

*Twice as Good*

**A History of Aboriginal Nurses**

**By**

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## **PART ONE: INTRODUCTION**

### **“Twice as Good”<sup>1</sup>**

Describing her experiences working as an Aboriginal Registered Nurse, Carol Prince states, “I’ve had to work twice as hard to prove myself. But in the end, I am twice as good!” Indeed, Aboriginal nurses have had to work double-time, often combining multiple roles. Over the last century, Aboriginal nurses have stood at the intersection of political goals for self-determination and an ideology which equates higher education with integration; membership with and certification by provincial and federal nursing organizations and accountability to Aboriginal people and communities; practices which engage with and appeal to both or either “Western” or “traditional” healing knowledge.

Examining the history of Aboriginal nursing is a fascinating way to explore the history of Aboriginal health and Aboriginal people as well as the history of nursing in Canada. The recruitment and retention of Aboriginal nurses has been a significant indicator of equity statistics of Aboriginal professionals, particularly in the last 50 years. Nursing has also been one of the more innovative fields of Aboriginal education, the proposal for a specialization in Aboriginal Health Nursing being the latest in a quarter-century of work to develop nursing programs that will appeal to Aboriginal students. Alongside education, land claims and rights to resources, adequate and accessible health care for Aboriginal people has been a consistent political issue in Canada for over 60 years and Aboriginal nurses have been central to these discussions. Aboriginal nurses were the first group of Aboriginal professionals to organize, doing so at a time of political activism for self-determination in education and health. In the field of traditional knowledge, Aboriginal nurses have been critical observers and participants in the transfer of knowledge about traditional medicine.

#### ***Overview***

This report will look at four periods of Aboriginal nurse history, using records of the Aboriginal Nurses Association of Canada and the National Archives of Canada, a range of secondary literature and the recollections of several Aboriginal nurses. Each section will first provide some historical context to nursing and Aboriginal health in the period. Next, developments in the education and work of Aboriginal nurses will be discussed using stories and examples to illustrate the challenges and achievements of Aboriginal nurses during each time period.

The first part outlines the barriers to nursing education in the period 1900 to 1945 and the work of Aboriginal nurses at this time including nurses’ aides, graduate nurses and war service. Until the 1930s, most nursing schools were closed to Aboriginal students, and nurses in this period faced discrimination in accessing both post-secondary education and different fields of nursing work. Most Aboriginal graduate nurses in the period worked at hospitals, while Medical Services Branch health centres were staffed by non-Aboriginal nurses and Aboriginal nurses’ aides.

The second period, from 1945 to 1969, was a period of expansion for both the nursing profession and the Medical Services Branch. At this time, nursing was fracturing and

specializing, resulting in both the narrowing and widening of the profession. Practical Nurse and Registered Nurse Assistant training were entrenched on one end of the nursing hierarchy and Baccalaureate programs on the other. At the same time, Indian Affairs became increasingly committed to monitoring vocational training for Aboriginal people and developed a number of opportunities for Native people to attain LPN and RNA employment. A large number of Native women took advantage of these three developments in an effort to get nurse qualifications and skills. However, many still had to overcome the barriers of racism in the education system, workplace, and in Canadian law and society more generally.

The third period, between 1969 and 1989, was one of organized political struggle towards self-determination for Aboriginal people in Canada and Aboriginal nurses partook in this struggle in significant ways. The Registered Nurses of Canadian Indian Ancestry (later the Aboriginal Nurses Association of Canada) formed with the distinct goals of improved health for Aboriginal people, Indian control of health services and the recruitment of people of Aboriginal ancestry to health professions. A correlation between health status and representation within the profession was entrenched, and a number of university and college programs aimed specifically at recruiting Aboriginal students. More professional Aboriginal nurses became Community Health Nurses in this period, and a significant number found influential positions in government, universities and community colleges. A theory of transcultural nursing was developed in this period and had an enormous impact on the criticism and development of health services for Aboriginal people. Aboriginal nurses were increasingly looked to as experts in this field.

In the fourth generation, 1989 to 2006, health transfer became one of the major issues concerning Aboriginal nurses. Aboriginal nurses continued to bring to light the issues discussed in the late 1980s, such as family and child abuse, alcoholism and violence, HIV/AIDS and Foetal Alcohol Syndrome. “Cultural Competency” and “Cultural Safety” became key concepts in the practice of nursing, as did the validation of and respect for traditional knowledge. The latest innovation in education, Aboriginal Health Nursing, demonstrates the most notable shift in Aboriginal nursing in the 20<sup>th</sup> century. The goal of Aboriginal nurses was no longer to augment participation, representation and a voice in the nursing profession, but to reform the profession itself to suit the cultural needs and intellectual goals of Aboriginal nurses and communities. The conclusion will draw these eras together and make some general observations about the history of Aboriginal nursing in the last century.

There is a long history of healers who deal with the spiritual, social, physical and mental health of their people. Our contemporary concept of ‘nurse’ was fashioned in the late 19th century and has largely excluded traditional health care providers and the large number of Aboriginal people who undertook non-licensed labour at hospitals, clinics and nursing stations throughout Canada. Out of respect for the work of these individuals, this booklet will focus on those nurses who undertook formal or informal education as Registered Nurses, Registered Nurses Assistants and Licensed Practical Nurses in the 20th century.

## **PART TWO: 1900-1945**

### **“My Time Has Come at Last”<sup>1</sup>**

#### ***Background***

In the first few decades of the 20th century, nursing became legitimized as a profession due to the critical assistance nurses provided to victims of tragedy including the First World War, influenza and other epidemics, and the Halifax explosion. This period also saw the expansion of the hospital apprenticeship system of nursing education in which nursing students staffed hospitals while concurrently gaining training.<sup>2</sup> The overall state of health of Aboriginal people was fairly poor and many communities were suffering from tuberculosis, malnutrition and other illnesses exacerbated by economic hardship and colonial policies related to schooling, land and resource appropriation and relief measures. Meanwhile, the centralized federal system of Indian Health Services run by Indian Affairs developed from ad hoc medical practices undertaken by traders, whalers and missionaries.<sup>3</sup> After the Department of Indian Affairs’ first chief medical officer in 1904, the department hired “field matrons” to supply simple remedies, to educate people, and to act in case of emergency. There were also “travelling nurses” who would make inspection trips to various agencies, hold baby clinics and travel to schools and homes giving assistance and advice about sanitation, diet, parenting, gardening and homemaking. By 1927 about 38 nurses worked for Indian Health Services<sup>4</sup> and this number grew over the period. Provincial nurses also served Aboriginal communities.

This professional advancement and health service consolidation occurred in a closed context, as until the 1930s, only a minority of hospitals were open to receive Aboriginal nursing students.<sup>5</sup> In fact, many Aboriginal nurses in this period trained in the United States, where they did not face the same ethnic barriers as they did in Canada.<sup>6</sup> Nursing personnel in Aboriginal communities was largely non-Aboriginal and a significant portion from outside of Canada. Still, there were a significant cadre of Aboriginal people working in various positions in hospitals and nursing stations throughout the country. A small but vital number of Aboriginal graduate nurses managed to overcome barriers to education and work, and were educated and employed in this period. Their time had come “at last” to partake in the health services delivered to their own people.

#### ***Education***

The education of Aboriginal nurses began long before they entered nursing schools. Early childhood experiences and the lessons learned among their families and communities often sustained them in the federal education system and prepared them for nurses’ training. A loving environment, a connection to community and an understanding of roles and responsibilities were the foundations needed to undertake nursing training and a career in health care later in life.<sup>7</sup> In her youth, Ann Callahan, a Cree Elder from Peepesequis First Nation, Saskatchewan, and an RN for many years in the city of Winnipeg, was helped to believe in herself as a child of creation. Well before the years she was sent to File Hills Residential School, she was constantly told that she was loved. For her, traditional ceremonies, visiting with elders and reconnecting with her community reinforced this philosophy throughout her young years and today as well.<sup>8</sup> Eleanor

Olson, a Cree Elder from Norway House and Peguis, was also prepared in these early years for a nursing career down the road. Until she was 9, she lived a traditional lifestyle, living off the land, and was educated by her grandparents and great-grandparents (who would not permit her to attend residential school). She recalls that by the age of 6, she knew all of her roles and responsibilities, which included knowing all of the names of different fish, game, and birds and knowing how to fillet, tan, bead, cure, and do quill work. Her responsibilities were also to make sure that all the moss was washed and dried for babies. Her grandmother gave her strong teachings on survival. While Eleanor was growing up, one of the main responsibilities of aunts was to help with different education processes and her aunts became involved in teaching her how to read. Eleanor worked very hard when she was young, and it was this hard work which provided her with the work ethics she would need to undertake nursing education and work later in life.<sup>9</sup>

Needless to say, these recollections contradict more popular depictions of Aboriginal family life in the early 20<sup>th</sup> century, which has been largely pathologized in religious, sociological, bureaucratic as well as economic interpretations. Many of the Aboriginal women who worked at hospitals in this period spoke their Indigenous languages and had to learn English in order to train and work as nurses. As such they provided invaluable skills communicating with Aboriginal patients in the hospitals. Not only did many overcome the regimes and poor quality of federal schooling at the time, but they also experienced the discrimination and racism so prevalent in Canadian society. That early education as children, therefore, was crucial to their later survival and success.

#### *Access to Nursing School*

Rosabelle Ryder was an extraordinary woman in many ways. Member of Assiniboine Reserve, and from Carry-The-Kettle, Sintulta, Saskatchewan, she attended Round Lake Residential School in Saskatchewan in the 1930s. Here, one of her teachers noticed her strong academic capabilities, encouraged her to go into nursing and “tried at many hospitals to have her admitted.” Unfortunately, at this time, they could not find a nursing school that would accept Indians. Later on in her education, while at the Brandon Residential School, her principal, Dr. Doyle, wrote to Indian Affairs and the St. Boniface Hospital in Winnipeg on her behalf. As was most often the case in these early years, the Superintendent of Welfare and Training of Indian Affairs decided over matters of post-secondary education for Native students. Once she was approved by both the school and Indian Affairs, she was fronted a fraction of the total cost of her entrance into training and she paid the rest out of her own savings.<sup>10</sup> From the start, Rosabelle was committed to living and working among her people and to her career, which included work at one of the largest Indian hospitals in the country, in Fort Qu’Appelle, Saskatchewan. She had a profound impact on Aboriginal nurses from Manitoba and Saskatchewan.

Many Aboriginal nurses from this period expressed an interest in helping their own people. But, in Rosabelle’s time, Canadian nursing schools were virtually closed to non-white women and the early Aboriginal nurses had to rely on the support of government and church officials in order to access nursing education. Also, women’s organizations such as the Imperial Order Daughters of the Empire, the Women’s Christian Temperance Union and the Women’s Auxiliary of the Anglican Church were active supporters of Aboriginal nursing students. These progressive, Christian, and middle-class women’s groups organized around issues such as temperance and prohibition, suffrage and missionary work, but they also rallied around female education, public health issues and the roles of women in society.

Residential school principals and Indian Agents were the most common referees for Aboriginal nursing students at this time. They would write to the Superintendent of Welfare and Training of the Department of Indian Affairs on the student’s behalf, commenting on their character, manners, academic abilities and their state of health. The Department would accept or decline financial support on a case-by-case basis, sometimes providing transportation costs,

tuition fees, books, uniforms and an allowance for room and board. Decisions about student loans were often made according to need and loans could be held against the student's parents and/or other family members, and/or future treaty annuities owed to the individual or her family. Funds flowed through principals or Indian Agents, instead of directly to the student. Along with funding came added surveillance by Indian Affairs; while non-Native students normally had only to contend with Matrons and perhaps their parents, Aboriginal students in addition had to deal with Indian Agents, the Superintendent of Welfare and Training of Indian Affairs and ex-school principals, all of whom were regularly informed by the Matrons of the student's progress.

#### *Barriers to Aboriginal Nurses, 1900-1945*

Aboriginal students wanting to become nurses at this time faced many challenges.<sup>11</sup> In the early part of the century, the entrance requirement for graduate nurse programs was two or three years of high school. However, the primary focus of Indian education at the time was assimilation, not academic achievement, and in residential schools, scholastic curriculum covered only a fraction of the day, sometimes as little as one or two hours, while the rest of the day was spent learning "usable skills" in manual training.<sup>12</sup> This "Half-Day System" put students at a distinct disadvantage academically, while manual training prepared them for vocations on the lower end of the socioeconomic scale. Many students had to ask the Department for permission to transfer to a different federal school or a provincial school in order to access the higher levels of secondary education. One student from Round Lake Indian Residential School in Saskatchewan expressed an interest in 1936 in going to Vancouver to finish her schooling with a view to entering Vancouver Hospital for nurse training. However, Indian Affairs instead encouraged her to either go to Brandon to finish high school or work as a housekeeper.<sup>13</sup> Another student, Jennie Neilson, from the Blood Reserve in Alberta, needed to transfer out of St. Paul's Residential School on the Blood Reserve in 1942, when, at the age of 16, she had attained the highest level at that school. She wanted to attend high school locally; however she had to go all the way to Sault Ste. Marie in northwestern Ontario to find a public high school that would accept Indian students. When she finished her exams there, she went to the St. Mary's Training School for Nurses and graduated three years later.<sup>14</sup>

Common assumptions about Aboriginal people's health at the time created another barrier to Aboriginal nursing students. While all applicants to nursing schools had to undergo medical tests before they could register, the assumption of ill health sometimes justified the disqualification of Aboriginal nurses from nursing schools, the cancellation of Indian Affairs financial support and 'special treatment' if they became ill at school. Those assumptions cost one student from Munsee in southwestern Ontario, who graduated from the London Victoria Hospital in the late 1920s. A "brilliant student; [and] ... a universal favourite with nurses and doctors," she "was hoping to go back to nurse amongst her own people; was ladylike in manner and dress; and had never given a moment's anxiety since her arrival at the hospital," according to the Supervisor of Nurses. But when she wanted to add to her qualifications by taking a course in Public Health Nursing at the University of Western Ontario, a clerk at the Department noted that she had been admitted as a tubercular patient in London and immediately cancelled her funding. Later it was explained that she actually only "had the flu ... This, and her studies, had been a heavy strain; and considering her nationality, it was thought wise to give her a complete rest."<sup>15</sup> These swift actions were based on a popular ideology that bound together ideas about race and health. There was a widespread racist understanding, explains Aboriginal health historian Maureen Lux, that Aboriginal peoples' poor health was a biological expression of the struggle of "primitive" peoples with "civilization."<sup>16</sup> Instead, as geographer Chantelle Williams argues, "Aboriginal peoples' health and well-being was intimately linked to local environments, and ... reflective of much broader processes, including political marginalization and environmental dispossession."<sup>17</sup> Many who wanted to be nurses could not pass medical examinations to get into nursing school and some had to withdraw from their program due to ill health. At the same time,

many were inspired to go into nursing because of firsthand experience with health services and a drive to overcome whatever was put in their way.

