SUBMISSION TO

THE ROYAL COMMISSION ON ABORIGINAL PEOPLES

TRADITIONAL ABORIGINAL MEDICINE AND PRIMARY HEALTH CARE

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ABORIGINAL NURSES ASSOCIATION OF CANADA

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EXECUTIVE SUMMARY

This submission to the Royal Commission on Aboriginal Peoples is presented by the Aboriginal Nurses Association of Canada (A.N.A.C.). Included is a discussion of primary health care, the attempts at collaboration between biomedical health care providers and traditional practitioners, and the results of a focus group session undertaken to determine how traditional Aboriginal medicine could be integrated into a primary health care framework.

A.N.A.C. was unable to meet its mandate of formulating a strategic plan for the integration of traditional medicine within a primary health care framework. This failure resulted from the polarization of viewpoints of the focus group participants, and the time frame for completion of the task.

A.N.A.C. maintains that a process must be established which will enable traditional practitioners and biomedical practitioners to work together. Recommendations are made with the hope that Aboriginal organizations, traditional medical practitioners, and mainstream health care providers will begin the long process of working together so that the health care needs of Aboriginal people will be met.

A.N.A.C. recommends:

1. That Aboriginal health care organizations and associations undertake the establishment of a demonstration project related to the development of a process or model for collaborative practice between traditional practitioners and biomedical practitioners.

2. That Aboriginal communities begin the process of examining their value framework.

3. That a primary health care framework be seen as essential for the development of health care services within Aboriginal communities, including the concept of healing centres as part of primary health care centres.

4. That traditional healers begin to establish linkages so that the following issues can be discussed and resolved:

    - preparation of healers
    - certification of healers
    - liability concerns
    - payment for healers
    - efficacy and effectiveness of traditional medical practices
    - their role in health promotion and illness prevention.

5. That biomedical practitioners:

    - see traditional healers as important to the spiritual and emotional healing of Aboriginal people
    - explore the role of traditional healers in health promotion and illness prevention activities.

6. That traditional and biomedical practitioners continue the dialogue. This should be done in conjunction with Aboriginal health care organizations and associations which could act as intermediaries for the two groups.

7. That education be provided to:

    - Aboriginal people regarding traditional health-illness beliefs
    - biomedical practitioners regarding the availability of traditional healers, and the types of healers that exist; for example, dream interpreters, herbalists, shamans etc.

INTRODUCTION

The Aboriginal Nurses Association of Canada (A.N.A.C.) welcomes this opportunity to present to the Royal Commission on Aboriginal Peoples the results of a focus group session undertaken to determine how traditional Aboriginal medicine can be integrated into a primary health care framework.

The Aboriginal Nurses Association of Canada is the national association of registered nurses of Aboriginal descent in Canada. Membership is drawn from all provinces and territories. Currently A.N.A.C. represents 400 registered nurses of Aboriginal descent. A.N.A.C. members serve as advocates and advisors on health care issues to government and non-government agencies.

A.N.A.C was established in response to growing concerns over the health and well-being of Aboriginal peoples. Our mandate includes the following:

- promoting improved health status for Aboriginal peoples;
- developing and distributing material related to Aboriginal health, medicine, and culture;
- facilitating and encouraging Aboriginal control of health care services for Aboriginal people;
- encouraging trans-cultural sensitivity by all health care students and providers of health care services;
- promoting an awareness of the special needs of Aboriginal people;
- promoting health care professions as a career option for people of Aboriginal ancestry; and
- developing and maintaining a registry of Registered Nurses of Canadian Aboriginal ancestry.

This mandate has led A.N.A.C. to conduct several health related studies as follows: Transcultural Nursing (1986), Alcoholism: A Family Disease (1987), Family Violence (1988), Women and Abuse (1989), and Child Sexual Abuse (1990). More recently A.N.A.C. has delved into the issue of primary health care, and the role that traditional medicine can play within a primary health care framework. A.N.A.C.'s initial look at traditional medicine and primary health care was completed in March 1992. This

earlier study laid the foundation for a second project which forms the basis of this submission to the Royal Commission on Aboriginal Peoples.

