

Barriers to Accessing Traditional Healer Travel Funding from Off-Reserve

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Abstract

Since the 1990s, medical transportation funding has been available to First Nations people with official Indian status for accessing traditional healers through Health Canada's Non-Insured Health Benefits program. However, for those living off-reserve in northeastern Ontario actually obtaining this funding is far more challenging in practice than in policy. This article identifies health policy disjunctures that present themselves as barriers to accessing Non-Insured Health Benefits travel funding from off-reserve to see traditional healers. My article argues that hidden social, financial, religious and geographic barriers severely impede off-reserve access to medical transportation funding that is used to access traditional healers. The purpose of my article is to make visible these hidden barriers and to encourage a dialogue surrounding issues of off-reserve health inequality, differential access and class-based access to the Non-Insured Health Benefits program. These findings are from my study entitled "Accessing Traditional Healer Travel Funding: It's Not "The Same for Everybody" (2012).

Keywords

First Nations, health access, traditional healers, Non-Insured Health Benefits, health inequities

Preface

Within Canada, First Nations people with official Indian status, whether residing on or off-reserve, are eligible for health care programs and services not covered by provincial health programs through Health Canada's Non-Insured Health Benefits (NIHB) program. This program also provides access to medical transportation funding which can be used for accessing traditional healers. Access to travel funding sounds good in theory, but as applicants living off-reserve quickly find out, having access in policy is not the same as actually being able to get it.

This article discusses barriers to accessing NIHB travel funding to access traditional healers from off-reserve. These were articulated by participants in the context of my study investigating the social organization of access to NIHB traditional healer travel funding. My study, which took place in northeastern Ontario from 2009 to 2012, answered 4 research questions, one of which was: What are the barriers/obstacles that off-reserve Anishinabek are confronted with when accessing traditional healing services through the Medical Transportation Policy Framework of the Non-Insured Health Benefits program? The problematic of my study emerged from the lived experiences of status First Nations people living off-reserve in northeastern Ontario as they encountered the social organization of access to traditional healer travel funding through the Non-Insured Health Benefits program.

Introduction

There are clear reasons why First Nations people living off-reserve need access to travel funding to see traditional healers. First, the importance of access to traditional healing services for First Nations people was brought to the forefront by the Royal Commission on Aboriginal Peoples (1996) which recommended that “the services of traditional healers, midwives and other practitioners should be assured for Aboriginal people who choose to consult them” (RCAP, 1996). However, even though traditional healing services are offered through programs and travel coverage is provided through Health Canada’s Non-Insured Health Benefits program (Section 8, 2010), many First Nations people living off-reserve are blocked from doing so by a range of barriers.

Second, access to NIHB travel funding for traditional healers begins a healing journey for residential school survivors and their descendants. To recover, residential school survivors themselves often advocate traditional healing services to recover from trauma. For example, elder Fred Kelly, in describing his own experience as a survivor and subsequent recovery, explained that “our therapies include the use of traditional practices and medicines, teachings and instructions, counselling and ceremonies, and language and history. The shaking tent, sweat lodges, sacred pipes, and traditional drums and songs of the Anishinaabe are a vital part of healing” (Kelly, 2008: 30). In the region of my study, many generations of children were forced from their homes into the Church-run Garnier residential school for boys or St. Joseph’s residential school for girls in Spanish, Ontario until the late 1950s.¹

Third, Ontario contains Canada’s largest proportion of registered First Nations people living off-reserve—70% (Statistics Canada, 2006). Many of them are 2nd and 3rd generation descendants of residential school survivors, and among the least economically viable people in Canada. They would benefit from accessing traditional healers as well, but cannot afford travel to them. For example, registered First Nations people in Ontario age 25 and younger have a median income of about \$7,800 per year—hardly enough to support basic living needs let alone travel to see healers (Statistics Canada, 2006). This income level is substantially lower than the official low-income cut-off (the poverty line) for single Canadians in either rural or urban locations (Canadian Council on Social Development, 2006). In terms of wellness in industrialized countries, studies have noted a link between low income and poor health and high income and better health (Machenbach, 2008; Wilkinson and Marmot, 2003; Kunst, Guerts, & Berg, 1995). In Canada, this is evidenced by higher First Nation mortality levels across all age groups and within most other areas of health (Letendre, 2002, 3).

Literature Review

My study is the first of its kind in Canada, therefore the published literature on access to NIHB travel funding from off-reserve to see traditional healers is non-existent. However, certain themes emerge

¹ These schools began operation on Manitoulin Island in 1825 and were transferred to Spanish, Ontario in the early 1920s. For a more detailed discussion about the Canadian residential school experience including the residential school experience in this area, please reference J.R. Miller’s *Shingwauk’s Vision: A History of Native Residential Schools* (1996). A noteworthy survivor account is Basil Johnston’s *Indian School Days* (1988). When I met Johnston at Cape Croker in 2002 and purchased his book he signed it “From former inmate #43. Basil H. Johnston.”

within literature on the more general topic of barriers to accessing traditional healers in Canada. This literature asserts that access to traditional healers is often stymied by Canadian medical establishment oversight and control, ignorance or fear about traditional healing practices, and lack of respect by regulated health practitioners. The literature also identifies barriers such as physician ignorance, gender, poverty, limited overall access, lack of support and failure of regulated health professionals to make recommendations for such treatments. Additionally, the organization and control of access to traditional healers by state and professional relations is identified as a barrier.

Since the 1980s, Canadian researchers began to study the use of traditional medicine and its potential integration with Canadian medical practices in First Nations clinics. In doing this, reports of various barriers to access and joint collaboration between these approaches began to emerge within the literature. The RCAP describes four main access barriers to traditional healers. These include “doctors who may be unsympathetic or ignorant” to traditional healing practices manifested by a paternalistic perception of First Nation healers and the absence of physician support, the continuation of an arbitrary process, maintaining a “fundamentally inequitable” Aboriginal health system, and the underfunding of NIHB with regard to traditional healers (RCAP, 1996). Martin-Hill (2003) in discussing challenges facing First Nations women, describes how class and the relationship between “poverty, identity, and gender” was a detriment to accessing traditional healing services. Class, as well as the relationship between poverty and poor health was also identified as a barrier to traditional healer access for women by Kasee (1995). Further, Shestowaky (1995) identified “limited access to traditional healing services” as a barrier to health care for urban First Nations women (cited in Brunen paper, 2000, 7). Two studies conclude that physician attitudes are a barrier affecting potential collaboration between traditional and allopathic medicine (Gagnon, 1989 and Zubek, 1994). Finally, the Aboriginal Nurses Association of Canada reports that status Indians are stymied in attempts to access traditional healers because physicians refuse to make referrals; that travel limitations on out of province travel interfere with access, and because associated expenses for healers, such as gifts (in accordance with cultural protocols) are not covered (Aboriginal Nurses Association of Canada, 2001: 5.5).

