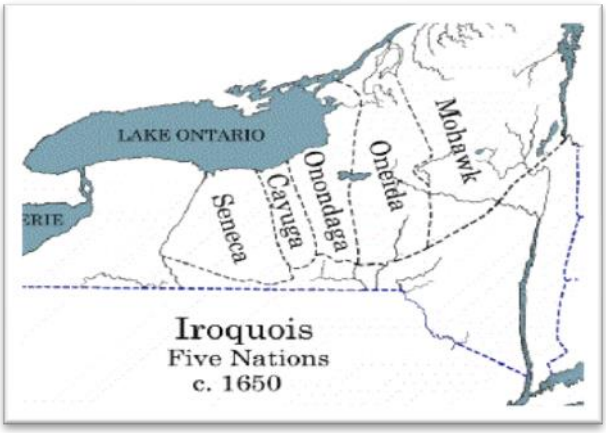
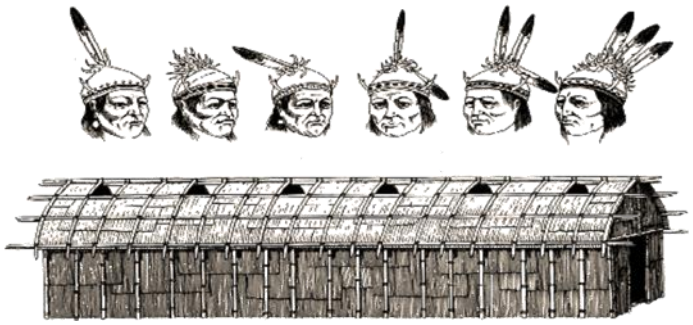
History:

The Haudenosaunee (also known as the "Iroquois") are a confederacy of six nations who occupy land along the Grand River, parts of New York State, and other locations in Canada and the United States. Originally made up of Five Nations (Seneca, Cayuga, Onondaga, Oneida, and Mohawk) living in New York State, they were first contacted by Jacques Cartier, and then later by the Dutch in the 17th century; who became their first trading partner.



The original location of the Haudenosaunee

When the French arrived in the New World, an alliance was made with the Haudenosaunee's enemy, the Algonquians. This alliance added to the pre-existing conflict between the Haudenosaunee and the Algonquians, and turned the Haudenosaunee against the French. After this time of fighting began to die down with the French, the Tuscarora came to the Confederacy seeking protection. They were a group who originated in the Carolinas and travelled north, fleeing from European conquest in their own lands. Thus, this alliance formed the Six Nations.



The symbol of the Six Nations represented by a longhouse
(left to right; Seneca, Tuscarora, Cayuga, Onondaga, Oneida, Mohawk)

Years later, the British came to conquer Canada from the French settlers. The Haudenosaunee chose to side with the British during these years of fighting. The British eventually defeated the French and gained control of Canada. Following this moment of history, the American Revolution began in 1775 which caused the Haudenosaunee to once again resort to fighting. This period of time tested the Haudenosaunee's alliances among one another; through the tribes joining opposing sides. The Tuscarora and Oneida chose to fight with the Americans, while the other four nations sided with the British. When the American Revolution ended, those who stayed in New York State were eventually driven out by the growing settlements. Some of the Haudenosaunee scattered to different parts of the States, while others came to Canada. The land near the Grand River was granted to the Six Nations by King George III in return for the land they lost, in fighting for the British in the war. The leader of this group was Joseph Brant (Thayendanegea). He was a Mohawk warrior chief who played a great role in the American Revolution by fighting for the British. With the Six Nations loss of strength from the war, Joseph Brant thought it wise to lease some of the land to the Europeans in order to get some sort of income for the Haudenosaunee. The village near the Grand River, where Brant led the Native people across was eventually renamed Brantford in honour of Joseph Brant. The Six Nations Territory remains in this area to this day, with other members living throughout Canada and the United States; in such communities as Akwesasne, Kahnewake, Ganienke, Kanesatake, Wahta/Gibson, Kanatsiohareke, and Tyendinaga.

Joseph Brant

A Traditional Village

As the land increasingly developed, more Europeans began to settle in the area. This caused the Native community to become a minority within their own land. Land disputes then began to take place between the two distinct groups of people. A majority of the land that was originally given to Joseph Brant and the Six Nations was handed over to the new settlers.

The Two Row Wampum known as *Kaswentha* was the primary basis on which the nations made a mutual agreement with the European nations. The belt is made of shells consisting of two purple rows placed on a white background. The two rows later represented the Haudenosaunee and the Europeans travelling side by side in the River of Life, with the First Nation in the canoe, and the European nation in a ship. The two boats travel side by side, but never interfere with each other's customs or ways of life.

The First Nation's culture was seen as "savage" and "primitive", so the Church decided to change this and take their culture from them. A form of schooling was put in place by the Anglican Church all over the country. These schools were called residential schools. The schools not only taught the general subjects, but also taught kids how to farm, sew, and cook. The schools were viewed, by the outside community, as a positive contribution to the First Nation communities across the country. Yet, the schools were viewed very differently within the native communities. The kids were taken out of their homes and away from their families by government agents, and were then placed in the residential schools. While being there, they were not allowed to speak their own language or dress in their traditional clothes or they would be beaten. Apart from being physically abused, the children were also verbally and sexually abused. These incidents added to the trauma that many native children encountered. When they were eventually old enough to live on their own, they were placed into the outside world with a whole new mindset. Their heritage became a thing of the past for them. Many of the survivors had no way of communicating with the families that they were taken away from which added to feelings of isolation. The abuse and personal grief they suffered was carried with them into their own families. The kids who attended the schools, who eventually became parents themselves, had no parenting skills to carry with them. Therefore, these poor parenting skills led to children deprived of the love that they deserved from their parents. This depravity of love and proper caring for the children was then passed onto their own children, which lead into a domino effect. Not every member of the community has felt the effects of residential schools. However, it is still very prevalent within this community. The last residential school closed in Canada in 1996.

Mohawk Institute, Brantford

The Residential Schools will always be a part of history that will never be forgotten by the Six Nations community. With the apology of the Canadian government in 2008 towards the forceful actions of assimilation towards the First Nation communities, steps of reconciliation have begun to take place.

The history of the Haudenosaunee was filled with pain, sorrow, betrayal, manipulation, and tactics of assimilation, but yet there have been times of resiliency, inner strength, victories, alliances, and a strong cultural identity. The Six Nations history still continues on a day to day basis, like any other culture, and will continue for years to come.

*for more information, refer to this website: http://www.haudenosauneeconfederacy.ca/index.html

http://www.historyforkids.org/learn/northamerica/before1500/history/iroquois.htm

http://www.innisfil.library.on.ca/natives/natives/chp9.htm

http://www.everyculture.com/multi/Ha-La/Iroquois-Confederacy.html

http://faculty.marianopolis.edu/c.belanger/QuebecHistory/encyclopedia/E.M.Chadwick-HistoryoftheIroquois.htm

http://www.canadianaconnection.com/cca/joseph_brant.htm

http://www.anglican.ca/rs/history/schools/mohawk-institute.htm

http://www.akwesasne.ca/tworowwampum.html

http://www.ganienkeh.net/2row.html

Tradition:

In the early society of the Haudenosaunee, the men would hunt, fish and go off to war, while the women took care of the fields and gathered the fruits and vegetables. The people believed that there was a Great Spirit who is in charge of the humans and the sky. The Great Spirit was known to be the maker of all things that are good. In opposition to the spirit was Evil Spirit, who was in charge of the underworld and all things that are evil. The Haudenosaunee believe that by burning tobacco, the people are able to pray to the Great Spirit. Dreams also play a significant role in the life of a member of the Haudenosaunee, as they are seen to show an individual direction for their life.

