

# Uncovering Aboriginal Nursing Knowledge through Community Based Participatory Research (CBPR)

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## Abstract:

*The significant under-representation of Aboriginal peoples in the health professions is problematic. Increasing representation is a promising strategy to narrow the gap in access to appropriate health care for Aboriginal peoples. A critical examination of the experiences of Aboriginal nurses working within the system enhances knowledge for promoting increased representation. This paper presents the Community Based Participatory Research (CBPR) process of a study with Aboriginal nurses in Atlantic Canada. The paper describes the innovative use of capacity building strategies to actively engage team members in all aspects of the research and in addressing the three goals of CBPR; research, education and action. The paper concludes with discussion of the significant role that CBPR can play in enabling people, especially those who have been historically marginalized, to reclaim their voices and engage in the participatory appraisal of the issues influencing the health and health care of Aboriginal peoples in the region.*

**Keywords:** Aboriginal Peoples; Health Care; Nurses; Community Based Participatory Research

## INTRODUCTION

Health care encounters and the politics that shape these encounters for Aboriginal people are important to examine as they represent and construct social, economic, and political realities which has direct impact on the health and health care access of this population (Beavan, 2009). The term Aboriginal refers to the Indigenous habitants of Canada, including First Nations, Inuit and Métis (Health Canada, 2006). The term Aboriginal peoples refer to political and cultural persons that stem historically from the original peoples of North America rather than collections of individuals united by so called racial characteristics (Vukic et al in press). For the purpose of this paper the authors use the term Aboriginal when referring to First Nations, Inuit and Métis. .

Given current efforts to recruit people of Aboriginal ancestry into nursing, an in-depth understanding of the professional experiences of Aboriginal nurses already in the system increases awareness of the issues they face in their worklife and elucidate some ways of addressing their under-representation within the health care system. For example, 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 recruitment and retention of more Aboriginal people into the profession. Such knowledge will facilitate evidence-based change within the profession so that Aboriginal and minority nurses presently in the system are empowered and enabled

to draw upon their unique culture, experiences, and knowledge and to bring the fullness of their diversity into health care settings.

The purpose of this paper is to describe the participatory process of a recent grounded theory study which actively engaged Aboriginal nurses in the Atlantic Region of Canada in the generation of Aboriginal nursing knowledge guided by the principles of community based participatory research (CBPR). Although the study findings include six key themes; cultural context of work-life; race, racism and nursing; socio-political context of aboriginal nursing; way forward; becoming a nurse; and navigating nursing, these are not the focus of this paper as they are presented elsewhere. This paper starts with a literature review to provide insight into current issues and trends in Aboriginal nurses' work life, followed by a discussion of the research methodology, and the principles of CBPR and OCAP-Ownership, access, control and possession to highlight the Canadian context of doing research with Aboriginal communities. We then present an account of how our team implemented the CBPR process within the context of specific project activities which fostered greater understandings of the ways in which race, ethnicity, and culture shape and affect the worklife of Aboriginal nurses in this region of world. Lastly, the paper discuss some key issues influencing the CPBR process in our study within the context of other studies that have used CBPR with Aboriginal peoples, and our own study findings. The paper concludes with some of the lessons learned in our journey of doing CBPR with Aboriginal nurses with the ultimate goal of improving the health of Aboriginal peoples.

## LITERATURE REVIEW

In the last few years, there has been growing interest in the impact of race, ethnicity, and racism within the nursing profession. Several studies have examined the experiences of Aboriginal and minority nurses in Canada, Britain, and the United States (Bessent, 2002; Calliste, 1996; Calliste, 1993; Das Gupta, 1996; Foster, 2006; Gregory, 2007; Head, 1986; Health Canada, 2006; Hezekiah, 2001; Hine, 1989; Martin & Kipling, 2006; Stephen, 1998; Vaughan, 1997; Wasekeesikaw, 2003). However, as Kulig and Grypma (2006) note very little is written about the history of Aboriginal nursing and despite their 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. This study also revealed that Aboriginal nurses were more likely to work in areas accessible only by plane.