HEALTH CARE ISSUES

The health, social, and economic status of Aboriginal people continues to decline. A.N.A.C, as well as various other sources, have identified several health and social problems which exist in Aboriginal communities. These include:

- family violence including child neglect (Dumont-Smith, 1991);
- alcohol and substance abuse (Dumont-Smith, 1991);
- suicide rates which exceed the rates among non-natives (Canada, 1988);
- youth alienation;
- accidental deaths due to motor vehicle accidents, drowning, fires, and firearms (Canada, 1988);
- inadequate parenting skills;
- continued lower life expectancies for both men and women (Canada, 1988);
- environmental concerns related to pollution, inadequate water, housing, overcrowding, and sanitation;
- growing rates of infectious diseases such as TB and HIV/AIDS;
- chronic illnesses such as diabetes m. and heart disease (Shah, 1985);
- inadequate nutrition; and
- mental health concerns such as low self-esteem and depression (Shah, 1985).

The erosion of cultural and traditional values has been cited as a contributing factor to the disintegration of Aboriginal communities, and the resulting decline in health, social, and economic status among Aboriginal people. Specific approaches such as Elder involvement, healing/talking circles, and cultural awareness activities (traditional values, beliefs, lifestyle and language), are being successfully used to deal with several of these problems, including family violence (Dumont-Smith, 1991), alcohol and substance abuse (Shestowsky, 1993), and mental health issues (Jilek, 1974; O'Neil, 1988; Koss, 1989).

A.N.A.C. is committed to the development of health care delivery systems designed to meet the health care needs of Aboriginal people. Recognizing that much ill health pervades the Aboriginal community, and acknowledging that the present health care delivery system is not totally responsive to the needs of Aboriginal people, A.N.A.C. continues to look for strategies which will improve health care services for Aboriginal people. One possible strategy relates to the use of a primary health care framework for health care delivery to Aboriginal people, and the incorporation of traditional Aboriginal health-illness beliefs, and traditional practitioners within that framework.

PRIMARY HEALTH CARE

Primary health care, as a concept, came into being in Alma-Ata in 1978 under the auspices of the World Health Organization. It was devised to ensure the involvement of communities in the planning, implementation, and evaluation of health care services (Innes, 1987; Mardiros, 1987; Epstein, 1988). It is based (WHO, 1978) upon the five principles of:

- community participation in the design, implementation, and evaluation of health care services;
- accessibility to health care services by all members of the community;
- a health care system which focuses on health promotion and illness prevention;

- co-operation among all health, social, and environmental agencies which impact upon health, and the redressing of socio-economic conditions; and

- the use of appropriate technology.

A primary health care approach requires that the health care system focuses upon the major problems of a community. This, along with the targeting of high risk groups for preventive, health promotive, curative and rehabilitative services, ensures that the health care needs of the community are met. Co-ordination of activities, and collaboration among those responsible for health, education, housing, environment and agriculture are essential to primary health care (Kleczkowski, 1984). This approach encourages the community to establish systems designed to improve the health status of its members.

TRADITIONAL ABORIGINAL MEDICINE

Traditional Aboriginal medicine continues to play a role in the lives of Aboriginal people. Forming the basis of Aboriginal health-illness beliefs and health care philosophy, it is intricately tied into traditional Aboriginal philosophy, religion, and spirituality. As well as providing Aboriginal medicine, elders and healers (Gregory, 1986) act as counsellors, community problem solvers, and role models for youth; and provide domestic advice, and historical and cultural information.

TRADITIONAL ABORIGINAL MEDICINE AND PRIMARY HEALTH CARE

Health status is based upon a number of factors including value systems associated with lifestyle choices, and beliefs regarding the determinants of health and illness. The health-illness belief system, and the cultural values of a people are paramount to well-being. Particularly with respect to Aboriginal communities, it has been noted (Gregory, 1986; Mala, 1988) that both traditional and non-traditional sources of support are necessary if the health status of the community is to improve.