Studying to be a nurse in a private institution often meant relocating, which added another barrier to many Aboriginal nurses. Some of the nursing schools attended by Aboriginal women during this time period include: Brandon General Hospital in Manitoba, Ottawa Civic Hospital, Toronto Hospital for Incurables (Weston Sanatorium), Women's College Hospital in Toronto, Bishop Newnham Hospital in Moose Factory, City General in Saskatoon and Nelson Hospital in British Columbia. Moving was costly and involved the financial assistance of friends, relatives and/or the Department of Indian Affairs, which had stingy, inconsistent and intrusive systems of student financial support. Many could not attend training, or had to cut their training short due to family and responsibilities or simply homesickness. Due to the general isolation felt by students, it was common for siblings, cousins or friends to travel together, for one to follow the other within a short time, or for students to attend nursing school at hospitals at or near which they had a family or community connection. Relocation for school was also often contingent upon the approval of Indian Agents. One student from Sheshegwaning Band in Northern Ontario attended nursing school at the Weston Sanatorium in the early '20s in a program which required a term at a New York hospital for special training in obstetrics. Indian Affairs was reluctant to allow her to travel, and according to the written record, it was only because she was denied entrance at any other nursing school in Canada that she was finally permitted her to go. She wrote in a letter upon this approval: "I am going to New York at last at the end of this month. I'll be there on the 1<sup>st</sup> of April. My time has come at last."<sup>18</sup>

Despite the Department's opposition, Aboriginal graduate nurses were extraordinarily mobile in this period, moving for training and work within and between provinces, from reserves to urban centres, and sometimes crossing international borders as well. For some, this travel was out of necessity. Many Aboriginal women seeking to become trained nurses also attended school south of the United States border, where they did not face the same ethnic barriers as they did in Canada.<sup>19</sup> Most of these women were members of Aboriginal nations that predate and straddle the border that separates the nations of Canada and the United States. Others travelled because they could not attain high school education in the residential school system. For example, Nora Gladstone, of the Blood Reserve in Alberta, went to St. Paul's Residential School and spent two years of high school at Bedford Road Collegiate in Saskatoon because it was difficult for Aboriginal students to attend high school in Alberta public schools. Nora, who had already represented Native people at the 1937 Coronation of George VI in London, England, was among four other Aboriginal girls who attended a course in Well-Baby Nursing at the Canadian Mothercraft Hospital in Toronto in the 1940s. Nora later went on to nursing school at the Royal Jubilee Hospital in Victoria, B.C. Nora's sister Doreen Gladstone, Martha Soonias, Daisy Horses and Nora were all invited by the New Zealand Government Nursing Department to attend a two-year midwifery training at St. Helen's Hospital in Auckland, New Zealand. While Daisy and Nora did not attend, due to illness and work elsewhere, Doreen and Martha went. Afterwards, Doreen stayed on in New Zealand as Supervisor in the City Maternity Hospital in Wellington and Martha worked at St. Helen's Hospital in Auckland. It is noteworthy that the midwifery program was training they could not receive in Canada. Aboriginal midwives were discouraged as health care providers in Canada at this time, and programs are still struggling for recognition in some provinces even today. It is ironic that while many of the Aboriginal nurses in this period would have been familiar with, and perhaps themselves delivered by traditional midwives, they could not learn or practice their methods at home. Officials, especially in the mid 20th century, began to more systematically regulate Aboriginal childbirth practices, and pressure Aboriginal mothers to have their babies in hospitals.<sup>20</sup>

Until the early 1970s, nursing education was undertaken at hospitals in programs which combined both student labour and education. Nurse Jennie Neilson recalls that in her nursing program, students would wake up at 6 a.m., do a 12-hour shift from 7 a.m. to 7 p.m. and curfew

was at 10 p.m. There was little time for anything but nursing school. She once felt like quitting after working a month of night shifts with one day off in between, but she held on to the end.<sup>21</sup> Like most Aboriginal and non-Aboriginal nursing students at the time, Jennie was in her late teens and early twenties. In nursing schools, and even within the profession, there was a fairly strict policy that nurses should be unmarried, and Aboriginal nurses were no exception – most were unmarried and self-supporting. Nurses at the time were to represent restrained sexuality and virtue, and married women and mothers were expected to quit the profession. This went on even into the 1960s, as Rozella McKay, a Cree/Saulteaux Community Health Nurse from Saskatchewan, recalls. As a student in the Diploma Nursing Program at the University of Saskatchewan in the early 1960s, she found the University Hospital was notably “liberal,” as it didn’t judge nurses who were married and/or pregnant, and who, at this time, were refused at other schools.<sup>22</sup> Many Aboriginal nurses from this period were from the Prairie Provinces and Ontario. Fewer were from British Columbia, and fewer still from the North.

### *Training in the North*

In the North, Indian hospitals and doctors working for the Medical Services Branch devised “modified” training programs for hospital staff, whereby hospital maids would advance to ward aides or nurse aides after a period of training. These courses taught cleanliness, punctuality, efficiency and discipline, as well as bed making, room cleaning, preparation of foods and trays and care of patients. One uncertified nurse’s aide training program offered by hospital staff in the Northwest Territories in the 1940s is described by Laurie Meijer Drees, a historian of the North. This program grew out of informal training practices in the area and engaged mission hospitals at Fort Smith, Aklavik, Fort Simpson and the Resolution Indian Residential School. While the training provided by this program was much like Practical Nurse and Nurse Assistant training, it appears that the scheme stands apart for its goal to “improve” the individual lives of the nurses-in-training and their families, rather than embracing the more widespread nursing ethic at the time, to selflessly serve others, and it was also out of date with the contemporary movement towards more systematic programs of nurse training elsewhere in Canada.<sup>23</sup> “This early program,” Meijer Drees argues, “characterized by lack of solid federal support, low expectations, and a piecemeal approach, could be viewed as the pattern for things to come in the field of Aboriginal nurse training until the 1970s. Programs that followed within the IHS [Indian Health Service] system were equally unsystematized, and focused primarily on training ‘aides’ and helpers, rather than seeking to promote full certification of Native nurses.”<sup>24</sup>

There was a certain ambiguity surrounding Northern graduate nurses in this period. On the one hand, there was a strong push to train and employ nurses from the North, but on the other, there was hesitancy around their ‘preparedness’ for further education and relocation and an unwillingness to officially accept financial responsibility for it. Doctors, Indian Agents and white women often acted as advocates and guardians for girls they thought had potential for nursing education, and made relatively intricate plans on their behalf. According to the written record, a student at All Saints Anglican Residential School in Aklavik, who was also the assistant to Dr. J.P. Harvey, was encouraged to work as a ward maid at Fisher River Hospital in Hodgson, Manitoba where, under the supervision of Matron Miss Olive Thomas (who was a former schoolteacher), she could obtain her junior matriculation through correspondence so that she could eventually qualify as a registered nurse. Miss Thomas, noticing her keenness, stated that it was out of the question for her to both work as an attendant and be expected to study and get her high school standing and suggested Mabel be sent to the city to finish her high school. To this, the department replied “[She] is pretty young for life in the city – having in mind her previous surroundings,” and asked Miss Thomas to keep her at Fisher River for a while and give her what training she could. It was felt that “this should help make her more useful to whomever might employ her in the city, and also make it easier for her to make a better start in a city school.” When Miss Thomas resigned in May of 1944, Dr. Ridge of that hospital and his wife took Mabel



to Winnipeg, stating they would care for her welfare and education. When Mrs. Ridge's mother became ill, she ended up attending Norwood Collegiate in Winnipeg, and then went to The Pas with Dr Ridge. In 1946, she was working on her Grade XI at The Pas Collegiate, and after matriculation, still planned to enter registered nurse training.<sup>25</sup>

For many northerners, relocation for education competed with community and familial responsibilities. One woman from Southampton Island was treated for extensive burns in the south in the mid 1940s. She attended school in The Pas while being treated, and lived with Reverend Campbell. It was thought by W.L. Falconer, of Indian Health Services, that "instead of returning ... [her] to her people when she is through with her treatment," that she should be given the opportunity to "obtain an education and qualify as a nurse for service amongst her own people." In the end, her grandparents did not consent to her continued absence and wanted her to return to her community. The Campbells respected this wish, and, fearing that she would be away from her community too long and would lose the language and "not be useful to work among her people," they consented to her return. Reverend Campbell wrote to Indian Affairs expressing his support of Aboriginal people having their own teachers, doctors and nurses. The only way to do this, he argued, was to bring education to them, as opposed to removing them from their communities. Here, in these early years, we find the arguments echoed in the pursuit to institute community-based nursing programs more than 40 years later.<sup>26</sup>

### **Work**

#### *Nurses' Aides*

In mere numbers, registered nurses were a minority in terms of Aboriginal people working in the field of health care at this time. Far more common were nurses' aides, ward aides, laundry workers, cooks, cleaners and interpreters, and many Aboriginal nurses started out working in these positions. This work was most often arranged by school principals and teachers.<sup>27</sup> For example, Eleanor Olson worked as a ward aide at the Norway House hospital on weekends while she was in school. It was this work that first got her interested in becoming a nurse. She remembers following and watching the other nurses working and asking them lots of questions about how to become a nurse. She later studied to be an LPN at St. Boniface Hospital and worked at Fisher River Hospital, Hodgson Hospital and as a Community Health Nurse in Peguis.<sup>28</sup> The responsibilities of nurses' aides ranged from bed making, room cleaning, preparation of foods and trays and care of patients, to dressings and drug administration. It is difficult to know the income of the average unlicensed nurse during this period. At Dynevor Indian Hospital in Selkirk, Manitoba (an Indian hospital run by the Anglican Church and then the Sanatorium Board of Manitoba), 1939 wages for the ward maids was at the rate of \$12.50 a month, compared to \$44.40 for the RN, \$69.15 for the Matron and \$35.00 for the 'undergrad' nurse.<sup>29</sup> In 1942, it was recommended that a woman who had received a certificate in home nursing from the Edmonton hospital after three years of training be paid \$20.00 per month for her services in Aklavik.<sup>30</sup> In their research on workers at St. Luke's Hospital in Pannirtuuq, Emily Cowall Farrell and Meeka Alivaktuk found that hospital workers' salaries were paid by nurses through a "barter and trade system."<sup>31</sup>

#### *Registered Nurses*

According to nurse historian Kathryn McPherson, in the early 20th century, institutional employment accounted for only one-fifth of the nurses in Canada, the other 80 per cent working in private duty and in public health service.<sup>32</sup> Most of the Aboriginal graduate nurses in this period, however, found jobs in hospitals. A number of Aboriginal women found private duty jobs caring for individual convalescents, but these positions were often associated with domestic service, not nursing. Aboriginal registered nurses seem to have been discouraged from working in the field of public health nurses until the 1970s. Public Health required a post-graduate course, and those who held the purse strings for Aboriginal students were often unconvinced of the

necessity of higher education for Aboriginal nurses. Nora Gladstone, who attended nursing school at the Royal Jubilee Hospital for Nursing in Victoria, B.C. and spent most of her career in British Columbia working at hospitals in Kitimat, Comox and Vancouver, states, "If I was to become a registered nurse today, I would stay at home and work among the people of the Blood Reserve. But back in the 1930s, there was no place for Native nurses on Indian reserves. For many years it was a struggle just to be responsible and to be the best in the profession I had chosen."<sup>33</sup> The tendency for Indian Affairs and the Medical Services Branch to discourage Aboriginal nurses from working in their own communities has its roots in this period. For those interested in working among Native people, a few hospitals seem to have been preferred by Native nurses: File Hills and Fort Qu'Appelle in Saskatchewan; Cardston and Charles Camsell in Alberta; Lady Willingdon, Ottawa Civic and the Toronto Hospital for Incurables in Ontario; and St. Boniface Hospital in Winnipeg.

### *War Nurses*

Aboriginal people throughout North America enlisted to serve in Canadian and U.S. armed services in both the First and Second World Wars, despite the fact that they were not Canadian citizens. Aboriginal people enlisted for the same reasons as non-Aboriginal people: patriotism, adventure, and an opportunity to earn a regular wage. They also joined for travel and educational opportunities, out of a tradition of war service and to support family members. Charlotte Edith Monture, from Six Nations, is the most well-known Aboriginal nurse who served in the First World War and was recognized by the Indian and Inuit Nurses of Canada as the first Canadian Indian to become a registered nurse.<sup>34</sup> Edith graduated with honours as an RN in 1914 at New Rochelle Hospital in New York. She joined the U.S. Army Corps in 1917 and served with the American Expeditionary Force in Vittel, France at Buffalo Base Hospital 23, where she treated soldiers who were shot or gassed. She returned to Six Nations in 1921, where she raised four children and worked part-time at the Lady Willingdon Hospital on the reserve until 1955.<sup>35</sup>

In the Second World War, more Aboriginal nurses undertook service. Irene Hoff, from Odanak, Quebec (Abenaki) joined the allies alongside her brothers. She worked with the 38<sup>th</sup> St. John's Ambulance Nursing Division in Ottawa, and left for Britain in 1944. She worked for a time at Winford Hospital, an emergency hospital near Bristol built for the war, and then was stationed near Glasgow, Scotland. Her patients were both civilian casualties and wounded soldiers sent home. After the war, Hoff returned to work at Indian Affairs, and remained in the army reserve as well. Later, she was asked to join the Canadian Women's Army Corps, and she worked her way through the ranks to become a Sergeant Major, retiring in 1974.<sup>36</sup>

Another army nurse was Isobel (Bella) Healey. Bella was born in 1912 in Fort McLeod and went to St. Paul's Anglican Residential School. In 1933, she graduated from Kootenay Lake General Hospital in Nelson, British Columbia. At the end of her first year, 1931, Bella had earned an average of 92.5 per cent, a higher standing than had ever been attained by any nurse in that institution.<sup>37</sup> According to a recent tribute in the *Alberta RN*, Isobel became the matron of the nursing school and nurse-in-charge at Onion Lake, Saskatchewan and later practiced in Fort Qu'Appelle, Saskatchewan and Wabasca, Alberta. She joined the Royal Canadian Air Force Women's Division in 1942 and married John Toth in 1943. She also worked in Lethbridge at the Galt Hospital, Lethbridge Auxiliary Hospital and the Southland Nursing Home.<sup>38</sup>

### *Conclusion*

When Aboriginal veterans returned to civilian life, the restrictions and inequities of their lot on reserves became so glaring that veterans' organizations and church groups mounted a campaign that resulted in the establishment of a Joint Senate and House of Commons Committee to revise the Indian Act. At this time, by Indian Act law, Aboriginal people could be enfranchised as Canadians against their will if they were educated and by marriage to non-status men. By the same law, non-Aboriginal women who married status men (including British war

brides of Aboriginal servicemen<sup>39</sup>) would automatically gain Indian status. Enfranchisement law dictated that Aboriginal people in Canada who became enfranchised would lose their legal rights as members of distinct nations. Rampant racism in society penalized Aboriginal people who identified publicly as Indian. All of this suggests to us that there were likely far more Aboriginal nurses during this period than we can ever know about. We do know, however, that throughout the first half of the 20th century, Aboriginal people saw in nursing a way to serve and help their people and several found positions as nurses in hospitals and nursing stations. They also worked overseas during the war and travelled internationally for work and school. In this period, it was still extraordinary to see an Aboriginal nurse, but those few who went into nursing at this time were important role models and inspirations to Aboriginal nurses later in the century.

## **PART THREE: 1945-1969**

### **“To Serve Other People of Indian Ancestry”<sup>1</sup>**

The period of Aboriginal history between 1945 and 1969 is marked by urbanization, political mobilization and a philosophy of “integration” as a step towards equality in Canadian society. Moreover, the period is also characterized by an expansion in Indian Health Services. In 1945, Indian and Northern Health Services were transferred to the Department of National Health and Welfare. Medical services were provided to status Indians and Inuit while other Aboriginal people were to consult provincial services, although the federal government ultimately desired to devolve its responsibility for registered Indians as well. A broadly publicized tuberculosis crisis among Native and Inuit people as well as the appalling treatment of Aboriginal veterans – still excluded from the rights of Canadian citizenship – stimulated widespread public interest in Aboriginal people. Expenditures by Indian Health Services alone rose from about \$2.5 million in 1945-46 to over \$10 million in 1950-51 and a multitude of graduate nurses, field nurses, medical officers, surgeons, full- and part-time physicians and others working on a fee basis joined the service in this period.<sup>2</sup> Technological innovations such as x-rays and airplane travel meant that surveys and studies on Aboriginal health could be performed on Aboriginal communities more efficiently and there was considerable growth in the number of reports on topics including tuberculosis, vaccination, diet and nutrition in the post-war years.

Increased professional standardization and division of labour occurred in the field of nursing in these years. New and more complicated procedures, as well as a proliferation of new drugs necessitated the reallocation of specific tasks from doctors to graduate nurses, and a change in the standards of nursing education. In response to this added pressure on the already overworked and understaffed general-duty nurses, hospitals employed an increasing number of trained Nurses Assistants and Licensed Practical Nurses. Most Aboriginal nurses in this period were RNAs or LPNs, however there were also a number of Aboriginal nurses among the few Bachelor-trained nurses in Canada at this time. It is also noteworthy that during this period, nursing schools relaxed their strict regulations in the profession and opened up to men and married women.

