



Aboriginal Health Nursing and Aboriginal Health:
Charting Policy Direction for Nursing in Canada

This document has been prepared by CNA to provide information and to support CNA in the pursuit of its mission, vision and goals.

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Table of Contents

Executive Summary.....	1
Introduction	5
Methodology	
1.1 Key Stakeholder Interviews and Online Survey.....	7
1.2 Literature Review	8
1.3 Consultation Process	9
Interview and Online Survey Findings	
2.1 Context.....	10
2.2 Priorities	13
2.2.1 Foundational Priorities.....	16
2.2.2 Practice-based Priorities.....	17
2.3 The Role of Key Players in Aboriginal Health Nursing	24
2.3.1 The unique role of nurses in meeting aboriginal people's health needs.....	24
2.3.2 The role of aboriginal organizations in supporting nurses working in aboriginal health contexts	24
2.3.3 The role of national nursing organizations in supporting aboriginal health nursing leadership	25
Literature Review and Consultation Findings	
Introduction	27
3.1 Integrating Indigenous Ways of Knowing and Being	27
3.1.1 Identified Needs	28
3.1.2 Current Initiatives	30
3.1.3 Remaining Gaps	30
3.2 Addressing Institutional Barriers to Aboriginal Health Nursing and Aboriginal Health	31
3.2.1 Identified Needs	31
3.2.2 Current Initiatives	35
3.2.3 Remaining Gaps	36
3.3 Education: Recruitment and Retention	37
3.3.1 Identified Needs	37
3.3.2 Current Initiatives	39
3.3.3 Remaining Gaps	41
3.4 Practising Nurses: Recruitment and Retention	42
3.4.1 Identified Needs	43
3.4.2 Current Initiatives	44
3.4.3 Remaining Gaps	45
3.5 Building Capacity for Leadership and Advocacy.....	46
3.5.1 Identified Needs	46
3.5.2 Current Initiatives	47
3.5.3 Remaining Gaps	48

Conclusion	49
References	50
Appendix A: List of Aboriginal Health Nursing and Health Advisory Group Members	53
Appendix B: Interview Guide/Online Survey Tool	54
Appendix C: List of Participants at October 2013 Roundtable	61

List of Figures and Tables

Figure 1: Survey and Interview Respondents' Aboriginal Identity (n=100).....	10
Figure 2: Survey and Interview Respondents' Aboriginal Identity by Response Method (n=100).....	11
Figure 3: Survey and Interview Respondents' Work Environment (n=130).....	11
Figure 4: Survey and Interview Respondents' Role in Aboriginal Health Nursing (n=130).....	12
Table 1: Project Priorities (n=89)	15
Figure 5: Strategies for Developing Leadership Capacity (n=74)	19
Figure 6: Does Your Organization Value and Support the Value of Indigenous Knowledge in the Skills Nurses Bring to their Practice? (n=108).....	22
Figure 7: Do Nurses who Provide Services to Aboriginal People have Adequate Access to the Training and Supports they Need to Integrate Indigenous Knowledge into their Practice? (n=108).....	22

Executive Summary

This discussion paper was commissioned by the Canadian Nurses Association (CNA), in collaboration with the Aboriginal Nurses Association of Canada (A.N.A.C.), to provide a document to guide policy development for strengthening and improving aboriginal health nursing, aboriginal health leadership and aboriginal health. A resolution adopted at CNA's 2012 annual meeting, the Aboriginal Nursing Strategic Plan, provided the genesis for this work. The resolution was identified by CNA as consistent with actions outlined in the 2012 National Expert Commission report and as in alignment with CNA's commitment to address inequities within the health system.

Two concepts specific to this area of nursing and nursing care — aboriginal health nursing and aboriginal nursing — are used throughout the report. A.N.A.C. has explored the term aboriginal health nursing since its inception in 1974. It was originally defined as “the way in which nursing care is provided to Aboriginal clients; and also the way in which nursing interventions are targeted towards Aboriginal communities and populations (i.e., community empowerment, etc.)” (Nowgesic, 1999). In 2001, A.N.A.C. developed a discussion paper on aboriginal health nursing and began a “genuine search for a new way of nursing and the challenges and benefits it presents for clients and populations born of social, physical, economic, political, historical, and cultural realities which Aboriginal people want to be faithfully reflected in nursing care” (A.N.A.C., 2001, p.40). Further to this, in 2006, A.N.A.C. initiated a dialogue on making aboriginal health nursing a specialty and to this end began a process of collaborating with other national organizations to advance aboriginal health nursing and recognize the importance of the social determinants of health, cultural safety and indigenous knowledge in nursing (A.N.A.C., 2006a).

Aboriginal nursing refers to clinical practice, research, administration and policy that specifically involve aboriginal nurses who provide aboriginal health nursing. Aboriginal nursing also refers to education programs that address the needs and concerns of aboriginal nursing students. It does not refer to a specialty in aboriginal nursing. The term is used to highlight the specific attention that needs to be paid to aboriginal nurses' unique needs, most of which are connected to the histories, geographies and systemic barriers and policies that have affected and continue to affect Aboriginal Peoples in Canada.

The discussion paper is informed by a number of knowledge and information sources, including primary data obtained through personal interviews with key informants and an online survey, and secondary data obtained through a review of targeted literature. These two types of data collection resulted in the development of the first draft of this document. The draft report was

then reviewed by key stakeholders and experts, including aboriginal nurses, representatives from provincial and territorial nursing jurisdictions, and members of CNA's aboriginal advisory group and specialty groups. Feedback from this consultation process informed the final draft.

Twenty-eight telephone interviews were completed. Of the total number of interviewees, 57 per cent self-identified as aboriginal nurses or aboriginal nursing administrators/educators and 33 per cent as practising registered nurses. Nearly two in 10 respondents reported that they had an education focus, typically in educating new nurses. Three in 10 indicated that they were involved in policy development and research. The online survey was widely disseminated across networks, resulting in 130 respondents, of whom 102 provided a satisfactory level of response for analysis. Sixty per cent of those respondents identified as non-aboriginal.

Two important gaps in the survey and interview data were noted: there were no Inuit respondents and no nurses who work on-reserve. It was agreed during the consultation process that both populations are a vital part of future policy discussions and that their voices need to be heard. Through the process of reviewing and developing the discussion paper, additional areas requiring consultation and research have been identified.

Respondents were given a list of 14 issues specific to nursing in an aboriginal context and generated from the preliminary review of the literature. Respondents were asked to rank these issues according to what they believed this project should address in developing a policy strategy to support nurses working with aboriginal people. Several issues were given the same ranking value, so that more than five emerged from the interviews and survey. Through a process of research and consultation with CNA's aboriginal health nursing and health advisory group¹ (see the list of members in Appendix A), the eight items that were ranked as the top five issues of importance were developed into five priority areas for strategic action:

- Integration of indigenous ways of knowing and being
- Addressing institutional barriers to aboriginal health nursing and aboriginal health
- Education: recruitment and retention
- Practising nurses: recruitment and retention
- Building capacity for leadership and advocacy

¹ Also referred to as the aboriginal advisory group in this report.

The priority areas are considered to be interdependent, not mutually exclusive. In particular, respondents cited institutional barriers such as racism as foundational issues that play an integral role in the other priorities. Integration of indigenous ways of knowing and being was also seen to have a potential impact on the other priority areas.

The consultation process ensured that the paper benefited from the insights of experts in the fields of aboriginal health and nursing, along with CNA members and key stakeholders. A roundtable of experts convened by CNA in Ottawa in October 2013 reviewed the first draft of the document. A summary of the first draft and the roundtable discussions was subsequently presented at a plenary session during A.N.A.C.'s 2013 national forum and was also disseminated electronically to CNA's member jurisdictions and Canadian Network of Nursing Specialties for comment. Feedback was submitted in writing. A synthesis of the additional information and perspectives gained through all aspects of the consultation process is included in the literature review and consultation findings section.

The integration of indigenous ways of knowing and being was considered by the participants in the consultation process to be primary and foundational to all the other priorities and to be the "lens" that integrates the other priorities. An effort was made to capture this perspective in the paper, while at the same time noting that more research is needed on the foundational nature of indigenous knowledge in aboriginal health and aboriginal health nursing.

During the consultation process, a number of stakeholders and experts expressed their appreciation that racism had been identified and named in the discussion paper. Participants agreed that the topic of racism needs to be given more weight because of its prevalence in and influence on aboriginal nurses' experiences and aboriginal health in general. Experts who participated in the CNA roundtable discussion noted that the literature on racism within the context of aboriginal health and aboriginal nursing is sparse and that policy discussions would be improved with additional research. They agreed that a more thorough discussion of racism as a foundational barrier and relevant strategies for action are needed. It was also noted that time is required to build trust and openness so that racism can be discussed.

It was evident from the roundtable discussion that while many institutions have in place policies designed to create enabling environments for aboriginal health, aboriginal nursing and aboriginal health nursing, these policies are not being implemented or championed. To that end, strategies are needed to ensure the adherence to such policies.

Throughout the consultation process, stakeholders affirmed that the collaboration of CNA, A.N.A.C. and aboriginal health stakeholders is very positive for the advancement of aboriginal health, aboriginal nursing and aboriginal health nursing. Stakeholders pointed out that collaboration can be enhanced by ensuring that all voices are heard and that OCAP principles guide the process.² Collaboration can also strengthen the contribution of A.N.A.C., which since 1975 has been an advocate for and the voice of aboriginal nursing, carrying out research and knowledge dissemination, strengthening bonds with communities while supporting its membership, promoting cultural safety and improvements in aboriginal nursing education, and honouring aboriginal health nursing role models. It was also pointed out that other stakeholders, such as nurses' unions and other organizations with a "large reach," could be brought to the table so that, as one roundtable participant said, we can "drop the walls and join hands."

Participants observed that the federal government, which has key decision-making responsibilities for aboriginal health, needs to be included in the discussion and that government officials would benefit from mentorship in indigenous ways of knowing and being. Participants also commented that interjurisdictional matters have major effects on aboriginal health and nursing and that provincial, territorial and regional representatives therefore also need to be part of the ongoing discussion.

The literature review and results of the online survey, interviews and consultation process all point to the need for strategic action that is specific to aboriginal nurses and aboriginal nursing. References were repeatedly made to inadequate funding for, support of and action on existing policies, which have created barriers and challenges to strengthening and improving aboriginal health nursing, aboriginal health leadership and aboriginal health.

The challenges and barriers are clearly documented. Both the researchers and the participants in the consultation process encourage the use of a strengths-based approach to acknowledge the progress being made, particularly in the area of nursing education. A.N.A.C.'s longstanding and important leadership was recognized, as was the need for the continuing support of the association's vision and work.

² OCAP principles refer to First Nations' ownership, control, access and possession of all information concerning themselves, their traditional knowledge and their culture, including information resulting from research (First Nations Centre, 2007).

Introduction

Founded in 1908, the Canadian Nurses Association (CNA) is a federation of 11 provincial and territorial nursing associations and colleges representing more than 150,000 registered nurses. The Aboriginal Nurses Association of Canada (A.N.A.C.), whose mission is to improve the health of aboriginal people by supporting aboriginal nurses and by promoting the development and practice of aboriginal health nursing, has been an advocate for and the voice of aboriginal nursing since 1975. A.N.A.C. carries out research and knowledge dissemination, works to strengthen bonds with communities while supporting its membership, promotes cultural safety and improvements in aboriginal nursing education, and honours aboriginal health nursing role models.³

In response to the diverse health inequities experienced by Aboriginal Peoples⁴ in Canada, and with knowledge of the need to strengthen the critically important role of aboriginal health nursing, CNA has identified aboriginal health and well-being as an area of focus. To support these efforts, CNA and A.N.A.C. collaborated to convene an aboriginal advisory group.⁵ These leaders and experts on aboriginal health nursing agreed that it was important to review the literature and consult with nurse leaders and key stakeholders about the current issues, needs, priorities and existing initiatives in aboriginal health nursing in order to form a foundation for this discussion paper and for the development of policy and action as these pertain to nurses working with Aboriginal Peoples. The research undertaken for this discussion paper includes a literature review; an online survey of aboriginal and non-aboriginal nurses and nurse educators; telephone interviews with a targeted sample of experts; a roundtable discussion with key stakeholders and topic experts held at CNA in Ottawa in October 2013; review of the draft discussion paper by the aboriginal advisory group; presentation of the paper at a plenary session during A.N.A.C.'s national forum in Vancouver in November 2013; and dissemination of the paper to CNA member jurisdictions and specialty groups, who provided written feedback.⁶

³ Please see the References section for the long list of A.N.A.C. publications on these and other topics.

⁴ The term aboriginal as used in the Canadian context refers to First Nations, Inuit and Métis people. See: www.statcan.gc.ca/concepts/definitions/aboriginal-autochtone2-eng.htm. The term indigenous, defined by the *Oxford Dictionary* as “originating or occurring naturally in a particular place; native,” is considered to be more uniting and less colonizing than the term aboriginal and is preferred by many First Nations, Inuit and Métis people in Canada. However, in keeping with the terminology used in the interview, survey and consultation phases, this document will use the term aboriginal when referring to these populations.

⁵ See Appendix A for a list of the advisory group members.

⁶ Those who provided written feedback are referred to as “commentators” in the consultation findings section of the paper.

This discussion paper has gone through a process of presentation, response and review. Expert stakeholders have provided their knowledge and perspectives to shape the document and make it as informed and relevant as possible.

Throughout the report, aboriginal health nursing refers to “the way in which nursing care is provided to Aboriginal clients; and, also the way in which nursing interventions are targeted towards Aboriginal communities and populations (i.e., community empowerment, etc.)” (Nowgesic, 1999). The way nursing care and interventions are provided is informed by indigenous knowledge, values and beliefs, Aboriginal nursing refers to clinical practice, research, administration and policy that specifically involve aboriginal nurses who provide aboriginal health nursing. Aboriginal nursing also refers to education programs that address the needs and concerns of aboriginal nursing students. It does not refer to a specialty in aboriginal nursing. The term is used to highlight aboriginal nurses’ unique needs, most of which are connected to the histories, geographies and systemic barriers and policies that have affected Aboriginal Peoples in Canada.