In response to the problem of nursing shortage in Canada, the Federal Government allocated \$100M over 5 years to "create and implement strategies to increase the numbers of Aboriginal health professionals" (Hanson, 2006). In addition, academic and community based researchers have collaborated with nursing organizations such the Aboriginal Nurses of Canada (ANAC) and Canadian Nurses Association (CNA) and have implemented a number of initiatives based on the premise that an increase in the number of practicing Aboriginal nurses is essential for the improvement of the health of

Aboriginal communities in the country (Hart-Wasekeesikaw, 2001). Australian-based research has also focused on need for recruitment and retention of Aboriginal nurses into training programs (Goold & Usher, 2006), as well as the need for nursing programs that take cultural diversity into account (Goold et al, 2006; Leibbrandt, Brown, & White, 2005). While data from Australia is not necessarily generalizable to Canada, Australian Indigenous groups share similar experiences of colonization to Aboriginals in Canada, and share a similar health status in comparison to non-Aboriginal populations (Kelly, 2006). It is likely, therefore, that some parallels exist. In Australia, difficulties in nursing student recruitment and retention are linked to poverty, geographic isolation, negative experiences in schools (Murray & Wronski, 2006), as well as to racism and lack of culturally relevant course content, lack of financial and practical support, and unfamiliarity with the university structure (Adams et al., 2005). Analysis of curricula from 29 undergraduate nursing programs reveals that course programs themselves need to include a greater emphasis on the health issues of Aboriginal and Torres Strait Islander people in order to prepare all students to work more effectively with diverse populations (Liebbrandt et al., 2005).

In 1999, The University of Western Australia introduced a comprehensive final year course on Aboriginal health issues. A study of the impact of this curriculum addition revealed “significant improvements in students’ preparedness to recognize Aboriginal health as a social priority and in their perceived ability, and future commitment, to work for changes in Aboriginal health” (Paul, Carr, & Milroy, 2006, p.524). Other recruitment and retention initiatives targeted at indigenous people in Australia include a satellite RN program designed to promote indigenous student retention by offering courses on site in remote areas (Usher, Lindsay, MacKay, 2005), and a learning support centre for Aboriginal students (Adams et al., 2005). Similarly, an integrated nursing access program has been developed in one of the Atlantic Provinces to improve access to nursing education for Aboriginal people (Orchard, Didham, Jong, & Fry, 2010). For these recruitment and retention efforts to be sustained, however, it is crucial to understand the work life experiences of Aboriginal health professionals currently working in the system. As one of the Aboriginal nurses who participated in our study advised, Aboriginal nursing recruitment efforts should focus on providing adequate support to students and on offering them a safe space in which to voice their concerns. She asserted:

*If we want more Aboriginal nurses...then we have to try and understand them, and maybe look at their culture, they're different, very different, and you need to understand that, and you've got to have some resources there to assist them in those times, that they're going to be, you know, because like I said they're moving away from home, they're adjusting to a different culture.*

## **RESEARCH METHODOLOGY**

This qualitative study was based on the principles of Grounded theory method as described by Glaser & Strauss (1967) and guided by the principles of Community Based Participatory Research (CBPR). The study examined the worklife of twenty-two Aboriginal nurses in Atlantic Canada.

Grounded theory is a qualitative method of inquiry that facilitates the development of theory from raw data in a rigorous and systematic manner (Glaser, 1978). The method was initially developed and published by Glaser and Strauss (1967) in their book, “The Discovery of Grounded Theory”. Grounded Theory fosters conceptualization of people, places and events so that the emergent theory may be applicable to relevant time, place and people with emergent fit and modification (Glaser, 2002). This kind of qualitative inquiry facilitates the discovery of rich descriptions that account for the pattern of behavior and unique experiences of the people undergoing the experience (Patton, 2002). As Glaser (1998, p.12) states, “this methodology fosters an honest approach to the data that lets the natural social organization of substantive life to emerge.” The data is not forced into theoretical frameworks instead it facilitates a deeper understanding of the people being studied. Understanding the phenomenon under study from the perspective of the participants is consistent with the principles of CBPR. It helped the research team to maintain an open mind and to actively listen to the stories of Aboriginal nurses in an effort to generate a theory that is grounded in their unique experiences. The research protocol received ethics approval from Dalhousie University Research Ethics Board (REB) and the M’kmaq Ethics Watch prior to commencement of the study. The primary mode of data collection was interviews and constant comparative method facilitated data analysis. Atlas ti computer software was used for data management.