The literature also indicates a sharp contrast between official recommendations for accessing traditional healers and what actually happens in practice within Canada. For example, even though the federal Medical Services Branch made recommendations as early as 1980 for a “closer working relationship between traditional healers and physicians” (cited in Gagnon, 1989, 176), in actual practice observers noted that “the government is only marginally supportive of the non-formal health care system” (Gregory, 1988, 42). Further, in 2003 the Canadian Medical Association (CMA) officially recommended the “integration of disease treatment services with health promotion and health education programs, and with traditional healing practices.” The CMA also recommended “An openness and respect for traditional medicine and traditional healing practices (e.g. sweat lodges, herbal medicines, healing circles)” (CMA Journal, 2003: 5). However, in actual practice it was noted that “Aboriginal people often request access to traditional healing methods, but many mainstream physicians are uncomfortable working with traditional healers for fear of retribution by the college” (Haley, 2003: 46).

Finally, the ability of professional and state relations to restrict access to traditional healers is also raised in previously noted studies (Gregory, 1988, 1989; Gagnon, 1989; Waldram, 1990; RCAP, 1996; Aboriginal Nurses Association of Canada, 2001; Haley, 2003; Maar, 2007). These studies identify the reluctance of physicians and regulated health professionals to make referrals to traditional healers, which is required to obtain NIHB travel funding; to recognize or accept the legitimacy of traditional healers; and the role of regulated health professionals as the primary gatekeepers in the traditional healer access process. These concerns are often manifested by an unwillingness to make referrals to traditional healers and subsequent denial of either travel reimbursement funding or advances in travel funding as required by NIHB regulations.

Methods

Drawing from the research approaches of institutional ethnography as articulated by Dorothy Smith (1999, 2006) and indigenous knowledge (M. Thrasher), my study was completed in 2012 and conducted off-reserve in the geographic area of northeastern Ontario from Sudbury to Sault Ste. Marie, Ontario. The research methods used included textual analysis, a medicine circle and semi-structured qualitative interviews with applicants, front line workers, elders, healers, and regulated health professionals. I drew from institutional ethnography and Indigenous knowledge approaches because they offered the best means for answering my research questions and the topic I planned to investigate. It also came from the central belief that people included in this study be respected as more than just research subjects, and the desire that this study would “make a positive difference for the researched” (L. Smith, 1999, 191).

Situating Myself: Awanakia? (Who are you?)

From both an indigenous and Western academic perspective, the notion of standpoint is important to clarify. During this study, Métis elder Michael Thrasher guided me throughout this research, continually emphasizing to me that “you can’t write about what you haven’t practiced” (Thrasher, 2008-2012). Further, according to D. Smith, “inquiry starts out with the knower who is actually located” in the social world instead of from “a bird’s eye view” above the social world (1999, 4, 54). Smith further states that typical “positionless accounts” often used for academic study are limited in their usefulness because they assume that people are capable of a “mode of knowing that has been attributed to God alone” (1999, 54-55). This distinction is important because embodied, located knowledge is critical to ascertaining what happens in practice.

I am a descendant of the Alnobak (Western Abenaki) people who have inhabited Vermont, New Hampshire, Maine and parts of southern Quebec since time immemorial. I am of mixed Abenaki, Métis, and European blood on both sides of my family. For the past 11 years I have resided in the Serpent River First Nation in northeastern Ontario.

My Abenaki ancestors were survivors. Even after surviving open warfare with the Iroquois and English for many years, the contemporary era was marked by other threats. In the 1700s, our ancestors survived English attacks by moving into the bush when they took place, leaving seemingly abandoned villages. This strategy of hiding in plain view and “blending in” and intermarriage with settlers worked for over 200 years (Calloway, 1990). More recently, in the 1930s, Vermont undertook a eugenics program which succeeded in forcibly sterilizing many Abenaki, classifying us as “river rats,” “gypsies,”

“pirates” or members of an “undesirable” race (Badaracco et al, 2001). This was followed in the 1940s by the U.S. federal government’s appropriation of Missisquoi River land for a wildlife refuge and forcibly removing the Abenaki community living there (Calloway, 1990). To add insult to injury, these injustices took place as the state of Vermont publicly proclaimed that we did not even exist within the state. It was not until the 1970s, that Vermont public schools began teaching that the state was inhabited before European settlement.

My entry point into Indigenous knowledge and traditional healers comes from oral tradition² and actual practice. I first began learning orally from elders and did not come into the published literature on Native Studies until later on. This is how I come into this issue. Over the past 18 years, I have accessed several traditional healers on my own and apprenticed under one as well. Within the academy drawing from oral tradition can be contentious because it privileges written sources and existing power relations with Indigenous people mandate following its rules.

The Indigenous knowledge I draw from in this study emanates from the values, philosophy and spirituality of First Nations people as I have learned and practiced it. It is important to note that while the primary elders I have learned from live outside the geographic area of this study, the roots of much of the Indigenous knowledge I have learned has a historical connection to, and roots in, this area. It has been conveyed to me orally that the family of one of these elders left from their original homeland in Lake Head (Thunder Bay) in 1710 for the Rocky Mountains in Alberta. Others have participated in ceremonies in this area as recently as the early 1960s when such activities were still illegal.

Finally, my First Nations understandings are not affiliated with a particular “school of thought” as one might find in the Western tradition.³ I have encountered attempts to make such distinctions in the past. To answer this, I turned to an Elder and asked her how to respond when asked about these kinds of distinctions in learnings--she laughed and said to tell them “kikinogwayb’matzowin” or the teachings of good life.

Institutional Ethnography

Institutional ethnography (D. Smith, 1999, 6-7, 79) was one of two research approaches drawn from in this study. This approach, which is an alternative way of doing sociology, was well-suited for this study because it explicates from individual or group social standpoints “how it happens” (DeVault and McCoy in D. Smith, 2006, 19) or “what actually happens” (Campbell and Gregor, 2004, 25). It does not seek generalizability, but rather to identify generalizing social relations that organize one’s everyday life. Further, it “is committed to exploration and discovery” (Smith, 2006, 1). It uses ethnographic skills to investigate social organization and emerged out of feminist critique of mainstream sociology drawing on Marxism and ethnomethodology.