The Haudenosaunee have many ceremonies that take place in accordance with the seasons throughout the year; the Maple, the Planting, Strawberry, Green Maize, Harvest, and Mid-Winter/New Year's Festivals. All ceremonies begin with thanksgiving and are oriented around giving thanks for the circle of life. The Maple ceremony takes place in March. This ceremony includes dancing, playing games, burning sacred tobacco and a feast. This festival also acknowledged that fact that the people made it through another winter. The Planting Festival followed the Maple Festival, and commemorates the clearing of the land and the planting of the vegetables. This festival takes place in April or May. During this festival the people offer prayers for "good growing weather with sunshine and soft rain". A feast will also

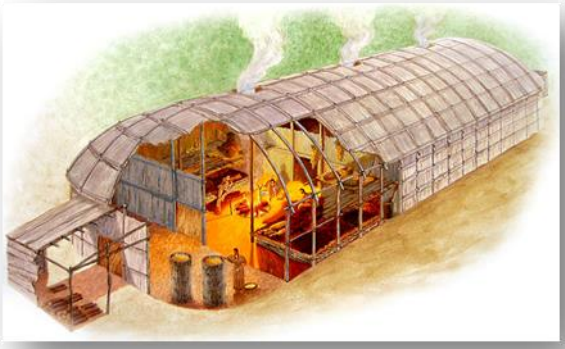
take place which celebrated the placing of sprouts in the ground. The Strawberry Festival takes place in late May/early June to celebrate the first wild strawberries of the season. This festival also initiates the planting of the corn and beans. In August, the Green Corn (or Green Maize) festival occurs. This festival honours the Creator who has given life to the people. It takes place when "the green corn stands tall in the fields". This ceremony is held for four days in which different meetings, speeches, prayers, dances, games and tobacco offerings take place. At the end of the festival, there is a feast that includes hot corn soup. One of the most important festivals was the Harvest Festival. During this festival, all of the vegetables are harvested. The people hang the corn, which was brightly coloured, within the longhouses. After this festival, all of the vegetables are stored for the winter. The final festival takes place in early January or February. This ceremony was called the Midwinter Festival. In one month after this festival, the year begins once again. A majority of these ceremonies are still practised, with some minor changes to the order of the ceremonies.

Lacrosse is the main sport of the Haudenosaunee people. The game includes a ball made of deer hide, filled with deer fur, and a stick which has a net on the one end. The main point of the game is to bring union within a group of people and to bring out the inner strength of an individual. This sport is now recognized as one of Canada's national sports.

A very sacred group of the Iroquois people is the False Face Society. In ancient times, they were a group that would initiate the healing ceremonies. If someone who was sick had a dream of a person wearing an ugly mask, the False Face Society would come to help them. They would bring noise makers with them made from turtle shells, chant, and sprinkle tobacco ashes over the individual that was sick. The members of the False Face Society wore masks of spirits that they would see within their dreams. If the person who was sick became healthy again, they would join the False Face Society and would wear a mask that was the same as the one in their dream.

The longhouse was originally used as a living quarters for the Iroquois people. It was made of wood and tree bark. The longhouse would typically be 20 feet high, around 20 feet wide, and approximately 40 to 200 feet long (depending upon the size of the clan). An individual longhouse would be designated to a single clan. A clan was made up of a group of people who were related through a clan mother, and her daughters. The daughters of the clan mother would live in the longhouse, along with their families. The longhouse was set up with platforms running along the inside wall. These platforms contained beds and storage areas. A common area was set in the middle where the different fireplaces would be. The smoke from the fires would exit through the holes that were placed directly above the fire pit. The longhouse represented unity and brought forth peace into the community. Each longhouse had a symbol above the doorway that represented the specific clan to which one belonged to. This

allowed travelers to enter the longhouses that belonged to their own clan. If a majority of longhouses were in a certain area, that area would be known as a village. A palisade would be placed along the perimeter of the longhouses to protect against trespassers and invading nations.



Today, the longhouses are used for traditional ceremonies and are placed at a sacred status. The modern longhouses are different from the traditional longhouses, in that they are no longer meant as living quarters. There are two entrances into the longhouse, one where the men enter, and the other for the women. Within the middle of the longhouse are two benches and two stoves. The people within the longhouse sit according to their clans. The men and women of the same clan sit on opposite sides, facing each other. There are different ceremonies that take place within the longhouse depending upon the season. The ceremony starts with a thanksgiving speech, which is offered to the Creator thanking him for all that he has done and provided. After that two male singers and two dancers are announced. There are always two dancers, with one who is used as a replacement. If there are two men in the middle, then a turtle rattle is used. If it is a group in the middle then they used a horn rattle. In a single year the different clans look after the longhouse ceremonies (i.e. turtles and wolf, bears and deer, etc.). They are in charge of setting the dates for the ceremonies. When they decided upon a date it has to be agreed upon by other members of the longhouse.

http://www.bookrags.com/research/iroquois-religious-traditions-eorl-07/

http://www.everyculture.com/North-America/Iroquois-Religion-and-Expressive-Culture.html

http://wiki.answers.com/Q/Iroquois_Tribe_Beliefs

http://www.peace4turtleisland.org/pages/longhouse.htm

http://www.multiculturalcanada.ca/Encyclopedia/A-Z/a6/6

Traditional Medicine and Practices:

Western medicine is primarily meant to heal a person's physical body. The traditional medicine, that the First Nations people use, is meant to not only heal the person's body but also their mind and spirit. It is meant for full restoration and healing which is meant to be a longer term treatment then Western Medicine. Traditional Medicine can treat Diabetes, Cancer, High-Blood Pressure, and other Chronic Diseases. Some of these medicines include Tobacco, White Pine, Cedar and White Corn. There are many different ceremonies that the Haudenosaunee associate with their medicine. These ceremonies include: Beaver, Eagle, False Face, Otter, and White Buffalo, along with many others. The ceremonies are related to the seasons: spring is known for planting, summer for gathering, fall for hunting and winter for resting. The knowledge of the uses and products of Traditional Medicine have been passed down through different family generations. The ancestors of old are believed to have received this knowledge through dreams and visions. The medicine is not meant for only the native community, but can be used to treat others who are not of First Nations descent. The use of traditional medicine is beginning to become more common within this community. The ceremonies and traditional practices allow the community to find a sense of belonging, strengthen the spirit, uplift the spirit, directs people on the path to take in their life, and help the people on a day to day basis.