The discussion paper includes a description of the methodology for gathering the information and undertaking the consultations; presentation of the interview and online survey findings; and presentation of the findings from the literature review and consultations according to five key priority themes.

Methodology

The discussion paper is informed by a number of knowledge and information sources, including primary data obtained through both personal interviews and an online survey with key stakeholders, and secondary data obtained through a review of targeted literature. These two types of data collection resulted in the development of the first draft of this document. The draft document was then reviewed by key aboriginal and non-aboriginal stakeholders and experts, including aboriginal nurses, members of CNA's aboriginal advisory group, representatives from provincial and territorial nursing jurisdictions, and members of CNA specialty groups. Feedback from this consultation process informed the final draft.

1.1 Key Stakeholder Interviews and Online Survey

Interview participants were identified by CNA and the aboriginal advisory group and were targeted based on their affiliations and areas of specific expertise in aboriginal health nursing and aboriginal health. In total, 44 key stakeholders were invited to participate in a telephone interview, of whom 28 completed the interview, yielding a response rate of 64 per cent. Telephone interviews lasted approximately one hour and allowed significant time for probing and discussion. Interviews were completed between August 27 and September 16, 2013. See Appendix B for the interview guide.

An online survey, using the same questions as in the telephone interviews, was constructed using the FluidSurvey platform. CNA distributed the link to the online survey via e-mail to a list of aboriginal health contacts, CNA member jurisdictions and CNA specialty groups. Contacts were asked to share the link within their own networks. The survey was made available for just over two weeks, between August 28 and September 16, 2013. CNA sent a reminder to complete the survey at the midpoint, September 9. There were 134 responses to the survey⁷; 32 were deleted because these respondents did not answer questions on priorities for aboriginal health nursing priorities or strategies. Of the 102 responses included in the analysis, 70 per cent (n=71) were complete entries. The other 31 responses, although incomplete, were included in the analysis because respondents provided both basic information about their organization and answered at least one question on the priorities or strategies for aboriginal health nursing.

⁷ The response rate for the survey cannot be calculated because it is not clear how many people received the survey link.

The following limitations should be considered when interpreting the findings from the interviews and the online surveys.

- The majority (60 per cent) of survey respondents self-identified as non-aboriginal, although the proportion of aboriginal interview respondents was relatively high (57 per cent).
- Given that 25 per cent of the survey respondent group was made up of academic stakeholders, findings may be slightly more reflective of education than the other domains of nursing.⁸
- Of the aboriginal respondents, the findings are more reflective of First Nation contexts (78 per cent). Researchers were unable to access survey or interview responses from Inuit people within the time frame of the data collection, and there were too few Métis respondents to distinguish Métis-specific priorities and strategies.
- Timelines for the survey and interviews limited the number of both aboriginal and non-aboriginal respondents.

1.2 Literature Review

The literature review was undertaken to find evidence of existing and emerging priorities in aboriginal health nursing, along with evidence of current initiatives that are addressing the needs and gaps in addressing these needs. The literature review targeted published and unpublished literature provided by CNA, A.N.A.C., the aboriginal advisory group and JRI consultants, as well as literature recommended by interview and survey respondents. To identify other documents, a Google search was employed using two key phrases: “aboriginal nursing priorities” and “aboriginal nursing policy.”

Initially, 30 documents were analyzed, and a list of 16 priority themes was developed. These priority themes were reviewed by members of the aboriginal advisory group and changes were made accordingly, resulting in 14 priorities that survey and interview respondents were asked to rank (Table 1). Following the October 2013 roundtable, and based on guidance from the aboriginal advisory group, a number of other documents were reviewed, resulting in a total of 53 literature review documents.

⁸ The domains of nursing are administration, direct care (which includes community and public health), education, policy development and research (CNA, 2008).

1.3 Consultation Process

CNA, with the assistance of A.N.A.C., the aboriginal advisory group and JRI consultants, convened a roundtable discussion of key stakeholders and topic experts in Ottawa on October 10, 2013. The purpose of the roundtable was to seek input and best advice on the content of the first draft of the policy document, including recommendations for building the capacity of aboriginal nurses and nurses working with aboriginal people and communities. Representatives from provincial and territorial nursing organizations, academic institutions, government and aboriginal organizations attended the roundtable either in person or by web broadcast. (A list of participants is provided in Appendix C.) The roundtable was opened and closed by an aboriginal elder, and a facilitator led the discussions. JRI consultants presented the findings of the paper and took detailed notes on the discussion. The event was recorded using WebEx technology.

Discussion was focused and highly engaged, with participants providing their perspectives on the findings and contributing knowledge from their own experience and from the experience of the group they represented. Some participants saw the gathering as a significant milestone in the relationship between aboriginal nurses and CNA — several aboriginal nurses commented that they had never had an opportunity to be in the CNA boardroom before. Participants noted the positive effect of the opportunity to meet face to face for such a productive exchange and for expanding their networks for mutual support and knowledge exchange.

A summary of the first draft of the document and the roundtable discussions was presented at a plenary session during A.N.A.C.'s annual forum in November 2013 and was also disseminated electronically to CNA's member jurisdictions and specialty groups, who provided written feedback. A synthesis of the additional information and perspectives gained through all aspects of the consultation process is included in the literature review and consultation findings section. The overall consultation process was guided by CNA, in collaboration with the CNA aboriginal advisory group.

Interview and Online Survey Findings

2.1 Context

There were 102 online survey participants and 28 telephone interview participants, for a total of 130 respondents. It should be noted that some online survey respondents did not answer all questions. As a result, the number of respondents (n) for any given question rarely adds up to 130. Given that the same interview tool was used for both the telephone interviews and the online survey, the data have been combined. Characteristics of the respondent groups are detailed in Figures 1 to 3.

The majority of respondents (60 per cent) identified as non-aboriginal (Figure 1). Of those reporting aboriginal identity (40 per cent), most (78 per cent) were First Nation. Nine respondents identified as Métis, and there were no Inuit participants.

Figure 1: Survey and Interview Respondents' Aboriginal Identity (n=100⁹)

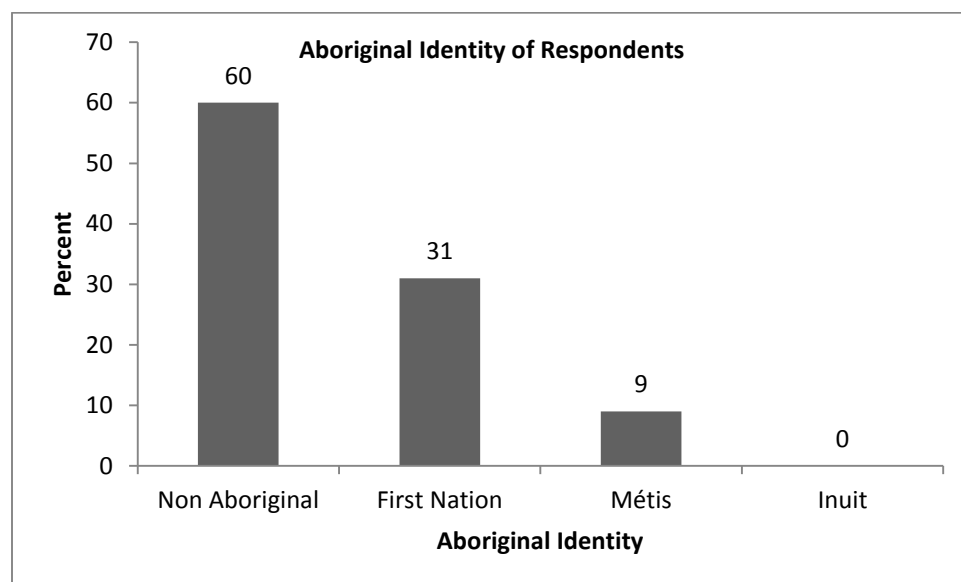
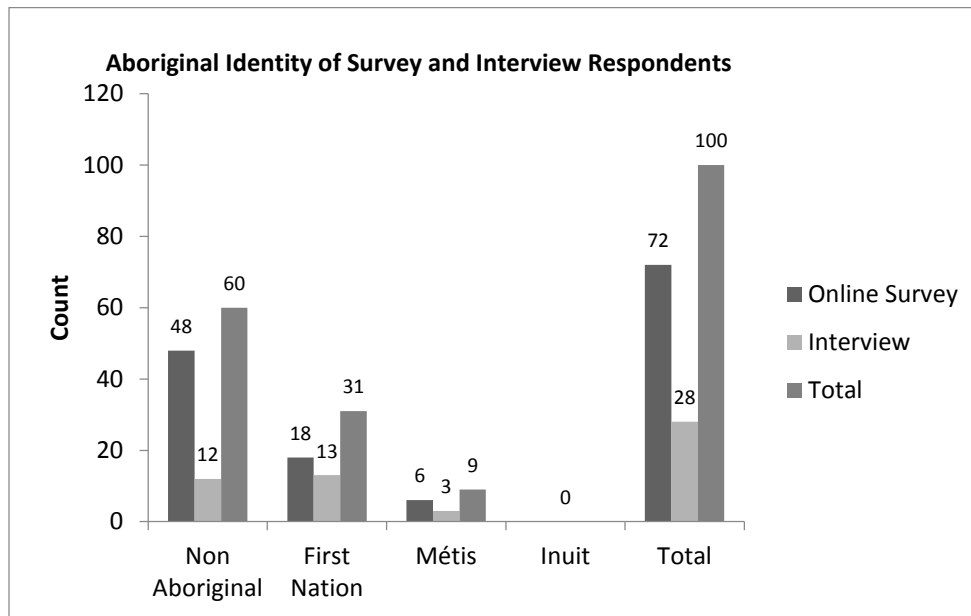


Figure 2 shows a breakdown of respondent identity by response method. The graph shows that a higher percentage of online survey respondents than interview respondents identified as non-aboriginal. The proportion of aboriginal interview respondents was relatively high (57 per cent), while aboriginal survey respondents made up only one third (33 per cent) of the sample. It is difficult to determine the true proportion of survey respondents who are aboriginal due to the high rate of non-response (29.5 per cent) to the question of identity.

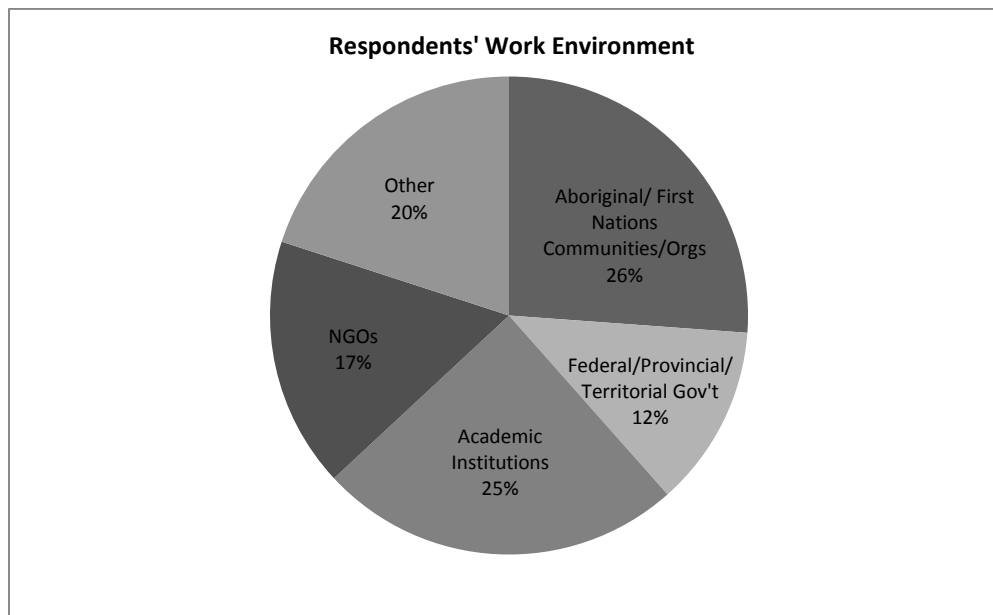
⁹ Aboriginal identity was available for only 100 of 130 participants.

Figure 2: Survey and Interview Respondents' Aboriginal Identity by Response Method (n=100¹⁰)



Over 25 per cent of all respondents (interview and survey) indicated that they work for an aboriginal or community organization (see Figure 3), and the majority of these (65 per cent) work in First Nations organizations. Twenty-five per cent of respondents reported working in academic institutions. Other work environments included hospitals, other health service delivery bodies, government and regulatory bodies.

Figure 3: Survey and Interview Respondents' Work Environment (n=130)

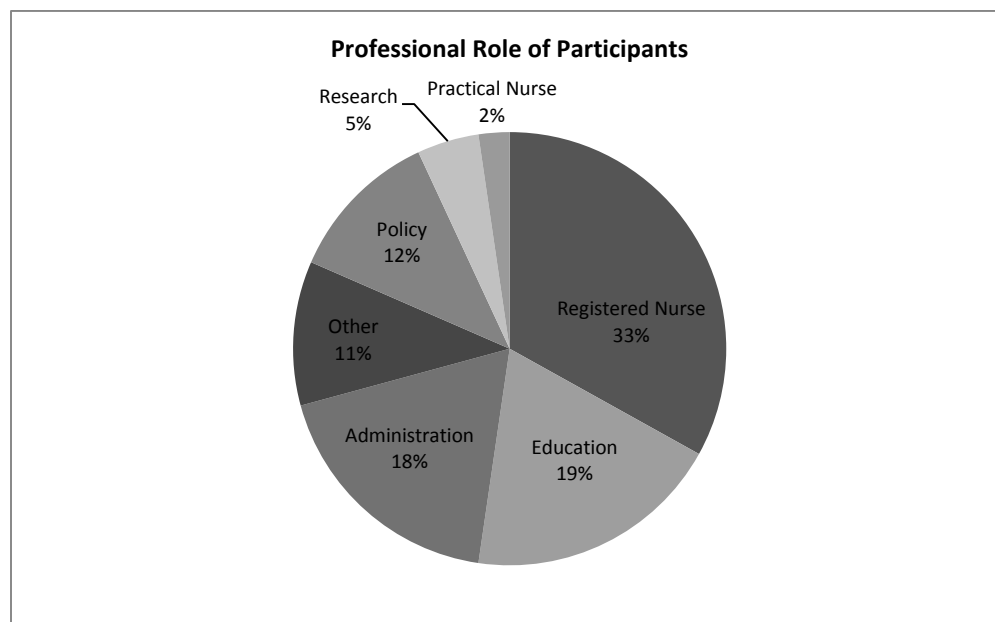


¹⁰ Aboriginal identity was available for only 100 of 130 participants.

