'cause when they do that, they question God. They question the Creator. That's all we have to know, really. When we understand, and know, and live by it, then there isn't ever going to be a need for all these things that people do to each other, all these atrocities, things like that. And what counts is we count, what counts is keeping our humanity, maintaining our humanity, enhancing our humanity so that we continue to grow, to evolve. I question, I wonder if this is as far as we will ever go as a human being, can we evolve to be more? (Tape J).

The fact that all beings on this planet are in existence, and arising out of unique communities and contexts, gives us the greatest wealth as a sentient species. With all the knowledge of the diverse peoples with diverse worldviews, we have the capacity to rise above irresponsible competition, to unite our commonalities and to work cooperatively towards the good of all life on this planet. It’s been said that if humankind would cooperate, we already have the knowledge, resources and technology to feed, cloth, house, educate and care for all the people and beings on this planet, with minimal waste or damage. The only thing standing in the way of global health is our fear of, belief in, and willingness to change. While the findings of this project are not intended to address contexts outside of Vancouver, the visions and inspirations within, are very portable to larger and even global contexts.

The key to enacting such global citizenship lays in facilitating the inspiration and collective visioning that global harmony is attainable through the actions of individuals. This in turn can facilitate and be inspired by the building of an awareness of our intimate interconnectedness as beings on this planet. Understandings of interconnectedness, on a personal level, can activate a sense of responsibility for others, which naturally motivates us towards the building of better relationships. Hence, from an Indigenous wholistic perspective, global health and global citizenship are attainable if traditional-based Indigenous principles and practices, which are tied to ecologically sound relationships, are learned and embraced by individuals, within community contexts.
Connecting Knowledges: Self, Community and Academia

syn-er-gy n. pl. syn-er-gies 1. The interaction of two or more agents or forces so that their combined effect is greater than the sum of their individual effects. 2. Cooperative interaction among groups, especially among the acquired subsidiaries or merged parts of a corporation, that creates an enhanced combined effect. [From Greek synergēs, cooperation, from synergēs, working together; see synergism] (Farlex, 2005).

Intellectual space needs to be created in academic institutions for re-validating these ancient tools, these wholistic processes for community-based knowledge generation and consideration, especially in fields edging into qualitative research where the boundaries and laws of the physical world do not wholly apply. Reduction of our humanity into concrete categories, through isolated observations does not produce a knowledge base founded on the reality of our wholistic human condition. Qualitative research, as research that looks into human perspectives or ways of being (ontology), knowing (epistemology) or doing (methodology) things, needs to incorporate a consideration and validation of all of our ways of knowing as human beings. That we don’t yet understand, or can’t yet prove the many things about our psycho-physical responses, emotions, spiritual or metaphysical experiences, or even our mental processes, doesn’t mean that those avenues are invalid roads to knowledge. It’s time to make the shift from knowing our outer worlds, to knowing our inner ones, in ways that expand the outdated parameters of science.

From an Indigenous wholistic perspective, our worldviews and ways of doing things aren’t just the disconnected settings and contexts for our research, they are the theories and methodologies of our research, and dictate how our research is done, how it is written and for what purposes. Our common knowledges are the directly experienced, community shared and synergized stories about how the world really is. Far from being a useless exercise in connecting personal and common knowledges to academia, graduate research for Indigenous peoples seems to provide a necessary luxury that enables the reflection, analysis and community applicable learning necessary for community synergism and consequent visioning for proactive change. Because it is primarily outside of the pressures of employment or funding agreements, graduate research enables a relative freedom to question the status quo, which is a necessary function for all human societies. Hence, this project confirms and echoes prior recommendations for maintaining a distance from controlling interests which may co-opt or inaccurately represent what is known to be true, for amoral or irresponsible gain, to ensure that our societies remain dynamic and responsive to the needs of our people.

Prognosis for Transmitting Traditional-Based Indigenous Health Knowledges in Vancouver

The motivations and agendas of this research are many, and have included from the beginning, an educational orientation to exploring the enhancement of traditional-based health services in Vancouver. To lead healthy lives, we have to learn how, first. The most appropriate people to teach traditional-based lifeways are the traditional knowledge holders, and specifically, traditional-based practitioners who specialize in assisting people to apply those teachings for their well-being. One of the assumptions that has been strengthened, by the shared stories and ideas of the participants, is that the teaching and learning of traditional-based lifeways are still integral to the continuity and resilience of many Indigenous peoples in Vancouver. Not only are
these ways of being, knowing and doing important, they can make the difference in the ability of Indigenous peoples to lead healthy lives, by helping individuals to understand their place as unique beings within the cosmos, with gifts to discover and share, and with responsibilities to take up.

The transmission of these lifeways, to existing and future generations, in Vancouver, has had many barriers and constraints, primarily through historical, continuing and internalized racism, through a lack of understanding of traditional-based health practices, through fears or doubts about traditional-based practitioners, and through the consequent inequities in addressing Indigenous health service needs, in diverse and culturally appropriate ways. By exploring these inequities, and by asking what an ideal situation would look like, participants have created a template for changing those inequities, through educational campaigns, through strategies for strengthening the profession of traditional-based health practice, and through recommendations for health service and societal change.

If traditional-based health practitioners can be supported in the ways suggested by the research participants, then the prognosis for transmitting traditional-based Indigenous health knowledges, to future generations of Indigenous Vancouverites, will be very good.

Traditional-Based Health Services and Indigenous Health in Vancouver

J: And this is what I do: like looking at traditional ways of life and what counts. I think that what counts is the universal human value of love. Every single human being wants to be loved and every single human being wants someone to love back. So how does all this violence and hurting other people help that value, it doesn’t at all. That is not love and we have to examine that, and question that, and how is that impacting and affecting our lives. As a people, also individually, that’s what counts. So a traditional-based health service providing that – I think that’s what helps us. Determining our own needs, our own direction, where we end up, where we go as human beings. I don’t think we as a people have ambitions or plans or minds on being world dominators. We just want to live, to live comfortably and live well. And we’ve been dragged into this modern world now, probably dragged kicking and screaming. It’s time for our people to accept that, but its also time for the rest of the world to, you know, open that door. See what we have to offer (Tape J).

An underlying rationale for this whole project has been that, on the average, Indigenous people in Canada are continuing to experience health problems in different, and in much higher rates, than average Canadians.

Despite reductions in infant mortality rates, improvements in education levels, and reductions in substance abuse in many Aboriginal communities, First Nations and Inuit people remain at higher risk than the Canadian population as a whole for illness and early death (The Standing Senate Committee on Social Affairs, Science and Technology, 2002). A recent document echoes these statements relevant to Indigenous children and youth in Canada (see Appendix Q). Up to sixty percent of Indigenous peoples in Canada have migrated to cities, where these health inequities continue to exist, and sometimes in higher proportions than for on-reserve Indigenous peoples. Vancouver (Vancouver Metropolitan + Fraser Health) is estimated to have an Indigenous population of 77,540 people, out of a total of 1.99 million people (Statistics Canada, 2005a, b; Fraser Health Authority, 1996). If the Vancouver Indigenous birth rate and age distribution is consistent with national figures, the estimates for the Indigenous
population and health service demands in Vancouver, will increase by close to 17,000, in about fifteen years. Currently, there are only 236 Indigenous-specific programs (Vancouver Aboriginal Council, 2005) within a milieu of 670 health service facilities, 26 hospitals and 46,665 employees (Vancouver Coastal Health Authority, 2005; Fraser Health Authority, 2005), coincident with unmet traditional-based health needs, for off-reserve Indigenous peoples, of approximately 15%.

Non-medical factors have been shown to play a much greater role in the health of people than previously thought. Culture has been listed as one of the factors, on par with socioeconomic status, employment, religion and other factors. Calls for more culturally appropriate services have been consistent since the early 1970’s (World Health Organization). One of the hypotheses of this project has been that health status inequities are not just a consequence of different ways of accessing existing biomedical-based services, but that existing services are insufficient to meet the health needs of traditional-based Indigenous peoples in Vancouver, because they are not designed from, or congruent with Indigenous worldviews.