In addition to experience and knowledge relevant to the study, participants were chosen on the basis of their ability to reflect and to clearly articulate ideas, as well as on time availability and willingness to participate in the research (Morse, 1991). Participants were recruited from community and health organizations within the Aboriginal communities, through personal and professional networks, as well as through snowballing effect. The sample size in grounded theory research is not usually predetermined, but rather it is based on the outcomes of theoretical saturation (i.e. when no new concepts are generated). In our study, theoretical saturation was reached when twenty-two nurses were interviewed. Because of the diversity of experience within the Aboriginal population, we employed maximum variation sampling strategy to purposively select a heterogeneous sample and to observe commonalities in their experiences (Pope and May 2000). Participants were chosen to represent the Aboriginal nurses in Atlantic Canada. The heterogeneity among the study participants was reflected in a number of indicators including clinical practice setting, employer, age, status of nursing practice (i.e., practicing and non practicing), etc. Interviewing the greatest variation of people undergoing the experience of being an Aboriginal nurse generated a rich set of data that provided the range and variation of categories required for a grounded theory study.

## **COMMUNITY BASED PARTICIPATORY RESEARCH (CBPR) PRINCIPLES**

Derived from participatory action research the focus of CBPR is on working with communities to create knowledge for change as opposed to the researcher doing research on a community (Minkler & Wallerstein, 2003). Participatory action research has evolved in the last four decades with community participants taking on roles formerly carried out by researchers from outside the social setting (Kemmis

& McTaggart, 2005). Contemporary participatory action research is a process of critical and reflective inquiry that gives voice to those who are usually silenced and empowers people to analyze their experiences as a means of effecting change (Etowa, Thomas-Bernard, Oyinsan, & Clow, 2007; Israel et al., 1998; Kemmis & McTaggart, 2005; Wright et al. 2009; McNiff & Whithead, 2006). Community involvement with the research design, implementation, and analysis, with the aim of combining knowledge and action for social change to improve community health and eliminate health disparities, is fundamental to CBPR (Israel, et al., 2005; Minkler & Wallerstein, 2003).

CBPR facilitates consciousness-raising and promotes critical thinking so that people are able to explore the root causes of their problem and to engage in action for change (Minkler et al, 2003). A shortcoming of existing health research on populations who are marginalized is that many studies are conducted *on* rather than *with* communities (Minkler et al, 2003) In the absence of genuine partnerships between those being researched and academic researchers, the questions posed by investigators, the instruments designed to answer these questions, and the conclusions reached may not be meaningful for the people being studied (Greenwood & Levin, 1998; Green & Mercer, 2001). Not only do these things devalue the experiences and expertise of marginalized populations, but they can also lead to misunderstanding or misidentification of the problems facing these populations as well as to inappropriate recommendations for change.

Community Based Participatory Research (CBPR) represents an integrated set of principles and values in which those being studied (the community) plays a central role in determining the research agenda and actively engages in all phases of the research project including the definition of the research questions and development of the proposal (Hall, 2001; Wallerstein & Duran, 2003; Wright, Roche, Von Unger, Block, & Gardener, 2009). Participatory research such as CBPR consists of three inter-related goals which drives the research process; research, education and action (Burgess & Purkis, 2010). These goals also serve as evaluation criteria for assessing the quality and integrity of the study (Reason & Bradbury, 2001). The research goal is accomplished collection and analysis of data while the education goal is addressed through information sharing and collective reflection (Bradbury and Reason, 2003). This process of education and reflection helps people to develop a better understanding about how their current situations have come to be (Kemmis & McTaggart, 2005). This increased awareness and a sense of appreciation for the history and contextual factors of the people under study leads to a desire for change as people begin to question their circumstances and to come to a consensus on strategies for creating change (Wallerstein & Duran, 2003). This desire for change leads to the social “action” goal or component of the CBPR approach as study participants, also referred to as co-researchers collaborate with other researchers and community members to engage in a collective social action to change their situation.