The ceremonies take place throughout the year to celebrate the different seasons and events that occur throughout the year. The annual ceremonies are: Midwinter, Maple Festival, Maple Syrup Harvest, Thunder Dance, Okiiweh, Hadueh, Sun Dance, The Moon Dance, The Blessings of the Seeds, Planting Season, Strawberry Ceremony, String Bean Festival, Mall Green Corn Ceremony, Green Corn Ceremony, Harvest Thanksgiving Festival, Medicine Mask Society, and then the Feast of the Dead. Other ceremonies that occur at other times throughout the year include; Gaiwiio, Bear, Eagle, and White Buffalo.

The Midwinter ceremony occurs in January and lasts for 5 – 8 days. This ceremony is meant to celebrate the renewal of life and to give thanks for life. The Maple Festival is in February for one day, which is meant to give thanks to the maple trees for providing sap. They also pray for the return of the sap and protection from tree limps or trees falling for those who go into the woods. Next is the Maple Syrup Harvest which is one day on the first week of March, and is done for an offering of thanksgiving. The following ceremony is the Thunder Ceremony, which is used for thanking the thunders for returning. The thunders must be heard on three separate occasions before having this ceremony. The Okiiweh (Feast for the Dead) takes place near the end of April and occurs all night. The graves are also cleaned at this time. The next ceremony is the Medicine Mask Society (False Face Ceremony) which is a ceremony to honour the masks that watch over the people. They thank the masks for keeping them safe

from strong winds and disease, which occur more frequently at this time of the year. The Sun Ceremony follows this and is done to honour the sun and to give thanks for continuing to do its duty. The Sun ceremony occurs in the beginning of May, on one of the mornings. The next ceremony is the Moon Chant (Moon Dance) which is also an offering to the moon. The Moon Dance takes place during the second week of May. With the continuous change of seasons the next ceremony takes place. This ceremony is called "Blessing the Seeds" at which time the people ask the Creator to bless the seeds that they have planted. Near the end of May, the "Completing the Planting Season" ceremony takes place. For one day in June, the people give thanks for all the berries and new life which is called the Strawberry Ceremony. The next ceremony is the Bean Ceremony which occurs during the summer. The following ceremony is the Small Green Corn ceremony which is for one day in August. The other corn ceremony which occurs shortly after is the Green Corn Ceremony. In October for four days is the Harvest Thanksgiving Festival. This ceremony is the time when all of the harvest is collected. Another Medicine Mask Society ceremony also takes place in October. The final ceremony of the year is the Feast for the Dead and it also occurs in October.

The Traditional Practitioner on the Six Nations Family Health Team helps individuals to find the source of their problem and to help them to heal themselves through; counseling, healing, or ceremony. The practitioner brings forth the teachings and practices of old and applies them to the lives of the people who come in.

http://www.fnhc.ca/index.php/initiatives/community_health/traditional_medicine/

http://traditionalhealing.suite101.com/article.cfm/first_nations_traditional_healing

http://www.naho.ca/publications/codeofBehaviour.pdf

Skye, Kristine. Six Nations Family Health Team, Traditional Healer

http://www.sntourism.com/tourHistory.htm

Community:

The Six Nations is seen as a community that is continuing to take in their own culture while embracing the ways of modern society. Yet, there is still a fear of persecution for practicing the ways of their culture and traditions. Intergenerational trauma (the effects of residential schools, poverty, colonialism, assimilation, reservations) has taken a significant hold on the community. Residential schools were one of the key factors in the intergenerational trauma. The schools have since been closed down, but the effect of the schools can still be felt within the community. The school was closed on June 30, 1970.

The Six Nations Territory is the largest First Nations reserve in Canada with a total band population of 22,294 with 11,297 living on the reserve (as of September, 2005). There are many events that hold this sense of tradition within the community; The Grand River Pow Wow, Bread and Cheese, Community awareness week, and solidarity week. Other events within the community are the Fair and the Stock Car Races. Six Nations also have a number of members who attend universities and are in graduate programs.

http://www.sixnations.ca/CommunityProfile.htm

http://www.sntourism.com/tourHistory.htm

Six Nations Health Care Services:

The Six Nations has a number of services that have been put in place in order to meet the community's needs. On the reserve there is: The Ambulance Service, the Birthing Centre, a Dental Clinic, Early Childhood Development, Health Promotion & Nutrition Services, Healthy Babies/Healthy Children, Long Term Care, Mental Health, the New Directions Group, School Nurses, and Sexual and Clinical Health Nurses.

The Ambulance Service:

The Ambulance Service was founded on January 1, 2000. It has a staff of 1 manager, 1 supervisor, 7 full time primary care paramedics, 12 part time primary care paramedics and 1 full time secretarial staff member. The Ambulance Service must undergo an exception by the Ministry of Health every two to three years, in order to see that they are keeping up to the provincial standards of an ambulance service. The service runs 24 hours a day, seven days a week and contains one in-service vehicle and one spare vehicle.

The Birthing Centre:

The Birthing Centre is a place that brings the Haudenosaunee's traditions into the birthing process. The midwives provide both Traditional and Contemporary midwifery services. Those who come to the Birthing Centre are offered a choice of services and programs that will "compliment and support personal beliefs and customs". The Birthing Centre is located on Sour Springs Road. It is supervised by an Advisory Committee which is a group of representatives from surrounding communities. The Birthing Centre offers a number of programs including: Prenatal Class/Prenatal Exercise Class, Moms and Tots Group, Male Self Care Workshops, Gardening Program, Woman in All Her Seasons (Adolescent Rites of Passage teachings; Childbearing, Menopausal, Grandmother), Female Self Care Workshops, Traditional Medicines Sessions, Traditional Parenting Workshop, Traditional Foods Gathering, and Family/Maternal Resource Library. The Birthing Centre also offers an Aboriginal Midwifery Training Program.

Dental:

The clinic is located in Gane Yohs Dental Office. The office has become more directed towards providing dental care for school-aged children, the elderly, and disabled. The office will provide emergency treatment but do to its increase in adult patients; non-emergency treatment for adults has been reduced. The dental clinic now refers adult patients to dentists off the reserve; this is in order that school children will be able to have proper treatment. The office is open from 8 a.m. to 4 p.m. and is closed from 12 p.m. to 1 p.m. for lunch. Adults are booked from 8 a.m. to 9:30 a.m. and 2:45 p.m. to 4 p.m., with the time in between reserved for children. The Dental clinic currently has a staff of two dentists, a dental hygienist, two dental assistants, a dental receptionist and a dental driver.

Early Childhood Development:

Early Childhood Development "plans, develops, co-ordinates and provides holistic well-being to elementary students of the Six Nations community by promoting and advocating a healthy lifestyle within family and individual". The program originated in 1995 as a pilot project that was used as a response program to the high and increasing level of in-school behavioural problems that have been identified by parents and teachers within the schools. The counselors work with children aged 0-6 years within the community. The counselors also use different strategies to deal with incidents of Fetal Alcohol Spectrum Disorder (FASD) within families, to improve the individuals' quality of life. The Early Childhood Development offers the following: Crisis Intervention, Individual Counseling, Group Counseling, Social Skills Training, Teacher Support and training, Parent Support and training, Advocacy, Case Management – assessment, consultations, monitoring, follow-up care and referrals. The following activities area also run by Early Childhood and Development: "Hanen Program Training", "Communication Skill Building", and "Interactive approaches appropriate for the growth and development of children 0-6 years old".

