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**Intersecting Identities:  
Exploring Urban Aboriginal Women's Experiences of Accessing Care**

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**Intersecting Identities:**  
**Exploring Urban Aboriginal Women's Experiences of Accessing Care**

Kimberley A. Van Herk

Thesis submitted to the  
Faculty of Graduate and Postdoctoral Studies  
In partial fulfillment of the requirements  
For the Masters of Science Degree in Nursing

School of Nursing  
Faculty of Graduate and Postdoctoral Studies  
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## ABSTRACT

The purpose of this master's thesis is to explore intersections within Aboriginal womens' descriptions of their experiences of accessing care in an urban context, and to explicate how service provider's perceptions of women's identity featured in their care encounters. This thesis is divided into three chapters. The first chapter provides a background on access to care for Aboriginal women living in urban contexts, outlines the methodology of the primary study, and explores the intersectionality paradigm used to complete the secondary analysis done for this study. The second chapter describes the results of the study. It begins by providing a general overview of the major themes and subthemes, followed by two manuscripts that have been written for submission for publication in scholarly journals. The third chapter discusses how this study has contributed to new knowledge for nursing, as well as the implications for nursing education, research and policy.

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*Love the earth and sun and animals*

*Despise riches, give alms to everyone that asks*

*Stand up for the stupid and crazy*

*Devote your income and labour to others*

*And your very flesh shall be a great poem*

## TABLES, APPENDIXES & FIGURES

### Tables

Table 1 Description of <i>Improving Access</i> Study Sample	Page 38
Table 2 Description of <i>Exploring Aboriginal Women's Experiences of Accessing Care</i> Study Sample	Page 45
Table A (from Manuscript #2) Summary of Research Steps	Page 123
Table 3 Use of an Intersectionality Paradigm in Nursing	Page 173

### Appendices

Appendix A Consent form for <i>Improving Access</i> Study	Page 199
Appendix B Interview guidelines for Service Providers and Leaders and Community Members	Page 201
Appendix C Ethical Approval from the University of Ottawa Research Ethics Board	Page 203
Appendix D Gendered Racism Analysis Chart	Page 204
Appendix E Example of Gendered Racism Analysis Chart	Page 205
Appendix F Log of Participation in Community Events	Page 207
Appendix G Demographic forms for Service Providers and Leaders and Community Members	Page 208

### Figures

Figure 1 The Research Process	Page 53
Figure 2 Unpacking the dynamics of care encounters: A diagram of the major themes and sub-themes describing Aboriginal women's experiences of accessing care	Page 65

## TABLE OF CONTENTS

Abstract.....	Page ii
Acknowledgements.....	Page iii
List of Tables, Appendices and Figures.....	Page v
 Chapter 1: Introduction to Study.....	 Page 1
• Research Purpose and Questions.....	Page 4
• Background	
○ Acknowledging Inequities in Access to Care for Aboriginal People living in Urban Centres.....	Page 5
○ Health Service Provision for Aboriginal Peoples.....	Page 8
○ Impact of Health Service Delivery on Aboriginal Women.....	Page 11
• Theoretical Underpinnings: Incorporating a Postcolonial Feminist Lens.....	Page 13
• Literature Review	
○ Health and Social Conditions of Aboriginal Women.....	Page 15
○ Barriers to Accessing Care for Aboriginal Women.....	Page 17
• Implications for Nursing.....	Page 24
• Locating Myself within the Research.....	Page 27

○ My Involvement with the local Aboriginal community.....	Page 30
○ Nursing Encounters.....	Page 32
• Developing the Research Study	
○ The Primary Research Study.....	Page 34
○ Developing the <i>Exploring Urban Aboriginal Women's Experiences of Accessing Care</i> Research Study.....	Page 38
• Analytical Lens-Intersectionality.....	Page 40
• Methodology	
○ Research Design.....	Page 43
▪ Sampling.....	Page 45
▪ Data Analysis.....	Page 46
▪ Thematic Analysis.....	Page 51
▪ Verification by Community Members.....	Page 53
• Enhancing Rigour.....	Page 55
• Conclusion.....	Page 56

## Chapter 2: An Overview of the Results

• Examining the Influence of Identity: The Participant Sample.....	Page 59
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○ Using a ‘White’ Demographic Form.....	Page 59
○ Fluidity of Identity.....	Page 60
○ Multiple Identities: Service Providers’ Roles within Urban Settings.....	Page 62
● Brief Overview of Results.....	Page 63
○ Mothering as the Focal Point for Women’s Interrelated Identities.....	Page 66
▪ The Imposition of the Presumed Superiority of Western Models of Mothering.....	Page 68
▪ Care Places Ensuring Safety and a Sense of Belonging.....	Page 70
▪ Service Providers ‘Working it Through’ with Aboriginal Mothers: Giving Care in “A Good Way”.....	Page 71
▪ Aboriginal Women Leading & Transforming Care.....	Page 72
● Conclusion.....	Page 74
● Manuscript #1-“ <i>Identity Matters: Aboriginal Mother’s Experiences of Accessing Care</i> ”.....	Page 76
○ Abstract.....	Page 77
○ Definitions of Identity and Social Location.....	Page 79
○ Background on Issues of Access for Aboriginal Women.....	Page 80
○ Theoretical Framework.....	Page 82

○ Methods and Procedures.....	Page 84
▪ Summary of Primary Research Study.....	Page 84
▪ Secondary Analysis of data: Exploring Aboriginal women's experiences of accessing care.....	Page 86
○ Results.....	Page 89
▪ Aboriginal mothering: the intersection of identities.....	Page 90
▪ The Imposition of the Presumed Superiority of Western Models of Mothering.....	Page 93
▪ Service Providers 'Working It Through' with Aboriginal Mothers: Giving Care in "A Good Way".....	Page 96
▪ Aboriginal Women Leading and Transforming Care.....	Page 99
○ Implications for Nursing.....	Page 101
○ Conclusion.....	Page 105
○ References.....	Page 106
• Manuscript #2- <i>"Examining Our Privileges and Oppressions: Incorporating an Intersectionality Paradigm into Nursing"</i> .....	Page 112
○ Abstract.....	Page 113
○ What is an Intersectionality Paradigm?.....	Page 114
○ Why an Intersectionality Paradigm?.....	Page 117
○ How has an Intersectionality Paradigm been used Previously?.....	Page 120



- How I Incorporated an Intersectionality Paradigm into my Nursing Research.....Page 122
- Implications for Nursing Practice, Research, Education and Policy....Page 132
- Conclusion.....Page 135
- References.....Page 137

### Chapter 3: Implications for Nursing

- Review of the Results.....Page 140
- Implications for Nursing
  - Nursing Practice
    - Identity and Forming Trusting Relationships.....Page 142
    - Affirming the Strength of Mothers.....Page 144
  - Nursing Education
    - Socialization of Nursing Students.....Page 150
    - Acknowledging the Importance of Identity within Nursing Education.....Page 152
  - Nursing Research.....Page 156
  - Nursing Policy.....Page 158

• Identity as a Useful Concept in Nursing	
○ Fluidity of Identity: The Importance of Self-Definition.....	Page 161
○ Multiple Identities: Service Provider’s Roles within Urban Settings...	Page 163
○ Leveraging Identity: Aboriginal Female Leaders.....	Page 165
○ Implications of Identity for Nursing Knowledge/Theory.....	Page 166
• Implications of Incorporating an Intersectionality Paradigm	
○ Implications of Incorporating Essed’s Gendered Racism Framework.....	Page 169
○ Intersectionality as an Important Paradigm Shift for Nursing.....	Page 171
• Limitations	
○ Sampling Limitations.....	Page 175
○ Data Collection Limitations.....	Page 176
○ Data Analysis Limitations.....	Page 177
○ Limitations of Conducting this Research as a White Academic.....	Page 178
• Conclusion.....	Page 180
Statement of Contributors.....	Page 182
References.....	Page 184

## CHAPTER 1: INTRODUCTION TO STUDY

*“All the knowledge that they gave in our culture, the knowledge is not owned. Like everything that we do, everything that we have, the Creator provides, so we’re just keepers of it until we pass it on. So once you learn, once we learn and understand something than it’s up to you. It’s your responsibility to pass that knowledge on” (P.16, P. 14)*

The following study, *“Intersecting Identities: Exploring Urban Aboriginal Women’s Experiences of Accessing Care”* (which from now on will be referred to as *“Exploring Urban Aboriginal Women’s Experiences of Accessing Care”*) examines Aboriginal<sup>a</sup> women’s experiences of accessing care within an urban setting. Aboriginal women experience significant disparities in health as a result of unequal access to health care services (Benoit, Carroll, & Chaudhry, 2003; Hare, 2004; Kurtz, Nyberg, Van Den Tillart, & Mills, 2008; Stout, Kipling & Stout, 2001). Previous research has indicated that poor access to preventive care affects not only individual woman’s health but also the health and well-being of Aboriginal children and families as Aboriginal women play a predominant caretaking role within their communities (Browne, Fiske, & Thomas, 2000; Kurtz et. al, 2008).

A significant amount of literature that has focused on Aboriginal women’s experiences of accessing care has emphasized physical issues of access such as transportation and geographical location. These issues do present serious barriers for Aboriginal women living in remote communities who must often travel long distances to obtain care (Hare, 2004; Stout et. al, 2001). However within urban settings, where care appears to be more readily accessible, Aboriginal women continue to experience disproportionate disparities in health and access to care (Tait, 1999).

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<sup>a</sup> Although the Canadian government may classify Aboriginal peoples according to their registration as treaty Indians, Band or First Nations members, or registered Inuit; this paper has incorporated the perspective that Aboriginal refers to those individuals who self-identify as First Nations, Inuit or Métis.

Within urban and rural settings, health researchers are beginning to focus on the social, cultural, and psychological dimensions of health care encounters. This includes an examination of how the nature of the relationship Aboriginal women has with their care provider impacts access. Health literature has acknowledged that discrimination, lack of understanding of cultural practices, and a desire for more Aboriginal representation within health professions are playing an important role in Aboriginal women's encounters with health care services and their decision of whether to return for services again (Browne et. al, 2000; Stout et. al, 2001; Tait, 1999). As one Aboriginal woman describing her personal experience accessing care, social work student Brunen (2000) writes; "I felt belittled, degraded and misunderstood enough times to almost convince me that I was not "good enough" to access health care" (p. 5).

There remains a pressing need to understand how issues of racism and discrimination alongside inter-related factors such as poverty and violence overlap in Aboriginal women's experiences of accessing health care services. The "oppressive social conditions such as racism, sexism and classism, that shape access to health care are the same conditions that shape inequities in health, with poverty being a major determinant of poor health" (Sherwin, cited in Pauly, MacKinnon & Varcoe, 2009, p. 118). In this paper, inequities in health refer to differences in health between populations or individuals that are a result of unfair or unjust circumstances (Norheim & Asada, 2009). However, Fiske and Browne (2008) argue that addressing such structural inequities is often ignored in favour of reconstituting differences in health between Aboriginal peoples and mainstream Canadians as primarily "cultural differences." Therefore rather than addressing inequities, health policy for Aboriginal peoples often contributes to positioning Aboriginal women as powerless and marginalized within health care discourses. Simply put, the complex issues contributing to Aboriginal women's experiences

of accessing care need to be examined using an approach which can explicate and account for these “identity politics.”

Issues of identity were examined in the nursing literature to locate this work within the professional body of knowledge. Though nursing database CINAHL was searched as well as nursing philosophy textbooks, a common definition of identity congruent with the study’s theoretical and philosophical standpoint was not found. A more detailed understanding of the concept of identity as it relates to the therapeutic nursing encounter and consequently Aboriginal women’s experiences of care is needed. A definition of identity in the social science literature was identified that resonated with what participants said about the complex ways in which identity featured in their everyday as well as healthcare encounters. Alcoff’s (2003) definition includes ideas of identities as both imposed and self made

“names we give to the different ways we are positioned by, and position ourselves within, the narratives of the past.’ They are both imposed and self-made, produced through the interplay of names and social roles foisted on us by dominant narratives together with the particular choices families, communities, and individuals make over how to interpret, and resist, those impositions as well as how to grapple with their real historical experiences. But the social meanings attached to such things as skin colour and body shape, the hierarchies of language and differential roles in reproduction, and the very significance afforded various identity markers are firmly in place when a given individual is born, circumscribing their flexibility and invoking a constellation of meanings that will come into play by their appearance or their birth certificate” (p. 3).

This definition of identity was identified within the sociology literature after the qualitative interviews for the primary study had been completed, and while planning for the secondary analysis was still in its infancy. This definition of identity has been implemented within this study because it resonated with what participants said about the complex ways in which identity featured in their everyday and health care encounters. The key features of this definition which

has implications for this study is that identity includes both those names which are self-made and imposed by others. These names are often the result of lived historical experiences whose meaning may be passed down through generations. As well, identity markers such as skin colour have social meaning and significance that position individuals within their social contexts. These features of identity will be further elaborated on within the results and discussion section of this thesis paper.

### Research Purpose and Questions

The purpose of this master's thesis is to examine how Aboriginal women living in an urban context describe their experiences of accessing care, and to explicate how service providers' perceptions of women's identity featured in their care encounters. An intersectionality paradigm was used to explore the ways identity impacts Aboriginal women's care encounters. After drawing attention to the identities Aboriginal women identified as impacting their care experiences, further analysis explored how these identities are related to the way in which Aboriginal women described care places and their encounters with healthcare professionals.

The main research questions that guided this study were:

- What are the factors which impact Aboriginal women's experiences of accessing care? How do Aboriginal women describe the impact of identity on their care encounters?

### Background

Why are issues of access for Aboriginal women a high priority? In order to understand why access is such a pressing issue and how to address it, it is necessary to provide some

background information on the complexities of health care delivery for Aboriginal peoples living in an urban setting. This section will begin with a brief description of the demographics of the Aboriginal population within Canada. By bringing awareness to the diversity reflected in Canada's First Nations, Inuit and Métis peoples, attention is drawn towards addressing the intricacies of access issues for Aboriginal people. Particular consideration will be given to understanding the increasing urbanization of Aboriginal peoples and the impact that this has on the design and delivery of health care. This will be followed by an explanation of how health care service design for First Nations, Inuit, and Métis peoples may impact access to care, and will conclude with the particular implications that this has for Aboriginal women.

*Acknowledging Inequities in Access to Care for Aboriginal People Living in Urban Centres*

The complexities surrounding access for Aboriginal women living in an urban centre is influenced by who Aboriginal people are and the “identity politics” which surround health care delivery for Aboriginal peoples. In Canada, the term ‘Aboriginal’ is used to recognize three distinct indigenous groups including First Nations, Inuit and Métis people. The diversity between and within these different ethnic groups are distinguished by different languages, land bases, and cultural activities as well as the complex interplay between self-made and imposed names that are ascribed to First Nations, Inuit and Métis peoples as a result of how they are positioned within Canadian society. The term ‘Aboriginal’ therefore can be misleading, as it lumps together different populations under a generic term (Kirmayer, Tait & Simpson, 2009). Brass (2009) notes the importance of locating the term ‘Aboriginal’ within its socio-historical context. He argues that

“in the case of indigenous peoples, Aboriginality implies that there exists an internally homogenous category of peoples in the world distinguished by

having been collectively “othered” or socio-politically marginalized from nation-state populations. In drawing attention to this social construction of Aboriginality, the aim is not to deny that Aboriginal peoples exist or that Aboriginality is an inauthentic source of identity. Rather the aim is to point out how the locally constructed cultural identities of some of the world’s human populations have been historically subsumed within a larger discourse. In other words, “Aboriginal” and “Aboriginality” are historical social constructions” (p. 362-63).

Throughout this thesis the term ‘Aboriginal’ is used to describe the commonalities between First Nations, Inuit and Métis women’s experiences of accessing care. However when participants have made efforts to talk in more specific terms, such as when describing the experiences of certain ethnic groups or nations, the language that they use to describe themselves will be adopted.

In Canada, 1.17 million people self-identify as Aboriginal people, accounting for 3.8% of the total population. First Nations peoples are the largest group, accounting for 60% of the Aboriginal population, while Métis make up 33% and the Inuit 4% of the population respectively. First Nations people are often subdivided into ‘status’ and ‘non-status.’ These terms were designated under the federal Indian Act, the implications of which will be further elaborated below in the discussion on the delivery of health care services.

Geographic distribution of Aboriginal people has shifted significantly over the last five decades. Approximately 56% of Canada’s Aboriginal population now reside in urban settings. The populations most widely recognized in urban settings are non-status First Nations and Métis (Kirmayer et. al, 2009). This shift is the result of a number of different issues, including an increase in Aboriginal populations both on and off reserve, a growth in the number of marriages with non-Aboriginals along with an increased tendency to cite Aboriginal ancestry, as well as the migration of people to urban areas for increased opportunities for better housing, education and



employment (Guimond, Robitaille, & Senecal, 2009; Norris & Clatworthy, 2003). These changes have particular significance for examining access to care; as Friendship Centres and Aboriginal Health Centres set up to meet the needs of the urban Aboriginal population have indicated that they do not have the resources needed to provide the programming and services needed for this growing population. Furthermore,

“Intergovernmental disputes, federal and provincial offloading, lack of program co-ordination, exclusion of municipal governments and urban Aboriginal groups from discussions on policy and jurisdictional matters, and confusion regarding the political representation of Aboriginal people in cities have all contributed to a situation that has had a negative impact on the ability of Aboriginal people to gain access to appropriate services in urban centres.” (Carter & Polevychok, 2004, p. 4).

Conflicts between the different levels of government regarding responsibility for the funding of health services for Aboriginal peoples has negatively impacted the health of Aboriginal people and resulted in a patchwork of fragmented and under-funded service delivery in urban settings (Bent, Havelock & Haworth-Brockman, 2008). Based on historical treaties and fiduciary responsibilities, the Federal government is responsible for providing funding for health care for First Nations and Inuit people recognized under the Indian Act (this is explained in more detail below). However, provincial governments are responsible for the delivery of health services for people living in provincial jurisdiction, and for physician, specialized and acute care services. In Ontario, administration of provincial health services was devolved to the Local Integrated Health Networks in 2006. This study’s sample population falls within the Champlain LHIN district, which has identified the necessity of reducing health disparities amongst Aboriginal people (Champlain LHIN, 2009). However, LHIN programming and services for Aboriginal people appear to be stymied as it is expected that there will be a health funding shortfall of over two billion dollars over the next five years (Assembly of First Nations, n.d.).