² The importance of preserving oral tradition and the ongoing tension between it and written discourse is noted in Renee Hulan and Renate Eigenbrod, ed. (2008) *Aboriginal Oral Traditions: Theory, Practice, Ethics*. Further, the use of oral tradition is identified as an Indigenous right in Article 13 of the *United Nations Declaration on the Rights of Indigenous Peoples* (2007). Canada formally signed this document in November 2010.

³ For example, some First Nations people follow teachings of the Three Fires Midewewin Society as articulated by Benton-Banai. There are many perspectives on this issue. For other perspectives on Indigenous knowledge or Indigenous methods, see the writings of Dr. Cora Weber-Pillwax, Dr. Michael Hart, Dr. James Waldram, and Dr. Leanne Simpson.

This approach draws from the experiences of individuals as entry points into social investigation instead of as data collected for analysis. It perceives the social world as being produced through the practices of people. It also refuses to turn people into objects for study. Further, instead of seeking to make generalizations about people's lived experience, as is done in conventional sociology, particular accounts are seen as ways of accessing more generalized social relations, they provide "a point of entry, the locus of an experiencing subject or subjects, into a larger social and economic process" (D. Smith, 1987, 157). It also explores some of the "...ideological and social processes that produce(s) experiences of subordination" and "the peculiar ways in which people themselves are implicated in ruling relations despite their intentions" (DeVault and McCoy in D. Smith, 2006, 19). IE was also well suited because it empowers those seeking to answer how their everyday lives are socially coordinated (Campbell, 2006, 90).

Further, these investigations aim toward "Inquiry, discovery [and] learning" (D. Smith, 2006, 2). In doing this, they make visible or identify disjunctures between bureaucratic practices that regulate daily lives across multiple settings. This is useful to "investigate and describe networks of co-ordered activities going forward simultaneously across a number of distinct sites of social action" (G. Smith, 1990, 636). Within this study, finding points within the institutional complex of First Nations health policy that connect to different sites of social activation revealed the social organization of those policies.

Indigenous Knowledge

The second research approach drawn from in this study was Indigenous knowledge. Indigenous knowledge, as I have learned it, originates from the philosophy, values and beliefs of First Nations people. It is a unique subject area that is not well documented, particularly regarding traditional healers and healing practices. It forms the basis for traditional cultural understandings that drive, guide, shape, and direct the research processes being used in this study. It is often shared by First Nations through cultural, historical, and other ties. Within it, there are connections between mental, physical and spiritual health and the notion that balance must be attained for good health.

Indigenous knowledge is also grounded in understandings on balance and the interconnection of Creation.⁴ Traditionally Indigenous people learned by doing and practicing, rather than through abstract discussions. This way, instead of describing what a concept is (the Western way of discussing Indigenous understandings), the concept is discussed for what it does. This way of perceiving is rooted in Indigenous languages. Consider, for example, the Abenaki word for beaver which is demakwa. In English, a beaver may be described by non-Natives as brown, fat, living in the creek, etc., however, in the Abenaki language it means "tree cutter" because this is what a beaver does.

⁴ Again, this is based on my understandings/oral tradition as learned and practiced over a period of years. This would include, for example, the interconnection of the four elements of Creation—the mineral, the plant, the animal and the human. However, it is not limited to that and includes the mind, body and spirit, the universe, the connection of this universe to other universes etc.

Interviews and Indigenous “Interviewing”⁵

Participants in this study were current and former employees of First Nations health organizations, such as front line workers in health centres, friendship centres, former executives of health centres, doctors and nurses who work with First Nations people and elders, healers and helpers. Of 21 persons interviewed, 17 had official Indian status as defined by the *Indian Act*, one was Métis and three were non-Native. Further, all but one front line worker has Indian status. All cultural protocols were followed including the use of tobacco in requesting permission and providing a gift to participants. The interviews were one-on-one, in depth, open-ended interviews that ranged from 30 minutes to 2 hours in length. At the beginning of each interview, informed consent documents and interview guidelines were explained and reviewed. Each person was randomly assigned a pseudonym to protect confidentiality. I prepared transcripts of each interview for participants and contacted each person to give them the opportunity to make corrections, clarifications and/or revisions to their initial statements. Additional permission was gained before quoting participants directly as well. Interviews were held at locations that were most convenient for participants, such as restaurants, shopping centres, public parks and coffee shops.

Because interviewing First Nations people is not the same as interviewing non-First Nations people, my study employed specialized interviewing techniques that are rooted in First Nations counselling practices as articulated by elder Michael Thrasher (2002). This was necessary because there are different forms of social cueing, ways of communicating and methods of interaction.⁶ With this in mind, Thrasher often emphasizes how “you must have 1,000 cups of tea with someone before you really know them.” Emphasizing commitment to a relationship with a person or a community was also a key aspect of my interviews.

Within Thrasher’s description of counselling techniques, listening, looking, thinking and caring are important elements when interacting with Indigenous people for counselling. These criteria also play a key role for researchers who plan to conduct “interviews.” Those four principles happen within the context of incorporating “caring eyes, caring ears, a caring mind and caring behavior” within dialog. In this way, when participants are initially met for interviews, the Indigenous interviewer accounts for what they “see” about a person and what can be done to make them feel comfortable. The tools to do this are gentleness, kindness, honesty and balance.

Next, through listening, not just hearing, the interviewer begins to understand what a person is trying to communicate. This often involves reading between the lines to “hear” what they are really trying to say. According to Thrasher, listening is done with one’s “whole being” and involves using the mind, body and spirit. In this way, every part of one’s being is focused on what is being said. This is critical within Indigenous culture because all historical information has been transmitted in this way and the Western way of listening lacks this important attribute. Caring listening establishes relationships and eliminates negative attitudes because the interviewer cares about what a person has to say. This is similar to

⁵ Adapted from Michael Thrasher’s medicine circle learnings on Counselling.

⁶ For a more in-depth discussion of First Nations communications and everyday interaction, see Roger Spielmann’s *Anishinaabe World* (2009).

institutional ethnography interviewing that requires the ability to “develop methods for listening around and beyond words” (DeVault, 1999, 66).