When the online survey and interview data are combined, there is a relatively good representation of frontline workers, educators, and policy and administration workers. As Figure 4 shows, 33 per cent of all respondents are practising registered nurses, while 19 per cent reported that they have an education focus, typically in educating new nurses, and 17 per cent indicated that they are involved in policy (12 per cent) and research (5 per cent). A higher proportion of interview respondents than survey respondents reported that they are involved in policy and administration (54 per cent vs. 40 per cent). Generally, participants reported that they play multiple roles in their organization, including advocacy and policy, policy and research, and policy and administration.

When asked which factors their organization considers in making decisions about the nursing needs of aboriginal people, respondents indicated that client needs, aboriginal organization/ community priorities and evidence are the most important factors. Funding and wise practices also figure into the decision-making process but are generally viewed as less important.

Figure 4: Survey and Interview Respondents' Role in Aboriginal Health Nursing (n=130)



2.2 Priorities

Respondents were given a list of 14 issues¹¹ specific to nursing in an aboriginal context and asked to prioritize the issues according to what they believed this project should address in developing a policy strategy to support nurses working with aboriginal people.

Table 1 presents the data in the order they were ranked by respondents. The following eight issues were the top five ranked priorities:

- Identifying institutional policies and practices and administrative barriers that make it difficult for nurses to provide the care that aboriginal people need (rank 1)
- Addressing racism in policy and practice (rank 2)
- Recruiting aboriginal people to the nursing profession (rank 2)
- Providing continuing education and professional development (rank 2)
- Developing leadership capacity (rank 3)
- Recognizing indigenous knowledge (rank 4)
- Developing mentoring programs (rank 4)
- Developing recruitment and retention strategies for nurses to work in northern and remote areas (rank 5)

One quarter (25 per cent) of respondents ranked institutional policies and practices and administrative barriers as their top priority for this project, and 63 per cent identified the issue in their top three priorities. One quarter (25 per cent) of respondents ranked the three issues of racism, recruitment and continuing education/professional development as either their first or their second priority. As a result, these three issues are each ranked number 2. Just over one-third (34 per cent) of respondents ranked developing leadership capacity as one of their top three priorities; as such it is identified as rank 3. The two issues of recognizing indigenous knowledge and developing mentoring programs were seen as equally important, with 36 per cent of respondents ranking them as their fourth priority or higher. Four in ten respondents (40 per cent) ranked recruitment and retention of nurses in remote and northern communities as their fifth or higher priority issue.

¹¹ The list of 14 issues was generated from the preliminary review of the literature, followed by consultation with CNA and the CNA aboriginal advisory group.

Lesser priorities for the majority of respondents in order of ranking are supporting aboriginal nurses as recent graduates (rank 6), implementing aboriginal elder support programs (rank 7), advocating on behalf of aboriginal nurses (rank 8), providing financial and other supports to aboriginal nurses while they attend school (rank 9), building research capacity among nurses (rank 10), and tracking aboriginal ancestry of nurses entering into the profession (rank 11).

Several respondents reported the need for an academic nursing specialty or program; however, it is difficult to quantify the degree to which this issue was an overall priority because it was not provided as an option for all respondents to consider.

The identified priority areas are not mutually exclusive. Many respondents noted their interdependence — that is, in order for change to occur in one area, meaningful change would be required in other areas. For this reason, a distinction is made between foundational and practice-based priorities. Foundational priorities, such as institutional policies and practices and administrative barriers and racism, which topped many participants' lists, are perceived to play an integral role in all of the other priorities.

Table 1 Project Priorities (n=89)*

Priorities	Cumulative Percent									
	Rank 1	Rank 2	Rank 3	Rank 4	Rank 5	Rank 6	Rank 7	Rank 8	Rank 9	Rank 10
Identifying institutional policies and practices and administrative barriers that make it difficult for nurses to provide the care that aboriginal people need	25%	47%	63%	70%	72%	76%	77%	84%	86%	90%
Addressing racism in policy and practice	13%	25%	43%	50%	56%	63%	67%	71%	80%	86%
Recruiting aboriginal people to the nursing profession	15%	25%	32%	38%	44%	50%	55%	62%	67%	73%
Providing continuing education and professional development	13%	25%	36%	44%	54%	63%	70%	79%	85%	88%
Developing leadership capacity	15%	24%	34%	43%	46%	50%	59%	61%	65%	74%
Recognizing indigenous knowledge	7%	18%	26%	36%	53%	61%	69%	72%	79%	82%
Developing mentoring programs	8%	15%	25%	36%	48%	57%	63%	71%	79%	82%
Developing recruitment and retention strategies for nurses to work in northern and remote areas	12%	22%	28%	31%	40%	47%	57%	64%	65%	67%
Supporting aboriginal nurses as recent graduates	1%	7%	14%	15%	27%	34%	40%	47%	57%	66%
Implementing aboriginal elder support programs	6%	7%	9%	18%	24%	31%	41%	48%	50%	55%
Advocating on behalf of aboriginal nurses	2%	6%	12%	18%	24%	26%	29%	38%	49%	50%
Providing financial and other supports to aboriginal nurses while they attend school	1%	2%	5%	14%	20%	23%	30%	32%	39%	48%
Building research capacity among nurses	7%	7%	11%	14%	17%	23%	33%	36%	38%	52%
Tracking aboriginal ancestry of nurses entering into the profession	3%	7%	9%	12%	19%	28%	30%	32%	34%	42%

* A note on the analysis: These data were analyzed by taking number of potential respondents to each question (89) and calculating the percentage of respondents who ranked the priority item as either 1, 2, 3, 4, and so on. The cumulative per cent was then calculated for each rank within each priority to ensure that all rankings were used to determine the overall rank for each priority area. For example, in order to determine the rank 2 priority, the percentage of respondents who ranked an issue as rank 1 was added to the percentage who ranked the issue as rank 2. Rank 3 was determined by adding rank 1, rank 2 and rank 3 percentages. This step was repeated until all rankings were identified.

2.2.1 Foundational Priorities

Identifying institutional policies, practices and administrative barriers that make it difficult for nurses to provide the care that aboriginal people need (rank 1)

This priority was seen as highly influential because changes in this area could positively influence many other priority areas and vice versa. For example, increasing the number of aboriginal nurses in health leadership positions could lead to the development of better policy and strategies to support ways that indigenous knowledge can complement biomedical health systems. Additionally, the implementation of policies to support indigenous knowledge practice (e.g., recognition of indigenous knowledge within the non-insured health benefits program) could lead to better use and integration of indigenous knowledge at the practice level.

The systemic changes that need to occur that could lead to significant trickle-down changes are those that result in a shift in Canadian values regarding equality for all citizens, whereby everyone knows how to access the health-care system as needed and participates as full citizens in the basic activities of life that are derived from adequate employment, housing ownership and supportive social networks. — Interview participant

In general, there was a sense among respondents that while barriers and needs are well-known and documented, there has been little action to address them in practice and policy. Participants emphasized the need for better coordination among aboriginal, provincial and federal health bodies; improvements in community nursing to ensure that nurses working in aboriginal communities receive equitable pay and opportunities for development; greater representation of aboriginal people in national leadership roles (e.g., in national nursing bodies); public policy that allows and legitimizes the use of traditional medicine and ceremony alongside Western models of care; and integration of holistic models of care into the biomedical model. The last two needs correspond with recognizing and integrating indigenous knowledge (rank 4).

Indigenous knowledge needs to be included as a perspective for providing care, and we need to ask for people to step outside of the Western mindset, using language that is shared and understood. — Interview participant

Addressing racism in policy and practice (rank 2)

Without adequately addressing racism in policy, we can't set the landscape for further development. — Survey respondent

Respondents recognized that, in order to improve the care that aboriginal people receive, racism needs to be addressed at all levels: in society, within education and within policy. Education was offered as a primary strategy to deal with racism. Suggestions provided by respondents include:

- systematically ensuring that both the general Canadian public and health practitioners understand the history, colonization, and current reality and policy affecting aboriginal people;
- recruiting aboriginal people to the nursing profession;
- providing relevant continuing education and professional development for nurses; and
- recognizing aboriginal health nursing as a speciality within nursing, with specific competencies.

2.2.2 Practice-based Priorities

Practice-based priorities focus on the need for all nurses working in aboriginal health contexts to provide the best possible care to clients and, on a broader level, to act as leaders in the advancement of aboriginal health nursing practice. The survey and interview results suggest that many organizations do have mechanisms in place that support nurses to provide care to aboriginal clients; however, judging from the responses, these efforts are not sufficient. Each of the practice-based priorities (recruitment, education, leadership, recognition of indigenous knowledge and mentorship) is discussed in detail below. Respondents also made several general observations:

- All nurses providing care to aboriginal people need to be better educated and given ongoing opportunities for professional development to improve quality of care.
- Nurses working in aboriginal contexts must have the same opportunity, pay and recognition as nurses who work in non-aboriginal environments.
- Leadership development opportunities should be targeted at aboriginal nurses.

Recruiting aboriginal people to the nursing profession (rank 2)

Supporting aboriginal nurses means understanding the unique pressures that they experience as members of a vulnerable group and of a provider group and the inherent tensions of balancing both roles. They bring history (real and/or vicarious trauma) with them and have to maintain their identity and loyalties while taking on a new role — very complex. — Interview participant

Many respondents emphasized the need for greater representation of aboriginal people in the nursing profession. Respondents noted a number of concerns that need to be addressed to improve recruitment, including overall improvement in the quality of education provided to aboriginal children, particularly in math and science, at the elementary and secondary levels; and better supports (financial and otherwise) for aboriginal post-secondary learners, many of whom have unique circumstances, such as supporting children or returning to school after years of being out of the system.

Respondents viewed recruitment of aboriginal nurses as an important part of the solution to many challenges in nursing practice in aboriginal contexts, particularly in the areas of bridging the gap between Western medicine and indigenous knowledge, reducing racism, and improving policy and leadership. It cannot, however, be assumed that all aboriginal nurses have an understanding of indigenous knowledge and racism. In the long term, employing a greater number of nurses who are aboriginal will mean having a greater number of people who can take on leadership roles within the profession.

Providing continuing education and professional development (rank 2)

The role of the nurses and their skills need to be better recognized and supported; continuing education would be needed here. — Interview participant

Several interview respondents noted that the roles that nurses take on in aboriginal environments are very different from nursing roles in other community health environments. Yet many nurses working in aboriginal environments are not prepared when they are hired, and some may not be supported to receive professional development after they are hired. As a result of these circumstances, continuing education figured highly on respondents' list of priorities. Many respondents also identified the need for a recognized aboriginal-specific specialty within the nursing field.

Respondents noted that cultural competence and continuing education that are specific to the health needs of aboriginal populations are very important but pointed out that some nurses may not be supported (financially or in allotment of time) to develop these skills. Specific concern was raised

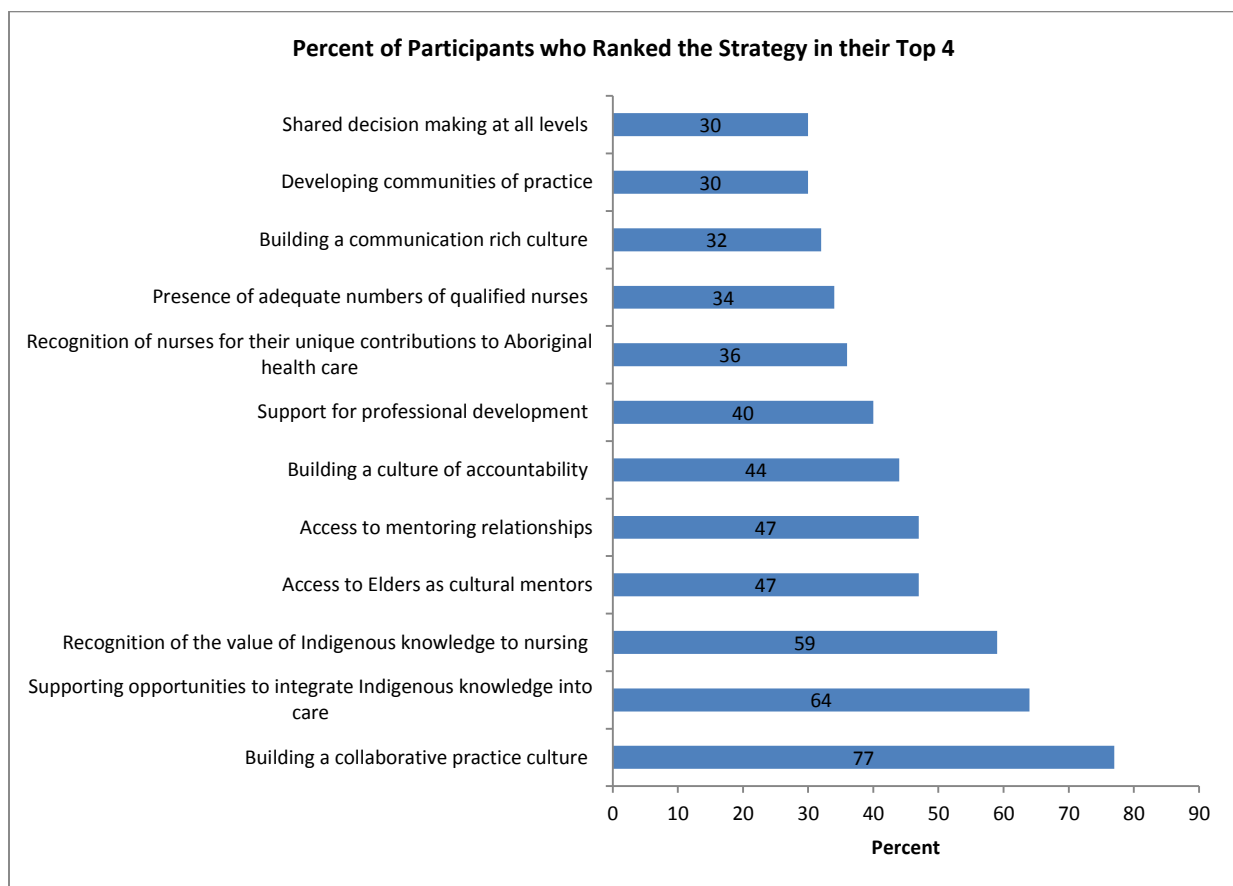
that nurses employed by some First Nation communities may have less access to professional development opportunities because of lack of funding. Lack of funding for professional development is also tied to unequal compensation and lack of recognition of the role that nurses play in aboriginal communities. Respondents did not clarify the reason for these challenges.

