An Overview Of Traditional Knowledge And Medicine And Public Health In Canada

January 2008

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)
ᑲᓇᑕᒥ ᓄᓇᖃᖅᑳᖅᓯᒪᔪᓄᑦ ᐋᓐᓂᐊᕐᓇᙱᓐᓂᓕᕆᓂᕐᒧᑦ ᑲᑐᔾᔨᖃᑎᒌᑦ

Report title: *An Overview Of Traditional Knowledge And Medicine And Public Health In Canada*

© Copyright 2008 National Aboriginal Health Organization

ISBN 978-0-9783246-9-8

Date Published: January 2008

OAAPH [now known as the National Aboriginal Health Organization (NAHO)] receives funding from Health Canada to assist it to undertake knowledge-based activities including education, research and dissemination of information to promote health issues affecting Aboriginal persons. However, the contents and conclusions of this report are solely that of the authors and not attributable in whole or in part to Health Canada.

The National Aboriginal Health Organization, an Aboriginal-designed and -controlled body, will influence and advance the health and well-being of Aboriginal Peoples by carrying out knowledge-based strategies.

This report should be cited as:

National Aboriginal Health Organization. (2008). *An Overview Of Traditional Knowledge And Medicine And Public Health In Canada*. Ottawa: Author.

For queries or copyright requests, please contact:

National Aboriginal Health Organization
220 Laurier Avenue West, Suite 1200
Ottawa, ON K1P 5Z9
Tel: (613) 237-9462
Toll-free: 1-877-602-4445
Fax: (613) 237-1810
E-mail: info@naho.ca
Website: www.naho.ca

Under the *Canadian Constitution Act, 1982*, the term Aboriginal Peoples refers to First Nations, Inuit and Métis people living in Canada. However, common use of the term is not always inclusive of all three distinct people and much of the available research only focuses on particular segments of the Aboriginal population. NAHO makes every effort to ensure the term is used appropriately.

INTRODUCTION

For Indigenous Peoples living in Canada and around the world, the inter-relationships between the physical, mental, spiritual, and emotional aspects of being are integral to individual and community health. This holistic view is increasingly being acknowledged and accepted by the mainstream health community, and is often described in relation to non-medical, or social, determinants of health, such as education, housing, economic status, social capital, etc. Relying solely on bio-medical concepts of disease and of health — as is often the case in western health — is not necessarily an effective system for disease prevention and public health in Aboriginal populations. Culture and ethnicity are among the key determinants of health now being recognized by Health Canada, Canada's federal health ministry. Research has demonstrated that culture and ethnicity are important to individual and community health because they influence an individual's interaction with the health care system, their acceptance of and participation in preventative health programs and services, their lifestyle choices, and their access to health information.

THE LAND

Canada claims sovereignty over an area covering nearly 10 million square kilometres. Geographically it is the second largest country in the world, spanning six time zones. Biological environments range from Arctic conditions in the Far North to temperate rainforests on the Pacific coast, and include some of the most fertile agricultural systems in the world. It also includes many of the largest remaining stands of boreal forest covering, in total, almost 15 per cent of territory across the heart of the country. The diversity of the land has resulted in a

diversity of Aboriginal Peoples, cultures and languages. Of fundamental agreement across these cultures is the importance of the land to their concepts of identity, place, and health.

THE PEOPLE

Canada is a confederated parliamentary democracy, with 10 provinces and three territories and has a population of approximately 33 million people. It is also one of the most culturally diverse countries in the world, and has two official languages — English and French. Of the Canadian population, 4.4 per cent, or over 1.4 million people, self-identify as having Aboriginal ancestry. The *Constitution Act, 1982,* acknowledges three Aboriginal Peoples in Canada — First Nations, Inuit and Métis. Aboriginal Peoples in Canada are subject to an array of legislation and other geographic, cultural and political boundaries and barriers when accessing programs and/or services. Aboriginal Peoples living in Canada are culturally, historically, linguistically, and socially diverse, as is their relationship with the federal and provincial/territorial governments. For example, the federal government administers a national health insurance program for First Nations and Inuit called the Non-Insured Health Benefits Program, but Métis do not have access to this program nor to many other 'Aboriginal' programs offered by the federal government. First Nations governments on reserve are eligible to take control of community health services through the Health Transfer Program, yet this program does not apply to Inuit or the Métis.