Health Promotion and Nutrition Services:

The goal of the program is "to plan, develop, promote and deliver quality holistic services to address the effects of related conditions on the physical, mental, spiritual and emotional aspects of the individual and family". Nutrition counseling with a registered dietitian (office or home visit) and Nutrition/Healthy lifestyles display are available through this service. The different programs that are offered are: Group Presentations (that target possible groups – toddlers, pre-schoolers, teens, adults and elderly. Any nutrition may be covered within these presentations.), Healthy Nutrition Classes, Diabetes Education Program, Baby Food Making Classes, Breastfeeding Support group, Feeding Your Baby Café, Prenatal Classes, Diabetes

Support Group, Canning/Preserving Workshop, and an Active Lifestyles Program (which offers Diabetes/Cardiac Exercise, Yoga, Qigong and many others).

Healthy Babies/Healthy Children:

The purpose of the program is "to ensure that all children develop at their highest level in the areas of cognitive development, communication, physical and psychosocial skills". The program was put in place in order that families on the Six Nations would have proper access to a service that will have a positive effect on their lives. Some of the annual activities that are run by Healthy Babies/Healthy Children are: Prenatal Classes, Parenting resources, Well Baby Clinics, Growth & Development screens, Car Seat Safety Days, Teddy Bear Picnic, and home visits by their Family Home Visitors and Community Health Nurses.

Long Term Care/Home and Community Care:

The Long Term Care/Home and Community Care program has twelve statements that they are based upon:

- Be consumer-driven based on need
- Respect and support peoples' desire for dignity, well-being, independence and choice
- Focus on the promotion of wellness by maximizing/maintaining human potential and improving quality of life
- Reflect Six Nations' culture and traditions as provided through attention to individuality and their future generations
- Ensure the full range of services are available and/or accessible to community members based on need
- Be administered and delivered by qualified, competent, efficient and culturally sensitive/knowledgeable caring staff
- Be accountable to the community for quality service provision, optimum care and financial accountability supported by an appropriate client redress process
- Foster service coordination and enhancement through a cooperative team building approach
- Build in evaluation methods to ensure quality assurance and efficient use of resources
- Recognize and be sensitive to our human resources in terms o rewards, life-long learning and empowerment
- Recognize the importance of continuity of assigned caregivers to establish and maintain client trust
- Respect the cultural importance of extended family and their role in providing needed client services

- The program also offers: a Case Management unit, Registered Nurses, Physiotherapist, Occupational Therapist, Community Advocacy Worker, Speech Therapist, Nutrition/Dietician, Traditional Healer, Physician, Community Support Program Services, Home Making/Personal Support Workers, Adult Day Care, and Supportive Housing.

Mental Health:

The Mental Health Team's primary goal is to:

- provide mental health crisis response service to Six Nations band members, residing on Six Nations of the Grand River Territory

- provide case management services to clients experiencing mental illness

- provide an opportunity for adult and child psychiatric consultations in a community integrated clinical setting.

- provide an advocacy role for clients and family members who are seeking various services in and out of the community.

- promote and enhance individual and family, and community awareness, education and understanding of mental health.

The Mental Health department offers the following services: Crisis response, Case Management, Psychiatric Assessment, Supportive Housing, Community Education, Rehabilitation Services, and Release from Custody.

New Directions Group:

The New Directions Group offers addiction services within the Six Nations community. They provide workshops and presentations into the schools and community to help with prevention. Promotional activities also take place in order to offer healthier and alternate lifestyles a part from addictions. Counseling is the main method that is used by the New Directions Group in order to help members of the community with their addictions.

School Nurse Program:

The School Nurse is "to deliver a School/Community Health Service based on the identified needs for Six Nations of the Grand River School children and community members which includes the following components: designing, developing, coordinating, implementing and evaluation various programs/components of this service". The school nurses offer various programs that they believe will enhance the health and well-being of students on the Six Nations reserve.

Sexual and Clinical Health Nurses:

The Sexual Health and HIV/AIDS Awareness Program were initiated in 1996 under Six Nations Council-Six Nations Health Services. It was developed and put forth by Dana Martin at the Ohsweken Public Health Office. The main focus is to provide vital health information of healthy sexuality to both male and female clients of all ages. The Clinical Nurses work at the Gane Yohs Health Centre (Ohsweken Public Health Office). They work with the Family Physicians within the Family Practice. The Sexual Health Nurses offer the following programs: Sexually Transmitted Disease (Infection) Testing, Sexually Transmitted Disease (Infection) follow-up and counseling, Helping clients to choose the method of birth control that's right for them, Pregnancy Testing, Prenatal Classes 1 to 1, Options counseling related to pregnancy, School visits to area Secondary Schools – for individual counseling related to sexual health, HIV testing which includes: Pre and Post-test counseling, HIV/AIDS Hotline, HIV/AIDS community Newsletter, Educational Information Presentations on Program Related Topics (Community or Organization Requests), Sexual Health Clinic with Dr. A East/Dr. K Hill 1x month, Teenage Pregnancy Prevention Program – Girl's/Guy's Night Out, Free Condoms given out at Public Health Office, and Women's/Men's/Couples Wellness Days. The Clinical Nurses offer the following programs: Cancer Awareness night, Pandemic Information Sessions, Diabetes Awareness events, Men's Wellness Clinics, and Preventive care and annual physicals for men.

*for more information on any of the services refer to:

http://www.snhs.ca/index.htm

The Family Health Team:

Family Health Teams are a group of health professionals who work within a collaboration setting to give patients, some who may not have a family health provider, the proper health care. The focus of Family Health Teams is chronic disease management, disease prevention and health promotion. The vision of the Six Nations Family Health Team is "We are a dynamic team of caring healers and practitioners who embrace Onkwehonwe, Western and alternative medicine to effectively nurture health and wellness". The mission of this particular Family Health Team is "We recognize and respect the parallels of Onkwehonwe and Western medicines in the spirit of the two row wampum, to help individuals, families and the community to journey along their pathway to optimal mental, physical, emotional, and spirit wellness".

The Family Health Team has four, main core strategies:

1. Comprehensive Diabetes Care
2. Holistic Pediatric Care
3. Support for traditional Healing knowledge and practitioners to retake the right place in the practice of medicine in the community.
4. Improve access to Primary Health Care and specialist services.

Core Strategy: Comprehensive Diabetes Care

1. Develop a comprehensive diabetes program for screening and management
2. Develop a comprehensive diabetes prevention strategy for across the life continuum.
3. Create a curriculum that incorporates traditional and western perspectives on diabetes prevention and treatment.

Core Strategy: Holistic Pediatric Care

1. Develop a multidisciplinary approach to Prenatal and Postpartum care
2. Integrate a full developmental screening into well baby visits at 2, 4, 6, 9, 12, 18, & 24 months and again annually until six.
3. Provide access to developmental programs and services to children age 19 months to adulthood.
4. Create a curriculum that incorporates traditional and western perspectives into child development for use within the family health team and the birthing centre in school within the community and as part of awareness making.