Developing leadership capacity (rank 3)

One in three respondents (34 per cent) ranked the development of leadership capacity as one of their top three priorities. Aboriginal nurses were seen to be under-represented in leadership positions throughout the system, whether in front-line practice, in national nursing organizations, or in policy development or administrative roles. Participants noted that aboriginal nurses should be better supported to develop leadership skills and assume leadership positions.

Respondents were provided with a list of 12 strategies for supporting leadership development in aboriginal health nursing (see Figure 5) and asked to prioritize them.

Figure 5: Strategies for Developing Leadership Capacity (n=74)



The top four strategies chosen by respondents, as shown in Figure 5, were as follows:

- Building a collaborative practice culture
- Supporting opportunities to integrate indigenous knowledge models into Western biomedical models of care
- Recognizing the value of indigenous knowledge to nursing
- Providing aboriginal nurses with access to mentoring from community elders and others

Recognizing indigenous knowledge (rank 4)

I think that it is disrespectful to think that indigenous knowledge is something that can be learned by taking a course. This is a very Western way of thinking, and it does not acknowledge the world view that some aboriginal people have.
— Interview participant

Indigenous knowledge comes from each specific community/band/nation.... It is not generalized, which we always try to do. If we do not have access to the traditional knowledge keepers, then we cannot integrate it into our practice. However, we do have the skills/knowledge to be culturally COMPETENT. Always. — Survey respondent

Our organization is focused on skill development and knowledge building. This is good since nurses who work in remote and isolated communities require this. BUT ... there's never time to focus on the cultural significance of our work. We need to slow down, listen and learn, and then integrate indigenous knowledge into our practice. Nurses are not supported to do this as there are never enough of them and there are always too many other priorities. — Survey respondent

Over half of respondents (53 per cent) ranked recognition of indigenous knowledge as one of their top five priorities. As shown in Figure 5, respondents also saw recognition of indigenous knowledge as an important strategy for developing leadership capacity in aboriginal health nursing and in overcoming systemic barriers. While the specific question asked was about recognition of indigenous knowledge, it was clear from the responses that participants also seek integration of that knowledge into Western, biomedical models of health.

Respondents viewed both cultural competence and indigenous knowledge as important concepts, but they saw them as distinct from each other, with challenges unique to each. The term cultural competence was used by respondents to refer to an understanding of the histories, experiences, politics and culture of a specific community or group, whereas indigenous knowledge was used to refer to aboriginal approaches to healing and wellness and general world views. Overall,

cultural competence was understood as something that can be addressed through education and experience, while integration of indigenous knowledge into Western biomedical models of health was considered a more complex undertaking that requires systemic changes. The discussion below focuses on indigenous knowledge, although some findings may also be relevant to cultural competence.

It appears that while many organizations represented in this survey value indigenous knowledge, there is still work to be done to privilege this knowledge in actual practice (see Figures 6 and 7). The challenges of integrating indigenous knowledge are related to foundational issues — namely, the failure of funders and policy-makers to formally recognize the importance and practice of indigenous knowledge by providing funding for indigenous knowledge approaches and incorporating indigenous knowledge into practice and into academic programming. Respondents noted that, in policy and practice, indigenous knowledge is not considered essential, although it may be added on, and that nursing pedagogy is rooted in the biomedical model. Examples of policy barriers provided by respondents include the prohibition of the practice of smudging by First Nations in hospitals and the lack of formal recognition of holistic care (e.g., traditional healers, naturopathy) under Health Canada's non-insured health benefits program.

Other practical challenges include:

- Identifying teachers and supporting them (financially and otherwise) to teach indigenous knowledge
- Deciding who should be trained (e.g., all students in nursing school or only those who will go on to work with aboriginal people)
- Determining how indigenous knowledge should be taught (e.g., whether it can be learned in a course)
- Recognizing that not all aboriginal communities or groups subscribe to traditional beliefs, and that there is no single cohesive set of traditional beliefs

Several respondents noted that at the practice level, there is a valuable opportunity for nurses to address health and wellness goals by leveraging traditional knowledge and the wisdom of elders. For example, one respondent noted the traditional belief that a child is on loan from the Creator and suggested that the teachings around this principle could help nurses to encourage new families to make healthier choices. Respondents pointed out that nurses could be better supported to incorporate indigenous knowledge into their practice if they were offered one or more of the following:

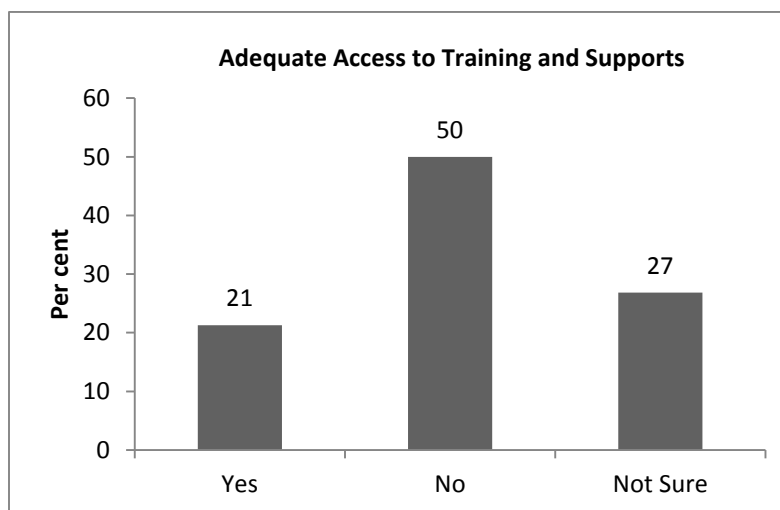
- Policy and funding to integrate indigenous knowledge into nursing practice

- Mentoring from community elders
- Recognition of the value of indigenous knowledge, and support for developing it, from community leadership and health management
- Encouragement from aboriginal nurses who are given support (funding and time) to share their indigenous knowledge, recognizing that not all aboriginal nurses have this knowledge to share and that those who do cannot offer these services in addition to a full workload

Figure 6: Does Your Organization Value and Support the Value of Indigenous Knowledge in the Skills Nurses Bring to their Practice? (n=108)



Figure 7: Do Nurses who Provide Services to Aboriginal People have Adequate Access to the Training and Supports they Need to Integrate Indigenous Knowledge into their Practice? (n=108)



Developing mentoring programs (rank 4)

As an aboriginal nurse, I find it very difficult (at times) to practise in the Western medical system that exists. It would be beneficial to have mentorship programs so that aboriginal nurses feel supported and understood. Ideally other aboriginal nurses could support students and new grads so that there was retention in the workforce. — Survey respondent

Nurses succeed best when they have attitudes of respect and compassion and are mentored by others who are more culturally knowledgeable. — Survey respondent

There are huge benefits that come from mentoring because when it's done well the relationships that are formed are powerful. The interpersonal experience can cross the boundaries of preconceived ideas or assumptions about people; negative experiences of people can melt away when opportunities are created and experienced through good mentorship programs. — Survey respondent

The need for mentoring programs was identified as a top priority, with nearly half of respondents (48 per cent) ranking it in their top five. As evidenced by the survey respondent quotations above, mentorship is seen as very important, but it is rarely used in practice. One participant noted that it would be important to identify how mentoring could work among front-line nurses and which best practices are associated with successful mentoring in an aboriginal context.

Developing recruitment and retention strategies for nurses to work in northern and remote areas (rank 5)

Far too many nurses are hired into First Nation communities without the appropriate skill level and preparation for leading, directing and administering care to clients in the community. Recruitment and retention are hampered by complex care clients, technology, internal pressures from leaders, inadequate remuneration, insufficient professional support, isolation issues, lack of family and friends, lack of crisis incidence stress support, violence. — Survey respondent

There are a number of reasons that recruiting and retaining nurses in northern and remote locations is more difficult. Not all nurses want to work in these environments, and those who do may only be willing to do so for a short period. However, participants suggested that recruitment and retention of nurses in these locations can be strengthened in part by addressing existing inequities — for example, by recognizing the important role that nurses play in the community

and by offering them equal compensation and better support (see discussion under continuing education and professional development [rank 2], above).

2.3 The Role of Key Players in Aboriginal Health Nursing

Respondents commented on the unique role of nurses, aboriginal organizations and national nursing organizations in supporting aboriginal health nursing. The results are presented below.

2.3.1 The unique role of nurses in meeting aboriginal people's health needs

One of the rewards of this type of nursing is that one person can still truly make a difference. I spend a lot of time helping clients navigate the racism and indifference of the provincial health-care systems. In a perfect world, I would not be spending so much of my time doing this when the system should be caring and inclusive. I'm persistent and assertive, but sometimes I get tired of the constant push back. And one of the worst offenders is the non-insured health benefits program. — Survey respondent

Nurses are the building block to our communities. — Survey respondent

When asked about the unique role of nurses in meeting the health-care needs of aboriginal people, respondents did not focus on clinical competencies (although these were implied) but on a host of other roles and responsibilities that these nurses take on. The role of nurses in aboriginal settings, particularly on-reserve, was seen as critically important because these nurses may be the only constant primary care provider. Their scope of practice was described as unique among nurses and as moving well beyond the clinical so as to include:

- providing culturally competent, safe care, while getting to know clients and their communities;
- acting as an advocate for and/or navigator on health and social determinants of health issues for clients; and
- implementing and adhering to a holistic model of health care (several respondents noted that nurses need to be better supported to do this).

2.3.2 The role of aboriginal organizations in supporting nurses working in aboriginal health contexts

Respondents made it clear that aboriginal organizations have a role to play in supporting nurses who work in aboriginal contexts. The fundamental challenge is that aboriginal health capacity within national organizations has been markedly diminished over the past several years as a result of the closure of the National Aboriginal Health Organization and significant funding cuts

to the health departments of several prominent aboriginal organizations, including the Assembly of First Nations, Inuit Tapiriit Kanatami and the Native Women's Association of Canada. Respondents identified advocacy, education and professional development, and partnerships as key roles for aboriginal organizations.

Advocacy

- Improved work conditions — pay equity, professional development opportunities and increased recognition of the important role that nurses play in communities
- Increased health funding
- Improved access to health care for aboriginal people
- Integration of indigenous knowledge into health care
- Recruitment of aboriginal people to nursing programs
- Development of policy and research (e.g., on how indigenous knowledge can be respected and practised within other belief systems and models of care)

Education and professional development

- Providing cultural competency training
- Sharing best/promising practices for nursing in aboriginal contexts
- Offering mentorship opportunities

Partnerships

- Forming partnerships with non-aboriginal and other aboriginal organizations to move priorities forward

2.3.3 The role of national nursing organizations in supporting aboriginal health nursing leadership

We are a forgotten minority, slaving away in our darkened cells for the intrinsic rewards of the work. I would like more recognition, and maybe we need a specialty practice certificate. This work is exhausting but very fulfilling. The amount of paperwork is overwhelming. Not only is there charting but endless reports for every level of government. The perception is that there are no checks and balances in the First Nation systems when, in truth, there is level upon level of mandatory reporting. — Survey respondent

There is too much fragmentation by funding organizations such as federal vs. provincial, and by the time one works through the system and the “deferral of responsible agency,” such as Health Canada’s First Nations and Inuit Health Branch, there is little energy left to do anything. CNA should be able to broaden

the reach for nurses and show leadership that is really groundbreaking rather than status quo. To do that we need to think differently and work differently. We are still filling out questionnaires such as this one that are the same questions that have repeatedly been asked and nothing happens. We need leadership as a discipline for indigenous health that can be applied to nurses working with aboriginal people, not just leadership within nurses in the field.
— Survey respondent

Partnerships, education and advocacy were seen by most respondents to be the primary role of national nursing organizations in building leadership capacity among nurses who work with aboriginal people. Partnerships with A.N.A.C. and other aboriginal organizations were seen as critical for success. Natural partners also include student nurses associations and schools of nursing. A small minority of participants indicated that the role of national nursing organizations should be research.

As indicated in the survey respondent quotations above, the multiple levels of government involved, the fragmentation of funding for aboriginal health and the required reporting are all very challenging for nurses who work in aboriginal health.

Respondents would like to see national nursing organizations focus on foundational issues such as racism and policy and administrative barriers. Suggestions for the role that national nursing organizations could play in education included development of aboriginal-focused community of practice groups, advocacy and support to recognize and facilitate mentoring opportunities, and the provision of training opportunities such as leadership courses.