Canada's three constitutionally recognized Aboriginal Peoples suffer a significantly lower health status than the general population. A range of socio-economic factors such as poverty and unemployment, overcrowded and inadequate housing, and high rates of addictions, suicide and unintentional injury negatively impact physical, emotional, mental, and spiritual health. In 2001, 17 per cent of First Nations, Inuit and Métis in non-reserve areas were living in crowded

conditions, compared to seven per cent of the total Canadian population.[1] Tuberculosis is affecting Aboriginal Peoples at a rate six times that of the national average, and diabetes rates are as much as four times that of the mainstream population. The life expectancy for Inuit is on average 10 years less than the Canadian average. In urban centres, 60 per cent of Aboriginal children live below the poverty line.[2]

TRADITIONAL KNOWLEDGE AND LANGUAGE

> "Speaking our own languages makes us strong in spirit, minds and heart. Language is like a song we need to hear all the time."[3]

Language is integrally linked to indigenous knowledge and practices. Without the continuance of language, a People's relationship with the land with which they live, their health and well-being, and cultural and traditional practices are compromised, as the means of transferring the complexities of indigenous knowledge is lost. There are 11 major indigenous language 'families' in Canada, representing more than 50 indigenous languages. Of these languages, only three are expected to survive.[4] In 2001, among Aboriginal languages reported as mother tongue, the three largest groups were Cree (80,000 people), Inuktitut (29,700) and Ojibway (23,500). Of those reporting Inuktitut as their mother tongue, 64 per cent live in Nunavut, and 30 per cent live in Quebec. Three-quarters of the Cree-speaking population live in Western Canada.[5] In a 2002 public opinion poll conducted by the National Aboriginal Health Organization, 57 per cent of Métis and 63 per cent of First Nations respondents identified the loss of land and culture to be significant contributors to poor health.[6] Métis children aged 14 and under are less likely than their Inuit and First Nations peers to speak or understand an Aboriginal language.[7]

HEALTH PRACTICES IN CANADA

Canada has a publicly funded national health care system, with various national, provincial, and territorial responsibilities, jurisdictions, and delivery systems. In 2002, Canada ranked fourth among G8, the eight largest industrialized economies, in total health expenditures as a percentage of Gross Domestic Product (GDP).[8]

While a commitment to equitable and publicly available health care is one of Canada's defining values, the health care system is under tremendous strain. Health care consumers and patients have faced increasing wait-times to access a range of health care services, from emergency room services to diagnostic tests and surgeries. The use of prescription drugs is the fastest growing category of health spending. According to the Canadian Institute on Health Information, spending on prescription drugs has increased five-fold since 1985, and totaled $21.4 billion in 2004. This represents an average expenditure of $681 per Canadian in 2004.[9]

Canadians, like their counterparts in the industrialized world, are increasingly turning to alternative or complementary therapies. A 1994 study by Statistics Canada reported that approximately 15 per cent of Canadians had used complementary therapies in the previous year. By 1997, an Angus Reid poll indicated that 42 per cent of respondents had used at least one form of alternative therapy. The most commonly used forms of alternative medicines were chiropractic care (36 per cent), massage and relaxation techniques (23 per cent each), and prayer (21 per cent).[10] Nearly 90 per cent of those respondents who utilized alternative therapies found the care they received to be either "very" or "somewhat" helpful. The most common reasons

given for using alternative therapies were to either prevent future illnesses, or to maintain health and vitality.[11]

Traditional medicines and practices remain an important part of the lives of Inuit, Métis and First Nations in Canada. A report conducted for the Ontario Women's Health Council in 2003 indicates that of 276 Aboriginal women respondents, 72.1 per cent reported consulting traditional healers, and 42.0 per cent sought out the services of medicine people.[12] Even in an urban setting, a significant number of Aboriginal Peoples access traditional medicines. According to the 2001 Aboriginal Peoples Survey, about 34 per cent of Aboriginal people living in urban areas had access to traditional medicines.

