

## The Socio-Political Impacts on Health Care that Effect Aboriginal Nurses Working in Aboriginal Communities

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### Abstract

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The work-life experiences of Aboriginal nurses in Atlantic Canada have been an understudied field. This paper will discuss the socio-political context of Aboriginal nursing, a major theme of a recent study which investigated the work-life experiences of Aboriginal registered nurses in Atlantic Canada. This major theme will be presented under three sub-headings; band politics, government-band relationship, and access to resources. The purpose of the study was to understand the quality and nature of their work-life as this understanding is fundamental to the development of effective health care programs for Aboriginal peoples. The research design was a grounded theory informed by community based participatory research (CBPR) approach. The primary mode of data collection was interviews with 22 registered Aboriginal nurses in the Atlantic region of Canada and constant comparative method facilitated data analysis. Atlas ti computer software was used for storage and data management. The discussion of these findings illuminate the centrality of Aboriginal nurses in the delivery of healthcare in Aboriginal communities and provides evidence of how Aboriginal nurses are delivering programs in the community. Implications for practice as Aboriginal nurses work to address Aboriginal health care and some suggestions for improving the work-life of Aboriginal nurses including some leadership and capacity building strategies are presented.

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**Keywords:** Aboriginal health, Socio-political context; Grounded theory, Aboriginal nurses, Community Based Participatory Research (CBPR)

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## 1. Background

The history of colonization has had a significant impact on the health of Aboriginal<sup>4</sup> peoples evidenced by the wide disparities in health status indicators (Adelson, 2005; Health Council of Canada, 2012). The key to narrowing the gap between Aboriginal and non-Aboriginal health status is the increased involvement of Aboriginal peoples in health delivery and policy-making (Adams, et al, 2005). The National Household Survey shows that 1,400, 685 people in Canada have an Aboriginal identity representing 4.3% of the total Canadian population (Stats Canada, 2011). According to Hunter, Logan, Goulet, and Barton, (2006) currently less than 1% of Canadian nurses identify as having Aboriginal ancestry. The Aboriginal Nurses Association of Canada (ANAC) claim the total number of Aboriginal registered nurses in Canada is unknown (ANAC, 2011). As the Canadian Association of Schools of Nursing Education/Association Canadienne des écoles de science infirmières (CASN/ACESI) and (ANAC) note the barriers and challenges to address the under-representation of Aboriginal peoples in health care is complex given the historical, social, cultural and economic realities facing Aboriginal people in Canada (CASN/ACESI, 2013). Hence our research set out to explore the work-life experiences of Aboriginal nurses and the issues they faced, which helped illuminate some possible ways to address their under-representation within the health care system.

In this research participants described tensions and contradictions that shaped their practice for advancing and promoting Aboriginal nurses in nursing. In the last few years, there has been growing interest in the impact of culture, ethnicity, racism and the socio-political context within the nursing profession (CASN/ACESI, 2013).

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<sup>4</sup> The term Aboriginal refers generally to the Indigenous peoples of Canada, including First Nations, Inuit and Métis. The Royal Commission of Aboriginal Peoples of Canada (RCAP) stresses that the term Aboriginal peoples refers to organic political and cultural entities that stem historically from the original peoples of North America, rather than collections of individuals united by so called racial characteristics. The term First Nations replaces Indian and the term Inuit replaces the term Eskimo. However, Indian and Eskimo continue to be used for example, "The Indian Act". Native also continues to be used, for example "The Canadian Native Mental Health Association". For the purpose of this paper we refer to Aboriginal when including First Nations, Inuit and Métis, and refer more specifically to First Nations and /or Mi'kmaq depending on the context, the literature and the participants referenced.