In the Canadian context, the Tripartite Council of Policy on Ethics has established the principles of ownership control access and possession (OCAP) principles (2008) when doing research with Aboriginal communities. First Nations have expressed many concerns about the way research has been conducted. The lack of meaningful research, research that does not benefit the community, pressure to support a research project, agendas dictated by others, lack of respect towards First Nations, misinterpretation of traditional knowledge and practices, stigmatizing and stereotyping and not having

control over data are some of the research issues expressed by First Nations. First Nations Center (2007) explains the principles of OCAP are in response to: “colonial, oppressive and exploitive research; an increase in First Nations research capacity and involvement; and widely shared core values of self determination” (p.9). CBPR is consistent with the OCAP principles outlined by Schnarch (2004) and the Canadian Institute of Health Research (CIHR) (2008). According to CIHR, participatory research is a valuable method for Aboriginal people to be agents of the research and agents of change. Further, the Interagency Advisory Panel on Research Ethics (2008) supports engagement between the community involved and the researcher which is initiated prior to the actual research activities and promotes mutual trust and communication. First Nations, Inuit and Metis organizations and communities propose participating as partners in all phases of the research process to protect their heritage, to ensure that their knowledge systems are authentically reflected in the research practice, and to secure equitable distribution of the benefits (Interagency Advisory Panel on Research Ethics). Implementing CBPR with Aboriginal nurses guided by the principles of OCAP to examine the work life of Aboriginal nurses supports the creation of respectful knowledge reflecting Aboriginal knowledge that is relevant to Aboriginal People.

This research was approved by the Mi’kmaq Ethics Watch at Cape Breton University and by the research ethics Board at Dalhousie University. The Mi’kmaq Nation inhabits parts of Atlantic Canada as well as New England in the eastern United States. The majority of Nova Scotia’s First Nations belong to the Mi’kmaq Nation (Dobblesteyn2006). Mi’kmaq Ethics Watch was established in Eastern Canada to insure that research done with Mi’kmaq is in keeping with the OCAP principles.

Our deliberate inclusion of OCAP principles within the CBPR frame underscores the conceptual consistency of the two set of values and principles: 1) Attention to the origins of the research questions- Questions originate from the communities and are shaped according to their needs; 2) The consistent and meaningful participation of the communities and persons ‘being researched’ including shared decision-making- Deliberative participation throughout the research process and according to self-determined strategies; and 3) Attention to the centrality of addressing issues of social justice in the outcomes of the research (Wallerstein & Duran, 2003); and Co-learning and reciprocal transfer of expertise among research partners including negotiation of information and capacities in both directions ( Wright et al 2009). For instance, while academic researchers share tools for community researchers to analyze the situation and to facilitate informed decision-making, community researchers share their expertise in “indigenous knowledge” and its application with academic researchers in the quest for mutual knowledge exchange and collaboration.

## **OUR JOURNEY THROUGH THE CBPR PROCESS**

CBPR has been conceptualized as having three key dimensions or goals; social research, education and social action (Burgess & Purkis, 2009; Wallertin and Duran, 2003). In this section of our paper we describe the strategic activities of the team which demonstrate the implementation of these dimensions of the CBPR. In recognition of the importance of staying true to the CBPR principles (i.e. collaborative work and mutual capacity building), the research team was strategically composed of two academic researchers and three registered nurses of Aboriginal ancestry. The non-Aboriginal members of the

research team have active connections with the Aboriginal community, health care services, policy makers, and other researchers and in the field of diversity and social inclusion in health care. During the process of this proposal development, a collaborative alliance was formed among members of the team and their respective organizations. This fostered mutual mentoring and knowledge exchange among team members as well as facilitated communication with the Aboriginal community. This democratic process of CBPR fostered the shared principles of information and capacity building among team members throughout the research process.

Although, the research idea originated from an academic researcher who was curious to engage Aboriginal nurses on the dialogue about increasing student enrolment from their community, members of the Aboriginal community and health organizations participated in the process of refining the research topic and the proposal development. Consultations with various health care professionals including individual Aboriginal nurses across the region, and other people who work in this area of research and health care helped to ensure that CBPR principles were adhered to and that the research proposal truly reflected the community's agenda.