The health problems affecting Aboriginal people today are multi-faceted. Some are related to lifestyle practices, while others are reflective of Aboriginal people's lack of control over their own destiny. We believe that traditional Aboriginal medicine can be used within a primary health care context, to strengthen the health promotive behaviours of Aboriginal people. The underlying principles and values of each are similar and lend themselves to integration. In A.N.A.C.'s 1992 study (Shestowsky, 1993) into primary health care and traditional medicine, it was found that primary health care and traditional Aboriginal medicine both:

- encourage the involvement of individuals, families, and communities in the development of health care programmes based upon identified community needs;
- are holistic in the sense of being concerned with overall human development;
- define health broadly by including as being important for health socio-economic and environmental factors such adequate food, nutrition, water, and basic sanitation;
- emphasize the prevention of illness and the promotion of health; and
- encourage self-care and responsibility for self.

It was evident that the traditional health-illness beliefs of Aboriginal people could be used within a primary health care framework to encourage self-care, illness prevention, and health promotion. What remained a question was how to integrate traditional practitioners into this framework given the opposing world views of traditional and biomedical practitioners.

ATTEMPTS AT COLLABORATION

Despite the fact that primary health care and traditional medicine share a number of philosophical beliefs and approaches to health care, and while traditional healers appear willing to collaborate with the mainstream health care system (Jackson, 1980; Gregory 1986), a genuine integration of traditional medicine within a primary health care framework has not yet occurred anywhere in the world (Velimirovic, 1990). Where attempts have been made, an assimilationist model has been used. Here, the traditional healer is trained in clinical assessment and basic biomedical procedures (Habicht, 1979; Neumann, 1982; Flahault, 1986; Sharma, 1990), and acts under the direction of mainstream health care professionals (Bichmann, 1979).

In Canada, Health and Welfare has been promoting a closer working relationship between traditional healers and mainstream health care workers. However, a formalized framework which would allow this to happen with ease, has not as yet been established. The Yukon Council of Indians (Wheatley, 1990) has been attempting to construct a model for integrating the traditional medicine of the Aboriginal people of the Yukon into the Yukon health care system. This work is ongoing and is utilizing a model whereby traditional and mainstream systems will be parallel to each other with referrals operating to and from one to the other. Here traditional healers will work alongside western practitioners in providing certain services.

Barriers have been identified whenever attempts at collaboration are made between traditional medicine and the mainstream health care system. These include:

- communication difficulties (Gregory, 1986);
- confidentiality issues (Gregory, 1986; Wheatley, 1990);
- lack of support for collaboration among health care providers (Gregory, 1986);
- ethical and legal problems (Gregory, 1986; Robb, 1988; Stalker, 1988; Wheatley, 1990);

- differences in the paradigm upon which treatments are based (Slikkerveer, 1982; Gregory, 1986; Blackett-Sliep, 1989; Wheatley, 1990);

- concerns regarding the absence of standardized treatments in the traditional system (Blackett-Sliep, 1989); and,

- payment for, and identification of, healers (Akerele, 1986; Wheatley, 1990).

Despite these problems it is generally understood that Aboriginal people wish to maintain access to traditional healers (Waldram, 1990; Avery, 1991). As well, it is acknowledged that in order to provide quality health care to Aboriginal people both systems must be accessible (Smoot, 1988; Bellakhdar, 1989; Malloch, 1989; Olsson, 1989).

FOCUS GROUP SESSIONS

In order to determine how traditional and biomedical practitioners could work alongside each other in providing health care to Aboriginal people, a workshop was convened in Winnipeg, Manitoba, between May 15-16, 1993. The purpose of this workshop was to discuss and develop a preliminary strategy for incorporating traditional Aboriginal medicine within a primary health care framework.

So as to obtain as many viewpoints as possible, participants were invited from across the country and included traditional healers, physicians, nurses, Aboriginal health centre managers and university academics. A total of twenty-nine individuals, both Aboriginal and non-Aboriginal, participated in this session (Appendix).

Three focus groups of approximately ten individuals in each were held over the course of a day and a half. Discussion was generated around the following issues:

1. the health problems affecting Aboriginal people and the strategies that can be used to deal with these problems;

2. the role of traditional medicine and traditional healers in improving the health of Aboriginal people;
3. mechanisms for collaboration between traditional medicine and biomedicine;

4. the barriers to collaboration; and

5. payment of healers.

RESULTS OF THE DISCUSSION

THE PROCESS

The focus group sessions constituted the beginning of formal interactions among the invited groups of participants. Full dialogue and thrashing out of the issues did not occur at these sessions. Because of this, we were unable to reach a consensus regarding a strategy for incorporating traditional Aboriginal medicine within a primary health care framework.