Several studies have examined the experiences of Aboriginal and minority nurses in Canada, Britain, and the United States (Calliste, 1996; Calliste, 1993; Das Gupta, 1996; Gregory, 2007; Health Canada, 2006; Hezekiah, 2001; Hine, 1989; Martin & Kipling, 2006; Wasekeesikaw, 2003). Kulig and Grypma (2006) note very little is written about the history of Aboriginal nursing and despite Aboriginal nurses' role in improving the health status of First Nations, Inuit, and Metis, very little research exists that explores the perspectives of Aboriginal nurses themselves. Kulig, Stewart, Morgan, Andrews, MacLeod, and Pitblado (2006) analyzed the results of a national survey of RNs working in rural and remote areas of Canada, in which 210 of the 3933 respondents self-identified as having Aboriginal or Metis ancestry. They found that 69.6% of Aboriginal nurses were originally from rural/remote communities, and that 66.7% chose to return to such areas because they wanted to work with their own people and raise families in smaller communities. Although these studies help provide a broad overview of Aboriginal nurses, further research is required to understand the day-to-day realities of Aboriginal nurses, and the tensions and contradictions shaping their practice. Finding out the current realities of being an Aboriginal nurse in Atlantic Canada including how their Aboriginal identity influences the quality and nature of their professional lives, will inform policy that may facilitate evidence-based change within health care so that Aboriginal nurses are empowered and enabled to draw upon their unique lived experiences to improve the quality of their work life and ultimately influence the health outcomes of Aboriginal Peoples.

## **2. Purpose**

This paper presents the socio-political impacts of health care and the effects on Aboriginal nurses working in Aboriginal communities. This is one of the major themes revealed in the findings of a study that explored the work-life experiences of Aboriginal nurses in the Atlantic Region of Canada. The theme will be presented under three sub-themes; 1) Band Politics, 2) Government–Band Relationships, and 3) Access to Resources. A discussion of the findings and implications for practice are shared to highlight the significance of this theme as it relates to Aboriginal nurses work-life experience in the context of the current socio-political environment in Aboriginal communities.

### **3. Research Methodology**

The study employed grounded theory involving 22 Aboriginal registered nurses in the Atlantic region of Canada informed by the principles of Community Based Participatory Research (CBPR) approach. In keeping with Ownership, Control, Access, and Possession (OCAP) principles for conducting Aboriginal health research (Interagency Advisory Panel on Research Ethics, 2009), Aboriginal Atlantic Canadians were an integral part of this research both as community partners, and as co-applicants. Priority was given to hiring an Aboriginal research assistant to work on the project (co-coordinating interviews, coding and analyzing data, etc...). This provided opportunity for mentoring and capacity building. In addition the research protocol was approved by the Dalhousie University Research Ethics Board and M'kmaq Ethics Watch prior to commencement of the study.

The primary mode of data collection was audio recorded interviews which were transcribed verbatim. Snowballing and theoretical sampling guided the participant recruitment process. The sampling process including sample size was determined by the process of theoretical sampling. Theoretical sampling involves the collection of data for theory generation whereby the researcher simultaneously collects, codes and analyzes data and decides on the direction of further data collection based on the responses of the participant (Glazer, 1978). As Glaser (2002) indicated, data collection was stopped when no new concepts emerged suggesting data saturation. Atlas ti computer software was used for data management and storage. Constant comparative method and regular team data analysis meetings facilitated data analysis. Member checking, peer debriefing and audit trail was employed to establish credibility of the study results and to ensure trustworthiness of the findings (Lincoln & Guba, 1985; Patton, 2002).

### **4. Characteristics of Study Participants**

The majority of the nurses who participated in this study worked in First Nations community settings. Very few of the participants worked in tertiary centers, or held positions in nursing administration, education or research. There are 35 Aboriginal communities in the four Atlantic Provinces in Canada. The nurses interviewed were all woman as there were no male Aboriginal nurses identified that worked in the Atlantic region. Over half of the nurses participating in this study were over 31 years of age.

The majority had over 10 years of experience. Most of the nurses interviewed had completed their formal nursing education with an undergraduate nursing degree. Two had gone on to complete a graduate nursing program degree. The demographic characteristics of the nurses are provided in Table 1.

**Table 1. Characteristics of Participants (N = 22)**

<b>Variable</b>	<b>Frequency</b>
<b>Age of Participant</b>	
20–30 years	4
31–40 years	4
41–50 years	5
> 50 years	7
Not Provided	2
<b>Sex</b>	
Female	22
Male	0
<b>Years of Nursing Practice</b>	
Less than 5 years	4
5–10 years	3
11–15 years	4
16–20 years	2
Over 20 years	9
<b>Highest Level of Education</b>	
RN Diploma	8
BSc.N/BN	12
MN/MPH	2

## 5. Results

The theme of the socio-political contexts of health care in Aboriginal communities refers to the relationships, bureaucracy and overall politics within the communities and in their relationship with the larger health care system and how this context influences the work-life experiences of Aboriginal nurses.