The participatory process was also evident in the *“research”* component of this CBPR as Aboriginal nurses were actively involved in the study as co-principal investigator, community partners, and co-investigators, and they participated in project activities including data collection, data analysis, and dissemination thereby creating opportunities for capacity-building. The *‘Education’* component of CBPR was demonstrated in the capacity building aspect of the project. This made possible the hiring of an Aboriginal student as a research assistant, who participated in all project activities including data collection and analysis, report writing, and dissemination. This provided a great hands-on mentoring opportunity. Educational events were held to optimize knowledge exchange among team members. For example, while academic researchers transferred research tools such as training on the use of atlas ti software, coding framework, research methods, community researchers shared their expert knowledge of indigenous ways of knowing and the meanings of events.

Although all team members did not participate in the interviews, we ensured that an Aboriginal person was part of those who conducted the interviews as this was a planned capacity building opportunity for the Aboriginal research assistant. Furthermore, all team members actively participated in data analysis meetings, another great forum for knowledge exchange and collective reflection. This helped to minimize possible misinterpretation of the cultural context of the nurses' experiences and raised awareness of the sociopolitical contexts of nursing practice in Aboriginal communities. It was enlightening especially for the non-Aboriginal to learn about the complex sociopolitical aspects of nursing work in Aboriginal communities. For example, one of our study participants 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. She recalled:

*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.'*

Another study participant echoed similar sentiments, and explained that council members made their decisions based on their own needs and circumstances. She noted:

*[Chief and Band Council] don't interfere too much in health issues because a lot of them don't really understand health issues unless they're sick. And when they're sick, that's when they're all concerned about health and everything else. But if they're healthy and well and don't need anything then they don't bother too much with the health centre. And unfortunately that is reflected in salary.*

To further build team capacity and strengthen all team members expertise in data analysis, an expert and a paid consultant in the field of qualitative data analysis using computer soft wares such as Atlas ti, Nvivo was invited to complete a set of training programs during the project team's "data analysis" meetings. This served as a capacity building initiative for all team members to have shared understanding of how Atlas ti and the data analysis process as a whole work. This expert was also available for one-on-one consultations with the research assistant to further build her data analysis skills with emphasis on the use of Atlas ti. The project lead also had one-on-one sessions with the research assistant on the theoretical underpinnings of the study including grounded theory and CBPR. We held meetings during the last phase (report writing and dissemination) of the project to re-examine themes, and re-sort where necessary, and to identify recommendations and future directions. This set of meetings served as forums for the Aboriginal nurses on the research team to assume control over the ways in which the study data was interpreted and to inform how it would be used to move forward with future research.

This active involvement and collective reflections motivated team members to plan for change which lead to the "social action" component of the CBPR. Actions completed by the Aboriginal people in the study are numerous ranging from political activism in terms of responding to the public concerning racism, presenting project findings to the First Nations' Chiefs and Council in the region, speaking passionately and confidently at several scholarly conferences about the finding of the study. Presentations at various Aboriginal and nursing events include the Aboriginal Nurses Association of Canada (ANAC) annual conference, Annual Atlantic Aboriginal Health Conference, the National First Nations Inuit Health Branch (FNIHB) research conference and knowledge exchange activities such as dialogues, workshops, conferences and symposia organized by related organizations including university schools of nursing. These dissemination activities have created good exposure for the project and networking opportunities which has led to invitations for team members to participate in other initiatives e.g. some are already involved in other studies in the field while some are involved in a mentorship program to increase the recruitment and retention of Aboriginal students in nursing programs in the region. It has provided opportunities to network with Aboriginal community leaders, nursing and health leaders, as well as researchers including representative from the Funding body (Atlantic Aboriginal Health Research Program), and the Aboriginal Nurses Association of Canada.