Respondents also suggested that national nursing organizations advocate for the creation of aboriginal health nursing as a specialized field of nursing tied to core competencies, and for the involvement of aboriginal people within the leadership and governance of mainstream nursing organizations in Canada.

Literature Review and Consultation Findings

Introduction

This section provides the findings from the literature review and a synthesis of the information that came from the consultation process. The organization of the literature review closely follows the five top priority themes that were developed from the eight items that survey and interview respondents ranked as the top five issues. These five priority themes are integrating indigenous ways of knowing and being; addressing institutional and systemic barriers to aboriginal health; education: recruitment and retention; practising nurses: recruitment and retention; and building capacity for leadership and advocacy. Under each of these five priority areas, evidence is presented from both the literature and the consultation process on identified needs, current initiatives and the gaps that remain in addressing needs.

3.1 Integrating Indigenous Ways of Knowing and Being

Minore et al. (2013) describe the concept of indigenous knowledge as follows:

“The acknowledgement of traditional knowledge, oral knowledge, and indigenous knowledge as having a place in higher learning along with literate knowledge. It also includes understanding First Nations, Inuit and Métis ontology,¹² epistemology¹³ and explanatory models related to health and healing; and First Nations, Inuit and Métis cosmologies (spirituality, range of religious beliefs)” (p. 7).

Browne, Smye and Varcoe (2005) argue that the dominance of the Eurocentric voice and ways of thinking and being has stifled and largely excluded indigenous ways of knowing and being, and that the growing assertion of an indigenous world view in health care and research can be an effective means of redressing the power imbalances of our colonial history.

In the literature, the discussion of integrating indigenous knowledge focuses largely on the ways it pertains to aboriginal health nursing education and nursing practice. The literature on this important aspect of cultural safety and human rights is emerging and not yet firmly established but speaks to the importance of creating space for “two-eyed seeing” (Bartlett, Marshall, & Marshall, 2007). First named by Mi’kmaq elder and author Albert Marshall, the concept of two-eyed seeing is the ability to hold one’s own cultural ways of seeing and understanding the

¹² The Merriam-Webster Dictionary defines ontology as “a particular theory about the nature of being or the kinds of things that have existence.” <http://www.merriam-webster.com/dictionary/ontology>

¹³ Stansfield and Brown (2013) define epistemology as “the nature, source, scope and justification of knowledge.”

world while respecting and being willing to work with another system of beliefs and another way of seeing the world, processing knowledge, and entering into human and spiritual relationships.

3.1.1 Identified Needs

Literature Review

More focused research, including research that is community-based and participatory, is needed to refine how best to incorporate indigenous ways of knowing and being into aboriginal health nursing and nursing education — including curriculum design and pedagogy.

A literature is emerging from indigenous authors to address the topic of indigenous ways of knowing and being as they relate to nursing and nursing education. As early as 1999, Nowgesic included indigenous ways of knowing and being in his definition of aboriginal health nursing. The importance of integrating indigenous knowledge into aboriginal health nursing is noted in A.N.A.C. (2006a) and Dion Stout and Downey (2006). The literature affirms that such an integration would change pedagogy and curricula in schools of nursing and would enrich standard nursing practice.

The more recent literature emphasizes the importance of integrating indigenous knowledge into nursing education and practice, including at the design stage. The International Council of Nurses supports “the integration of cultural care knowledge and training for cultural competence into all levels of nursing education” (Douglas et al., 2009, as cited in Canadian Association of Schools of Nursing [CASN], 2013, p. 3). A.N.A.C. (2011b) notes that it is important for First Nations students to have access to traditional knowledge holders and/or eminent scholars on faculty, particularly through the role of elders-in-residence, and that this access is in place in some institutions.

Stansfield and Browne (2013) suggest concrete ways in which nursing curricula could incorporate indigenous knowledge as a way to broaden the perspectives of nurses and create “two-eyed seeing.” One of the keys to achieving two-eyed seeing is to adopt a process-oriented mode of thinking, rather than focusing solely on content (Stansfield & Browne, 2013). Others, including CASN (2013), emphasize the importance of experiential learning as suitable for aboriginal students. Stansfield and Browne (2013) write that indigenous knowledge has the potential to enrich nursing curricula by emphasizing the relational aspect of nursing and by providing a strengths-based approach to indigenous health. In this regard, Waneek Horn-Miller, coordinator of McGill University’s First People’s House, has stated that “an academic education

based on contemporary teachings, combined with our own ancestral knowledge, will allow us to ‘emerge with our hands held forward’ into a promising future” (Gregory, 2007, p. 174).

In reporting on indigenous nurses’ perspectives, Etowa, Jesty and Vukic (2011) emphasize that integrating indigenous ways of knowing is important because of the power of traditional healing to improve the health and well-being of Aboriginal Peoples: “These traditions stem from a broader belief system, one that understands that for most indigenous peoples, kinship, the cosmos and the universe form the foundation of their identities as peoples.” Dion Stout and Downey (2006) note that these practices involve non-measurable evidence that “stems from intuition, ancestors, dreams, totems and stories” which need to be acknowledged and given due consideration in health-care relationships (p. 330).

Consultation Process

Please consider identifying indigenous health as a foundational strength for all Canadians — a gift and treasure from First Peoples to all Canadians to achieve health for all (spiritually, physically, emotionally, mentally). — Commentator

Make indigenous knowledge the foundation and strength/traction to guide this policy as a solution-based document so we may move forward in a good way, led by our elders, traditional knowledge and ways of being. — Commentator

At the October 2013 roundtable discussion, participants clearly articulated that honouring and incorporating indigenous knowledge, or indigenous ways of knowing and being, should be the first priority, as well as an overarching theme for policy directions. Having indigenous knowledge as the foundation would be the key to operating from a strengths-based approach. It would involve employing indigenous processes, not merely adding content, and preserving the integrity of an indigenous approach rather than building on the predominant biomedical paradigm. It was noted that A.N.A.C. and individuals in aboriginal health nursing have been advocating for and acting on honouring indigenous knowledge for a long time, but that the association’s current collaboration with CNA could present an opportunity to make formal supports more mainstream, using CNA’s influence.

Participants in the roundtable discussion pointed out that, to implement change on this priority, there needs to be an education process whereby non-aboriginal people working in health care, government and nursing education learn the fundamentals of indigenous ways, and that this education should come from the communities and indigenous knowledge experts, according to their own ways of teaching. One participant suggested that these strategies need to go beyond nursing education to other fields, and that such strategies could be achieved through

interdisciplinary collaboration with other allied and health professions. Commentators stressed the need for champions among faculty, additional research and tools such as educational materials designed by indigenous experts (perhaps an elders' panel). To avoid the mistake of assuming a "pan-aboriginal" reality, it was emphasized that strategies could be undertaken at the regional level to reflect the diversity of aboriginal cultures.

One commentator cautioned that integration may not be the best goal if the result is homogenization, whereby the integrity of indigenous knowledge is disrupted and the biomedical model prevails.

3.1.2 Current Initiatives

A.N.A.C. (2002a) recommends including personal experience as well as theoretical ways of knowing in aboriginal health curricula. Gregory (2007) cites Thompson Rivers University as an example of one institution that is integrating aboriginal ways of knowing and being. The university's Future Plans course includes "faculty development aimed specifically at curriculum reform to enhance the relevance of the nursing curricula to both Aboriginal students and Aboriginal peoples' health and to increase the significance and contribution of Aboriginal knowledge and ways of knowing" (p. 69).

A promising practice specific to Inuit nurses is the Nurses for Nunatsiavut project, which has been cited by CASN (2013) as "an innovative education program designed by Inuit for Inuit nursing students" (p. 5).

In some cases, practice guidelines for culturally competent care include providing patients with optional access to traditional medicines. Minore et al. (2013) report that the College of Nurses of Ontario includes such a guideline for the incorporation of traditional medicine when requested by clients of First Nations, Métis or Inuit heritage.

3.1.3 Remaining Gaps

The literature affirms that much remains to be done to create environments in which indigenous ways of knowing and being are respected and employed in educational institutions and workplaces. Nursing administrators and educators are cautioned that incorporating indigenous knowledge must be done with careful consideration to the diversity of indigenous ways of knowing and being and with respect for issues of ownership and misappropriation and cultural safety (Stansfield & Browne, 2013). Minore et al. (2013) reiterate how important it is for

individuals and systems to recognize and understand the diversity of cultural beliefs and practices among Aboriginal Peoples in Canada.

Although the literature search was not exhaustive, few examples were found where indigenous knowledge is being incorporated into aboriginal health nursing education and aboriginal health settings, suggesting the need for greater effort in this area.

3.2 Addressing Institutional Barriers¹⁴ to Aboriginal Health Nursing and Aboriginal Health

This section presents the evidence from literature sources on the issue of institutional and systemic structures that impede the provision of the best aboriginal health care and the full and culturally safe participation by aboriginal nurses. These barriers include social determinants of health, which can have profound effects on health and access to health care and which affect all parties involved in aboriginal health nursing. The literature review and consultation process identified racism toward Aboriginal Peoples as a significant and ongoing issue that is systemic in Canadian society and evident in institutional practice. Inadequate recognition of the importance of cultural competence and cultural safety was also identified as an institutional barrier to aboriginal health.

3.2.1 Identified Needs

Literature Review

Unique Social Determinants of Health: The literature identifies the need for a heightened awareness of the unique social determinants of health that, in addition to the standard health determinants, exert powerful effects on Aboriginal Peoples in Canada. The National Expert Commission (2012) recognizes that health inequality arises in large part from inequalities in the determinants of health, such as income, education, employment and lack of self-determination and control. “Those with low levels of income and education, who live in inadequate housing, with limited access to health care and a lack of early childhood support and social supports, are more prone to poor physical and mental health outcomes than those living in better circumstances” (p. 11). The National Expert Commission (2012) has paid particular attention to the health of Aboriginal Peoples, because “so much of the health care of First Nations, Inuit and Métis peoples falls to nurses, especially in isolated northern communities” (p. 20), and calls for nothing less than “system transformation” to change the current status (p. 37).

¹⁴ It was suggested by a participant at the October 2013 roundtable discussion that the term institutional barriers could perhaps be replaced by socio-structural barriers.

Browne et al. (2005) write that the power imbalances and inequities that have arisen from the colonial history of the Aboriginal Peoples in Canada, which still continue today, must be the lens through which we approach health and health care for Aboriginal Peoples, because these inequities continue to powerfully influence peoples' health, well-being and life chances. The authors argue that a knowledge and recognition and understanding of these impacts are fundamental to taking the necessary actions to de-colonize nursing practice.

The effects of these unique determinants cannot be overstated. Colonization has had a powerfully negative impact on Canada's Aboriginal Peoples and their health (Vukic, Jesty, Mathews, & Etowa, 2012). Dion Stout (2012) writes that structural violence such as that enacted in the residential schools system must be considered a "health, social and health care determinant" (pp. 11-12). Dion Stout, a leader and scholar in aboriginal nursing, also names the structural violence of colonial domination, including the reserve system and residential schools and the resulting grief and loss, as the root cause of the health, social and health-care inequities experienced by Aboriginal Peoples. She points out that Aboriginal Peoples "have been rendered complacent, fatalistic, and unwell by past injustices" (Dion Stout, 2012, p. 11). She suggests that we must broaden our view of "poverty" to include the many injustices and harms inflicted on Canada's Aboriginal Peoples: "Poverties of all kinds have stolen productive capacity and independence from many Indigenous people, leaving them confused, traumatized, and in poor health." (Dion Stout, 2012, p. 12). She maintains that wellness can be achieved through Aboriginal Peoples' self-determination (Dion Stout, 2012).

Historically, the harms made to Aboriginal Peoples' physical and mental health through national policies were inflicted at all levels — cultural group, community, family and individual — and the harm needs to be repaired at all levels (Barron, 2009). The societal structures that need to be considered for systemic change include health and educational institutions, federal policies and the Canadian social landscape as a whole.

Racism: The experience of racism must also be considered as a powerful structural barrier to full aboriginal participation in nursing, and to the experiences of aboriginal people in the health care system, as well as a determinant of health (CASN, 2013). The report of the A.N.A.C. (2005a) annual conference summarizes a discussion of the need to address racism and the need for cultural competence in aboriginal health care:

It was recognized that, although many values are shared, First Nations across Canada are diverse, which necessitates flexibility. Nurses need to understand the people they're working with. Stories need to be told, to enable non-Aboriginal people who work with Aboriginal people to understand their perspectives. There are ongoing impacts of racism and residential schools, and many Aboriginal people continue to suffer from timidity. (p. 12)

In its position statement on promoting cultural competence in nursing, CNA (2010) states “that in every domain of practice, nurses must not discriminate on the basis of a person’s culture” (p. 1). Racist beliefs and stereotypes have been shown to reduce the quality of nursing education for aboriginal nurses (Martin & Kipling, 2006), as well as the health care received by aboriginal people (Browne et al., 2005).

In a report of aboriginal nurses’ perspectives on their work experience, participants identified racism and conflicts with teachers as factors affecting their work environment (Etowa et al., 2011). In a study of aboriginal nurses in Atlantic Canada, participants noted experiences ranging from “subtle” to “blatant” racism, racism directed at them personally, and the witnessing of racial discrimination against aboriginal patients in the health-care system (Vukic et al., 2012). The study authors state that racism is systemic, that it is maintained by “policy inaction,” and that it results in culturally unsafe care “because the power to make decisions, to take collective action, and to allocate resources resides at this level” (Vukic et al., 2012, p. 7).

Cultural Competence: CNA (2010) defines cultural competence as “a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals, and enables [them] to work effectively in cross-cultural situations.” Cultural competence within the health-care system and among health-care professionals is critical to addressing institutional barriers, and is essential in today’s nursing care (Chabot, 2006; A.N.A.C., CASN, & CNA, 2009a; Rowan et al., 2013). Cultural competence has been validated as a necessary core competency for all nurses and other health-care providers. Integrating cultural content and an understanding of aboriginal processes and paradigms into nursing education can result in increased cultural understanding and knowledge (A.N.A.C., CASN, & CNA, 2009a; CASN, 2013; Rowan et al., 2013; Minore et al., 2013).

