

A Guide for Working with Aboriginal People of Northwestern Ontario

A Stroke Resource for Healthcare Providers



healthy
together

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Preface

My dad once said “The White people were given the gift of their medicines. We were also given the gift to know our medicines. Do not reject either one. Both are good”.

My dad was a wise, humble and loving human being. My dad was in his late 90’s when he passed away. My dad will always be in my heart as well his life teachings which I hope I am living his teachings.

For most of the Aboriginal people, the meaning of the medicine goes beyond prescription that a regular doctor may prescribe to their patients to, hopefully, heal or control a physical illness. For many Aboriginal people, the definition of medicine includes the following: connection to mother earth, going for a walk in the bush, a smudging ceremony, a gathering with a community, a sunrise, playing with a child, sitting down with an Elder to share is medicine.

From what I have seen, there are more and more Aboriginal people returning to their medicines and traditional healing ways. The uses and the practices of the medicines among all Aboriginal people can be similar but unique as well.

There are Aboriginal people, who have chosen to utilize both Aboriginal and non-Aboriginal medicines. And

yet another group may decide to use Aboriginal medicines only. The last group will use non-Aboriginal medicines. What is common among the group is they are seeking to be healthy in all aspects of their lives. So, I believe all the medicines are all equally important and play a role in gaining our health and well-being.

My dad had also said “all those things we used to make medicines came from all sources available to us and we were all given what we need to live on earth from our Creator” As my dad said “all is good”

Today, there is more and more information about Aboriginal people, their beliefs, values, practices, traditional teachings, ceremonies and medicines are available to explore and read. To be able to provide the best health care to the Aboriginal population, it is a good thing to have some knowledge and insight into who we are and where we come from.

To the health care providers, it might be a good idea to ask questions of your patients what they practice and use. The knowledge will assist you to provide the best health care and treatment.

Brenda M. Mason, Elder

Revised March 5, 2012

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Purpose

This toolkit provides clinical and educational tools, Aboriginal history, stroke information and best practices, which can assist health service providers to engage and offer effective stroke-related education and care to Aboriginal individuals and families.

Ontario is home to a diverse mix of Aboriginal groups and cultures. There are three main Aboriginal groups in Ontario; First Nations, Inuit and Métis. For this toolkit, the term “Aboriginal” refers collectively to these Aboriginal groups and cultures living in Ontario.

Target Audience

This toolkit was designed for healthcare professionals (e.g., clinicians, healers) and health providers (e.g., family health teams, community agencies, healing centres and hospitals) that work with Aboriginals, their families and communities at any stage of stroke prevention, care or recovery. This toolkit refers to these audiences collectively as health service providers.

Contact Information

All feedback on the content of this toolkit should be directed to the Northwestern Ontario Regional Stroke Network at nwestroke@tbh.net. This document was published by the Northwestern Ontario Regional Stroke Network in March 2012.

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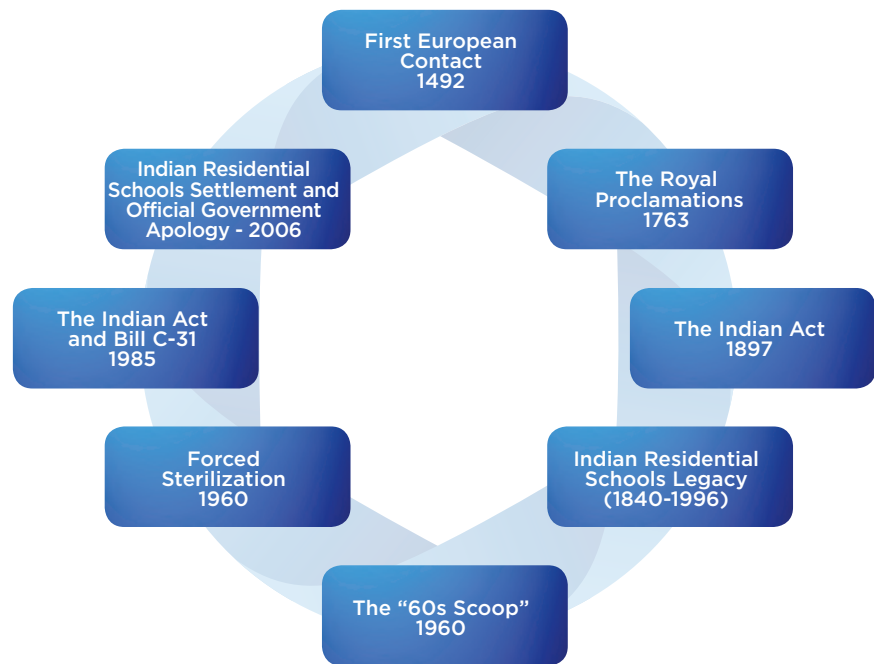
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Section 1: **Canadian Aboriginal History**

Introduction

It is widely accepted that Canada's history of colonization and assimilation practices toward Aboriginal People has negatively impacted their ability to maintain traditional ways of life (King, Smith & Gracey, 2009). These negative impacts include loss of land, culture and language, and have been shown to have had a lasting impact on Aboriginal individuals' quality of life (Hill, 2003). As a health service provider working with Aboriginal individuals, it is important to understand their history and health issues. It is equally important to remember that each individual is unique (whether Aboriginal or not) and that these events may or may not be relevant. (Government of Saskatchewan, 2009)



Historical Events

Before European Arrival

Aboriginal people were living in North America long before Europeans arrived. While difficult to determine, it is believed that there were approximately 500,000 people living in what is now Canada (with estimates ranging from 200,000 to 2,000,000) (O'Donnell, 2008). These people were organized into approximately 600 communities (also known as tribal groups or bands). Many of these communities had similar characteristics, including being divided into clans based on lineage (i.e., the line of descendants of a particular ancestor), and holding the belief that all elements of nature were sacred. As clan members married into other clans, these communities grew. It is also believed that Aboriginal people enjoyed relatively good health during this period, including control of disease, as well as high levels of physical and mental wellness.

First Interactions (1492)

When Christopher Columbus arrived in South America in 1492, the Aboriginal people were welcoming. The Spanish however, tortured, abused, killed and enslaved Aboriginal people. It is estimated that the Aboriginal population was reduced by half during the first two years of Columbus' rule. The Europeans also had doubts as to whether Aboriginal people in the Americas were human (at this time only Christians were

considered human). However, in 1512, Pope Julius II declared that "Indians are truly men...they may and should freely and legitimately enjoy their liberty and possession of their property; nor should they be in any way enslaved."

The Royal Proclamation (1763)

The Royal Proclamation of 1763 established British protection over unsettled land belonging to Aboriginal communities, and recognized Aboriginal ownership of land not already colonized. This Proclamation is considered to be one of the strongest guarantees of Aboriginal land rights.

Struggle to Maintain Aboriginal Identity

By the 19th century, government policies changed to reflect "colonial dominance" of the Aboriginal nations. The new Dominion of Canada no longer needed Aboriginal people as allies in war, or required their skills for the fur trade. Instead, the Dominion needed land for new settlers. This led to a new goal for the Dominion: Aboriginal assimilation through legislation.

The Indian Act (1867)

The Indian Act describes the administration of almost every aspect of Aboriginal life. It had three main principles: 1) to civilize Aboriginal people, 2) to manage Aboriginal people and their lands; and 3) to define who could and could not hold "Indian Status."

This legislation was designed to assimilate Aboriginal people into European culture. Aboriginal people became wards of the state, and their land became "reserves." Previously signed treaties were ignored and Indian Agents were hired to enforce the new legislation. The intent of the Indian Act is best summed up in the words of Duncan Campbell Scott, the Deputy Superintendent of Indian Affairs from 1913 to 1932:

I want to get rid of the Indian problem... Our objective is to continue until there is not a single Indian in Canada that has not been absorbed into the body politic and there is no Indian question and no Indian department (Leslie, 1978).

Christianity was imposed on Aboriginal people as a means of civilizing them. Cultural ceremonies, such as Sweat Lodges and Shaking Tent were outlawed in 1884. Persons caught celebrating these events could be imprisoned. Banning these traditional gatherings assisted missionaries in their attempts to replace Aboriginal beliefs with Christian beliefs.

The right to vote was a major feature of the Indian Act. If an Indian person accepted the right to vote (or own property or serve in the military), he or she had to relinquish their Indian Status. This was not changed until 1960, when the Federal Elections Act was amended to allow Indian people to vote.

Section 1: Canadian Aboriginal History

From then on, an Aboriginal person could retain Indian Status and be a Canadian citizen at the same time.

The Indian Act also spelled out conditions for being an Indian woman. It considered any woman married to an Aboriginal man to be an Indian, fully allowed to live and be buried on a reserve (i.e., she gained Indian Status). However, an Aboriginal woman married to a European man was considered a member of Canadian society (i.e., she and their children lost Indian Status).

A **Shaking Tent** rite was a popular ceremony among the Ojibwa, Innu, Cree, Penobscot and Abenaki. The client would pay a Shaman to build his or her tent and the Shaman would enter it at dark. Singing and Drumming was used to summon the Shaman's spirit helpers, whose arrival was signaled by the shaking of the tent and animal cries. The spirits were used to cure the ill and for anti-sorcery.

The **Sweat Lodge** has been called "the most powerful structure in the world." It is a place specially constructed to conduct ceremony. Sweats vary from purification and cleansing to healing sweats. It is said that the Sweat Lodge during ceremony "responds" to what the participants need.

(Anishinawbe Health Toronto)

Residential Schools (1840-1996)

The Indian Act required Aboriginal parents to send their children to residential schools. These schools had three objectives: 1) to convert Aboriginal people to Christianity, 2) to teach reading, writing and arithmetic, and 3) to develop Aboriginal children into farmers and housekeepers.