## DISCUSSION

Doing CBPR with Aboriginal communities provides an approach to doing research that is respectful and relevant to the community. This approach requires researchers to build relationship and trust with a community to do research that is meaningful to the community. Aboriginal Peoples are resisting research that is done by non Aboriginals. Similar to the process enacted in our research on the worklife of Aboriginal nurses. MacAulay et al. (1999), who have used CBPR in their work with First Nations communities to address diabetes in the community, describe the key components of CBPR as; mutually created knowledge, sharing of expertise and resources of community members through collaboration, mutual education, and acting on results of research that addresses questions that are relevant to the community. The process is based on mutually respected partnerships between community and researcher. Such partnerships are strengthened through mutual agreement concerning the research question, design, implementation, analysis and dissemination. In this study Aboriginal nurses partnered with academic researchers in making decisions about the research question, design, implementation, analysis and dissemination of research specific to Aboriginal nurses' work life experience and was an innovative research experience for all members of the research team. This positive relationship proved to be a learning experience for all members of the research team. This is evident in the current community mobilization and activism of team members.

Lay person's involvement in the analysis of research data is important in CBPR. Szala-Meneck and Lohfeld (2005) identified the significance of the community advisory team's involvement in developing interview questions and analyzing interview data in a Hamilton Care Giver Respite Project. According to Szala-Meneck et al. (2005) by including the community advisory team in the analysis, the rigour of their qualitative data analysis was increased, and the process provided community members with an opportunity to learn new skills. Castleden, Garvin and Huu-ay-aht First Nations (2008) present a CBPR project where Huu-ay-aht First Nations were interested in better understanding the environment and health risk perspectives in Huu-ay-aht traditional territory. The research process was inclusive of the Huu-ay-aht First Nations community from inception to dissemination of the research findings and is an excellent example of the principles of CBPR: sharing power, fostering trust, developing ownership, creating community development, and building capacity with First Nations and academic institutions (Castleden et al. 2008). This experience is similar to the experience of our team where the many activities of the team and the data analysis process became great capacity strengthening tools. For example, team members who were initially intimidated by the use of computers, public speaking, and the technical language of data analysis became much more comfortable with these activities. One team member proudly told the rest of the team how the process has helped her to embrace technology and to even buy a laptop for her own personal use. Another team member has since started a professional program in the health and humanity field and yet another has been actively participating in public speaking about the socio-political issues that impact on the worklife of Aboriginal nurses.

One of the challenges of doing community based participatory research is the competing interests and motivations which are often embedded in the complexities of power. As Wallerstein and Duran (2003) note, "In CBPR, there is never a perfect equilibrium of power" (p.39). So as a research team we

acknowledged this reality and situated ourselves by our different social locations within the context of the study; our gender, race, class and status. CBPR fostered the reworking of an unbalanced power relation to the extent possible by expanding access to the material, strategic and political means. This was evident in the transforming relationship grounded in deep trust and respect which became the basis of our project activities including the knowledge translation events. There are many sources of motivations and ‘ideological commitments’ that come in to play among CBPR practitioners, therefore one must recognize and mobilize the underlying ‘participatory research paradigm’ which unites all partners in a given CBPR work (Minkler & Wallerstein, 2003; Wright et al 2009).

In our project, CBPR provided a dynamic platform for navigating the process of relationship building and the mutual transfer of capacities between the Aboriginal and non-Aboriginal research team members. Acknowledging the different and situated knowledge of the sets of team members, facilitated the process of negotiating our diverse interests, strategies and collaborative practices originating from our divergent social locations, values, worldviews and motivations. Distinguishing between Aboriginal and non-Aboriginals can be problematic as it may foster the process of othering. This term has been used in the literature to explicate how the discourse of difference can promote racialization and an essentializing gaze on culture as static by categorizing a person as ‘other’ with fixed beliefs, not taking into account differences in class, gender, age, context, or location. Vukic and Keddy (2002) have written about the marginalization of othering in northern Aboriginal communities in Canada.

Othering has the potential of marginalizing Aboriginal Peoples or rendering Aboriginal knowledge as a commodity to exploit, appropriate, or, potentially, misinterpret. Similarly, the idea of “othering” came in play in our study especially within the theme of “racism” where Aboriginal nurses clearly articulated the impact of racism on their worklife experiences. One participant said,

*I now realize the complexity of culture and racism and that it is an ongoing battle as each new generation comes to the fore. Being an Aboriginal nurse, I have firsthand experience of living the “other” and therefore feel that I have a degree of sensitivity in this area. However, I can have the “other” as well when it comes to non-Aboriginal people. In working with non-Aboriginals in my community, I find that I am, at times, teaching the way of life and dispelling the generalizations perceived by non-Aboriginals*