If, as the literature and research participants relate, traditional-based health practices are still important to many Indigenous Vancouverites, and if health is influenced by worldviews, then health inequities can be reduced by supporting the development of traditional-based Indigenous health services in Vancouver, through educational campaigns, networking, the establishment of a practitioner council, the development of guidelines, and the establishment of multiple centres for traditional-based Indigenous health practices.

Personal Plan for Action

“Accountability” and “transparency” may well be the buzz words of development into the next decade. Bringing the voice and experience of poor people to bear on development issues will, however, be the acid test for whether these words achieve anything more than “buzz” status. And even if people’s attempts to talk and to listen are successful at field level, donors, governments and policy makers still have to be convinced (Slim & Thomson, 1995).

After putting so much of myself, as the researcher, into this dissertation, I must make reference to some personal conclusions, relevant to enhancing traditional-based health services in Vancouver. I have been explicit about my plan to create a public document, and to present this research at both community and academic levels; this is about accountability and transparency at the field level. Beyond my academic commitments to the community, through knowledge transfer, dissemination and sharing, I intend to play more active roles in the support of traditional-based practices; to do otherwise would show a lack of integrity or consistency with the theme of relationship. As the old adage goes, “the proof is in the pudding”; research for community development - that includes oral testimony - carries with it the responsibility of working towards reducing inequalities and creating positive change; the voices of the people have to be taken seriously. I agree with Slim and Thomson, and with the participants in this project, and believe that to create space for enhancing traditional-based health services in Vancouver, my next actions must include an engagement with donors, governments and policy makers, as well as with people in the Aboriginal community, alongside any practitioners who decide to work on creating a council, or cooperative centre, or integrated teams. We are all here together in Vancouver, in Coast Salish territory, and must enter into good relationships, to create more health care and educational options for our people, and especially, Indigenous people.
Gitche Migwetch! Thank you Creator, Great Mother, Grandmothers, Grandfathers, Teachers, Elders and All My Relations, for my life, the gifts, your guidance, your prayers, and the protection that you have brought into my life, without which I would not be here, or know anything.
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Endnotes

1 My father lost his Indian Status when he joined the Canadian Armed Forces, through the [dis-] Enfranchisement Act. Thereafter, he wasn’t allowed to live on the reserve. In 1985, after Bill C-31, my father was invited back to his community, which opened the door for the rest of our family.

2 “All our relations” is a traditional-based phrase that refers to all the beings (animate and inanimate) on this planet and beyond, and reflects the Indigenous wholistic principle of interconnectedness.

3 Throughout the process of talking to people during this research project, it was repeatedly confirmed and stressed that an Elder is a person, who carries, teaches and applies wisdom and knowledge acquired from teachers or through spiritual processes. As such, not all old people are Elders and younger people may be addressed as Elders by the wisdom and knowledge they carry.

4 Traditional-based health services, in this dissertation, are those health services that are provided by traditional-based-Indigenous-North American-knowledge holders, and which are essentially, health education services.

5 While the term Indigenous is used to refer to any people who have ancestors who’ve inhabited a specific continent, for many generations (as in indigenous to), in this dissertation Indigenous means Indigenous North Americans.

6 While there are Coast Salish participants in this dissertation, the focus of the research is to reflect a profile of suggested enhancements to traditional-based health services, for those urban community members who don’t have access to traditional-based Coast Salish health and education services, like those provided within Longhouse traditions.

7 This phrase refers to those health services that have arisen from a predominately western European tradition of reductionistic science, which has favoured a Newtonian, or machine model of human functioning. This phrase may also be replaced in this dissertation by the terms “Mainstream”, or “Western” health services, according to who is speaking and in what context.

8 “Culturally appropriate ways” usually refers to efforts to be sensitive and accommodating to Indigenous peoples and their ways of being, knowing and doing.

9 “Conscientization” refers to a process of increasing knowledge and understanding about one’s challenges.

10 “Beings” in this dissertation is being used similar to “all my relations”, as a reference to all that is sentient and/or connected through spirit.

11 In this dissertation, worldviews mean perspectives based on a cohesive system of beliefs, values, ways of being (ontologies) and ways of knowing (epistemologies)

12 Hierarchies of belonging are organized around colloquial, categorical terms of identity. For Indigenous people living in Vancouver, such terms include Status, non-Status, Treaty, non-Treaty, on-reserve, off-reserve, traditional, non-traditional, Metis, mixed blood, Bill C-31, Sell-Out and Apple. Conversely, relative to Indigenous people, some of the most derogatory terms for people sympathetic to, or allied with Indigenous people, are Wannabe or Turning Indian, from there we could hypothesize up the power ladder of the non-Indigenous. Status and power become situational, according to one’s shifting, perceived and assumed position.

13 Grounded research, as discussed by Bob Dick (2005) is the process of theory emerging out of real-life people and situations, through constant comparison, categorization, saturation and sampling, memoing and sorting.

14 In Chapter 34: Standpoint Theory (Available on-line: http://www.afirstlook.com/manual5/ed5man34.pdf#search='Standpoint%20Theory'), Julia Wood offers two reasons why the [research] standpoints of women and other marginalized groups [like traditional-based Indigenous peoples] are less partial, distorted, and false than those of men in dominant positions. 1. Marginalized people have more motivation to understand the perspective of the powerful than vice versa. 2. Marginalized people have little reason to defend the status quo.

15 Anishnaabek and Anishnaabe are Ojibway language terms (pl. & s.) for being of “the people” and have various translations. One of my favorites is spontaneous being.

16 I use the term Native here to reflect the timing of a personal shift in terminology that arose as the result of conscientization about the racist and derogatory uses of the term Indian.

17 Full circle refers to a traditional-based Indigenous principle that our learning and healing journeys are completed when we recognize similarities between where we started and where we’ve arrived.

18 While facts are defined as “truths”, in practice they could be said to be “dominant” or “official” truths. Relational refers to “relation. n. what one person or thing has to do with another”. Factual or relational knowledge refers to knowledge arising from official or relational sources.

19 Effective healing specialties like Anishinaabe shaking tent ceremonies, Midewiwin degrees, singing and dancing require years of preparation and training, incorporate numerous levels of knowledge and skill development, and a high degree of mobility and commitment to service.

Funding from ACADRE enabled support of Indigenous protocols (gifts, feasting, travel), development of this work through conferencing & networking, and printing, childcare and living costs.

Presented to ACADRE, March 10, 2005


Saving Bochert’s emailed model created a formatting error which corrupted text within the beads.

A version of this section has been submitted for publication to the Canadian Journal of Native Education.

See an excerpt from Elders Guide Us, Youth Inspire Us, published in the RedWay magazine, in Appendix K.

Statistics Canada (2003) reports that the Aboriginal birth-rate is at one-and-a half times the Canadian rate, which is posted (Statistics Canada, 2004) as of 2004, as 9.6 births per 1000 population (B.C.). This indicates a birth rate for Aboriginal people in B.C., as of 2004, of 14.4 births per 1000 population.
Appendix A: Two Row Wampum Treaty
(www.kahnawake.com, 2005)

"When the Haudenosaunee first came into contact with the European Nations, treaties of peace and friendship were made. Each was symbolized by the Gus-Wen-Tah or Two Row Wampum. There is a bed of white wampum which symbolized the purity of the agreement. There are two rows of purple, and those rows have the spirit of your ancestors and mine. There are three beads of wampum separating the two rows and they symbolize peace, friendship and respect..."

Excerpted from presentations to the Special Committee on Indian Self-Government by the Haudenosaunee Confederacy and from Wampum Belts by Tehanetorens.

The Two Row Wampum laid the foundation for all treaties and agreements that were made with Europeans during the colonial history of North America. Wampum belts were used during this period to record and authenticate events and agreements. The concept of the Two Row was developed by our ancestors so they could peacefully co-exist, conduct trade and share resources with the European Nations. The Two Row embodies the principles of sharing, mutual recognition, respect and partnership and is based on a nation to nation relationship which respects the autonomy, authority and
jurisdiction of each nation.