With a caring mind, the interviewer can separate emotions, which are the expression of feelings, from feelings which are the expression of spirit. This allows an interviewer to find the root causes of unwellness and determine if remarks or comments originate from hurt feelings instead of intellectual analysis. For example, this may occur during an interview when a participant expresses feelings, particularly sadness, happiness or anger, that evidence to the interviewer that the actual origin of these behaviors may be unrelated directly to the topic of discussion, but instead based in long-standing or unresolved emotional issues that trigger a response. When these happen, an interviewer may respond with understanding, empathy and caring behavior such as smudging with sage or sweetgrass, moving the conversation into a safer terrain, and allowing that person to express their feelings in a safe and non-threatening environment. Caring behavior in this form of communication marks when concepts such as kindness, caring and gentleness can be put into motion to make transformations within our lives so we can be healthy in our mind, body and spirit.

Within this way of Indigenous interviewing, all measures must be taken to meet “eyeball to eyeball.” Trying to conduct this process through e-mail, telephone or other printed mediums is insufficient. Further, this way also necessitates establishing trust. When listening takes place, trust becomes part of the process and evidences a commitment from those doing the “research.”

During interviews, a medicine circle was also used to help participants describe their experiences. This medicine circle was divided into four quadrants based on the four cardinal directions designating the Eastern direction as physical aspects; the Southern direction as mental aspects; the Western direction as emotional aspects; and the northern direction as spiritual aspects. In this way, participants presented with this circle indicated the quadrant(s) in which their experience took place. It also provided them with an opportunity to describe and recall events/experiences that may have otherwise been overlooked.

Critical Textual Analysis

Critical textual analysis was also a research method used in this study. Individual accounts described in interviews led my investigation into critical textual analysis that included the Indian status card, the *Medical Transportation Application - Traditional Healer Services form* (the preapproval form) and the *Confirmation of Visit to Healer* form. Institutional ethnography discovers how texts, such as policies and forms, play a critical role in socially organizing activity. Through these texts, which are activated by people using them, connections are made at different sites and these practices are made visible to illustrate their organization.

Textual analysis is useful because it shows how individual activities in various locations and different periods of time are coordinated “across time and place” (DeVault and McCoy, 2006, 21). It has been noted that the use of documents is critical to state ability to coordinate and manage its operations through connecting and coordinating seemingly unrelated tasks ranging “from interdepartmental memoranda to job descriptions to statistical data” (Ng, 1996, 23). According to D. Smith, texts may include “words, images or sounds that are set into a material form of some kind from which they can be read, seen, heard, watched, and so on” (2006, 66). Textual mediation also coordinates “sequences of

action,” that are “replicable” and link any other person who engages with it to “the same words, images or sounds” (2006, 66). As coordinators of action, they connect local activities with those taking place on a broader scale. As official forms, they are used to construct artificial versions of reality by extracting selective information, often denying everyday lived experience, and placing it into institutional and ruling categories.

Findings

Starting with interviews to describe the lived experience of people who applied for NIHB travel funding to see healers, it soon became clear that those living off-reserve often encountered a range of barriers in pursuit of this funding. From my interviews eight primary barriers were identified by participants. These were then organized by theme into the categories financial barriers, social barriers, bureaucratic barriers and geographic barriers.

Barriers Shaped by Social Location

Before exploring barriers to access, it is important to discuss how a person’s social location shapes barriers they may encounter when seeking travel funding. The term social location refers to aspects that shape the context of one’s “social relations” or such factors as “...a person’s background, situation or circumstances” (Mykhalovskiy, et al, 1994, 1).

For First Nations people living off-reserve, social relations play a major role in the ability to access travel funding to see traditional healers. For purposes of this study, such social relations include First Nations Indian status, broader class relations, living on or off-reserve and one’s location as either an employee or friend or relative of an employee working in First Nations health centres or other key positions within the preapproval process. These are important factors because the preapproval process is complex to the extent that in some cases workers with up to 15 years of experience have difficulty helping clients complete it. To make matters worse, some band workers and NIHB processors inform workers/clients that they are ineligible for these services; certain healers are designated as officially “approved” while others are not; and travel authorization is processed in such an arbitrary manner that travel funding to access healers is at best a hit or miss proposition.

In discussing social location, it is also worth reiterating that about 86% of the participants interviewed (18 out of 21) are classified by the government of Canada as First Nations. Seventeen have “official” Indian status, one is Métis and three are non-Native. Further, only one front line worker interviewed did not have Indian status. Knowing this is important because as First Nations people their lives are entwined within institutional relations that engage in oppressing First Nations people, but they are also oppressed themselves by how these relations impact their personal, family and community lives. While they often take up or share in the standpoint of applicants, they still must participate within relations and texts that organize this process. They are subjected to the same rules and regulations of the *Indian Act* and NIHB. This is unique because these workers cross back and forth in social location. In one instance they may be applicants who suffer the same or similar indignities as people they service in their daily work, but in another they are potential gatekeepers for applicants. This is worth noting because front line workers in other studies, particularly those pertaining to welfare or HIV treatment access, are unlikely to change social location and become regulated as applicants.

Bureaucratic Barriers

Lengthy Preapproval Waits

Bureaucracies, such as Non-Insured Health Benefits, are not known for processing forms and materials quickly. Bureaucratic organizations focus more on whether or not the forms are filled out correctly and if procedures and policies have been followed. This mode of operating presents a barrier to those off-reserve seeking to access travel funding because of the time involved in applying for preapproval before access and obtaining travel reimbursement after.

Waiting for preapproval (which takes anywhere from a week to a month) is a disincentive because it is different than when one seeks allopathic medical care. One can access a physician or emergency counselling in a hospital emergency room at any time, but accessing a traditional healer is relegated to a process that does not allow such access. In describing the effect of waiting the length of time required to obtain preapproval on decision-making, Amik stated “I think our people would access healers more if they didn’t have to go through such a long wait to access travel dollars” (interview, March 3, 2010).