Study participants not only talked about their own experiences of racism, they also shared their observations of racism toward Aboriginal patients by non-aboriginal health professionals. For example, one nurse recalled:

*I’ve seen blatant racism in the hospital setting that shouldn’t be allowed and a lot of it is, and as an aboriginal person I see more centered around aboriginal more so than Black people or Asian people or anything like that. When they come in the hospital they’re like “oh, they’re probably drunk” or things like that*

Participants also commented on the extent to which their education, training, and workplaces did not address the issue of cultural safety or working effectively across cultural boundaries. For example, one of the study participants indicated that nurses working in Aboriginal communities often did not receive adequate and appropriate cross-cultural care training as part of their education. She said:

*We're not bringing First Nations people into the classroom to actually talk to people about what their culture is, we're taking it from a textbook and saying 'oh' just blanket statement 'First Nations people don't like to be looked at in the eye.' That seems to be in every textbook I've read on cultural competency. And I, I have yet to see that, um, First Nations people don't like to be stared at and they don't like to stare back at people um, but that doesn't mean they don't like to do eye contact. So, so those stereotypes are still in the textbook and nobody has corrected them. And here we are 2009 and we're still taking that concept and so no I can't say that we're doing a good job.*

Distinctions between Aboriginal and non Aboriginal worldviews runs the risk of making generalizations about Aboriginal culture without considering individual and tribal differences or appreciating the dynamic nature of cultural worldviews, values, beliefs and understandings. Nevertheless, to ignore Aboriginal worldviews is also problematic as Aboriginal Peoples recover from the legacy of colonization to regain a sense of balance and harmony within their collective historical identities. Thus, knowledge of the distinguishing features of these two standpoints is important to appreciate the priority Aboriginal nurses have in their work life. Adapting services to be culturally and socially relevant is important but insufficient because it does not speak to the totality of Aboriginal understandings or to the self determination and self reliance of Aboriginal Peoples (Vukic, Gregory, Martin-Misener & Etowa, In Press). CBPR provides an avenue to do research that transcends the potential of othering as communities work towards doing research that is relevant and creates action for change that is in keeping with Aboriginal understandings.

## CONCLUSIONS

Although knowledge is a key source of power and control over one's circumstances, it would be an overstatement to suggest that the work of achieving an in-depth understanding of the complex factors influencing Aboriginal nurses' worklife fully address the complex power dynamics influencing Aboriginal health care. Deconstructing other societal and systemic power structures are also central for understanding the forces that would drive and sustain positive change in this field. While CBPR has been instrumental in raising awareness of the issues influencing Aboriginal nurses' worklife and maximizing our efforts to serve as catalyst for change in this area, we are mindful of the challenges ahead particularly in relation to the complex power dynamics and sociopolitical factors surrounding health care in Aboriginal communities in Canada. As one participant said, the lack of direction and support from government compromises the sustainability of health programs. She asserted "*What I [came] to understand was that in that health transfer process, they [Government] 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."*

In spite of these challenges, the research team is hopeful that our individual and ongoing dialogue and reflections will sustain our efforts to facilitate needed change, which is lead by Aboriginal nurses themselves. As one of the study participants said,

*[Aboriginal communities] ...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*

As researchers working with historically marginalized populations, we must seek to change the power relations that prevent us from creating an environment where all voices count in the decision-making arenas. Because CBPR is conducted in real-world circumstances, and involves close and open communication among people who may have unequal distribution of power and other resources, the researchers involved must pay close attention to ethical considerations in the conduct of their work. They must ensure that the relevant partners, committees and authorities have been consulted, and that the principles guiding the work are accepted in advance by all stakeholders. Targeted effort must be made to ensure those who have been in positions of disadvantage influence the work, and that their wishes, in terms of the degree of participation, are respected. Fostering the participation of Aboriginal peoples in various sectors of the health care system is an integral part of efforts to understand and address the complex issues influencing the health of Aboriginal peoples. As the Aboriginal nurses who participated in this study indicated, Aboriginal peoples have the agency and talents necessary to create change in their communities (including health care) and they should be provided the opportunity to play leadership role in addressing their own health needs including health service provision.

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