Children were forcibly removed from their families and placed in schools located in remote areas. The use of any Aboriginal language was prohibited, and children were punished severely for speaking their language, even if they did not speak/understand English. As a result, many children died of poor health conditions at the schools.

Many ran away from school and were severely punished upon their return. Others encountered sexual abuse by school officials and/or suffered severe psychological harm as a result of their suppressed Aboriginal identity.

Within these institutions, Aboriginal children lost their culture, identity and traditions, as well as trust and respect for others and themselves. These were replaced with feelings of shame and low self-worth. Furthermore, those who were not direct victims of abuse were often witnesses, and suffered the effects of intergenerational trauma.

Residential schools began a legacy of despair for Canadian Aboriginal communities. The schools had nearly destroyed Aboriginal communities by suppressing traditional language, culture and spirituality. It has been argued that many Aboriginal people lost their knowledge of traditional parenting practices during this era. The last of the 130 residential schools closed in 1996.

Reserves

In order to develop land across Canada, the government pressured Aboriginal people to settle on reserves. Reserves were kept far enough apart to discourage communities from forming alliances against the government. Indian Agents were sent to reserves, where they lived and were heavily involved in many aspects of Aboriginal life such as:

- Education, law and order
- Granted permission for Indians to leave the reserve (doing so without permission could result in imprisonment)

During this time, the federal government also had control over the financial transactions of Aboriginals. This meant that any sales and purchases were strictly monitored under a permit system. Aboriginals needed a permit to:

- Sell cattle, grain, hay, firewood, lime, charcoal and produce grown on the reserve
- Buy groceries or clothes

As Aboriginal communities developed their own elected governments during the fifties and sixties, they eventually did away with the role of the Indian Agent and the permit system.

Forced Sterilization

In the sixties, British Columbia and Alberta developed policies to stop "mental defectives" from having children. These policies stipulated consent was no longer required to perform sterilizations when a client was deemed mentally defective or "incapable of intelligent parenthood." Aboriginal women became targets under this policy and a disproportionately high number of Aboriginal women were sterilized.

The Sixties Scoop (1960-1985)

The sixties scoop (also known as the stolen generation) refers to the adoption, under the expanded Children Welfare Act, of approximately 20,000 Aboriginal children by non-Aboriginal families across North America. To "protect" Aboriginal children, welfare workers removed them from their families rather than trying other interventions or counseling. These children were often apprehended from their homes without the knowledge or consent of their families or communities and had no mechanism to contact their birth families (Philip, 2002).

Bill C-31 and Bill C-3 (1985, 2010)

According to the Indian Act, Aboriginal women lost their Indian status if they married a man who did not also have Indian Status. Her children would also not receive Indian status. However, this was in conflict with the Canadian Charter of Rights and Freedoms which guaranteed protection of rights equally for men and women. Bill C-31 (passed in 1985) amended the Indian Act to give these women and their children status. By 1992, over 81,000 people had regained status.

On March 11, 2010, the Federal Government introduced legislation to enhance gender equity in the Indian Act. Bill C-3 ensures that grandchildren of women who lost status as a result of marrying non-Indian men gain Indian Status in accordance with the Indian Act (INAC, 2010).

Residential School Apology (2008)

Two years after the federal government reached a \$1.9 billion settlement with the survivors of residential schools, the Prime Minister (Stephen Harper) formally apologized to the survivors and their families on June 11, 2008. Excerpts from his speech:

The treatment of children in Indian Residential Schools is a sad chapter in our history...I stand before you, in this Chamber so central to our life as a country, to apologize to Aboriginal people for Canada's role in the Indian Residential Schools system...The government now recognizes that the consequences of the Indian Residential Schools policy were profoundly negative and that this policy has had a lasting and damaging impact on Aboriginal culture, heritage and language. While some former students have spoken positively about their experiences at residential schools, these stories are far overshadowed by tragic accounts of the emotional, physical and sexual abuse and neglect of helpless children, and their separation from powerless families and communities. The legacy of Indian Residential Schools has contributed to social problems that continue to exist in many communities today (Canada, 2009).

Summary

Knowledge regarding the devastating impact of colonization and other historical events on Aboriginal communities is critical to understanding the current Aboriginal physical, emotional, mental and spiritual health status. These events have resulted in loss of culture, values, language and kinship between communities. They have been shown to contribute to high incidence of family violence, sexual abuse, substance abuse, suicide, social issues and widespread chronic disease for Aboriginal Canadians.

Today, Aboriginal leaders are taking responsibility for healing the grief and loss in their communities. As well, Elders continue to pass on the knowledge and wisdom to keep Aboriginal culture and traditional healing methods alive for future generations.



“I just want to be accepted, respected and honoured for who I am and what I do”.

Brenda Mason, Elder



Section 2: **Aboriginal Health Status**

As a health service provider, one of the ways you can provide care in a culturally sensitive manner is by becoming familiar with each client’s customs, beliefs and values. For example, when working with an Aboriginal who is either at-risk of having a stroke or a stroke survivor, a general understanding of their culture, beliefs and values will likely facilitate improved communication. It will also be useful to have awareness of the social determinants of health which directly impact Aboriginal communities. This section of the toolkit will provide a summary regarding the health status of Aboriginal People across Canada, as well as their culture and beliefs regarding health and medicine.

Social Determination of Health is the premise that one’s health is determined by complex interactions between social and economic factors (e.g., family size, wealth and education), the physical environment (e.g., living conditions) and individual behaviour (e.g., smoking, level of physical activity) (Canada, 2009).

Social Determination of Health

A recent Health Canada report indicated that Aboriginal Canadians have poor health, when compared with the rest of the Canadian population. Furthermore, these health outcomes are likely somewhat due to poor social, living and economic conditions (listed below). There is also evidence that Aboriginal Canadians have more negative health behaviours than the rest of Canadians (e.g., higher rates of smoking).

Social Determinant of Health	Aboriginal Population	Canadian Population
Overall smoking rate	58.8%	24.2%
Report heavy drinking on a weekly basis	16%	7.9%
Body Mass Index (BMI) = at least overweight	73%	48%
50-59 year olds who have had a mammogram	73.3%	88.3%
Holding a university certificate, diploma or degree*	5.1%	22.7%
Graduated from high school by age 20*	36%	84.6%
Unemployment rate*	27.7%	7.3%
Employment rate*	37.4%	61.7%
Median annual income*	\$10,631	\$22,274
Households below CMHC adequacy standards*	22.4%	2%

*Compared on-reserve Aboriginals with general Canadian population (Canada, 2009).

Beyond the social determinants that affect the health of all Canadians, the negative impact of certain historical events (e.g., residential schools) on the current health status of Aboriginal Canadians is widely accepted. A literature review by King, Smith & Gracey (2009) reported that historical factors including colonization, globalization and migration have created some unique social determinants of health for Aboriginal Peoples, including loss of language, loss of culture and disconnection from the land; all of which have negatively impacted the health of Aboriginal Canadians. As an example, having a strong “connectedness with the land” has been shown to positively affect the health of Canada’s Inuit communities (Kirmayer, Fletcher & Watt, 2009).

Many Indigenous groups believe that the devastation of their lands through globalization and commercial exploitation and climate change is equivalent to a physical assault... Kirmayer and colleagues thus point out that the widespread destruction of the environment through commercial developments should be understood as attacks on Aboriginal individuals and communities that are equivalent in seriousness to the loss of social role and status in a large-scale urban society. As traditional custodians of the land, dispossessed Indigenous peoples have lost their primary reason for being. Additionally, these investigators, in their studies of the Inuit of northern Canada, showed that mental health and healing can be powerfully affected by eating country food, hunting, and camping on the land (King, Smith & Gracey, 2009, p.81).

Demographics

The 2006 census indicated that the number of Canadians with self-reported Aboriginal ancestry was 1.17 million (representing 4% of Canada's population). It also indicated that the First Nations population grew by 45% from 1996 to 2006. The biggest contributing factor to this growth was fertility, as the Aboriginal birth rate was 1.5 times the overall Canadian rate. This growth is nearly six times greater than that of the non-Aboriginal Canadian population, making Aboriginals one of the fastest growing population groups (Statistics Canada, 2006).

Aboriginal Group	2006 Population	% Increase (1996-2006)
First Nations	698,025	45%
Métis	389,785	91%
Inuit	50,485	26%
Total	1,172,790	9%
Multiple & other*	34,500	34%

*Includes persons who reported >1 Aboriginal identity group and those who reported being a Registered Indian and/or Band member without reporting an Aboriginal Identity (Statistics Canada, 2006)

Numbers may be limited as they are based on individual Who actually identified self as Aboriginal. Data collection in 2006 differed from previous data collection. Use with caution for growth percentage.

In Ontario in 2006, the census indicated there were 242,495 self-identified Aboriginal individuals (representing 2% of the Ontario population). The table below reports the Canadian population and Thunder Bay Aboriginal population (Statistics Canada, 2006).

Census Area	Total Population	% that is Aboriginal	Total Population Size		
			First Nations	Métis	Inuit
Canada	31,241,030	4%	698,025	389,780	50,480
Thunder Bay	121,055	8%	7,420	2,370	40

*Ontario only (Statistics Canada, 2006)

In 2006, approximately 65% of Aboriginal people lived in an urban area. Another 18.3% lived in non-reserve rural areas. The 2006 Ontario Aboriginal population was much younger than the non-Aboriginal population. The median age of the Aboriginal population was 29.7 years, compared with 38.9 for non-Aboriginal people (Statistics Canada, 2006).