As a result of these complicated funding structures “there can be extremely complicated wrangling about who pays for ambulance service, provincially funded medications, dental care and other health services. Many people get caught up in the red tape and are often not clear what their own rights are, or those of their children” (Prairie Women’s Centre of Excellence, 2009, p. 122). The following section will describe the further complexity of health delivery for Aboriginal peoples by describing briefly how health care is funded differently for different ethnic populations.

### *Health Service Provision for Aboriginal Peoples*

The federal and provincial government’s lack of understanding or acknowledgement of the diversity of Aboriginal cultures and way of life has, and continues to create, barriers to accessing care. This is the result of “over 400 years of colonization and more than 150 years of legislation” (Bent et. al, 2008, p. 16). Differences in how health care is administered and delivered to First Nations, Inuit and Métis peoples are based on differences in legal status within and between these groups and has implications for their access to care, specifically what health service benefits they are entitled to (Bent et. al, 2008). The socio-historical basis of establishing legal rights for Aboriginal peoples was confounded by gender-based ideologies and has had particular implications for Aboriginal women. The situation for First Nations, Métis and Inuit are described below.

#### *First Nations*

“First Nations people in Canada, as a group, are divided into categories under Canadian law which create jurisdictional issues for access to health services” (Prairie Women’s Centre of Excellence, 2009, p. 117). Treaties that were made with First Nations people historically were a

lawful agreement with the Federal government promising the exchange of land for goods and services including healthcare. Those First Nations individuals who were identified as members of an Indian band which had signed treaties or other such agreements with the Federal government were given 'status'. This legal term, and who was entitled to it, was the main reason for the Indian Act of 1869. Through the creation of the Indian Act and the terms 'status' and 'non-status', the government was able to limit their contractual agreement by determining who was or wasn't entitled to the services as set out under the original treaty documents (Moss, 1997). This has important ramifications for access to care because those who have 'status' have access to non-insured health benefits from the Federal government. These non-insured health benefits included free medical services, as well as programs provided under the First Nation and Inuit Health Branch (FNIHB) including Aboriginal health centres, drug and alcohol treatment facilities, and healthy babies programs (Kirmayer et. al, 2009).

A large number of people who self-identified as First Nations were not given status or lost their status as a result of changes made to the Indian Act. These people are identified by the government as 'non-status' and are not eligible to receive health benefits. Since the Indian Act was centered on "the law of the blood", in which status was determined by the number of Indian grandparents one had, it overlooked migration and the fact that people may not have immediate connections with a band. Consequently First Nations individuals who were born in urban areas or who had lost contact with their band have had difficulty obtaining status (Torpey, 2000).

### *Inuit*

The Inuit obtain services from a mixture of federal, provincial/territorial and other health agencies. However like First Nations peoples, much of their care is covered by the federal

government under FNIHB. FNIHB is responsible for administering the “N#”; a piece of identification the Inuit must carry in order to access their non-insured health benefits including medication, medical equipment and supplies, dental and vision benefits (Inuit Tapirisit Kanatami, 2004; Tungasuvvingat Inuit Community Services, n.d.).

### *Métis*

The Métis were not included in treaties and therefore are not recognized legally by the federal government as a unique group. As a result they do not have access to non-insured health benefits and fall under provincial health care funding. Since their health care is largely provided by the provincial health care systems, they receive little to no access to specialized culturally appropriate health care and programming. However, they do occasionally fall under federal initiatives for Aboriginal programming targeted towards specific illnesses such as diabetes, HIV/AIDS prevention, and tobacco reduction (Women of the Métis Nation, n.d.). As a result of jurisdictional issues there has been very little research done on Métis people, which prevents the planning and funding of adequate services for Métis people.

It is clear that the design and delivery of health care services for Aboriginal peoples has resulted in a highly confusing bureaucratic structure. The terms ‘status’, ‘non-status’, and N# are administrative or bureaucratic categories used to denote rights to care as defined by the Indian Act and have important implications for access to care. These categories have created a great deal of confusion, both among Aboriginal people and health care providers, regarding rights to access to care across jurisdictions in relation to location of residence as well as ethnic identity. Despite conflicts with universal access to health care under the Canada Health Act, no Canadian studies were found that examined the implications these administrative and legal categories have

for access to care. Although there are important historical differences between the United States and Canada's experiences of colonization, both countries have set up reserve systems with associated legal ramifications and rights. An American study done by Zuckerman, Haley, Roubideaux & Lillie-Blanton (2004) indicates that those American Indians who have health services covered by Indian Health Services (similar to those health services covered by the Indian Act) are more likely to access health care than non-insured American Indians. Such bureaucratic terms as `status` portray how power dynamics established as a result of historical and current relations with the federal government, shape and hinder Aboriginal people from accessing an equitable level of care as other Canadians. It also underscores how imposed identities have been central to Aboriginal rights, and therefore must be examined to understand the influence of current identity issues on access to care.

### *Impact of Health Service Delivery on Aboriginal Women*

The different entitlement to health benefits and other social services amongst Aboriginal groups "affects Aboriginal women's daily lives. The rules determining what specific services are included in programs are complex and difficult to understand, and changes in policies create additional uncertainty" (Bent et al, 2008, p. 16). A very poignant example of how these rules have affected Aboriginal women's access to health care has been the gender discrimination encoded within the Indian Act. As a result of the Indian Act of 1869, First Nations women who married non-Aboriginal men, as well as their children, were stripped of their status and denied any rights to health entitlements. This has important considerations for this study as the sexism associated with the Indian Act is believed to be part of the reason for the migration of Aboriginal women and their children from reserves to urban settings (Bent et al, 2008).

Although Bill C-31 was passed in 1985 to end the gender discrimination of the Indian Act; it did not reverse status but allowed women and their children to apply for registration. However First Nations women continue to argue that this has not completely solved issues of access to the resources that they are entitled to as Aboriginal peoples (Bent et al, 2008; Furi & Wherrett, 2003). While Bill C-31 was enacted to end gender discrimination, it also included greater control by Indian bands over their own affairs. This included bands being able to control their own membership (Department of Indians Affairs and Northern Development, 1995). For those First Nations women who may have regained their status through Bill C-31, but who were not listed as band members (this is particularly difficult for women born in an urban setting who have not had contact with their reserve or band), they cannot and do not have access to special health services because their band has the right to determine what they will or will not compensate (Bent et al, 2008).

Entitlement to health services is particularly concerning for Aboriginal mothers, who remain most often the primary care givers of children. These benefits are of a diverse nature, including tax benefits, access to post-secondary education and non-insured health benefits, as well as the community support that comes from cultural identification (Mann, 2005). For Aboriginal women and children, particularly single mothers, those of low socio-economic status, or with severe health concerns, having access to the benefits of registration can mean the difference between receiving health care, education and a safe place to live or not.

This section provided a brief background on the demographics of Canada's Aboriginal population, with a particular focus on the reasons for, and implications of, increasing urbanization. It also provided an introduction to the complexity of funding of health care for different Aboriginal populations, the underlying power dynamics associated with funding and the

implications that this has for Aboriginal women and their access to care. The following section provides an introduction to the theoretical lens that has been incorporated into the literature review, methodology and design of this study.

### Theoretical Underpinnings: Incorporating a Feminist Postcolonial Lens

A feminist postcolonial lens was adopted to critically explore the dominant discourses that have previously explained issues of access for Aboriginal women. Racine (2003) defines this approach as

“a critical perspective aimed at addressing health inequities related to asymmetrical power relations, at disrupting the relations of ruling that silence ‘culturally different Other’ voices; at integrating subjugated knowledge in nursing theorization; at developing transformative knowledge directed at achieving social justice by correcting health inequities arising from social inequities affecting people of the South” (p. 96).

Postcolonial theories are primarily interested in constructions of ‘race’, ethnicity and culture, and the unequal power relations that govern different population groups’ access to care as a result of colonialism and neo-colonial practices. Incorporating a postcolonial lens helps nurses become interested with “the burden of history” and its impact on the health and well-being of people in the present day (Browne, Smye & Varcoe, 2005). However postcolonial theories have been criticized for their lack of attention to issues of gender; therefore, perspectives from feminism have been incorporated to extend the theoretical boundaries of both postcolonial and feminist thought (Browne, Smye & Varcoe, 2007).

A feminist postcolonial perspective proves useful in examining and uncovering the power structures that govern society, social relations, and shape health care encounters by examining the “political, historical, cultural and economic contexts” from which health inequities arise for Aboriginal women (Racine, 2003, p. 96). By incorporating this lens researchers attempt to attend

to the different voices and social-historical locations that have often been ignored or oppressed within health discourses. This is of particular benefit in analyzing the processes that have led to issues of unequal access for Aboriginal women. “Transformative knowledge” is gained through listening to Aboriginal women’s experiences of accessing care and unpacking the imbalanced power relations which pre-dominate their discourses, paying specific attention to issues of race, gender, culture and class. I’ve chosen to focus my analysis on issues of gender rather than sex, because issues of access revolve around Aboriginal women’s “socially constructed roles and relationships, personality traits, attitudes, behaviours, values, relative power and influence” rather than their biological characteristics (Chow, Pederson, Haworth-Brockman, & Bernier, 2009, p. 11). Thus this project becomes as Anderson (2000) describes, a forum to express the “multilayered socio-political contexts of access” for Aboriginal women (p. 227).

The use of a feminist postcolonial lens is also particularly helpful for interpreting health care discourses around culture. Culture is often spoken about as though it is a static entity which often separates or differentiates “racialized” groups in order to help provide “culturally competent” care. A feminist postcolonial lens becomes helpful in digging out “the essentializing effects of cultural categorizations and the assumptions that underpin them (e.g. that certain groups adhere to specific behaviours)” (Anderson, Kirkham, Browne, & Lynam, 2007, p. 182).

### Literature Review

The purpose of the literature review was to a) describe the health and social conditions Aboriginal women experience which makes issues of access particularly pressing and b) explore the barriers Aboriginal women encounter while attempting to access care. Nursing and social science databases were searched including CINAHL, Pubmed, and PsychINFO as well as selected Aboriginal databases including the Bibliography of Native North Americans and First



Nations Periodical Index for English language articles between years 2000 and 2009. A search strategy was tailored to each database using search terms: Aboriginal Women, First Nations Women, American Indian women, Inuit Women, Métis women, encounters with health care, health disparities, access, cultural care, cultural competence and intersectionality.

The results of the literature review begin with an exploration of the health and social conditions of Aboriginal women, with a particular focus on the social determinants of health. This will be followed by an exploration of the barriers Aboriginal women encounter while attempting to access care with an explicit analysis of female led households, the ongoing ‘gaze of the state’ on Aboriginal mothers, and how the design and delivery of health care impacts Aboriginal women’s access to care.

### *Health and Social Conditions of Aboriginal Women*

As a result of enduring historical marginalization and economic and political conditions sanctioned by colonial and neo-colonial policies, Aboriginal people have not had equal access to employment, housing, fair legal counsel, health services and other social determinants of health, and consequently experience disproportionate levels of unemployment, violence, incarceration, poverty, and physical and mental illness (Browne, Smye & Varcoe, 2005; Henry, Tator, Mattis & Rees, 2000). When considering the social circumstances of Aboriginal people however, Aboriginal women continue to present at a far greater disadvantage than Aboriginal men, illustrating aptly the intersections between race and gender in creating systemic burdens of illness (Native Women’s Association of Canada (NWAC), 2007a).

Disparities in access to preventive health services for Canada’s young and rapidly growing population of Aboriginal women and children is a pressing health care issue (Mann,

2005). Aboriginal people experience poor access and use of preventive childhood services, creating significant disparities in pregnancy outcomes and child mortality rates between Aboriginal and non-Aboriginal peoples (Bridge, 1999, Luo, Wilkins, Platt, & Kramer, 2004; Smith, Edwards, Varcoe, Martens, & Davies, 2006). For example, Aboriginal people experience significant peri-natal and infant health challenges including teen pregnancy (9% of Aboriginal children live with teenage mothers as compared to 1% in non-Aboriginal population), fetal alcohol spectrum disorder (estimates of prevalence range from 2.8-9.1/1000 live births as compared to 0.3/1000 live births in the Canadian population) and excess infant mortality from preventable causes including injuries, sudden infant death syndrome (SIDS) and infections (Baldwin, Grossman, Casey, Hollow, Sugarman, Freeman, & Hart, 2002; Luo, Kierans, Wilkins, Liston, Uh, & Kramer, 2004; Luo, Wilkins et. al, 2004, Smith et. al, 2006).

As explained earlier, Aboriginal women experience a multitude of preventable health issues as a result of inequities in the social determinants of health which are a legacy of colonial and neo-colonial policies (NWAC, 2007a). This is manifested in higher incidences of diabetes, tobacco addiction, HIV/AIDS, mental illness, and cervical cancer than non-Aboriginal women and Aboriginal men (Kurtz et. al, 2008; Mann, 2005; NWAC, 2007a). Aboriginal women are also more likely to be treated for addiction and related issues such as fetal alcohol spectrum disorder (Mann, 2005, NWAC, 2007a). Furthermore Aboriginal women encounter a disproportionate amount of spousal and sexual violence. In 2004, the Statistic's Canada General Social Survey (GSS) reported rates of spousal assault more than three times higher amongst Aboriginal women than non-Aboriginal women (NWAC, 2007a). Violence against Aboriginal women is also considerably more serious as Aboriginal women are more likely to need medical attention, take time off of work, and feel that their lives are in danger than non-Aboriginal

women who encounter violence (Brownridge, 2003; NWAC, 2007a; Statistics Canada, 2006). Recently, the Canadian Feminist Alliance for International Action argued in its report “No Progress: No Action” that the Federal government has taken no action, despite active calls for inquiries from non-governmental organizations including Amnesty International, into the numbers of murders and disappearances and the grave social and living circumstances of many Aboriginal women (Canadian Feminist Alliance for International Action, 2010).

Other inequities in the social determinants of health that Aboriginal women encounter include significant levels of poverty; Aboriginal women are twice as likely to live in poverty as non-Aboriginal women a result of individual and institutional discrimination (Browne, 2001, Browne & Smye, 2002, Jacobs, & Williams, 2008, Lenon, 2000, Miko, & Thompson, 2004). Furthermore they encounter significant difficulties obtaining safe and affordable housing, weaker community infrastructure, poor nutrition, barriers to accessing and obtaining higher levels of education, job training, or other socioeconomic opportunities (Casavant, 1999; Jacobs & Williams, 2008; Mann, 2005; NWAC, 2007a). These systemic inequities and pressing health disparities are reflected in Aboriginal women’s access to care. The following section will explore barriers to accessing care experienced by Aboriginal women.

### *Barriers to Accessing Care for Aboriginal Women*

In the literature describing barriers to care for Aboriginal women, two themes appeared to be prominent: lack of supports for female led households; and the enduring legacy of colonialism within health care structures.

*Lack of Supports for Female-Led Households*

Aboriginal families' experiences of accessing care is particularly affected by the large number of female-headed households that occur within this population and the barriers that are specific to the lived experience of Aboriginal women. Aboriginal families are twice as likely to be headed by single mothers as compared to non-Aboriginal families and Aboriginal mothers aged 15-24 are three times as likely to be lone mothers as compared to the general population (Benoit et. al, 2003). Furthermore, Aboriginal female-headed households are more likely to have larger families; thirty-three percent of Aboriginal female-headed households had three or more children while only sixteen percent of non-aboriginal female-headed households did (Harvard-Lavell & Corbiere Lavell, 2006). In an address to the Senate Subcommittee on Population Health, Dr. Andre Lalonde (2008, May 28) the Executive Vice-President of The Society of Obstetricians and Gynaecologists of Canada, noted that Aboriginal mothers are most likely to be affected by poverty;

“If you are a woman...

if you are a single woman...

if you are an aboriginal woman...

if you are a pregnant woman...

...there is a very good chance you will be poor, that your pregnancy will be affected by your poverty, that your child will be poor, and that your child's health will be affected by poverty.”

These mothers face a substantial number of barriers while attempting to access health and social services including poverty, low rates of employment, domestic abuse, mental health issues and previous negative encounters with health and social services (Benoit et. al, 2003). In conclusion, despite single mothers often requiring more supportive care as a result of poverty and the social

realities of being a lone parent, Aboriginal women often have a harder time accessing care because of issues around transportation, childcare, and judgement about their mothering abilities.

*The ongoing 'gaze of the state' on Aboriginal mothers*

Aboriginal mothers have and continue to encounter significant levels of discrimination and oppression from both the government and health care professionals, which impacts their ability to feel safe accessing care for themselves and their children (NWAC, 2007b; Cull, 2006). The failure of healthcare organizations and providers to acknowledge First Nations, Inuit and Métis women's diverse cultural practices negatively influences access to meaningful care, and the opportunity to promote Aboriginal women's' health and sense of mastery as parents (Cull, 2006). Such failings disregard evidence that "maintaining one's ties to the traditional past, to the cultural and symbolic structure of one's culture, imparts a significant sense of power...(such as) a sense of identity, connection, and self-confidence" (Tsosie, 2000, p. 574). The disregard by service providers of cultural teachings and the lived realities of poverty has led to the apprehension of a disproportionate number of Aboriginal children and consequently the fragmentation and trauma of individuals and families. Cull (2006) argues that

"Aboriginal women that come under the scrutiny of child protection agencies are being measured and judged by the standards of the ideal white, middle-class, nuclear family. The more a mother deviates from that norm, the more she is vulnerable to state observation and intervention" (P. 146).

Canada's colonial history has included ongoing attempts to assimilate Aboriginal people into Canadian society. This has had particularly devastating consequences for Aboriginal mothers, who have suffered significantly from state observation and intervention through the

residential school experience, the “60’s scoop<sup>b</sup>”, and presently through the ongoing removal of Aboriginal children from their homes by the Children’s Aid Society (CAS) (Cull, 2006; Stratton, 2007). Cull (2006) argues that

“being an Aboriginal mother involves navigating parenthood under the pervasive, critical glare of the state. The theme that links the state’s past and present treatment of Aboriginal mothers involves the non-empirically supported, implicit notion that Aboriginal women are “unfit” parents in need of state observation, guidance, and at times, intervention” (p. 141).