Core Strategy: Support for traditional healing knowledge and practices related to the right full place in the practice of medicine in the community.

1. Participate in the healing & relationship building with traditional medicine practitioners
2. Work with healers to develop parallel practice including ways to share knowledge

3. Provide support at all levels for traditional healing practitioners' procedures and practitioners in the community.

Core Strategy: Provision of Primary Health Care and Specialist Services

1. Provide Primary Health Care to the Six Nations Community
2. Implement a seamless referral network for specialist services and other health service agencies
3. Implement and EMR system
4. Effective clinical policies and procedures that support collaboration and enable family health team professionals to perform within their scope of practice as set out by the professional licensing bodies.
5. Increase Aboriginal Health Professional resource pool by delivery of preceptor ship programs to health professional students in collaboration with local colleges, universities and aboriginal education institutions

http://www.health.gov.on.ca/transformation/fht/fht_mn.html

Values Statement:

We acknowledge the culture of the Haudenosaunee as our historical beginning and we embrace the diversity of beliefs, values and life situation of the community. We centre our vision of the basic diversity of beliefs, values and life situation of the community. We centre our vision on the basic L.A.W.S.e. (land, air, water, sunlight, sustenance and exercise) of healthy life and our reciprocal relationship with each other and all of creation to maintain wellness prevents illness and treat disease. In this way we believe that healing and wellness are nurtured:

- When we daily acknowledge and value our original ways of healing and medicines and utilize the tools of western medicinal knowledge and practice to meet the health needs of the community;
- When the physical, mental, emotional and spiritual needs of the person and their families are the focus of our attention and take priority over system needs;
- When we engage in a continuous process of looking inward and seeking community input for the purpose of improving both individually and as a team.

Chronic Disease Management within the SNFHT:

Type 2 Diabetes Mellitus

Diabetes:

"Diabetes Mellitus (commonly referred to as diabetes) is a group of metabolic diseases characterized by high blood sugar (glucose) levels, the result from defects in insulin secretion, or action, or both" (http://www.medicinenet.com/diabetes_mellitus/article.htm). In both type 1 and type 2 diabetes insulin production and/or function is hindered. If left without medical attention this can lead to a number of health conditions such as: micro and macrovascular diseases, kidney failure, never damage and blindness. Medically, diabetes is seen as an improper distribution of sugar within the blood due to the lack of insulin. From a First Nations cultural perspective, diabetes is viewed as a result of intergenerational trauma. The trauma originated from residential schools, cultural assimilation, being placed involuntarily on reserves and cultural persecution. Those who were the victims of this period of time passed on their hurt and anger from generation to generation, resulting in high-stress levels and cases of depression to their children. Stress causes the body to obtain high-blood sugar levels through the distribution of cortisol within the blood, which extracts high amounts of sugar in the blood, and leaves the sugar within the blood. Due to the high level of sugar obtained in the blood, the pancreas is overworked in trying to produce insulin. A continuous pattern of this process can cause the individual to eventually end up with type 2 diabetes.

Medically, type 2 diabetes is first treated through weight reduction, a diabetic diet, and consistent daily exercise. If these methods do not control the extreme blood sugar levels then oral medication is required. If this is still not sufficient then treatment with insulin is required. The overall medical goal of the medication and lifestyle choices for individuals with diabetes is to allow their body's insulin to function properly in order that the sugar will be properly distributed throughout their bodies. The First Nations approach towards diabetes is to deal with the intergenerational trauma through; counseling, traditional ceremonies, the use of traditional medicine and through different events directed towards living a healthier life. Overall, the First Nations approach to dealing with diabetes is holistic, meaning that is designed to meet the individual's mental, physical, emotional and spiritual needs.

The Six Nations Family Health Team uses an approach to diabetes that focuses on partnering with the client in living a life that supports good health. The person with diabetes is understood first as a whole person. One who has his or her own set of beliefs, values and past experiences. The focus of the therapeutic relationships are to work with the individual, and his or her family when appropriate, to manage the sometimes very complex life circumstances that can come with living "on reserve". While follow up appointments are planned to accomplish

certain targets as per medical practice guidelines the form of communication may differ. Many times discussion will revolve around what is going on in a person's life in general and working with them to improve their insight into a family situation, come to terms with an event or occurrence that has affected the community as a whole (residential school, loss of family connections, recent land claims dispute), or just listening to the narrative of how the person sees diabetes and how it affects their life. It is the view of the Six Nations FHT that allowing this narrative to occur is part of the healing process. It is central to the clinical management plan in assisting our clients to manage their lives and in turn their diabetes. As a matter of fact this narrative is often more effective in helping clients ability to manage diabetes than even medical therapy.

One way we have organized our clinics to help meet the varied needs of clients is to stratify their visits based on individual situation. Those clients whose diabetes management is not on target or who have had difficulties with self management or following up with regular care are seen in a diabetes clinic involving the multidisciplinary team. During these clinics the client first meets with the clinic nurse. The nurse assesses vital signs, checks the glucose monitoring log and cap glucose in office, weight, and height and briefly discusses how they have been in general since the last visit. The main goal for the nurse is to ascertain the disposition of the patient and inform the primary care provider and other team members if there are issues that may affect the visit. If the primary provider has identified the need for a full LEAP (lower extremity assessment program) or an EKG the nurse would complete that at this time.

The dietitian and Registered Social Worker will see the client next. These team members help clients to identify needs and set goals and to provide them with important information that can be of benefit in addressing their life situations and diabetes. If it is identified that the client is in need of more in depth assistance than the dietitian or social worker will schedule a private consultatation outside of the office visit. The last provider to see the client is the Doctor or Nurse Practitioner. At this time a physical assessment is done and medications assessed in accordance with how well the diabetes is managed. An important part of this time in the visit is the opportunity for clients to express other concerns that they have not had the opportunity to discuss or have not felt comfortable bringing forward in the visit.

http://www.cfp.ca/cgi/content/full/55/4/386

http://www.medicinenet.com/diabetes_treatment/article.htm

Philosophy of Care Delivery:

The Six Nations Family Health Team (SNFHT) offers health care within a range of holistic programs and services. Our multi-disciplinary approach requires on-going communication between individual providers and teams. There is implied consent to the sharing of information

among health care providers who are equally bound to maintain confidentiality. It is therefore important that all clients be aware of what information may be shared between providers and who those providers are.

A client should also be made aware of the limits to protection of their privacy. Some legislation requires that staff reveal confidential information to others. For example, the Child and Family Services Act require health professionals to report child abuse. A complete listing of situations where a provider is required by law to disclose PHI is found in appendix 6.

At times, SNFHT may pay consulting health professionals to: consult about client care, help coordinate care, offer supervision to some staff, and provide teaching opportunities for staff and students. Providers are encouraged to bring forward client issues to the consulting professional in an effort to improve client care. Clients brought forward will remain anonymous.

All new clients will be informed of the Health Centre's policy regarding privacy of PHI through any of the following methods: signage, printed information, and/or personal discussion. SNFHT's Privacy Statement (Appendix 1) will be posted in visible areas throughout the Centre. A written statement will also be available for clients and posted on the web site once established.