Discussion and dialogue were impeded for two reasons. First, and most important, was the polarization of viewpoints. This polarization was evident between the Aboriginal and non-Aboriginal groups, and between biomedically trained practitioners and traditional healers. Unexpected and perhaps more problematic was the polarization within the Aboriginal group, and within the group of traditional healers. Strongly evident was a conservative element which was desirous of isolation, suspicious of the intentions of the participants, and sceptical of the benefits of discussion and dialogue.

The second impediment had to do with the length of time for discussion. As this was an initial attempt at open dialogue it took a considerable amount of time for participants to trust and feel comfortable with each other. By the end of some focus group sessions, the barriers to discussion appeared to be coming down. Unfortunately, by then, the group discussions had ended and participants were making their way home.

Although a detailed strategic plan for the incorporation of traditional medicine within a primary health care framework did not result from this workshop, participants were able to agree on a number of items. As well, areas requiring further discussion were identified.

AREAS OF AGREEMENT

The major areas of agreement (Table 1) can be categorized into three groups as follows:

1. the major health issues facing Aboriginal people;
2. the potential role of traditional medicine; and
3. the need for a primary health care framework.

With respect to the major health issues facing Aboriginal people, participants agreed that efforts must be directed at helping Aboriginal people deal with their unresolved anger and grief. Especially seen as important are interventions directed at the low self-esteem felt by many Aboriginal people and what appears to be a loss of cultural and spiritual identity. Also seen as important to health are the socio-economic issues which Aboriginal people face, in particular, poverty and underemployment.

Participants agreed that traditional health-illness beliefs and traditional healing practices could be beneficial in two major areas: 1. in emotional and spiritual healing, and 2. in coping with a chronic illness. It was also suggested that traditional healers could have a role in health promotion since traditional medicine addresses the need for a balance among the spiritual, physical, emotional, and psychological aspects of self.

Healing the spirit of the communities was seen as essential to the future well-being of Aboriginal communities. The traditional beliefs of balance, peace, harmony, and health were seen as a way to bring about this healing.

It was agreed that a primary health care framework, where health care programs are designed by the community to meet community defined needs, would be beneficial for Aboriginal communities. This community-based approach to health care would ensure that community members had a measure of control over the direction of their services and would ultimately result in community empowerment.

It was suggested that healing centres could be part of the primary health care system. These gathering places could allow for the sharing of ideas, as well as the provision of emotional support and healing. There was a sense of agreement surrounding the need to incorporate traditional healing practices into primary health care centres. It was felt

that all staff should be able to run healing circles with traditional teachings forming the basis of all work.

TABLE 1

AREAS OF AGREEMENT

CATEGORIES	ELEMENTS
Health Issues	1. unresolved anger and guilt 2. lack of identity 3. lack of self-esteem 4. de-spiritualization 5. poverty 6. underemployment
Potential Role for Traditional Medicine	1. emotional and spiritual healing 2. coping with chronic illnesses 3. health promotion/illness prevention
Primary Health Care	1. basis of health care centres 2. incorporation of healing centres 3. community directed health care 4. community control and empowerment

AREAS REQUIRING FURTHER DISCUSSION

The unresolved areas relate mainly to the pragmatic issues surrounding the inclusion of traditional medicine and traditional practitioners into the primary health care system. These (listed in Table 2) are as follows.

TABLE 2

ISSUES REQUIRING FURTHER DISCUSSION

1.	Concept of Illness
2.	Preparation of Healers
3.	Certification of Healers
4.	Liability
5.	Payment of Healers
6.	Model for Collaboration

Concept of Illness

With respect to illness, the Aboriginal viewpoint holds that illness is not necessarily a bad thing. It is often sent to help people re-evaluate their lives. This illness belief is at odds with the biomedical model which hopes to cure most, if not all ailments. Although it is acknowledged in biomedicine that not all illnesses can be cured, the underlying reason given is that a cure has not yet been found. According to the traditional practitioners, the fact that a traditional healer fails to cure a person may have nothing to do with the skills of the healer, but may be due to the reason for the ailment. This reason resides in the spiritual realm.