The treaty was first concluded with the Dutch in 1645 and extended to the British when they conquered the Dutch in 1664. Thereafter, it became known as the Silver Covenant Chain but retained the original spirit and intent of the Two Row. In metaphorical terms, the two rows symbolize two paths or two vessels traveling down the same river of life together. One, a birch bark canoe, represents the Aboriginal peoples, their laws, their customs and their ways. The other, a ship, is for the European peoples, their laws, their customs and their ways. They travel down the river together, side by side, each in their own boat; neither trying to steer the others vessel.

The parties to the Silver Covenant Chain agreed to come together regularly to polish the chain so as to restore their original friendship. They also promised to pass the treaty down from generation to generation so that its intent would never be forgotten. The Mohawks of Kahnawake have carried the idea of the Two Row and the Covenant Chain through history and use it to guide them in their contemporary relationships. Most Canadians however, are unaware of the nature, intent and purpose of the peaceful and co-operative relationship that was originally formed and agreed to by their predecessors.

The Mohawks of Kahnawake honor the legacy left by their ancestors and will continue to advocate renewing the historic relationship with Canada based on the respect and recognition of the principles embodied within the Two Row Wampum.
Appendix B: Constitutional Rights of the Aboriginal Peoples of Canada

PART II
RIGHTS OF THE ABORIGINAL PEOPLES OF CANADA

Recognition of existing aboriginal and treaty rights

35. (1) The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.

Definition of “aboriginal peoples of Canada”

(2) In this Act, “aboriginal peoples of Canada” includes the Indian, Inuit and Métis peoples of Canada.

Land claims agreements

(3) For greater certainty, in subsection (1) “treaty rights” includes rights that now exist by way of land claims agreements or may be so acquired.

Aboriginal and treaty rights are guaranteed equally to both sexes

(4) Notwithstanding any other provision of this Act, the aboriginal and treaty rights referred to in subsection (1) are guaranteed equally to male and female persons.

Commitment to participation in constitutional conference

35.1 The government of Canada and the provincial governments are committed to the principle that, before any amendment is made to Class 24 of section 91 of the “Constitution Act, 1867”, to section 25 of this Act or to this Part, a constitutional conference that includes in its agenda an item relating to the proposed amendment, composed of the Prime Minister of Canada and the first ministers of the provinces, will be convened by the Prime Minister of Canada; and

(a) the Prime Minister of Canada will invite representatives of the aboriginal peoples of Canada to participate in the discussions on that item.

(b)
Appendix D: Research Handout

An Examination of the Access to, and Provision of 'Traditional-Based' Health Services by and for Indigenous Peoples in Vancouver: Creating Balance with Stories

Research Questions

The primary goal of this study is to answer the question:

"How can the access to, and provision of 'traditional-based' health services be enhanced for urban-based Indigenous peoples?"

Since this question may be answered in many ways, further questions are needed to streamline the focus of this study. The following questions, when asked among the Indigenous community members and relevant agency facilitators in Vancouver, provides a deep qualitative and community-based avenue for answering the primary question:

"What counts as 'traditional-based health service provision in Vancouver'?"

"What are the barriers, constraints and facilitative factors that impact on issues of traditional-based health service provision in Vancouver?"

"What are the barriers, constraints and facilitative factors that impact on issues of access to traditional-based health services for Indigenous people in Vancouver?"

Sensitizing Issues

The barriers, constraints and facilitative factors, mentioned above, are potentially embedded in the following issues raised by healers themselves:

- Working with non-traditional-based health service providers and agencies
- Working with people from diverse Nations & cultural backgrounds
- Sharing and protecting knowledge
- Working outside of traditional territories, and specifically, in cities
- Ethics and protocols in traditional-based practice
- Balancing traditional-based practice with the need to make a living
- Organizing for support
- Passing on knowledge
- Processes and protocols for accessing appropriate healers

Research Process

Research gatherings will be designed to encourage the story-telling or storywork methodology (see above, and Archibald, 1997; Atleo, 2000; VanWynsberghe, 2001; Kawagley, 1995), using a talking circle. Talking circle methodology is beautifully described in the following excerpt:

"...Talking Circle as Methodology Enacted."
Traditionally a Sacred ceremony
   a Gift from the Ancestors.
A physical reality
   a Metaphysical experience.
An egalitarian structure
   each voice acknowledged
   heard in turn.
To choose words with care and thoughtfulness
is to speak in a Sacred manner.
We can each have our own Voice
speak our own Truth... (Graveline, 2000, p. 364).

The first gathering will be organized as a 4-hour informal exploratory workshop, where
the background, rationale, sensitizing issues and arising questions will be presented briefly as a
beginning story during the researcher’s contribution to an introductory circle.
The beginning story will be designed to lead naturally into an invitation to others to share their
stories and ideas. Participants will be asked to expand on the researcher’s story, by providing
their own stories and ideas, relevant to the research questions. This workshop will be recorded
by audiotape and written notes; if requested, participants’ contributions will not be used.

After the first gathering, up to 15 of the community members, traditional-based healers,
and agency representatives will be invited to participate in more in-depth individual interviews
(approximately 1 hour in length, each), using the same beginning story method. Selection will
include considerations of each participant’s ability and aptitude to contribute depth, relevance,
uniqueness and diversity of knowledge, as demonstrated in the first gathering. The researcher
will try to select an equal number of people for each participant group (eg. 5-5-5). During each
interview, the researcher’s beginning story will be kept short and include an interest in focusing
on areas that may have been only briefly touched on during the first gathering. Interviewees will
be asked to respond specifically to the research questions and sensitizing issues.

Following individual interviews, another gathering of the participants will be held, using
the talking circle methodology. The initial findings will be presented as a draft collective story
during the 3 hour workshop, when participants will be given the opportunity to verify and extend
preliminary examples, conclusions and recommendations. This second workshop will be
recorded by audiotape and written notes; if requested, participants’ contributions will not be
used.

The participants will be invited to dedicate a maximum of 9 hours over 21 months
(September 2003 to May 2005). Participation is voluntary and participants may withdraw at any
time. The community gatherings and interviews will be conducted at public locations most
conducive to telling stories about traditional-based health services in Vancouver. Refreshments
will be provided. There will be no monetary compensation, unless future funding for this project
allows. Unless they wish to be identified, names will be removed from all documents, except
consent forms, and identified by code. Only the researcher will have access to the code-names,
audiotapes, notes and consent forms, which will be kept in a locked facility for the duration of
the study. Audiotapes and notes will be destroyed or returned to interviewees upon completion
of a 5 year storage period, unless there is unanimous consent, initiated by participants to
continue storing them.

During summary, analysis and write-up of the information gathered, all participants will be
given opportunities for editing, and additional feedback through direct communication and
during the thesis defense.
Appendix E: Relational Validity and Resonance

Internal and External Relational Validity

A: Just for today we are starting a series of two workshops for C. and C is from my Nation on Dad’s side, the Anishnabe people, and so it makes sense that I would help support in this good way, ‘cause we’re kind of in a home away from home. And then my good Elder, friend and mentor – G here – is also from back home. So following the good teachings, that we create extended families where ever we go, I’d like to acknowledge you all in that way (Gathering Tape 1).

E: So there’s something inside of me that won’t accept anything less. It seems that’s what I need – and I can go to other forms of Chinese medicine, South Asian Indian medicines – I’ve tried those things but they don’t seem to be what I need. So I’m very happy to be a part of this discussion and research.

C: so what kind of parameters would you put around traditional based health services vs non-traditional based health services?

E: Well if for me it would have to be an Aboriginal or First Nations person practicing. It would have to be from that source and not just someone else doing it. Because maybe they learned certain things but there’s something missing. A spirit or mind or cells or in memory or its something that I don’t feel it matches me.

C: Resonating?

E: Yes, its something that, it’s what I search for. And I’m very critical, careful about approaching traditional or traditional-based, it’s more like traditional based in an urban setting. Cause I want to make sure what people are practicing are real. But that’s kind of hard to find in the city because people are away from the original system. So I smudge and sometimes ... for a while ... very strongly, in a positive way.