Record Keeping:

Health records are kept for service planning and monitoring of client progress. All regulated health care professionals are expected to document in the health record. Traditional Healers and Traditional Midwives are exempt from the Regulated Health Professions Act and therefore do not have access to the CMS or EMR. (Other staff are expected to document in the health record include social workers and medical secretaries who are providing significant client information are expected to document.)

Procedures for Opening and Maintaining a New Record:

A new health record is created by the reception staff and on some occasions by a provider. All health records are kept electronically. Some clients may come with printed health record information and in such case these records are maintained in the computer database.

Information that is recorded on registration must legally include name, address, and date of birth. OHIP number must be included if applicable.

A client may have a health record open, but may not be accessing all services at the health centre (i.e. may be identified as a diabetes program or foot program client but not be seen by the medical team). Client information is to be regularly checked and updated to ensure

its accuracy by both reception staff for demographic and registration information, and by the provider for health and wellness issues.

Access to Client Information:

Staff providing direct services to clients, their managers and their administrative support personnel may have access to client records. All access to client information will be on a need to know basis. Security features of the EMR (Electronic Medical Record) will enable different staff to have different levels of access to the client record. For example, staff assigned to collect data, and volunteers and students who work with clients as part of their assigned work, may have access to client registration information but not to the electronic medical record. This access will be decided upon by the Privacy Officer in collaboration with the Primary Providers.

Clients Access to their Health Record:

Clients own the information in their record while the governing body of the SNFHT owns the actual record.

All clients have the right to access health information contained in their health record. Access may be in the form of a printed copy of the record compiled by the provider or may be a reading of the original electronic record. In the later case, the primary provider must be present to ensure that records are not altered or removed. Often the primary provider and/or provider who rendered the service in review will want to be present to offer clarification of any part of the record and to offer support.

The client has the right to all information in their record, including consultation reports marked confidential.

Refusing Access:

In limited circumstances, clients may be denied the right of access to their record if this poses a serious risk to themselves or to others. A table of detailed reasons why access may be refused is found in appendix 2. The decision to deny access must be given in writing to the client by the Privacy Officer. The client then has a right to challenge this decision with a complaint to the SNFHT Privacy Officer, and if not resolved to the Provincial Information and Privacy Commissioner.

Procedure:

- Clients will request access to their records in writing using the appropriate form (appendix 3).

- Clients will be encouraged to specify which part of their health record they are requesting access (e.g. counseling notes, imaging results, medical record).
- The request will be received and the identity of the individual confirmed.
- The receptionist will then give the request for the access to the primary provider who will review the request and share it with other providers who have documented in the chart.
- The primary provider will determine if any legal reasons exist to refuse access as per appendix 2.
- The primary provider will then respond to the request with instructions to either print the chart or to arrange a time to review the chart in person.

Time Frame:

The request for access to the health record will be processed within a maximum of 30 days. In most cases, SNFHT will provide access to the record within 5 working days. Any extensions to the 30 day maximum must be documented clearly with the reason given, and a date when the record will be ready.

Correcting the Clinical Record:

After reviewing their records, the client may feel that their record is not correct or complete. The client has the right to ask for the record to be corrected. It is recommended that all requests are made formally in writing and submitted to the primary provider. In general, the provider must make the requested correction if the client can show to your satisfaction that the record is not correct or complete for the purposes intended and the client is able to provide the correct information.

When Corrections are not required:

You do not have to correct the record:

- That was made by you and where you do not have sufficient knowledge, expertise and authority to correct the record (this would include your ability to validate the new information being provided).
- If you reasonably believe that the request for correction is frivolous, exasperating or made in bad faith (requests should only be refused for these reasons in the rarest cases).
- If the client has failed to demonstrate that the record is not correct or complete.
- If the client has not given you the information you need to make the correction.

*it is important to note that a professional opinion or observation made in good faith about a client does not need to be corrected.

Refusing a Request to Correct the Record:

- If a request is refused for any of the reasons above, a letter must be sent to the client outlining the reasons for refusal.
- The client has a right to make a complaint about the refusal to SNFHT's Privacy Officer and if necessary to the Provincial Information and Privacy Commissioner.
- The client also has a right to make a brief note about the correction refused and have it scanned into the chart. This note must be shared with other providers where relevant.

Procedure for Correcting the Clinical Record:

- The client completes in writing a request to correct the record.
- The identity of the client is verified by reception or the person receiving the request.
- The primary provider is responsible for assessing the request to correct the record and sharing it with other team members who have documented in the chart.
- Ideally the correction should be done by the individual who originally wrote the record.
- The incorrect information should be clearly marked as erroneous and the correct information added.
- The entry must be dated and electronically signed.
- The corrected information must be shared with other providers who are sharing care of the client.

Time Frame:

- All requests for chart corrections must be responded within 30 days.
- The client must be notified in writing if an extension is required with a clear reason for the delay stated and a time frame for completion of the request. The extension cannot be longer than 30 days.

Consent to Collect, Use and Disclose PHI:

There are two types of consent set out in the PHIPA legislation that pertain to collection, use and disclosure of Personal Health Information.

Implied Consent:

Implied consent permits you to conclude form the circumstances that a client would reasonably agree to the collection, use or disclosure of the client's Personal Health Information. An example of this is when a client requests to be registered to receive health care, their

consent can be inferred for the collection of their PHI. Similarly when a client is referred to another provider either within or without SNFHT, their consent to share information can be inferred.

Express Consent:

Express consent is obtained when clients explicitly agree to the collection, use and disclosure of their Personal Health Information. Express consent can be given in writing, orally, by telephone or electronically.

Express consent is needed when the information being disclosed is not for purposes of providing health care. An example would be sharing information with another provider in the community for purposes of research. Express consent is also needed if the information is being provided to a non-health care provider. An example would be sending information to an insurance company or to a client's employer.

Express consent is also required to use Personal Health Information to gather statistics about programs, mail out client information surveys and research purposes. A form for this purpose will be reviewed and signed by all clients and their response recorded in the registration screen. A copy of the form can be found in appendix 4. A sample form for withdrawing this express consent is in appendix 5.

Withdrawing or Limiting Consent:

- Clients have the right to withdraw their consent to collect, use or disclose their health information at any time.
- Clients have the right to limit access to parts of their charts if they desire. For example, a client may request that a counselor not share information with their physician or nurse practitioner or may ask that their HIV status not be shared with another provider.
- It is important to ensure that the client understands the consequences of withdrawing their consent or limiting access to parts of their health record, and this discussion should be documented.

Release of Client Information to External Agencies/Persons:

With Consent:

Clients have a right to request transfer of their medical records and to expect that the service is done in a timely fashion. The original chart is kept electronically, and the relevant parts are printed out for transfer. The client must give consent for transfer of records, and it is good practice to request a signed release of information form. This release is then scanned into the category "forms".

It is acceptable to release information by phone with the client's verbal consent, if it is not feasible to obtain written release without causing undue delay or otherwise jeopardizing care. At the next visit, the client should sign a "Consent to Release of Information" form.

The process originates with the medical secretaries who collect the signed form.