The theme will be presented under three sub-themes; 1) Band Politics, 2) Government–Band Relationships, and 3) Access to Resources.

## 5.1 Band Politics

Band politics captures the various discussions threaded throughout the data around the decision-making structures of the First Nations communities. Many of the participants talked about the political structure of the band, and reflected on how this structure shaped their experiences as First Nations community nurses. Several participants pointed out how the band chief and council had ultimate control within their communities, and therefore had the power to make decisions around funding and resources that had a direct impact on community nursing, either for better or for worse. Band politics will include discussion on the categories of 5.1.1 nurses valued/not valued and money, and 5.1.2 funding as these categories are relevant to the theme on band politics. One participant used the term "*political interference*" to describe how her community's chief and council intervened in health-based programming regardless of the wishes and assessments of the health care providers.

The politics are frustrating ... The chief and council can overrule any decision you make as a professional, and they're not nurses. So, for example, you say, "This person needs two or three days a week of homecare support care services" and they'll say, "Nope, you give them twenty-four hour care."

A participant talked about the implications of the band structure for job security, explaining that community nurses' jobs were vulnerable to changes in council given the level of control that leaders were able to exercise around community resources. In emphasizing this point, she gave an example of a chief who appointed his brother to the position of health director.

Several of the band-employed nurses talked about their personal involvement in band politics. One nurse expressed discomfort around becoming political, and even around engaging in political discussions with patients. As she explained, "*You don't want to be political when you're the nurse in the community. You just want to be the nurse and that's it.*" Another nurse felt that the leadership in her community was not ready to listen to the nurses:

I think first of all the Aboriginal community, the political Aboriginal community, the politics part of it has to recognize that RNs have a voice and they do have something to say that's worthwhile because we're all working for improvement in First Nations health.

Secondly, I think our licensing body for RNs [registered nurses] has to support where we're going. If you're talking just mainstream nursing, um, of all walks of life they're telling us to advocate, they're telling us to be politically involved, go and lobby for this, go and lobby for that. But I think our licensing bodies throughout Canada have to realize that First Nations nurses have to be very careful when they do that, especially involving First Nations communities. It's not seen as our place yet to tell leadership how to run their community or what would improve it. Um, I think nurses have a lot of great ideas on how to improve the health of the community, but I really don't think that the leadership is listening yet. I don't know that they think RNs are the people to bring that forward.

She went on to assert that First Nations community nurses would benefit from training on how to advocate for themselves and for community health services in a respectful manner. She presented her vision for an ideal setup in which community nurses could present a collective voice to the health director, who in turn would present the nurses' concerns to the chief and council. She did not believe that any such process was in place currently.

Not all of the nurses were as reluctant to engage in politics as others. One nurse also tried to stay away from political discussions when interacting with her patients, but in terms of her own role in politics, she found it easier to advocate with the leadership because she had family members in council. Another nurse talked about the importance of building relationships with the band leadership. She had even held a position on council previously in her career and was able to influence decisions that had positive outcomes for the health of the community. One nurse felt that the political structure of First Nations communities was advantageous because of its potential for community-based programming and decision-making. She explained how "*communities have the opportunity to go to chief and council and voice their concerns . . . and chief and council [have] the political structure there to start the process,*" and argued that this system could serve as a model for other communities across the country.

#### 5.1.1 Nurses Valued/Not Valued and Money

Several of the participants shared that they did not feel valued in their work as community nurses.

The nurses I know could be making far more money in the hospital setting [than] in public health setting. But they choose to work in their communities. They choose to take that decrease in pay to be with their communities. I think that deserves more respect than what I'm seeing them getting, you know, as a group.

In her interview, one nurse stated explicitly that while she enjoyed her work, she did not feel valued. Another nurse reported having heard stories from nurses in other departments who did not feel valued. Another participant pointed out that nursing and medical associations, as well as the general public, did not recognize the specialized knowledge and skills of Aboriginal community nurses. For one nurse, this undervaluing was especially frustrating given the fact that there is such high expectations of community nurses.