C: You’re not the first person who’s talked about ancestral connection and selecting appropriate healing modalities in terms of goodness, yeah. Almost everyone I’m working with in this program has mentioned that at one time or another, yeah, so there’s something, I think there’s something, a strong link to that.

E: There must be because when I go when I’m in the prairies. When I’m there I feel something very strong, very powerful and it makes me feel excited inside and I’m thinking about, I need to connect to my roots and when I find that then I’ll know more about other people in this setting, so maybe I need to go back to that connection and find out from Cree and Metis. For me it’s the Cree where that knowledge is. So that’s what I’m hoping to do. I have a friend who has gone quite deeply into other, more like eastern meditation and training for a healer and I’m open in my mind to do meditation so I phoned and as how much their training would cost, cause they are going to have a retreat, a week’s retreat. And I thought “oh good timing, and do meditation and this is great.” I knew it was costly and they said it was $750 dollars, and then I thought this “no, maybe I’m supposed to go that route” and then I thought to myself after a while “if I’m going to spend $750 dollars I’m gonna go to Manitoba.” “I’m gonna go and spend this money there and find what I need to find.” “Because I’ll just be going on another path that’s not going to get me what I want (Tape E).

In the same way that Turner uses triangulation (1969) to produce an emergent truth, the analyses of this study are validated by the incorporation of multiple perspectives or voices. While participants from three relevant groups were considered to be the focal contributors to this
study, in reality, their roles were usually multiple. A further level of study was created through researcher participation in the community research gatherings and dialogues, combined with personal reflection. Other perspectives were incorporated by examining prior relevant literature (see previous chapters), which in turn, helped to inform the discussion process, without going to a structured interview technique.

The methodology, described above, was used to ensure that more accurate and detailed knowledge was produced, for both broader and deeper understandings of the traditional-based health service relationships and interconnections. Doing storywork, is a balanced and appropriate (wholistic) research methodology for both the research focus and context. It was stimulated and maintained by applying the principles of respect, relevance, reciprocity and responsibility. If we expand and apply Kirkness and Barnhardt’s model, this meant respecting participants and their stories for who and what they were, ensuring that the research goals, design and processes were relevant and in good relationship with participants views of the world, and offering reciprocity in the research relationships, in a way that helped participants exercise responsibility over their own lives. Storywork methodology, as implemented in this study, involved adapting the unfinished story method to an Indigenous talking circle context, towards the creation of a collective story.

Knowledge arising from the gatherings, interviews, personal reflection, and literature review is validated by internal relational validity and by external relational validity (Campbell, 1957). In counseling theory, the process of knowledge arising from multiple sources is called convergence. This term is more accurate when considering a research emphasis on relationships in multiple domains or aspects of being, and when referring to a focus on what I call relational validity, as opposed to concrete, discrete or absolute considerations of validity in knowledge. For example, if people agree that something is important, then it probably is, to them. Relational validity, in this example, is different than quantitative validity if we understand that the focus should be on agreement rather than on how many people are involved. For example, if a group of people say that researching the access or provision of traditional based health services in Vancouver, is important, then the arguments that follow will be relationally valid. That others may not want traditional-based health services in Vancouver, is important when considering the infringement of Indigenous rights to self-determination (external relational validity), but is irrelevant to the inherent validity of the first group’s activities (internal relational validity). A visual representation of these ideas is given in Figure 6. While some perspectives may be overlapping, others are more remote from each other.

In response, cultural relativists might say that everyone’s entitled to their opinion and have a right to be heard on whatever the issue is. Where relational validity transcends the group is when we consider the equity between groups. Where theories of cultural relativity may employ the argument that equality means “fair” or same treatment between all groups, this does not address, and often makes invisible, the inequities in power relationships. For example the dominance of biomedicine may be considered the product of “laisse faire” democracy, where dominance is the result of a “natural selection” by consumers. The reality in Canada is that there are many immigrant medical traditions being practiced but they are marginalized by the requirement to meet the biomedical establishment’s criteria for legitimization. Biomedicine is firmly entrenched and is protected by a web of beaurocratic policies and legislation that maintains its
dominance. Other groups, like chiropractors, massage therapists, naturopaths, midwives and acupuncturists have managed to establish some credibility through the creation of associations or registration systems, but are still under the monolithic gaze and influence of the biomedical establishment.

Traditional-based health services do not require the legitimization of the biomedical establishment to be internally, relationally, valid enterprises. When we look at the historical and contemporary relationships between Indigenous and Canadian institutions, we must accept that the enhancement of traditional-based health services has an external relational validity. Aboriginal rights to self determination, as First Peoples, are entrenched within Canadian treaties, historical documents, legislation and the 1982 Canadian Constitution Act. The irony, and Canada’s greatest embarrassment, is that the documented, “real” status of Indigenous peoples in Canada does not reflect the ideal status, as reflected in the constitution. Indigenous peoples and Indigenous institutions, like traditional-based health services, continue to be greatly marginalized within Canadian society.

Concurrently, from a diversity and social justice perspective, the enhancement of traditional-based health services should be supported on a population basis, along with the support of other non-European-based health services, as a socially just reflection of the diversity within Vancouver and Canada. If Canadians truly want an egalitarian society, then the inequalities and power dynamics between dominating Euro-Canadian-centred, and marginalized Indigenous and ethnic health and education institutions, must be addressed in proactive ways, through changes at societal, institutional and community levels.

Personal Relational Validity and Resonance

An additional test of validity that I give, to both my dreams and to what people say, is to question the resonance between the knowledge being received, and the knowledge gained during prior experiences in my life. The result of this testing could be called personal relational validity and might be represented by the circles within the traditional-based health service group, in Figure 1, above. Another term for personal relational validity might be internal congruence, where the beliefs, values and knowledge within one’s psyche are integrated to a point of consistency and congruence. When new beliefs, values and knowledges aren’t consistent with existing ones, then either they are denied, or one’s whole paradigm (or world view) shifts to accommodate the new information, sometimes by denying other, previously integrated, beliefs, values and knowledges. Everyone has acquired immense amounts of knowledge from their day-
to-day experiences, which we must acknowledge if we are to respect that everyone is knowledgable. To do otherwise, for example by prioritizing knowledge gained from texts or isolated experiences, we are negating the connection between human reality and the position of research in society.

As an example of resonance, I’d like you to consider again the place of important personal events upon our lives. They may form primary foundations for our world views, and for how we relate to others and for what purposes. One of the most important sources of knowledge in my life was a near-death experience. In that drowning experience, as I left my body, I was given the opportunity to feel, see and experience, this world, other worlds, and other non-physical beings. With a deep sense of belonging, connection and omniscience, I understood the place of humanity, our ancestors and other spirits in this universe. All of the teachings of philosophers, religions, traditional knowledge holders and my own dreams are tested with these “near-death-eyes” to determine resonance, relevance and relationship, which together I sometimes call truth.

Everyone has their own set of internal truths, which bring guidance and influence upon future events. Essentially, the people and processes that mirror and thereby validate who we understand ourselves to be, share in and help us to expand, test and maintain a particular reality. That there are different world views, realities or ways of experiencing the world doesn’t negate our realities, and in fact, only strengthen some of our deepest tenets about the uniqueness and intrinsic worth of every life.

The following situation is an example of applying resonance, relevance and relationship in a learning situation. When given teachings around a sweat lodge, in Cree territory, three Elders spoke. The first Elder spoke about practical considerations which would have been useful if I was going into the sweat lodge at that time. The second Elder talked about the relationship between the sweat lodge and other traditional teachings, which helps when learning about Cree culture. The third and eldest Elder spoke about humans as spiritual beings, and about the place of humanity in the universe; and so, because I am interested in how people conceptualize spirit, I was inspired to pay particular attention to this Elder. Each of the teachings shared by the Elders was related to, and supported by what the other Elders shared, and relevant to learning about sweat lodge ceremonies. All levels of knowledge are useful, but the knowledge that is about spiritual understandings is the most resonant, relevant and related to what connects us as human beings, and thereby has the greatest potential for prioritizing our lives in ways that will inspire us to become good people and live good lives, for the good of All Our Relations. That the Elders never spoke about specific details or specific people shows congruence with a world view that prioritizes the spirit over material, mundane or individualistic aspects of existence.