1. It is then passed on to the primary provider who in turn gives direction to the secretaries as to the preparation of the document to be printed.
2. A notation is made in the chart by the medical secretary when the information is transferred which includes the date and name to which it was transferred.

Special Cases:

Minors:

There is no minimum legal age to give consent to release records. The provider must ascertain whether the minor is capable of understanding adequately what he/she is directing, and the consequences of the disclosure. If this competency is not established, the information can only be released through consent of the parent or other legal guardian.

Minor Clients of Separated Parents:

The Children's Law Reform Act permits an 'access parent' of a minor child to obtain health information about that child. However, many other factors may affect the right of an access parent to such information such as a court order, a separation agreement, a marriage contract, the fact that that parents live outside Ontario and so forth. Therefore, unless you understand the family situation and have the consent of both parents, you should seek advice from legal sources or the CMPA before providing information to an access parent.

Deceased Clients:

The executor of a deceased client's estate is generally entitled to review and have copies of the deceased client's records, and to give permission for third party viewing. However providers are encouraged to get legal advice if there are any questions or where full clarity is lacking.

Incompetent Clients:

Where the client has been declared incompetent under the Mental Incompetency Act, access must be granted to the committee appointed under that Act and consent to third-party disclosure must be given by that committee. Where the client is deemed incapable of giving consent and where there is no committee, third party disclosure may be granted to the nearest relative who has the legal authority to do so i.e. Power of Attorney, guardianship, trustee.

Release without Consent:

Client information may be released without consent when required by law or in emergency situations where withholding, information could cause serious harm to the client or another person. In these situations only, the information directly relevant to the circumstances should be disclosed to the appropriate party i.e. police, or Children's Aid. If possible, the client should be informed when these situations happen, except when notification could put the client or someone else at risk. The table in appendix 6 outlines all of the situations where mandatory disclosure must take place.

A manager is to approve the release of information when there is a subpoena, search warrant or court order. Legal counsel may be sought. It is important to read the document closely and only comply with what is specifically requested. It will be necessary to determine if all types of information on the client are required, or only that of a specific program/service.

Ensuring Privacy and Security of Personal Health Information:

Communication Procedures:

Telephone:

Phone messages should consist only of a name and phone number, unless the client has consented to have a more detailed message. To facilitate this process, when the client gives consent for a message to be left this fact will be recorded on the common intake form.

Access to reception voicemail messages must be secured. Replay of voicemail messages must not be audible.

Fax:

Our fax machines for client information are located in a secure area and use preprogrammed numbers whenever possible to send transmissions. All transmissions are sent with a cover sheet that indicates the information is confidential. Reasonable steps will be taken to ensure that health information is received only by a secure fax machine. This may involve among other measures, calling first to confirm the fax number and confirm the location is secure.

E-mail:

SNFHT providers and staff have been assigned secure email accounts with Ontario MD for emailing client information when needed. All communication via email about clients will either use initials or refer to the client by their chart number. Email for communication with clients is not permitted at this time.

Post/Courier:

When health information is sent by post or courier, it is placed in a sealed envelope, marked as confidential, and directed to the attention of the authorized recipient.

Physical Security:

- All client health related information is to be kept in secure areas such as reception or specifically designated filing area where access is limited to providers and staff members.
- These areas including reception must be securely locked at all times when no staff is on duty.
- Filing cabinets and drawers containing Personal Health Information must be securely locked when not in use.
- Files/records may be taken to satellite locations only when it is believed to be essential for client care. The records are to be signed out and kept in a secure place at all times when off site. All records are to be returned within one working day.

Client records are not to be left open or unattended anywhere in the Centre. Informal notes should be kept in locked drawers. After transferring information to client charts, or when the client information is no longer required, it is to be shredded.

Electronic Security:

Six Nations Family Health Team commits to follow provincial guidelines for electronic medical records are set out in Ontario Regulation 114/94, Sections 20 and 21 (appendix 7). Specific guidelines are as follows:

- All computers have access logging and are password protected.
- Passwords are not to be shared or given out under any circumstances. Passwords for the EMR are changed every three months.
- Access logging will be run on a three monthly basis, and a summary report submitted to the privacy officer.
- Access to the various parts of the health record, for staff, is on a need to know basis as determined by the Privacy Officer in consultation with the primary provider(s) and in accordance with PHIPA and relevant policies regulating Personal Health Information.
- Client information should never be left open on a computer screen. Monitors must be situated in such a way that clients are not able to view the screen.
- All computer terminals must have the ability to be easily and quickly locked by the user.
- All users must log off or suspend access when leaving the work area even briefly.

- SNFHT employs a firewall and virus scanning software to prevent unauthorized modification, loss, access or disclosure.

Storing Client Information:

Client records, both written and electronic, are the property of the governing body of the SNFHT. It is the responsibility of SNFHT through the Privacy Officer to secure client information against loss, fire, theft, tampering, access, or copying by unauthorized persons.

Electronic Back-Up:

- Electronic back-ups of the EMR will be run on a daily basis.
- On a monthly basis the tape will be stored off site in a secure location.
- The electronic back-ups will be tested for integrity on a regular basis.

Retaining and Destroying Client Information:

All health records compiled at SNFHT must be kept for 10 years after the date of last entry in a file or 10 years after a client reaches, or would have reached, 18 years of age. If the Centre ceases operation, clients will be notified that they have two years in which to transfer their health record to another physician or to claim the record themselves. Two years after notification, the record may be destroyed.

Information that has been scanned or otherwise entered into the chart may be shredded according to SNFHT policy and procedure. Copies of previous health care records may also be shredded originator of the document. No originals of health records compiled in other centres may be destroyed unless in compliance with The Law and Components of Medical Records – Ontario Regulation 114/94, Section 19.

All paper information with Personal Health Information will be physically shredded when destroyed. All electronic information must be disposed of securely. This implies physically destroying the hard drive of computers that may have stored Personal Health Information or magnetically erasing the tape. In addition all other media (CDrom, diskettes, tapes, etc.) with Personal Health Information must be physically destroyed when their use is no longer required.

Agreement to the Privacy and Confidentiality Policy:

All staff (including casual employees), consultants, students, and volunteers (including Board Members) are expected to sign the Confidentiality Statement (appendix 8) and be aware of, and adhere to the Privacy Policy. The right to privacy of information is to be upheld within the Centre. In order to ensure adherence to this policy, all providers, staff, students and volunteers are expected to:

- Limit discussion of client personal information to the context of improving client care and/or protect the safety of others within the health centre, such as when a client is threatening, verbally and/or physically abusive to others, damaging property, etc.
- Avoid discussion of clients in situations where other clients may hear the discussion.
- Respect the privacy of the client phone conversations and make all efforts to not overhear them.
- Raise any observed violations in confidentiality directly with the person making the violation and/or with their manager.

Ensuring privacy with external agents and contractors:

SNFHT may use external agents and contractors to perform various tasks and roles within the health centre. At times these agents will be involved in collecting, using or disclosing health information. SNFHT will ensure that all external agents:

- Have permission to collect, use, disclose, retain and dispose of Personal Health Information on SNFHT's behalf.
- Use the information only for the stated purpose and for no other purpose except as permitted or required by any law.
- Alert SNFHT if the information they handle is stolen, lost, accessed by unauthorized persons, or used, disclosed or disposed of in an unauthorized manner.