2006 Population	Total	Male	Female
Total Ontario	12,028,900	5,877,875	6,151,020
Total Aboriginal Ontario	242,490	117,585	124,900
First Nations (single response)	158,400	75,955	82,440
Métis (single response)	73,610	37,025	36,580
Inuit (single response)	2,035	940	1,100
Multiple Aboriginal Responses	1,905	885	1,025
Other Aboriginal Responses	6,540	2,785	3,755
Registered Indian Status	Total	Male	Female
Registered Indian	123,595	58,780	64,815
Not a registered Indian	11,905,300	5,819,095	6,086,205
Characteristics of Aboriginal Population	Total	Male	Female
Median Age	29.7	28.5	30.8

(Statistics Canada, 2006)



Section 3: **Aboriginal Health Beliefs**

Philosophies on Health and Wellness

Ontario is home to a variety of Aboriginal people: Algonquin, Mississauga, Ojibway, Cree, Odawa, Pottowatomi, Delaware, and the Haudenosaunee (Mohawk, Onondaga, Onoyota'a:ka, Cayuga, Tuscarora, and Seneca) (Spotton, 2007). Northwestern Ontario is home to Ojibway, Oji-Cree and Cree. It is important to remember that each Aboriginal community in Ontario has unique characteristics and needs. These include different languages, spiritual beliefs, history and cultural teaching. However, there are a number of common, fundamental traditions and cultures that are listed below. Understanding and respecting the cultural practices of an Aboriginal client will help support an effective treatment plan.

Wholistic Perspective

Ontario's Aboriginal population has a wholistic perspective on health and wellness. This means that physical, emotional, mental and spiritual wellness are each a component of good health. Furthermore, when these components are balanced, an individual is in harmony with nature. Aboriginal culture also includes the concept of connectiveness, which describes the connection between the Aboriginal people and Mother Earth.

Today, Aboriginal leaders are taking responsibility for healing the grief and loss in their communities. As well, Elders continue to pass on the

knowledge and wisdom to keep Aboriginal culture and traditional healing methods alive for future generations.

Aboriginal Connectiveness – Aboriginal individuals, families, communities and nations are connected in the Sacred Circle. An emotional, physical, mental and spiritual imbalance affects everyone.

It is important to recognize that every treatment has a cultural component. Western medicine is primarily focused on diagnosis as an outcome, whereas Aboriginal medicine focuses more on the environment in which the patient may recover.

It is important to remember that within the Aboriginal population there are hundreds of tribes. Each one of these tribes is somewhat the same but have a variance in their tribal belief systems, community practices and different languages



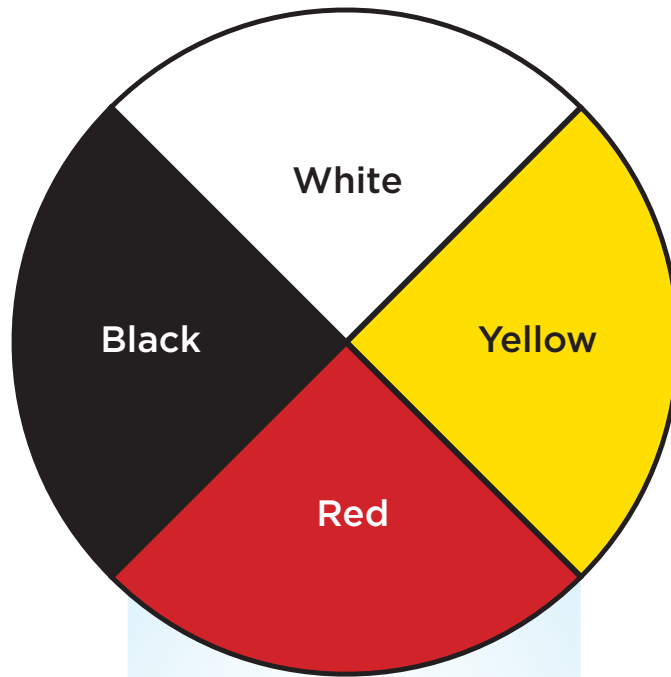
Religion: Please do not assume that all Aboriginal people are practicing traditional ways. Some Aboriginal people are Christian, some are traditional and some are a combination of both.

The Sacred Medicine Wheel

Numbers have always played a significant role in traditional Aboriginal culture. The number four, for example, is one of the most sacred. The Medicine Wheel is a ceremonial healing tool built around the number four. The Aboriginal population values the Medicine Wheel as a holistic and sacred symbol, given to them by the Creator.

The Medicine Wheel can be expanded to include other wheels, such as the emotions wheel, or the mind wheel. These wheels may be used to explain or examine emotions that impede personal growth. It requires many years to learn each wheel's teachings. Collectively, the wheels symbolize that an individual must balance wellness of mind, body and spirit, as well as live in harmony with the natural environment. An Aboriginal client may consider illness to be the result of an imbalance in one or more of these areas.

It is important to recognize that every treatment has a cultural component. Western medicine is primarily focused on diagnosis as an outcome, whereas Aboriginal medicine focuses more on the environment in which the patient may recover.



How it works: The wheel revolves endlessly in a clockwise direction, symbolizing the continuous cycles of life. It also symbolizes the Powers of the Four Directions and the interrelatedness of all life's elements.

How it was taught: The Medicine Wheel was originally explained with a circle being drawn in the earth. The symbols were then gradually drawn as their meanings were explained by an Elder. The Elder would begin with an explanation of the four directions: north, east, south and west. He may then have gone on to explain some of the following concepts:

- The changing seasons: early fall, fall, winter, early spring, spring and summer.
- The four stages of life: childhood, adolescence, adulthood and old-age.
- The races: red, white, black and yellow.
- The four elements: water, air, fire, and earth.
- The four sacred medicines: tobacco, cedar, sage and sweetgrass.

Section 3: Aboriginal Health Beliefs

Traditional Medicine

Aboriginal populations use a variety of natural resources to create medicines. The four sacred medicines include tobacco, cedar, sage and sweetgrass, and can be used as part of a healing practice or ceremony. These medicines, healing practices and ceremonies are often collectively referred to as traditional Aboriginal medicine. The World Health Organization (WHO) defines traditional Aboriginal medicine as:

The sum total of knowledge, skills and practices based on the theories, beliefs and experiences Indigenous to different cultures, whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement of treatment of physical and mental illness.

Aboriginal medicine contains folk remedies and treatments passed down over time. Many formed the basis and can be found in Western pharmaceutical treatments.

The Four Sacred Medicines

Tobacco (the East) is always used first as an offering for everything and in every ceremony. Tobacco is given to the Aboriginal people so they may communicate with the spirit world. It opens up the door to allow that communication to take place. Offering Sacred Tobacco is a way of giving thanks in advance of a request. Tobacco is generally not smoked, except on special ceremonial occasions.

Sweetgrass (the North) is used for purification of thoughts and the environment.

Cedar (the South) is used for purification of the home and protection. It also has restorative medicinal uses. Cedar grows during the winter months reminding the Aboriginal people that medicines are always available. When cedar is put into the fire with tobacco, it crackles, calling the attention of the spirits.

Sage (the West) is used to prepare people for ceremonies and teachings. Sage is used for releasing what is troubling the mind and for removing negative energy. It is also used for cleansing the homes and sacred items.

Adapted from Aboriginal Perspectives on Health and Wellness, Marilyn Morley, Webinar Series, 2009

The following are examples of plant medicines used primarily in Northwestern Ontario:

Plant / Medicine	Use	Preparation	Medicinal Content
Balsam Fir	Colds	Inhale Vapors	Nasal Stimulant
Mountain Ash	Allergies	Tea From Bark	Antihistamine
Cedar	Allergies	Tea From Boughs	Antihistamine
Poplar	Back Pain	Tea From Roots	Analgesic

It is important to note that most substances (e.g., traditional medicines/medication) have active ingredients which can affect health and interact with other medicines/medication. Similar to the health service providers who practice western medicine (i.e., modern practices aimed at restoring and maintaining health by preventing and treating illness), traditional medicine is usually provided by a number of specialized Aboriginal practitioners. A publication by Canada's National Aboriginal Health Organization (NAHO) describes the roles of these practitioners (Hill, 2003). The Helper description was gathered from the Alberta College of Social Workers' Aboriginal Social Work Committee (Gladue et al., 2008).

“You have to use them (tobacco plants) with respect, as prayers and offerings in ceremonies, so they’ll reward you. But if you use them without respect, if you smoke them like cigarettes, their power will kill you.”

Winters, Solomon, Hill, Pego and Victoria, 2000

For further information, please go to:

http://www.med.uottawa.ca/sim/data/Aboriginal_Medicine_e.htm

DID YOU KNOW?

Aboriginals discovered the first chewing gum, which was collected from spruce trees. Some of these “chewing gums” were used to relieve toothache, headache, and indigestion.
www.aadnc-aandc.gc.ca

Section 3: Aboriginal Health Beliefs

Herbalist – A practice that emphasizes botanical and pharmacology knowledge of the indigenous plants and fauna. Often these individuals work closely with other Indigenous doctors and assist in providing remedies for individuals whom they or others have diagnosed. Their practice can be highly specialized in one field, such as remedies for snakebites, or as diverse as the illnesses themselves.

Medicine man/woman – A practice that may and often does possess all of the previously listed gifts and more. Their work usually engages in ritual, ceremonial activity and prayer. In some societies they are identified as “medicine men/women” because they possess sacred bundles, sacred pipes, sacred masks, and the rights to rituals, songs and medicines that have been inherited from their parents, grandparents, or that they earned through apprenticeship with a respected medicine man or woman. Depending on their nation, they are also conductors of community ceremonies such as Healing Circles, Shaking Tent, and Sweat Lodge, to name a few. It is normative for these individuals to sacrifice their daily lives to ritual, prayer and healing.