The A.N.A.C. (2011b) national forum report provides commentary on the need for cultural competence training that will remedy a situation in which “cultural destructiveness,” “cultural incapacity” and “cultural blindness” have caused harm to Aboriginal Peoples in the health-care and health education systems (p. 10). The report notes that a high percentage of nurses indicated a desire for cultural competence training as part of their professional development (A.N.A.C.,

2011b). In an A.N.A.C. 2013 online survey of aboriginal nurses' educational needs, 53 per cent of respondents identified a desire for training in cultural competency and cultural safety. A recent study of Canadian schools of nursing found that schools that have an environment of cultural competence and cultural safety have higher student retention rates (Rowan et al., 2013).

Cultural Safety: A.N.A.C., CASN and CNA (2009a) presents the concept of cultural safety, noting that it goes beyond the focus of cultural competence, which is on skills, knowledge and attitudes. "Cultural safety is predicated on understanding power differentials inherent in health service delivery and redressing these inequities through educational processes" (p. 2). The concept of cultural safety places the focus on the experience of the aboriginal person in the system, and not only on the knowledge and behaviours of individuals and systems. Creating an environment of cultural safety would require strategies such as providing more aboriginal content and more aboriginal teachers in the nursing education system. It would also require systemic changes that would address racism and incorporate an indigenous knowledge and world view into nursing education and practice.

Browne et al. (2005) argue that the "culture of health care," with its widely accepted practices and policies that have created inequities in health-care service delivery, can "threaten the cultural safety of Aboriginal peoples." The literature identifies cultural safety as a requirement for both aboriginal clients in the health-care system and aboriginal students in nursing programs. Yet curricula, by and large, have focused on cultural competence rather than cultural safety (A.N.A.C., 2002a, 2005a; College of Registered Nurses of British Columbia [CRNBC], 2009; Minore et al., 2013; Rowan et al., 2013). One of the ways in which cultural safety for aboriginal nurses could be enhanced is through increased knowledge and understanding by non-aboriginal Canadians, particularly non-aboriginal nurses, of the history and contemporary realities of Aboriginal Peoples (A.N.A.C., CASN, & CNA, 2009a).

CASN (2013) sums up the key to enhanced cultural competence and cultural safety by recommending that we "build respectful relationships" and "promote social justice and equity while providing care" (pp. 10-11).

Consultation Process

We would like to have an indigenous school of nursing. There are many of us trying to increase the number of faculty and to mentor nursing students and high school students. Students would flock to such a school.

— Expert roundtable participant

Immersion in First Nations communities where the community is the teacher is an excellent strategy and should be structured and promoted as an anti-racism educational strategy for faculty and administrators. — Commentator

At the October 2013 roundtable discussion, there was agreement that addressing institutional and systemic barriers, most particularly racism, is vitally important for creating both cultural competence in the non-aboriginal population and cultural safety for aboriginal nursing students, practitioners and clients. Participants shared knowledge of how institutional barriers are keeping the numbers of aboriginal nursing students low — for example, a shortage of dedicated enrolment places in nursing education. While it was noted that progress has been achieved, particularly by A.N.A.C., it was also observed that aboriginal health is worsening. One aboriginal health expert suggested that we use the concept of “syndemics” to understand the cumulative and interconnected effects of multiple harms to Aboriginal Peoples. For example, research has shown that asthma rates are higher in populations that have lower socioeconomic status and in children who are exposed to violence (Singer & Clair, 2003).

A number of workshop participants suggested that action on racism and other systemic barriers should not be confined to nursing, but that we should, as one person put it, “drop the walls and join hands” to make changes across the health care-system. Participants also pointed out that governments, as key stakeholders in collaborative actions for change, need education and capacity to understand aboriginal contexts and issues. More than one participant noted that interjurisdictional issues can create significant institutional barriers for Aboriginal Peoples. Another suggestion was that the nursing examination and institutional accreditation processes could be a vehicle for more widespread awareness and action to create cultural safety. A number of participants and commentators stated that the issues are well-known and have been for some time, but that this knowledge has not resulted in effective actions to end racism and other systemic barriers. Others encouraged CNA and A.N.A.C. to undertake in-depth research on institutional barriers as a foundation for action on building respectful relationships. One commentator noted that it is not enough to have general anti-racism and anti-harassment policies — aboriginal-specific policies are necessary. It was also stressed that simply having the right policies in place does not go far enough; institutions need champions and mechanisms to ensure adherence to policies.

3.2.2 Current Initiatives

A.N.A.C. has been a champion of cultural competency and cultural safety in aboriginal health nursing and nursing education for many years (A.N.A.C., 2007a, 2007c; A.N.A.C., CASN, & CNA, 2009a, 2009b, 2009c). Together with CNA and CASN, A.N.A.C. has developed a

framework and curriculum for implementation in schools of nursing through a multi-year initiative called Making it Happen: Strengthening Aboriginal Health Human Resources. The initiative, which was funded by Health Canada's Aboriginal health human resources initiative, also involved the participation of six Canadian universities and colleges¹⁵ (A.N.A.C., CASN, & CNA, 2009c). The framework is the basis for the development of curricula in a number of Canadian schools of nursing. A.N.A.C. has partnered with the Canadian Healthcare Association's learning department to implement the framework (A.N.A.C., CASN, & CNA, 2009c).

CASN (2013) provides recommended actions for educating nurses on the social determinants of health that are particularly relevant to aboriginal people's health, and highlights a number of projects across the country that are taking action to increase cultural competence and cultural safety. The concepts of cultural competence and cultural safety are also supported in principle by the International Council of Nurses.

3.2.3 Remaining Gaps

Although concrete steps are being taken, more policy actions are needed to address systemic racism and the shortage of cultural competence and cultural safety (Vukic et al., 2012). Rowan et al. (2013) suggest that institutions (including governments) need a "champion" within the institution, as well as dedicated financial resources, to ensure the implementation of and adherence to policies and initiatives of cultural competence and cultural safety. The relationship between racism and the understanding and incorporation of indigenous ways of knowing in aboriginal health nursing needs closer examination.

A greater number of aboriginal faculty and more aboriginal content are needed in nursing education. The Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons of Canada (2009a, 2009b) have developed core curriculum for residents and physicians for providing culturally safe care; however, this curriculum does not appear to be fully integrated into medical faculty curricula. One roundtable participant noted that progress has been made in the sector of general indigenous education, and that cultural safety could be incorporated into nursing education.

Greater knowledge and understanding of cultural safety and cultural competence by non-aboriginal nurses is needed. As discussed in the next section on nursing education, much remains

¹⁵ The six institutions that partnered with A.N.A.C., CASN and CNA in the Making it Happen initiative are St. Francis Xavier University, Nova Scotia Community College, Laurentian University, Trent University, the University of Alberta and Langara College (A.N.A.C., 2006b).

to be done to provide culturally safe education and learning environments for aboriginal students (A.N.A.C., CASN, & CNA, 2009b).

3.3 Education: Recruitment and Retention

This section explores some of the challenges related to the recruitment and retention of aboriginal and non-aboriginal nursing students who want to work in aboriginal health. The priority of recruiting aboriginal people to nursing programs and retaining them in their programs is noted.

3.3.1 Identified Needs

Literature Review

Access to aboriginal nurses helps to improve health status for aboriginal communities (Kulig et al., 2010). Thus, further action is needed to increase the recruitment of First Nation, Inuit and Métis students to nursing programs, including at the graduate level (Gregory, 2007; Vukic et al., 2012).

While the actual number of aboriginal students in nursing programs is unknown (A.N.A.C., 2006b; see also A.N.A.C., 2006a, 2011b; CNA, 2010), the representation of Aboriginal Peoples in nursing programs (and, according to Vukic et al. [2012], in the profession) is low. Etowa et al. (2011) cite figures from 2002 estimating that only 0.7 per cent of the Canadian undergraduate nursing student population were aboriginal and less than 1 per cent of Canadian nurses were aboriginal. Gregory (2007) notes, furthermore, that there is a shortage of First Nation, Inuit and Métis graduate students who, as nursing school faculty, would not only help to provide cultural safety for students in nursing programs but also strengthen the research capacity within aboriginal health nursing. In a recent survey of Canadian schools of nursing (including 12 deans of nursing), respondents reported that between 1 per cent and 10 per cent of nursing students identified as aboriginal and that this percentage was even lower for aboriginal faculty (Rowan et al., 2013). Despite this awareness of the low numbers, most respondents indicated that their institutions lacked policies to recruit aboriginal faculty.

Barriers to the success of aboriginal students in nursing programs have been noted in the literature. First Nation, Inuit and Métis students need an education that includes teaching from staff who are culturally competent and an education system that can provide both personal and cultural safety and supports (A.N.A.C., 2002a, 2005a, 2006b, 2011b; Minore et al., 2013), while also encouraging and supporting student success (A.N.A.C. 2006a). According to A.N.A.C.

(2006b), best practices for recruitment and retention of aboriginal students in nursing education need to focus on supports at every level of nursing education, including:

- gaining entry into programs;
- completion of their program;
- assistance with finding their own role as an aboriginal person in making a meaningful contribution to nursing practice and adapting the profession to themselves and other aboriginal people;
- preparation for graduation from the program; and
- preparation for nursing employment.

A.N.A.C. (2006a) and Minore et al. (2013) have identified the following as some of the specific barriers to aboriginal students' success: shortage of available child care, the need for counselling supports to build confidence and self-esteem, inadequate secondary school preparation, and the need for flexible programs that allow students to study while they are employed. Inadequate preparation for college or university among aboriginal students has been identified by Rowan et al. (2013) as an area requiring attention. The literature also notes that, since many aboriginal men and women from rural or remote places enter nursing programs as mature students, distance education should be used to augment the curricula to help meet their needs (A.N.A.C., CASN, & CNA, 2009c; Minore et al., 2013).

The A.N.A.C. (2011b) national forum report includes discussion of the lack of aboriginal content and aboriginal faculty in most nursing programs and notes that the little aboriginal content that does exist tends to be problem-oriented. Minore et al. (2013) suggest that taking a strengths-based approach that focuses on best practices and improvements would provide more supportive workplace and educational environments for aboriginal nurses. The authors go on to suggest that nursing education needs a pedagogy that recognizes and appeals to an aboriginal approach to learning, which tends to be holistic, visual and collaborative (Minore et al., 2013).

Consultation Process

There needs to be a special focus on recruiting aboriginal youth into the nursing profession — especially given population demographics; this is an opportunity for an improved quality of life for them. The young people need to get involved. — Expert roundtable participant

We need to develop and support career trajectories of aboriginal women and men as faculty and researchers and in advanced practice. There has to be better recognition of aboriginal nursing students as a scarce and valued human

resource requiring strategies and supports specific to their context and preferred career trajectory. We need research to understand more about the preferred career trajectory and how it is supported. — Commentator

Participants at the October roundtable discussion and commentators on the first draft of this paper pointed out that more aboriginal people need to be encouraged to choose nursing as a profession and that more effort needs to be dedicated to retaining them in education programs until they graduate and secure employment. This effort will require additional dedicated funding and greater participation by the federal government. Participants noted that the standard of high school education for aboriginal students needs to be raised in order to prepare them for post-secondary education, and that even children as young as age 11-12 could be informed about nursing as a career choice by attending nursing summer camps. It was suggested that CNA could encourage nurses to self-identify as aboriginals in order to gain a better understanding of how many aboriginal nurses are practising in Canada.

A number of commentators suggested that increasing the number of aboriginal faculty in nursing education programs could be a key to recruiting and retaining more aboriginal students, and that, in addition, all faculty should have training in cultural competence and cultural safety. Others maintained that stronger linkages need to be created between nursing education programs and communities and indigenous knowledge experts, in order to increase indigenous knowledge and to give the necessary supports to aboriginal students. The creation of an aboriginal nursing specialty was suggested as a strategy by some commentators, and one roundtable participant called for the creation of an aboriginal school of nursing.

The use of a strengths-based approach (as also described in the literature) was encouraged by several commentators to acknowledge the progress that has been made in some areas of education, as well as in relation to other priority themes.

3.3.2 Current Initiatives

Academic supports are being provided to students in a number of ways. Mentoring, including peer mentoring, has been identified as an effective support mechanism for aboriginal nursing students (A.N.A.C., 2005a, 2006b; A.N.A.C., CASN, & CNA, 2009a; Minore et al., 2013). The A.N.A.C., CASN and CNA (2009b) framework recommends mentorship programs as a core competency. Mentorships can serve to heighten awareness in both aboriginal and non-aboriginal students and faculty (Minore et al., 2013). A.N.A.C. is currently partnering with a number of academic institutions to develop a mentoring program for aboriginal nursing students (Etowa et al., 2011).

The literature review found evidence that mentorship programs are offered at four schools — University of Saskatchewan, Sault College, McGill University and Thompson Rivers University (Gregory, 2007) — and that mentorship is a recommended professional development support in British Columbia (CRNBC, 2009). Furthermore, A.N.A.C. (2007b) has produced a booklet, “I Want to be a Nurse,” that identifies scholarship, bursary and award listings for prospective aboriginal nursing students.

At least one Canadian school of nursing provides tutoring, particularly in the areas of anatomy and physiology, to support students who do not have a strong background in these areas (Rowan et al., 2013). Another promising practice highlighted in the literature is the University of Lethbridge’s support program for aboriginal nursing students, which has been in place since 2007 (Kulig et al., 2010). The program is presented as a model for other programs because its design, implementation and evaluation are informed by an aboriginal perspective. Indigenous knowledge is valued and promoted in the initiative, which also benefits the nearby aboriginal community and is educationally sound (Kulig et al., 2010).