As a result of this systemic discrimination, Aboriginal children are drastically over-represented in state care. In May of 2005 the Wen:de study, which took place in three provinces in Canada, found that status Indian children were overrepresented within the child welfare system; 0.67% of non-Aboriginal children were in care as compared to 10.23% of status Indian children. That means that an Aboriginal child is fifteen more times likely to be apprehended than a non-Aboriginal child. What is particularly concerning about these figures is that this trend does not appear to be getting better, but worse. Reports by the Federal government indicate that between 1995 and 2001 the number of Aboriginal children being apprehended by the state increased by 71.5% nationally. Overall there are more Aboriginal children in care now than there were at the height of the residential schools (First Nations Child & Family Caring Society of Canada, 2009).

Aboriginal children are also taken into care under different conditions than non-Aboriginal children. Poverty, poor housing, and parental substance use, which are often coined under the term ‘neglect’ are the overriding factors leading to the disproportionate removal of Aboriginal children, while in non-Aboriginal cases domestic violence is the main reason for the

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<sup>b</sup> The sixties scoop represents the beginning of a mass state removal of Aboriginal children and youth from their families, beginning in the sixties, and of which, traces remain today. It involved relocating children away from their homes and communities into distant locations with non-Aboriginal families. Records were not kept of children’s Aboriginal names or places of birth, and therefore if children’s names were changed, there was no way to trace their personal histories. As a result, generations of Aboriginal peoples have lost ties with their family roots (Cull, 2006).

removal of children from their homes (Petrowski, 2009). As a result of such pervasive discrimination, Aboriginal women have expressed concern about service providers' lack of knowledge of traditional parenting practices and negative judgments of their abilities as mothers (Long & Curry, 1998). Equally concerning is that as a consequence of Aboriginal mother's fears of their children being taken away, Aboriginal women may actually delay accessing health care in a timely manner. This may be particularly true for women with substance abuse or mental health issues who in fact, should be receiving more supports (Prentice, 2004).

*The enduring legacy of colonialism within health care structures*

Inequities in access to care experienced by Aboriginal peoples can be attributed in great part to the impact of the colonial mentality on the design and delivery of health care structures. The health care setting, the way in which services are provided, and the attitudes of healthcare professionals are some of the ways in which the colonialist mentality continues to be perpetuated and create barriers for Aboriginal women and their families attempting to access care (Lenon, 2000). Anderson and Reimer Kirkham (2002) describe how

“the gendering and racializing of the health system has an impact on healthcare policies that are tailored to the Eurocentric cultural beliefs on health and illness of the ‘two founding peoples’-thus silencing the voices of Aboriginals, Métis and people of the South in the shaping of the Canadian healthcare landscape” (cited in Racine, 2003, p. 93).

This quote draws attention to the lack of space that is made for Aboriginal women's voices within health care policy and health care service delivery. Fiske & Browne (2008) note that “whether discredited by allusions to adverse lifestyle choices, cultural differences, entitlements, or by a combination of all three, Aboriginal women find themselves displaced as citizens within health care policies that resonate with popular perceptions and nationalist politics” (p. 30). They argue that rather than acknowledging that Aboriginal women are acting out their rights as

Aboriginal citizens by attempting to access the services owed to them by the government, Aboriginal women are defined as freeloading subjects who are unfairly benefiting on the backs of the personal wealth of Canadian citizens. They go on to note that “when the medical subject is redefined as a racial subject and her role as a citizen is misrepresented as a freeloading subject of the state, her voice in policy making is displaced and her credibility and commitment to the country as a whole are called into question” (Fiske & Browne, 2008, p. 30). This quote gives voice to the systemic nature of the discrimination and silencing of Aboriginal women’s voice in the health care system.

In their study of on-reserve First Nations women’s encounters with mainstream health services, Browne et. al (2000) reported that Aboriginal women accessing care felt dismissed and “not listened to”, experienced discriminatory attitudes, and felt that there was a lack of understanding by health care professionals of their personal circumstances. Another study in Vancouver done by Kurtz et. al (2008) explored the barriers Aboriginal people encountered while accessing care. The study found that Aboriginal people’s encounters with mainstream services were marked by racism, discrimination, and communication barriers. In contrast, while accessing Aboriginal-run health centres, participants identified these centres as being safe places where they felt supported and where the care providers were Aboriginal.

Tait (1999) found in her Montreal study that Aboriginal women encountered discriminatory attitudes from social workers while attempting to use their status card to obtain services, and that there was a lack of services available to women who were actively using substances. In another study taking place in Vancouver, Benoit et. al (2003) found that Aboriginal women experienced a lack of anonymity or security while accessing care, experienced a lack of culturally relevant services, and felt the absence of health care



professionals who understood the historical backdrop of Aboriginal women's lives. However they also noted that within urban Aboriginal Health Centres, Aboriginal women appreciated supportive and non-judgemental attitudes, an informal service delivery model, and non-hierarchical relationships between staff and clients, all of which they felt reflected traditional Aboriginal values.

All of these studies reported similar findings about the prevalence of racism and discrimination in Aboriginal women's encounters with mainstream services that often made them feel unsafe or uncomfortable accessing care. Those studies which reported on Aboriginal women's encounters with Aboriginal health centres noted that women felt safe and described positive encounters at these centres (Benoit et. al, 2003; Kurtz et. al, 2008). These findings were a major strength of the literature as they were verified across a number of studies and indicated that there was a need to understand more about the nature of the therapeutic encounter in impacting Aboriginal women's access to care. Alongside this, a number of studies also reported issues of discrimination and racism and poverty (Benoit et. al, 2003; Browne et. al, 2000; Kurtz et. al, 2008; Tait, 1999). By incorporating an intersectionality paradigm, this study hopes to more closely examine how different oppressions women faced, including racism and classism, interacted in their encounters, specifically by looking at how nurses and other service providers' perceptions of women's interrelated identities contributed to their care experiences. As both Kurtz et al (2008) and Benoit et. al (2003) noted, while Aboriginal women felt safer accessing Aboriginal health centres, there was not a lot of detail given as to how the design of health spaces influenced women's perception of safe care. This is an important gap in understanding how health care organizations can be designed in a manner which promotes Aboriginal women's sense of safety.

Overall, the literature overwhelmingly indicated that Aboriginal women face significant disparities in access to the social determinants of health which has contributed to considerable health inequities as compared to Aboriginal men and non-Aboriginal women. As well, Aboriginal women face a number of complex barriers to accessing care for themselves and their families, including a lack of support for female-led households alongside ongoing discrimination and oppression of Aboriginal mothering by the state, and accessing a health care system that is not inclusive of Aboriginal women's voices. There continues to be a need to better understand what service providers, organizations, and social structures can do to help reduce these inequities. This study hopes to contribute to closing this gap by explicating the intersecting factors Aboriginal women described as contributing to their care encounters, and particularly examining the implications of how Aboriginal women's identities are perceived within care encounters. The following section will describe the implications that this type of study has for nursing and the potential benefits of using an intersectionality paradigm within nursing.

### Implications for Nursing

The literature clearly indicates that Aboriginal women continue to feel unsafe accessing care as a result of service providers' racist and discriminatory attitudes, and a health care environment that perpetuates and sustains these attitudes and behaviours. This is a significant concern for the nursing profession, which plays an important role in helping Aboriginal women access care.

Within the nursing profession there continues to be a need for increased awareness of the importance of acknowledging one's own cultural and social location and the implications that these have for the therapeutic relationship. During our nursing education, we are socially

constructed to be “a nurse”, and thereby provided with the guidelines of what is considered to be ‘good’ or ‘evidence-based’ care. However, during the education process nurses may or may not be given the tools or necessary attitudes needed to take individual identities, particularly marginalized identities, into account when considering how care should be provided (Blackford, 2003). These practices are considered “culturally unsafe” and “disempower the cultural identity and well being of an individual” (National Aboriginal Health Organization (NAHO), 2007).

Cultural safety involves the recognition that each individual has a cultural identity and that in order to provide safe care, one must recognize the “social, economic and political positioning of certain groups within society” (Browne & Smye, 2002, p. 46; Hart-Wasekeesikaw; 2009). Pauly et. al (2009) quote MacKinnon as proposing that “access refers not only to the availability of required services but also to how the services are delivered at point of care (e.g., cultural competence of health-care providers). These inequities play an important role in creating poorer health outcomes.” (p. 119). Inequities in access to care cannot be accounted for solely on the individual level but must be addressed through a widespread examination of the discourses of oppression and discrimination that shape health care policies and delivery and thereby reduce access for certain marginalized populations (Pauly et. al, 2009). The cultural competence of a nurse, therefore, can not only be accounted for at the individual level but must also be addressed at a larger systemic level by addressing healthcare professional’s education and the design and delivery of health care services. Cultural safety thereby also becomes

“concerned with fostering an understanding of the relationship between minority status and health status as a way of changing nurses’ attitudes from those which continue to support current dominant practices and systems of health care to those which are more supportive of the health of minority groups” (Browne & Smye, 2002, p. 47).

Acknowledging “cultural safety” as an important concept in delivering health care to Aboriginal women and their families provides nurses the opportunity to address inequities in health, specifically in relation to issues of access and power in order to avoid reproducing or recreating traumas upon Aboriginal people (Browne & Smye, 2002).

Consequently, this study will be potentially beneficial for nursing in two ways. First, the use of an intersectionality paradigm, which is a relatively recent concept to nursing and has had only minor uptake, offers nurses the opportunity to deconstruct the power dynamics that structure nursing practice, research, education and policy. This is an important paradigm shift that must occur in order for nursing to be considered “culturally safe” and to reach and meet the needs of marginalized populations. In doing so, the nursing profession will increase their understanding of the multiple contextual factors which impact Aboriginal women’s and other marginalized population’s health.

Second, using this paradigm offers nursing the opportunity to explore in greater depth the multiple factors which impact why Aboriginal women do or do not feel safe accessing services. An intersectionality paradigm offers nursing the opportunity to explore the interrelated micro and macro aspects of different concepts and experiences such as access, which has the potential for the discovery of new practical solutions to nursing issues. As well, by exploring issues of identity and how service provider’s perceptions of Aboriginal women’s identity can influence their access to care, nurses can become more self reflective of how their identity and perceptions of patients’ identities influences access to good care. In using these approaches and concepts within research, nursing may be able to contribute new knowledge that will prove instrumental in reducing the health disparities evident among Aboriginal women and other marginalized populations.

### Locating Myself within the Research

Many times as researchers we like to acknowledge ourselves as the experts in our line of work, that we have a specialized area of expertise on which we are consulted. As I have delved deeper into this topic, I have realized more and more how little I really know. What I can offer is the stories that have been shared with me and my personal learning experience in the hopes that someone else will appreciate the significance of these for their own learning. Therefore before beginning, I would like to reiterate my gratitude for the opportunity to have met the individuals whose stories are told here. These stories were written with my respect and I am honoured to have had them shared with me.

As a researcher exploring the implications of identity on Aboriginal women's experiences of accessing care, it is important and necessary to situate myself within the research project, to frame my 'paradigm of inquiry' (Anderson, 2000). My identity impacts my research; it plays a part in my choice to do qualitative research and in my theoretical perspective. As an active participant in the research process my identity also impacts the quality and validity of the research. I played various roles in the research; as an interviewer in the initial interviews, and in an active interpretive role through my analysis of the participant's stories. My 'self' and who I am and the multiplicities of my identity has played a role in me being interested in this work, in my relations and engagement with the Aboriginal community, in my ability to carry out this research, and in how I choose to present the stories I have been told.

By describing myself and in situating myself within the research, there is some part of me that fears 'losing face'. Part of it comes from a fear of not being experienced enough as a researcher or academic to use and fully understand such a complicated theoretical framework or

to present the participant's stories in a manner that truly gives voice to their stories. The other part of it comes from a social reality in that I have been schooled in a system where researchers often remain faceless. The researcher is assumed to be well-educated, middle-class, Caucasian, male and ultimately in a high position of power, both in their place within society but also in their role within the research. However I choose to identify myself because it is important in explaining how I have come to my conclusions. More importantly, considering how participants identified having to constantly defend their identity while accessing care, I think it is easily justified that I should have to explicitly point out my identity, my position in relation to the research, and how I have come about to my conclusions.

Recently as part of a reflective exercise I was asked to identify who I was and the parts of me that I bring forward with me into the work that I do. I am a partner, a daughter, a sister, a friend, a co-worker, a nurse, a graduate student, in my mid-twenties, a Canadian of Dutch-western European descent, and I have a rural background. These are parts of me; but they are formed as a result of relations with others and with societal institutions. I have brought these parts forward with me as I have established relationships with the Aboriginal community and with my research partners. I have come to understand that these identities frame, and sometimes cloud, my perspective. Being a nurse, and particularly being a white nurse, while conducting this research has forced me to reflect on my own location and how I can help make myself more aware of the power dynamics within care encounters. I often find I am "catching myself" in which I take a double look at where my perceptions have come from, or why I am approaching a patient a certain way. Explicitly stating my identity is also a way of asking: how can we do care in a better way when working with people with different identities from our own? How do I position myself within the care encounter? How do my patients see me? How can I bring all the

best parts of myself forward in the care encounter to help people receive good care while respecting and acknowledging the personal gifts, needs and desires of the person for whom I am caring? These are questions that I continue to reflect on.

It is my understanding as a nurse and as a researcher that in order to provide good care or do research with the goal of improving care, I must come from a place of understanding and respect for the individuals that I encounter. This includes making a personal effort to try to increase my understanding of their worldview, the cultural group whom they associate with, the roles and identities they value about them self, and an understanding of how they view health and achieving personal wellness. My goal in nursing and in doing research with Aboriginal women is to be as Anderson (2000) writes “inclusive of the voices that will interrupt the taken-for-granted structures inscribed upon us through relations of power” (p. 225).

Therefore my involvement and interest in this type of research and this particular research project comes from my understanding that as a nurse I have a professional responsibility to respond to the needs of Aboriginal women while accessing care and to attend to the power dynamics that are present. I also believe that access to health care for marginalized populations’ presents as a social justice issue that requires greater attention. I want to use my position as a researcher to understand Aboriginal women’s experiences but I do this in order to positively impact my nursing practice and to share what I have learned with other nurses. Therefore the results of this research have been written in such a way as to share what the women have said and make explicit my interpretations. The following section will provide a brief background on my involvement with the local Aboriginal community and relevant nursing experience in order to help the reader understand how I came to be involved in doing this type of work and how my perceptions have been changed and continue to be challenged as a result.

*My Involvement with the Local Aboriginal Community*

A very important aspect of doing work with Aboriginal communities is the development and maintenance of relationships; as one leader in the community said to me when I first began doing this work, “you’re not going to get anywhere without engaging in relationships.” My experience has been that this has been both the most challenging aspect of engaging in research with Aboriginal people as well as the most rewarding part.

In the year previous to my involvement in the original research study, I had become actively engaged with the local Aboriginal community and particularly one of the Aboriginal health organizations involved in our study. I worked alongside their Aboriginal Homeless Outreach Team and developed an evaluation report that focused on how this team promoted resiliency amongst First Nations, Inuit and Métis individuals who were street-involved. For eight months, I participated in a weekly lunch that was designed to promote a sense of community, improve homeless individuals’ access to care, and reconnect them with their culture.

Every Friday, the Outreach team held a lunch of traditional food at a local Community Health Centre. The whole Outreach team was present so participants were able to access a nurse practitioner for primary care needs, as well as be referred to other appropriate services. A Grandmother was also an important team member who engaged in culturally meaningful crafts and activities with participants and who was present to share traditional stories and teachings if participants were interested in learning. Attending this event every week was an important part of my development, as it provided me with an understanding of people’s lived experiences and a different cultural context and method by which care could be delivered successfully. More



importantly, through this work I developed relationships with community members, which have been a tremendous source of guidance and knowledge along this journey.

Through my role in the primary research project (described below) I attended a number of community events that helped me gain an understanding of the dynamics of the local community, the context within which Aboriginal organizations function, and an opportunity to engage in celebration. Some examples were a Halloween dance for families and children, a gala to fundraise for a local Aboriginal organization, and a celebration at the local university in honour of two Aboriginal students entering the faculty of medicine. These were both formal and informal events in which I was witness to the incredible amount of diversity within the local community as well as the sense of openness and invitation extended to members outside of the Aboriginal community. Through these experiences I learned about the importance of focusing on the strength and resilience of individuals in light of their communities, the strength gathered in celebration, and the importance of working with each other to create something stronger and better together. A powerful image that has stayed with me is dancing in the circle at the Halloween dance and watching the different movements, the bright colours of our costumes, the various family make-ups, the multiple ethnicities that were present, but most importantly the way that we all moved together to create something that was very strong and powerful and to which everyone belonged.

I have also been fortunate to engage and learn from local community leaders and Elders. These have been wonderful, enriching experiences which taught me about the teachings of humility, wisdom and respect. One such experience was on a cold winter's day when I was supposed to drive my car across town to an Elder's home. My car would not start so I called him and he offered to come pick me up at the bus stop. When I arrived at his house, he had also made

me muffins and coffee. We had a wonderful discussion as he shared his knowledge of the history of Aboriginal peoples as well as his understanding of being a member of the Turtle clan.

I also had the opportunity to work with a really wonderful, intelligent, and funny executive director from the local Aboriginal community health centre with whom I have presented with at a number of conferences. I remember showing up to one of our meetings with a long list of references I had collected on Aboriginal health issues. She looked me in the eye and told me, “you don’t need those. We already know that.” This was a reminder to me of the importance of speaking with people who have lived experience and of respecting and honouring their knowledge.

### *Nursing Encounters*

I think it is also important to acknowledge that outside of my academic work, I continue to work part-time as a registered nurse, which impacts my lens as a researcher considerably. As a nurse I have had very rich encounters with Aboriginal people and with mainstream health care provider’s understandings and reactions to working with and providing care to Aboriginal people. These experiences have had mixed emotions tied to them but have impacted my perceptions of issues of access considerably.

In the year prior to beginning my masters, I worked as a mental health nurse with people suffering from treatment-refractory schizophrenia. During this time I was the primary nurse for a Cree man who suffered from severe psychotic breaks. My relationship with him profoundly marked my understanding of providing culturally safe care to Aboriginal people. During the year that I worked alongside him, I had the opportunity to learn more about his Cree culture and engaged with him and his grandmother to provide him care. I also learned about the difficulties

in helping him to obtain care that would reflect these cultural teachings. When I spoke with our team about a cultural healing event that I thought might be of some benefit for him in his recovery journey, the team quickly turned down this idea as irrelevant and possibly damaging. His care was completely encapsulated by the biomedical model with no reflection of his culture or background within his care plan. I wanted to support this client in engaging with his culture and his community in order to help him progress in his healing, but was strongly discouraged and censured by the healthcare team.