Healer – A gifted individual who may heal in a variety of ways, including all of the above and or a “gift” of touch, or energy work – meaning that ritual is not always needed. Healers can be ritualistic, but also may have an ability to use a variety of therapies to heal people spiritually, emotionally or physically.

Midwife – Often, these practitioners are women with specialized knowledge in prenatal care, birthing assistance and aftercare. The midwife may employ the use of massage, diets, medicines and ritual, prayers and/or counseling. Traditional midwifery exists worldwide and involves a variety of skills, often biophysical, but can also include spiritual and ritual activity as well.

Helper/Natural Helper – Aboriginal Helpers are identified by the community, Elders or family. Aboriginal community members all have responsibilities to society as “helpers” and work in various environments ranging from spiritual to community without boundaries by sector.

Aboriginal people may utilize both traditional and western health services to meet their wellness needs. These needs include broad aspects of Aboriginal health, such as culture, language and geographical location. This is true to the extent that a 2002 survey by NAHO found that 60% of the Aboriginal sample indicated loss of land and culture to be a significant contributor to poor health.



Aboriginal Families and Communities

In many Aboriginal communities, members of the same clan are considered family, linked through a common ancestry. Examples of clans include: Bear Clan, Fish Clan, and Crane Clan. Depending on the situation of your Aboriginal client, the term “family” may only refer to immediate relatives, such as a spouse, parents, siblings or children. However, “family” may also include an extended network of grandparents, aunts, uncles and cousins.

According to the rules of clan membership, each member is required to marry outside the clan to which they belong. Over generations, this may result in each family in a community being related by descent or marriage. In rural clans, where membership has remained stable over time, family and community often represent the same group. Aside from descent and marriage, Aboriginal Ontarians may be related through adoption. It is still common practice in many communities for parents to give a child to another family in the clan. In some cases, a fertile couple would agree to have one of their children adopted at birth by a childless couple. These two families would then contract a special bond with each other for life.

Similar to contemporary Canadian families, each Aboriginal family is responsible for nurturing children and preparing them to function well in society. While this goal is similar, the process is likely different:

When a young man goes out on a hill to seek the vision of who he is to be and what gifts are uniquely his, it is not because he is preparing to go out into the world and seek his fortune. Rather, he comes back to the camp or the village to obtain advice from his uncles or grandfather on the meaning of his experience, and to exercise his medicine (or personal power) in the service of his family and community (Brenda Mason, First Nations Elder).



Elders

Aboriginal communities have great respect for the wisdom gained over the course of one’s life. Individuals recognized as Elders have earned the respect of their community and are people whose actions and words convey consistency, balance, harmony and wisdom in their teachings. They hold invaluable knowledge and skills (NAHO, 2009).

Chief

The Chief is the elected leader of an Aboriginal community or clan (similar to a mayor for non-Aboriginal communities). Along with the other elected council members, the Chief leads all governance, decision-making and administration of various community services. The Chief also represents the community’s interests at the provincial/territorial level.

Decision Making

Every Aboriginal family member usually has a responsibility in decision making. Furthermore, there may be no family leader who makes decisions independently. In the event that an Aboriginal stroke survivor requires a substitute decision-maker, it may be important that all family members are included in the process, understand what decision needs to be made and are given time for contemplation.



Section 4:
**Aboriginal Culture -
Tools, Considerations and
Guidelines for Cultural Safety**

Cultural Safety/Cross-Cultural Safety

Definition and Value

As a Canadian health service provider, the services you provide to clients should be patient or client-centered. According to the Institute for Healthcare Improvement (IHI), client-centered care refers to:

Care that considers clients' cultural traditions, their personal preferences and values, their family situations, and their lifestyles. It makes the client and their loved ones an integral part of the care team who collaborate with health service providers in making clinical decisions. Client-centered care puts responsibility for important aspects of self-care and monitoring in clients' hands - along with the tools and support they need to carry out that responsibility. Client-centered care ensures that transitions between providers, departments, and health care settings are respectful, coordinated, and efficient.

Given the cultural diversity of the Canadian population, client-centered care often includes elements of cultural safety. While it is difficult to define the scope of cultural safety, Canada's National Aboriginal Health Organization (NAHO) cites the definition of culturally unsafe practices as "any actions that diminish, demean or disempower the cultural identity and well being of an individual" (2006). Cultural safety can also be extended to include an examination of the power imbalances and institutional discrimination that occur in Canadian society, or an understanding of historical elements and their relationship to current Aboriginal health status.

Practicing Cultural Safety/ Cross-Cultural Safety

There are some practical ways to provide culturally safe and culturally sensitive care. These are of course above and beyond the professional courtesies which you would show anyone at-risk of having a stroke, a stroke survivor or their family. The guidelines for practicing culturally sensitive care presented below were compiled from three sources: Bird, 2002; NAHO, 2008; and Consultation with our local Aboriginal partners.

These guidelines are presented in the following themes:

1. Communication

Establish a common communication method.

- An Aboriginal individual's comfort with eye contact, touch and personal space, as well as conversation pacing may be different than the typical non-Aboriginal person.
- Emotional control is also common among Aboriginal people. This means that certain types of speech intonation or body language may not have the same meaning for you and your Aboriginal client.
- Aboriginal people may listen passively to information you are sharing with them. This does not necessarily mean they are unengaged.
- Recognize that your discussion with an Aboriginal client or their family may have a slower pace than what you are accustomed to. Furthermore, you may need to accept some conversation pauses or silences.
- You may encounter a client or family member that makes little or no eye contact. In some Aboriginal cultures eye contact is considered rude.
- Pictures may be a helpful method of explaining or educating a client or their family.
- Ensure a translator is available for both verbal and written communication.

Know when to use direct and indirect communication.

- Your client may exhibit a type of communication requiring you to read between the lines. Explain to your client that you will ask questions to better assess and serve his/her needs, and that it is not your intent to be insensitive or offensive when asking questions.
- Encourage your client to tell their story rather than conducting a formal assessment

2. Building Rapport

Connecting with your client

- An Aboriginal client may feel as though they have no control over their care. To assist in building

rapport, focus attention toward factors that are controlled by the client, such as personal autonomy, personal goals and growth, the ability to change one's path.

- Assist the client to recount their successes in overcoming past issues. Wherever possible, discuss their options while outlining the pros and cons of each option, and let the client make a decision based on the information presented.

During the encounter

- Identify personal goals
- Recognize and reinforce personal strengths
- Identify social/community networks/resources and encourage building of social supportive networks
- Identify the client's options and rights

3. Understanding Health Beliefs and Practices

Show respect for traditional approaches to healing.

- Aboriginal clients bring their personal history, including their cultural values and beliefs to the healthcare system. Learn about your client, and the Aboriginal community you are serving, in order to teach and offer a bicultural approach to care.
- Be aware of the important aspects of Aboriginal history and the cultural amplifiers that may affect the relationship between you and your client.
- When compiling a client history, find out what band(s) or tribe(s) they belong to.
- Without requesting details, ask your client if they use traditional healing services and medicines.
- Be aware that an Aboriginal client may believe in causes and cures that do not fit with established western medical practices.
- Be aware that some Aboriginal people believe that speaking about illness may lead to its occurrence.
- Understand that for Aboriginal clients, the concept of "next of kin" may be broadly interpreted.

Explore the client's comfort with healthcare.

- An Aboriginal person may feel uncomfortable questioning authority. They may agree to something when they would actually prefer to decline or are unsure. The decision maker(s) should be encouraged to speak frankly with you about their preferences and opinions.
- Recognize that an Aboriginal person may be more comfortable with uncertainty regarding the long-term effects of illness and disability than the general population.
- Be aware that some Aboriginal people will consistently minimize health problems.
- Creating an Aboriginal-friendly environment (including Aboriginal art and design) may improve your client's and their family's comfort with healthcare. They may need to see themselves reflected in the healthcare environment.

Many Aboriginal people will listen quietly and intently to the information being shared with them. It is important not to interpret this response as being "passive".

4. Information and Support

Ensure the client and their family understands the healthcare system, as well as the resources and supports that are available to them.

- Be aware of available Aboriginal resources, support groups and accommodation services in your area.
- An Aboriginal client may feel isolated and alone especially if stroke support services are not available in his/her area. If possible, create these support systems within your practice in a safe environment.
- Be aware that Aboriginal resources and support systems are almost always limited in rural or remote areas.

- Remember that an Aboriginal client may be coming from one jurisdiction to another (federal to provincial) which brings additional limitations.

Refrain from judgment regarding traditional healing services and medicines the client may have accessed. A judgmental response could harm the trust and confidence you have established with your client.

- Discuss western medicine and its uses, and encourage the use of both western medicine and traditional medicine whenever possible.
- Suggest to your client that traditional healing and western medicine are more effective together, than separate.
- Encourage and validate your client's effort to access Aboriginal-specific resources.

5. Family and Decision Making

Encourage and support the Aboriginal client and their family. Include them in all aspects of care, decision-making, and education.

- With the client's permission, share a copy of the care plan with the Aboriginal client and family.
- Ask the client and/or family if they wish to nominate a person to speak on behalf of the family. Acknowledge and involve the person nominated.
- Include appropriate Aboriginal staff in the client's care (if available). They may provide assistance with the decision-making process, if this is agreed to by the client and family.

6. Ceremony, Song and Prayer

Offer the Aboriginal client the choice of having a healing ceremony (eg. Smudging is the first thing in ALL ceremonies) throughout their care.

- For many Aboriginal people, ceremony is essential in protecting and maintaining spiritual, mental, emotional and physical health.
- Allow time for ceremony and do not interrupt unless the physical care of the client is compromised.
- If there are concerns of why ceremonies cannot occur within your facility, discuss possible options with the team, client and family.

Be aware and respectful of sacred/ceremonial items and discuss any handling requirements with the client and/or their family.