### ***Education***

#### ***Assistants and Aides***

Provincially standardized Certified Nursing Assistant and Practical Nursing courses made the most profound impact on Aboriginal nurses’ education in this period. Relative to graduate nursing programs, these courses were less expensive and prolonged, which appealed to some Aboriginal nurses who could not afford a RN education.<sup>3</sup> Ruth Christie, a Cree nurse from Loon Straits, Manitoba, attended a 12-month program at St. Boniface Hospital in Winnipeg in the 1960s. She states, “The reason I took LPN rather than RN was because I didn’t want to be that much of a burden on my parents, you know, to provide, because I didn’t have assistance like First Nations students do today. And my parents, you know, I don’t think there were times when my Dad earned the amount of money that would have been needed to support me.” Ruth recalls receiving financial, emotional, lodging and other forms of support from her large extended family

while she trained at St. Boniface School of Nursing in the 1960s. She got by during school with the help of her family: her dad gave her \$25 per month for rent while she boarded, her brother gave her a television set, she visited with brothers and cousins while in the city, and she got her sister's family allowance, \$8 per month for spending money, and then in turn supported her sisters when they went to school.<sup>4</sup>

RNA and LPN courses were offered at colleges and hospitals and entrance requirements included: "An interest in nursing; good health; references; age: 18-40 years; and Grade VIII (Entrance certificate)."<sup>5</sup> Explaining the program at St. Boniface, Ruth states, "[i]t was a year, so you did four months of theory and eight months of practical and then you had to write a state-board exam. It was an all-day exam and there were 500 questions, and I think the minimum was 350 correct ones, and I had 448 correct. I can remember seeing this letter coming and I knew what it was because of the return address. I was nervous about opening it up but you know, I studied really hard because I thought how much my parents put into it, I wanted to make them proud of me."<sup>6</sup> Popular programs included the Vancouver Vocational Institute for Practical Nursing, the Nurse's Aide course in Calgary, the St. Boniface's school for Practical Nursing, Nursing Assistant's courses in Sudbury, Hamilton, Toronto, Kingston and London, and Nurse's Aide training at the Canadian Vocational Training Centre in Saskatoon. The program at the Vancouver Vocational Institute was very popular; by 1962, it was estimated that over 250 Indian students had attended.<sup>7</sup>

The Department of Indian Affairs and Health and Welfare avidly promoted Registered Nurse Assistant and Licensed Practical Nurse courses. As they did not require full matriculation, they were ideally suited to the Department's mandate for vocational education at the time and some Aboriginal women were pressured to take LPN and RNA courses, being told they would not succeed in a Registered Nurse program.<sup>8</sup> Two programs offered nurse's aide education to specifically Aboriginal women. The Nurse's Aide course in Calgary had a "preliminary" "trial" period of a month or more at Charles Camsell Hospital in Edmonton to "determine the student's aptitude." The Vancouver Vocational Institute offered a similar internship program at the Coqualeetza Indian Hospital. As explained by Meijer Drees, the hospital placed three students at a time for a two-month internship to gain experience in tuberculosis and paediatric nursing. The Indian Health Service also assisted in placing Aboriginal girls in short-term jobs to "provide the initial experience and help to put the Indian on an equal starting basis with the white girl."<sup>9</sup> "Equality" in this context was a flimsy façade of paternalism: many women got into RNA and LPN programs after working as nurse assistants anyway. As Meijer Drees argues, efforts to train and recruit Aboriginal health care workers are characterized by a deep-rooted sentiment that "Aboriginal peoples were somehow "behind" in their ability to acquire training and employment at higher levels."<sup>10</sup>

Another program offered in the 1950s was Alberta's School for Nursing Aides in Edmonton. This program was sponsored by the provincial department of public health, and like many RNA or LPN courses, was designed to relieve the nursing shortage in provincial hospitals and "make it easier for girls in northern Alberta wishing to train as aides." Students in this school needed grade 9 and were between the ages of "17 ½ and 40." This program also had an "assessment period" for Indians only, which had to be completed before they could go to the school. This added two months to the entire course. During this "assessment period," which usually took place at Charles Camsell Indian Hospital, it was determined "if the girls will make good in the nursing field. They are judged on their interest in the work, personality and behaviour both on and off duty. The successful ones are then recommended to go to the school." When recommended, the regular course ran for 40 weeks, with 19 weeks of theory and practice in the school, and two 10-week periods in various Alberta hospitals, and then a final week of exams at the school. There was no charge for the course and during the training, students were given a small amount of money. Their salaries, when finished, amounted to 70 per cent of a graduate nurse's wage. It was said that 23 Indian students graduated from this institution between 1951

and 1958, all of whom were successful in finding employment, 12 of whom worked with Indian Health Services.<sup>11</sup>

There were a number of other ways that Aboriginal people entered health professions in the period. Charles Camsell and other Indian hospitals and sanatoria offered “in-house” training for Aboriginal patients<sup>12</sup> and many used the time they spent as patients preparing for future nursing education. Also, many were trained informally at Indian hospitals, and “Training on the Job” programs run by the Department of Indian Affairs – or “TOJ” – formalized this type of apprenticeship training. T.O.J. contracts were sometimes part of a larger, more stably funded vocational training program run from 1957 onwards by Indian Affairs called the Placement and Relocation Program. The Department of Health and Welfare also had employment programs of its own, although none of them involved educating professional Aboriginal nurses. In the 1960s, the focus of the Department of Health and Welfare shifted noticeably towards Community Health Representatives (CHRs). This program aimed to provide Native people greater control in the planning and undertaking of health programs and grew out of international work in the field of community development. CHRs were also, in part, meant to streamline the work of Medical Services Branch nurses and can therefore be seen as part of the general devolution of graduate nurse tasks to nurses’ aides. In fact, in the earliest CHR program development, the women who were trained as CHRs were called “Nurses’ Aides.”<sup>13</sup>

### *Registered Nurses*

While CHR courses specialized in Aboriginal health education, Registered Nursing education still had no such focus in this period. Some Aboriginal RN students, however, did take advantage of what specialization was offered in nursing education at the time, including Nursing Administration, Public Health, and Psychiatric Nursing. Bachelor programs grew in this period, and nurses such as Marilyn Sark, Janet Fontaine and Jean Isbister Ahenakew became degree nurses in this period.<sup>14</sup> According to McPherson, in 1962 only 148 graduated from basic baccalaureate programs in all of Canada, and it was heralded as a significant professional accomplishment.<sup>15</sup>

There were a number of Aboriginal RNs who added public health nursing specialties to their credentials. As was common at the time, most worked for a while before going back for their public health nursing specialty. For example, after Miss Edith Eileen Green, of Tyendinaga, graduated from her RN course at the Toronto General School of Nursing, she worked in Belleville and Moose Factory before enrolling at the University of Toronto for advanced training as a public health nurse. She completed the course in the spring of 1960 and, after working at Manitowaning Indian Hospital on Manitoulin Island, became the public health nurse in charge of the Nipissing Agency at Sturgeon Falls, Ontario.<sup>16</sup> Miss Gloria Akiwenzie, of Cape Croker Reserve, went to St. Mary’s School of Nursing in Kitchener and later worked at both Seaforth Hospital and Kitchener-Waterloo Hospital before taking a Public Health Nursing course at the University of Western Ontario and was later appointed as public health nurse for Bruce County.<sup>17</sup> Mrs. Kay Smallface, of Saddle Lake Reserve, graduated from RN Archer Memorial Hospital in Lamont in 1954. She worked at Charles Camsell Hospital, Edmonton and the Blood Indian Hospital, Cardston, and went to England and Germany with her husband for a year and a half. Upon her return, she was employed at Hobbema Indian Hospital, St. Paul’s Indian Residential School, Cardston and by the North Eastern Alberta Health Unit. In 1960, she interrupted this work to study at the University of Alberta on a provincial bursary, graduating with a diploma in Public Health Nursing, and returned to the Alberta Health Unit.<sup>18</sup>

The Indian Affairs Department does appear to be more amenable to funding Registered Nursing students during this period, although it was still not intent on providing full access to post-secondary education to Aboriginal students. The Indian Affairs Department offered some scholarships to Aboriginal students and had a special category for those who wanted to go into nursing.<sup>19</sup> Otherwise, Aboriginal students applied for band or Indian Affairs funding. While Ann

Callahan was at the Winnipeg General in training in the early 1950s, she claimed her tuition, books and \$25 dollars for spending money from Indian Affairs. She found the Indian Agent, through whom her funding flowed, was not at all encouraging. When he filled out her clothing order, he told her “Don’t come back” and “You probably won’t make it anyway.”<sup>20</sup> A consistent policy regarding Aboriginal student funding had yet to be devised, and many Aboriginal students struggled through this time to make ends meet.

It is noteworthy that for some Aboriginal nurses in this period, it was not race restrictions but age restrictions that caused the most problems – several matriculated before they reached 18, and had to wait before being able to go to nursing school. It was for this reason that Marilyn Sark, Mi’kmaq nurse from Lennox Island, PEI entered a university program instead. Wilma Strongeagle spent this ‘gap’ year working as a ward clerk.<sup>21</sup> Still in this period, Aboriginal nurses recall being the only Aboriginal students in their class and many felt lonely at school, being far away from home, family and community. Ann Callahan equates nursing education in this period with residential schooling – it was equally alienating. This is ironic, as Carol Prince, a Cree RN from Nelson House First Nation, went to nursing for the express purpose of getting away from (Birtle) Residential School.<sup>22</sup> “There were few Aboriginal people residing in Winnipeg,” when Ann Callahan went to nursing school in the ‘50s. She recalls, “If it were not for two or three families whose husbands were in the armed services, I would have been lonelier. Oftentimes, they invited me to their homes to enjoy an Aboriginal meal, music and their unique humour.”<sup>23</sup> Marilyn Sark also made friends while at nursing school, some of whom she still keeps in contact with today. Nursing school was very physically demanding at this time, with a heavy load of courses and work, but, as Marilyn remarks, “We were all in the same boat.” Also, like other Aboriginal nurses in this period, she points out that she was young; she graduated from the program at the age of 21.<sup>24</sup>

### **Work**

Employment surveys undertaken in the ‘50s and ‘60s reveal that Nurses’ Aides, Practical Nurses, Ward Aides, kitchen and laundry help were more accessible jobs than Registered Nursing for Aboriginal people during this time period. Indeed, Aboriginal staff accounted for up to 25 per cent of Medical Services Branch employees by the 1950s.<sup>25</sup> Officially, the duties of nurses’ assistants and practical nurses were patient care and preparation of ward and supplies. They “were empowered to perform all nursing tasks that did not involve assisting doctors with procedures or injecting/inserting anything into patients’ bodies.”<sup>26</sup> Ward aides performed housekeeping, messenger and cleaning duties, carried and collected trays, tidied linen and supply cupboards. However, it is clear that in practice, their jobs were often very similar to Registered Nurses, with the exception that Aboriginal RNs and LPNs had communication skills that non-Aboriginal nurses lacked. When Eleanor Olson, a Cree woman from Norway House who trained in Winnipeg in the 1950s got a job in Peguis, she was the “Doctors’ Nurse.” She travelled around with doctors to different outposts doing everything from delivering babies to community health. “I was the boss!” she recalled. She did a lot of work that RNs do today. “And I had to do it,” she said, “because there weren’t that many nurses – Aboriginal nurses then. Not that many. There was some, but they all had their places to work.”<sup>27</sup>

In the 1950s, a number of Aboriginal RNs entered into programs with the clear intent of working among their own people. This was true despite, or perhaps because of the fact that Indian Health Services (and all services for Aboriginal people at that time, in fact) operated without consultation with Aboriginal communities. Aboriginal nurses like Theresa Paupanekis of Norway House, Manitoba, saw in nursing an important role in helping to improve health and living conditions for Native people.<sup>28</sup> In an essay entitled “Why I Became a Nurse,” Mrs. Wilma Strongeagle of The Pas, who worked at St. Anthony’s Hospital in The Pas and Fort Qu’Appelle Indian Hospital, wrote: “It was a wonderful feeling to nurse some of my people. I really felt at home ... I am now in a position where I can care for my people. To see a sick person come back

to health – whether the patient is Indian nor not, is a wonderful experience.”<sup>29</sup> While nursing has always been a profession loaded with gendered expectations of service, in these years for those of Aboriginal ancestry, it began to symbolize considerably more than that. The service ethic became closely tied to the contemporary struggles and aspirations of Aboriginal communities.

The aim to work among Indian people did not necessarily, however, mean working at an Indian hospital. With increasing numbers of Aboriginal patients being transferred to southern and centralized hospitals and sanatoria as well as a growing population of Native people moving to urban land, Aboriginal nurses in non-federal hospitals provided Aboriginal patients essential language and cultural contact. Working in Winnipeg, Ann Callahan remembers a lot of Aboriginal patients coming from the North. She found it was wrong that they bore tags with their names, where they were from and what illnesses they had. She thought there should be an interpreter for the people, to help to understand why they were there. She worked in ambulatory care, where many were escorted by receiving home personnel. Aboriginal nurses who looked for housing in urban areas faced the same challenges as other Aboriginal people moving to the city. When Ann looked for a place to live in Winnipeg, she found that she was refused housing, and sent her husband, a white man, out to look for her.<sup>30</sup> Many Aboriginal nurses, like Ruth Christie, found accommodations with friends or family while at school.<sup>31</sup>

Many Aboriginal women continued nursing full- or part-time while raising their families. They often did not have any other choice, but from their recollections, there were no regrets. At this time, maternity leave was often six weeks or even shorter, and sometimes women took time off later in life as their children got older. Many made arrangements for baby-sitters, or boarded children while they were working, and made use of connections through Friendship Centres and extended families. **These women worked against prevailing norms, and took advantage of career opportunities, out of necessity juggling both the responsibilities of nursing and their responsibilities at home.**

There is a way in which Aboriginal nurses describe their experiences of discrimination and racism in these first two periods of Aboriginal nurse history. Many speak of being non-assertive when starting out, and getting mad at themselves for not knowing how to respond to blatantly racist remarks, and for being taught not to talk back. Some ignored these comments, looking to their relations for love and approval and thinking, “It’s their problem, not mine.” They didn’t have time to bother reacting to these comments, “Life’s too short.” **Many Aboriginal nurses balance stories of racism with those about people who advocated for and supported them.**

While for the most part, Aboriginal women felt they were treated “as anyone else,” and that “your background didn’t matter,” upon reflection, **many Aboriginal women did feel that they were treated differently once people found out about their background.** And while details about a person’s background were often unimportant to the day-to-day work of nurses, there were moments in which they became critical. For instance, Ruth Christie, who went through LPN training in the 1960s, didn’t feel as if there was any discrimination against her at nursing school. But when it came to the point at which students at her school went for their isolation treatment, Ruth feels that her background was an issue for the matrons:

“My Mom had no record of my immunizations and see, I was supposed to go to St. Rose Du Lac, that was the isolation technique you would get – it could have been for TB, it was almost like a sanatorium. When I was a nurse-in-training, that is where you would go to get your isolation technique ... they said, ‘Oh well, she’s probably been exposed to TB, because she comes from, you know, a Native community.’ And the Sister, I think it was a Sister, it might have been one of my instructors, ‘No, she should have it too. We don’t know whether, you know, she has resistance or not, we’re just assuming because she’s Native.’ ”<sup>32</sup>



There also seems to be a way in which being in nursing presupposed a relatively mainstream, non-Aboriginal identity. Unless one was 'visibly' different, or declared their heritage in these contexts, they were presumed to be and were probably mostly treated as non-Native. This type of assumption exposed Aboriginal nurses to much more 'subtle' forms of racism. For example, when Jennie Neilson was working abroad in Bermuda, the head nurse at the hospital told all of the Canadian nurses, "You're in the top drawer of society and that's where you want to be at. Don't go out with Portuguese and black men." The head nurse also told them that "just like in Canada they wouldn't go out with an Indian on a reserve, they shouldn't go out with men of other races in Bermuda."<sup>33</sup> While Rozella McKay was grocery shopping in Punnichy, a woman in the store followed her around, asked to help her, and then quizzed her. Once Rozella informed her that she was a nurse, the store lady's whole attitude changed. While Rozella didn't feel different from other Native people from Punnichy, in this woman's eyes, she was.<sup>34</sup> When Marilyn Sark took one of her patients to Summerside Hospital, one of the nurses there stated, "Aren't you wonderful to be working with those people..."<sup>35</sup> The assumption that nursing makes Aboriginal people somehow different continues to create problems for Aboriginal nurses. This kind of racism continued throughout the contemporary period as well. For example, Cree nurse Faye Isbister-North Peigan recalls a non-Native client telling her that she must be "one of the better ones."<sup>36</sup> On the other hand, within Aboriginal communities some Native nurses struggled with the assumption that being a nurse made them inherently different. Eleanor Olsen recalls other Aboriginal women saying to her "You think you know everything."<sup>37</sup>

### ***Conclusion***

In this chapter, we have examined Aboriginal people in the expanding and diversifying nursing profession in the 1950s and '60s. Aboriginal RNs were again in the minority of Aboriginal nurses and they faced many of the barriers discussed in Part Two. However, the expansion of opportunities in nursing meant a noticeable growth in the numbers of Aboriginal women applying for and attaining nursing training, particularly in the more formalized Registered Nurse Assistant and Practical Nurse courses offered throughout Canada. These women practiced at a time when expanded opportunities were still met with a racist assumption that being Native and being a nurse was somehow incompatible. For example, Registered Nurses were depicted by the Department of Indian Affairs as model 'integrated' citizens. Despite these challenges, Aboriginal nurses in this period prevailed, and they currently represent a significant portion of an aging Aboriginal nurse population.<sup>38</sup> In speaking with nurses working in this period, very few recall other Aboriginal nurses, and if they do, their numbers are few and far between. It was not until the 1970s, through political activism, that Aboriginal nurses found a voice as a collective.