Cultural and spiritual practices in many cases cannot be separated from Aboriginal concepts of health and healing practices and are as diverse as the many Peoples that utilize them. Historically, many of these practices were denounced, devalued, and in some cases, outlawed specifically through legislation such as the Indian Act[13]. The imposition and influence of Christian-based religions has also had a major impact on diminishing the transmission, use and perceptions of traditional practices such as shamanism in the Arctic.[14] There have been and continue to be, however, many individuals in First Nations, Inuit, and Métis communities who have taken on the responsibility of carrying this knowledge. This includes the collection and use of natural remedies as well as some fundamental concepts of public or population health which flow naturally from Aboriginal concepts of land, languages and relationships within communities — which is generally referred to as indigenous or traditional knowledge.

There is increasing recognition of the value of indigenous knowledge and practices, and their potential contribution to increasing the health and wellness of First Nations, Métis and Inuit in Canada. As the Canadian government contends with the many financial and human resource pressures that have an impact on the health care system across the country, there is also increasing interest in the potential application of indigenous practices to enhance public health prevention and promotion programs and interventions. There is an emerging recognition among decision-makers and program and service designers that programs and services targeted to indigenous peoples must reflect indigenous knowledge, values, and principles to affect positive health outcomes.

There are a range of national, provincial and territorial health policies, strategies and initiatives in Canada. The Province of Ontario, home to more than 200,000 Aboriginal people,[15] has an Aboriginal Healing and Wellness Strategy.[16] The Strategy funds four major types of initiatives — community wellness workers, crisis intervention teams, health liaison and health outreach — as well as specialized projects such as healing lodges, treatment centres, and Aboriginal health access centres. These and similar programs are, however, an exception and not the norm across the country. Integration of indigenous knowledge and healing practices in Canada, in partnership with Inuit, Métis and First Nations communities, continues to be fragmented and implemented at an *ad hoc* basis.

There are immediate opportunities to advocate for the recognition and integration of Aboriginal traditional knowledge and practices into national public health policy. The federal government has recently created a national public health agency mandated to develop a public health agenda

and policy in Canada. The impetus for the creation of this body was Severe Acute Respiratory Syndrome, or SARS, which caused a public health crisis in Canada in 2003. While the mainstream population is focusing on emergency responses to imminent health emergencies and the promotion of healthy lifestyles, the Aboriginal population of Canada is viewing this as an opportunity to continue addressing the many and broad social and environmental factors that negatively affect their health. It also provides an opportunity to create appropriate health approaches and interventions based on indigenous culture, language and knowledge.

CASE STUDIES

Given the diversity and complexity of the cultural, geographic and jurisdictional landscape of Canada, this paper presents three case studies that illustrate some unique approaches to traditional knowledge and medicine and public health in Canada.

Midwifery Services: The *Innulitsivik* Health Centre

There are approximately 45,000 Inuit in Canada, living in 53 remote communities along the Arctic coastline. These communities span four time zones, and over 90 per cent are only accessible by air travel year-round. Most Inuit came into contact with outsiders in the 1950s, moving into permanent settlements soon after. Some argue that the federal efforts to move Inuit into communities was an exercise to assert Canadian sovereignty in the Arctic, although the federal government contends it was in order to provide health care and other social services to Inuit as citizens of Canada. Western medical practices were originally introduced by a range of outsiders including whalers, Europeans involved in the fur trade, clergy and later by British

public health nurses. Over time, nursing stations were established in all the communities, but physicians and most other health services remain scarce.