At the present time, I nurse with a local not-for-profit organization that provides health care to people who are homeless and street-involved. Aboriginal people are disproportionately represented on Canadian streets, and some researchers have estimated that Aboriginal people constitute upwards of forty percent of Canada's homeless population (Social Data Research Ltd., 2005). As a result of this work, I am continuously reflecting on ways to engage with marginalized Aboriginal individuals in order to help improve their access to care. The following section describes how I became involved in research that explores how to improve access to preventive services for Aboriginal families living in an urban context.

### Developing the Research Study

The following section describes my involvement in the primary research study, *“Improving Access to Preventive Health and Social Services for Pregnant and Parenting Aboriginal Families living in an Urban Setting”* (which for the purposes of clarity I have shortened to the *“Improving Access Project”*). As a result of my work in the primary study and the recognition that there was an opportunity to further examine the data, this research study, *“Exploring Aboriginal Women's Experiences of Accessing Care”* was developed.

### *The Primary Research Study*

I have been working as a research assistant on the *Improving Access* study over the past twenty months. This study is led by Dr. Dawn Smith from the School of Nursing at the University of Ottawa and is funded by the Canadian Institute of Health Research (CIHR). The goal of this study is to improve access to health and social services for pregnant and parenting urban Aboriginal families with children under the age of six.

### *Methodology*

The *Improving Access* study uses a postcolonial, participatory action research approach to allow for collaborative engagement between researchers, organizational decision-makers and participants and includes concepts of social justice, sustainability and fostering increased levels of consciousness (Mill, Allen, & Morrow, 2001). Participatory research involves continuing cycles of problem posing, dialogue and action/reflection in which knowledge is constructed, validated, shared and used by the community (Dickson, 2000). While doing research with Aboriginal populations, this approach to research is especially important related to previous negative encounters with researchers and academia in which research was done “on” participants, rather than “with” participants. The *Improving Access* study incorporated a participatory approach by having Aboriginal partners involved in framing the research questions, developing and refining study design, selecting methods, developing the budget and timeline. As well, the Advisory Board which incorporated Aboriginal leaders, organizational leaders and family members, oversaw project development and dissemination.

*Ethics*

Every effort was made during the design of the *Improving Access* study to incorporate ethical principles including respect, partnership, healing and education. A consent form was designed to ensure the safety and support of participants who chose to engage in the interview process (See Appendix A). Sensitivity was of the utmost importance in attending to the power dynamics during research encounters, as well as to the language that was used in the consent form, in conducting the interviews, and in analyzing and reporting the results. Participants were made aware that professionals with whom they were familiar with from the participating organizations were available for debriefing sessions after completing the interviews. As well, discussion about ownership, control, access and possession of data and research products is a continuing process with the Aboriginal organizations involved in the research project.

The *Improving Access* study obtained ethical approval from the University of Ottawa Research Ethics Board, two Aboriginal health organizations, two mainstream community health centers utilized by the Aboriginal community, and the local public health unit. These organizations represent a variety of different approaches for the delivery of health care to Aboriginal families and represent various sectors, organizational policies and practices, and provider team compositions, and were purposively selected by the primary investigator based on their provision of preventive early childhood services.

Leaders from these organizations comprise a research Advisory Group, which has helped the research team make decisions about the design and methodology of the study, as well as form a community research agreement. This Advisory Group has played an imperative role by working with the research team to keep the study relevant to the local community. It has also

been an important source of knowledge about culturally appropriate ways of conducting research and has helped the research team carry out the study in an ethically and culturally safe manner. For example, we consulted the Advisory Group about what would be an appropriate way of relaying our appreciation to participants for engaging in our study.

### *Setting*

The *Improving Access* research study took place in a large metropolitan centre in Canada. This metropolitan centre has one of the largest and fastest-growing urban Aboriginal populations in Canada; therefore access to health services was recognized as an urgent issue that needed to be addressed.

### *Design*

The *Improving Access* project was designed as a mixed methods study with the initial phase involving qualitative interviews. Individual stakeholders were considered to be Aboriginal parents and Elders, leaders (e.g. Executive Directors; program managers) and providers (e.g. nurses, early childhood educators, social workers, lay support workers, family physicians) recognized for their knowledge and skills relevant to care for Aboriginal parents. I was actively involved in conducting interviews with service providers from Aboriginal health and social service organizations as well as Aboriginal family members. Initially key informants were selected from each of the partner agencies based on their experiences and perspectives on care for Aboriginal families. Using network sampling methods, potential participants were then contacted and sent a letter of invitation to participate in their choice of individual interview or focus group in a location of their choosing. Family members were given \$25.00 to compensate them for costs and inconveniences of participations (e.g. travel and childcare costs). Following

informed consent, interviews of 45-60 minutes were completed by a trained interviewer using a semi-structured interview guideline. Interviews were tape recorded and transcribed.

### *Sample*

Thirty-nine interviews were conducted with service providers and Aboriginal families. As can be seen in the table below, the majority of the sample was female and self-identified as being Aboriginal. Of those who did not identify as being Aboriginal, most of the community members and leaders were married to someone who self-identified as being Aboriginal or had adopted an Aboriginal child. The majority of our community members and service providers had obtained some level of post-secondary education ( $n=30$ ). As well, most of the service providers, both Aboriginal and non-Aboriginal, had been working at Aboriginal organizations for more than five years ( $n=18$ ). The following table describes the number of leaders, community members and service providers who identified as Aboriginal. Of all of those who identified as being Aboriginal, 6 identified as being Inuit, 17 as being First Nations, and 3 identified as Métis.

<b>Table 1: Description of <i>Improving Access</i> Study Sample</b>					
	Aboriginal	Non- Aboriginal	Gender Male/Female		Years of Experience (Average)
Leaders & Elders	4	1	1	4	All had worked at least 5-10 years in Aboriginal health
Providers	14	10	2	22	72% had worked five years or more in Aboriginal health
Community Members	8	2	2	8	N/A

The interview questions focused on gaining an understanding of a) who are Aboriginal people living in the urban setting, b) what influences their experiences of accessing care and c) what are the larger systemic level factors that influence their ability to access good care. A list of the original research questions, one for service providers and leaders and one for community members, can be found in Appendix B. At the present time, this research study is in the data analysis stage, of which I continue to be actively involved in.

*Developing the ‘Exploring Urban Aboriginal Women’s Experiences of Accessing Care’  
Research Project*

As a result of my relationships with the local Aboriginal community and my involvement in conducting the research interviews, I began to plan my thesis research. Service providers I spoke with talked about the high numbers of single mothers accessing Aboriginal health centers and the particular needs of these women;



*Well we're mostly talking about families that don't have fathers. And you know we have the highest rate of young single moms without a second parent in this country. And that is very evident. I mean we are the microcosm of exactly what's happening in this country, it happens here. You want to see the amount of moms and their babies and the amount of mothers and fathers and their babies, there's an extreme end (Participant #2, P. 9).*

Another important influence that contributed to development of this thesis was the number of times I heard Aboriginal participants state the importance of having healthy parents in order to have healthy children;

*You know, it's almost one and the same. You know, in order to have good childcare you have to have good parenting skills so by supporting the parents that way and offering workshops as well as the other stuff we make a strong family which in turn helps the children get off to a running start (Participant 15, P. 5).*

Through my involvement with the *Improving Access* study I came to understand that there were a significant number of single Aboriginal mothers accessing care centres who encountered considerable and unique barriers as a result of layers of discrimination and oppression. The individual stories that I heard often focused on how participants felt that health care professionals made prejudgements about their care based on fixed notions of race, culture, gender and class identities. I became particularly interested in the barriers Aboriginal women encountered while attempting to access care and in understanding how the intersecting 'locations' from which Aboriginal women speak, including race, gender and socioeconomic status, impact these experiences (Racine, 2003; Shield, 2008). As a result and with consultation with community leaders and Advisory Board members, I designed a secondary study to explore the specific needs of Aboriginal woman and mothers when accessing care for themselves and their children and to explore how identity featured in their care encounters.

It is important to note that in this study "*Exploring Urban Aboriginal Women's Experiences of Accessing Care*" I have chosen to incorporate a very broad view of care. The "*Improving Access*" study focused on Aboriginal families' experiences of accessing preventive

care. However, participants' stories incorporated multiple locations of care including acute, tertiary and primary as well as preventive and social service providers including lawyers, Children's Aid Services and police officers. What I came to understand is that women's encounters with one organization affected their feelings about accessing other services and other care institutions and may also affect how quickly they access services or where they go for help the next time they are in need. Participants often described service organizations as acting on a continuum with one another, and that the way in which women were treated within one organization could not be separated from the possibility of how they would be treated in another mainstream institution. Therefore, whether or not Aboriginal women were accessing institutions whose explicit mandate was to promote health or provide health care was irrelevant; what mattered for the women was whether they felt that they were being cared for and whether these experiences affected where and when they would access care in the future.

The following section examines the theoretical underpinnings of the *Aboriginal Women's Experiences*-secondary analysis study, an intersectionality paradigm.

### *Analytical Lens-Intersectionality*

Intersectionality arises from postcolonial feminism and extends its theoretical lens by examining the fluid mechanisms of power involved in interlocking oppressions and privileges (Reimer Kirkham & Anderson, 2002). An intersectionality paradigm posits that

“people's experiences are simultaneously the product of how they identify themselves, how they are seen by others, and how they interact with others. Because intersectionality theory seeks to understand how these aspects of self and society interact, it challenges theories and practices that privilege single categories, such as race or gender, in explanations of human experience, including health” (Chow, Pederson, Haworth-Brockman & Bernier, 2009, p. 163).

An intersectionality paradigm is particularly important for understanding and framing Aboriginal women's stories, whose experiences have been shaped by the intersecting forces of colonization, removal from traditional land bases, forced assimilation, residential schools, patriarchy and the ongoing removal of Aboriginal children from their homes.

Consequently, Aboriginal women's experiences need to be understood within the context of their own social, political, historical, economic, and geographical contexts. As Anderson and McCann (2002) note, "not all women share similar struggles or experiences; historical positioning, constructions of 'race' and racialisation, and class relations all intersect to become critical elements in any analysis" (p. 16-17). This study hopes to contribute to our understanding of how the historical and political events which shape Aboriginal women's lives interrelate with issues of gender, cultural identity, ethnicity, class, sexuality, age, 'ableness', etc. to contribute to Aboriginal women's experiences of accessing care. Through the use of an intersectionality paradigm, attention will be explicitly given to how participants make sense of their health care encounters in terms of these discourses (Lloyd, 2005). This approach towards Aboriginal women's experiences of accessing care holds promise as a way in which to portray Aboriginal women's experiences within the contexts which they live, in order to resist status quo descriptions which deny Aboriginal women their own story within the research narrative (Guruge & Khanlou, 2004).

Aspects of Aboriginal women's identity as described above are embedded in power relations that are features of basic human interactions. Such power relations are dynamic and they are constantly changing within human interactions so as to continuously reinforce and/or weaken one another (Olsivik, 2007). Bhabha (1994) draws awareness to the social and political

importance of understanding these multiple contextual factors that shape Aboriginal women's lives and their experiences of accessing care. He argues that

“the move away from the singularities of ‘class’ or ‘gender’ as primary conceptual and organizational categories, has resulted in an awareness of the subject positions-of race, gender, generation, institutional location, geopolitical locale, sexual orientation- that inhabit any claim to identity in the modern world. What is theoretically innovative, and politically crucial, is the need to think beyond narratives of originary and initial subjectivities and to focus on those moments or processes that are produced in the articulation of cultural differences. These ‘in-between’ spaces provide the terrain for elaborating strategies of selfhood-singular or communal-that initiate new signs of identity, and innovative sites of collaboration, and contestation, in the act of defining the idea of society itself”(p. 2).

These ‘in-between’ spaces prove important in examining as Dhamoon and Hankivsky (2008) describe the “complex, irreducible, varied and variable effects which ensue when multiple axes of differentiation-economic, political, cultural, psychic, subjective and experiential-intersect in historically specific contexts” (p. 2). By coming to an understanding of these power discourses, practical solutions of how to change these structures can be design and implemented (Hogey, Turritin, & Das Gupta, 2007).

Within the health care system, setting and interaction, intersectionality may also allude to the multiple sources that influence one's physical, spiritual and mental well-being. By recognizing that influences come together in distinct ways and lead to distinct health outcomes for individuals/groups, an intersectionality paradigm provides context to health experiences and draws attention to the dynamic interplay between the individual, family, community, health organizations and the larger social structures and systems (Guruge & Khanlou, 2004). Because the original study focused on both Aboriginal and non-Aboriginal health and social service centers, an intersectionality paradigm is also useful in examining how different care places and care relationships also contribute to women's encounters and the way in which they are

perceived. The following section describes the incorporation of an intersectionality paradigm into the research methodology and design.

### *Methodology*

The following section describes the research design, sampling, gendered racism analysis, thematic analysis and verification by community members.

*Research Design.* *‘Exploring Aboriginal Women’s Experiences of Accessing Care’* is a secondary analysis of data from the *Improving Access* research study. Hakim (1982) described a secondary analysis as “any further analysis of an existing dataset which presents interpretations, conclusions or knowledge additional to, or different from, those presented in the first report on the inquiry as a whole and its main results” (p. 1). Secondary analyses may include studies that are more dense or comprehensive, focused on a particular sub-topic, or social group, or which pay closer attention to certain policy issues and questions. For the purposes of this study the secondary analysis focused on a particular social group; Aboriginal women, and used a different theoretical perspective, intersectionality, to explore their experiences of accessing care.

Many researchers may argue against the validity of a secondary analysis as a way of completing qualitative research as it erases the ability for researchers to “study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meanings people bring to them” (Creswall, 2003, p. 15). In this particular instance, however, two important distinctions mitigate this concern. First, the purpose and design of the study was identified in collaboration with community members and participants, based on early impressions in a participatory research study. Participants and community leaders clearly identified that the particular experiences of Aboriginal women are central to understanding issues of access

experienced by pregnant and parenting Aboriginal families living in urban contexts. As such, development of a secondary line of inquiry is in keeping with the philosophical and practical purposes of participatory research. Second, a secondary analysis was done on data which I was involved in originally collecting. I was firmly entrenched in the original research study; I did the majority of the interviews and as such, interacted with participants in their “natural settings”. Therefore it is suffice to say that I did have a good “feel” for the complexity of the questions that were asked. In this instance the secondary analysis is congruent with the emergent nature of participatory research, and serves to validate the depth and complexity involved in the primary research study.

Support was obtained for the secondary analysis from the two community health centres, a public health unit and one of the aboriginal health centres involved in the original research project. The other Aboriginal health centre chose not to participate as they were not sure how this research would be of benefit to their organization. As a result, their transcripts were not included in the analysis, limiting the analysis to twenty-one participants. Ethical approval for this study was obtained from the University of Ottawa (see Appendix C) and funding was obtained through the Anisnabe Kekendazone Ottawa NEAHR centre.

As was stated earlier, the primary research study used a participatory action, community-based research methodology, which continued to be used as an underlying framework to conduct this research project. Participatory action works well with a postcolonial feminist perspective because it invokes that “women of Colour whose voices have been silenced-must be involved in the social production of knowledge that reflects their socio-historical location” (Anderson, 2000, p. 226). The participatory action framework was incorporated into this study by involving female Aboriginal leaders in the design, including female Aboriginal leaders, grandmothers, mothers

and service providers in the verification meeting, and in deciding the language that would be used to share the results. Key informants from among participants were consulted with on a regular basis to debrief on issues arising during the analysis and writing, and to provide feedback and improve clarity of the analysis and writing prior to submission for publication.

*Sampling.* Twenty-one participants were included in the secondary analysis. Table 2 summarizes the sample by self-defined ethnic identity, gender and role in Aboriginal service provision.

Table 2: Description of *Exploring Aboriginal Women's Experiences of Accessing Care* Study

Sample

Ethnicity	Gender		Roles			Total
	Male	Female	Leaders	Service Providers	Family Members	
First Nations	2	7	1	7	1	9
Inuit	2	2	0	1	3	4
Métis	0	0	0	0	0	0
Non-Aboriginal	0	8	1	5	2	8
Total	4	17	2	13	6	21

As can be seen in the chart, the majority of the sample was female and First Nations. A limitation was that there were no Métis participants recruited despite approaching the major Métis organization in the research setting to try and increase Métis participation. Participants came from rural, reserve and urban areas, were of different ages, had different levels of engagement with the local Aboriginal community, and had had many different care experiences.

Although there are a significant number of non-Aboriginal participants, it is important to note that a number of women, both service providers and family members, who did not identify as being Aboriginal, identified having children who were Aboriginal. This was the result of adoption of an Aboriginal child or of marriage to someone who identified themselves as Aboriginal. I refer to this as “fluidity of identity” and discuss this more in the results in Chapter 2, as well as how the demographic sheet we gave imposed certain categories of identity onto Aboriginal people living in an urban context without taking into consideration the ways in which they would want to describe themselves.

While immersed in the research data, transcripts and stories were purposely selected for inclusion in the analysis. Five transcripts were selected for ‘richness,’ e.g. those which plainly acknowledge that First Nations, Inuit and Métis women have particular issues and experiences while accessing care or those transcripts which gave voice to women’s stories and the implications of women’s interrelated identities in such experiences.

*Data analysis.* After choosing the five main transcripts Essed’s (n.d.) ‘gendered racism’ analysis was used to help “identify how intertwining systems of domination are expressed and experienced” in the everyday lives of Aboriginal women. Essed (n.d.) developed this analysis in two cross-sectional studies of gendered everyday racism, in which she examined “how everyday racism operates through and interferes with gender and other systems of oppression. As a concept ‘everyday racism’ has been useful in showing that systemic racism is reproduced largely through routine and taken-for-granted practices and procedures in everyday life.” What is particularly important about Essed’s concept, which has particular implications for its use in nursing, is that it opposes the idea of racism as an individual problem. Rather, by focusing on recurring ‘ordinary’ events, gendered everyday racism focuses on the social attitudes and



behaviours which structure larger systems such as health care (Essed, 1991). Essed (1991) notes, “the notion of everyday racism is defined in terms of practices prevalent in a given system. Not that practices are not just ‘acts’ but also include complex relations of acts and (attributed) attitudes” (p.3).