## **PART FOUR**

### **“Nursing Has Been My Life”<sup>1</sup>**

In 1969, the Canadian government proposed to dissolve the special status and rights of Aboriginal people and abandon the *Indian Act*. The proposal, called “The White Paper,” moved to terminate federal responsibility and accountability and transfer all services to provinces in an effort to foster legal, social and economic equality between Aboriginal and non-Aboriginal people in Canada. The vision of social equality in Canada pointed to welfare legislation such as universal access to health care as an example of progressive social policy. But while universal medical care endeavoured to provide all Canadians with equal access to health care, to Native people, health care has always been a political issue involving treaty rights. To Native people, the “Medicine Chest Clause,” negotiated into Treaty Six, meant that a comprehensive health care plan which incorporates all aspects of present day health care should be available to all Native people. In this period, rights to health care as well as glaring health inequities and poor health services became important symbols of not only the neglected rights of Aboriginal people to adequate medical care, but also of how marginalized Aboriginal people had become, even when it came to the delivery of services to their own people.

This was a period in which First Nations, Métis and Inuit peoples organized formally for unmitigated and constitutionally based rights to self-government and status as Aboriginal peoples in Canada. Seeking control over health and education programs delivered to their people was an integral aspect of these larger efforts towards decolonization and the advancement of a self-government agenda. In an attempt to address the issues of self-determination and poor health, the Registered Nurses of Canadian Indian Ancestry (RNCIA) formed with the goal of improved health for all Aboriginal people. The organization immediately began to tackle the issue of recruitment and retention of Aboriginal health care professionals, linking the education and employment of Aboriginal people in health professions with the amelioration of health conditions on reserves and in northern communities. The organization also aimed to establish a mechanism to lobby on behalf of health care for Indians in Canada.<sup>2</sup> After looking more closely at the early history of the organization, we will turn to the experiences of Aboriginal nurses and nursing students in this period, highlighting some of the innovative Native and Northern nursing education programs, the development of a theory of transcultural nursing and the work of the increasing number of Aboriginal Community Health Nurses.

#### ***Registered Nurses of Canadian Indian Ancestry***

In the early 1970s, Jean Goodwill, an RN from Little Pine, Saskatchewan and Baccalaureate-prepared public health nurse Jocelyn Bruyère from Opaskwayak Cree Nation, Manitoba, worked to create a platform and a gathering place for Aboriginal nurses in Canada. The inaugural meeting of the Registered Nurses of Canadian Indian Ancestry (RNCIA) in 1975 was an important turning point in Aboriginal nurse history. RNCIA was the first organization for professional Aboriginal people in the country and its original goals were unlike those of any other nursing organization in Canada. RNCIA’s first objective was to assist in the improvement of the

health status of Aboriginal communities. The organization also aimed to recruit Aboriginal people to health professions, facilitate local control of Indian health and participate in the creation of studies about Aboriginal health. As its title suggests, RNCIA incorporated both status and non-status registered nurses, an inclusive objective indicated also in its subsequent name changes: in 1983 to the Indian and Inuit Nurses of Canada; and in 1992 to the Aboriginal Nurses Association of Canada, a title which recognizes nurses of all three distinct Aboriginal groups in Canada: First Nations, Inuit and Métis.

Jean Goodwill was a charismatic leader for the new organization. Hospitalized in her youth with tuberculosis, she spent several years at the sanatorium in Prince Albert, where she developed an interest in nursing which grew when she became a nurse's aide for a short while in Saskatoon. She was part of the small but expanding cadre of Aboriginal people who achieved standardized nursing training in the 1950s (she graduated as an RN from the Holy Family Hospital in Prince Albert, Saskatchewan). She then worked at Fort Qu'Appelle Indian Hospital and at the Indian Health Service nursing station at La Ronge.<sup>3</sup> After a year working in Bermuda, she returned to Canada with "different objectives," seeking involvement in the growing number and strength of Indian political organizations. Her nephew recalls, "She once told me that her work as a public health nurse was an exhausting and frustrating experience. The health problems in Indian communities were largely caused by poverty and poor living conditions. No amount of work on her part would change that. What was needed were changes to government policy and political action."<sup>4</sup> She became the executive director of the Winnipeg Indian Friendship Centre for two years, got a job with Indian Affairs and Northern Development in the Cultural Development section and later worked as an editor of *The Indian News* and other publications. When she helped organize RNCIA, she was working with the Secretary of State and as a nursing consultant to the Medical Services Branch. She shortly after became the advisor on Native Affairs to the Assistant Deputy Minister in 1978, and then the Special Advisor on Indian Health to the Minister of National Health and Welfare. In her speeches from this era, she argued that the best health services for Aboriginal people would be delivered by people with a similar cultural background. "The lack of Native nurses continues to be a problem," she stated in 1982, "I still say we have a unique expertise out there. They could be in a consultative capacity to health-related programs. Besides our technical training, many of us can communicate in our own language, we understand the customs and traditions of our people. All of us nurses can learn so much from one another."<sup>5</sup>

The first initiative of RNCIA was to canvas Native nurses. The resulting study, *Barriers to Employment and Retention of Native Nurses*, showed that funding of students, racial prejudice, inadequate preparation in math and chemistry, social and cultural isolation at school, employment opportunities in their home areas, and support from community members were all factors affecting Aboriginal nurses.<sup>6</sup> The study was followed up by numerous initiatives to support Aboriginal nursing students and professionals. The organization worked tirelessly to promote nursing at career and job fairs and gathered financial support for educational bursaries for Aboriginal nursing students (including the Baxter Fellowship's Travenol Awards, the Grace Easter Memorial Scholarship and the Jean Goodwill Scholarship). RNCIA also became engaged with the most significant concerns facing Aboriginal nurses and communities. While issues like women's health, alcohol, domestic violence and drug use exploded in the Canadian media, they were carefully discussed and acted upon by Aboriginal nurses and became the themes of ANAC annual conferences, workshops and publications.

RNCIA organized in a period of political activism and resistance to colonialism within Canada. Interestingly, several other Indigenous nursing organizations formed at about the same time and with similar goals as the ANAC. The National Alaska Native American Indian Nurses Association (NANAINA) formed in 1971 and the National Council of Maori Nurses formed in 1983.<sup>7</sup> In the United States, the National Black Nurses Association (NBNA) was founded in 1971 with the objective of confronting issues of inequities in health care and a lack of voice

within the profession. Clearly, both Indigenous people and other people of colour saw in the promotion of the nursing profession an important vehicle for the improvement of their own people's health and wellness and a greater share of control over their own destiny.

### ***Nursing Education***

#### ***Support for Registered Nursing***

The pursuit of "Indian control" was critically linked to the education and employment of Aboriginal professionals and in this period, the Registered Nurses diploma became a benchmark of success in the struggle towards improved health status of Aboriginal people and their advancement more generally. During this period, registered nursing education programs moved out of hospitals and into colleges and universities and within the profession, a distinction between Diploma and Bachelor programs was entrenched. This distinction affected Aboriginal nurses in a particular way. The Medical Services Branch required a university degree before a nurse could take charge of a health centre, nursing station or practice public health in Aboriginal communities and to this effect, great efforts were made to support all Aboriginal nurses in obtaining these educational qualifications.<sup>8</sup> A significant number of Aboriginal nurses upgraded their qualifications from LPN or RNA to RN and from RN to BN. The Medical Services Branch also offered Community Health upgrading courses in the "In-Service Training Program" for Community Health Nurses working for the Medical Services Branch. These courses aimed to teach the skills nurses needed to work in Aboriginal communities, however have been criticized as they were not credited anywhere but in Indian Health Services and because nurses not employed by the Branch were not permitted to attend them.

Various efforts were undertaken to steer Aboriginal students into registered nursing programs including the Indian and Inuit Health Careers program (IIHC), Access programs and the Native and Northern Nursing programs. Begun in 1984 and headed by the Department of National Health and Welfare with assistance from the Indian and Inuit Nurses of Canada, the Indian and Inuit Health Careers Program was a major impetus for encouraging Aboriginal people into professions and for developing innovative nursing education for Aboriginal students.<sup>9</sup> The program funded various initiatives including Native-specific programs, bursaries and scholarships and professional development. A major goal of the program was to provide social and cultural environments to overcome the alienation experienced by Aboriginal students in the mainstream education system. One of these initiatives was the National Native Access Program to Nursing (NNAPN) at the University of Saskatchewan. Funded by the Medical Services Branch, this pre-nursing program was created to assist Aboriginal students in meeting admission requirements to degree-granting nursing schools. Students attended a nine-week spring course in which they experienced the university environment, upgraded skills, and gained study, exam writing and library research skills, as well as exposure to field work. The program has enjoyed success,<sup>10</sup> and as a result, there are several other Access programs available to Aboriginal students.

A number of other programs appealing to Native students were developed in these years including the Blue Quills/Grant MacEwan Community Diploma Nursing Program, the Inner City Nursing Project/Red River Community College, the Northern Nursing Education Program in Thompson, Manitoba/Red River Community College, the Native Health Careers Access Program/Caribou College, the Native Nurses Entry Program/Lakehead University, and the Northern Native Indian Professional Nursing Program in British Columbia. In 1986, Jean Goodwill, then the President of the Indian and Inuit Nurses of Canada and the director of the IIHC program in Saskatchewan, counted 13 programs offered across the country in a speech she gave at the hearings on Indian education at the Assembly of First Nations.<sup>11</sup> Many of these programs took a "community development approach" to nursing education. Pat Stewart, then a band nurse in The Pas who helped to develop a Northern Bachelor of Nursing Program in Manitoba, explains:

“A community development approach ... bridges cultural differences; builds on existing knowledge, attitudes and skills; utilizes local resources; provides educational opportunities suited to the setting; develops personnel who already have roots in the region; provides training and employment opportunities that meet perceived Native needs and priorities and last but not least, places an important service under local control.”<sup>12</sup>

The key objectives were to educate people from reserves and northern areas who would return to these areas, a concept linked to the ongoing problems of high nurse turnover rates and instability in Indian Health Services. Marilyn Tanner Spence, an RN from northern Manitoba, graduated with her diploma in nursing in Thompson, Manitoba in 1988. She chose this program specifically because “it was available and in the community that I lived in.”<sup>13</sup> Although she had originally wanted to go to medical school, the nursing program was an access program, and more affordable. Marilyn later went on to achieve a nursing degree from the University of Manitoba in 1992, and a Masters of Arts from the University of Victoria in 1998. She also worked as a nurse in hospital and nursing station settings, at the Manitoba Keewatinowi Okimakanak (an organization which lobbies on behalf of the 26 First Nations it represents), helped to develop university curriculum for an expanded role for nurses, helped to establish a nursing program in Norway House, Manitoba and was a board member of the ANAC.

There are important distinctions between nursing education programs targeted at Aboriginal nurses in this period and those which came before such as the Calgary, Edmonton and Vancouver courses. First, these programs focused on RN as opposed to LPN and RNA training. Second, these programs were designed for Native nurses, and it was hoped that they would enable registered nurses to retain cultural integrity and sensitivity, thereby impacting the quality of service provided in Aboriginal communities. While the programs sometimes struggled with competing objectives, inconsistent funding and a lack of cooperation in terms of recruitment and regulation,<sup>14</sup> there was a consensus that nursing curriculum needed to shift in order to prepare all nurses to serve Aboriginal people and communities in culturally appropriate ways. The emphasis in this period on cultural sensitivity in nursing education indicated the possibility of an ever-widening space for Aboriginal nurses in the profession. At the same time, an increase in their numbers was associated with an improvement in the quality of education and service of all nurses in Canada.

### ***Work***

The correlation between the poor health status of Aboriginal people and their under-representation in the health professions was made not only by Aboriginal organizations, but by government agents as well. Various policies in the 1970s and '80s officially legislated increased employment of Aboriginal nurses including the 1979 Indian Health Policy, the Canadian Human Rights Act,<sup>15</sup> the 1978 Treasury Board Policy,<sup>16</sup> and a 1981 Governor-In-Council Order.<sup>17</sup> Still, in 1983, of the 800 nursing positions in the Medical Services Branch, only 31, or four per cent, were filled by Native nurses.<sup>18</sup> Aboriginal nurses who worked in these positions found ‘subtle’ prejudice such as tokenism and paternalism and more outright discrimination such as the MSB’s practice of discouraging Native members of the community from visiting the living quarters of nursing stations. Further, the MSB was perceived to have poor work environments and administration practices and limited opportunities for Aboriginal nurses to work in their own home communities.