With the imposition of western medicine came the medicalization of childbirth, and the criminalization of the practice of traditional Inuit midwifery. Expectant mothers are still routinely evacuated thousands of miles from their families and homes to give birth in southern hospitals. This separation from families and homes has been linked to a decrease in birth weights, an increase in birthing complications, an increased likelihood of post-partum depression, and an unnecessary strain on family relations.[17]

There is currently a resurgence of interest in the reintroduction of traditional Inuit midwifery and birthing practices and "bringing birth back to the community,"[18] with different Inuit regions offering varying degrees of access to such services. In the Nunavik region of Quebec, Inuit women are served by medical facilities in three communities that offer integrated Inuit midwifery with the support of western medicine, as required.[19] The *Innulitsivik* Health Centre in Puvirnituq, Nunavik has been operating since 1986. This centre is unique in that maternity services are provided by a team made up of both traditional Inuit midwives and western medical practitioners, and protocols for maternal care are set by an interdisciplinary council. The *Innulitsivik* Centre also provides 'on the job' midwifery training. Inuit midwives are the lead caregivers for maternity, including pre- and post-natal care. The midwives have access to a variety of western medical services with on-site physician services, and specialist consultations are conducted by phone or medevac.

The James Bay and Northern Quebec Agreement (JBNQA) was signed in 1975.[20] This agreement between the federal and provincial governments, energy and development corporations, and the Grand Council of the Crees (Quebec), and the (then) Northern Quebec Inuit Association, was one of the first indigenous land claim agreements in Canada. The agreement addresses *inter alia* the land regime, environmental and social protection, local government provisions, education, and health and social services. Part 9, Section 15 of this agreement defines the Nunavik Regional Board of Health and Social Services as the body responsible for all provincial and federal health services for the region of Nunavik, including the *Innulitsivik* Centre. To this end, the Inuit of Nunavik exercise, to a certain degree, control over health service delivery in their region. This centre has become a model of integrative health services, attracting attention from both indigenous and non-indigenous organizations and institutions from across Canada and around the world.

In 1999, the Quebec provincial government legalized midwifery. On the surface, this is a positive event, however, this legislation recognizes only one midwifery training program in the Province of Quebec.[21] Although the act allows for "special arrangements" with Aboriginal Peoples, at this time the Inuit midwives trained at the *Inuulitsivik* Centre are ineligible for licensing in their home province. Fortunately, negotiations have begun with the Quebec Ministry of Health to ensure midwives trained at the centre are eligible for provincial licensing.

A similar birthing centre operates in Nunavut, a third federal territory that was created in 1999, where 85 per cent of the population is Inuit. A birthing centre with Inuit midwives serves one region in the vast territory. Due to funding issues, limited capacity, or provincial/territorial

legislation, Nunavut's two other regions have little if any access to traditional Inuit midwifery. A new birthing centre is scheduled to open in Cambridge Bay, Nunavut, in the fall of 2005, serving the western region of Nunavut.[22] The centre will employ three midwives. It should be noted that the Nunavut Government has made the integration of *Inuit Quajimajatuqangit*, or Inuit knowledge, a priority in the development of government institutions, programs and services (including health services), and has developed six primary guiding concepts and principles.[23]

There is increasing provincial and territorial government federal interest in enhancing midwifery services in Inuit communities. This is in response to increasing criticism, both domestically and internationally, of the failure of governments to provide Inuit equitable access to basic health care services taken for granted in southern 'population belt' near the Canada-U.S. border, where the majority of Canadians reside. There is a Canada-wide trend of decreasing numbers of maternity care providers — this trend is most affecting rural and remote communities. Increasing access to traditional midwifery practices would result in a reversal of this trend in Inuit regions.