The term ‘gendered racism’ initially came about as a result of second wave feminism, in which it was brought to the attention of mainstream feminists (a white middle-class construction) that what was being described as women’s issues (such as the vote and the right to work outside the home) were not the most pressing issues for a majority of women (Essed, 1991). Women who were poor, who experienced systemic racism, or encountered large amounts of violence did not identify with mainstream feminism and their “women’s issues”. It became apparent that dominant discourses of feminism had reiterated some of the same injustices onto racialized, poor women that had been bestowed upon them by the dominant male image. By claiming the ‘white, middle-class’ experience as the dominant ideology from which to frame the needs of women, feminism ignored the needs and the multiple meanings of feminism as understood by millions of different women coming from various social and cultural contexts. Among the most deeply marginalized and ignored among colonized societies have been the needs of Aboriginal women.

As a result of this major overlook within feminism, the concept of ‘gendered racism’ came about to make apparent how women of different races and ethnic backgrounds have different experiences because of their intertwined identities not only as women, but also as coloured women (Essed, 1991.; hooks, 1984). The term has expanded to also incorporate multiple identities that may perpetuate inequities as experienced by women including socioeconomic status, age, ableness, sexuality, etc. What is important to note is that by using this method of analysis I hope to come to an understanding of when and possibly why these different

identities come into play when Aboriginal women attempt to access care in urban contexts. For instance, during the *Improving Access* study our research team came to understand that it seemed that there was a particularly insidious form of racism that Aboriginal women experienced. Participants felt that being identified as an Aboriginal person was much worse than being identified as a ‘woman of colour’ for instance. These sorts of experiences and understandings are important and need to be considered in the analysis to come to an understanding of how they shape women’s experiences and how they have arisen.

In order to examine these complex and interrelated factors, a ‘gendered racism’ analysis incorporates seven components which are then broken down into further units of analysis. A visual chart of Essed’s (1991) gendered racism analysis can be found in Appendix D with an example of how it was used in Appendix E. The seven components are:

*Situation: what has occurred?* This is a brief description of a particular incident in time; in this research project, situations revolve around First Nations, Métis and Inuit women’s experiences of accessing health care, social services and/or support. It will also include particulars such as how these women identify themselves and what services they are accessing (mainstream vs. Aboriginal).

*Relation to the research question:* This component was included by the author to keep the analysis focused on issues of access as particularly experienced by Aboriginal women, and to ensure that it remained practically oriented.

*Context: Involves examining who was involved, where, and when the situation took place.* This is probably the most important and in-depth component of the analysis as it involves closely examining the situation and the ‘layered’ identities involved. What is involved in the situation?

Does it take place in a mainstream health organization or an Aboriginal health centre? How is the centre funded and what are the implications? Are there health care professionals involved? Are they male or female? Who is the Aboriginal woman involved? What particular components of her identity, both her understanding and the health care professional/organizations perception of her identity, are influential in this situation? This particular component of the analysis helps draw attention to the power dynamics of care encounters.

*Complication: Relation to Outcome of Care:* The complication is the turn of events, which Essed (1991) coined as “the unacceptable”, or what went wrong in the situation. This part of the analysis examines what occurred in the context of the care situation that affected the woman’s ability to get the care she needed at that particular time. The “unacceptable” is what was wrong or unjust about the care situation from either the perspective of the Aboriginal women in the story, the perspective of the Aboriginal individual telling the story about Aboriginal women’s experiences of accessing care, or from the perspective of the author. The author also included “the acceptable” to describe care situations in which women described receiving good care.

*Explanations: participants understanding of the situation and the outcome.* This part of the analysis looks at the particular reactions of the women involved in the situation and the possible intersections of racism, sexism, classism, etc. What do they believe occurred in the situation? Do they feel that they were treated in an acceptable manner? Why do they believe that they were treated in the way they were? What parts of their identity do they identify as contributing to the way in which they were treated? This part of the analysis is particularly telling of women’s situations-do women feel as if they were treated badly, worse or differently than other women because of a particular component or combination of their identities? If they do, what do they do about it? If they don’t, what meaning does this have for them as individuals, for the way care is

given to them and in general, for their health and well-being? In positive care encounters, explanations examine why women feel that the encounter was positive and what contributed to this experience.

*Argument: relation to other similar experiences.* The argument component takes a step away from the situation and makes a broader statement about whether the event is unique or whether it reinforces systemic oppressions. This is done by linking Aboriginal women's experiences with literature about other women's experiences of accessing care and particular situations that may lead to unequal access.

*Reaction: evaluation of outcomes.* This element examines what happened as a result of the 'unacceptable' situation. Did the women go back to the care place to receive health services? Did they involve other people in the situation? Did the health care professional recognize that the individual woman was not happy with the services provided? Did they care? Did the organization acknowledge that their mandate did not meet the particular needs of the individual?

The result of using a gendered analysis is a thorough investigation into the different components of the care encounter, including the interrelated identities of both the client and service provider, how these identities were perceived, as well as the context within which care was given. What is particularly important is that these sub-elements of the analysis are linked with the most important part; how did Aboriginal women feel about the care encounter and what happened as a result? Incorporating these different steps of the analysis allows nurse researchers to critically reflect and examine the different elements of the care encounter in order to explicate those factors which led Aboriginal women to feel dissatisfied with their care experience. By explicating these factors and examining them separately story by story, I was then able to look at

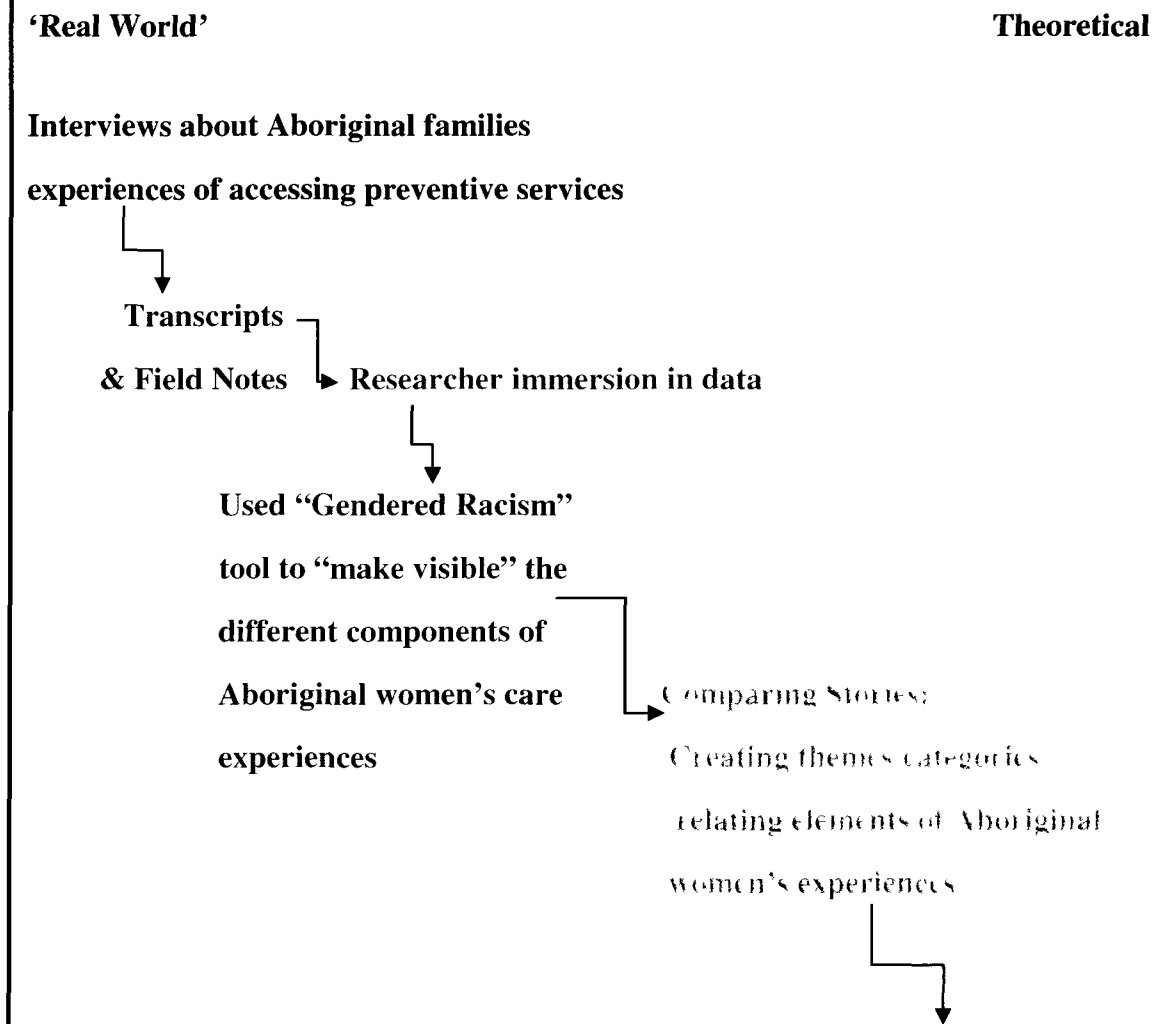
how women's stories were similar or different, and begin to develop themes, as is described in further detail below.

*Thematic Analysis.* After completing an analysis of the five 'rich' transcripts and creating written descriptions of the stories, the larger body of interview transcripts were examined to identify any other stories that were relevant. This is an attempt to capture the 'silence.' Brazilian Pedro Demo (2002) explains that in qualitative research, there are occasions where only one example may be needed to provide a full explanation. However he points out that frequency is so often considered a sign of validity that oftentimes those insights that are gained from that which is censored or difficult to express are often overlooked or ignored. With this in mind, the larger body of transcripts were analyzed in order to capture "the silence" of Aboriginal women's experiences, in the hopes of capturing experiences that were not explicitly shared but through deeper digging became apparent.

A thematic narrative analysis was used to code all of the transcripts for themes relating to Aboriginal women's experiences of accessing care, particularly focusing on the seven subcomponents found within the gendered analysis framework. Although the results are not written in such a way as to divide them into the subcategories of the gendered racism analysis, these categories are represented within the four major subthemes found in the results. After coding the transcripts for themes they were further analyzed for patterns, consistencies and contradictions such as comparisons between First Nations, Inuit and Métis women's' stories, contrasting women's experiences at different care places, and examining how the identities of care providers created different encounters. Thematic narrative analysis was chosen because it gives voice to those who are often unheard by providing descriptions of individuals' "experiences, beliefs and perception" (Benoit et. al, 2003). This involved a continuous process of

“finding relationships” among stories in order to show similarities between different experiences of accessing care, while also drawing out small segments of individual stories to closely examine the nuances of the context and people involved (Benoit et. al, 2003). Alongside the raw interview data, descriptive field notes were analyzed to ensure that the way in which the results were being analyzed and written reflected the context under which the original data was collected.

Below is a visual representation of what the data gathering and analysis process looked like in this study.

**Figure 1: Research Process**

*Verification by Community Members.* After comparing stories and creating a list of themes and subthemes, a verification meeting was organized with members of the local

Aboriginal community to share the initial results with them and to see if the way in which the results were being communicated made sense to them. A leader from the Aboriginal organization who had contributed a great deal to the study was consulted and agreed to have the meeting in a space within the Aboriginal health centre. She suggested three service providers; one of whom was a First Nations woman who had encountered a lot of racism and prejudice during her life, another First Nations woman who worked with mothers and infants, as well as a non-Aboriginal service provider who had been working within the community since the centre had opened. A number of service providers were also consulted for consideration of clients who would be interested in participating. As a result of these service provider's relations, three women attended the meeting; one First Nations grandmother, one Inuit grandmother and one First Nations mother.

The diversity of women's experiences reflected within the verification meeting was important to ensure that the results of this study resonated with different Aboriginal women's encounters. The women that attended the verification meeting came from reserve or rural areas, lived in urban areas but continued to have connections with their land bases, were First Nations and Inuit, were different ages and had had different experiences of accessing care. However, despite these differences, there were a lot of similarities between their stories of care encounters and those of the primary research participants.<sup>c</sup> The wording of the themes, subthemes, and explanations were discussed for issues of language, and feedback was given to help keep the writing as close as possible to the phrasing Aboriginal women chose to describe their experiences.

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<sup>c</sup> Please note that some of the original research participants also participated in my verification meeting. However I also included other women from the community in order to ensure that my research continued to be relevant.



*Enhancing Rigour*

The criteria for rigor for this research included reflexivity, dialectical validity and credibility. Reflexivity is “the process of considering how the researcher’s own actions, beliefs and values have affected the situation and its interpretation” (Benoit et. al, 2003). Throughout my involvement in the primary research project and this secondary analysis, I wrote field notes and reflective notes describing my experiences and my personal reflections on what had occurred. I also found myself examining my nursing encounters more closely for issues of power and continuously being aware of my social location within the research process. For example, I reflected on how my identity as a white, female researcher affected the dynamics of the interview process, the way I worded questions, and how my relationship developed with the participant during the interview process.

Dialectical validity refers to a constant analysis and comparison of the interactions between theory, practice and research while examining the tensions, contraindications and complexities involved in relating these three discourses (Badger, 2000). Strategies used to enhance dialectical validity included peer debriefing as well as collaborative discussions with key stakeholders and front line workers. This also included writing my thoughts while collecting data or completing the analysis and reflecting on how my ideas had progressed over time.

The final important point of rigor is credibility. Credibility ensures that the researcher’s interpretation of the data does not lose the “truth value”; therefore that the original meaning is not lost in the translation (Mill & Ogilvie, 2003). This is particularly important in research which involves another cultural group with a particular set of values and worldview. Steps that were taken to ensure reliability included recording of the researcher’s biases and assumptions; data

management methods that allowed results to be traced back to their source in case of need for further clarification; and a participant verification meeting (described above).

A list of themes, quotes, and experiences/stories which reflected the diversity of the participants' experiences was included in verification meeting which helped to add richness and meaning to the presentation of results, and facilitated discussion regarding interpretations of the data and identification of any missing gaps and/or linkages. A number of community events were also attended by the author in order to develop further relations within the urban Aboriginal community. A log of these events (see Appendix F) was created as well as a field note for each event to record impressions. Attention was particularly paid to the importance of collaboration with community partners from both Aboriginal and non-Aboriginal organizations. Collaboration with community partners and health care providers established a greater understanding of the contextual nuances of the research (Mill & Ogilvie, 2003). Direct quotes from the interviews were also used as an important part of the research manuscript so that the participants' voices were explicitly captured.

## Conclusion

This chapter provides an introduction into the major premises of this master's thesis which seeks to explore Aboriginal women living in an urban context's experiences of accessing care, and to describe how identity featured in their care encounters. The chapter began with a definition of who Aboriginal people living in an urban setting are and described the complexities involved in providing health care to Aboriginal peoples as a result of bureaucratic structures. From there, issues of access for Aboriginal women were critically examined using a postcolonial feminist lens. A thorough literature search explored the health disparities experienced by

Aboriginal women, as well as the barriers they encounter while attempting to access care. By exploring what the literature has previously said about Aboriginal women's experiences of accessing care, it was concluded that there has not been a critical analysis into how the interrelating aspects of Aboriginal women's identity such as race, gender, and socioeconomic status, contribute to Aboriginal women's care experiences, particularly how service provider's perceptions of women's identity contribute to Aboriginal women's access. The potential benefits of exploring this gap in theory were analyzed for the nursing profession. The researcher described her place within the research before introducing the analytical lens and methodology used to conduct this research.

The introductory chapter provides a backdrop to the 'raison d'être'; the results. The following chapter, Chapter 2, begins with an overview of the major themes and subthemes found in the results. This is followed by two articles that will be submitted to academic journals for the purposes of publishing. The first article, "*Identity Matters: Aboriginal Mother's Experiences of Accessing Care*" describes how service provider's perceptions of Aboriginal women's identity contributed to their experiences of accessing care. Through an exploration of the concept of identity, this manuscript provides a fresh perspective on how inequities in access have come to be such a grave concern among Aboriginal women, and suggests new ways of addressing this critical issue. The second article is titled, "*Examining our Privileges and Oppressions: Incorporating an Intersectionality Paradigm into Nursing.*" As well as outlining an intersectionality paradigm and its relevance and use for nursing, this manuscript argues for nursing to make a larger effort to critically examine the power dynamics prevalent in nursing in order to better address the health disparities of the most marginalized populations in society.

## CHAPTER 2: AN OVERVIEW OF THE RESULTS

Chapter two is an overview of the results of this thesis study and sets up the reader to view these through the feminist postcolonial lens adopted in the study. It comprises a discussion on the diversity of identities reflected in the participant sample; a brief overview of the main themes and subthemes that were found while completing this research; and an in-depth exploration of the themes, subthemes and methodology in two manuscripts written for publication. The manuscripts provide further richness and depth to the results by including participants' quotes that describe their lived experiences of accessing care.

When our research team spoke with First Nations, Inuit and Métis women about their experiences of accessing care, we heard women share similar encounters and feelings, although they came from varied backgrounds, land bases<sup>d</sup>, ethnic identities, and ways of describing themselves. Their stories were shared with the intention of producing knowledge that could be used to provide better access to culturally safe care for Aboriginal women and their families. Participants expressed their desire to have health care providers understand that each woman accessing care has a story to share and that without recognizing and respecting a woman's individual values, health care providers may fall short of providing them with good care. However participants also acknowledged the necessity of appreciating the world view of First Nation, Inuit and Métis peoples and the incorporation of a communal perspective. Therefore the women's stories are conveyed here in a way that tells a larger community story within the urban

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<sup>d</sup> Land bases refer to different geographical locations from which Aboriginal women identified that their nations arose or where their reserves were located. I chose to incorporate this as a feature of women's identity because it is my understanding that where Aboriginal people come from forms a large part of their traditions and teachings. Often when I have heard Aboriginal people introduce themselves at conferences or formal community events, they have given their name, and if they know it, the name of their nation, clan and geographical area where their families are from.

setting that does not separate women from the context of their families, communities, land bases and histories.

### Examining the Influence of Identity: The Participant Sample

The following section will describe some important analytical outcomes that arose from the participant sample. These include the use of a ‘white’ demographic form, the fluidity in participants’ description of their identity, and the multiple identities of Aboriginal service providers within the urban community. These different elements all have something important to teach us as nurses and researchers about how identity influences our work, particularly when engaging in relationships with individuals or groups who represent an identity different than our own.

#### *Using a ‘White’ Demographic Form*

Whenever researchers ask participants to fill out a demographic sheet, they are asking participants to define who they are; their identity, according to categories the researcher feels are of relevance to the study topic. These *a priori* identified categories enable a researcher to estimate the transferability of findings from their study vis-à-vis other populations. However one participant in our study, Claire (a pseudonym is used for the sake of clarity) identified that rather than attempting to make our data transferable to other populations, our research team needed to first consider the unique experiences of Aboriginal people living in an urban setting that were not applicable to the general urban population.