The teachings of my dream about a healing lodge on the outskirts of Vancouver, and the teachings about reality and responsibility from traditional knowledge holders were validated personally by their resonance, relevance and relatedness to the knowledge I've integrated from my near-death experience. This reality that I live in is shared by many, and is echoed by the collective story of the research group.
Appendix F: Consent Form

THE UNIVERSITY OF BRITISH COLUMBIA

Consent Form

Title of Research Project: An Examination of the Access to, and Provision of 'Traditional-Based' Health Services by and for Indigenous Peoples in Vancouver

Principal Investigator: Jo-ann Archibald. Associate Professor, Department of Educational Studies. (604) 822-5286

Co-Investigator: Dawn Marsden. Ph.D. student, Department of Educational Studies. The information gathered by this research project will be used in the creation of a thesis, as part of the requirements of a doctoral degree. As such, the thesis will become publicly accessible.

Purpose of Research: The purpose of this research is to answer the question "How can the access to, and provision of 'traditional-based' health services be enhanced for urban-based Indigenous peoples?" It is intended to provide a research foundation for addressing the Royal Commission on Aboriginal Peoples' recommendation to include more traditional healers in health services for Aboriginal people. You have been asked to participate because you provide, use, or facilitate Indigenous traditional-based health services. As such, you are one of the most appropriate people to include, in any effort to answer the research question.

Study Procedures: If you participate in this study, you will be invited to share your stories and ideas, relevant to the research question, with the co-researcher and up to 29 other participants.

In the first 4-hour, circle-format workshop, the co-researcher will provide more details on the research question in the form of a story. You will be given the opportunity to expand on the researcher's story by providing your own stories and ideas. This workshop will be recorded by audiotape and written notes; if requested, your contributions will not be used.

Up to 15 of the first workshop participants, chosen for their diversity in knowledge, will be invited to share more in-depth stories during 1-hour, audiotaped, individual interviews held at another time. The recordings from the first workshop and interviews will be studied for common themes, diversity in experience and recommendations. The findings of this study will be written alongside participants' stories, which will be used to give examples. If your
You will not waive any legal rights by signing this consent form.

Your signature below indicates that you have received a copy of this consent form for your own records.

Your signature indicates that you consent to participate in this study.

Participant Signature       Date

Printed Name of the participant signing above.
Appendix G: Interview Consent Form

Interview Consent Form

Title of Research Project: An Examination of the Access to, and Provision of 'Traditional-Based' Health Services by and for Indigenous Peoples in Vancouver

Principal Investigator: Jo-ann Archibald, Associate Professor, Department of Educational Studies, (604) 822-5286

Co-Investigator: Dawn Marsden, Ph.D. student, Department of Educational Studies. The information gathered by this research project will be used in the creation of a thesis, as part of the requirements of a doctoral degree. As such, the thesis will become publicly accessible.

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Study Procedures: If you participate in this study, you will be invited to share your stories and ideas, relevant to the research question, with the co-researcher and up to 29 other participants. All participants will be eligible to participate in a 4 hour exploratory workshop. You have been chosen, along with up to 14 other study participants, to participate in 1-hour, audiotaped, individual interviews because of the diversity or depth of your perspective, and/or your interest in sharing more stories during an interview process. The findings of this study will be written alongside participants' stories, which will be used to give examples. If your stories are included, the co-researcher will provide you with an opportunity to edit or withdraw them from the study.

The initial findings will be presented during a 3 hour workshop, where you will be given the opportunity to comment on or add to the conclusions. This workshop will be recorded by audiotape and written notes; if requested, your contributions will not be used. The recordings from the second workshop will be studied for additional themes, diversity in experience and recommendations. The findings of this study will be added to the final draft and presented at a thesis defense, which will be open to the public. Comments and recommendations at this
Appendix H: Research Gathering Agenda

“Enhancing the Access to and Provision of Traditional-Based Health Services By and For Indigenous People in Vancouver”

Agenda
December 12, 2003

Goal for the Day: Contribute to Creating a Collective Story
Facilitator Alannah Young, Opaskwayak Nation.

Sign In, feedback & consent forms at entrance
Refreshments

Prayer
Overview
Introduction Circle
  o Break –
Collective Story Circle
  • Restatement of the Research Questions
  • Beginning story
  • Participant stories & ideas
Summary
  o Break –

Next Steps
  o Research
    o Invitation to Community Action

Thank You & Prayer
Appendix I: December 12th, 2003 Gathering Notes

How can the access to, and provision of traditional-based health services be enhanced for urban based Indigenous peoples?

Multi-tribal healing centre, aboriginal run, consulting with aboriginal people & communities, appropriate space for healing, core funding, integrated health teams, community advisory, accountability, ecological models, balance, spiritual

Provincial legislation – problematic (eg healers and plant use protected in Ontario, but not in B.C.), issues of liability, regulation and licensing,

Wholistic health, canoe/medicine circle, traditional protocols, dreamwork, importance of names/clans

**Hope, culture is healing**

**Focus on aboriginal identity, what we want – health**

**Ethics in practice, consequences, councils, advisory**

Pay equity, acknowledgement of healing work, reconciliation (eg $26,000 vs $93,000), honouring, compensation equivalent to phd, honorariums preclude benefits, equitable exchange, inclusive, adaptation to contemporary conditions, many healers at poverty level

Actively promote awareness, use AHF guidelines, guidelines for spiritual advisors, healers, medicines, ceremonies,

**How to transform, grieving, appropriate spaces, intergenerational grief,**

Awareness training, sensitivities, cultural protocol, practicing traditional values, elders council, honouring

**Elders, meeting monthly to discuss what needs to be done, create**

Natural healing resources, networking, include oral and relational, articulation of All My Relations, researching ourselves, appropriate communication, activism, sharing stories, gifts, acceptance, choices, encouragement, vision, future generations
Appendix J: Interview Questions

How can the access to, and provision of 'traditional-based' health services be enhanced for urban-based Indigenous peoples in Vancouver?

The following are suggested areas of discussion:

- What counts or should count as 'traditional-based health service provision?'
- What barriers or constraints get in the way of traditional-based health service access and provision in Vancouver?
- What facilitates or supports the access and provision of traditional-based health services in Vancouver?
- What would be the ideal, traditional-based health service situation in Vancouver?
- What is necessary to create this ideal situation in Vancouver?
We invite you – urban youth, women, men, and Elders – we invite you to rekindle the seventh fire, to fulfill the prophecies and your personal visions, to realign with the spirit and values that have kept us strong throughout these turbulent times. We invite you to help bring together the hearts of our community so that we can speak with good voices and create strong partnerships with each other, the Coast Salish peoples whose lands we are residing in, and the leaders and people from many other Nations.

The Vancouver Aboriginal Community is made up of more than 45,000 people from ancestral Nations across the land! Hundreds of agencies have each been trying to serve the needs of our community, with good heart, but without unified community-based leadership. Imagine what we can do if we all work towards a common vision, a vision of a good life for all our people! Let us look beyond our differences and unite under the clans, the family networks that have kept our families strong, our leaders sure and our futures limitless for tens of thousands of years.

Let us create a new foundation, based on old values, a new framework for living, the way we want to live, the way of kinship. Let us realign our agencies to serve us better. Let us realign the care of our children, the opportunities for learning and work, the provision of food and shelter, the strengthening of our bodies, the support of our disadvantaged brothers and sisters, the protection and guidance of our people, the care of our Elders, our life purposes and connections to the land and who we really are in the universe. Let us realign these important things in a way where we are rejoined, where everyone belongs, where everyone is important, and where we share and celebrate the relationships, challenges and fulfillments of living in this complex world, with each other.

This flag design is a work-in-progress and was created to represent a vision of how the urban Aboriginal community can be realigned, through the adoption of a clan system of organization. The vision was formally presented to the Vancouver Aboriginal Council on June 17th, 2004.