If you don't happen to get along with chief and council then your pay can stay the same or your pay can be lowered. But the expectation, or not necessarily lowered, but the expectations of your workload will be higher. You're expected to take on more programming. You're expected to put out more and more; for instance in my community the community health nurse is not only the community health nurse but also the home and community care nurse so she's expected not only to do prenatal programming, as the nurse in that community you're expected to do a prenatal program, you're expected to do community health nursing. You're expected to do immunizations. You're expected to do any of the health teaching. You're expected to do all of the home and community care work. Plus do whatever else chief and council wants you to do as far as representing them in other areas. So you're not paid, you're not valued as well as you would be in other places or other positions.

Only one nurse spoke explicitly about how she did feel valued as a community nurse. This nurse had been band employed previously, but she had left to take on a position in government. After she left her community, the elders made a point of telling her that they wanted her back.

For the band-employed nurses who participated in this study, 'feeling valued/not valued' was connected to and reflected in salary. Several nurses shared their frustrations around the fact that they made less money than they would have if they worked for the government or in a hospital setting outside of their communities.

These nurses chose to work in Aboriginal communities for various reasons, but some resented the lower pay because they felt it reflected the fact that they were not valued. As one nurse stated:

[Council members]don't realize how hard it is to get nurses to stay ... so to them, as Aboriginal nurses, you're fine, you don't have to get paid what the going salary is.

One nurse felt that white nurses were more welcomed in her community than Aboriginal nurses. When she was hired, council fought her on salary and benefits. She believed that they "*figured that they could get away with more with me.*"

### 5.1.2.Funding

The government provides First Nations communities with the finances to operate health programs and services.For some of the nurses who participated in this study, this structure meant that they were responsible for applying for funding, a responsibility that they would not likely have had if they worked in a hospital setting.Several nurses commented on the amount of work required to obtain and to "stay on top of" funding

One nurse conducted a needs assessment in her community and determined the need for a culturally sensitive community-based clinic.Once the clinic was open, she had to fundraise to keep it going. Another participant, a government employed nurse, addressed the lack of training and instruction that nurses received around applying for funding:

So they might give me a task, you know, here's the tobacco strategy, because tobacco is health related, they give it to a nurse.See what you can do with it.And you just go from there and that's all that you get, that's all the guidelines.

Here's the form from Health Canada, fill it out, and hopefully you'll get money we can do something with it.I don't see how any hospital education would have prepared me for writing a tobacco strategy proposal.

Another participant, a band-employed nurse, pointed out that trends in funding, that is, "*whatever their new buzz word is for that year for the funding priorities,*" determined which issues received financial support. As an example, she pointed out the lack of programming in place to deal with sexual abuse, as it may not be a priority from funding agencies.

## 5.2 Government–band Relationships

Government–Band Relationships paints a broad picture of how political structures affect community nurses in specific ways. It includes the experiences of government-employed nurses, as well as discussions pertaining to the relationship between the government and Aboriginal communities. Several of the Aboriginal nurses who participated in this study were government employees who worked in connection with First Nations communities. They occupied positions that were higher paying than those of their band-employed counterparts, and in several cases, filled administrative or supervisory roles. In their interviews, these nurses talked about some of the circumstances and challenges they faced in their unique location as government-employed Aboriginal nurses. Government-employed nurses had to go through a process of clarifying for themselves where their loyalties lay, and what it meant to represent Aboriginal communities while occupying a government role. One nurse had only been a government employee for a few months at the time of her interview, and she spoke at length about the conflict she felt around having to balance her commitment to her community with the mandates of her job.

In some ways we could look at it and say, okay, well you're going to be an advocate for First Nations at the government level but at the same time I'm a government employee in which I have to carry out the government's mandate. So even though I've only been there for three months, I know that there already exists that conflict within me as to which side I'm actually with. ... I mean to me I'm there to advocate for the community and try to make changes but I'm not sure I'm going to be in a job that can do that.

But just that I'm there as an Aboriginal person, nurse, to advocate for First Nations people and you know if it gets too tough then you move onto a job and I do miss being in the community. To me that's where the change happens is in the community.