Claire argued that our demographic questions were not relevant to her lived experience as a First Nations woman (See Appendix G for copy of original demographic forms). Claire suggested that the demographic form should have included questions about individual’s

participation in local Aboriginal community events, their relationship with Elders and teachers in the community, whether they eat traditional food, and whether they speak a traditional language. Claire's observation cuts to the bedrock of considerations of identity in research and health care: researcher-defined categories of identity do not provide an explanation or a description of the richness and complexity of participants as they would define or describe themselves. Claire's contention with the demographic form was that it was very much oriented towards a white, Western worldview, and that it should have incorporated more Aboriginal values.

When researchers fail to capture departures between their own (which most often represent the dominate 'white', middle-class, male perspective) and participants' views of identity, they miss the opportunity to describe and change how their own powerful discourses may differentially shape or mis-shape peoples' identities (Bhaba, 1994). By articulating as Bhaba 1994) defines; "strategies of selfhood-singular or communal-that initiate new signs of identity, and innovative sites of collaboration" (p. 2), Claire argued for the inclusion of different identities and worldviews into the research process. Such dialogue is essential to explicating the dominance of Western values in research processes and outcomes, and flags a specific example of how self-defined identity can be subordinated, dismissed, or misshapen by dominant discourses.

### *Fluidity of Identity*

Another important aspect of the participant sample was the fluidity of the terms that they used to identify themselves. Fluidity refers to both the shifts in people's identity over time, as well as the scope and subtle variations in how they used the concept of identity, which are not captured in 'mainstream' identity categories. It also refers to Aboriginal people changing how

they choose to self-identify according to the situation, according to events or life stages, and according to personal changes such as progression along a healing path. These changes in identity are to be expected (for all of us), and respected by health care providers.

For example, on the demographic sheet used to collect information about our participants, we asked people to identify themselves according to whether they were First Nations, Inuit or Métis under the ‘ethnic identity category.’ However, during the interview process, participants often expanded or qualified the meaning of how they identified themselves. They often incorporated their nation, land base and/or clan as being important to their identity as well as being married to non-Aboriginal individuals or people with different ethnic identities from themselves. Participants also acknowledged the identity negotiations that occurred in families as a result of having Aboriginal children either by marriage to an Aboriginal person or adoption of an Aboriginal child.

The narrowly defined categories of identity used on the demographic sheet did not account for these “in-between” spaces in which many of our participants lived. Rather than adhering to rigid definitions of ethnic identity, we came to understand that there was a need to acknowledge a more fluid sense of identity that accounted for these multiple familial make-ups in the urban setting. Oftentimes, more than one culture/religion/language was being adhered to or incorporated within families; and therefore multiple identities and worldviews were being carried out within the familial structure. Understanding the fluidity of participant’s identities was an important component of understanding the complexity of providing culturally safe and responsive care to Aboriginal families in the urban setting.

*Multiple Identities: Service Providers Roles within Urban Settings*

Through my involvement in the *Improving Access* study, my relationships with local Aboriginal community members and leaders, and my work with a local Aboriginal homeless outreach team as described in chapter 1 (pages 24-35), I came to understand the importance of the multiple identities of service providers within the Aboriginal organizations in which they were employed as well as within the local urban community. Service providers were recognized for their professional identity in their roles at local Aboriginal organizations, but also often regularly attended and participated in local community events such as Pow Wows, and were family members and friends within the local Aboriginal community. This is a different model than is seen in mainstream models of care, in which professionals are expected to keep professional boundaries and not associate with clients outside of work time. Therefore within mainstream models clients have very little association with service provider's personal identity.

Although Aboriginal service providers spoke about the necessity of having professional boundaries, they also recognized that these looked different because of the small tight-knit nature of the local Aboriginal community and their association with this community as an Aboriginal person. Female service providers spoke about how their personal identity as mothers had an important influence on their ability to provide care and empathize with clients' who were mothers. They spoke about encountering similar experiences as their clients while accessing care for themselves and their children, and understood the necessity of having a safe place to go to access care. Service providers lived experiences of racism and discrimination while accessing care helped them to empathize with the particular needs of Aboriginal clients and prompted them to provide care that was more responsive. Since Aboriginal service providers were often active community members who were engaged in incorporating traditional models of health and well-



being into their own lives, they acted as role models for how to blend traditional with contemporary medicine. Participants identified that this was important because it made Aboriginal clients feel less shy to talk about herbs and medicines that they may have been using, and also gave them a space to learn more about traditional remedies within the urban setting.

Therefore, service provider's multiple identities strengthened not only their position within the community, but also their credibility with those accessing care. Participants identified that clients felt more comfortable accessing care from someone who may have encountered some of the same lived experiences as themselves, particularly experiences of racism and discrimination. They also acknowledged feeling better understood accessing care from someone who had the same or a similar value system to their own. In conclusion, Aboriginal service provider's multiple identities contributed to Aboriginal people feeling safe and comfortable to access care at Aboriginal organizations.

### Brief Overview of Results

During this research it became clear that issues of access for Aboriginal women in an urban centre were particularly impacted by identity dynamics within care encounters. This was considered noteworthy because many of the participants were women who lived in poverty, experienced violence, and faced a number of the physical or practical barriers to accessing care that are often described in health literature when describing issues of access (Hare, 2004; Stout et. al, 2001). However, when participants talked about the particular experiences of women, they spoke about the nature of the care relationship, and particularly how service providers` perceived and treated women as being extremely influential to whether or not they would access that service again.

The major theme that arose from exploring Aboriginal women's experience of care in the urban setting was that Aboriginal women's identity as *mothers* was the focal point for how the intersections of women's identities (including gender, ethnicity, race, class, marital status, etc<sup>e</sup>.) influenced the ways in which they saw themselves as perceived and treated by service providers within care encounters. The four sub-themes that arose from this major finding describe positive and negative dynamics associated with how Aboriginal women's identity was perceived which facilitated and hindered access from the perspective of Aboriginal mothers. The first section describes negative encounters within which women often expressed not feeling respected or affirmed as a result of the way in which their identities were perceived and treated within the care encounter. The sub-theme that describes this is titled the "*imposition of the presumed superiority of Western models of mothering*". On the other hand, positive encounters *reaffirmed Aboriginal mother's* strengths as a result of provider's positive perceptions of their identities. The sub-themes which describe this type of care encounter include:

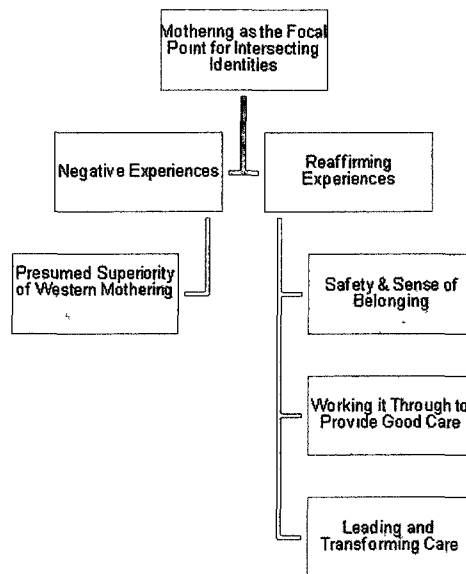
- Care places ensuring *safety and a sense of belonging* for Aboriginal women
- Service providers '*working it through*' with Aboriginal mothers to provide care in "a good way"
- Aboriginal women *leading and transforming care* in an urban setting

A diagram of the major theme and sub-themes and the relationships between them can be seen below, with an ensuing description.

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<sup>e</sup> Please note that these were the identities women explicitly acknowledged as affecting their experiences of care. However as noted in the limitations of my study, because I did not specifically have the chance to ask women about what parts of their identity they believe affected their experiences of care, this list is not exhaustive.

**Figure 2:** Unpacking the dynamics of care encounters: A diagram of the major themes and sub-themes describing Aboriginal women's experiences of accessing care



The left side of the diagram describes the sub-theme associated with Aboriginal women's descriptions of negative encounters with mainstream care institutions. When Aboriginal mothers access care, they described encountering the "*imposition of the presumed superiority of Western models of mothering*." Women described having negative stereotypes imposed upon their identity by service providers. This included health care providers making value statements about their mothering abilities and traditional views of mothering. They often described feeling ostracized on account of their intersecting identities as Aboriginal mothers, particularly as poor, young, single mothers.

Contrary to these negative experiences were encounters which facilitated access to care, which were most often described as taking place at Aboriginal centres. Participants from these organizations recognized that as a result of Aboriginal women's lived experiences of violence

and discrimination, that it was necessary to provide *a sense of safety and belonging* while accessing care. Service provider participants at these organizations also recognized the need to provide care in a different way; in a way which was supportive of, and provided agency to, Aboriginal women. This is described in the sub-theme “service providers ‘*working it through*’ with Aboriginal women to provide care in a good way.” When Aboriginal women were able to find safe care places and therapeutic relationships, they described being able to take “that initial step” to help themselves, their families and their communities and *lead and transform care* within the urban setting. These women are creating positive changes for the way care is provided to Aboriginal people in the urban setting.

The following section will begin by describing why mothering was the focal point for Aboriginal women’s interrelated identity. This will be followed with a description of how Aboriginal women’s identities as mothers was negatively perceived, in turn negatively influencing Aboriginal women’s access to safe and culturally appropriate health care. After speaking about the factors which hindered Aboriginal women’s access to good care, factors described as having facilitated Aboriginal women’s access to safe and appropriate care are outlined in three sub-themes.

#### *Mothering as the Focal Point for Aboriginal Women’s Interrelated Identities*

Traditionally the role of mothers has been highly valued within Indigenous societies and remains a strong focus for Aboriginal women’s identity in contemporary Aboriginal communities. Yet, Aboriginal women presently and historically have suffered a significant amount of violence and discrimination, particularly in their role as mothers. This is a result of the

introduction of patriarchy, residential schools, the sixties scoop<sup>f</sup> and the ongoing disproportionate removal of Aboriginal children from their homes (Cull, 2006). These events have caused Aboriginal women to feel vulnerable in their identities as mothers, particularly within health and social care settings. Consequently, while mothering represents a role of pride and honour within one's community and family, as a result of historical events, Aboriginal women often do not feel safe accessing mainstream services for themselves and/or their unborn child.

Describing women's experiences as mothers became significant in the context of the primary study for a number of reasons. A significant finding that arose from the *Improving Access* study is that in order to help ensure that infants and children are accessing preventive care; parents need to be able to obtain the care and supports they require. As well, single female-led households are highly represented within the families accessing preventive services at the Aboriginal organizations involved in the study. Therefore by focusing on women's experiences, I hope in part to help health care providers understand how they can more effectively reach out to a group of families with particular needs, single female-led families.

It is clear that the intersection of Aboriginal women's multiple identities alongside their mothering role is an integral factor in their descriptions of their experiences of accessing care. The mothering identity is woven through the following sub-themes as the underlying identity factor which impacts access.

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<sup>f</sup> This period of time is not well registered within the public mind, therefore I will explain it briefly. The sixties scoop represents the beginnings of a mass state removal of Aboriginal children and youth from their homes which began in the sixties and of which traces remain today. It involved relocating children away from their families and communities into distant locations including the U.S., and with non-Aboriginal families. Records were not kept of children's names or places of birth and so often times, if children's names were changed, their personal histories were often erased. This has created a generation of Aboriginal people who lost ties to their familial roots (Cull, 2006).

*The Imposition of the Presumed Superiority of Western Models of Mothering*

When First Nations, Inuit and Métis women described negative care encounters they spoke about experiences in which they felt that there was a continuation of the colonizing experience. These stories were about Aboriginal women feeling disrespected and judged as a result of service provider's paternalistic attitudes towards their identity as Aboriginal mothers. Women often spoke about not feeling good enough to access an equitable level of care as other Canadians, and feeling very disconnected from mainstream health care and their perspectives of health and illness. They shared personal stories about accessing care in which they were 'automatically' discriminated against and stereotyped. The way in which Aboriginal women were treated by health care professionals often left them with the impression that there was something wrong with them, e.g. they did not fit within the dominant discourses of the female patient, and particularly the dominant perceptions of mothers. Certain groups of Aboriginal women were described as being particularly subject to such stereotyping and discrimination. These included women who are visibly darker in colour or who "appear" more Aboriginal, Inuit women, the elderly, women who are street-involved or involved with the criminal justice system, young women, and women who come from very remote or northern communities.

First Nations, Inuit and Métis women also described encountering a very condescending attitude from health care professionals which did not respect or acknowledge their traditional knowledge and personal views of mothering. As a result, they often felt that health care providers were imposing their own values of mothering, and imposing a vision of an "ideal mother." Women described feeling powerless and voiceless within the care interaction in their role as mothers. Health care professional often had very little understanding of them as individual women, their families, their histories or the context within which they lived. One

mother at the verification meeting described this as a discrepancy between the biomedical model and traditional ways of mothering. Women felt that value was placed upon how well they would follow the orders set out for them by the dominant biomedical model. This often interfered with how women and their families chose to take care of themselves and their children throughout the periods of pregnancy and parenting. However the author came to understand that women often felt that they had no choice but to choose to follow the dominant biomedical model, or to say that they would follow it, in order to be viewed as good mothers. If they did not, they ran the risk of being considered “bad” mothers and of having their children taken away.

Participants’ statements often incorporated references to past historical events, signifying that historical relations between the colonizers and the colonized, in which Aboriginal people had to be “taught” how to be “civilized,” remain constant in the minds of Aboriginal women today. Therefore the “*imposition of the presumed superiority of Western models of mothering*” strongly incorporated how historical events Aboriginal mothers, their families, and their communities have experienced influences women’s current perceptions of health care settings and encounters. This suggests the importance of acknowledging women’s histories both as individuals and as members of larger communities that have suffered enormously at the hands of the government and government institutions, including healthcare. Women’s stories incorporated events like the Oka Crisis, residential schools, children being removed from their home by CAS, and previous negative encounters with health care professionals. These experiences with mainstream institutions represented a continuum of violence and subjugation that has often led to an inherent mistrust of the health care system and care providers. This subtheme is about recognizing that for Aboriginal women accessing care, there continues to be an imposition of

Western values on Aboriginal mothers, and an associated disregard for their identity, which affects their present day experiences of accessing care.

The following sub-themes describe care encounters in which efforts were made to facilitate Aboriginal women feeling safe and secure to access care by establishing places and relationships within which Aboriginal women could feel good about their identity, and develop and nurture mothers' personal agency to care for themselves and their children.

### *Care Places Ensuring Safety and a Sense of Belonging*

An important sub-theme that ran through First Nations, Inuit and Métis women's stories was the need to have comfortable, secure care places that they felt safe to access. Safety and belonging were mentioned as important aspects of the design of care places as a result of the significant amount of violence and discrimination that they deal with in their everyday lives as a result of how others perceive their identity as Aboriginal women. These were particularly crucial aspects for women with mental health issues and women living in abusive housing situations. Women spoke about the necessity of finding and creating safe places for themselves, their families and their community to come together to access care. These were places where women were able to not only share their difficulties and concerns, but also feel safe talking about and practicing traditional teachings and where they could demonstrate personal agency by contributing to decisions regarding their care.

When women talked about Aboriginal care places they usually spoke about them in terms of positive experiences of care in which efforts were made at a policy or organizational level to make them feel physically safe and understood, and where efforts included giving them a sense of belonging. Aboriginal mothers and service providers described the types of supports



care places needed to consider to help women feel safe and provided for. These included efforts to make places “women-friendly”, which included consideration of the location of the building, an examination of the design of the care environment, provision of healthy meals and daycare, as well as the timing and delivery of programs (see future writings by Van Herk, Smith, et al).

*Service Providers ‘Working it Through’ with Aboriginal Mothers: Giving Care in “A Good Way”*

‘*Working it through*’ was about service providers giving care in a way that acknowledged the personal agency of women by working alongside women to support them on their journey of wellness. This was about creating a care space in which women felt good and were made to feel proud of their identity as Aboriginal women. This subtheme was primarily about the importance of the therapeutic relationship in women’s experiences of accessing care and about the mutual “work” that was required to build and develop a positive, respectful encounter. What is of particular importance to note is that the way in which the relationship between care providers and Aboriginal mothers is described is completely different from that which is described earlier in the sub-theme “*the imposition of the presumed superiority of Western models of mothering.*” Rather than imposing Western values, this sub-theme is about service providers respecting and incorporating Aboriginal mother’s values and identity. There were a number of components that were part of the “work” needed to build this relationship including:

- Recognizing, acknowledging, and respecting women’s values and providing care in such a way as to incorporate them. This might mean speaking a traditional language or incorporating cultural practices into care.

- A time commitment to create a safe relational space within the health care encounter. This may mean that service provider's need to allocate more time for an appointment when addressing a particularly sensitive topic for example.
- Building core principles of non-judgement and respect into the therapeutic relationship. Women described the importance of being able to talk about the difficulties of parenting as a single mother without feeling judged that they were not doing a good job.
- Service providers taking on an advocacy role while helping women to engage with other mainstream services where they did not feel safe or supported. Women talked about the support provided when Aboriginal service providers talked to their lawyers for them or went with them to talk to Children's Aid.

Aboriginal women spoke most frequently about encountering this type of care relationship at Aboriginal organizations where service providers were often Aboriginal and had similar worldviews and lived experiences as mothers that they provided care to. By engaging in these relationships Aboriginal mothers were able to work through their issues with the support of service providers to come to a place of health and wellness. However what is important to acknowledge about this sub-theme, is that it was the development of safe and trusting therapeutic relationships that supported women's identity and enabled women to feel comfortable to return to access care.

#### *Aboriginal Women Leading and Transforming Care*

This major theme describes the courage First Nations, Inuit and Métis mothers exhibited in taking pride in their personal identity within care settings. This was about women developing personal agency to seek out places where they received good care, were treated with respect, and

where their knowledge as mothers and of traditional ways was valued. This subtheme was not only about women taking pride and celebrating their identities, but was also about women resisting the negative identities imposed upon them by others, predominantly health care providers. The self-pride and resiliency exhibited by women was an important characteristic that was eloquently exhibited in women's stories when they spoke from their role as mothers and as individuals demanding the best care not only for themselves but also for their children. In this subtheme, women were resisting dominant narratives about Aboriginal mothers and were also demanding that their expertise as mothers be recognized and respected.