- Participate in education and training opportunities around sacred and ceremonial processes.
- Give the family member or an Aboriginal staff member the option of caring for any items.
- Exercise particular care with gender-specific protocols for ceremonial items.
- Inform the client and/or family member of the location and any risk(s) regarding storing the items.

Moon Time

The women are honoured and respected for the gift they have been given as life givers. Women must keep themselves of good mind, body, and spirit at all times. There is a natural cleansing cycle that occurs for women each month that helps them stay healthy. Some people call this the menstrual cycle, the period, or the menses.

Very often amongst the Aboriginal people you will hear of a time called "the moon time". The name is understood to be symbolic of the grandmother moon that travels the sky at night. The moon is honoured by the women in different ways and as she becomes full once a month so do women. This is a time when the blood flows from a woman and she is considered to be at her greatest strength. It is a time for women to stay quiet, to think, and to meditate about who they are as women. This is also a time when the women should be looked after and cared for. Women are powerful during this time and, out of respect for that power, they do not attend ceremonies, feasts, and Pow-wows where sacred items such as drums, outfits, feathers, eagle whistles, rattles, and pipes will be present. In this same manner the women do not wear their outfits to dance in the circle of life at the Pow-wow. (Harold Flett)

7. Food

Become familiar with the basic principles regarding treatment of your client's food, access to traditional food and practical ways of respecting these principles.

- For example, in some cultures, menstruating women should not prepare or serve food due to their spiritual power.
- In many cases, these principles/beliefs will align with good health and safety procedures that should be practiced by staff. They should not cause excessive burden or variation from usual practices.

8. Body Parts, Tissues or Substances

Fully communicate procedures and options regarding removal, retention, return or disposal of body parts/tissue/substance.

- Record and carry out the wishes of the Aboriginal client and/or family regarding these issues.
- Different protocols can exist for remains such as placentas and bodily fluids.



9. Pending and Following Death

Learn about any Aboriginal family specific customs related to death. The family should be notified, supported and involved where death is expected.

- Be aware that large numbers of family members may be present.
 - Provide opportunities for the family to perform cultural and spiritual rites for the deceased.
 - Be respectful of ceremony and protocols, and allow time for their performance.
 - Work with the family to appoint a contact person, thus minimizing the amount of communication required. Be aware that community leaders may get involved and act as the non-family contact person.
- In some cultures, the body is not to be left unattended following death.
 - Some Aboriginal communities believe when someone is ailing, two care givers should attend. If only one attends, the ailing person may think they are dying which may result in agitation.
 - Be aware that the family may also gather and sing at the bedside prior to death and upon death to help the soul travel.
 - There may be a belief that when someone passes, the family or community must open a window or door to let the spirit go home.

Belief that death involves passage into a world that is not feared; one will meet with ancestors in the spirit world to live for eternity; dying is a time to communicate, settle differences and make peace (Turner-Weeden 1995, cited in Hotson et al 2004). An understanding of these beliefs are important so that health service providers do not accept a stereotype that Aboriginal fatalism means that Aboriginal patients are more likely to “give up” when confronted with a life threatening diagnosis.

Cultural Amplifiers

While the approaches mentioned above can assist you to provide culturally safe care, it may be valuable to consider some barriers and issues which can impede these approaches. Some of these barriers may be referred to as cultural amplifiers (i.e., cultural factors that magnify the difficulties faced by Aboriginal people when accessing healthcare [Bird, 2002]).

Barriers to Accessing Healthcare

1. Travel

- Aboriginal people may travel daily, weekly or several times a year from reserve/rural areas to urban areas. Travel occurs for many reasons, including family visits, ceremonies, job and educational opportunities, substance abuse and illness.

2. Distrust of Authority

- Aboriginal people have a long history of mistrust of the government as a result of broken treaties, lost land, reserves and residential schools, as well as ongoing experiences with racial and ethnic discrimination.

3. Fear of Breach of Confidentiality

- Breaches of confidentiality have been a serious issue in many Aboriginal clinics. This often occurs in reserve/rural communities where rumors can spread quickly, although comparable breaches also occur in urban clinics.

4. Modesty

- Many Aboriginal people are modest about their bodies and find it uncomfortable to undress, discuss their bodies or perform self-examinations. Consequently, an individual may not notice or wish to discuss personal bodily changes.

5. Language and Culture

- Many cultural elements are contained within the context of an Aboriginal language. Many words and concepts are not easily translated into English, and some cannot be translated.
- Northwestern Ontario has 3 main languages: Ojibway, Oji-Cree and Cree. There are 19-20 dialects. Check your local hospital for language resources.

6. Mortality

- High rates of mortality are a part of most family and community experiences for Aboriginal people. It is not unusual for an individual to have someone in his or her family commit suicide, be a victim of a homicide, or lose a relative in a fatal automobile accident.
- Youth suicide is a major problem for Aboriginal communities. Statistics show an Aboriginal suicide rate two to three times higher than the non-Aboriginal rate for Canada, and within the youth age group the Aboriginal suicide rate is estimated to be five to six times higher than that of non-Aboriginal youth. (Health Canada 2003)

Additional Considerations for the Clinical Encounter

A number of models have been developed to assist health service providers conduct clinical interviews with Aboriginal clients. Note: While these can help frame your clinical interview, they may not collect all the necessary information, or may include questions/areas that are irrelevant: Use as appropriate.

BELIEF Model*	LEARN Model**	ETHNIC Model***
Health Beliefs: What caused your illness/problem?	Listen to the client's perspective	Explanation: How do you explain your illness?
Explanation: Why did it happen to me?	Explain and share one's own perspective	Past Treatment: What treatment have you tried?
Learn: Help me to understand your belief/opinion	Acknowledge differences and similarities between these two perspectives	Healers: Have you sought any advice from traditional healers?
Impact: How is this illness/problem impacting your life?	Recommend a treatment plan	Negotiate mutually acceptable options
Empathy: This must be difficult for you	Negotiate a mutually agreed upon treatment plan	Agree on Intervention
Feelings: How are you feeling about it?		Collaborate with client, family and healers

*Dobbie et al. (2003), **Berlin & Fowkes (1983) and ***Levin et al. (2000)

Your Beliefs and Lens

Another component to delivering culturally safe and culturally sensitive care is understanding the preconceived notions and beliefs that you bring to the clinical encounter. The following questions and thoughts may help you reflect upon, and understand your “lens” as a health service provider.

1. What kind of energy are you emitting? Is it positive? Does it come from a place of compassion? Is it in the spirit of caring?
2. What prejudices do you have that could potentially block you from providing client-centre care?
3. What is the tone and rhythm of your voice? Are you speaking in a calm manner?
4. Do you understand the social issues affecting this person (e.g., social situation, housing and transportation)?
5. Has the client been treated with respect, care, compassion and dignity?
6. Have you understood the client’s spiritual/religious philosophies?

Health empowerment in Aboriginal communities encompasses health services that are community-driven and developed by, for and with Aboriginal communities.

Collaborating with Aboriginal Communities

As a health service provider, you may find yourself working with the Aboriginal client, their family and community in a group setting. This can be both an effective and challenging way to provide education and care (Crosato & Leipert, 2006). There are some important considerations when working with an Aboriginal community (Kowalsky et al., 1996) and have been adapted for this document.

Specific Guidelines for Working with Aboriginal Communities

- Recognize that the Aboriginal community is in charge.
- Consider the implications of the number of clinicians.
- Be honest about your motives.
- Recognize and respect the spiritual component.
- Respect confidence and guard against taking sides.
- Follow the lines of authority and show respect.
- Be aware of general etiquette expectations.

General Guidelines for Community Collaboration

- Be yourself and participate in the community.
- Monitor your feelings.
- Be ready to teach and to share ideas.
- Be prepared for the unexpected.
- Allow for time.
- Be sensitive.

- Consider what facilitates interaction with community members.
- Enjoy and allow humor.

There may also be an opportunity for you and an Aboriginal community to collaboratively develop a stroke program or service. To guide these types of collaborations, Ontario’s Aboriginal Healing and Wellness Strategy (AHWS) published *New Directions: Aboriginal Health Policy for Ontario* (1994). This document stresses the need for mutually respectful relationships with Aboriginal individuals and communities. These relationships will hopefully aid the development of effective and appropriate stroke services. Furthermore, these relationships may help mobilize the community’s involvement in your stroke initiative. Below are some other collaboration principles from the AHWS:

- Incorporate Aboriginal cultural sensitivity training as a preliminary stage to community engagement activities.
- Develop an understanding of historical colonization and its impacts on the health, wellness, and spirituality of Aboriginal people, in the context of stroke.
- Encourage an empowerment process with Aboriginal collaborators, and recognize their right to decision-making.
- Encourage the development of Aboriginal-driven health programs and services.



Section 5: **Stroke Information and Best Practices**

Stroke in Aboriginal Populations

Research has shown that Canadian Aboriginal people are twice as likely to die from stroke (71.5 per 100,000) when compared with the general Canadian population (34.2 per 100,000). Aboriginal people are also more prone to obesity with a risk just over 1.5 times that of the general population. Furthermore, the rate of diabetes among Aboriginal people in Canada is three to five times that of the general population (HSF, 2010). Consequently, it is important to understand not only the warning signs for stroke, but also the risk factors for stroke and the impact of stroke on the person, their family and the community. This information presented below has been independently researched, written and reviewed by the Heart and Stroke Foundation (2010, 2010a) and is based on scientific evidence.




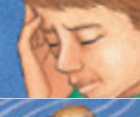

Definitions

Stroke - A stroke is a brain attack. It occurs when blood flow to the brain is interrupted or when a blood vessel ruptures. Cells in and around the stroke site begin to die and part of the brain stops working. Basic functions, such as communicating, walking, thinking, and personality, may be changed.