As a way of mediating this conflict, this participant sought out mentors. She identified her mentors as being Aboriginal people who had worked for the government for longer than she had, who had *"managed to stay there and be okay with it."*

While this nurse focused on the internal conflict her position brought about for her, another spoke about having to juggle different roles, stating, *"I wear two hats. Well, multiple hats. I'm a nurse. I'm Mi'Kmaq First Nations, I'm a nurse, and I work with Health Canada. So those are my three roles."* She commented on a disconnect that she noticed around the government failing to support Aboriginal community programs. But rather than experiencing internal conflict around her role(s) she viewed her position in government optimistically, as a path to fostering positive change. As she explained, *"My famous quote is, if Obama can be president, poor little Indian girl should be able to make some changes in [government body], right?"*

Although the experiences of the Aboriginal nurses who participated in this study differed in part based on whether they were band employed or government employed, the relationship between government and the communities themselves had an impact on the work-life of Aboriginal nurses working in and around the First Nations communities, regardless of who employed them. Two participants, both government employees, emerged as key informants who were able to provide a broader scope of the political relationship between bands and government along with the issues around jurisdiction and control of resources that shape this relationship which affects the working lives of Aboriginal community nurses.

One nurse was a federal employee at the time of her interview, but previously had worked as a band-employed community nurse. Both she and her colleague discussed health transfer, the process in which government-funded programs had transferred from government jurisdiction to band control. According to both of these nurses, the government provides First Nations communities with funding for health programs, without transferring the knowledge of how to run them.

When programs come down from [government body],... we get money but we don't get the program guidelines or standards because it's seen as it's up to chief and council or the health director. Well, ok, if it already exists can we like borrow it? So we actively have to ask for those things, they're not automatic.

So we've just gotten into this rhythm of, well we've got money, so now we've got to create guidelines, but we don't really have to. ... If nurses were government employees that would automatically be provided.

Both of these nurses used the words *paternal* and *patriarchal*, respectively, to describe the relationship between the government and First Nations communities. As one nurse explained, "The government is like our mom and dad, and we have to ask for money to do whatever we want to do, or ask permission to do whatever we want to do. So that comes up in meetings with the government, especially if there's a new program that comes down and we have to do it their way.

The second nurse described the health transfer process,

There's been a real disconnect I think in how that relationship has evolved. I think it's been one of patriarchal initially. Like we're coming in to help you Indian people and we'll do it on our turf, our time, and when it suits us. You know, we won't call. You got transfer, we won't train your nurses, we won't support you.....

Her interview revealed that this disconnect between government and community has several implications for health providers and services in First Nations communities. For example, bands are left to make decisions regarding health services funding allocations, but are not equipped to do so. As a result, nurses are underpaid and are not given the supports that they need.

They just say this is the health budget, do with it what you want to. If you want to pay your nurse \$30,000 and if you can get somebody to do it for that cheap then you pay them that. Like we're not going to tell you. But then there's some things that they will decide, we are going to tell you what you can. So there's a lot of inconsistencies there. And I've picked them up.

I've challenged them many times on that... That your nurses have a scale that they go by that they get paid, but you didn't pass that on to the bands to say this is what we expect you to pay nurses? Like just something as simple as that didn't even happen. They didn't educate the bands like you know nurses have to belong to an association, they have to be registered, like bands don't know all that. How would they know that administration piece?

The lack of direction and support from government compromises the sustainability of health programs.

What I [came] to understand was that in that health transfer process is they transferred money but they didn't transfer the knowledge that was required to help build capacity so that the health program would be a sustainable program.

First Nations community nurses do not receive the support that they need by way of mentorship.

Even though the area that I worked in was not an isolated area, you often felt like you were in isolation because you really couldn't call upon, your nurse colleagues and say, so how do you do this, or how do you go about doing this, or I need help doing this, or can you offer me a break here, I need to get away; you know, we've had two suicides and I just can't handle this anymore.

Relationships between community nurses and government-employed nurses played out on both interpersonal and jurisdictional levels. On an interpersonal level, several participants found that interactions among groups of nurses were positive. One band-employed participant talked about having "*a positive relationship*" with public health nurses. She went on to talk about a meningitis outbreak during which government nurses came in to the community to assist:

When there was a meningitis outbreak in [place] they came to help the community. So after that it became a better and stronger relationship because of that. Yep. So then we started having meetings and networking and the districts came together. The First Nations communities came together and then [organization] people came together and started meeting and started working together.