A 2007 review of aboriginal nursing in Canada found that all schools of nursing had a policy supporting the recruitment of more aboriginal students and that specific efforts were being made in Saskatchewan, Manitoba, Nova Scotia, Newfoundland and Labrador, and Nunavut (Gregory, 2007). The A.N.A.C. (2006a) report of the forum on the Aboriginal health human resources initiative specifically mentions the University of Saskatchewan’s native access program to nursing, as well as a nursing education program developed for Inuit people in Labrador.

Etowa et al. (2011) reported on supports for aboriginal students, including the University of British Columbia’s aboriginal nursing students’ recruitment programs, the First Nations University of Canada and the University of Saskatchewan, in addition to related initiatives undertaken by A.N.A.C. The University of Saskatchewan’s access program addresses barriers to student success by supporting entry-level students to meet the requirements in cases where they have not been adequately prepared.

Nunavut Arctic College sends recruitment packages to all nursing stations and schools in 26 Nunavut communities and advertises the nursing program on radio and TV. The Nunavut government provides a variety of supports and incentives — financial, academic and personal — to encourage recruitment of Inuit nursing students (Gregory, 2007). In addition, the Nunavut Arctic College curriculum (from the Collaboration for Academic Education in Nursing) incorporates Inuit culture by including, among other strategies, the use of Inuit words in

relation to anatomy and physiology (Gregory, 2007). Students can complete practicums in communities of their choice.

The A.N.A.C. (2011b) national forum report notes how important it is for First Nations students to have access to traditional knowledge holders and/or eminent scholars among the faculty, particularly through elders-in-residence, a role that exists in some institutions (p. 14).

A promising practice is to provide elders on site to support students. Access to elders is being provided in the Nova Scotia Community College's practical nursing program, in a component dedicated to improving cultural knowledge (CASN, 2013), as well as at Nunavut Arctic College and at the University of Toronto's First Nations House (Gregory, 2007). Several other schools offer access to elders as part of their support programs, including the Thompson River University aboriginal nursing project, which elders helped to design (Gregory, 2007).

A curriculum presented at the A.N.A.C. (2011b) national forum included the following: colonial and post-colonial¹⁶ administrative policies and practices; aboriginal demography, health determinants and health status; indigenous concepts of health and healing; and access and barriers to the care system. The College of Registered Nurses of British Columbia includes among its core competencies for entry-level nurses an understanding of the factors influencing aboriginal health (CRNBC, 2009).¹⁷

3.3.3 Remaining Gaps

Despite the desire for change and the efforts made over the past several years, the recommendation by the National Expert Commission (2012), that “nurses and other health professionals should advocate for and actively support the recruitment, education, employment and retention of First Nations, Métis and Inuit people ... into the health professions” (p. 45), suggests that not enough progress has been made in this area.

A recent study by Rowan et al. (2013) concludes that there is a need for more policy and financial supports for recruitment of aboriginal faculty to Canadian nursing schools as well as for institutional champions to promote the integration of cultural competence and/or cultural safety into undergraduate nursing curricula.

¹⁶ Post-colonial in this case refers to the period after colonization. It should be noted that there is some controversy about using the term “post-colonial” (Czyzewski, 2011).

¹⁷ At the October 2013 roundtable discussion, one participant expressed the view that curriculum development should also be done at medical schools, and Elder Annie Smith St. George noted that she provides indigenous knowledge for medical students at the University of Ottawa.

Creating a specialty in aboriginal health nursing is noted in the literature as a key strategic action that could meet current and future needs. A.N.A.C. (2001) has advocated for many years for the creation of such a specialty. The A.N.A.C. (2011b) national forum report notes that the majority of nurses surveyed believed there should be a specialty in aboriginal health nursing. The report of the A.N.A.C. (2002a) survey showed almost unanimous support for such a specialization, noting that it would provide “critical” support for improved nursing practice in communities. This same survey demonstrated A.N.A.C. membership support for the association’s leadership role in promoting specialization at the planning and policy levels. Specialization was discussed again at the A.N.A.C. (2005a) annual conference, where it was additionally noted that policy change could be supported by, among other things, high-quality evidence or research and research–policy linkages.

CASN (2013) has advocated for the inclusion in curricula of the social determinants of health that are particularly relevant to the health of Aboriginal Peoples. At a minimum, aboriginal health nursing education needs to prepare nurses for the complexities and realities of aboriginal health and the settings in which the nurses will work. There is a need for curricula that provide aboriginal nurses with the knowledge and skills necessary to work in rural/remote communities (Minore et al., 2013; Stewart et al., 2006). Curricula would include preparation for an expanded scope of practice (A.N.A.C., 2005a; National Expert Commission, 2012) that could include education on the commonality of concurrent disorders, attention to environmental health, chronic disease management (including self-management — National Expert Commission, 2012), health promotion, disease prevention, health funding and governance.

Throughout the consultation process, participants and commentators emphasized that primary and secondary school education for aboriginal students is underfunded and that addressing this situation would better prepare aboriginal students to enter nursing. Additional financial support for aboriginal nursing students (who are often mature students with families) could also assist in retaining students in nursing programs.

3.4 Practising Nurses: Recruitment and Retention

This section examines the needs of nurses practising in the area of aboriginal health and strategies that have an impact on their recruitment and retention.

3.4.1 Identified Needs

Literature Review

Health Canada, through the First Nations and Inuit health branch (FNIHB), has traditionally been the primary employer of nurses practising in First Nations and Inuit communities (A.N.A.C., 2002a). However, over the past 20 years, the situation has changed as communities have achieved greater self-determination in health through health transfer, self-government agreements and community development. Today, many nurses are employed by First Nations health authorities (A.N.A.C., 2002a). In a 2013 A.N.A.C. survey of the educational needs of nurses working in aboriginal communities, 60 per cent of respondents indicated that they were employed by a band council and another 20 per cent identified a local or regional health authority as their employer.

Professional supports, continuing education and practice guidelines are some of the strategies that have been identified in the literature to retain practising nurses. Aboriginal nurses are keen to access more professional development opportunities (A.N.A.C., 2002d, 2013). The 2013 A.N.A.C. survey of nurses' educational needs revealed that nurses' professional development priorities were cultural knowledge, management/administration skills and updates to clinical practice guidelines. Respondents to the survey also demonstrated a desire for skills such as conflict resolution that would help create a healthier workplace (A.N.A.C., 2013). In 2002, A.N.A.C. stressed the importance of placing "an emphasis on Aboriginal nursing issues, meaning that this population recognizes their issues as distinctly meaningful from a cultural perspective and, therefore, worthy of a 'deeper understanding'" (A.N.A.C., 2002b, p. 12).

Key factors affecting aboriginal nurses' decisions to work in aboriginal health settings were proximity to home and the opportunity to work in a small rural community, followed by practice considerations such as salary, benefits and job security (Stewart et al., 2006). In a national survey of RNs working in rural and remote areas, 210 of the 3,933 respondents self-identified as having aboriginal or Métis ancestry, of whom 69.6 per cent were originally from rural/remote communities and 66.7 per cent had returned to such settings because they wanted to work with their own people and raise their families there (Kulig et al., 2006, as cited in Vukic et al., 2012).

In a report of indigenous nurses' perspectives on their work experience, participants identified inadequate funding and lack of available child care, as well as lack of social support, racism and conflicts with teachers, as barriers to their experience of continuing education (Etowa et al., 2011).

Specific support strategies are required for aboriginal nurses working in rural and remote settings, which are often characterized by a lack of physician care and inadequacies in infrastructure and equipment. A research study on the needs of aboriginal nurses working in rural and remote communities revealed that these nurses are more likely to report a work environment that includes emotional abuse (Stewart et al., 2006). While the majority of nurses who participated in this study felt the need for more education, they also perceived barriers to meeting this need, including language (A.N.A.C., 2006a). A.N.A.C.'s 2013 survey of nurses working in aboriginal health settings found that respondents considered language to be a barrier to effectively accessing educational opportunities. More research and evaluation studies are needed to expand our knowledge in this area.

Consultation Process

We are aware of aboriginal nurses who are ready to further their education at a graduate level but they are unable to leave their communities, often due to child and family responsibilities and lack of funding to assume full-time studies. If supported, they are a wealth of a future resource for nursing education, advanced practice and leadership for system change required to meet the needs of the people and the communities. — Commentator

Professional associations should partner with health authorities and educators to develop, pilot and research strategies, and this is urgent. For example, we could pilot a new graduate internship and evaluate outcomes such as cost-effectiveness in human resources and impact on health, as well as dollars. These should be immediate priorities. — Commentator

Commentators described the needs of practising nurses, particularly those working in First Nations settings and in small rural communities, as a “huge” issue that has major impacts on retention in the workforce. A number of commentators noted that the needs have been fairly well documented (by A.N.A.C. in particular), but that there has been little funding support to respond. Sharing of best practices, mentoring and internships were mentioned a number of times as strategies for supporting practising nurses early in their career. Commentators pointed out that nursing in small and remote communities requires a different scope of practice and that nurses need to be prepared for this reality.

3.4.2 Current Initiatives

A.N.A.C. (2002a, 2002b) has provided leadership by undertaking research to identify workplace and employment issues that affect recruitment and retention, identifying and advocating for best practices, and developing an inventory of resources and programs for increasing recruitment and

retention of practising nurses. A.N.A.C. (2003b) has also advocated for a role in building organizational capacity in government and communities to improve working conditions that will support recruitment and retention of practising nurses in First Nations and Inuit communities.

The other literature reviewed provided scant evidence of what is being done in the area of recruitment and retention of practising nurses in aboriginal health settings. An example of a promising practice cited by the National Expert Commission (2012) is the mentoring of facility-based nurses by mobile nurses, which has reduced patient visits to emergency rooms. In 2004 the federal government dedicated \$100 million over five years to “create and implement strategies to increase the number of Aboriginal health professionals” (Vukic et al., 2012, pp. 1-2). A.N.A.C. has been active in advocating and partnering to develop recruitment and retention strategies.

3.4.3 Remaining Gaps

One recommended strategy to improve recruitment and retention is to develop employment mentoring programs for aboriginal nurses to help ensure their success in the workplace (A.N.A.C., 2011b; Stewart et al., 2006).

Providing accessible and affordable continuing education, particularly in clinical practice skills, has been cited as another way to support and retain practising nurses (A.N.A.C., 2002a, 2013; Stewart et al., 2006). One option to increase access to professional development is to make continuing education courses offered in the summer more affordable and accessible to nurses working in aboriginal health (A.N.A.C., 2002a).

Interprofessional linkages, particularly with other nursing professionals, can also strengthen professional supports for aboriginal nurses (Stewart et al., 2006).

Access to innovative practices and reliable evidence through a national clearinghouse (supported by government) is another mechanism that has been promoted to support the professional and skills development of aboriginal nurses (Gregory, 2007). Gregory also provides suggestions for strategic action to increase the recruitment and retention of new nursing program graduates, including targeted mentoring programs, further development of nurse managers, targeted field teaching units and enhancement of the capacity of community health representatives. Also important is the formation of strategic partnerships among key stakeholders, such as FNIHB, schools of nursing and aboriginal communities (A.N.A.C., 2006a, p. 5; Gregory, 2007, p. 25).

3.5 Building Capacity for Leadership and Advocacy

Building leadership capacity includes developing future nursing leaders through education and supporting practising nurses to become leaders in aboriginal health nursing. Creating leaders will improve practice and provide role models for early-career nurses, as well as enhance the comfort level of aboriginal nurses in their workplace. The priorities discussed above, particularly addressing institutional barriers and improving recruitment and retention of both nursing students and practising nurses, are also highly relevant to building leadership capacity.

3.5.1 Identified Needs

Literature Review

CNA's position statement on nursing leadership affirms that "nursing leadership is about critical thinking, action and advocacy — and it happens in all roles and domains of nursing practice. Nursing leadership plays a pivotal role in the immediate lives of nurses and it has an impact on the entire health system and the Canadians it serves" (CNA, 2009, p. 1).

In some of its earlier publications, A.N.A.C. describes leadership as encompassing "sound health delivery system management" that includes not only nursing leadership but also leadership from communities in the areas of recruitment and retention, employment orientation, workplace conditions and professional development (A.N.A.C., 2002b, 2003b). One of the greatest needs that A.N.A.C. (2003b) identified with regard to workplace conditions for nurses in communities is the need for "greater supervision, education and support after hiring" (p. 5).

Minore et al. (2013) comment that having more aboriginal nurses in leadership positions can help to increase the comfort level of aboriginal nurses in the workplace while providing role models to early-career nurses.

Advocacy would involve championing systemic and policy changes that improve the education and workplace experiences of aboriginal nurses, as well as encouraging the recruitment of larger numbers of aboriginal people into the nursing profession. Advocacy by aboriginal nurses themselves would include supporting and working for the changes they deem necessary to improve not only their own work situation and the health care provided by nurses in aboriginal health settings, but also aboriginal health in general. The National Expert Commission (2012) states that in its consultation process it "heard a call for nurses to be champions for excellent care and caring in all clinical settings, and especially to champion primary and preventative care. Nurses are a trusted and prominent voice advocating on behalf of Canadians and in partnership with other professionals" (p. 30).

Consultation Process

We do have an aboriginal model of mentorship. We frame it around the life cycle — we learn from our elders. — Expert roundtable participant

One of the key points made during the discussion on leadership during the October roundtable was the importance of mentorship at various levels, including students receiving credits for mentoring. A.N.A.C. told the roundtable participants that it is moving forward on mentorship by developing a framework for evaluation and signing memoranda of understanding on the framework with three universities. A roundtable participant shared the Northwest Territories' success in supporting students and early-career nurses through supports provided in high school for choosing courses and through on-the-job mentoring of new graduates by more seasoned professionals. The British Columbia Nurses' Union has created the Aboriginal leadership council as a safe space for union members who identify as aboriginal to address the historic and systemic discrimination faced by First Nations, Inuit and Métis people and to foster the development of aboriginal nursing leadership in the province.