While there were few Aboriginal nurses in Community Health by the early to mid 1960s, the trend increased in the 1970s. Community Health provided opportunities for nurses to work closely with communities and to participate in health programming and delivery on reserves, but also demanded particular skills and expectations in terms of communication. Rozella McKay earned her diploma at the University of Saskatchewan in 1963 and entered into Community Health in August of 1965 after working at the University Hospital and Fort Qu’Appelle Indian

Hospital. Rozella believes that getting to know the community is integral to being a Community Health Nurse. She also advises that for this job, you “have to want to talk.” You don’t impress anyone with “10-inch words,” she advises, but you have to relate to people, and encourage participation and discussion.<sup>19</sup> Community Health nurses were influential in raising and addressing the Aboriginal health issues in their communities. Grace Vincent, an Algonquin Community Health Nurse at Rapid Lake Reserve in Quebec, described her experiences at a National Nurses Workshop sponsored by the Medical Services Branch in 1984. The issues she raised included smoking and drug use, cancer and heart disease and the changes in family life such as the effects of the Indian Act on marriage of Native women, and the importance of grandparents to the raising of Native children. She also spoke to the changing attitudes of the Native clientele that Community Health nurses serve, a group which, she found, was divided into ‘traditionalist’ and ‘integrationist’ sectors. She believed that nurses should put their own personal opinions aside and treat everyone as an individual. She also raised the argument that although traditional knowledge was not readily available, there was a need for nurses to combine old and new knowledge to serve communities appropriately.<sup>20</sup>

In the 1984 study on the *Barriers to Employment and Retention of Nurses*, less than half of the respondents to the survey were employed by the Medical Services Branch. Others worked in various positions in hospitals, nursing homes, for the V.O.N., as well as in government and at community colleges and universities.<sup>21</sup> A handful of nurses found top positions in the Medical Services Branch during this time: in 1980, Jean Goodwill became the Special Advisor on Indian Health to the Minister of National Health and Welfare; Carol Prince was the Special Advisor to the Assistant Deputy Minister of Health Canada from 1980 to 1987; and Madeline Dion Stout became the Special Advisor on Native Issues to the Minister of Health and Welfare and the Director of the Indian and Inuit Health Careers Program of the Medical Services Branch. There were also a growing number of Aboriginal nurses taking on positions in colleges and universities in this time period and especially into the 1990s. For example, Fjola Hart-Wasekeesikaw was an instructor at the Access Program to Nursing at the University of Saskatchewan and has since taught, lectured, and studied at several educational institutions including the University of Manitoba's Faculty of Nursing, Norway House Cree Nation Site, a satellite Bachelor of Nursing Program.<sup>22</sup> Ann Callahan was the Academic Co-ordinator and a counsellor at Red River College Access Program for Nurses until her retirement in 1996 and Jocelyn Bruyère worked as an educator for the Red River Community College Access Program for its Southern Nursing Program. Rozella McKay taught classes with childcare workers at the Saskatchewan Institute of Applied Science and Technology and “Health 101” at Saskatchewan Indian Federated College off-campus class at Yorkton.<sup>23</sup> In these positions, Aboriginal nurses like Fjola, Ann, Jocelyn and Rozella had the opportunity to directly inspire and encourage Aboriginal nursing students and had an important influence on the direction and content of nursing education.

The most important development in the field of Aboriginal nursing theory in the 1980s is cross-cultural nursing. Cross-cultural nursing can trace its roots in part to the contemporary critique of eurocentrism and widespread support for multiculturalism. Cross-cultural approaches permitted both a discussion of the impact of cultural difference from the patients’ perspective as well as that of the care provider, and this generation of Aboriginal nurses found in cross-cultural nursing a way of expressing and addressing many of the struggles they and their communities faced with regard to Western health care and health care providers. One Indian nurse explained in 1978:

“I often wonder how much the nurses working among Indians know about – as opposed to what they think they know. More important, how many have any idea, any awareness of their own unconscious prejudices and stereotyped thinking? Whenever our people seek health care, they are vulnerable to the unconscious racism of health care workers

and they suffer accordingly. It is dehumanizing and degrading to be stereotyped in this way – as any woman ought to know.”<sup>24</sup>

Carol Prince, who has taught cross-cultural training workshops, states that the objective of cross-cultural training is to improve the relationships between Native clients and health care providers through understanding. She finds that body language, shyness and respect has often been misunderstood by health care providers as apathy, and so cross-cultural training is about two groups understanding each other’s language and values and relating to each other in a meaningful way. It is not one-sided, Carol states, but involves an examination of all different kinds of beliefs and backgrounds.<sup>25</sup> Cross-cultural care requires an understanding of illness not only within the patient’s cultural context, but also within that patient’s experience of colonialism and the power relationship between patients and health care providers. Marie Ross, from Indian Brook, Nova Scotia, who graduated as a registered psych nurse assistant in 1949 and registered nurse in 1982, explains the importance of understanding Aboriginal women patients’ experience, and the importance of earning their trust. “Aboriginal women often have tragic histories of betrayal by authority figures, including their own parents. Some Aboriginal women have been subjected to further betrayals by relatives, teachers, priests, ministers and others in power positions who take advantage of the weak.”<sup>26</sup> ‘Cross-cultural’ training paved the way for later developments in ‘Cultural safety’ and ‘Cultural competency.’

Through concepts such as cross-cultural practice, *culture* and its study became integral to nursing education and work. Aboriginal nurses bore their fair share of the weight of the work of defining, teaching and practicing cross-cultural care, as a result of what Jean Goodwill called their “unique expertise.” In 1978, Pauline Steiman explained:

“A native nurse is really a split personality. As a nurse, she must try to explain to her people what she has learned and understands of the new scientific world. To do this successfully, she must also maintain her identity as an Indian, remember and respect the psychological influences, beliefs and customs of the Native people. Our people desperately need better health care and education. The nursing profession can help us to achieve this goal if only they will continue to develop expertise in learning about the Indian people and their needs in the home and in the community.”<sup>27</sup>

### **Conclusion**

A RNCIA brochure from this period asked, “Are you an Indian who is a nurse? Or are you an Indian nurse?”<sup>28</sup> It continues,

You understand your people,  
You understand their problems,  
You speak their language...  
Because you are one of them ...  
Help Us Improve Indian Health

In this period, an Indian nurse identity crystallized which combined a strong belief in social and cultural responsibility with a professionalizing nursing ethic. Ill health among Aboriginal people was increasingly associated with the effects of colonization, and remedy was ever more tied to the recruitment of Aboriginal health professionals, especially to positions within the Medical Services Branch. In this period, being a nurse was never about just being a nurse. It was also about self-determination, good health for Aboriginal people, addressing the effects of colonization, and dialoguing with communities, nursing associations, health organizations, the federal government and nursing schools. It was ultimately about gaining recognition as experts in both nursing and Aboriginal health.

**PART FIVE: 1989-2006**  
**“Mentor the Young”<sup>1</sup>**

***Background***

The last two decades have been both hopeful and disappointing in terms of developments in Aboriginal history. Residential schools exploded as a key issue defining Aboriginal experience of church and state in Canada in the last hundred years. Occupations such as those at Oka, Gustafson Lake and Caledonia, the *Marshall Decision* at Burnt Church, and the shooting death of Native activist Dudley George are some of the organized resistance which brought Native issues forcefully to other Canadian public. Court struggles over rights to land, resources and self-government such as *Delgamuukw v. British Columbia*, the creation of Nunavut and the Nisga’a treaty land claims agreement in British Columbia continued to force the recognition of Aboriginal rights in Canada as a continuing practice, not just a souvenir of the historic ‘necessities’ or ‘accidents’ of colonialism. A Royal Commission on Aboriginal People, the result of five years of research into the situation of Aboriginal people across the country, made clear the continuing inequities in health standards and access to services. It recommended the establishment of healing centres and lodges under Aboriginal control, the continued support of mainstream health and social services, financial support to meet the needs of housing, water and sanitation on reserves and acknowledgement by the federal, provincial and territorial governments that a full range of education services, including post-secondary education, is both of crucial importance to Aboriginal self-government and also the responsibility of the Crown. One of the responses to the Royal Commission was the establishment of the National Aboriginal Health Organization, which is a national forum directed at improving the health of Aboriginal people in Canada and providing health information. Supporting the recruitment, retention and training of Aboriginal people in health care professions is one of its five objectives.

In 1989, Treasury Board approved authorities to support the transfer of Indian health services from Health Canada to First Nations and Inuit communities wishing to assume control. It was the most significant outcome of decades of efforts by First Nations and Inuit to regain control over the services delivered to their people. While the policy impacted the contracts and work of only a segment of the Aboriginal nurse population, it nonetheless ushered in a new era of nursing in Aboriginal communities. In this period, it was felt that Indigenous people should have the support to address health issues in their own culturally appropriate ways. This includes shaping high-level and accessible educational programming that is appealing to Aboriginal students, forging a closer working relationship with communities and producing scholarship that is sensitive to the effects of colonization on health and directly addresses Aboriginal health needs. It also includes accountability to Aboriginal patients and developing approaches to culturally appropriate care. Integral to all of these processes is the preservation and practice of traditional healing methods. These developments are fundamental to the history of Aboriginal nursing education, research and work and together indicate that in this period, Aboriginal nurses were changing the profession of nursing itself to suit Aboriginal people and communities.



## ***Education***

Improved recruitment of Aboriginal people to post-secondary health-related programs has been a stated goal of countless task force studies, official health policy and Aboriginal organizations since the 1960s. The most recent plan is the Aboriginal Health Human Resources Initiative (AHHRI), a five-year initiative funded by Health Canada which aims to develop a strategy to increase the number of health care workers, improve retention and “adapt health professional curricula to reflect Aboriginal cultural and traditional needs and knowledge to deliver optimal care to Aboriginal clients.” In this model, recommendations are made in four stages of health care education. In the Upstream stage, basic education should be improved, with an emphasis on science, mathematics, English and literacy, and support for students should be available, as well as the marketing of health careers through role models and recruitment information. In the Transitions phase, preparatory or transition courses offered by colleges and universities should be promoted and supported. In the third stage, access and admission requirements should be receptive to Aboriginal students, and student supports should be available, including practicum opportunities, mentors, counsellors, and adequate funding support. Dr. Eileen Antone, an Oneida professor at the Ontario Institute for Studies in Education, shows that the strategy to recruit and retain Aboriginal health professionals must be guided by a focus on “Aboriginal Content and Process.” This includes explicit policies of admission, seat saving for Aboriginal students, and an Aboriginal subcommittee to nursing admissions committees. Standards which come from Aboriginal communities, rather than those which are formulated outside them, should be considered as appropriate admission guidelines for nursing schools.<sup>2</sup> In the Future Practice stage, AHHRI recommends continued mentoring and advice, skills upgrading to advanced levels, culturally appropriate work places, and support for laddering to other education levels.<sup>3</sup>

“Laddering” is an educational pattern that is characteristic of nursing education. What is meant by the ladder approach is the attaining of nursing qualifications through stages – often quite separate in time and location – in order to change or upgrade positions or practice within the broader nursing profession. It is reflective of both the professionalization history of nursing more generally, but also it is quite common within the experiences of the Aboriginal nurse population. For example, Carol Prince jokes that she goes to school “about every 10 years,” having achieved her RPN in 1965, her RN in 1972, and her BN in 1987.<sup>4</sup> Faye Isbister-North Peigan graduated with her Nursing Diploma, then went on to take her B.N. with a dual focus on community health and health education after upgrading at the University of Lethbridge. She then did a Master’s of Arts which focused on Teaching and School Counselling directly following that, and is currently exploring the possibilities of undertaking a Ph.D. in Nursing or Education. The laddering approach is indicative of the high level of skills required of Aboriginal nurses, the desire for on-going upgrading and skills acquisition characteristic of the contemporary profession, and the strong impetus towards Baccalaureate training in nursing.

The most significant change in Aboriginal nursing education in this period is the concerted effort to change health professions to suit Aboriginal people, as opposed to the other way around. This is most clearly demonstrated in the latest development in Aboriginal nursing education, Aboriginal Health Nursing (AHN). AHN locates health disparities of Aboriginal people within the “culture of the health care system, which, rather than alleviating the marginalizing conditions, perpetuates them.”<sup>5</sup> According to the Aboriginal Health Nursing Initiative, a tripartite partnership between the Aboriginal Nurses Association of Canada, the National Aboriginal Health Organization and the University of British Columbia, a “lack of awareness of the social and historical context of health care and the inability of health practitioners to appropriately address these differences has contributed towards high rates of non-compliance, reluctance to visit mainstream health facilities even when service is needed, and feelings of disrespect and alienation.”<sup>6</sup> Originally developed in the late 1990s by Aboriginal nurses, AHN is a way of providing health care to Aboriginal clients which validates Indigenous-

based practices and knowledge and endeavours to incorporate and accommodate Aboriginal health sciences and Aboriginal values into the nursing process. Such validation, as defined by Evelyn Voyageur, an Aboriginal nurse from Vancouver Island, requires an equal appreciation of Aboriginal Elders, healers, traditional knowledge and traditional healing practices alongside biomedical approaches.<sup>7</sup> AHN also takes “cultural competency” and “cultural safety” as two priorities which directly address problems in the delivery of nursing care in Aboriginal communities. Culturally competent nursing is defined as the end result of a process of developing consciousness which includes cultural awareness, cultural knowledge, cultural understanding and cultural sensitivity and then adapting care to be congruent with a client’s culture. Cultural safety is a mutually interdependent concept which speaks to the client’s perception within the health care encounter. Developed by Maori nurses and midwives, and in particular by Maori Nurse Dr. Irihapeti Ramsden, cultural safety recognizes the impact of nurses and their identity on the nursing practices and defines as unsafe any practice which “diminishes, demeans, or disempowers the cultural identity and well-being of an individual.”<sup>8</sup> In Aboriginal Health Nursing, therefore, there are measures to ensure the safety of Aboriginal patients and communities from their own perspectives, and resources to provide Aboriginal nurses with ways of delivering culturally appropriate care.

There is recent debate in nursing on the ways in which concepts of “culture” are used in nursing education and practice. D. Patricia Gray and Deberah J. Thomas argue that the philosophical basis for current views of culture is essentialist and presumes that culture is extremely narrow, fixed in time and stable over time. Practices such as “cultural competence” rely on change and action at the individual level, and thus obscure the larger forces that are inherent to the construction of issues related to culture. Moreover, these practices as they stand, construct the dominant group as homogeneous, unafflicted and “normal.” Cultural competence in essence facilitates the client’s conformity to and use of the existing system, which does not result in any real change or modification in the overall institution. The authors tell us that it is important to make visible the processes, agents and forces that shape people’s lives instead of classifying people by presumed cultural “facts.” It is also important that we reveal the dominant interests that our notions of culture serve.<sup>9</sup>

Another current and innovative field in Aboriginal nursing education is midwifery. The field of midwifery is often misconstrued as either “new” and novel or ancient and passé and it is often not associated with mainstream medical practice. But in fact, several Aboriginal nurses relate to this practice on a firsthand basis.<sup>10</sup> Gaining control over Aboriginal childbirth has played a central role in how non-Native-controlled health services gained legitimacy in Canada<sup>11</sup> and therefore the reclamation of childbirth and the practice of midwifery are central to the project of restoring balance and harmony in Aboriginal communities. It is only within the last 10 years or so that midwifery has become once again a legal field of practice more generally, and Aboriginal people are somewhat marginalized in many of the current debates about appropriate legislation, education and registration. Midwifery education is, however, undertaken in community-based programs in Ontario and Quebec and in four-year university programs elsewhere in Canada. The Aboriginal Midwifery Education Program [AMEP] is the first four-year university program for Aboriginal Registered Midwives and is designed for Aboriginal students particularly in northern Manitoba. Practicing midwives operate out of various other health centres or are hired privately.<sup>12</sup> There are also a number of birthing centres including the Inuulitsivik Maternity Centre in Puvirnituk, Northern Quebec, the Rankin Inlet Birth Centre in Nunavut, the Iewirokwaw Midwifery Program in Akwesasne, and Tsi Non:we Ionnakeratstha ona:grahsta: Six Nations Birthing Maternal and Child Centre in Ontario.

While developments in AHN and midwifery suggest a larger space for Indigenous programming knowledge within academia, there is still a concomitant demand for having Native people in counselling and teaching roles as well. This kind of support is crucial particularly in demanding programs like nursing, which are constantly testing and pressuring students.