Integrated Healing: The First Nations Health Program at the Whitehorse General Hospital

The First Nations Health Program at the Whitehorse General Hospital is an innovative program in the Yukon Territory that integrates traditional knowledge and medicines in an in-patient setting. The population of the Yukon is approximately 40,000, of whom approximately 23,000 reside in Whitehorse, the territorial capital. There are 14 First Nations in the Yukon, with a total Aboriginal population of approximately 7,300. The federal government transferred the

responsibility for health care delivery to the territorial government in 1992. The territorial government entered into a third-party agreement with the Council of Yukon First Nations, which oversees the First Nations health program at the Whitehorse General Hospital.

An Elders Working Group developed the program during a series of consultations and visioning exercises held between 1995 and 1998. Its purpose is to advocate for First Nations people at Whitehorse General Hospital to ensure quality and culturally sensitive holistic health care. The Elders were involved in all aspects of the development of the program and services, from visioning of the healing room and gathering traditional medicines, to developing operating policies and job descriptions.

The First Nations Health Program at the Whitehorse General Hospital offers seven programs, including a traditional medicine program. Patients may choose to receive the services of a traditional healer, including traditional medicines. Money is never offered in exchange for treatment. Rather, a gift may be offered to the healer. The traditional medicine program coordinator consults with physicians on traditional medicines and practices to be used, and the program has received increased acceptance by western health practitioners at the hospital. Patients may access a healing room, which was opened in 1999, for ceremonies, funerals, talking circles, preparation of medicines, or for quiet time with family. In 2003, the healing room was given a traditional name – Naa Ku – meaning ‘place of healing’ in Southern Tutchone.

Traditional medicines, their uses, preparation methods and dosages are documented, and medicines are gathered under the supervision of Elders and medicine people during the summer

months. The program follows the clan system and traditional laws of the indigenous peoples of the Yukon.

Clara Schinkel, a Yukon Elder, says “People passed on the knowledge from one person to another. They usually had certain people that were traditional medicine people, men or women. The knowledge that they carried really went in great depth, traditionally they don’t just deal with the symptoms, they deal with the whole thing. A lot of it is caused by emotions that bring about the physical illnesses. The medicine people would deal with all parts of a person: emotional, spiritual, mental and physical. This is what a traditional medicine person would deal with. Families still use traditional medicines.”[24]

Drug and Alcohol Treatment: Métis Addictions Council of Saskatchewan

The Métis Addictions Council of Saskatchewan Inc. (MACSI) is one of the longest established Métis-controlled health programs in Canada. MACSI was founded in 1969 to provide rehabilitation, education and prevention services to all Aboriginal peoples seeking help for drug and alcohol abuse in the province of Saskatchewan. Today it operates treatment centres in Regina, Saskatoon and Prince Albert, targeting Métis and First Nations and open to all Saskatchewan residents. MACSI’s mission:

> To reduce and eventually eliminate the harmful effects of alcohol and drug abuse among Aboriginal people[s] and to assist communities in restoring a balanced and harmonious lifestyle. The key to overcoming the addiction is to restore harmony — to become WHOLE. Each time a client leaves our programs with a feeling of being whole, with an inner peace and equipped with the necessary living skills to continue their journey and assist others, we have achieved our goal. The goal is lifelong recovery — mentally, spiritually, physically and emotionally.[25]

MACSI is an affiliate of the Métis Nation – Saskatchewan, a political organization representing the interests of Métis in the province of Saskatchewan, which has a Métis population of approximately 44,000.[26] According to Canada's 2001 Census, there are approximately 295,000 self-identified Métis in Canada, representing 30 per cent of the total Aboriginal population.[27] Métis are recognized, along with Inuit and First Nations, in the *Constitution Act, 1982*, as one of Canada's three Aboriginal Peoples.

MACSI receives core funding from the Saskatchewan government and its programs adhere to provincial health care guidelines. In 2003-04, it served over 1,100 clients, the majority Aboriginal. MACSI's primary in-patient treatment services — a 28-day structured program — has incorporated a formal, traditional healing component, administered by community Elders, at each of its treatment centres. Reflecting the needs of their clientele, Métis and First Nations Elders conduct on-site group counselling, consistent with cultural protocols, one half-day per week, returning for one-on-one counselling and therapy as requested by individual clients.