Further, if someone is told that an appointment with a healer may not be available for several weeks or months, they are less inclined to pursue it. Workers emphasized the timely need for such access because many wait until the last possible moment to obtain treatment. When they decide to see a healer “It’s now!” (Mohneeze interview, September 16, 2009)). Ninatig described that these kinds of delays can have tragic consequences. The “journey” she is referring to is to the spirit world:

If a person needs a traditional healer right then and right now and they don’t have the means to get there—heaven forbid they have to take their journey before that even happens... (interview, June 23, 2010)

Gatekeepers

Another bureaucratic barrier posed by the current process is the presence of numerous gatekeepers situated at different points who enforce complex rules, regulations and formalities. To obtain preapproval for travel funding, one must successfully clear front line workers, health care staff, Chief and Council, healers and NIHB workers. Participants and workers described how each person holding a position within this chain has the ability, by virtue of their position, to frustrate or stymie the efforts of applicants.

Within this maze of rules and regulations, there are several places where one’s efforts may be obstructed. For example, a front line worker answering the phone in a reserve health centre, friendship centre or information location can stop someone from proceeding further simply by refusing to provide information. If workers do provide forms and information to off-reserve applicants at this stage, worker time constraints (many workers hold a variety of positions) may prevent them from helping people fill out the forms. Further, health care workers (nurses and doctors) who are required by NIHB to sign the preapproval forms can refuse to do so if they disagree with the validity of someone’s medical reason for seeing a traditional healer. Chief (and Council) can refuse to officially recognize the healer (as required by NIHB) one plans to access. Personal opinions and religious beliefs among Chief and Council, for example, play a role in support or resistance to traditional healing practices. On reserves where support for traditional practices is marginal, then support for travel to healers is nonexistent. NIHB Workers can also refuse preapproval depending on how they interpret the travel policy. Some workers interpret

narrowly and others do so more broadly. Finally, the healer (although unlikely) can prevent someone from accessing travel reimbursement by refusing to sign the *Confirmation of Visit to Traditional Healer* form that is required by NIHB and presented at the time of treatment.

For example, early in the research process, I called the Non-Insured Health Benefits preapproval line to ask about interviewing staff for my study. During my brief call, I spoke with a front line worker about my research topic. I explained my interest in clarifying an initial impression that applicants living off-reserve went through a different process and had different experiences obtaining travel funding to see traditional healers compared to those living on reserve. Upon hearing this, he abruptly cut me off, stating, “No, the process is the same for everybody.” This brief conversation made me aware of gatekeepers as a major barrier—officially it’s “the same for everybody,” but in reality front line workers have a great deal to do with whether or not someone from off-reserve can apply for funding.

An example of NIHB workers as gatekeepers was also described by Ninatig who described her encounter when attempting to obtain transportation funding to bring healers into a community health or treatment centre. Ninatig found that NIHB workers imposed significant hurdles on bringing a healer into a First Nation centre:

So, I said ok, and I sent the letter and they said we need to know the accommodations and everything. I had to make a list of everything to Non-Insured Health Benefits and this took a couple weeks to do. So, finally we got to that part and I sent the letter. Next, I had to design a letter for him to sign that he came here, that I witnessed it and the things he had done along with mileage. I said ok, could you send that to me and they said no they can't. Then there was another block—they approved him coming, approved to pay his accommodations, approved to pay his mileage...then I said ok, this is the amount. They said no. They said we need a paper with his address and we are going to mail it to him. He waited six months... (interview, June 23, 2010).

Other participants in the study who live off-reserve and sought travel funding also described the diversity of their encounters with front line workers as gatekeepers. These are illustrated by the first-hand accounts of M'Sheeken, Megis and Ookwemin illustrate disjunctures between official discourse on access to travel funding and what happens when applicants living off-reserve try and obtain it.

M'Sheeken (Turtle): “It was very frustrating. It was saddening--makes you angry. You know the services are available.”

She described what she encountered when inquiring about obtaining travel funding:

When I wanted to go see a traditional healer, I made that contact with that worker from my First Nation and she said she couldn't help me because I wasn't living on the reserve.

She said I had to live on the reserve, and then I thought—I don't have any resources to do anything (interview, September 12, 2009).

Megis (Shell): “If you don't live on the rez, you are dead in the water.”

Megis described his encounter with a front line worker from his band:

I called my rez in (name omitted) and they had told me that I had to get a letter of confirmation that I was there and I couldn't do that because we hadn't gone through ceremonies yet and that made it impossible for me to get a letter of confirmation because we hadn't done that yet. That turned me off right then and there. I said: how do you want me to do this? I said there were people coming to this ceremony from all over—from Thunder Bay, and they're getting their hotel rooms funded (interview, September 19, 2009).

Because he lacked sufficient resources to travel to the healer on his own, he needed travel funding, however, to obtain funding he was told to travel to that healer, have them sign a letter and return it to the band so his travel subsidy could be provided. It was a no-win situation from his point of view. He explained “I said: What’s the issue here? I want to go to see a traditional healer and I have to get a signed piece of paper from her and I can’t do that until I go to see her.”

Ookwemin (Black Cherry): “It’s easy to do. If you just come in here and get a prescription to see a healer and this and that and they give you a cheque.”

In contrast to M’Sheeken and Megis, Ookwemin (who had inside contacts) found that obtaining preapproval for travel funding to see a traditional healer from off-reserve was straightforward:

I didn't need anything before. I only needed a prescription from a nurse practitioner or a doctor. And I got that just saying that I was seeing a traditional healer for personal reasons. That was all I needed for documents that were required. Then the clerk sent in the prior approval and waited for the prior approval and I was given my cheque just before I left (interview, July 7, 2010).

Finally, the complicated level of the forms constitutes another form of gatekeeping. Participants and workers asserted that the complexity level of the forms and preapproval process is intentionally organized to discourage people from seeking travel funding. If someone lacks education, skills required or bureaucratic understanding needed to obtain and provide the necessary information required by the forms, they will often quit and fail to complete the preapproval process.

Lack of Assistance and Inconsistencies

Several participants and workers indicated that NIHB often provides inadequate and inconsistent support for those seeking travel funding. Without follow up on paperwork submitted for travel reimbursement, paperwork submitted incorrectly or incompletely languishes unprocessed until inquiries are made about its status. For example, if paperwork is incorrectly or incompletely filled out, the processing of a client’s file stops and neither clients nor front-line workers are notified. Consequently, health-related travel plans may remain unresolved for extended periods until researched by someone intent on resolving this issue.

In addition, NIHB often provides inconsistent and conflicting information to inquiries. Some people are told by NIHB workers that they cannot call NIHB and must obtain information through other channels, while others are told it is ok to do so and readily speak with preapproval workers or even supervisors. Further, some people are allowed access to high-level supervisors and even regional directors when preapproval workers deny travel funding and others cannot. Some NIHB workers coach people on “how to fill out the paperwork” so that one may include the appropriate catchphrases preapproval workers are looking for, while others do not.