Aboriginal nurses also stress the importance of both emotional and financial support. Because student allowances often do not adequately cover all expenses, Aboriginal students often have to rely on family members for support. For example, Faye Isbister-North Peigan notes that while she received tuition and book fees, “financially, my student allowance only covered basic rent, utilities and groceries for the first two weeks of the month.”<sup>13</sup>

Blair Stonechild, a Cree-Saulteaux professor of Indigenous Studies at First Nations University of Canada argues in his book on the history of post-secondary education that the “role of Aboriginal post-secondary education has evolved from a tool of assimilation to an instrument of empowerment.”<sup>14</sup> Education is no longer equated with assimilation or integration – it is now directly associated with both addressing colonialism and shaping one’s own destiny. As Faye explains, “the history of government control, assimilation tactics, and religious influences have negatively influence[d] First Nations people who are the keepers of the land. It is First Nations who will now determine their destiny via education and understanding and taking pride in their identity and their history.” Education is like the buffalo, which was the main source of livelihood for the Blackfeet people and was used for various different things: “The buffalo sustained the tribes.” Like the buffalo, education will be one of the influences that will again sustain the tribe along with strengthening the language and knowledge of cultural identity.<sup>15</sup>

### **Work**

The transfer of services from the Medical Services Branch to bands was the enactment of a decade of work towards self-determination in the health field. Negotiated through “Transfer Agreements” separately by individual bands, some band nurses in this period had the option of working directly for bands instead of the federal government. Not all Aboriginal nurses were band-employed, however the impact of transfer has made significant waves within the profession and due attention has been paid to those nurses who underwent this significant change. A study of band nurses in 1991 (both those under transfer agreements and those with contribution agreements) showed that many felt empowered by the change, saw improved services, more freedom to directly deal with the concerns of the community, flexibility in programming and improved relations with the community. On the other hand, in terms of salary, benefits, job description and access to professional development, many nurses were somewhat disappointed in their new positions.<sup>16</sup> In response to this change, the ANAC published a handbook for those wishing advice when contracting with bands, and a handbook for bands describing the role of the nurse in Aboriginal communities.<sup>17</sup> Moreover, band nurse workshops created some sense of solidarity for those who otherwise felt isolated and without professional support in transfer situations. Still, some Aboriginal nurses feel that there continues to be a need for a strong advocate for band-employed nurses<sup>18</sup> and that there needs to be more support for Aboriginal nurses to attend workshops or access educational leave to keep up on new skills and developments in nursing and administration.<sup>19</sup> Moreover, there continues to be wage parity issues, and the need to address the labour concerns of nurses who are working right now.<sup>20</sup> The impacts of health transfer on the work of Aboriginal nurses include a closer working relationship with bands and the opportunity to effect change in policy at the local level.

Community health as opposed to hospital nursing has become the central focus of Aboriginal nursing in these recent years, although working in communities has always been a goal of many Aboriginal nurses. Despite the growing number in community health positions, many Aboriginal nurses ‘start out’ working at hospitals and Rozella McKay suggests that this approach is still the best. This hands-on experience is crucial, she argues, especially as in community health, you often get called on to do various different jobs.<sup>21</sup> It was in the hospital where Faye Isbister-North Peigan initially worked that she points to examples of practicing culturally competent care. In practice, Faye explains, “I made a point of ‘hunting’ for First Nations clients and visiting with them to ensure they were confident with the care they were receiving. I spent a lot of time explaining procedures and advocating for them with health care

personnel.” Faye defines her approach to community health as “holistic.” She states: “If we holistically and truthfully address the determinants of health and work on improving these, then we will have ‘healthier communities.’ Health has become a personal responsibility; the best of the health professionals cannot make anyone healthy if you do not take responsibility for your health.”<sup>22</sup>

As illustrated in the recent 30-year celebration of the Aboriginal Nurses Association of Canada, Aboriginal nurses have played an important role in “making knowledge” about both nursing and Aboriginal health. From the late 1980s onwards, several key issues were researched by Aboriginal nurses including family violence, diabetes, drug, alcohol and tobacco use, AIDS and foetal alcohol syndrome. After she graduated from the University of Ottawa in 1987, Carol Prince missed her own graduation to attend the Circumpolar Health Conference in Sweden, where she presented a study on Native suicides, a report that was also published. Two years later, she became involved in a study on Alzheimer’s at the University of Manitoba Northern Health Research Unit. The list is exhaustive, but as more Aboriginal nurses returned for post-graduate degrees, these nurses in turn also contributed to growing literature on Aboriginal health. Jocelyn Bruyère, one of the founders of the ANAC, used her Cree language skills to analyze Cree cultural understandings of “twisted mouth” (Bell’s palsy) and Type II diabetes. Her work frames the experiences of and response to illness within Cree cultural understandings.<sup>23</sup> In a recent article, she explains that Cree understandings of history, spirituality and relationships to the land demonstrate that diabetes is perceived as relatively “new” and associated with changes in food procurement, preservation and preparation, environmental disruptions and external control.<sup>24</sup> Madeline Dion Stout, who holds a Master’s in International Affairs, has also made a name for herself in Aboriginal women’s and children’s health research and Ann Callahan wrote a Master’s thesis on the reclamation and retention of Aboriginal spirituality of Indian Residential School Survivors.<sup>25</sup> In these studies, an understanding of Aboriginal health issues was put within cultural understandings, and associated with not only the effects of poverty, discrimination and social marginalization, but also colonization. Many of these initiatives were undertaken with the collaboration, advice and guidance from Elders in the community. The body of knowledge created by Aboriginal nurses is indicative of a wide range of linguistic, cultural, research and analytical skills held by many Aboriginal nurses that must be recognized.

It is clear that this new scholarship is very much needed in the field of health care. Maya Chacaby, an Ojibwe student at the University of Toronto, recently conducted a study about the production of knowledge about Aboriginal health and nursing by analyzing over 6,000 articles on the subject. She found that publications by Indigenous authors addressed all four key areas of priority in Aboriginal health: sovereignty, equal access, “integration” (meaning the inclusion of Aboriginal world views, knowledge and people in the research process), and recruitment of Aboriginal people into all fields of nursing, including nursing education.<sup>26</sup> By asking the questions: “Who benefits from the knowledge production about Indigenous people?” and “Who is this knowledge being distributed to?,” Chacaby is directly addressing the current concerns of Aboriginal people in health research, as outlined in the current ethics protocol for health research, called “OCAP.” OCAP stands for Ownership, Control, Access and Possession, four principles which are “fundamentally tied to self-determination and to the preservation and development of their [Aboriginal] culture.”<sup>27</sup>

The fourth significant shift in employment is that Aboriginal nurses in teaching positions have increased in number. For example, Carol Prince taught Health Care Aides at Keewatin Community College, in both Nelson House and Norway House, preparing some of the students who would in turn work at the Personal Care Home she helped to create.<sup>28</sup> Marilyn Tanner-Spence helped to establish a nursing program in Norway House, steering course development and creating the curriculum for the expanded role for nurses currently delivered at the University of Manitoba (The Primary Care Skills Program). When she was hired, the North had lobbied for about 15 years to have a full degree program.<sup>29</sup> One of the current goals of nursing recruitment

is to encourage Aboriginal nurses to attain higher education so that they can affect more change in college and university curriculum and direct the content of health education. Of course, this would also require concomitant support in terms of university hiring priorities and student funding sources. Aside from teaching, Aboriginal nurses across the country also branched into various different fields, influencing developments in such areas as counselling, law, politics and international development. For example, Rose Toodick Boyko, of British Columbia was an RN in northern Quebec before going to law school and being appointed judge of the Ontario Court. Marsha Forrest, a Mohawk nurse in British Columbia, has served as the vice-president of the BC nurses union, and is very active in the Canadian Women's Health Network. In the 1990s, Marie Ross, who served as executive director of the Aboriginal Nurses Association of Canada, worked at Indian Health Services as the Director of Mental Advisory Services.<sup>30</sup> Tina Fox, who graduated from the Calgary School of Nursing Aides in 1960 and worked as a nurse in Alberta and Nova Scotia, was the first woman to serve on the Stony Tribal Council and worked as a family and criminal court worker, program manager and wellness facilitator and recently completed Brandon University's First Nations Aboriginal Counselling Program in 2003.<sup>31</sup>

In this period, Aboriginal nurses have gained from the experience and knowledge of Aboriginal nurses who practiced throughout the 20th century. Advancements in Aboriginal nursing education have hinged on the knowledge and guidance of Elders, many of them senior nurses themselves. They have combined a career in health services and specific knowledge of distinct Aboriginal cultures to provide expertise on matters such as protocol and ethics, healing processes for communities and individuals, programming for various Aboriginal populations including prisoners, residential school survivors, health and social service workers and others and the sharing of traditional knowledge. Senior nurses are also grounding and stabilizing future Aboriginal health care workers. Lillian McGregor is one of these influential nurses. The first Elder-in-Residence and "Grandmother" at the University of Toronto's First Nations House, Lillian earned her diploma in nursing in Toronto after having moved there from the Whitefish River reserve of Birch Island, Ontario in the late 1930s. Many Native students identify with her, as she too was young, alone in the city "trying to finish an education, a minority fighting to preserve her own heritage while assimilating in a society that in her youth was outwardly racist towards Native people."<sup>32</sup> What led Lillian into nursing was her grandmother's influence. She was a midwife who used wild herbs and other traditional medicines to deliver babies in the community. In an interview with the *Toronto Star*, Lillian recalls, "She knew so much... She knew which remedies were for sores that wouldn't heal, what was best for heart problems, for those who had trouble breathing. I used to tag along when she picked her medicines, listening to her talk about what to pick and when, how to prepare them and store them. She kept them all in a little back porch in her log home. It was like a pharmacy."<sup>33</sup> Lillian uses traditional teachings when counselling at the university.

The history of the use of traditional knowledge and medicine has an important place in the history of Aboriginal nursing. Officially banned until the 1950s, and discouraged long afterwards, traditional medicine never disappeared. In fact, respect for and preservation of "Indian medicine" was an important original objective of the Aboriginal Nurses Association of Canada since its inception. In the 1970s, traditional medicine was perceived as being a key element to the "empowerment" of Aboriginal people,<sup>34</sup> and the recovery of a long history of Aboriginal health and healing before contact. By the 1980s, traditional knowledge was seen as integral to the training and practice of Aboriginal health professionals, was integrated within nursing education and was sign of both cultural sensitivity and culturally appropriate programming. It is now thought that traditional knowledge should be foundational to the functioning of Aboriginal health centres and services across the country.<sup>35</sup> Throughout, Aboriginal nurses have been very active in making traditional knowledge and medicine available to all community members.

Spirituality was the theme of the annual ANAC conference for 2006. Gaye Hanson opened the conference with her own experiences of spirituality in nursing. She found that spirituality was in fact an important part of her nursing education, but that now it is only really recognized in palliative care situations. She would like to see it more a part of nursing, and the conference proved this. Alice Reid, who is an Elder and works in Home and Community Care at the Bigstone Health Commission of the Bigstone Cree Nation in Wabasca, Alberta, reaffirmed that Aboriginal people have the capacity to access knowledge and spirituality at all times.<sup>36</sup> The incorporation of traditional teachings and understandings into health teachings has been one way of both educating and providing culturally competent care. For example, Lisa Dutcher uses the medicine wheel as a tool to understand balance and interconnectedness in spiritual, physical, mental and emotional aspects of both nursing and health. The values taught by the medicine wheel, including respect, caring, sharing, honesty and trust, are all incorporated into the spiritual aspect of Aboriginal nursing.<sup>37</sup> The Braid has also teaches important lessons regarding holistic care. Lucy Barney, an RN from Lillooet First Nation, uses the Braid Theory to explain Aboriginal healing. The strands of the Braid each represent a factor in wellness; the Mind, the Body and the Spirit. Each of the strands and all of the components it represents mingle to form a braid. The braid teaches that three aspects of health, psychology, physiology and spirituality are interconnected, and that, for example, one aspect, such as the physical, cannot stand alone.<sup>38</sup>

### ***Conclusion***

This latest period in the history of Aboriginal nursing can tell us much about the profound shifts and changes over the last 100 years. In nursing education, perhaps the most defining feature of these years is the issue of retention and recruitment of Aboriginal nurses; while Aboriginal people still remain overrepresented in the health care system, they are underrepresented in health careers.<sup>39</sup> While often depicted as a recent crisis, the issue is in fact close to 100 years old. Aboriginal communities, Indian Affairs and Health Canada have been consistently complaining about a lack of Native health care workers. At first, the issue was presented as a 'shortage' issue; Medical Services couldn't find enough nurses to fill positions. By the 1970s, it was seen as a 'representation' issue, or an affirmative action issue. Throughout, Aboriginal nurses have argued that their culture and language were what made them crucial care providers and as a result, in this recent period, they have made an enormous impact on the ways nursing is taught and practiced in Aboriginal communities. Their endeavours to support self-determination in the health field have impacted health policy in myriad ways as well. Health transfer changed the employment procedures and influence of many Aboriginal nurses. Moreover, there is a significant, accessible and growing body of knowledge by and for Aboriginal nurses which examines traditional knowledge, Aboriginal health concerns, and labour practices and experiences. While Aboriginal nurses are still underrepresented in the classroom and in the workplace, many note that continually more and more Aboriginal nurses and other health care professionals staff their workplaces.

## PART SIX: CONCLUSION

As members of distinct Nations and cultures as well as skilled health care professionals, Aboriginal nurses have played critical roles in the developments of Aboriginal health services, professional nursing and nursing education. But while Aboriginal health history takes shifts in policy, epidemiology and health services as markers in its past, this booklet has attempted to demonstrate that Aboriginal nursing has a history too, which mutually influences other developments in nursing history, Aboriginal health history and Aboriginal history. Within each generation, there have been competing and sometimes contradictory factors which shaped the experience of Aboriginal nursing work and education. These factors are not restricted to each period nor do they represent the experiences of all nurses who studied and worked at that time, but they do tend to particularly influence, define or limit nurses in those eras.

In the first period, 1900 to 1945, many hospitals, nursing stations, outposts and health centres serving Aboriginal communities came to rely on the labour of Aboriginal nurses' aides, cooks, laundry workers, firemen, and housekeepers. However until the 1930s – and in fact much later in some cases -- Canadian nursing schools remained closed to Aboriginal students. Perhaps the most defining moment in this period of Aboriginal nursing history was when students of Aboriginal ancestry were finally “permitted” to enter nursing schools. Their access to higher education continued to be restricted, however, due to several “invisible” and incipient factors including a compromised academic background at residential schools, the necessity of relocation and assumptions about the poor health of Aboriginal people. Despite these considerable barriers, there were a significant number of Aboriginal graduate nurses who found jobs largely in hospitals at this time.

The second period, 1945 to 1969, is one of notable expansion. These years saw the reception of men into the nursing profession, the growth of health services to Aboriginal people, the increase of Licensed Practical Nursing and Registered Nurses Aide programs and an ever-increasing number of Aboriginal nursing students. In particular, the mid 1950s were especially good years for Aboriginal nursing student registration. While Aboriginal nurses in these years continued to be inconsistently supported by band or Indian Affairs funding, they were showcased by the Department of Indian Affairs in its publications and annual reports. “I was a feather in their cap,”<sup>1</sup> Marilyn Sark noted, suggesting that the Department took for itself credit for nurses' own work and education. Aboriginal registered nursing students in this period were likely to associate their higher training with a desire to improve the health conditions in their home communities. Ironically, most of these students did not, until later, find nursing positions in their own communities. Moreover, the Department cast the higher education of Aboriginal people such as nurses as an indication of the success of its policy of Indian integration. The desire to serve one's own people competed with the assumptions at the time that a professional education fostered assimilation into mainstream Canadian society.

The acknowledgement of the limits of integration and “equality” for Aboriginal people in Canada, as well as the infringement this process had on treaty rights led to the organization of Aboriginal groups for the purposes of self-determination, or “Indian control” in the language of the time. This was the context for changes in Aboriginal nursing in the third generation (1969-

1989). The organization of the Registered Nurses of Canadian Indian Ancestry, or RNCIA in 1975 was a significant moment in Aboriginal nursing history. RNCIA had ten objectives, most of which dealt with six basic principles: health promotion and research, consultation, facilitating Aboriginal control of Aboriginal health, influencing nursing education, recruitment, and maintaining a registry of Aboriginal Registered Nurses.<sup>2</sup> The organization played a central role in bringing to light problems related specifically to Medical Services nursing including recruitment and retention of nurses, the underrepresentation of Aboriginal nurses in the profession, and the problem of cultural alienation of Aboriginal patients within the health system. In short, nursing – and professional nurses particularly – became laden with the responsibilities of decolonization. In this period, we see a separation of Aboriginal nursing from a long history of hospital labour and a new focus on promoting health careers, influencing federal health research and programming, and making university and college nursing education accessible and relevant to Aboriginal students.