This sub-theme demonstrates the resilience, and often defiance with which women self-identified as Aboriginal peoples, as women and as mothers. It is important to recognize the courage and strength it often took women to feel confident to self-identify, to assert one's self in the face of such heavy layers of discrimination. This was reinforced at the verification meeting, where one participant described the bravery Aboriginal women leaders exhibited as "their ability to speak out on behalf of us". When women took actions to defend themselves and their identity, there was an understanding that this action was larger than their self; they were upholding the pride and resiliency of Aboriginal peoples within the care setting. It should be noted that the way in which care settings have previously been described implies being in a position of weakness on the part of Aboriginal women, and therefore increases the importance of the efforts being made to re-establish relations of equality, pride, and agency.

Participants often described Aboriginal women as the community members who had "taken that initial step" to do things in a good way, not only for themselves, but for their children and their communities. Even though women's stories were often filled with discrimination and poverty, Aboriginal women are often the ones leading their communities forward, developing

new programs and service delivery models. Therefore this major sub-theme is not only about individual woman taking pride in themselves as individuals; it is about women building their communities by articulating their pride as Aboriginal people and their capacity to transform and build new models of providing care.

### Conclusion

The introduction of this chapter examined the findings that arose from an analysis of the participant sample and provided an introductory description of the major theme and sub-themes of this thesis study. It began by exploring the major theme of Aboriginal women's identity as mothers and described how the perception of Aboriginal mothering is the focal point for how women's interrelated identities impact their experiences of accessing care. Four sub-themes described the dynamics associated with Aboriginal mother's experiences of accessing care. One sub-theme, the "*imposition of the presumed superiority of Western models of mothering*," described how service providers' attitude and treatment toward Aboriginal mothers' identity prevented them from feeling safe to access care. The other three sub-themes were: 1) Care places ensuring *safety and a sense of belonging* for Aboriginal women; 2) Service providers '*working it through*' with Aboriginal mothers to provide care in "a good way"; and 3) Aboriginal women *transforming and leading care*. These three sub-themes described dynamics of Aboriginal women's care encounters which *reaffirmed women's identity* and contributed to their sense of safety and belonging while accessing care.

These major findings will be further elaborated on within the following two manuscripts, "*Identity Matters: Aboriginal Mother's Intersecting Experiences of Accessing Care*" and "*Examining our Privileges and Oppressions: Incorporating an Intersectionality Paradigm into*

*Nursing.*” Both articles written for publication have been formatted according to the style requirements of the journal they have been submitted to. Article one “*Identity Matters: Aboriginal Mother’s Intersecting Experiences of Accessing Care*” explores how service providers’ perception of Aboriginal women’s layered identities within the health care context impacts care encounters and, in this way, also affects whether or not Aboriginal women feel safe accessing care services. It has been submitted to *Contemporary Nurse* to be included in their December issue on advances in Indigenous Health Care. *Contemporary Nurse* is recognized internationally as a journal which publishes articles that push the status quo in nursing and challenges nurses to think critically about cross-cultural issues. The second paper, “*Examining Our Privileges and Oppressions: Incorporating an Intersectionality Paradigm into Nursing*” examines how the intersectionality lens proved useful in exploring issues of access for Aboriginal women and the potential this paradigm offers for nursing research and policy. This paper has been submitted to *Nursing Inquiry* for their quarterly issue. *Nursing Inquiry* is an international journal renowned for exploring issues related to nursing practice.

**Identity Matters:**

**Aboriginal Mother's Experiences of Accessing Care**

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**Abstract:** This paper reports on research examining how service provider's perception of Aboriginal women's identity contributes to their experiences of accessing preventive care during pregnancy and parenting in an urban setting. An intersectionality paradigm was adopted to conduct a secondary analysis of purposively selected transcripts of exploratory interviews with Aboriginal women. Findings indicate that how Aboriginal women's identity as mothers was perceived by service providers was the focal point at which women's described positive or negative experiences of accessing care. These conclusions challenge nurses' understandings of developing therapeutic relationships with marginalized populations and highlight the necessity of examining how perceptions of identity shape issues of oppression and discrimination within therapeutic relationships.

**Key Words:** feminist postcolonial, Aboriginal women, identity, intersectionality paradigm

While access to safe and appropriate health care has been internationally recognized as a basic human right<sup>1</sup>, Aboriginal people continue to face discriminatory practices while attempting to obtain care, compromising their ability to achieve good health.<sup>2</sup> Previous research indicates that those individuals identified as the racialized 'Other' within health care interactions often encounter negative attitudes by health providers towards their identity.<sup>3</sup> Anderson & McCann<sup>4</sup> describe the 'Other' as a specific social category and space that defines 'non-western' people including Aboriginal<sup>5</sup> peoples, according to social constructions of 'race' and culture differences that marginalize and label them as inferior. Consequently, Aboriginal peoples and other populations marginalized through 'othering' processes are often 'blamed' for difficulties they face attempting to access care on account of their 'cultural differences'.<sup>5</sup> As a result, they must try to access a health care system that is not designed to recognize or engage with them as human beings.<sup>6</sup>

To address the under-lying causes of these widespread patterns of inequities, some nurse researchers have begun to critically examine how issues of access are related to broader social

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<sup>5</sup> Although the Canadian government classifies Aboriginal peoples according to their registration as treaty Indians, registered Inuit, Band or First Nations members, this paper has incorporated the perspective that Aboriginal refers to those individuals who self-identify as First Nations, Inuit or Métis.

concerns including poverty, racism and discrimination.<sup>7, 8, 9</sup> By beginning to explore these topics, nurse researchers have taken a leading role in explaining the need for an approach that will align our knowledge and practice with our emancipatory aims of social and structural change.<sup>10</sup> However, nursing needs to move towards locating the identity dynamics present in practice at the bedside within the larger inter-related web of social and systemic oppressions which create health inequities. The importance of identity to nursing's emancipatory intentions has not been adequately considered in theory or in practice. A robust and widely understood definition of identity and proactive approach to understanding and addressing how identity impacts different populations' access to care is needed. An intersectionality paradigm, as a way of seeing and viewing the world, is being used for these purposes in social sciences, but has only recently begun to be used in nursing.<sup>11</sup> An intersectionality paradigm seeks to understand how "aspects of self and society interact; it challenges theories and practices that privilege single categories, such as race or gender, in explanations of human experience, including health".<sup>12, p. 163</sup>

The purpose of this paper is to explore the implications of how service provider's perceptions of Aboriginal women's identity influences their experiences of accessing care in an urban setting. A feminist postcolonial approach is used to critically examine why issues of access are such a pertinent issue for Aboriginal women. Participants and methods in the primary research study are summarized including decisions leading to the need for a secondary analysis examining how identity influences Aboriginal women's experiences and access to care. Methodology, design, sampling and the incorporation of an intersectionality paradigm into the secondary analysis are described. The bulk of the paper shares Aboriginal women's stories of accessing care, and describes how the meaning attached to Aboriginal women's identity featured in their care encounters. Concluding remarks examine the implications of this study for nursing.



## DEFINITIONS OF IDENTITY AND SOCIAL LOCATION

Examining the concepts of social location and identity has important implications for nursing, not only in understanding the meaning of care for marginalized populations, but also the politics of providing care. Although identity is the main focus within this paper, it is important to differentiate it from social location as these concepts are closely associated with one another.

Grenier<sup>13</sup> describes the concept of social location as the multiple and often shifting societal hierarchies and divisions (e.g. age, class, ethnicity, gender, ‘race’, sexuality) which structure experience. An important part of examining social location is the incorporation of a critical analysis of power dynamics, privileges and oppressions associated with these divisions.

Examining location is an integral part of an intersectionality paradigm as Hulko notes, “the ways in which identities intersect and oppressions interlock are fluid and varied because the meanings that are ascribed to identity categories and the power afforded or denied to specific social groups are based on the specific socio-cultural context in which these social processes occur”.<sup>14, p 42</sup>

In order to explore how issues of identity have been used in nursing, a literature search was completed to locate this work within the professional body of knowledge. Though nursing database CINAHL was searched as well as nursing philosophy textbooks, a common definition of identity congruent with the study’s theoretical and philosophical standpoint was not found. A more detailed understanding of the concept of identity as it relates to the therapeutic nursing encounter and consequently Aboriginal women’s experiences of care is needed. A definition of identity in the social science literature was identified that resonated with what participants said about the complex ways in which identity featured in their everyday as well as healthcare encounters. Alcoff’s definition includes ideas of identities as both imposed and self made;

“names we give to the different ways we are positioned by, and position ourselves within, the narratives of the past.’ They are both imposed and self-made, produced through the interplay of names and social roles foisted on us by dominant narratives together with the particular choices families, communities, and individuals make over how to interpret, and resist, those impositions as well as how to grapple with their real historical experiences. But the social meanings attached to such things as skin colour and body shape, the hierarchies of language and differential roles in reproduction, and the very significance afforded various identity markers are firmly in place when a given individual is born, circumscribing their flexibility and invoking a constellation of meanings that will come into play by their appearance or their birth certificate”.<sup>15, p.3</sup>

This definition of identity has been implemented within this study because it resonated with what participants said about the complex ways in which identity featured in their everyday as well as health care encounters.

## **BACKGROUND ON ISSUES OF ACCESS FOR ABORIGINAL WOMEN**

Aboriginal peoples in Canada encounter disproportionate levels of unemployment, violence, incarceration, poverty, and physical and mental illness, as a result of inadequate access to the social determinants of health including employment, housing, fair legal counsel, and health services.<sup>16</sup> These inequities are a direct result of the devastating impact of colonization and the associated economic, political and social disadvantages which have resulted from longstanding systemic racism.<sup>17</sup> However, when considering issues of health and access among Aboriginal peoples, Aboriginal women present at a far greater disadvantage than even Aboriginal men, illustrating clearly the historical legacy of sexist and racist policies in creating systemic burdens of illness.

Aboriginal women have suffered significant repercussions from the legacy of colonialism and as a result have been identified as one of the most marginalized populations within Canada. From birth, Aboriginal females face discrimination for their ‘race’, gender and class. They

confront “identity politics” that determine the rights owing to them according to their “status” as an Aboriginal person. These rights are most often determined by white men (i.e. the government).<sup>16</sup> They encounter inequitable access to the social determinants of health which is reflected in higher levels of extreme violence, poverty, unemployment, poor housing and nutrition.<sup>18, 19</sup> As a result, Aboriginal women are disproportionately afflicted with diabetes (Aboriginal women are twice as likely to have diabetes as Aboriginal men), HIV/AIDS (Aboriginal women account for 50% of all HIV positive tests among Aboriginal people vs. 16% of non-Aboriginal women), addiction and related issues such as fetal alcohol syndrome (admissions to hospital for alcohol related accidents are three higher among Aboriginal females than for the general Canadian population) as compared to Aboriginal men or non-Aboriginal women.<sup>18, 19, 20, 21, 22</sup> Poor access to care affects not only the well-being of individual woman but also has repercussions for the health and welfare of Aboriginal children and families as Aboriginal women play a predominant caretaking role within their communities.<sup>23</sup>

Aboriginal families’ experiences of accessing preventive care are particularly affected by the large number of female-headed households, and the barriers specific to the lived experience of single mothers. Aboriginal families are twice as likely to be headed by single mothers and Aboriginal mothers aged 15-24 are three times as likely to be lone mothers as compared to non-Aboriginal families. These mothers face a substantial number of systemic barriers including poverty, low rates of employment, domestic abuse, mental health issues and previous negative encounters with health and social services that often make it nearly impossible for them to access care in a timely manner.<sup>24</sup> As a result, Aboriginal mothers encounter significant peri-natal and infant health challenges include teen pregnancy (9% of Aboriginal children live with teenage mothers as compared to 1% in non-Aboriginal population), Fetal Alcohol Spectrum Disorder

(estimates of prevalence range from 2.8-9.1/1000 live births as compared to 0.3/1000 live births in Canadian population) and excess infant mortality from preventable causes including injuries, sudden infant death syndrome (SIDS) and infections.<sup>25, 26, 27, 28</sup>

Previous studies that have examined Aboriginal women's care encounters found that Aboriginal women felt dismissed and "not listened to", experienced discriminatory attitudes, a lack of culturally relevant services or understanding by health care professionals of their personal circumstances and historical backdrop.<sup>20, 23, 24, 29, 30</sup> These findings indicate that there continues to be a need for increased attention to the psychosocial, cultural, and historical components of the therapeutic relationship, which are integral parts of nursing care. However within nursing there have been few studies which have critically examined nurse-patient interactions, and even fewer which have examined interactions with Aboriginal clients.<sup>29</sup> Alongside this, there has been little exploration of the concept of identity or the implications that the meaning attributed to women's identity has for the nature of care encounters and consequent impact on access to care. Examining how issues of identity affect access to care is an important area of study for nursing, particularly while examining Aboriginal people who, as a result of historically insidious marginalization, experience decreased power and pervasive discrimination within care encounters.<sup>29</sup> Therefore this study will contribute to new knowledge by focusing on how perceptions of Aboriginal women's interrelated identities within care encounters affects Aboriginal women's experiences of care, thereby impinging on their access to safe and responsive care.

## **THEORETICAL FRAMEWORK**

The use of a postcolonial feminist lens is of particular benefit in analyzing the processes that have led to issues of unequal access for Aboriginal women as it attends to the different

voices and socio-historical locations that have often been ignored or oppressed within health discourses. Postcolonialism is primarily interested in drawing attention to inequities that have been brought about as a result of colonization and ongoing neo-colonial processes as well as interrupting “race-thinking”.<sup>17</sup> However, although postcolonialism attends to issues of race, it has not necessarily acknowledged issues related to gender, therefore feminist perspectives have been included to broaden the lens of both postcolonial and feminist theories.<sup>31</sup>

An intersectionality paradigm, as way of viewing the world, arises from postcolonial feminism and is used in this study to examine the interrelations between colonialism and neocolonialism with issues of gender, race, class, and sexuality within the different political, legal, economic and historical contexts which Aboriginal women live within.<sup>32</sup> As a way of seeing the world, an intersectionality paradigm is helpful in examining how women’s lives are shaped by how they define themselves, how they are perceived by others, the choices and opportunities available to them, and how they interact with the world around them.<sup>31</sup> Use of an intersectionality paradigm enabled more explicit attention to exposing the imbalanced power relations which dominate Aboriginal women’s stories of their care encounters, with particular focus on how race, class and gender inequities have arisen, how they are related to each other and how they continue to impact Aboriginal women in their everyday lives.<sup>33</sup>

Incorporating an intersectionality paradigm into analyzing issues of access for Aboriginal women explicates how Aboriginal women’s experiences have been shaped by the intersecting forces of colonization, including confiscation of traditional land bases, forced assimilation, residential schools, patriarchy and the continuous removal of Aboriginal children from their homes. Therefore, Aboriginal women’s lived experiences of the interrelations between ‘race’, gender, ethnicity, and class need to be understood within the context of their own social,

political, historical, economic, and geographical contexts. As Anderson and McCann<sup>4</sup> note, it is important to acknowledge that we cannot generalize women's experiences; but must acknowledge how historical experiences and constructions around 'race', class and gender intersect to affect women differently within their own life trajectories. An intersectionality paradigm provides a discourse to portray Aboriginal women's experiences within the contexts which they live, in order to resist status quo descriptions which deny Aboriginal women their place within the research narrative.<sup>34</sup>

## METHODS AND PROCEDURES

### Summary of Primary Research Study

The need for this study "*Intersecting Identities: Exploring Aboriginal Women's Experiences of Accessing Care*" (referred to as "*Exploring Aboriginal Women's Experiences of Accessing Care*") came about during conduct of a participatory research study titled "*Improving Access to Preventive Health and Social Services for Pregnant and Parenting Aboriginal Families living in an Urban Setting*" (referred to as "*Improving Access*") (Smith, Peterson, Edwards, Andrew, 2008). The *Improving Access* study is being carried out in a large metropolitan centre that is home to one of the largest and fastest-growing urban Aboriginal populations in Canada. Using a critical postcolonial perspective, the goal of the study is to identify organizational and system-level strategies to improve access to preventive care for pregnant and parenting urban Aboriginal families with children under the age of six.

Two Aboriginal organizations and two mainstream community health agencies are partners in the study. These organizations provide preventive services for pregnant and parenting populations, and were purposively selected by the primary investigator to represent a number of

different health care delivery approaches. The study involves three phases; data collection and verification, knowledge translation strategies, and knowledge uptake. Ethical approval was obtained from the University of Ottawa Research Ethics Board, boards of three of the agencies, and the research ethics committee of the fourth agency. Research agreements were developed with the two Aboriginal organizations involved.<sup>35</sup>

In Phase One, qualitative interviews of 45-60 minutes were completed by a trained interviewer using a semi-structured interview guide with Aboriginal parents, Elders, leaders (e.g. Executive Directors; program managers) and providers (e.g. nurses, early childhood educators, social workers, lay support workers) recognized for their knowledge and skills relevant to care for Aboriginal parents. Network sampling methods were used to recruit participants, beginning with key informants from each of the partner agencies. Interviews were tape recorded and transcribed and analyzed concurrently as data was collected, using an inductive interpretive approach. Regular meetings were held with an Advisory committee which was composed of leaders from the participating organizations, Aboriginal parents, and Elders. The Advisory committee were consulted and actively involved in making decisions about the design and implementation of the study and were particularly helpful in ensuring that the study was community-oriented and remained culturally safe. While conducting the interviews for the primary study, the need to examine the particular experiences of women was identified. This was validated by the Advisory committee and community leaders as a priority issue to be more fully understood within the study, and as a result the following secondary analysis was designed.

Before moving on to describe this study, it is important to identify the social location of the three authors involved. The researcher and primary author for this study is a Caucasian female, in her mid-twenties and works as a Registered Nurse. The secondary author and principal

investigator of the primary study is a Caucasian female who works as an Associate Professor in the School of Nursing. The third author is a Caucasian female who is a Full Professor in the School of Political Studies and Director of Centre on Governance.

### **Secondary analysis of data: Exploring Aboriginal women's experiences of accessing care**

Secondary analyses include studies that are more dense or comprehensive, focused on a particular sub-topic or social group, or which pay closer attention to certain policy issues and questions.<sup>36</sup> A secondary analysis was chosen as an appropriate method for two reasons. Based on early impressions in the *Improving Access* study, the purpose and design of this secondary study was identified in collaboration with community leaders and members of the Advisory committee. Participants acknowledged that the unique experiences of Aboriginal women are central to understanding issues of access experienced by pregnant and parenting Aboriginal families living in urban contexts. Therefore, the development of a secondary analysis is in keeping with the philosophical and practical purposes of participatory research. Secondly, the primary and secondary authors were heavily involved in the collection of the primary research study; they did the majority of the interviews and engaged with participants in their “natural settings”. In this instance the secondary analysis extends descriptions of the depth and complexity of participants' experiences identified in the primary research study.