Another participant also experienced "*very good information sharing*" among groups of nurses, while another talked about how she had successfully "*made a lot of partnerships with the province*" as a way of gaining access to resources.

One participant noticed a disconnect between band- and government-employed nurses, and found that this disconnect stemmed from a lack of understanding around Aboriginal nursing or nurses working in Aboriginal communities.

We've had many workshops where we've invited them, our provincial licensing body and policy practice, policy and practice nurses to come down and meet with our group and this was in early 2000/2001. And to be honest with you they really, they really did not understand what we were talking about. We tried to explain to them we're employed by a chief and a council and a community and we answer to them. And we're not unionized and we're not politically savvy because we don't have a big body behind us helping us. ...At one point they didn't know if we were even private contractors hiring out our services to the band. Were we employed by the band or were we employed by federal health? So there was some confusion there. Who were we working for? Is it the federal [organization]? Or is it the band? Or are we consultants? Or should we be insured on our own? So many questions surrounding Aboriginal nursing in communities.

Some participants commented on the relationships among groups of nurses in ways that focused not on personal interactions, but on jurisdictional issues that determined access to health resources for Aboriginal communities. These nurses found that lack of clarity around roles and responsibilities, as well as rigid jurisdictional boundaries, had the potential to impact negatively on health service provision. One participant provided two examples of how lack of collaboration among nurses employed with various bodies caused Aboriginal patients to fall through the cracks. The first example pertained to post-partum care:

...The time when it came to be a problem or when it was seen to be a problem was when, for example, the moms would have their baby in one of the [city] hospitals. If they were Aboriginal, say from [community], the public health nurse wouldn't come and do a visit with them in the hospital... it's because the community members here are receiving care from the nurses here and we don't share the same computer system. We're not on the provincial computer system.

The second example pertained to immunizations:

They weren't doing immunizations for our teenagers in the high school. Ok, well that's a problem. What happens if there's an outbreak? We don't get included in the mass immunization? It was through discussions and realizing that, you know, the virus isn't going to stop at border of [community], it's going to spread.

And it's really very silly why they wouldn't do our high school, because we weren't on the computer system and their perception was that there's lots of native students in the high school and we can't possibly input 200 students every time we do the Grade 9 needles.

She went on to explain how the two groups of nurses began to collaborate, and as a result, the students in the area were no longer separated for immunizations.

### 5.3 Access to Resources

The third sub-theme of the Socio-political impact of Aboriginal nurses working in Aboriginal communities refers to the specific meaning given to the various political activities. Several participants discussed access to resources. One nurse, a government employee, spoke positively about access to resources and identified several programs and services that were accessible to the First Nations communities with whom she worked, including home and community care programs, a methadone clinic, and drug abuse awareness programs for youth. Other participants, however, spoke mainly in terms of the lack of access to resources within their communities.

Some nurses pointed out a lack of health services for community members. One nurse referred to her community as "*under-resourced*," in part due to the shortage of funds to hire more nurses. Another nurse referred to the absence of adequate physician services in her community. A third nurse pointed out that the funding agencies did not provide enough money for programs, and she identified the core issue as being that funding decisions reflected agency priorities rather than community needs.

Several participants identified a lack of accessible resources for community nurses themselves. One participant shared that while she was able to access information and support from an "*older nurse in a different community*," the government department that was supposed to provide her with this kind of support was not helpful. One participant addressed the fact that community nurses had the opportunity to attend fewer information sessions and workshops than hospital nurses. She also talked about her difficulties in obtaining support from the licensing body around policy writing.

If you need that licensing body to help you with policy or some direction, they can't help you. And I have had the experience of calling them numerous times and asking them about policy and how to develop a policy because most bands don't have any, and asking them for some direction or some help or assistance as a group, you know, we'll pull all the Aboriginal nurses together working in communities, can someone come and help us with the policy? And really they're not even able to do that. They can give us the basics, you know, a policy should say this and say that, but in terms of actually sitting with us as a specific group and saying, "These are your concerns and you need to make sure they're documented in policy and you have some protection," I don't feel that they're the body to help us with that. So if your licensing body can't help you with that, I don't know who can. Because really, if we run into difficulties or something should happen, I don't know that they'd be able to help, to support the nurse.