The results of the efforts put forth in the third generation are evident by the fourth (1989-2006). The transfer of health services to bands, the participation of Aboriginal people in creation of research about Aboriginal health, the promotion of Aboriginal cultures in nursing education, and the strengthening of the importance of cultural identity and a shared cultural connection with clients are defining features of Aboriginal nursing for this generation. Aboriginal nurses in this period developed concepts of cultural competency and cultural safety in nursing which are sensitive to the perspective of patients. They have also insisted upon the respect and validation of traditional healing and Indian medicine by mainstream and community health providers. These considerable achievements have been made despite chronic underfunding in all sectors (with the exception, perhaps, of health research). Individual transfer nurses have taken pay cuts and lost benefits; university and college programs faltered due to federal and provincial funding and subsequent management issues; and even the Aboriginal Nurses Association of Canada itself lost core funding in 2000. It is clear that the continuing innovations in Aboriginal nursing education and practice need to be supported by consistent and reliable funding, and followed up with firm hiring policies in favour of Aboriginal candidates.

Aboriginal nurses are critical observers of the shifts in nursing and Aboriginal health. Marsha Forrest has noted over her 30-odd year experience at the Hospital in Queen Charlotte that while at first the hospital had “a lot more acute and pediatric patients,” public health programs and community health representatives' emphasis on prevention has meant that “we rarely get pediatric patients now.”<sup>3</sup> Carol Prince has noticed some of the more devastating changes in nursing in the last few years. She has seen cutbacks, Native nurses having a hard time getting the support that they need to attend meetings and gatherings, the shift from nursing stations to Health Centres and the centralization of emergencies to fewer areas, the minimizing of opening hours at Health Centres and cutbacks on overtime, resulting in poorer service.<sup>4</sup> Marilyn Sark noted that more Aboriginal people in her community are more proactive about health, for example, in prenatal care. She also finds that it is now easier to get an education, as students do not have to go away to boarding school anymore. When Marilyn started working in 1972, there were only a few people with diabetes, but it has increased a lot recently, and now almost all families in the community are affected by it. Family violence continues to be a major issue as well. Rozella McKay also noted the rise in diabetes and its complications. She has also noticed the growth of Aboriginal nurses in the profession. While she was alone as an Aboriginal woman in her nursing diploma course, now as a Community Health Nurse at File Hills, Saskatchewan, all four RNs are First Nations or Métis, and seven of the 25 nurses in the Fort Qu'Appelle area are Aboriginal.<sup>5</sup> Role modelling, Julie Lys, RN from the NT, reminds us, must be accompanied by the strong leadership in communities, as well as a supportive mechanism which helps nurses to transition back to communities from school.<sup>6</sup>

In Aboriginal nurses' written and oral records, there has been one important and consistent element: almost every Aboriginal nurse refers to one or more nurses who have



influenced her life and work in some way. While the retention and recruitment of Aboriginal nurses continues to be a guiding issue, opening up the long and interesting history of Aboriginal nursing's past to new nurses may help them to contextualize their own dreams and goals alongside those of the ones who have come before.

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## Notes

### Part One

<sup>1</sup> Carol Prince, *ANAC Interview*, August 16, 2006. *ANAC Interviews*, *ANAC Surveys* and *ANAC Survey/Interviews* were held over e-mail or the phone and resulting profiles of nurses are held at the Aboriginal Nurses Association of Canada office in Ottawa, Ontario.

### Part Two

<sup>1</sup> Library and Archives Canada [LAC] Record Group [RG] 10 Volume 3199 File 504, 178. Letter from Agnes Sampson, March 19, 1921.

<sup>2</sup> Kathryn McPherson, *Bedside Matters: The Transformation of Canadian Nursing, 1900-1990* (Toronto: Oxford, 1996).

<sup>3</sup> James B. Waldram, D. Ann Herring and T. Kue Young, *Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives* (Toronto: University of Toronto Press, 1995).

<sup>4</sup> Dominion of Canada, *Annual Report for the Department of Indian Affairs for the Year Ending March 31, 1927* (Ottawa: Printer to the King's Most Excellent Majesty, 1927), pp. 10-11.

<sup>5</sup> These include Toronto General Hospital, Ottawa Civic, St. Boniface Hospital in Winnipeg, the Good Samaritan Hospital in Brandon, the Toronto Hospital for Incurables, Midland General, London Hospital, McKellar General Hospital in Fort William and Nelson General Hospital, British Columbia. After surveying hospitals in Ontario in 1930, A.F. MacKenzie, Acting Assistant Deputy and Secretary of Indian Affairs found that only 15 hospitals in Ontario were "open to receive Indian girls in training as nurses." LAC RG 10 Volume 3199 File 504, 178, Letter to Rev. T.B. R. Westgate, DD. from A.F. MacKenzie, Acting Assistant Deputy and Secretary, May 12, 1930.

<sup>6</sup> Laurie Meijer Drees, "Training Aboriginal Nurses: the Indian Health Service in northwestern Canada, 1939-1975" (unpublished paper: April, 2002), pp. 6-7.

<sup>7</sup> Ann Callahan, *Interview*, March 26, 2006. *Interviews* were held in person and are a component of dissertation research. According to their wishes, some will eventually be held at the Aboriginal Nurses Association of Canada office in Ottawa, Ontario.

<sup>8</sup> *Ibid.*

<sup>9</sup> Eleanor Olson, *Interview*, July 14, 2006.

<sup>10</sup> LAC RG 10 Volume 3199 File 504,178. Letter from A.G. Hamilton, Inspector of Indian Agencies, Manitoba to Secretary of Indian Affairs Branch, December 12, 1936; Letter from R.A. Hoey, Superintendent of Welfare and Training to A.G. Hamilton, December 21, 1936; Letter from A.G. Hamilton to R.A. Hoey, May 20, 1937.

<sup>11</sup> Aboriginal nursing students are still facing many of these challenges today. Health Canada, *Against the Odds: Aboriginal Nursing* (Ottawa: National Task Force on Recruitment and Retention Strategies, 2002).

<sup>12</sup> John Milloy, *A National Crime: The Canadian Government and the Residential School System, 1879-1986* (Winnipeg: University of Manitoba press, 1999); J.R. Miller, *Shingwauk's Vision: A History of Native Residential Schools* (Toronto: University of Toronto Press, 1996); and Jean Barman, "Separate and Unequal: Indian and White Girls at All Hallows School, 1884-1920," in Jean Barman, Neil Sutherland and J. Donald Wilson, eds, *Children, Teachers and Schools in the History of British Columbia* (Calgary: Detselig Enterprises, 1995).

<sup>13</sup> LAC RG 10 Volume 3199 File 504, 178. Letter to A. F. McKenzie, Indian Agent, Broadview from Deputy Superintendent General, November 14, 1936.

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- <sup>14</sup> Stacy O'Brien, "Jennie Nielsen," *Lethbridge Herald*, Monday, June 5, 2006, A3. Acknowledgement to Faye Isbister-North Peigan for this article.
- <sup>15</sup> LAC RG 10 Volume 3199 File 504, 178. Letter from Ontario Women's Christian Temperance Union to Duncan C. Scott, May 6, 1929; Letter from Deputy Superintendent General to Mrs. May R. Thornley, Ontario Women's Christian Temperance Union, May 14, 1929; Letter from May R. Thornley to Duncan Campbell Scott, May 13, 1929; and Letter to Mrs. Bycroft, from Hilda Miskokomon, June 25, 1929.
- <sup>16</sup> Maureen Lux, *Medicine That Walks: Disease, Medicine and Canadian Plains Native People, 1880-1940* (Toronto: University of Toronto Press, 2001).
- <sup>17</sup> Chantelle Richmond, "The Contribution of the Geographer for Understanding Aboriginal Health," Institution of Population and Public Health *Pop News* Issue 11 (Sept. 2006), <http://www.cih-irsc.gc.ca/e/32161.html#Contribution>. Accessed October 2006; and C. Richmond, S.J. Elliot, R. Matthews and B. Elliot, "The Political Ecology of Health: Perceptions of Environment, Economy, Health and Well-being among 'Namgis First Nation'" *Health and Place* (30 April, 2004).
- <sup>18</sup> LAC RG 10 Volume 3199 File 504, 178. Letter from Agnes Sampson, March 19, 1921.
- <sup>19</sup> Meijer Drees, "Training Aboriginal Nurses," pp. 6-7.
- <sup>20</sup> "Much Travelled Indian Girl Again on Move," *Calgary Herald* Saturday, September 7, 1940 in RG 10 Volume 3199 File 403,178; Anglican Church of Canada General Synod Archives, *The Living Message*, Reports of the Committee Re The Special Education of Indian Girls 1931-2 and Report of the Committee on Follow-Up Work Among Indian Girls 1933-1957; and Judith Kulig and Sonya Grypma, "Breaking Down Racial Barriers: Honouring Pioneer Aboriginal Nurses from the Blood Reserve," *Alberta RN* 62: 8 (October 2006): 16.
- <sup>21</sup> O'Brien, "Jennie Nielsen."
- <sup>22</sup> Rozella McKay, *ANAC Interview*, July 31, 2006.
- <sup>23</sup> McPherson, *Bedside Matters*.
- <sup>24</sup> Meijer Drees, "Training Aboriginal Nurses," p. 10.
- <sup>25</sup> LAC RG 10 Volume 8767 File 1/25-7-3, pt. 1. Letter from R.A. Gipson, Deputy Commissioner, Northwest Territories, to Dr. P.E. Moore, Acting Superintendent of Medical Services, Indian Affairs, October 26, 1943; and LAC RG 10 Volume 8767 File 1/25-7-5, pt. 1. Letter to Dr. W.L. Falconer, Acting Assistant Superintendent of Indian Health Services, from R.A. Gibson, Deputy Commissioner, June 28, 1946.
- <sup>26</sup> LAC RG 10 Volume 8767 File 1/25-7-3, pt. 1. Letter to W.L. Falconer, Indian Health Services from Rev. Campbell, Sept. 17, 1946.
- <sup>27</sup> For example, Sandy Bay, Manitoba Elders remember that some of the girls were taken after they finished school to work at St. Boniface Hospital in Winnipeg, Manitoba as nurses' aides and in the kitchen. George Beaulieu, *The Elders Tell Their Stories* (Sandy Bay, Manitoba: Prepared for Sandy Bay Education Foundation, Inc., 1996).
- <sup>28</sup> Olson, *Interview*.
- <sup>29</sup> Archives of the Diocese of Rupert's Land, Correspondence Statements, Reports, 1935-1939, Diocesan Trust – Dynevor Hospital. Letter to Mr. R.H. Pook, Secretary Treasurer, Synod of the Diocese of Rupertsland from J. Hellen M. Park, May 17, 1939, Re: Staff at Dynevor Hospital. I believe these numbers are based on monthly wages.
- <sup>30</sup> LAC RG 10 Volume 8767 File 1/25-7-5, pt. 1. Letter to Dr. H.W. McGill, Director, Indian Affairs Branch from R.A. Gibson, Deputy Commissioner, Administration of the Northwest Territories, December 9, 1942.
- <sup>31</sup> Emily Cowall Farrell and Meeka Alivaktuk, "The Work We Have Done: Relationship, Investment and Contribution. The Inuit Workers at St. Luke's Hospital, Pannirtuuq 1930-1972" (unpublished paper), pp. 11-12.
- <sup>32</sup> McPherson, *Bedside Matters*, 47.

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- <sup>33</sup> Nora Gladstone in Kulig and Grypma, "Breaking Down Racial Barriers," 16.
- <sup>34</sup> "Special Awards," *Indian and Inuit Nurses of Canada Newsletter* Volume 1 Number 1: 2.
- <sup>35</sup> Department of National Defence Website, "Native Soldiers, Foreign Battles: Nurse Overseas," <http://www.vac-acc.gc.ca/general/sub.cfm?source=history/other/native/nurse>; and "Special Awards," *IINC Newsletter* 1:1: pp. 2 and 9.
- <sup>36</sup> Directorate of History and Heritage, Department of National Defence. History of Aboriginal Peoples in the Canadian Military. Interview, Irene Hoff (QC-4) recorded on Sept. 26, 2001 at Odanak, Que. Interviewed by John MacFarlane. Transcribed by John Maclean, 613 269 27.
- <sup>37</sup> Anglican Church of Canada General Synod Archives, "Report of the Committee on Special Education of Indian Girls," *The Living Message* XLIII: 11 (November 1932): 411.
- <sup>38</sup> Kulig and Grypma, "Breaking Down Racial Barriers," 15.
- <sup>39</sup> Some of the British war brides were nurses themselves. For example, Ann Callahan's sister-in-law, Mary Thomas was a World War II war bride who worked at the Fort Qu'Appelle Indian hospital; Callahan, *Interview*. Also, Elsie Sark came from England to the Lennox Island Indian Reserve in 1918, but she was not employed as a nurse on Lennox Island. John Sark, one of the 36 Micmac volunteers from P.E.I., wooed her while he was convalescing in England; M. Olga McKenna, *Micmac by Choice: Elsie Sark, an Island Legend* (Halifax: Formac Publishing Company Limited, 1990). Elsie Sark is Marilyn Sark's mother-in-law.

### Part Three

- <sup>1</sup> "Mohawk Girl Is Nurse-In-Charge at Nipissing," *The Indian News* 4:4 (April 1961): 3.
- <sup>2</sup> Department of National Health and Welfare, *Annual Reports*. To this was added the services of provincial Public Health Nursing Services, Red Cross and VON.
- <sup>3</sup> Ruth Christie, *Interview*, March 28, 2006.
- <sup>4</sup> Christie, *Interview*.
- <sup>5</sup> LAC RG 10 Volume 8767 File 1/25-7-5, pt. 1. Letter from B. Davidson, Reg. N. Inspector, circa. 1952.
- <sup>6</sup> Christie, *Interview*.
- <sup>7</sup> "Here and There," *Indian News* 6:2 (October 1962): 8.
- <sup>8</sup> Conversation at ANAC meeting, Sudbury, 2006.
- <sup>9</sup> Ottawa, *Indian and Northern Health Services, Directorate Report*, 1960, p. 13. As cited in Meijer Drees, "Training Aboriginal Nurses," p. 11.
- <sup>10</sup> *Ibid.*, p. 13.
- <sup>11</sup> "Relieve Nurse Shortage" *Edmonton Journal* clipping in *The Camsell Arrow* 11:5 (January February 1958); and "Indian and Eskimo Aides Help Take Care of their Own at Camsell," *The Camsell Arrow* 11:15 (January-February 1958): 44.
- <sup>12</sup> Department of National Health and Welfare, *Directorate Report* (Ottawa: Queen's Printer, 1960), p. 44.
- <sup>13</sup> Moreover, two women who worked as RNs with the Manitoba Provincial Northern Health Service were expected to take on duties assigned to Community Health Workers elsewhere in conjunction with their present duties as Practical Nurses. LAC RG 29 Volume 2706 File 804-4-2 pt. 2. Letter to Mr. O. Leslie, Regional Supervisor, Winnipeg, from J. M. Bell, The Pas Agency, Jan 8 1963/4.
- <sup>14</sup> Marilyn Sark, *ANAC Interview*, September 6, 2006 and Faye Isbister-North Peigan *ANAC Survey/Interview*, August 3, 2006.
- <sup>15</sup> McPherson, *Beside Matters*, 221.
- <sup>16</sup> "Mohawk Girl Is Nurse-In-Charge at Nipissing," *The Indian News* 4:4 (April 1961): 3.
- <sup>17</sup> "Cape Croker Girl Nurse for 700 Crippled Children," *The Indian News* 4:2 (May 1960): 5.
- <sup>18</sup> "Enjoys Public Health Work," *The Indian News* 7:1 (December 1963): 6.
- <sup>19</sup> "Twenty-Nine Awarded Scholarships," *Indian News* 6:3 (February 1963): 4. In that year,

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Marie Bacon (Pointe Bleue), Marilyn Francis (Lennox Island), Theresa Stevens (Chapel Island Band), and Bernice Stonechild (Muscowpetung Band) were awarded nursing scholarships.