Financial Barriers

Paying Up Front

With regard to the financial capability and willingness of one’s First Nation band to pay in advance for travel, applicants living off-reserve typically must pay for travel out of pocket and submit for reimbursement. This is socially organized by NIHB through the maintenance of different funding models for those on or off-reserve. Funding for medical transportation on-reserve is provided through “contribution agreements,” in which bands obtain funding to meet on-reserve health demands, in contrast to “operationally managed benefits” for those living off-reserve, which requires those applicants to pay for travel and then submit for reimbursement (Health Canada, 2010).

Participants living off-reserve, workers and others noted that having to pay for travel up front was a major barrier to access. They said that the burden of this is almost insurmountable given the limited financial means that most First Nations people have.

Participants were also dismayed by the fact that those living on reserve were able to obtain advanced travel in contrast to them. Even though they are all status Indians registered with INAC, somehow living off-reserve delegates them to a lesser status. M’Sheeken explained how she felt after being turned away from help by nearby bands because she is registered to a different one:

It was very frustrating. I was thinking—what’s wrong with this picture—where do we as off-reserve people go--there’s got to be something implemented to make it better. It was being angry, I felt like: Why? Why are you not doing this just because I am not a band member (interview, September 12, 2009).

Providing differential services to those living on reserve compared to those living off-reserve has class and political implications. Politically, it divides First Nations people into two groups—those on reserve who are actually eligible for Indian status benefits, and those off-reserve who are theoretically eligible for those benefits, but not in actual practice. This fosters jealousy and resentment among those living off-reserve. Second, access to healers, because the process for those off-reserve can require paying up front, effectively limits access based on financial means and position in class relations. Those with higher incomes can readily access healers because travel funding is not needed, however for those lacking financial means, this access is often unavailable. Weengushk, a physician who works with First Nations clients discussed how access to traditional healers is affected by this:

The people who are accessing that service, generally are more educated, are more affluent. And I think that one of the things that we

are really missing is the ability to access those who are more disadvantaged and marginalized and we are not doing that (interview, October 1, 2009).

The unfairness of requiring people to pay up front for services was raised in 2010 with regard to a proposed change to NIHB pharmaceutical rules. Under current rules, people are not required to pay in advance for medications. According to the proposed changes, status Indians would be required to pay in advance for medications and then be reimbursed later by NIHB. In addressing these proposed changes, Grand Chief Madahbee of the Union of Ontario Indians stated that the changes would violate the government's "fiduciary duty." He further stated that "Our people should not have to pay for their prescriptions up front—we just can't afford to do so" (2010).

Travel Funding is too Low

When travel funding is provided, both for individuals travelling to access healers and healers brought into communities, it is minimal and inadequate to cover transportation expenses. According to the Canadian Centre for Policy Alternatives (2010, 3), the median annual income of status First Nations persons in Canada is about \$19,000 (roughly 30% lower than the Canadian median income of \$27,000). Consequently, it is not surprising to find that many people, both on and off-reserve, do not own vehicles. To attend medical appointments, they often must rely on family, friends or community members. Even if more people are involving in providing transportation, the amount provided for transportation does not increase. Further, even though financial supports exist to cover travel to doctors and medical specialists (such as provincial travel grants); these are not available for accessing traditional healers.

When compared to transportation funding provided to federal government employees travelling on business (as of October 2010), the inadequacy of this becomes painfully clear. For example, the rate paid for NIHB medical transportation mileage is about 64% lower than the rate paid to federal employees (\$0.20/km vs. \$0.55/km) and the rate paid for meals is 30% lower than that paid to federal employees (\$48/day vs. \$68/day). In addition, the rate paid for accommodations at private residences is 73% lower than that paid to federal employees (\$13.50/day vs. \$50/day). Federal employees also receive a daily incidental allowance of \$17.30/day which is not paid to those traveling on medical transportation.⁷

To complicate matters further, the pathetically low rate of \$0.20 per kilometer is subject to downward revision based on NIHB formulas. This is because NIHB maintains differential travel rates depending on the roads accessed to reach one's destination. In these cases, the rate of \$16.5 cents per kilometer is applied to travel defined as "commercial travel" and \$20 cents per kilometer for "non-commercial travel." Commercial travel is defined by NIHB as travel to one's destination via provincial highways (for example, Highway 17, which connects Sudbury to Sault Ste. Marie). In contrast, non-commercial travel is defined as travel not on public highways, but travel off these highways on side roads that connect to one's ultimate destination. Travel on these roads is paid at the rate of \$20 cents per kilometer. In this way, when one travels to a destination that is located directly off the main highway,

⁷ Both federal employee and NIHB travel reimbursement rates were provided by study participants M'Skeeken, Benashi, M'kwa and Asemaa during interviews.

one will be paid the rate of \$16.5 cents per kilometer, but if this travel involves traversing roads connecting the main highway to the destination, then NIHB calculates the portion of one's trip made on highways (at the rate of \$16.5 cents per kilometer) and side roads (\$20 cents per kilometer) to determine the total travel reimbursement one is eligible for.

There are other practices that may relate to the broader issue of Canadian medical establishment failure, including the CMA, to acknowledge the legitimacy of First Nations traditional healers. For example, health inequities exist because of the differential level of health care access maintained by funding provided by provincial travel grants through the province of Ontario's Northeastern Health Travel Grant Program (2011). This program pays higher mileage rates for medical transportation travel to Western doctors or medical appointments, but this travel funding is not available to people seeking access to First Nations healers. The Northeastern Health Travel Grant Program reimburses travel at rates more than double that of NIHB (\$0.41/km compared to NIHB rates ranging from \$16.5 cents/km to \$20 cents/km). This program is not open to those seeking access to traditional healers, whether status First Nations persons or not. According to program guidelines, one is eligible for a Northeastern Health Travel Grant, if:

- you are an OHIP insured Ontario resident on the date of treatment, and your primary place of residence is in the districts of Algoma, Cochrane, Kenora, Manitoulin, Nipissing, Parry Sound, Rainy River, Sudbury, Timiskaming or Thunder Bay;
- you are referred for specialty health care that is an insured service under the [Health Insurance Act](#);
- a northeastern physician, dentist, optometrist, chiropractor, midwife or nurse practitioner has referred you before the travel takes place;
- you are referred to a medical specialist who is certified by the Royal College of Physicians and Surgeons of Canada (RCPSC), or a Winnipeg (Manitoba) physician enrolled on the Manitoba Health Specialist Register and permitted to bill as a specialist; **or** you are referred to a physician who holds a specialist certificate of registration issued by the College of Physicians and Surgeons of Ontario (CPSO) in a recognized medical or surgical specialty other than family or general practice; and the nearest specialist/designated health care facility able to provide the type of care you require in Ontario or Manitoba is at least 100 kilometers from your area of residence. (2011)

Amik reflected on the difficulties of providing travel based on these inadequate funding levels:

So, if I was going to send someone to (name of organization omitted), maybe all they would get is \$300 and they're traveling all the way there and all the way back and depending on the food, they won't get the meals if they leave at certain times of the day. They tell you how long it's going to take to get there. They say "You don't have to leave that early, you can leave at this time." And they don't have to pay that. So that's what they do and you don't get very much anyways. The prices on there are practically nothing (interview, March 3, 2010).

Funding provided for food and lodging only covers the person accessing treatment—not the person who may be driving them. The preapproval form allows applicants to request a “medical escort” however, these requests are approved only when a person is physically unable to drive and not when they lack access to a vehicle. If people are giving gas money to a friend or family member using medical transportation funding, then expenses such as vehicle maintenance, depreciation and insurance, which are factored into government transportation coverage, are not included. It is also difficult for those accessing travel funding to cover food and lodging expenses if they are obtaining a ride from someone.

Slow Travel Reimbursement

For those who must pay for travel expenses out of pocket, the time it takes to be reimbursed can be a month or more. When M’Sheeken returned from travel, she had to make copies of all the receipts, letters and forms that comprised her travel package. She then mailed this to NIHB, waited for a period of time, did not hear anything for about a month, called to inquire about the status of her reimbursement and then was informed that NIHB lost it within their office:

They told me to go, get the receipts and then come back with those receipts and then send them back. They (NIHB in Thunder Bay) lost everything the first time I mailed it in; I had to mail it in again and then it took two months to get reimbursed. It was a good thing I photocopied everything (interview, September 12, 2009).

Consequently, even if the forms are correctly filled out, it can take an unreasonable amount of time to be reimbursed for travel expenses. This is important to note because paying up front and waiting up to several months for reimbursement creates a real financial hardship. For people struggling financially, even if resolute enough to tolerate the hurdles of the preapproval (or disapproval) process, this final insult also deters them from applying.

Geographic Barriers

Only Interprovincial Travel Allowed

State jurisdiction imposed on First Nations people impedes access to healers. For First Nations people living in Ontario, funding is only provided for travel within the province and not other provinces or the U.S. regardless of proximity to the border. Because of this, even though it may be more cost effective for someone living in Sault Ste Marie, Ontario to access a healer across the U.S.-Canada border in Sault Ste Marie, Michigan (roughly 7 km away), federal travel restrictions prohibit this. Amik explained that people seeking healers in Sault Ste Marie, Michigan only receive travel funding to the Ontario side of the U.S. border. To help clients, she often drives them to the U.S., pays bridge tolls out of her own pocket, and then drives them back to Ontario after treatment. It is difficult to understand how travel is covered for more costly long distance trips, such as accessing a healer in Toronto, which takes about 9 hours of travel (according to Mapquest) and is roughly 586 kilometers each way, but not for nearby Sault Ste Marie, Michigan (2010).

Social Barriers

Lack of Social Support Networks

For many living off-reserve, social segregation and lack of support networks present a barrier to access. This barrier pertains to the emotional distance one feels or experiences when they live away from home and find they are treated like strangers by their home community when they call for help. These sentiments were articulated by M'Sheeken:

It's kind of shitty to be an Indian off-reserve. You really feel like an outsider to your own geographical community and sometimes to your own community. There are these labels, and divisions and invisible boundary lines that are put there and you are just standing there going "What the heck?" What hoops do I have to go through now? (interview, September 12, 2009)

Many people living off-reserve feel socially isolated because they are away from their home community, family and social support networks. A First Nations person living in a non-Native community off-reserve without these supports often feels isolated. Calling their own communities to inquire about accessing this service and being treated with disrespect makes them feel even more isolated and alienated.

Conclusion

For applicants tenacious enough to stick with it after starting out, the stress created by barriers they encounter seeking travel funding often negates the wellness obtained by accessing traditional medicine. The NIHB process is marked by significant obstacles including paying up front, numerous gatekeepers, lengthy time delays, long preapproval waits, lack of social support networking, inadequate funding for transportation, only allowing interprovincial travel and the general lack of help and inconsistencies provided by NIHB. Workers described that many applicants who inquire about traditional healer travel funding simply laugh and walk away when told how difficult it will be to actually obtain it. Just knowing about the barriers and complexity of obstacles that await applicants overwhelms and discourages many living off-reserve from seeking funding they are entitled to.

It is also disheartening to find access so greatly affected by one's social class. Health Canada (2010), which proclaims on its website that it "is working with First Nations people and Inuit to improve their health," falls far short of this goal by maintaining an inequitable health transportation access system that is socially and economically biased against First Nations people. Inappropriate advantages in access should not be conferred to the "more educated" and "affluent" (Weengusk, 2010) among First Nations people because this replicates the inequity of Canadian class relations and limits good health and wellness. In addition, providing medical transportation on the premise that it "improve(s) their health" when in reality maintaining unequal and differential benefits to those living off-reserve is unfair and ultimately pits First Nations people against each other in competition for limited financial resources.

First Nations people live in a world of polar opposites. We face disjunctures everyday between programs, policies and laws claiming to help us, but which actually do the opposite. In our dealings with the government, particularly where our communities are involved, we have become accustomed to seeing significant differences between what is officially said and what actually happens. Obtaining access to travel funding to see traditional healers through NIHB is just one example of these disjunctures.

The *Traditional Healer Services Travel Policy* allows the government to have it both ways. On one hand, it appears publicly supportive of First Nations traditions and culture by maintaining it, but on the other hand, by making it so inaccessible; they do not have to properly fund it. First Nations programs and services often contain neoliberal rhetoric about promoting self-sufficiency and personal responsibility while simultaneously increasing dependence on a central authority, such as the band office or Department of Aboriginal Affairs.⁸ Further, we are forced to seek permission before undertaking projects aimed at increasing self-sufficiency, such as establishing businesses, building homes or even organizing grass roots committees, from the very people and organizations that often play a role in oppressing us.