The rectangle represents a longhouse, to acknowledge the traditions of our many Nations and especially the longhouse traditions of this land. The yellow represents the Eagle clans and the eastern doorway; the white represents the Killer Whale clans. The red represents the Wolf or Four Legged clans and the western doorway. The black represents the Raven clans. The centre circle represents spirit which unites us all. The brown circle represents the earth and the Vancouver Aboriginal community. The green circle represents all other life and beings, a reminder that we are all connected and must be inclusive. The red hoops represent seven values that are common to us all, and which can guide us in the realignment of our community: wisdom, love, respect, bravery, honesty, humility and truth.

We know that if the whole community takes up this collective vision and works together to make it a reality – youth, women, men, Elders – our community can be transformed very quickly! The time is right! Dare to reveal your heart! Contact us now to join this movement and to find out about our first community forum. Contact Amelia McComber at...
Appendix L: IHPR Non-Medical Determinants of Health
(IHPR reception handout)

INTERSECTUAL COLLABORATION ON THE NON-MEDICAL DETERMINANTS OF HEALTH: THE ROLE OF HEALTH REGIONS IN CANADA

Institute of Health Promotion Research
University of British Columbia
2206 East Mall, 4th Floor
Vancouver, BC V6T 1Z3
About IHPR

ABOUT THE PROJECT RESEARCH TEAM NON-MEDICAL DETERMINANTS OF HEALTH INTERSECTUAL COLLABORATION PROJECTS NEWS

NON-MEDICAL DETERMINANTS OF HEALTH

INCOME AND SOCIAL STATUS

This is the single most important determinant of health. Health status improves at each step up the income and social hierarchy. Higher income levels affect living conditions such as safe housing and the ability to buy sufficient good food.

SOCIAL SUPPORT NETWORKS

Support from families, friends and communities is associated with better health. The health effect of the support of family and friends who provide a caring and supportive relationship may be as important as risk factors such as smoking, physical activity, obesity, and high blood pressure.

EDUCATION

Health status improves with level of education. Education increases opportunities for income and job security and gives people a sense of control over their lives? key factors which influence health.

EMPLOYMENT AND WORKING CONDITIONS

Unemployment, under?employment and stressful work are associated with poorer health. Those with more control over their work and fewer stress?related demands on the job are healthier.

SOCIAL ENVIRONMENTS

The values and rules of a society affect the health and well?being of individuals and populations. Social stability, recognition of diversity, safety, good relationships and cohesive communities provide a supportive society which reduces or removes many risks to good health.

PHYSICAL ENVIRONMENT

http://www.ihpr.ubc.ca/NMDH/nmdh_determinants.htm

25/01/2005
Physical factors in the natural environment (e.g., air, water quality) are key influences on health. Factors in the human-built environment such as housing, workplace safety, community and road design are also important influences.

**PERSONAL HEALTH PRACTICES AND COPING SKILLS**

Social environments that enable and support healthy choices and lifestyles, as well as people's knowledge, behaviours, and coping skills for dealing with life in healthy ways, are key influences on health.

**HEALTHY CHILD DEVELOPMENT**

The effect of prenatal and early childhood experiences on subsequent health, well-being, coping skills, and competence is very powerful. For example, a low weight at birth links with health and social problems throughout a person's life.

**CULTURE**

Culture and ethnicity come from both personal history and wider situational, social, political, geographic, and economic factors. Multicultural health issues demonstrate how necessary it is to consider the interrelationships of physical, mental, spiritual, social, and economic well-being at the same time.

**GENDER**

Gender refers to the many different roles, personality traits, attitudes, behaviours, values, relative powers and influences which society assigns to the two sexes. Each gender has specific health issues or may be affected in different ways by the same issues.
Appendix M: Seven Fires Prophecy
(Available online at www.elderswithoutborders.org)

The Seven Fires Prophecy

Seven prophets came to Anishinabe. They came at a time when the people were living a full and peaceful life on the North Eastern coast of North America. These prophets left the people with seven predictions of what the future would bring. Each of the prophecies was called a fire and each fire referred to a particular era of time that would come in the future. Thus, the teachings of the seven prophets are now called the "Seven Fires".

The first prophet said to the people, "In the time of the First Fire, the Anishinabe nation will rise up and follow the sacred shell of the Midewiwin Lodge. The Midewiwin Lodge will serve as a rallying point for the people and its traditional ways will be the source of much strength. The Sacred Megis will lead the way to the chosen ground of the Anishinabe. You are to look for a turtle shaped island that is linked to the purification of the earth. You will find such an island at the beginning and end of your journey. There will be seven stopping places along the way. You will know the chosen ground has been reached when you come to a land where food grows on water. If you do not move you will be destroyed."

The second prophet told the people, You will know the "Second Fire" because at this time the nation will be camped by a large body of water. In this time the direction of the Sacred Shell will be lost. The Midewiwin will diminish in strength, a boy will be born to point the way back to the traditional ways. He will show the direction to the stepping stones to the future of the Anishinabe people.

The third prophet said to the people. In the "Third Fire" the Anishinabe will find the path to their chosen ground, a land in the west to which they must move their families. This will be the land where food grows on water.

The fourth Fire was originally given to the people by two prophets. They come as one. They told of the coming of the light skinned race.

One of the prophets said,"You will know the future of our people by the face the light skinned race wears. If they come wearing the face of brotherhood then there will come a time of wonderful change for generations to come. They will bring new knowledge and articles that can be joined with the knowledge of this country, in this way, two nations will join to make a mighty nation. This new nation will be joined by two more so that four will form the mightiest nation of all. You will know the face of the brotherhood if the light skinned race comes carrying no weapons. If they come bearing only their knowledge and a hand shake."

The other prophet said,"Beware if the light skinned race comes wearing the face of death. You must be careful because the face of brotherhood and the face of death look very much alike. If they come carrying a weapon .... beware. If they come in suffering.... They could fool you. Their hearts may be filled with greed for the riches of this land. If they are indeed your brothers, let them prove it. Do not accept them in total trust. You
shall know that the face they wear is one of death if the rivers run with poison and the fish become unfit to eat. You shall know them by these many things."

The Fifth Prophet said, "in the time of the Fifth Fire there will come a time of great struggle that will grip the lives of all Native people. At the warning of this Fire there will come among the people one who holds a promise of great joy and salvation. If the people accept this promise of a new way and abandon the old teachings, then the struggle of the Fifth fire will be with the people for many generations. The promise that comes will prove to be a false promise. All those who accept this promise will cause the near destruction of the people."

The prophet of the Sixth Fire said, "in the time of the Sixth Fire it will be evident that the promise of the fifth fire came in a false way. Those deceived by this promise will take their children away from the teachings of the ELDERS, Grandsons and Granddaughters will turn against the ELDERS. In this way the ELDERS will lose their reason for living... they will lose their purpose in life. At this time a new sickness will come among the people. The balance of many people will be disturbed. The cup of life will almost be spilled. The cup of life will almost become the cup of grief ".

At the time of these predictions, many people scoffed at the prophets. They then had medicines to keep away sickness. They were then healthy and happy as a people. These were the people who chose to stay behind in the great migration of the Anishinabe. These people were the first to have contact with the light skinned race. They would suffer most.

When the fifth fire came to pass, a great struggle did indeed grip the lives of all Native people. The light skinned race launched a military attack on the Indian people throughout the country aimed at taking away their land and their independence as a free and sovereign people. It is now felt that the false promise that came at the end of the fifth fire was the materials and riches embodied in the way of life of the light skinned race. Those who abandoned the ancient ways and accepted this new promise were a big factor in causing the near destruction of the Native people of this land.

When the Sixth Fire came to be, the words of the prophet rang true as children were taken away from the teachings of the ELDERS. The boarding school era of "civilizing" Indian children had begun. The Indian language and religion were taken from the children. The people started dying at an early age.... they had lost their will to live and their purpose in living.