Clients are asked to self-identify their Aboriginal status upon intake and are offered the traditional programming component based on their cultural background and preference. In one treatment centre, a qualified staff member provides a cleansing ceremony every weekday morning. Each centre has a room set aside where clients are encouraged to practice their ceremonial and spiritual traditions. Off-site cultural practices, such as sweat lodge ceremonies, are also made available to clients, with all arrangements, including transportation, co-ordinated - by MACSI staff.

Selection of Elders for the program is based on community customs; that is, those who are respected for their knowledge and recognized by their communities as Elders are asked to work with MACSI clients. An honorarium is offered to Elders for their scheduled half-day sessions, and it is common for them to see clients at other times on a volunteer basis. Elders are not regular employees of MACSI. They engage in a working relationship with MACSI and its clients based on traditional protocols.

In the future, MACSI plans to begin serving their clients traditional foods, such as venison and moose meat. This requires a special exemption from the provincial government because fresh meat would be obtained by donation from hunters, as is customary in Métis and First Nations cultures. As well, MACSI is exploring an initiative that will encourage youth to work with Elders to learn of traditional medicines and accompany an Elder to harvest seasonal plants and herbs.

CONCLUSION

There seems to be increasing acceptance of indigenous practices by health care practitioners and policy and decision makers, as evidenced by programs such as the First Nations Health Program in the Yukon and the Aboriginal Healing and Wellness Strategy in Ontario.

However, concurrent with the potential benefits of increased use of traditional medicines, knowledge and practices is the need for adequate protections for all forms of indigenous knowledge. Aboriginal knowledge holders in Canada have grave concerns about

misappropriation of this knowledge for commercial purposes. Concerns also continue regarding the federal government's lack of respect for indigenous knowledge as a valid source of information and evidence for effective policy development. These issues have been explored more fully in other work of the National Aboriginal Health Organization with Aboriginal Elders and Healers. A more complete discussion can be found in the document *Traditional Medicine in Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicines,* by Dawn Martin-Hill, Ph.D.

One of the key themes of the brief case studies provided that must be reinforced is the fact that any health programs, services, or systems developed must be fully inclusive of First Nations, Inuit, and Métis at all levels. The respect for, and use of, indigenous knowledge and practices in the development and implementation of public health programs can only hope to succeed if the holders of that knowledge are allowed to define the how, when, where, who, what and why of its utilization in the best service of Aboriginal Peoples.

---

[1] Health Canada. *Aboriginal Peoples Survey 2001 – Initial Findings: Well-Being of the Non-Reserve Aboriginal Population* (Ottawa: Minister of Industry, 2003), quoted in Canadian Institute for Health Information, *Improving the Health of Canadians 2004* (Ottawa: Canadian Institute for Health Information, 2004), p. 86. Figures are for the non-reserve population, i.e. those not residing on "Indian reserves," and inclusive of those self-identifying as North American Indian, Métis or Inuit.
[2] Rodolfo Stavenhagen United Nations Commission on Human Rights Report of the Special Rapporteur on the situation of human rights and fundamental freedoms of indigenous peoples, Rodolfo Stavenhagen, Addendum: Mission to Canada, E/CN.4/2005/88/Add. 3, p. 10.
[3] National Aboriginal Health Organization. Aboriginal Women and Girls' Health Roundtable Report, (Ottawa, Ontario) 2005.
[4] Lakehead University. Introduction to Native American Linguistics, Department of Languages. "Handout 1:Currently Spoken Canadian Aboriginal Languages". 1999. http://bolt.lakeheadu.ca/~jomeara/canadianLanguages.html
[5] http://www12.statcan.ca/english/census01/products/analytic/companion/lang/canada.cfm#aboriginal
[6] National Aboriginal Health Organization, First Nations and Métis Health Public Opinion Poll (Ottawa, Ontario) 2003, pg. 11,12.
[7] Statistics Canada. *A Portrait of Aboriginal Children Living in Non-reserve Areas: Results from the 2001 Aboriginal Peoples Survey* (Ottawa: Minister of Industry, July 2004), p. 17-19.