Preparation of Healers

The traditional healers rejected a formalized process for the preparation and training of healers. Although Aboriginal ceremonies and rituals are structured in themselves, it was maintained that Aboriginal healers cannot practice within a structured environment. Therefore, the biomedical systems of training and standardization would not be suitable.

It was acknowledged that different healers had different gifts; ie. some work with stones, herbs, or spirits, and these could not be standardized. It was stated that not all healers had to apprentice their craft as they receive instruction from the metaphysical realm.

Certification of Healers

There are no formalized mechanisms to evaluate healers. Often the healer is evaluated by the changes that occur in the life of the person receiving care from the healer. An underlying assumption is that all healers are qualified. It is believed that fraudulent healers will be taken care of by a natural or metaphysical process.

It was noted that traditional healers are not allowed to share certain information or they will lose their powers. This makes it difficult to evaluate and study their treatments.

Liability

There was discussion regarding liability issues. Some healers believed that there was a need for legal protection of the healers. In particular they were seeking protection from prosecution for practising medicine without a licence. Although there was not a focus upon consumer protection, participants suggested that there be a discussion regarding the protection of the public from fraudulent healers.

Payment of Healers

A great deal of time was spent discussing payment for healers. It was acknowledged that healers must be valued for their wisdom, knowledge and work. However, there was some difficulty regarding what this precisely meant in terms of monetary amounts,

as the healers were reluctant to place a dollar value on their work. Historically, it was noted that healers were supported by their communities, suggesting that a salary might be acceptable. Consideration was also given to the need for varying pay scales for different activities; for example, healing, workshops, consultation. It was suggested that funding be made available for these activities.

Models of Collaboration

No agreement could be reached on the issue of collaborative models. The Aboriginal participants felt very strongly that any models had to be developed by themselves. Traditional healers suggested that while there could be an awareness of the differences between biomedicine and traditional medicine, there could not be a true understanding. It was the belief of many traditional practitioners that the best that could be attained was respect for and acceptance of the differences.

RECOMMENDATIONS

Aboriginal people are confronted with many health care problems. The Aboriginal Nurses Association of Canada (A.N.A.C.) believes that the time has come for concerted action aimed at alleviating both these problems and their causes. This action must involve Aboriginal communities, traditional medical practitioners, elders, and biomedical practitioners.

A.N.A.C. maintains that a process must be established which will enable traditional practitioners and biomedical practitioners to work together. These recommendations are made with the hope that Aboriginal organizations, traditional medical practitioners, and mainstream health care providers will begin the long process of working together so that the health care needs of Aboriginal people will be met.

The Aboriginal Nurses Association of Canada recommends the following:

Demonstration Project

That Aboriginal health care organizations and associations undertake the establishment of a demonstration project related to the development of a

process or model for collaborative practice between traditional practitioners and biomedical practitioners.

A demonstration project will allow for the continuation of dialogue, the establishment of process, the detailing and resolution of problems and barriers, and the evaluation of results. All these elements are essential to the establishment of a healthy working relationship between traditional medical practitioners and biomedical health care providers. This recommendation should be implemented in conjunction with the recommendations listed below.

Value Framework

That Aboriginal communities begin the process of examining their value framework.

This should entail a discussion related to the kind of health care system that is envisioned for Aboriginal communities, including decisions related to the types of practitioners and services desired.

Community-Based Approaches to Health Care

That a primary health care framework be seen as essential for the development of health care services within Aboriginal communities.

Healing Centres

That the concept of healing centres be incorporated as part of primary health care centres.

This will entail the involvement of Aboriginal communities, traditional healers, mainstream health care providers, and Medical Services Branch of Health and Welfare. These centres can be seen as places where traditional healers can become involved in providing spiritual and emotional care.

Traditional Healers

That traditional healers begin to establish linkages so that the following issues can be discussed and resolved:

- preparation of healers
- certification of healers
- liability concerns
- payment for healers
- efficacy and effectiveness of traditional medical practices
- their potential role in health promotion and illness prevention.

Biomedical Practitioners

That biomedical practitioners:

- see traditional healers as important to the spiritual and emotional healing of Aboriginal people
-
- explore the role of traditional healers in health promotion and illness prevention activities.

Working Relationships

That traditional and biomedical practitioners continue the dialogue. This should be done in conjunction with Aboriginal health care organizations and associations which could act as intermediaries for the two groups.