The checklist in appendix 9 will be used to guide contract arrangements and monitoring of external agents.

Fundraising:

Six Nations Family Health Team commits to not use Personal Health Information for fund raising purposes unless explicit consent from the client is obtained.

Complaints:

Six Nations Family Health Team has a standardized process and procedure for dealing with client complaints and which is defined in the Complaints Policy. Complaints as they pertain to privacy of information will be directed to the privacy officer.

Glossary of Aboriginal and Health-Related Terms

Aboriginal People

Indigenous peoples of Canada are identified in Section 35 of the *Constitution Act* of 1982 as including Indians (status and non-status), Métis and Inuit people.

Assembly of First Nations

A national organization that promotes the interests and concerns of all First Nations in Canada, including justice, health, education, family and children's services, and Aboriginal rights.

Band

An organization structure defined in the *Indian Act*, which represents a particular body of Indians as defined under the *Indian Act*.

Band Council

Body elected according to the provisions of the *Indian Act*, charged with the responsibility for "the good government of the band" and with federally delegated authority to pass by-laws on Indian Reserve Lands.

Chief and Council

The elected representatives of a community, who are responsible for the affairs of a band; much as a board of directors is responsible for the management and administration of a non-profit society.

Community Health Nurses (CHN)

Community health nurses are funded by the First Nations and Inuit Health Branch to work in First Nations communities. The services they provide include communicable disease control, environmental health, treatment services (where applicable), emergency response planning and health promotion and prevention.

Community Health Representatives (CHR)

First Nation's health educators are funded by FNIHB (First Nations Inuit Health Branch) to work or reserve. CHR acts as advocates for healthy living. Traditionally, they have played an important role as intermediaries between FNIHB community health nurses and community members.

Department of Indian and Northern Development (DIAND)

A federal department that has primary responsibility for meeting the federal government's constitutional, treaty, political and legal responsibilities to First Nations, Inuit, and Northerners…referred to as Indian and Northern Affairs Canada (INAC).

Extended Family

A group of individuals associated by birth, marriage, or close friendship that nurture and support one another.

First Nation

An Aboriginal community or governing body organized and established by an Aboriginal community. Usually used interchangeably with “Band”. Many bands started to replace the work band in their name with First Nations in the 1980’s. It is a matter of preference by individual bands.

First Nations Inuit Health Branch-Health Canada (FNIHB)

Formerly the Medical Services Branch, FNIHB works with First Nations and Inuit People, a group of people who have a unique relationship with the federal government. The nature of the work has shifted from direct delivery and management of services to a focus on the devolution of health services to First Nations.

Indians

A term used historically to describe the first inhabitants of the “New World” and used to define indigenous people under the federal *Indian Act*. The term has generally been replaced by “Aboriginal people”, as defined in the *Constitution Act* of 1982.

Indian Act

Federal legislation designed to give effect to the legislative authority of Canada for “Indians and Lands reserved for Indians,” pursuant to S. 91 (24) of the *Constitution Act*, 1867.

Indian Reserve

Defined in Section 2 of the *Indian Act* as a; tract of land that has been set apart by the federal government for the use and benefit of an Indian band. The legal title to Indian reserve land is vested in the federal government.

Indigenous

Indigenous means “native to the area”. In this sense, Aboriginal Peoples are indeed indigenous to North America. Its meaning is similar to Aboriginal Peoples, Native Peoples or First Peoples.

The term is rarely used, but when it is, it usually refers to aboriginal people internationally. The term is gaining acceptance, particularly among some Aboriginal Scholars to recognize the place of Aboriginal Peoples in Canada’s late-colonial era and implies land tenure. The term is also used by the United Nations in its working groups and in its Decade of the World’s Indigenous People.

Inuit

Inuit are the Aboriginal People of Arctic Canada. Inuit live primarily in the Northwest Territories, Nunavut and northern parts of Quebec and throughout most of Labrador. They have traditionally lived north of the tree line in the area bordered by the Mackenzie Delta in the west, the Labrador coast in the east, the southern point of Hudson Bay in the south, and the High Arctic islands in the north. The word Inuit means “the people” in Inuktitut and is the term by which Inuit refer to themselves. The Indian Act does not cover Inuit. However, in 1939, the Supreme Court of Canada interpreted the federal government’s power to make laws affecting “Indians and Lands reserved for the Indians” as extending to Inuit.

Medicine People

From a Western perspective, this concept refers to a branch of medicine encompassing treatment by drugs, diet, exercise, and other non-surgical means. From an Aboriginal perspective, it refers to people who promote wellness usually by using herbs, sweats, diet, exercise and other non-surgical means.

Métis

A term for: people of mixed ancestry whose history dates back to the days of the fur trade when Aboriginal people, particularly the Cree, and French or French-Canadian or Scottish and others married. Métis people have historically been refused political recognition by the federal government and have since been recognized as Aboriginal people in the *Constitution Act*, 1982.

Native

Native is a word similar in meaning to Aboriginal. The term is increasingly seen as outdated (particularly when used as a noun) and is starting to lose acceptance.

Non-Insured Health Benefits for Status Indians (NIHB)

The Non-Insured Health Benefits Program provides a limited range of health related benefits to eligible beneficiaries who are status Indians, recognized Inuit and recognized Innu people. The NIHB Program offers specific health related benefits not provided by other agencies such as provincial and territorial health plans or other third party plans. These include premium coverage for MSP, transportation from remote and isolated areas to centres where needed services are available, prescription drugs, medical supplies and equipment, dental care and vision care, and other limited benefits.

Non-Status Indian

Non-Status Indians are people who consider themselves Indians or members of a First Nation but whom the government of Canada does not recognize as Indians under the Indian Act, either because they are unable to prove their Indian status or have lost their status rights. Non-status Indians are not entitled to the same rights and benefits available to status Indians.

Registered Indian

A Registered Indian is a person who is defined as an Indian, under the *Indian Act,* and who is registered under the *Indian Act*.

Reservation

A reservation is land set aside by the United States government for the use and occupation of a group of Native Americans. The term does not apply in Canada.

Reserve

The definition of a reserve is in Section 2 of the *Indian Act* and is defined as follows; a tract of land that has been set apart by the federal government for the use and benefit of an Indian band. The legal title to an Indian reserve land is vested in the federal government.

Status Indian

Status Indians are people who are entitled to have their names included on the Indian Register, and official list maintained by the federal government. Certain criteria determine who can be registered as a status Indian. Only Status Indians are recognized as Indians under the *Indian Act* and are entitled to certain rights and benefits under the law.

Tribal Council

A Tribal council is a voluntary group made up of several bands and represents the interests of those bands. A tribal council may administer funds or deliver common services to those bands. Membership in a tribal council tends to be organized around geographic, political, treat, cultural, and/or linguistic lines.

Tribe

A tribe is a group of Native Americans sharing common language and culture. The term is used frequently in the United States, but only in a few areas of Canada (e.g., the Blood Tribe in Alberta).