One nurse expressed frustration over the fact that the white nurse who replaced her after she left her position was given medical equipment that she had asked for but had never received. Another nurse talked about her experiences working in a community where she would have to attend to the bodies of deceased patients who in some cases were family members or people she had known personally. She commented on the lack of support services available to provide debriefing for those types of experiences.

The information that participants provided in their interviews revealed the extent to which politics play a role in access to resources for First Nations communities. On the one hand, many community nurses felt frustrated by the lack of funding available for programs and support.

On the other hand, an Aboriginal nurse who worked in government expressed her frustration over times when she was not able to give communities as much money as they needed "*to deliver a decent program*" despite her advocacy role. Jurisdictional issues also shape access to resources both for the communities and for the nurses themselves. One nurse articulated this connection most explicitly:

What's provided on reserve for First Nations and what's provided for off reserve First Nations, is different than what's provided for mainstream Atlantic Canada or the public at large. And we have too many dividing lines. So if you're on reserve, you get this service from the province. If you're on reserve, you don't get this service. So there's a lot of boundaries and jurisdictions in being Aboriginal.

I think within even the Aboriginal population there's jurisdictions. There's differences in whether you are fully status, or you know what your status is, or where you come from, you know whether you're from a different territory than another First Nations person, so there's a lot of differences too in Aboriginal culture.

Another participant explained how jurisdictional divides caused First Nations community nurses to fall through the cracks when it came to accessing unions.

Well the federal nurses at [organization] have [name] and the provincial nurses have their provincial unions, but we can't belong to them, or even if we do belong to them they can't do anything for us. So what's the sense of belonging to them? Because we work in federal jurisdiction which they have no jurisdiction. So we're in no man's land when you're working in First Nations. You don't have a contract, most nurses don't have contracts. Most nurses can't belong to unions, and there's no wage parity.

Another nurse addressed issues around access to resources, but offered a slightly different analysis. She agreed with the other nurses that the bands were not given enough by way of money and resources, but she argued that the heart of the problem was the First Nations communities' dependence on government funding. She believed that these communities had the resources to be self-sustaining. She explained her position as follows:

Even though we don't get enough government support, for example, one of the programs that they have here is to do one of the home visits with high risk moms, but in a community that has 70% moms using alcohol or drugs during pregnancy you can't do that. And you have one baby born every week, you can't manage that kind of caseload with two outreach workers. But yet, that's how much money we get, we really only hire two people. So that's an example of how we don't have nearly enough financial resources. But this community, and other large communities like this, do have the potential to pool the resources within themselves and be independent, self-sustaining communities and recognize that they have strengths that have gotten them through the toughest of times over the last 500 years. You don't have to rely on governments to give you money to do what you want to do. You have the resources, you have the strengths.

And the Aboriginal communities aren't always told, you do have good things about you, we're always focused on what we don't have, we have high rates of alcoholism, we have high rates of diabetes, yeah, but we have a great sense of family, they have a great sense of community that I think has carried them through the worst of times. Residential school, any kind of assimilation, they have strengths that have gotten them through things that other communities might not have gotten through. And so to focus on what they do well and to do that better I think would really propel the community into a whole new sense of who they are. So I don't think they need to focus on, well you're not giving us enough money, you're not giving us enough, we always say that but they have the resources within the community to be able to finance their own programs. They really do. Yeah. But I think that they always think that they're not good enough. They're not good enough to deliver their own programs, they're not good enough to support their own programs but they really are and they really need champions to promote that within them.

Aboriginal nurses, as illustrated above believe that Aboriginal communities have several strengths. The Aboriginal nurses stressed that they are doing the best they can in spite of the lack of financial resources. They expressed their concerns of feeling undervalued regardless of their commitment to providing high quality health care. Even though many of the participants expressed feeling unrecognized and undervalued for their work in Aboriginal communities; they still are able to work from a strength-based approach.

## 6. Discussion and Implications

The colonial process of Aboriginal People has resulted in poor health, diminished self-determination, social exclusion, and a lack of influence in policies that directly relate to Aboriginal individuals, and their health care (Reading & Wien, 2009). Upon examination of the interview data, it is clear that band-level politics, government-level politics, the relationships between band and government employed nurses, and the relationship between the government/funding agencies and the bands themselves were all significant in shaping the work-life of Aboriginal nurses working in Aboriginal communities. The centrality of Aboriginal nurses are illuminated in this study. The nurses spoke about some of the advantages of community work, as well as about some of the challenges specific to this context. Reflections on the impact of existing political structures emerged throughout these interviews.