The continuation of this dialogue may open the door for the future development of collaborative ventures and models.

Education

That education be provided to:

- Aboriginal people regarding traditional health-illness beliefs
- biomedical practitioners regarding the availability of traditional healers, and the types of healers that exist; for example, dream interpreters, herbalists, shamans etc.

CONCLUSION

The Aboriginal Nurses Association of Canada (A.N.A.C.) was unable to meet its mandate of formulating a strategic plan for the integration of traditional medicine within a primary health care framework. Failure was due to the polarization of viewpoints and the time frame for completion of the task. Additional meetings are required before traditional and biomedical practitioners are able to freely and fully discuss the impediments to collaboration. In particular, traditional healers must begin the process of organizing and discussing these issues among themselves.

A.N.A.C. believes that traditional medical practitioners and biomedical practitioners can and must work together. It is our belief that the best hope for the establishment of a working relationship between these two groups is the development of a demonstration project. Such a project will provide an arena where the barriers impeding collaboration can be broken down. The results of a demonstration project can also be applied elsewhere. This would help ensure that working relationships between traditional practitioners and biomedical practitioners become the norm, and do not remain isolated events dependent upon the good-will of those involved.

Working relationships require openness, hard work, and honest discussion if they are to be successful. A demonstration project may be the vehicle necessary to stimulate the understanding and trust required by both biomedical and traditional practitioners.

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REFERENCES

Akerele O. WHO and Traditional Medicine. International Traditional Medicine Newsletter, University of Illinois at Chicago, 2(2): 3, 6, Feb. 1987.

Avery C. Native American Medicine: Traditional Healing. Journal of the American Medical Association, 265(17): 2271, 2271, May 1991.

Bastien J. Cross-cultural Communication between Doctors and Peasants in Bolivia. Social Science and Medicine, 24(12): 1109-1118, 1987.

Bellakhdar J. A New Look at Traditional Medicine in Morocco. World Health Forum, 10(2): 193-9, 1989.

Bichmann W. Primary Health Care and Traditional Medicine - Considering the Background of Changing Health Care Concepts in Africa. Social Science and Medicine, 13B: 175-82, 1979.

Blackett-Sliep Y. Traditional Healers and the Primary Health Care Nurse. Nursing RSA, 4(11): 42-4, Nov/Dec 1989.

Canada. Health Status of Canadian Indians and Inuit - Update 1987. Minister of National Health and Welfare, Ottawa, 1988.

Dumont-Smith C., Sioui-Labelle P. Phase 1: National Family Violence Survey Indian and Inuit Nurses of Canada, Ottawa, 1991.

Epstein L., Eshed H. Community Oriented Primary Health Care: The Responsibility of the Team for the Health of the Total Population. South African Medical Journal, 73(4): 220-3, Feb 20 1988.

Flahault D., Roemer M.I. Leadership for Primary Health Care. WHO Public Health Papers #82, World Health Organization, Geneva, 1986.

Freeman M., Motsei M. Planning Health Care in South Africa -- Is There A Role for Traditional Healers? Social Science and Medicine, 34(11): 1183-1190, 1992.

Garro L. C. Continuity and Change: The Interpretation of Illness in an Anishinaabe (Ojibway) Community. Culture, Medicine and Psychiatry, 14(4): 417-54, Dec 1990.

Gregory D. Nurses and Human Resources in Indian Communities: Nurse Perceptions of Factors Affecting Collaboration With Elders And Contact With Traditional Healers On Indian Reserves And In Health Centres in Manitoba. Unpublished Master's Thesis, University of Manitoba, 1986.

Habicht J.P. Assurance of Quality of the Provision of Primary Medical Care by Non-Professionals. Social Science and Medicine, 13B: 67-75, 1979.

Hoff W. Traditional Healers and Community Health. World Health Forum, 13: 182-187, 1992

Innes J. Primary Health Care in Perspective. Canadian Nurse, 83(8): 17-18, Sept. 1987.

Jackson E. A Working Inventory Of Community-Based Initiatives In The Health Field Being Undertaken By The Indian And Inuit Peoples. Report Of Advisory Commission on Indian and Inuit Health Consultation, Government of Canada, Ottawa, 1980.