In the confusing times of the sixth fire, it is said that a group of visionaries came among the Anishinabe. They gathered all the priests of the Midewiwin Lodge. They told the priests that the Midewiwin way was in danger of being destroyed. They gathered all the sacred bundles. They gathered all the scrolls that recorded the ceremonies. All these things were placed in a hollowed out log from the (Ironwood tree). Men were lowered over a cliff by long ropes. They dug a hole in the cliff and buried the log where no one could find it. Thus the teachings of the Elders were hidden out of sight but not out of memory. It was said that when the time came that the Indian people could practice their religion without fear that a little boy would dream where the Ironwood log, full of the Sacred bundles and scrolls were buried. He would lead his people to the place.
The Seventh Prophet that came to the people long ago was said to be different from the other prophets. He was young and had a strange light in his eyes. He said "in the time of the Seventh Fire (New People) will emerge. They will retrace their steps to find what was left by the trail. Their steps will take them to the Elders who they will ask to guide them on their journey. But many of the Elders will have fallen asleep. They will awaken to this new time with nothing to offer. Some of the Elders will be silent out of fear. Some of the Elders will be silent because no one will ask anything of them. The New People will have to be careful in how they approach the Elders. The task of the new people will not be easy.

If the new people will remain strong in their Quest the Water Drum of the Midewiwin Lodge will again sound its voice. There will be a Rebirth of the Anishinabe Nation and a rekindling of old flames. The Sacred Fire will again be lit.

It is at this time that the light skinned race will be given a choice between two roads. If they choose the right road, then the Seventh Fire will light the Eighth and final Fire an eternal Fire of peace, love, brotherhood and sisterhood. If the light skinned race makes the wrong choice of the roads, then the destruction which they brought with them in coming to this country will come back at them and cause much suffering and death to all the Earth's people.

Traditional Mide people of Ojibway and people from other nations have interpreted the "two roads" that face the light skinned race as the road to technology and the other road to spiritualism. They feel that the road to technology represents a continuation of headlong rush to technological development. This is the road that has lead to modern society, to a damaged and seared Earth. Could it be that the road to technology represents a rush to destruction? The road to spirituality represents the slower path that Traditional Native People have travelled and are now seeking again. The Earth is not scorched on this trail. The grass is still growing there.

The prophet of the Fourth Fire spoke of a time when "two nations will join to make a mighty nation". He was speaking of the coming of the Light skinned race and the face of brotherhood that the light skinned Brother could be wearing. It is obvious from the history of this country that this was not the face worn by the light skinned race as a whole. That mighty nation spoken of in the Fourth Fire has never been formed.

If the Natural people of the Earth could just wear the face of brotherhood, we might be able to deliver our society from the road to destruction. Could we make the two roads that today represent two clashing world views come together to form a mighty nation? Could a Nation be formed that is guided by respect for all living things? Are we the new people of the Seventh Fire?
Appendix N: Draft Proposal for a Traditional-Based Practitioner Council Resource Centre

Draft Project Proposal for a Traditional-Based Health-Education Practitioner Council Resource Centre

Proposal Writer: Dawn Marsden, for the Traditional-Based Health Research Group

**Background**

This project stems out of a UBC Educational Studies graduate research project entitled “Enhancing the access to, and provision of traditional-based health services, by and for Indigenous peoples, in Vancouver”, which is based on two gatherings and 22 interviews with traditional-based health-education practitioners, their clients and facilitators in Vancouver. As such, this proposal is motivated directly by the findings of the research, which recommend the establishment of appropriate space for traditional-based knowledge sharing, the establishment of a cooperative self-screening council of traditional-based Indigenous health-education practitioners (healers), the establishment of traditional-based guidelines, ethics and standards for screening, practice, training, referral and collaboration, the establishment of a service-support fund for the support of council member activities, and the collection, production and dissemination of relevant information. The primary intent of these recommendations was to establish and develop the profession of traditional-based health-education practice, by and for Indigenous peoples, with an understanding that a future goal would be to collaborate, create teams and partnerships with non-Indigenous professionals, towards the integration of such practices, as legitimate service options, within mainstream service systems.

The ultimate motivation for such a project is to recognize and facilitate the key role that traditional knowledge holders and traditional-based health-education practitioners play in the continuity and resilience of Indigenous peoples, and in the sustainable relationships between people, land, waters and other beings.

**Definitions**

Vancouver, in this project, refers to the Greater Vancouver Regional District (GVRD), and includes all those peoples, beings, resources and places that are relevant to, or related to traditional-based Indigenous health-education practices within the GVRD.

Traditional-based Indigenous health-education, in this project, refers to all those health-education principles, and practices which are based on and reflect multi-millenial relationships between specific peoples, lands, waters and beings, within specific territories, and which thereby, promote wholistic, sustainable, responsible and respectful relationships between peoples, lands, waters and beings, within Vancouver.

Self-screening, in this project, refers to inclusive member submission to gender appropriate, council screening of criminal records, background and training, and in-council interviews. Referrals to practitioners will only be made, under the direction of the council, specific to council assessments of criminal records, background, training and character and to that practitioner’s willingness to abide by council guidelines, ethics and standards for screening, practice, training, referral and collaboration.

Service-support fund, in this project, refers to contributions and commitments of money, services, and goods, for the support of traditional-based Indigenous health-education practitioners and their services. This fund has been recommended as a contemporary adaptation
of historical protocols around practitioner-client relationships, which provided for the needs of practitioners. Practitioner services will be enabled, but not secured by the fund.

**Guiding Principles**

The guiding principles for this project are

- to engage in relationships that actively respect, include and reflect the diversity of traditional-based Indigenous health-education practitioners and practices in Vancouver,
- to protect the integrity, intellectual property and confidentiality of traditional-based health-education practitioners and their knowledge
- to ensure the equitable dissemination and distribution of associated resources as appropriate, to the general public
- to ensure the equitable dissemination and distribution of associated resources and funds, as appropriate, to practitioners
- to acknowledge and reflect through agreements, the pre-existing rights and territories of Coastal Salishan peoples

**Goals**

The structural goals of this project are

- to support community-based recommendations for enhancing the access and provision of traditional-based Indigenous health-education services, by and for Indigenous peoples, in Vancouver
- to raise the profile of traditional-based knowledge, practices and practitioners, in Vancouver,
- to provide a resource for people in the GVRD
- support the development of the traditional-based Indigenous health-education profession
- to support the development of guidelines, ethics and standards for screening, practice, training, referral and collaboration
- to support the creation of collaborations, teams and partnerships between traditional-based Indigenous health-education practitioners and other practitioners

The active goals of this project are

- to provide space conducive to traditional-based knowledge sharing,
- to create a collection of relevant books, articles, videos and current events,
- to facilitate public use of the collection,
- to facilitate an internet, phone and mail network for traditional-based Indigenous health-education practitioners, and for other interested parties
- to facilitate the development of a cooperative council of traditional-based Indigenous health-education practitioners, for the purpose of creating traditional-based guidelines, ethics and standards for practice, training, protection, referral and collaboration.
- to establish a service-support fund for the support of cooperative council members and their activities, and
- to support the production and dissemination of relevant information and materials
- to evaluate and report on project activities, on a monthly basis, to community partners

**Short-Term Strategies**

1. Identify and involve community partners for establishing the centre
2. Collect seed funds, equipment, resources and furniture
3. Identify and set-up a resource centre location
4. Hire a half-time administrator to manage the centre, funds and resources, and to facilitate the goals of the project, subject to the guidance of the council.

**Long-Term Strategies**


**Partners**

It is recognized that many of the goals of this project have been espoused by many other peoples and agencies within Vancouver, and that the benefits of such a project may be far reaching. In the interest of establishing good relationships around this project, considering primary intents and future goals, the involvement of all relevant partners will be welcomed. The role of partners is to collaborate on, support and guide the implementation of the goals and strategies, relevant to the development of a self-determining, self-sufficient and self-sustaining resource centre, fund and council.