Many of the community nurses were band employed, which meant that they answered to the community chief and council who hired them. The nurses referred to how unions and licensing bodies were not clear on their mandate of how to support nurses employed by the chief and council. In their interviews, this group of nurses addressed political structures and balances of power at the band level, and spoke about how chief and council's decisions in relation to the hiring of health care workers, the provision of health services, and the distribution of financial resources shaped their working lives as nurses. These nurses had to advocate for appropriate services for community members as well as negotiate their own working conditions. Some of the nurses interviewed for this project were government employed. In contrast, they worked alongside communities, but they held positions that were generally higher-paying than those held by band-employed nurses, and they were responsible for carrying out government mandates. These nurses spoke about the balancing act involved in working for their communities while answering to the government.

Fostering the active participation of Aboriginal nurses in various sectors of the health care system is vital for understanding and addressing the complex issues influencing the health and health service delivery for Aboriginal peoples (Aboriginal Nurses Association of Canada, 2009). Based on the findings of this research, nurse educators are encouraged to employ the recommendations put forth by the Canadian Association Schools of Nursing Education/Association Canadienne des écoles de science infirmières (CASN/ACESI), and the Aboriginal Nursing Association of Canada (2013).

The need to prepare nurses to develop leadership and negotiating skills as they work towards addressing past inequities as well as current healthcare responsibilities is essential. Advocacy and negotiation skills would benefit nurses as they build partnerships with chief and council and community leaders. There is a dearth of literature on Aboriginal nurses as the emphasis in Canada has been on recruiting and retaining Aboriginal students in nursing education. As this study has shown, Aboriginal nurses have the agency and talents necessary to create change in their communities and should play a leadership role in advocating for, and addressing Aboriginal health care needs. These nurses have revealed the current realities of being an Aboriginal nurse in Atlantic Canada, including how their Aboriginal identity influences the quality and nature of their professional lives.

These findings have the potential to inform policies on recruitment and retention of more Aboriginal nurses, and inform evidence-based change within the profession so that Aboriginal nurses presently in the system are empowered and enabled to draw upon their unique cultures, experiences, and knowledge to influence change. Further recommendations of specific targeted initiatives to enhance the work-life of Aboriginal nurses are suggested:

- Develop an integrated program or system to identify, support and enhance the leadership skills of Aboriginal RNs.
- Ensure band-employed nurses have equitable supports as nurses working in non-Aboriginal health care settings, including pay equity.
- Provide a safe workplace environment that fosters anti-racist and anti-bullying practices.
- Provide ongoing and continuing education to help support the capacity and development of nurses working in Aboriginal communities (i.e. cultural competency, cultural safety, etc.).
- Continue to support the efforts of organizations to promote the recruitment and mentoring of Aboriginal nurses.

The theoretical insights generated in this study will contribute to conceptualizations that will be central in understanding and addressing the multiple issues affecting nurses generally and Aboriginal nurses in particular.

The socio-political context identified in this research project highlights important insights into Aboriginal nursing, and sensitive issues. Addressing these multiple issues requires targeted efforts at various levels of the health care system. These findings challenge health and human resource planners to review the models employed to guide their decisions and to consider the socio-political context of health services. Aboriginal nurses in particular are caught in a web of inconsistencies that influence Aboriginal people in their communities. Policy makers, employers, nursing and health care leaders, and nurse educators need to take into account the complexity of challenges that arise from the socio-political context of working in Aboriginal communities and the impacts on Aboriginal nurses and their work-life experiences. The invisible and often undervalued work of Aboriginal nurses in First Nations communities is problematic. The relevance accorded to equity of work-life supports for Aboriginal nurses similar to non-Aboriginal nurses working in Aboriginal communities warrants attention.

Further, if Aboriginal nurses are valued for their services, supported to contribute to policy, and have input into decision making regarding the health challenges facing Aboriginal communities, then this can contribute to decreasing the wide gap in health disparities for Aboriginal peoples.

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