This duality seems ingrained within the social organization within which we exist. We have become so accustomed to hearing one thing officially and seeing something completely different in actual practice that it is now a point of reference within our operating framework. For example, we have treaties to protect our rights and land, but are subjected to laws like the *Indian Act* that take away our rights and land. We are expected to find ways of self-governing and often try to do with initiatives such as forming customary band election codes, only to find that they have to be approved by Indian Affairs before we can actually use them.

For people seeking wellness, being able to access traditional healers is a life changing activity. When someone is facing challenges relating to economic and social class relations, being able to obtain travel funding to do so can be the difference between obtaining bimaadiziwin (good life) or remaining mired in unhealthy life circumstances. In closing, one participant remarked how critical the nature of access to traditional healers is to achieving bimaadiziwin and peace of mind:

It's really small in the grand scheme of things, but you know what? Tonight that person is going to have great dreams. They are going to be comforted knowing that three weeks down the road they are going to be going somewhere where they are going to get some help (Megis interview, 2009).

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⁸ Until 2011 this organization was named the Department of Indian Affairs and Northern Development.

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Appendix 1

Glossary of Terms⁹

Elders - Within First Nations communities, elders are often those who have reached the point in their own lives, by virtue of their life experience, in which they can begin to serve as resource people in matters of spirituality, leadership, traditional matters, community affairs, counselling and guidance.

Anishinabek – This term is commonly used to refer to First Nations people of Ojibway, Odawa and Potawatomi ancestry. The historical territory of this group encompasses roughly one-third of Turtle Island (North America).

Traditional Healers – people who have learned or spent a considerable period of their lives learning/apprenticing from elders/traditional healers and who provide these services to those seeking healing in such aspects of ceremony to include herbalism, traditional doctoring, spiritual guidance, or other aspects as required.

Reserve – According to the Indian Act (2002, 3), a reserve “means a tract of land, the legal title to which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of a band.”

Indian - According to the Indian Act (2002, 2), this “means a person who pursuant to this Act is registered as an Indian or is entitled to be registered as an Indian.”

Band - According to the Indian Act (2002, 1), this “means a body of Indians (a) for whose use and benefit in common, lands, the legal title to which is vested in Her Majesty, have been set apart before, on or after September 4, 1951, (b) for whose use and benefit in common, moneys are held by Her Majesty, or (c) declared by the governor in Council to be a band for purposes of this Act.”

Band Council - According to the Indian Act (2002, 1), a “council of the band” means (a) in the case of a band to which section 74 applies, the council established pursuant to that section, (b) in the case of a band to which section 74 does not apply, the council chosen according to the custom of the band, or where there is no council, the chief of the band chosen according to the custom of the band.”

⁹ Additional definitions are also provided within the *Medical Transportation Policy Framework of Non-Insured Health Benefits* (pages 21-22).

Appendix 2

List of Participants

1. M'Sheeken (Turtle) is Anishinabek-kwe and lives off-reserve in northern Ontario. She accessed the Medical Transportation Policy to obtain travel funding to see a traditional healer and described her experiences. (interview, September 12, 2009)
2. Megis (Shell) is Anishinabek from a reserve in northern Ontario. He lives off-reserve and obtained travel funding to see a traditional healer from off-reserve. (interview, September 19, 2009)
3. Ookwemin (Black Cherry) is Anishinabek-kwe and lives off-reserve in northern Ontario. She accessed the Medical Transportation Policy to obtain travel funding to see a traditional healer and described her experiences. (interview, July 7, 2010)
4. Amik (Beaver) is Anishinabek-kwe and has worked in the field of traditional health and wellness for about 15 years. (interview, March 3, 2010)
5. Ninatig (Maple) is Anishinabek-kwe and has worked as a healer's helper and front line worker in the field of traditional health for over 20 years. (interview, June 23, 2010)
6. Mohneeze (Mary) is Anishinabek-kwe and has worked in First Nations health and advocacy organizations in Ontario for over 20 years. (interview, September 16, 2009)
7. Asemaa (Tobacco) is Anishinabek-kwe been a front line worker in First Nations health organizations for over 20 years. (interview, April 7, 2010)
8. Benashi (Bird) is Anishinabek-kwe and has worked as a front line worker and a manager in various First Nation health organizations for over 16 years. (interview, February 8, 2010)
9. M'kwa (Bear) is Anishinabek-kwe and has been worked in the field of First Nations health for over 20 years. (interview, February 18, 2010)
10. Nodin (Wind) is Anishinabek-kwe and has worked in First Nations health programs for over 20 years. (interview, April 12, 2010)
11. Giizhik (Cedar) is Anishinabek-kwe has worked in First Nations health and advocacy programs for over 20 years. (interview, September 23, 2009)
12. Migizi (Bald eagle) is Anishinabek-kwe and has worked in First Nations Health policy and First Nations health in northern Ontario for over 20 years. (interview, September 17, 2009)
13. Odemin (Strawberry) is a non-Native official in a northern Ontario First Nations centre. (interview, April 20, 2010)
14. Papasse (Woodpecker) is Anishinabek-kwe and has worked in First Nations health for over 35 years. (interview, September 4, 2009)
15. Weengushk (Sweetgrass) is a non-Native physician working in a First Nations health in northern Ontario. (interview, October 1, 2009)

16. Waagoosh (Fox) is a non-Native nurse working in a First Nations health in northern Ontario. (interview, February 25, 2010)
17. Myeengun (Wolf) is a First Nations Elder and healer who has been involved in First Nations health and wellness programs and services for over 40 years. (interview, January 21, 2010)
18. Ginoozhe (Northern Pike) is an Anishinabek Elder and healer who has traveled throughout Canada over the past 30 years. (interview, March 16, 2010)
19. Aagimaak (Black Ash) is an Anishinabek Elder and a healer who has worked with First Nations people for over 30 years. (interview, June 30, 2010)
20. Wiigwaas (Birch) is Anishinabek-kwe and has worked in the field of traditional health for many years. She is Ginoozhe's oshkebewis (helper). (interview, March 16, 2010)
21. Mitigomizeh (Oak) is Metis-kwe and has accessed traditional healers and lived in northern Ontario all of her life. (interview, June 11, 2010)