Jilek W.G., Todd N. Witchdoctors Succeed where Doctors Fail: Psychotherapy among Coast Salish Indians. Canadian Psychiatric Association Journal, 19: 351-5, 1974.

Kleczkowski B., Elling R., Smith D. Health System Support for Primary Health Care. WHO Public Health Papers #80, World Health Organization, Geneva, 1984.

Koss J.D. Expectations and Outcomes for Patients Given Mental Health Care or Spiritist Healing in Puerto Rico. American Journal of Psychiatry, 144(1): 56-61, Jan 1987.

Malloch L. Indian Medicine, Indian Health -- Study Between Red and White Medicine. Canadian Woman Studies, York University, Toronto, 10(2&3): 105-112, Sum/Fall'89.

Mala T. Traditional Versus Non-Traditional Medicine: Must One Die For The Other To Exist? Health Care Issues in the Canadian North, D.E. Young (editor). Boreal Institute for Northern Studies, University of Alberta, Edmonton, 44-47, 1988.

Mardiros M. Primary Health Care and Canada's Indigenous People. Canadian Nurse, 83(8): 20-24, Sept. 1987.

McKenzie A., Mazibuko R. What is Primary Health Care?. Nursing RSA, 4(11): 30-31, Nov/Dec 1989.

Neumann A.K., Lauro D. Ethnomedicine and Biomedicine Linking. Social Science and Medicine, 16: 1817-1824, 1982.

O'Neil J.D. Referrals to Traditional Healers: The Role of Medical Interpreters. Health Care Issues in the Canadian North, D.E. Young (editor). Boreal Institute for Northern Studies, University of Alberta, Edmonton, 29-38, 1988.

Olsson K. Caribou Bones and Labrador Tea. Canadian Nurse, 85(2): 18-21, Feb. 1989.

Oyeneye O.Y. Mobilizing Indigenous Resource for Primary Health Care in Nigeria: A Note On The Place of Traditional Medicine. Social Science and Medicine, 20(11): 67-89, 1985.

Robb J.C. Legal Implications to Traditional Medicine. Health Care Issues in the Canadian North, D.E. Young (editor). Boreal Institute for Northern Studies, University of Alberta, Edmonton, 131-7, 1988.

Shah C.P, Farkes C. S.. The Health of Indians in Canadian Cities: A Challenge to the Health Care System. Canadian Medical Association, 133 (9): 859-863, 1985.

Sharma A., Ross J. Nepal: Integrating Traditional and Modern health Services in the Remote Area of Bashkharda. International Journal of Nursing Studies, 27(4): 343-53, 1990.

Shestowsky B. Traditional Medicine And Primary Health Care Among Canadian Aboriginal People. Aboriginal Nurses Association of Canada, Ottawa, 1993.

Slikkerveer L.J. Rural Health Development in Ethiopia: Problems of Utilization of Traditional Healers. Social Science and Medicine, 16: 1859-72, 1982.

Smoot E.C., Kucan J., Schlenker C.J. The Craniofacial Team and the Navajo Patient. Cleft Palate Journal, 25(4): 395-402, 1988.

Stalker P., Felix A., Irvine J. Investigation of Traditional Medicine Models in To-day's Society. unpublished paper, University of Saskatchewan, Saskatchewan, 1988.

Stone L. Cultural Influences in Community Participation in Health. Social Science and Medicine, 35(4): 409-417, 1992.

Tan M. L., Querubin M., Rillorta T. The Integration of Traditional Medicine Among Community-based Health Programmes in the Philippines. Journal of Tropical Paediatrics, 34(2): 71-4, April 1988.

Velimirovic B. Is Integration of Traditional and Western Medicine Really Possible? Anthropology and Primary Health Care, J.Coreil and J.D. Mull (Editors). Westview Press, Boulder, Colorado, 51-78, 1990.

Waldram J.B. Access to Traditional Medicine in a Western Canadian City. Medical Anthropology, 12(3): 325-48, August 1990.

World Federation of Public Health Assoc. International Conference on Primary Health Care Alma-Ata USSR. World Fed. of Public Health, Halifax, 1978.

World Health Organization. International Conference on Primary Health Care. WHO, Alma-Ata, 1978.