**Short-term Budget (Three Years)**

In kind donations

As an extension of researcher commitments to dissemination of research related information and findings, the researcher will be contributing seed funding, services, equipment and resources as follows:

- a collection of books, papers and videos relevant to traditional-based health-education practice
- a desktop computer with Microsoft Office and Endnote software
- a bookshelf
- consultations
- $2000 for the service-support fund
- a copy of the *Enhancing traditional-based health-education service in Vancouver* dissertation (once approved and submitted)
- a copy of the related document *Guidelines for Accessing Traditional-Based Indigenous Health-Education Services in Vancouver* (once approved)

Approximate value: $12,000

To complete a minimum budget, resources will need to be secured, as follows:

- 600 square feet (min) of centrally located resource office space, ideally within a healthy environment, within or next to green space: $1000/month or in kind donation x 3 yrs $36,000
- $20,000/year, for half-time administrator, or in kind service x 3 yrs 60,000
- $2000/year, for operating supplies x 3 yrs 6,000
- $4000/year, for utilities (phone, heat, hot water, electricity) x 3 yrs 12,000
- $4000 for start-up furnishings and equipment (couch, desk, chairs, all-in-one, phone), or in kind donations 4,000
- $2000 for start-up supplies (meeting and gathering food, photocopies, gifts) 2,000

Total costs for setup and operation of 1st three years $120,000
Averaged per year: $40,000/year
The Problematic of

‘Indigenous Theorizing’: A Critical Reflection

Professor Graham Hingangaroa Smith

The University of British Columbia
(To Whare Wananga o Awanuiarangi)

AERA Annual Conference
April 10th 2005
Montreal, Canada.
discussion I would tentatively offer as a starting point the minimal set of conditions that ought to inform a claim to 'indigenous theorizing'. [Indigenous Theories]

i. It is connected to a specific cultural location and site (contextual); it is tested in practice;

ii. It is organically connected (made with the people, not just in the academy - is reflected on and grown through praxis);

iii. The person proposing the claim to 'theory' has some cultural skills and is able to connect with the epistemological foundations of the knowledge, language and culture related to the people to whom the theory is applicable; (cultural skill)

iv. It is transformative (status quo is not working – must focus on change)

v. It is portable (rather than universal)

vi. It has the flexibility to critique and renew itself (praxis)

vii. It is engaging of other theory, able to justify its existence (movement toward theory not away)

viii. It is Critical (able to critically engage new and traditional formations of colonization – colonization from external forces and internal colonization already working within and through ourselves)

ix. It is responsive to multiple sites of struggle and engagement (flexible)

x. It is easy for the people to understand (speaks to people)

This list is a beginning of a discussion. We now need to begin a wider discussion to add delete and hopefully at the same time interrogate our own work.

Summary.

Indigenous theorizing has been a crucial part of the New Zealand Maori revolution of the 1980s. Maori have come to understand that colonization is being perpetrated in multiple sites in multiple ways (often simultaneously) and that the struggle for indigenous theorizing in respect of the New Zealand Maori context has been to shift the focus of
Appendix P: Text for Wampum Research Model

Self                      Community                         Academia

desire to learn &
give back to family
& Aboriginal
community

1. **pre-study issues**
   - Working with non-traditional-based health service providers and agencies
   - Working with people from diverse Nations & cultural backgrounds
   - Sharing and protecting knowledge
   - Working outside of traditional territories, and specifically, in cities
   - Ethics and protocols in traditional-based practice
   - Balancing traditional-based practice with the need to make a living
   - Organizing for support
   - Passing on knowledge
   - Processes and protocols for accessing appropriate healers

desire to expand on what is known

2. **How can traditional medicine be supported?**

3. transmission of traditional knowledge

4. **How can the teaching and learning of traditional medicine be supported?**

5. background in public health, vision of traditional-based health centre, near-death experience re: spiritual foundation to life
   - Teachings of interdependence, interconnectedness, balance, respectful relationships, mental-physical-emotional-spiritual domains
   - Ecological theory, systems theory, critical theory, holism, participatory action research theory, community-based theory

6. Indigenous holism

7. **How can the access to, and provision of ‘traditional-based’ health services be enhanced for urban-based Indigenous peoples in Vancouver?**
<table>
<thead>
<tr>
<th>8</th>
<th>desire for respectful process, personal preference for narrative styles</th>
<th>oral storytelling, talking circles, 4 R’s of Aboriginal health research</th>
<th>narrative inquiry, phenomenology, hermeneutics, critical ethnography</th>
</tr>
</thead>
<tbody>
<tr>
<td>9</td>
<td>storywork through talking circles, with cultural protocols</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>desire to listen &amp; speak with whole self, prayer</td>
<td>listening, asking questions, Ojibway teachings, Coast Salish teachings</td>
<td>facilitation, focus groups, interviews, journaling, audiotaping, unfinished story-collective action frame method</td>
</tr>
<tr>
<td>11</td>
<td>beginning-collective story method, invitation to share stories, audiotaping</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td><strong>How can traditional medicine be enhanced in Vancouver?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>visual model-making, brainstorming, inspirations, prayer, thoughts &amp; feelings, revisiting questions, theory &amp; methodology</td>
<td>emergence of collective story, editing of selected text &amp; evaluation of writing context, modification &amp; approval of text, as advised</td>
<td>triangulation, convergence, emergence, themes, repetition, importance, logic, translation, revisiting questions, theory &amp; methodology</td>
</tr>
<tr>
<td>14</td>
<td>triangulated, emergent, approved, collective story dissertation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>fulfilling commitments, desire to affect positive change</td>
<td>giving back to the community, communal property</td>
<td>intellectual property, benefit sharing, expansion of knowledge, change in status quo</td>
</tr>
<tr>
<td>16</td>
<td>presentation of dissertation, as advised, copies to participants &amp; university, revised booklet for community dissemination, return of tapes</td>
<td></td>
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</table>
Appendix Q: Excerpt from *Report on the Health Status and Health Needs of Aboriginal Children and Youth* (Southern Alberta Child & Youth Health Network & the Aboriginal Health Program of the Calgary Health Region, 2005)

Under the Literature Review Executive Summary, the following are listed as factors relevant to the health status of Aboriginal children and youth:

- Infant mortality in general, and Sudden Infant Death Syndrome (SIDS) in particular, are greater problems for the Aboriginal population than the general population.
- Aboriginal infants living on-reserve appear to be at the least risk for low birth weight followed by non-Aboriginal infants, with Aboriginal infants in non-reserve areas being at the greatest risk.
- Aboriginal infants are at a greater risk for high birth weight than their non-Aboriginal peers.
- Aboriginal infants are less likely to be breast-fed than their non-Aboriginal peers, but when they are, it is for a longer period of time.
- Aboriginal people appear to be at a greater risk for infections, and these infections may be more severe than in their non-Aboriginal peers.
- Aboriginal children are more likely to be admitted to hospital in the first year of life for respiratory infections, diarrhea, and gastroenteritis.
- Significant percentages of Aboriginal children and youth in southern Alberta are reported as having long-term health conditions.
- The prevalence of type 2 diabetes mellitus or non-insulin dependent diabetes mellitus (NIDDM) is two to six times greater in the Aboriginal population than in the general population and there is a trend towards more youth exhibiting early onset of the disease.
- Obesity, which can be related to the development of NIDDM, is found in 6% of Aboriginal boys and 5% of Aboriginal girls in Canada. Other significant health problems for Aboriginal children and youth in Canada and southern Alberta include: ear problems, allergies, asthma, bronchitis, and to a lesser degree heart conditions and kidney problems.
- Aboriginal children and youth in Canada have a much higher rate of injury and death than the general population.
- Initial data suggests that Aboriginal children and youth do experience some mental health concerns, and are more likely to visit a doctor for mental health concerns than their non-Aboriginal peers.
- Suicide is a significant problem for Aboriginal youth with a suicide rate that is five to six times greater than their non-Aboriginal peers.
- There is substantial concern about substance abuse amongst Aboriginal youth, but other than tobacco, there is little empirical evidence indicating that substance use is greater amongst Aboriginal youth than their non-Aboriginal peers. Similarly, although there is great concern about Fetal Alcohol Spectrum Disorder (FASD) within Aboriginal communities, to date there are no valid comparisons of prevalence rates of FASD for Aboriginal and non-Aboriginal communities.