Several commentators urged nurses, CNA and non-aboriginal organizations to continue to support A.N.A.C. to be a strong and influential voice for aboriginal nurses and aboriginal health nursing. As one commentator wrote, "All nurses should understand and contribute to this priority."

3.5.2 Current Initiatives

A.N.A.C. has been endorsed by its membership and by the Assembly of First Nations as a leader in furthering aboriginal health nursing, and should continue to be supported in this role through financial and partnership supports (A.N.A.C., 2002a, 2005a). A.N.A.C. is a national leader in advocating for aboriginal practising nurses, particularly those working in indigenous communities (A.N.A.C., 2002a, 2002b, 2003b, 2005a, 2006b).

A.N.A.C.'s leadership is evident in many areas, including in developing a framework and curriculum for cultural competence and cultural safety, making recommendations on recruitment and retention, providing leadership supports, defining the needs of aboriginal health nurses through research, and highlighting the history and current role models in aboriginal nursing (A.N.A.C., 2005b, 2007c, 2011a, 2013).

A.N.A.C. has built effective partnerships to extend its advocacy efforts, including with CNA and CASN, as well as FNIHB (through funding initiatives).

In British Columbia, the new First Nations Health Authority reports that to serve communities better, it is supporting community applications for the Nurse Practitioners for British Columbia (NP4BC) initiative. To date this support has resulted in more than 10 new nurse practitioner positions serving First Nation communities (First Nations Health Council & First Nations Health Authority, 2013).

3.5.3 Remaining Gaps

The literature suggests that having more aboriginal faculty in nursing schools will help to create the aboriginal nursing leaders of the future. Some progress has been made in building leadership capacity through mentorship programs in nursing education. However, there appears to be much less progress in developing leadership capacity in practising nurses, particularly those in First Nation communities, and even less so for those in small and remote communities.

It can also be inferred from the literature that addressing structural and systemic racism and providing greater cultural safety in the workplace will create an atmosphere in which aboriginal nursing leadership can blossom. This is deemed true not only in faculties of nursing and policy development environments but also in community workplaces and regions.

The literature affirms that advocacy at all levels is still required to move initiatives and policy forward to a place where aboriginal health nursing is supported financially and with the necessary actions (Vukic et al., 2012; Stansfield & Browne, 2013).

The National Expert Commission (2012) calls for nurses to “intensify their role as leaders of system transformation, including a far-reaching overhaul of the ways we deploy and employ nurses. That will mean supporting and expecting every nurse to practise to the top of his or her scope of practice. But the scope must also be expanded appropriately to meet changed and changing health needs, to encompass functions including, but not limited to, prescribing, and admitting and discharging patients across all types of health facilities” (p. 37).

Conclusion

Through a process of research and consultation, five priority areas for strategic action were identified:

- Integration of indigenous ways of knowing and being
- Addressing institutional barriers to aboriginal health nursing and aboriginal health
- Education: recruitment and retention
- Practising nurses: recruitment and retention
- Building capacity for leadership and advocacy

The priority areas are considered to be interdependent, not mutually exclusive. In particular, respondents cited institutional barriers such as racism as foundational issues that play an integral role in the other priorities. Integration of indigenous ways of knowing and being was also seen to have a potential impact on the other priority areas.

The literature review and results of the online survey, interviews and consultation process all point to the need for strategic action that is specific to aboriginal nurses and aboriginal health nursing. References were repeatedly made to inadequate funding for, support of and action on existing policies, which have created barriers and challenges to strengthening and improving aboriginal health nursing, aboriginal health leadership and aboriginal health.

The challenges and barriers are clearly documented. Both the researchers and the participants in the consultation process encourage the use of a strengths-based approach to acknowledge the progress being made, particularly in the area of nursing education. A.N.A.C.'s longstanding and important leadership was recognized, as was the need for the continuing support of the association's vision and work.

Respondents cited the need for institutional support and strategic action by aboriginal and nursing organizations, as well as for individuals who will act as champions and mentors to advance aboriginal health nursing, aboriginal health leadership and aboriginal health.

The story of aboriginal nursing has not been fully documented. It could be better told if it included the contribution of aboriginal nursing to the Canadian health landscape. A.N.A.C. (2005b, 2007c, 2011a) has made progress in this area, through the development of documents that are continuing to tell the story of aboriginal nursing in Canada, past and present.

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Appendix A: List of Aboriginal Health Nursing and Health Advisory Group Members

R. Lisa Bourque Bearskin, RN, MN, PhD candidate. Sessional Lecturer, Faculty of Nursing, University of Alberta. President, Aboriginal Nursing Association of Canada.

Tania Dick, MN, NP(F). Nuu-chah-nulth Tribal Council Health Outreach Program, Port Alberni B.C.

Bernice Downey, BScN, MA, PhD candidate. Sole proprietor, Minoayawin Consulting.

Lisa Perley-Dutcher, RN, MN. Director of the Aboriginal Nursing Initiative and Senior Nursing Instructor, University of New Brunswick.

Claudette Dumont-Smith, RN. Executive director, Native Women's Association of Canada.

Fjola Hart Wasekeesikaw, RN, MN. Executive Director, Aboriginal Nurses Association of Canada.

Dorothy Laplante, RN, BScN, NP, MScN. Associate Director, Office of Clinical Trials, Therapeutic Products Directorate, Health Canada.

Julie Lys, NP. Fort Smith Health and Social Services Authority.

Earl Nowgesic, RN, PhD candidate. Dalla Lana School of Public Health, University of Toronto.

Appendix B: Interview Guide/Online Survey Tool

Informing Policy and Building Capacity of Aboriginal Nurses and Nurses Working with Aboriginal Peoples

Thank you for your willingness to participate in this interview. We have contacted you to gather your input into the development of policy directions to strengthen the leadership capacity of Aboriginal nurses and to support Aboriginal health nursing, which encompasses Aboriginal and non-Aboriginal nurses in the provision of health care to Aboriginal people and communities. The Aboriginal Nurses Association of Canada 2007 document, *Framework for Cultural Competency and Safety in Aboriginal Health Nursing, Living in Dignity and Truth*, describes Aboriginal health nursing as the way nursing care and interventions are provided to Aboriginal people and communities, which includes the areas of clinical practice, education, research, administration and policy, and is informed by Indigenous knowledge, values and beliefs of Aboriginal people.

The information provided will inform a stakeholder discussion planned for early October. This roundtable will examine identified policy priorities and possible strategic approaches to those priorities. A final document will synthesize the information gathered through a literature review, interviews, an online survey and the stakeholders' meeting. The report will be available to stakeholders.

You will not be identified in any report or document produced by this project. You may choose to stop participating at any time. If you have any questions about this survey or the project, please do not hesitate to contact Andrea Johnston at andrea@johnstonresearch.ca.

This work is led by the Canadian Nurses Association and guided by its Aboriginal Advisory Committee.

START

Do I have your consent to participate in this project?

1. Yes
2. No: Type in 1 or 2 below

--

1. What type of environment do you work within? Mark only 1 answer.

1. First Nation community/organization
2. Aboriginal community health organization
3. Provincial / territorial government
4. Federal government
5. Academic institution
6. Non-governmental organization
7. Hospital
8. Other health service delivery
9. Other: TYPE A NUMBER from 1 to 9 BELOW

--

IF OTHER (9) ANSWERED ABOVE, SPECIFY

--

2. Which of the following best describes your role or involvement in the Aboriginal nursing environment? Mark only 1 answer.

1. Administration
2. Policy
3. Research
4. Education
5. Clinical/community practice Registered Nurse
6. Clinical/community practice Nurse Practitioner
7. Other health professional
8. Other: TYPE A NUMBER from 1 to 8 BELOW

--

IF OTHER (8) ANSWERED ABOVE, SPECIFY

--

3. How does your organization support nurses to provide care to Aboriginal people and communities? Answer each item that applies to your organization.

Read through the list, then TYPE THE NUMBER “1” without quotes, in each box that applies, LEAVE OTHER BOXES EMPTY.

1. Aboriginal nursing unit / branch / department

2. Aboriginal nursing programs in place

3. Implement Aboriginal nursing policies

4. Provide a nursing environment that supports access to culturally competent and safe care

5. Support nurses to access training/conferences

6. Support nurses to attend cultural and traditional learning opportunities

7. Engage in partnerships and agreements with Aboriginal organizations and communities

8. Support policies or protocols that promote access to culturally competent and safe care

9. My organization does not provide support.

10. Other

IF OTHER (10) ANSWERED ABOVE, SPECIFY

Now please describe your answer below

4. When making policy, program, or other decisions regarding the nursing needs of Aboriginal people, what factors does your organization consider the most important?
[Rank order FROM 1 TO 6.]

1. Client need (type rank 1 to 6 in box below)

2. Evidence-base (type rank 1 to 6 in box below)

3. Funding (type rank 1 to 5 in box below)

4. Identified wise practices (type rank 1 to 6 in box below)

5. Aboriginal organizations’/communities’ priorities(type rank 1 to 6 in box below)

6. Other: (type rank 1 to 6 in box below)

Are there any other factors that you would consider important?

Please describe the basis for selection of the three top areas.

- 5. In your opinion, what strategies would strengthen leadership development (build capacity) among nurses who provide care to Aboriginal people and communities?**
Mark the top 4 by deciding which of the four are important, then type the rank value in the selected item box using the values from 1 to 4. You do not have to type in a number for the remaining selections.

1. Building a collaborative practice culture

2. Building a communication rich culture

3. Building a culture of accountability

4. Supporting opportunities to integrate Indigenous knowledge into care

5. Presence of adequate numbers of qualified nurses

6. Access to mentoring relationships

7. Developing communities of practice

8. Shared decision making at all levels

9. Support for continued professional development

10. Access to elders as cultural mentors

11. Recognition of the value of Indigenous knowledge to nursing

12. Recognition of nurses for their unique contributions to Aboriginal health care

Are there any other strategies that you would recommend?

Please describe YOUR ANSWER FOR THESE TOP FOUR

6a. Does your organization recognize and support the value of Indigenous knowledge in the skills nurses bring to their practice? Type in 1 or 2 or 3 below.

1. Yes
2. No
3. Not sure

6b. If NO to 6a, what changes are needed to recognize and support the value of Indigenous knowledge?

7a. Do nurses who provide services to Aboriginal people have adequate access to the training and supports they need to integrate Indigenous knowledge into their practice? Type in 1 or 2 or 3 below.

1. Yes
2. No
3. Not sure

7b. If NO to 7a, what changes are needed?

8. Based on your knowledge and experience, what are the priority areas this project should address in developing a policy strategy to support nurses working with Aboriginal people? [Rank order using a Rank from 1 to 10 for each item.]

A. Building research capacity among nurses

B. Developing recruitment and retention strategies for nurses to work in northern and remote areas

C. Addressing racism in policy and practice

D. Identifying institutional policies, practices and administrative barriers that make it difficult for nurses to provide the care needed for Aboriginal people

E. Providing continuing education and professional development

F. Developing leadership capacity

G. Advocacy on behalf of Aboriginal nurses

H. Mentorship programs

I. Elder support programs

J. Recruiting Aboriginal people to the nursing profession

K. Providing financial and other supports to Aboriginal nurses while they attend school

L. Supporting Aboriginal nurses as recent grads

M. Recognition of Indigenous knowledge

N. Tracking Aboriginal ancestry of nurses entering into the profession

O. Other:

Are there any priorities missing in your opinion?

Please elaborate on the top 5 areas you selected.

9. In your view, are there changes that need to be made to the health care system that would better support nurses to provide quality nursing for Aboriginal people? If so, please describe. (i.e., policy/practice, legislation, jurisdiction, etc.)

10. What do you consider, if any, to be the unique role of nurses in meeting the health care needs of Aboriginal people?

11. Please describe the role you see for Canadian nursing organizations – such as but not limited to the Canadian Nurses Association – in building the leadership capacity of nurses who work with Aboriginal people?

12. Please describe the role you see for Aboriginal organizations in building the leadership capacity of nurses who work with Aboriginal people?

13. Can you suggest research materials or grey literature that would help inform the project's work?

14. Do you self-identify as Aboriginal?

First Nation = 1 Métis = 2 Inuk = 3 No = 99 Decline to answer = 88

15. Would you like to add anything else?

END

Thank you for taking to time to participate in this interview!

The Johnston Research team.

www.johnstonresearch.ca

Appendix C:

List of Participants at October 2013 Roundtable

Participants

Terri Belcourt*	Saskatchewan Registered Nurses' Association
Robin Buckland	Public Health Agency of Canada
Amanda Carruthers	Society of Obstetricians and Gynaecologists of Canada
Josephine Etowa	University of Ottawa, faculty of health sciences, school of nursing
Leila Gillis	First Nations and Inuit health branch, Health Canada
Rhonda Goodtrack*	Aboriginal Nurses Association of Canada
Mae Katt*	Registered Nurses' Association of Ontario
Michelle Martinson*	British Columbia Nurses' Union aboriginal leadership circle
Joy Peacock*	Yukon Registered Nurses Association
Susanne Priest*	Nurses Association of New Brunswick
Natalie Quinn	Congress of Aboriginal Peoples
Geraldine Selkirk*	College of Registered Nurses of Manitoba
Jill Skinner	Canadian Medical Association
Christine Sorensen	British Columbia Nurses' Union
Annie Smith St. George	Aboriginal elder

Aboriginal Health Nursing and Health Advisory Group

Lisa Bourque Bearskin
Tania Dick
Bernice Downey
Claudette Dumont-Smith
Fjola Hart Wasekeesikaw
Dorothy Laplante
Julie Lys
Earl Nowgesic
Lisa Perley-Dutcher

Consultants

Marcia Barron	Johnston Research Inc.
Patricia Baxter	Independent consultant and facilitator
Andrea L. K. Johnston	Johnston Research Inc.

Canadian Nurses Association

Lisa Ashley
Rachel Bard
Debbie Grisdale
June Webber

* Joined via webex technology