<sup>20</sup> Callahan, *Interview*.

<sup>21</sup> Wilma Strongeagle, "Why I Became a Nurse," *Indian News* 6:2 (October 1962): 4.

<sup>22</sup> Prince, *ANAC Interview*.

<sup>23</sup> Callahan, *Interview*.

<sup>24</sup> Sark, *ANAC Interview*.

<sup>25</sup> Department of National Health and Welfare, *Annual Report of the Department of National Health and Welfare* (Ottawa: Queen's Printer, 1953), 34. "Supporting the medical officers and nurses were 1,150 valued employees whose skills and efforts make a medical service possible. Of these 295 were Indians or Eskimos. The additions during the year included 138 positions of appropriate classifications."

<sup>26</sup> McPherson, *Bedside Matters*, 222.

<sup>27</sup> Olson, *Interview*.

<sup>28</sup> "Nurse-in-Training will serve in North," *Indian News* 1:1 (January 1955): 4.

<sup>29</sup> Strongeagle, "Why I Became a Nurse," 4.

<sup>30</sup> Callahan, *Interview*.

<sup>31</sup> Christie, *Interview*.

<sup>32</sup> *Ibid.*

<sup>33</sup> O'Brien, "Jennie Nielsen."

<sup>34</sup> McKay, *ANAC Interview*.

<sup>35</sup> Sark, *ANAC Interview*.

<sup>36</sup> Isbister-North Peigan, *ANAC Survey/Interview*.

<sup>37</sup> Olson, *Interview*.

<sup>38</sup> Isbister-North Peigan points to an aging population of Aboriginal nurses as one of the issues Aboriginal nurses are facing today, because this will "create a lack of corporate knowledge in the Aboriginal nurse population, as there is a continuing need to mentor the young." Isbister-North Peigan, *ANAC Survey/Interview*.

#### **Part Four**

<sup>1</sup> McKay, *ANAC Interview*.

<sup>2</sup> For example, RNCIA had a consultative role in the development of the Indian Health Policy of 1979, a policy to engage Native people in the planning, budgeting and delivery of health care. RNCIA members also played a key role in the development of the principles of the transfer of health services to bands in the 1980s.

<sup>3</sup> "In Memory of Jean Goodwill, 1928-1997," *The Aboriginal Nurse* 15:1 (April 2000): 12.

<sup>4</sup> Doug Cuthand, "Pioneer Native Nurse Will Be Missed," *Star-Phoenix*, [Saskatoon] April 29, 1997, Forum, A5.

<sup>5</sup> Jean Goodwill, "Notes for Speech to NWT RNA April 29 1982," LAC R11504 (Aboriginal Nurses Association of Canada Records) Volume 2 File 10 "ANAC Personnel – Employees Goodwill, Jean, 1."

<sup>6</sup> LAC R11504 Volume 32 File 32-5 Jean Goodwill, *Barriers to Employment and Retention of Native Nurses* (Indian and Inuit Nurses of Canada and Medical Services Branch, February 1983).

<sup>7</sup> The Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN) was founded in 1997.

<sup>8</sup> LAC R11504 Volume 2 Folder 2-10 "Field Trip to Winnipeg – May 17-21, Jean Goodwill."

<sup>9</sup> The goal of the IHC program was to "stimulate the interest of Indian and Inuit students in the health disciplines, to encourage them to choose health careers and then make it easier for them to achieve this goal." "A New Federal Program: Indian-Inuit Professional Health Career Development," *IINC Newsletter*, 1:1: 3.

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- <sup>10</sup> Waldram, Herring and Young, *Aboriginal Health in Canada*, pp. 251-252.
- <sup>11</sup> LAC R11504 Volume 33, File 33-17 “Hearings on Indian Education – A.F.N. Oct 6, 1986: Tape transcript: Jean Goodwill.”
- <sup>12</sup> Pat McCormick Stewart, “Helping people to help themselves – a community development approach to nursing education,” *The Canadian Nurse* 80: 1 (January 1984): 36.
- <sup>13</sup> Marilyn Tanner-Spence, *ANAC Survey* July 25, 2006.
- <sup>14</sup> For example, see literature on Manitoba programs: G. Connell, R Flett & P Stewart, “Implementing Primary Health Care Through Community Control: The Experience of Swampy Cree Tribal Council,” *Circumpolar Health 90: Proceedings of the 8<sup>th</sup> International Congress on Circumpolar Health, Whitehorse, Yukon, May 20-25, 1990* (Winnipeg, University of Manitoba Press, 1991), pp. 44-46; E. Thomlinson, D. Gregory, & J. Larsen, “The Northern Bachelor of Nursing Program: One solution to problems in health care provision,” *Circumpolar Health 90: Proceedings of the 8<sup>th</sup> International Congress on Circumpolar Health, Whitehorse, Yukon, May 20-25, 1990* (Winnipeg: University of Manitoba Press, 1991), pp. 145-148; E. Thomlinson, “Northern Bachelor of Nursing Program: Issues in the Implementation of a Curriculum to Meet Community and Nursing Needs,” *Redressing the Imbalance: Health Human Resources in Rural and Northern Communities: Proceedings from a Conference Hosted by the Northern Health Human Resources Research Unit, Thunder Bay, Ontario, October 21-24, 1993* (Thunder Bay, On: Lakehead University Centre for Northern Studies, 1995), pp.489-95; and David Gregory, Mary Jane L. McCallum, Karen R. Grant and Brenda Elias, “Self-Determination and the Swampy Cree Tribal Council: A Case Study Involving Nursing Education in Northern Manitoba,” paper presented at the Manitoba First Nations Centre for Aboriginal Health Research, Health Services Research Project Symposium, March 2006, Opaskwayak Cree Nation.
- <sup>15</sup> Section 15 of the Act provided access for Aboriginal people to equal employment in the Public Service.
- <sup>16</sup> This policy called for affirmative action in hiring Indian, Inuit, Métis and non-Status Indians in the Public Service.
- <sup>17</sup> The 1981 Order-In-Council authorized DIAND to restrict recruitment and selection for positions in the Indian and Inuit Recruitment and Development Program and the Native Development Program.
- <sup>18</sup> LAC R11504 Volume 32 File 32-5. Jean Goodwill, *Survey of Native Nurses*, 1983, p. 10.
- <sup>19</sup> McKay, *ANAC Interview*.
- <sup>20</sup> “Community Health Nurse’s Perspective,” *INAC Newsletter* 1:1: 6-8 and 15-16.
- <sup>21</sup> Jean Goodwill, *Barriers to Employment and Retention of Native Nurses* (Indian and Inuit Nurses of Canada, 1984), p. 16.
- <sup>22</sup> “Awards and Achievements,” *The Aboriginal Nurse* 15:1 (April 2000): 13.
- <sup>23</sup> McKay, *ANAC Interview*.
- <sup>24</sup> “Focus on Native Health” *The Canadian Nurse* 74:9 (October 1978): 8.
- <sup>25</sup> Prince, *ANAC Interview*.
- <sup>26</sup> John Soosaar, *Daily News* [Halifax], Local News Section, February 5, 2006, 8.
- <sup>27</sup> Pauline Steiman, “Caring for Indian Outpatients,” *The Canadian Nurse* 74:9 (October 1978): 40.
- <sup>28</sup> LAC R11504, Volume 1 File “ANAC Administration – Brochures and Logo: 1983-93,” Brochure: Registered Nurses of Canadian Indian Ancestry.

## **Part Five**

- <sup>1</sup> Isbister-North Peigan, *ANAC Survey/Interview*.
- <sup>2</sup> Dr. Eileen Antone and Maya Chacaby, “Aboriginal Health Human Resources,” Panel discussion presented at the ANAC Conference, Sudbury, 2006.
- <sup>3</sup> Wendy McBride and David Gregory, “Aboriginal Health Human Resources Initiatives: Towards

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the Development of a Strategic Framework,” *Canadian Journal of Nursing Research* 37:4 (December 2005): 89-95.

<sup>4</sup> Prince, *ANAC Interview*.

<sup>5</sup> Aboriginal Nurses Association of Canada, *Aboriginal Health Nursing Project: Initiating Dialogue* (Draft Discussion Paper, March 31, 2006), p. 7.

<sup>6</sup> National Aboriginal Health Organization, “Analysis of Aboriginal Health Careers Education and Training Opportunities,” January 2003, pp. 39-41, cited in ANAC, *Aboriginal Health Nursing Project*, p. 8. One expression of this kind of disrespect by the health care system has been in the perception by non-Aboriginal health care providers that health care is “free” to Aboriginal people, a perception which disregards Aboriginal treaty rights and fiduciary obligations of the federal government and humiliates the client.

<sup>7</sup> Evelyn Voyageur, Draft Proceedings from the A.N.A.C. Annual General Assembly, September 15-16, 2005, 7, cited in ANAC, *Aboriginal Health Nursing Project*, p. 27.

<sup>8</sup> Dianne Wepa, “Cultural Safety in Aotearoa New Zealand”, 2005, preface, cited in ANAC *Aboriginal Health Nursing Project*, p. 21.

<sup>9</sup> D. Patricia Gray and Deberah J. Thomas, “Critical Reflections on Culture in Nursing,” *Journal of Cultural Diversity* 13:2 (Summer 2006): 76-82.

<sup>10</sup> Isbister-North Peigan, *ANAC Survey/Interview*. Faye was delivered at home by her great-grandmother who was a traditional midwife and healer. Also, in a dedication to Jean Goodwill, her nephew recalls: “My grandmother was a midwife who delivered many babies on the reserve. Jean followed her example and, after graduation, went to La Ronge where she and a nurse's aide provided the primary health care for the community. The first year she was there, she delivered about 50 babies, removed numerous fishhooks from kids and tourists and tended to a wide variety of other health needs.” Cuthand, “Pioneer Native Nurse.”

<sup>11</sup> Patricia Jasen, “Race, Culture, and the Colonization of Childbirth in Northern Canada,” in Veronica Strong-Boag, Mona Gleason, and Adele Perry, eds., *Rethinking Canada: The Promise of Women's History* (Don Mills: Oxford University Press, 2002), p. 361.

<sup>12</sup> Dena Carroll and Cecilia Benoit, “Aboriginal Midwifery in Canada: Blending Traditional and Modern Forms,” *Canadian Women's Health Network Magazine* 4:3 (Spring 2001) at National Aboriginal Health Organization, Information Centre on Aboriginal Health Website, [www.ica.h.ca](http://www.ica.h.ca); and National Aboriginal Health Organization, *Midwifery and Aboriginal Midwifery in Canada*, May 28, 2004.

<sup>13</sup> Isbister-North Peigan, *ANAC Survey/Interview*.

<sup>14</sup> Blair Stonechild, *The New Buffalo: The Struggle for Aboriginal Post-Secondary Education in Canada* (Winnipeg: University of Manitoba Press, 2006), 2.

<sup>15</sup> Isbister-North Peigan, *ANAC Survey/Interview*.

<sup>16</sup> Claudette Dumont-Smith and Pauline Sioui-Labelle, *Survey Results of Band-Employed Nurse Participants in the Transfer of Health Services to Indian Control* (Indian and Inuit Nurses of Canada: March 1991).

<sup>17</sup> LAC R11 504 Volume 41 File 41-12, “Negotiating an Employment Contract” (Draft) August 9, 1990.

<sup>18</sup> McKay, *ANAC Interview*. Unfortunately, the ANAC itself was undergoing fiscal struggles particularly in the last 10 years, with the announcement in 1996 that the federal government was phasing out funding to the association by the year 2000, and that the basis of ANAC's support shifted from core to project funding.

<sup>19</sup> Prince, *ANAC Interview*.

<sup>20</sup> Valerie Gideon, “Overview of Assembly of First Nations' Health Initiatives,” Paper delivered at the ANAC Annual Conference, 2006.

<sup>21</sup> McKay, *ANAC Interview*.

<sup>22</sup> Isbister-North Peigan, *ANAC Survey/Interview*.

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- <sup>23</sup> Jocelyn Bruyère, "Understandings about type II diabetes mellitus among the Nêhinaw (Cree)." M SC Thesis, U Manitoba, 1998; and Jocelyn Bruyere and Linda C. Garro, "He travels in the body": Nêhinaw (Cree) understandings of diabetes," *The Canadian Nurse* 96:6 (2000): 25.
- <sup>24</sup> Jocelyn Bruyère, "Nêhinaw (Cree) Socioeconomic, Political and Historical Explanations about the Collective Diabetes Experience," in eds. Mariana Leal Ferreira and Gretchen Chesley Lang *Indigenous Peoples and Diabetes: Community Empowerment and Wellness* (Durham, NC: Carolina Academic Press, 2006), pp. 123-138.
- <sup>25</sup> Ann Callahan, "On Our Way to Healing: Stories from the Oldest Living Generation of the File Hills Indian Residential School," MA Thesis, U Manitoba, 2002.
- <sup>26</sup> Maya Chicaby, "Aboriginal Health Human Resources," Paper delivered at the Aboriginal Nurses Association of Canada Conference, Sudbury 2006.
- <sup>27</sup> National Aboriginal Health Organization website: [http://www.naho.ca/firstnations/english/ocap\\_principles.php](http://www.naho.ca/firstnations/english/ocap_principles.php)
- <sup>28</sup> Prince, *ANAC Interview*.
- <sup>29</sup> Tanner-Spence, *ANAC Survey*.
- <sup>30</sup> Soosaar, *Daily News*. Marie Ross also achieved training as a group psychotherapist as well as a Bachelor of Arts in English Literature and history from the University of Toronto.
- <sup>31</sup> Cory Fox, *Windspeaker* Vol 20 Issue 11, pg. 32 (March 2003).
- <sup>32</sup> Anjali Baichwal, "Wisdom of the Ancestors," news@uoft, Jan 15, 2001. <http://www.news.utoronto.ca/bin1/010115g.asp>
- <sup>33</sup> Dan Smith, "Wise Grandmother," *Toronto Star* October 21, 1996, E 1 (People).
- <sup>34</sup> LAC R11504 Volume 1, File 1-17 "Traditionalism for Empowerment" Jean Goodwill, ca. 1985.
- <sup>35</sup> According to Marsha Forrest, who works at a hospital in Queen Charlotte, B.C., Haida traditions and herbal preparations were used by patients along with Western medicine and in consultation with a physician to treat everything from rashes to cancer. Barbara Sibbald, *The Canadian Nurse* 96:9 (October 2000): 52.
- <sup>36</sup> Alice Reid, Keynote Paper, "A White Uniform Traded In for Rubber Boots, Jeans, a Rifle and an Orange Pack Sack," Paper presented at the Aboriginal Nurses Association of Canada Conference, Sudbury 2006.
- <sup>37</sup> Lisa Dutcher, "Community Needs Assessment Guide: A Wholistic Approach in Identifying the Needs in Aboriginal Communities," Paper presented at the Aboriginal Nurses Association of Canada Conference, Sudbury 2006.
- <sup>38</sup> Lucy Barney, "Around the Kitchen Table: Aboriginal Women Strengthening Their Learning," Paper presented at the Aboriginal Nurses Association of Canada Conference, Sudbury 2006. See also Holistic Health Care, The Braid Theory Developed by Lucy Barney <http://www.bccdc.org/downloads/pdf/std/01Braidtheory.pdf>
- <sup>39</sup> Julie Lys, "Aboriginal Health Human Resources," Paper presented at the Aboriginal Nurses Association of Canada Conference, Sudbury 2006.

## Part Six

- <sup>1</sup> Sark, *ANAC Interview*.
- <sup>2</sup> The National database of Aboriginal health professionals currently relies on self-identification.
- <sup>3</sup> Sibbald, *The Canadian Nurse*, 52.
- <sup>4</sup> Prince, *ANAC Interview*.
- <sup>5</sup> McKay, *ANAC Interview*.
- <sup>6</sup> Lys, "Aboriginal Health Human Resources."