[8] Canadian Institute for Health Information. http://secure.cihi.ca/cihiweb/dispPage.jsp?cw_page=media_17dec2003_e
[9] Globe and Mail. "*Drug spending on rise.*" April 5, 2005.
[10] Ramsay, Cynthia, Michael Walker and Jared Alexander. *Alternative Medicine in Canada: Use and Public Attitudes*, (Vancouver: The Fraser Institute, 1999). http://www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=172.
[11] Ramsay, Cynthia, Michael Walker and Jared Alexander. *Alternative Medicine in Canada: Use and Public Attitudes*, (Vancouver: The Fraser Institute, 1999). http://www.fraserinstitute.ca/shared/readmore.asp?sNav=pb&id=172
[12] Ontario Women's Health Council. *Learning More Today for Ourselves and Our Children: An assessment of consumer health information for Aboriginal women*, August 2003, p. 57.
[13] *Indian Lands Act*. R.S.N.S. 1989, c. 219.
[14] There are numerous studies and articles that describe the influence of Christian-based religions on Aboriginal Peoples and cultures in Canada. The reader may wish to refer to the Chapter 10 of the final report of the Royal Commission on Aboriginal Peoples (http://www.ainc-inac.gc.ca/ch/rcap/sg/sgm10_e.html), or Vol. 21, no. 1-2, *Études Inuit Studies*, Université Laval, 1997, Québec (Québec).
[15] Indian and Northern Affairs Canada. "Ontario First Nations Demographics". http://www.ainc-inac.gc.ca/on/pppp_e.html.
[16] Aboriginal Healing and Wellness Strategy. http://www.ahwsontario.ca.
[17] National Aboriginal Health Organization. *Midwifery and Aboriginal Midwifery in Canada*. 2004.
[18] Epoo, Brenda, Van Wagner, Vicki. Presentation to the Aboriginal Women's Health Roundtable, Ottawa, Ontario, April 2005.
[19] Since the Puvirnituq, Nunavik midwifery centre opened in 1986.
[20] Indian and Northern Affairs Canada. "The James Bay and Northern Quebec Agreement And The Northeastern Quebec Agreement ." http://www.ainc-inac.gc.ca/pr/info/info14_e.html.
[21] There are 14 Inuit communities in the Nunavik region of Quebec. The provincially accredited midwifery program is offered in Trois Rivieres, a southern, urban centre, approximately 2,000 kilometers from the regional centre of Kuujjuaq. There are significant cultural, linguistic and geographical barriers to participation and completion of the program by Inuit students in Nunavik.
[22] CBC North. "Kitikmeot to open Cambay midwifery centre."May 2, 2005. http://north.cbc.ca/regional/servlet/View?filename=cambay-midwives-02052005.

[23] These principles are: Piliriqatigiinngniq**:** working together for the common good;
Avatimik Kamattiarniq**:** the maintenance of environmental wellness;
Pijittsirarniq**:** the contribution to the common good through services to others and leadership, concepts which are not mutually exclusive, but inherently part of the same ideal of wisdom in Inuit culture;
Pilimmaksarniq**:** empowerment;
Qanuqtuurunnarniq**:** resourcefulness and adaptability;
Aajiiqatigiinngniq**:** co-operation and consensus.
Pauktuutit Inuit Women's Association. *Applying Inuit Cultural Approaches in the Prevention of Family Violence and Abuse,* (Ottawa, Ontario) 2005.

[24] First Nations Health Program, Whitehorse General Hospital. Pamphlet., nd
[25] http://www.metisnation-sask.com/affiliates/macsi.html
[26] Based on self-identified Métis population. See Statistics Canada, *2001 Census*. http://www12.statcan.ca/english/census01/products/analytic/companion/abor/groups2.cfm .
[27] Ibid.