Ischemic Stroke - Ischemic stroke is caused by an interruption in the flow of blood to the brain (as from a clot blocking a blood vessel).

Hemorrhagic Stroke - A hemorrhagic stroke is a stroke caused by the rupture of a blood vessel with bleeding into the tissue of the brain.

Transient Ischemic Attack (TIA, also known as a “mini-stroke”) - TIA is a sudden but temporary period of decreased blood flow somewhere in the brain causing stroke-like signs and symptoms (e.g. difficulty speaking or moving one side of the body) from a few minutes up to 24 hours. Also known as a “TIA”, this is a major warning sign of a potential full stroke.

Warning Signs for Stroke & TIA	
Sudden weakness, numbness or tingling	
Sudden trouble speaking or understanding	
Sudden vision changes	
Sudden headache	
Sudden loss of balance	

Risk Factors

Non-Modifiable Factors (Meaning they cannot be controlled)

1. Age

Although stroke can occur at any age, most strokes affect people aged 65 and older.

2. Gender

Until women reach menopause they have a lower risk of stroke than men. As time goes on, more women than men die of stroke.

3. Family History

Risk of a stroke is higher if close family such as parents, sisters or brothers have had a stroke before the age of 65.

4. Family Background

First Nations, Inuit or Métis are more likely to have high blood pressure and Type II diabetes, and as a result are at greater risk of heart disease and stroke than the rest of the population.

5. Prior heart attacks, strokes or TIAs

Modifiable Factors (Meaning they can be controlled)

6. High Blood Pressure (also known as Hypertension)

High blood pressure occurs when the force of blood pushing against artery walls is too high. Constant high pressure will eventually cause damage to the artery wall and weaken it. A person cannot tell they have high blood pressure. It must be measured by a health service provider. High blood pressure is the number one risk factor for stroke and therefore it must be kept in control to reduce the risk of stroke. Medications must be taken exactly as prescribed.

FACT: High blood pressure has been found to be almost twice as common or slightly less common in Canadian Aboriginal Peoples when compared to the rest of Canada, depending on the Aboriginal subgroup being surveyed (Macmillan et al., 1996). Regardless of this discrepancy, higher rates of obesity

and smoking (which are associated with higher rates of hypertension) make high blood pressure a significant risk factor for stroke in Aboriginal communities.

7. Lack of Physical Activity

People who do not participate in regular physical activity have a higher risk of stroke. An active, healthy lifestyle can assist in managing high blood pressure, high blood cholesterol, excess weight and stress. Adults should participate in 30 to 60 minutes of moderate physical activity every day. It is important to start an exercise program slowly and increase the level of activity over time. Consider choosing activities that are enjoyable and fun and can be done with family and friends.

FACT: Only 21.3% of First Nations adults living on-reserve get sufficient physical activity (i.e., greater than 30 minutes of moderate to vigorous activity for four or more days per week) (Canada, 2009).

8. Overweight

Being overweight places more strain on the heart and is associated with high blood pressure. People that are overweight carry a higher risk of having a stroke. Some of the things that people trying to lose weight should consider include: eating a healthy diet including foods that are lower in fat, losing weight slowly, avoiding “fad” diets, using less fat in cooking and managing the size of food portions.

FACT: Approximately 37% of Aboriginals over 18 years old are overweight, and another 36% are obese. This is striking when compared to the rest of Canada, where 33% are overweight, but only 15% are obese (Canada, 2009). Overweight and obesity ranges are determined by using weight and height to calculate a number called the “body mass index” (BMI).

9. Smoking

People that smoke or are exposed to second-hand smoke have an increased risk of stroke.

The bad health effects of smoking include:

- The buildup of plaque in the arteries
- Higher risk of blood clots
- Lower oxygen levels in the blood
- Strain on the heart

Smokers should be encouraged to quit and provided with the appropriate resources/tools.

FACT: In 2003, only 41.6% of First Nations adults living on-reserve were non-smokers, whereas 75.8% of the rest of Canadians were non-smokers (Canada, 2009).

10. Diabetes

Diabetes develops when the body has a problem with a hormone called insulin. Insulin helps move sugar (known as glucose) in food from the blood into the cells of the body where it can be used as energy. If the body cannot produce insulin or does not respond properly to insulin, then glucose builds up and damages

blood vessel in the body. Damaged blood vessels can cause problems with heart disease, strokes, eye damage, kidney disease and nerve damage.

FACT: First Nation, Inuit and Métis are at higher risk of developing Type II diabetes, a serious medical condition that may lead to heart disease and stroke. It is important for Aboriginal adults to be tested for Type II diabetes every one or two years if they are overweight or obese, if they are not physically active, or if they eat unhealthy foods. Individuals with a waist measurement more than 40 inches/102 cm for men, and 35 inches/88 cm for women are at high risk for Type II diabetes. Furthermore, a 1996 study found that diabetes (both type one and two) affects 6% of aboriginal adults, compared with 2% of all Canadian adults (MacMillan et al., 1996)

Canadian Best Practice Recommendations for Stroke Care

The evidence-based Canadian Best Practice Recommendations for Stroke Care are intended to help reduce practice variations and close the gaps between evidence and practice. The purposes of the recommendations are to ensure that stroke care continues to reflect contemporary stroke research evidence and expert opinion.

The updated Best Practice Recommendations 2010 content focuses on:

- Public Awareness of Stroke
- Prevention of Stroke
- Hyper acute Stroke Management
- Acute Stroke Management
- Stroke Rehabilitation
- Managing Stroke Care Transitions
- Cross-Continuum Topics in Stroke Management

These guidelines can be found on-line at:
www.strokebestpractices.ca



Section 6: **Additional Resources**

Introduction

This section presents a variety of resources that will assist you to provide care and education for an Aboriginal at-risk of stroke, stroke survivor, and their family. These resources include educational material, best practice guidelines and a list of community service agencies that can be accessed for client support or programs.

Aboriginal Knowledge Centres

Za-geh-do-win Information Clearinghouse

This centre collects, compiles, catalogues and distributes Aboriginal-specific information, resource materials, research and documents to Aboriginal communities and groups regarding family violence, family healing and health. Website: www.za-geh-do-win.com

Information Centre on Aboriginal Health (ICAH)

ICAH is a service provided by the National Aboriginal Health Organization (NAHO). ICAH is a database of information on bibliographic and web-based resources, programs and services, health careers, and scholarships and bursaries. Website: <http://www.naho.ca>

Aboriginal Services & Community Agencies

Aboriginal Health Access Centres

These centres offer a blend of traditional Aboriginal approaches to health and wellness and contemporary primary health care in a culturally appropriate setting. Programs include: pre and post-natal care, nutrition, health education, disease prevention, and counseling. Ontario's Aboriginal Health Access Centres are listed below.

Ontario Federation of Indian Friendship Centres (OFIFC)

OFIFC is a provincial Aboriginal organization representing the collective interests of the 27 centres located throughout the province. The OFIFC administers a number of programs (which are delivered by local Friendship Centres) supporting health, justice, family support, employment and training. Friendship Centres also develop and deliver local initiatives in areas such as education, economic development, children's and youth initiatives, and cultural awareness. Website: <http://www.ofifc.org>

Keewaytinook Okimakanank Telemedicine (KOTM)

KOTM deliver clinical, educational and administrative videoconferencing and communication services to First Nation communities in Ontario. Website: <http://telemedicine.knet.ca>

Métis Nation of Ontario (MNO)

MNO celebrates and advocates for Métis culture, heritage and values. MNO provides programs on employment, education, health (including long-term care, healing, wellness, pediatric and child health, responsible gambling, diabetes awareness), economic development, housing and community access. Website: www.metisnation.org

National Aboriginal Health Organization (NAHO)

NAHO is an Aboriginal body committed to influencing and advancing the health and well-being of Canadian Aboriginal Peoples by carrying out research, advocacy and education. Website: <http://www.naho.ca/>

Ontario Native Women's Association (ONWA)

ONWA was established to promote the advancement and equality of Native women. Founded in 1972, ONWA works to address political, social, educational, economic and justice issues. ONWA has over 80 volunteer groups, made up of both on and off reserve communities. ONWA offers programs related to diabetes awareness, gambling awareness, human resource development, aboriginal women's leadership development, housing, aboriginal and healing wellness, health policy, mental health, community health outreach, community wellness and community development. Website: www.onwa-tbay.ca

Aboriginal Canada Portal (Government of Canada)

The Aboriginal Canada Portal provides information related to First Nations, Métis and Inuit online resources and government programs and services. The website contains government and non-government reports, projects and services in the health and social services fields. It also contains links to Aboriginal health-related associations and research centres. Website: www.aboriginalcanada.gc.ca

First Nations, Inuit and Aboriginal Health (Health Canada)

This website provides information on Health Canada's work to improve the health of First Nations and Inuit people. Together with Aboriginal organizations and communities, Health Canada carries out activities focused on health promotion, infection control and chronic disease prevention. Website: www.hc-sc.gc.ca/fniah-spnia/index-eng.php

Aboriginal Affairs and Northern Development Canada

AANDC supports both Aboriginal Canadians and northerners to improve social well-being and economic prosperity, develop healthier, more sustainable communities, as well as participate more fully in Canada's political, social and economic development. Website: www.aandc-aadnc.gc.ca

Aboriginal Health Related Strategies/Initiatives

Aboriginal Healing & Wellness Strategy (AHWS)

The goal of the AHWS is to improve the health of Aboriginal individuals, families, communities and nations. The AHWS is designed, delivered and controlled by Aboriginals, but administered by the Government of Ontario. The AHWS informs health policy and health service delivery regarding Aboriginal services in Ontario. Website: www.ahwsontario.ca

Chiefs of Ontario

The Chiefs of Ontario is an organization that discusses the planning, implementation and evaluation of all local, regional and national matters affecting the First Nations people of Ontario. Website: <http://chiefs-of-ontario.org>

Aboriginal Tobacco Program (ATP)

Led by Cancer Care Ontario, the ATP works with Aboriginal communities to decrease and prevent the misuse of tobacco. Many Aboriginal communities have a unique and sacred relationship with traditional tobacco. In those communities, the ATP does not seek to create “tobacco free” communities; rather they want to create “tobacco wise” communities that use tobacco in a sacred way and do not feed a powerful and deadly addiction. Website: www.tobaccowise.com



Listing of Aboriginal Organizations in NW Ontario

Atikokan

Atikokan Native Friendship Centre

P.O. Box 1510
307-309 Main Street W
Atikokan, ON POT-1C0
Tel: (807) 597-1213
Fax: (807) 597-1473
www.ininewfriendshipcentre.ca

Atikokan & Surrounding Area Interim Métis Council

Box 1630, 33 Birch Rd.
Atikokan, ON POT 1C0
Tel: (807) 597-2954

Dryden

Dryden Native Friendship Centre

53 Arthur Street
Dryden, ON P8N 1J7
Tel: (807) 223 4180
Fax: (807) 223-6275
<http://ofifc.org>

Northwest Métis Council

34A King Street
Dryden, ON P8N 1B4
Tel: (807) 223 8082
Fax: (807) 223-8083
www.metisnation.org

Fort Frances

Fort Frances Métis Nation (Aboriginal Healing and Wellness Strategy - AHWS)

PO Box 403
(426 Victoria Avenue)
Fort Frances, ON P9A 3M7
Tel: (807) 274-1386
Toll Free: 1-888-793-3334
Fax: (807) 274-1801

United Native Friendship Centre

P.O. Box 752,
516 Portage Avenue
Fort Frances, ON P9A 3N1
Tel: (807) 274-3762
Fax: (807) 274-4110

Gizhewaadiziwin Access Centre

P.O. Box 686
Fort Frances, ON P9A 3M9
Tel: (807) 274-3131
Fax: (807) 274-6280
www.gizhac.com

Geraldton

Thunderbird Friendship Centre

301 Beamish Ave. West
P.O. Box 430
Geraldton, ON POT-1M0
Tel: (807) 854-1060
Fax: (807) 854-0861

Kenora

Waasegiizhig Nanaandawe'iyewigamig

212 Fourth Ave S
Kenora, ON P9N 1Y9
Tel: (807) 467-8770
Tel: (877) 224-2281
www.kahac.org

Kenora Métis Council

70 Park St. Kenora, ON
Tel: (807) 468-2034
Fax: (807) 468-1979

Ne'Chee Native Friendship Centre

P.O. Box 241,
1301 Railway Street
Kenora, ON P9N 3X3
Tel: (807) 468-5440
Fax: (807) 468-5340

Red Lake

Red Lake Indian Friendship Centre

Box 244, 1 Legion Road
Red Lake, ON POV 2M0
Tel: (807) 727-2847
Fax: (807) 727-3253
http://ofifc.org/centres/Red_Lake_Friendship_Centre.php

Sioux Lookout

Nishnawbe-Gamik Native Friendship Centre

P.O. Box 1299
52 King Street
Sioux Lookout, ON P8T-1B8
Tel: (807) 737-1903
Fax: (807) 737-1805
<http://ngfcreceptionslkt.myknet.org>

Sunset Women's Aboriginal Circle

72 Front St, 2nd Floor
Sioux Lookout
ON P8T 1A5
Tel: (807) 737-7922
Fax: (807) 737-7031

Sioux Lookout First Nations Health Authority

61 Queen Street
P.O. Box 1300
Sioux Lookout, ON P8T 1B8
Tel: (807) 737-1802
Toll free: 1-800-842-0681
Fax: (807) 737-1076
www.slfnha.com

Equay-wuk (Women's Group)

16 Fourth Avenue N.
Sioux Lookout, ON P8T 1C4
Tel: (807) 737-2214
Toll Free: 1-800-261-8294
Fax: (807) 737-2699
www.equaywuk.ca

The Jeremiah McKay Kabeshewikamik

60 Seventh Ave
Sioux Lookout, ON P8T 1H5
Tel: (807) 737-1676

Thunder Bay

Thunder Bay Native Friendship Centre

401 N. Cumberland St
Thunder Bay, ON P7A 4P7
Tel: (807) 345-5840
Fax: (807) 344-8945
www.tbifc.com

Nishnawbe Aski Nation

100 Back Street. Unit 200
Thunder Bay, ON P7J 1L2
Tel: (807) 623-8228
Fax: 807 623-7730
www.nan.on.ca

Ontario Native Women's Association (ONWA)

380 Ray Boulevard
Thunder Bay, ON P7B 4E6
Tel: (807) 623-3442
Toll Free: 1-800-667-0816
Fax: (807) 623-1104
www.onwa-tbay.ca

Thunder Bay Métis Council (Aboriginal Healing and Wellness Strategy - AHWS)

226 May Street South
Thunder Bay P7E 1B4
Tel: (807) 624-5022
Toll Free: 1-800-265-2595
(807 area only)
Fax: (807) 623-7036

Aboriginal Responsible Gambling Strategy (ARGS)

100 Backstreet Road
Unit #200
Thunder Bay, ON
Tel: (807) 623-8228
Direct line: (807) 625-4930

Anishnawbe-Mushkiki (Aboriginal Health Access Centre)

29 Royston Court
Thunder Bay, ON P7A 4Y7
Tel: (807) 343-4843
Fax: (807) 343-4728
www.anishnawbe-mushkiki.org

Biidaaban Healing Lodge

PO Box 219
Heron Bay, ON POT 1R0
Tel: (807) 229 3592
Fax: (807) 229 0308
www.biidaaban.com

Dilico Anishinabek Family Care

200 Anemki Place
Thunder Bay, ON P7J 1L6
Tel: (807) 623-8511
Toll Free: 1-800-465-3985
Fax: (807) 626-7999
www.dilico.com

Matawa First Nations

233 S. Court St.
Thunder Bay, ON P7B 2X9
Phone: 807-344-4575
Toll Free: 1-800-463-2249
Fax: 807-344-2977
www.matawa.on.ca

Stroke Education Resources

Heart and Stroke Foundation of Ontario (HSFO)

HSFO offers a wide variety of resources related to stroke and cardiovascular health for education and clinical practice. Some specifically address Aboriginal issues, and all are available online, free of charge. Below is a sample of HSFO resources. Website: www.heartandstroke.com

Taking Control:
Lower your risk of heart disease and stroke: A Guide for Aboriginal Peoples



Health Information Catalogue



Are you at risk of heart attack or stroke?



HSFO Professional Resource guide



Let's Talk About Stroke



Get your Blood Pressure Under Control



Living with cholesterol



Northwestern Ontario Regional Stroke Network

In partnership with HSFO and the Ontario Stroke Network (OSN), the Northwestern Ontario Regional Stroke Network produced videos addressing Aboriginal stroke. These videos are available online, free of charge. Website: www.nwostroke.ca

Heartbeat of the Anishnawbe Nation

Learning about stroke and blood pressure management by means of both medical and Aboriginal traditions. The video will help you to understand how stroke and blood pressure is affected by smoking, diet, exercise, alcohol and medication. The language of the video is Ojibwe and dubbed in Oji-Cree and English. (19 Minutes)



As the Rivers Flow: Brain Attack

Following the path of the river, this DVD uses Aboriginal (or the animal system) and medical teachings to understand the symptoms of a stroke. The nature of warning signs and where to go for help are also discussed. The available languages of the video are Ojibwe, Oji-Cree and English. (17 Minutes)



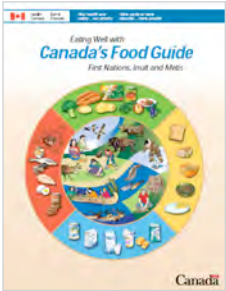
ACT FAST 1-2-3! Youth of the Anishnawbe Nation Learn About Stroke

The "Talking Stick" passed from one community to another, helps children understand: what a stroke is, what are the warning signs and symptoms, stroke prevention, and where/how to seek help in case of a stroke. (11 Minutes)



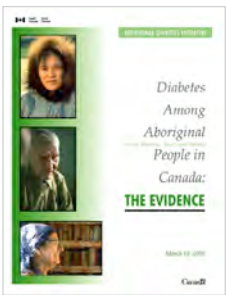
Related Resources

Nutrition & Hypertension



www.hypertension.ca/chep

Diabetes (Government of Canada)



sc.gc.ca/fniah-spnia/pubs/diseases-maladies/_diabete/2001_evidence_faits/index-eng.php



Aboriginal Diabetes Initiative:
Prevention and Promotion Program
www.hc-sc.gc.ca/fniah-spnia/pubs/diseases-maladies/_diabete/2000_moauipp-ppmahrimu_program/index-eng.php



Diabetes Fact Sheet: First Nations and Inuit Communities

http://www.hc-sc.gc.ca/fniah-spnia/pubs/diseases-maladies/_diabete/2000_reserve-program/index-eng.php

Stroke Services & Agencies

March of Dimes / Stroke Recovery Canada

March of Dimes is the largest rehabilitation organization in Ontario, and serves people with physical disabilities of all ages. Their mission is “to maximize the independence, personal empowerment and community participation of people with physical disabilities”. Stroke Recovery Canada® was created to help stroke survivors and their families regain independence, find support and learn to survive and thrive after stroke. Each local program is offers peer and post recovery support, education and community integration services for stroke survivors, their caregivers, families and health care providers. Website: www.marchofdimes.ca

Ontario Stroke System (OSS)

OSS is a Ministry of Health and Long Term Care initiative that promotes access to evidence-based care and strives to improve outcomes for stroke survivors. The OSS spans the continuum of care from prevention to community re-integration. The OSS is made up of 11 regions and provides services through regional stroke centres, district stroke centres and secondary prevention clinics. Regional and district stroke centres provide expertise in stroke care, and access to hyper-acute treatment. These centres also have a coordination and leadership role in the creation of an integrated stroke system. Secondary prevention clinics provide interdisciplinary stroke prevention services to those people who have had a transient ischemic attack (TIA) or are at high risk for a stroke. The clinics also provide triage for urgency cases, assessment services, treatment plans and patient education. Services vary by location. Feel free to contact the appropriate centre or clinic below to access specific services or resources in your area. Website: www.ontariostrokenetwork.ca/

Stroke Prevention Clinics and Tele-Stroke Sites in NW Ontario

City/Area	Hospital	Address	Type	Website
Thunder Bay	Thunder Bay Regional Health Sciences Centre	201 - 980 Oliver Road Thunder Bay, ON, P7B 7C7 807-684-6702 807-684-6700	North Western Ontario Regional Stroke Network Stroke prevention clinic	www.nwostroke.ca
NW Ontario	Wilson Memorial General Hospital	28 Peninsula Road P.O. Box W Marathon, ON P0T 2E0 807-229-1740	Stroke prevention clinic	www.wmgh.net
	Lake of the Woods District Hospital	21 Sylvan Street West Kenora, ON P9N 3W7 807-468-9861	Stroke prevention clinic Telestroke site	www.lwdh.on.ca
	Riverside Health Care Facilities, Inc.	110 Victoria Avenue Fort Frances, ON P9A 2B7 807-274-3266	Stroke prevention clinic Telestroke site	http://riversidehealthcare.ca
	Sioux Lookout Meno Ya Win Health Centre	1 Meno Ya Win Way P.O. Box 909 Sioux Lookout, ON P8T 1B4 807-737-2877	Stroke prevention clinic	www.slmhc.on.ca
	Dryden Regional Health Centre	P.O. Box 3003 58 Goodall Street Dryden ON P8N 2Z6 807-223-8200	Telestroke site	www.dh.dryden.on.ca

GLOSSARY OF TERMS

Aboriginal Community: A group of Aboriginal people who share similar beliefs, traditions and cultural identity. These groups exist through shared political, cultural, spiritual and /or other affiliations.

Band: A body of Indians for whose collective use and benefit lands have been set apart or money is held by the Crown, or declared to be a band for the purposes of the Indian Act. Each band has its own governing band council, usually consisting of one Chief and several councillors. Community members choose the Chief and councillors by election, or sometimes through custom. The members of a band generally share common values, traditions and practices rooted in their ancestral heritage. Today, many bands prefer to be known as First Nations.

Cultural Sensitivity: Cultural Sensitivity is getting to know and understand other cultures and perspectives. It involves recognizing the lived experiences of all people, including aspects similar and different to our own and that our actions affect other people.

Determinants of Health: In 1948, the World Health Organization (WHO) declared that more than the absence of disease, health is, “a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.” In 1998, Health Canada developed a list of social factors and conditions that lead to healthy people and communities called determinants of health. These factors include culture, social support, education, literacy, income, employment and working conditions, social and physical environments,

personal health practices, coping skills, health child development, biology, genetic endowment, health services and gender. These health determinants come together to help people and communities reach a state of complete physical, mental and social well being. Because all of these determinants of health are linked together, many people experience specific or structural challenges to accessing equitable health services and resources. They may lack access for many reasons such as poverty or homelessness and/or racism or discrimination.

First Nation: A term that came into common usage in the 1970s to replace the word “Indian,” which some people found offensive. Although the term First Nation is widely used, no legal definition of it exists. Among its uses, the term “First Nations people” refers to the Indian people in Canada, both Status and non-Status. Many communities also use the term “First Nation” in the name of their community. Currently, there are 615 First Nation communities, which represent more than 50 nations or cultural groups and 50 Aboriginal languages.

Inuit: Inuit are the Aboriginal people of Arctic Canada. About 45,000 Inuit live in 53 communities in: Nunatsiavut (Labrador); Nunavik (Quebec); Nunavut; and the Inuvialuit Settlement Region of the Northwest Territories. Each of these four Inuit groups have settled land claims. These Inuit regions cover one-third of Canada’s land mass. The word “Inuit” means “the people” in the Inuit language called, Inuktitut and is the term by which Inuit refer to themselves. The term “Eskimo,” applied to Inuit by European explorers, is no longer used in Canada.

Métis: Metis are one of three recognized Aboriginal people in Canada, along with the Indians (or First Nations) and Inuit. Approximately one third of all Aboriginal people in Canada identify themselves as Métis. Census data from 2006 shows Métis as the Aboriginal group that experienced the highest growth at 91%, reaching 389,785 people.

Status Indian: A person who is registered as an Indian under the Indian Act. The act sets out the requirements for determining who is an Indian for the purposes of the Indian Act.

Non-Status Indian: An Indian person who is not registered as an Indian under the Indian Act.

Treaty Indian: A Status Indian who belongs to a First Nation that signed a treaty with the Crown.

Indian status: An individual’s legal status as an Indian, as defined by the Indian Act.

Reserve: Tract of land, the legal title to which is held by the Crown, set apart for the use and benefit of an Indian band.

Tribal council: A regional group of First Nations members that delivers common services to a group of First Nations.

Wholistic: Rather than “holistic”. Many residential school survivors view the term “holistic” as holy and may have bad feelings about the term. They view the term “wholistic” as the “whole” body and all encompassing.



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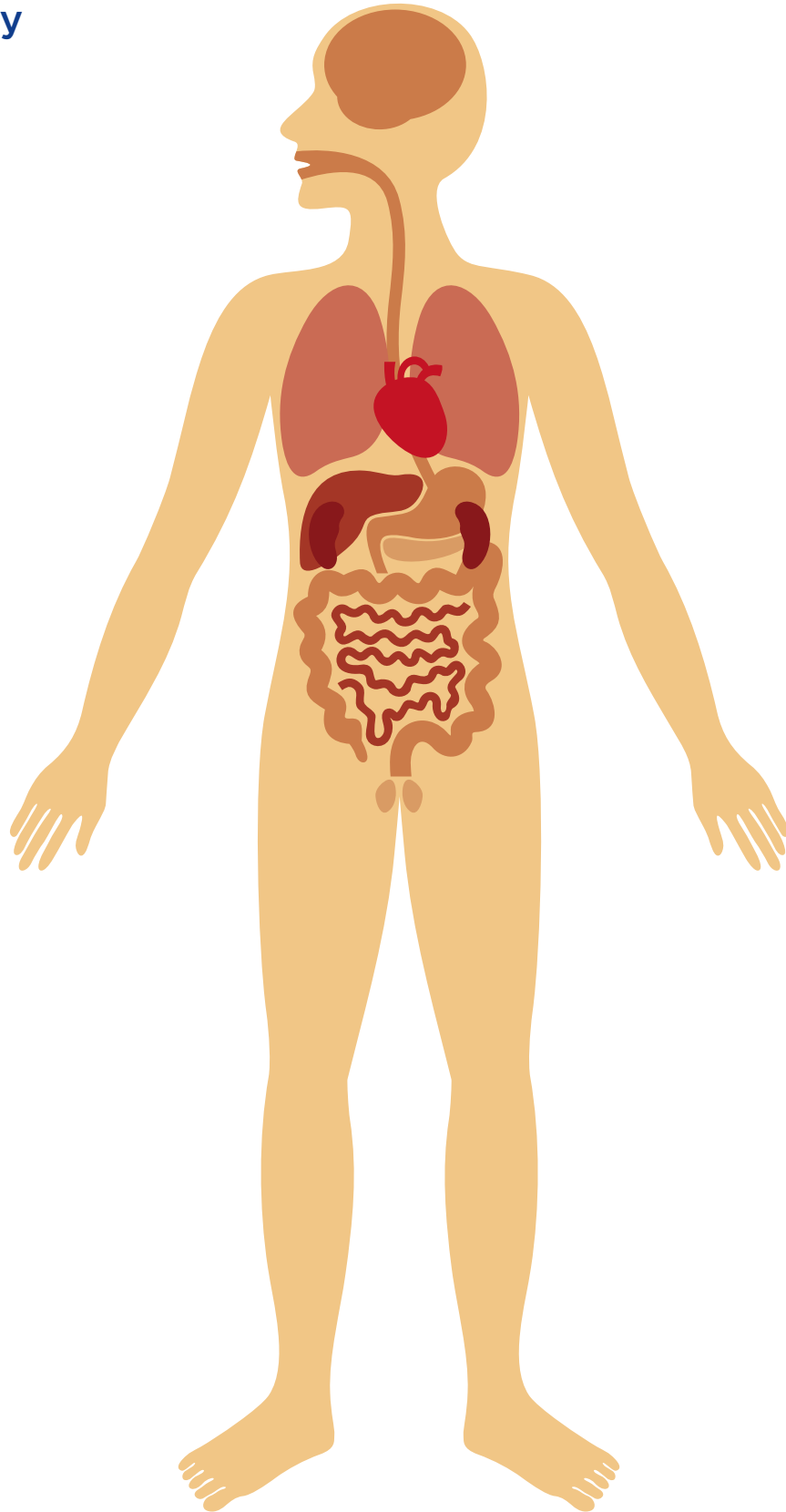
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Map of Treaties and Health Facilities



The Human Body

Use this image as a guide to show various body parts and their relationships to one another. The use of this type of tool may be of particular benefit to individuals who are visual learners.



healthy
together



A condensed version of this document
can be found at www.nwestroke.ca