Ethical approval for “*Exploring Aboriginal Women's Experiences of Accessing Care*” was obtained from the University of Ottawa Research Ethics Board. Support was acquired for the secondary analysis from two community health centres, public health and one of the Aboriginal health centres involved in the original research project.<sup>h</sup> The following table

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<sup>h</sup> The other Aboriginal health centre chose not to participate as they were not sure how this research would be of benefit to their organization.



describes the sample used in the secondary analyses. An important point to acknowledge is that there are a significant number of Aboriginal female service providers whose voices are heard in the results of the study. An important finding that arose while conducting the primary study was that Aboriginal female service providers described themselves not only in their professional roles but also in their community roles as mothers, sisters and aunties. They often acknowledged facing the same type of discrimination and racism as their patients while accessing care for themselves and their families at mainstream organizations. Therefore their voices are included throughout the results of this paper, alongside mother's voices, because service providers described themselves as both professionals but also as mothers and community members accessing care for their own families.

Ethnicity	Gender		Roles			Total
	Male	Female	Leaders	Service Providers	Family Members	
First Nations	2	7	1	7	1	9
Inuit	2	2	0	1	3	4
Métis	0	0	0	0	0	0
Non-Aboriginal	0	8	1	5	2	8
Total	4	17	2	13	6	21

*Sampling.* While immersed in the research data, transcripts and stories were deliberately selected for inclusion in the analysis. The analysis began with five transcripts purposively selected for 'richness'; those which plainly acknowledge that First Nations, Inuit and Métis women have particular experiences while accessing care or those transcripts which gave voice to women's stories and the implications of women's layered identities.

*Data analysis.* Essed's<sup>37</sup> 'gendered racism' analysis was used to identify how interrelated systems of domination/oppression play out and are experienced in the everyday lives of Aboriginal women in the five purposively selected transcripts. A 'gendered racism' analysis incorporates seven components: the situation, relation to research question, context of situation, relation to outcome, participants understanding of the situation and outcome, relation to other experiences, and an evaluation of the outcomes.<sup>i</sup> Story threads which reflected occasions where care was impacted by the meaning associated with Aboriginal women's identity were identified, and described in a tabular form corresponding to the seven components. Explications of the intersections and how they may have featured in the participants' experiences was achieved through reflection-writing-dialogue cycles. Dialogue was sought through peer debriefing (e.g. with co-authors) who are familiar with both Aboriginal women's experiences and intersectionality.

After completing an analysis of the five 'rich' transcripts and writing descriptions of the stories, the larger body of interview transcripts (n=21) were examined to identify additional relevant stories. A thematic narrative analysis was used to code all of the transcripts for themes relating to Aboriginal women's experiences of accessing care, focusing on the seven subcomponents found within Essed's framework.<sup>24</sup> This inductive process began by making notes of the specific components found within each individual story, focusing on the identities used to describe the Aboriginal women by herself and the care provider, descriptions of the care provider, and descriptions of the care environment and therapeutic relationships. Comparisons were made between different descriptions of Aboriginal women's care encounters, making

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<sup>i</sup> Please note that the primary author chose to modify the wording used to describe these different categories within the context of her own research in order to make them more relevant to her thesis study. She chose to incorporate the category "relation to research question" to help keep the analysis relevant to her data.

particular note of identity descriptions, meaning ascribed to identity descriptions, care relationships and care settings. Alongside the raw interview data, descriptive field notes were used to provide context to the interview data. Through this continuous inductive process, a list of themes and sub-themes with illustrative quotes was created.

A description of preliminary results was shared at a verification meeting. The location, participants and format for the meeting was organized with members of the local Aboriginal community. The meeting occurred at one of the participating Aboriginal organizations, and involved sharing initial results with three service providers and three Aboriginal women in a non-formal discussion using a PowerPoint presentation. Wording of the major theme, sub-themes, and explanations were discussed and feedback provided to keep the phrasing as close as possible to how Aboriginal women described their experiences.

*Limitations.* Considering that there is not enough length to provide all of the limitations of this study, the main one will be described. As a result of this study being a secondary analysis, the authors did not have the opportunity to talk with women about what they thought about how service providers' perceptions of their identity impacted their care experience. Therefore different answers may have been provided had participants been specifically asked about the implications of meaning attached to their identity.

## RESULTS

The results of this study describe participants' outlook of how perceptions of Aboriginal women's identity by service providers impacts Aboriginal women's experiences of accessing health care and social service agencies. The major theme that was derived from Aboriginal women's poignant descriptions was that their role as mothers was the pivotal point at which how

their identities (gender, ethnicity, race, class, and marital status) were perceived by service providers intersected to impact their care experiences. How Aboriginal women's identity as mothers was perceived within care encounters generally resulted in two types of care experiences; those which were negative in which the meaning ascribed to Aboriginal women's identity by service providers was problematic and delayed or prevented women from feeling safe to access care, and those encounters which "*reaffirmed women's identity as mothers.*" Within negative encounters, Aboriginal mothers described receiving bad care as a result of the way in which they were perceived and treated within care encounters. This is described in the subtheme; the "*imposition of the presumed superiority of Western models of mothering.*" However participants also identified positive encounters that *reaffirmed women's identities as mothers* as a result of provider's positive perceptions of strengths associated with their identities. This was described in the sub-themes:

- Service providers '*working it through*' with Aboriginal mothers to provide care in "a good way"
- Aboriginal women *leading and transforming care* in an urban setting.

### **Aboriginal mothering: The intersection of identities**

The role of mothering was found to incorporate many different, but interrelated, aspects of Aboriginal women's identities together to impact their care experiences. Traditionally the role of mothers has been highly valued within Indigenous societies. From encounters with the local Aboriginal community and through reading works by Aboriginal women, the authors came to understand that within Aboriginal communities there remains a strong focus on the role of women as mothers. As one Aboriginal service provider noted,

*I think all indigenous cultures across the world knew they had to focus on the woman and the kids. You know the women are the life-givers, the women carry the knowledge, the grandmothers are the ones that carry all of that and the children are the future (P. 3, P. 19).*

However, Aboriginal women presently and historically have suffered a significant amount of violence and discrimination in their role as mothers. This is a result of the introduction of patriarchy, residential schools, the sixties scoop<sup>j</sup> and the ongoing disproportionate removal of Aboriginal children from their homes.<sup>38</sup> Therefore Aboriginal women's identity as mothers remains highly tumultuous within the health care setting as it represents two very different dynamics. On the one hand, through the action of mothering, of giving birth, of employing traditional and contemporary ways of mothering, Aboriginal women may personally be choosing to reclaim an aspect of their roles as women, both on an individual level but also within their communities. This is particularly significant as a result of the historical processes that have attempted to disrupt this process and have left many mothers without parenting skills. Taking on the role of 'mothering' is therefore "resisting" the dominant narrative and reaffirming one's identity; becoming a mother ensures that one's story will continue and that traditions and cultural practices will remain. As one First Nations community leader commented on mothers who access prenatal services at the Aboriginal community health centre where she works;

*They understand very well what they have lost and are seeking to reclaim it. (P. 2, P. 9)*

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<sup>j</sup> This period of time is not well registered within the public mind; therefore it will be explained briefly. The sixties scoop represents the beginning of a mass state removal of Aboriginal children and youth from their homes which began in the sixties and of which traces remain today. It involved relocating children away from their families and communities into distant locations often with non-Aboriginal families. Records were not kept of children's names or places of birth and so if children's names were changed, their personal histories were often erased. This has created a generation of Aboriginal people who have lost ties with their familial roots.<sup>38</sup>

However as a result of historical events, Aboriginal women experience some level of vulnerability accessing care in their role as mothers. They often do not feel safe accessing mainstream services for themselves or their children in the fear of being labelled as ‘bad mothers’. One First Nations mother talked about the experiences of her grandfather attempting to run away from residential school and tied his experiences in with her own.

*One thing I remember my grandfather telling me, he said he had to walk for four days, sometimes a week just to get back home ‘cause he always ran away and when you ran away and they found you, you got the whip. So he told me horror stories and ever since then I did not accept that apology one bit...I don’t trust government, I never did and never will ‘cause they always pardon me for saying this, screw over Aboriginals like they did in Ganonogue, like the Oka crisis...I remember living through that Oka crisis...to this day I do not trust CAS or government and I never will (P.1, P. 14-15).*

The role that the 60’s scoop and the ongoing disproportionate removal of children by Children’s Aid Society (CAS) have played in Aboriginal women’s experiences of accessing care cannot be underestimated. In almost every interview with both service providers and family members, CAS was mentioned at least once as a factor which deterred women from accessing care in a timely manner. However participants pointed out that in the urban setting where the research occurred, CAS has started to work alongside local Aboriginal organizations in an attempt to establish better working relations, and learn how to provide culturally safe interventions.

Aboriginal women’s role as mothers was the pivotal point at which the meaning ascribed to their identities by service providers intersected to impact their care experience. How their identity as mothers was perceived and treated within care encounters impacted whether their experiences of care were affirming or negative, and thereby impacted their access to safe and responsive care. The following section will begin by describing Aboriginal mother’s negative experiences of accessing care in which women’s identities were treated in a manner that was disrespectful and prevented Aboriginal women from obtaining an equitable level of access to

care. The results conclude by describing care encounters which *reaffirmed women's identity* and facilitated Aboriginal mother's access to care.

### ***The Imposition of the Presumed Superiority of Western Models of Mothering***

*Because, frankly, I believe that when an Aboriginal mother walks into a mainstream clinic, I think it's possible that she's prejudged and will be given information and maybe that wasn't the information that she was seeking (P. 11, P. 7).*

When First Nations, Inuit and Métis women described negative care encounters, their stories were about feeling disrespected, judged, and misunderstood as a result of mainstream service providers' paternalistic attitudes towards their identity as Aboriginal mothers. One Inuit service provider spoke about accompanying a young Inuit woman during her delivery.

*It was funny because when I was helping this little one give birth, the doctor had just graduated or he was still a med student or something. Anyways he was telling her, my mom there, he was telling her, "don't scream. Now push without screaming" and she was screaming. I felt like saying to him, "hey look, no uterus, no opinion. You've never done this before, let her scream, right. What does it hurt if the woman is screaming?" (P, 8, P. 18)*

What is of importance to note is the power differential between a young, well educated male providing care to a young, Inuit woman in extreme pain. This woman is in an environment that is foreign to her, lying in an extremely vulnerable position, and is being told how to act while having very little control over the situation or the consequences. A number of women recounted similar stories in which they encountered expectations about how they should behave and act during the delivery of their child. When women told stories about feeling very powerless, their experiences were often related to their gender (female patient vs. male doctor), their age (often very young), their ethnic and cultural identities (First Nations, Inuit, Inuktitut speaking vs. white, English speaking) and differences in status as a result of relational roles (doctor vs. patient).

Experiences such as the delivery of a baby were tied very closely to norms about mothering and dominant discourses about the female patient, which `othered` Aboriginal women and often invoked feelings of failure and judgement. For example an Inuit grandmother talked about accompanying her daughter to the delivery room. She explained that traditionally Inuit women do not yell during the delivery however the doctors and nurses kept telling her daughter to yell because it was their cultural expectation that this was what women did during childbirth. Although these two stories describe Inuit mothers encountering the opposite stereotype about how they should “behave” during childbirth, the important point about both of these stories is that it was the conviction of the service providers knowing what was best for these mothers that was the problem, as it did not attend to what these women wanted their birthing experience to look like, nor did it reaffirm women’s mastery in their mothering role. By not attending to these women as individuals, or being aware of their own social location within the care encounters, these service providers risked not only imposing their own values upon these mothers, but also further oppressing them within their new role.

Biomedical discourses taught to health care providers often do not account for the cultural meanings attached to such major life transitions as birth, and as a result service providers may unknowingly be involved in `othering` discourses that marginalize Aboriginal mothers. One young First Nations mother described this as a “discrepancy” between Western culture and traditional ways of knowing. A study of Dutch nurses working with migrant families found similar results. Van Der Zwaard found that the advice of nurses was “based on particular orthodoxies about normal and deviant family relations and motherhood...professional interferences have had an impact on the lives and self-images of mothers”.<sup>39, p 1138</sup> These



interferences were found to have important implications for how safe Aboriginal women felt accessing care.

For example, participants spoke about a lack of understanding of the context within which many Aboriginal women live, particularly Aboriginal women living in poverty or who were single mothers. Women often spoke about how being both poor and Aboriginal affected their access to care, both practically (difficulty getting transportation to services) but also at a relational level (discrimination and racism) as a result of how service provider`s perceived their interrelated identities as Aboriginal poor single mothers. One service provider described the interaction of ethnic status, gender, and socioeconomic status on Aboriginal mother`s experiences of accessing care.

*There`s a whole different way of child rearing and just being. They`re going to people who don`t have a concept about the culture, no concept of where they are coming from and no idea where that person is going to. Are they going back to a shelter tonight? There is such a disparity in the determinants of health between Aboriginal and non-Aboriginal. So it`s basic fundamental rights that are just not there. (P.9, P. 7)*

This quote reflects the disparities evident in Aboriginal women`s personal stories and the lack of insight into the lived realities of some Aboriginal women`s lives. What is important to recognize is that the lack of understanding of women`s lived experiences was often described as being very dangerous for Aboriginal women. For instance, one Aboriginal service provider described an Inuit mother having her children taken away by CAS because she had no food in her cupboards. However service provider`s failed to notice that she had a freezer full of caribou meat to feed her children. Stories such as this often reflected service providers` implicit assumptions that Aboriginal mothers could not parent well and reflected a system which punishes mothers for being poor.

Women's stories of health care interactions often reflected the historical relations between the colonizers and the colonized, in which Aboriginal people had to be "taught" how to be "civilized". Therefore the "*imposition of the presumed superiority of western models of mothering*" reflects a continuum of violence and subjugation towards Aboriginal women that has often led to an inherent mistrust of the health care system and care providers. Certain groups of Aboriginal women were identified as being particularly oppressed including women visibly darker in colour or who "appear" more Aboriginal, Inuit women, the elderly, women who are street-involved or associated with the criminal justice system, young women and women from very remote or northern communities. In conclusion, service provider's negative perceptions of Aboriginal women's identities as mothers made women feel particularly vulnerable within care encounters and often resulted in them not accessing care in a timely manner or not accessing care at all for fear of CAS. However in the following sections, participants describe care encounters in which efforts were made to transform Aboriginal women's experiences of accessing care by *reaffirming* Aboriginal women's identity.

***Service providers 'working it through' with Aboriginal mothers: Giving care in "good way"***

When Aboriginal women described '*working it through*' they spoke about service providers positively acknowledging their identity while also recognizing their historical experiences, the context within which they lived, and providing them the necessary support and care. One Aboriginal service provider described what this might look like in practice.

*We have an over-representation of Aboriginal children in foster care. And although it's meant well, we don't really know how much of that is prejudged because of who they are and what their ethnicity says. So trust is really important because otherwise they're not going to open up to you and speak freely and think that they can. If they think you're going to call foster care right away and say you know, I've got this mother, blah, blah, blah. You have to be really aware of that. (P.11, P. 10-11).*

This quote shows how the overwhelming fear of judgement and child apprehension influences access to preventive care. Conversely, the trust that is the subtext of *working it through* also demonstrates the wonderfully accepting and positive view of Aboriginal health care providers, who see the possibility of improvement. As the participant elaborates,

*So for example, if you know a mother's drinking but you see she's showing up to your programs, it's sort of one of those situations where you really have to know what your relationship is gonna be. You know you want her to tell you that she's drinking so that you can work on it with her. And find her the right ways instead of interrogating her because then you may never see her again. Obviously we have a professional duty if we know that a child's being abused in vivo that we need to do something. But I'm just thinking that in order for it to be safe and that she's not gonna do something crazy like go on a binge or take her life or who knows, you need that trust because when they walk out of here, we don't know what they're doing. I think by showing that we're gonna feed you, we're gonna get you emergency supplies if needed, no questions asked. And you can speak to me with no questions asked. I'm not gonna automatically judge you and say, 'well I can't believe you drank a beer and I'm gonna call CAS right now,' you know? It's working it through and getting them to call CAS on their own and say 'Listen, I want to keep this baby and I wanna figure out how I'm gonna do it.' And, you know, that's when it's successful. Then they feel like their power is back (P.11, P. 10-11).*

This story demonstrates service providers giving care in a way that acknowledged the personal agency of women by working alongside them to support them on their journey of wellness. It is about the mutual investment of both the service provider and woman that is required to build a positive, respectful therapeutic relationship that helped women feel safe returning for care. There were a number of components that were part of the “work” needed to build this relationship. The first component included acknowledging and respecting client’s identity and providing care in such a way as to incorporate women’s values. This was fostered at Aboriginal organizations by hiring Aboriginal staff that spoke traditional languages with clients and incorporated cultural practices into care if women acknowledged wanting cultural aspects of care. One First Nations health care consultant described this method of care as

*a whole life cycle approach and it's very spiritual... you're looking at the teachings and the creation stories, all of those stories have a message about what it means to be a good parent....what it means to keep children safe and nurture children (P. 14, P. 3).*

For some women, having Aboriginal service providers was also about the safety of being with someone “who looked like them”, about the safety of having someone who reflected their own identity. This was particularly important for women who had encountered a lot of racism and discrimination while accessing mainstream services.

“*Working it through*” as described in women’s stories was also about building core principles of non-judgement and respect for women’s identity into the therapeutic relationship. This was about acknowledging where women were on their personal wellness journey and helping them make good choices for themselves by providing the necessary supports. One First Nations female leader described the implications of providing care in ‘a good way’ as compared to negative care encounters.

*When they are given good care and are given the possibility of care, I think you can change any woman. If you support any woman she will take what little she can get and she will make it a thousand fold...they are the workers and keepers of families and it's no different here. But to give them, this is the difference. Here you give them something but you also give it to them in a good way, in a way they understand...and when I'm say 'giving' I mean her giving, her trying harder, her pushing that extra step. You know her getting up and standing and being propelled by pure physics sometimes. That she moves that extra time and that extra day that makes that difference in her life. And I think without the right supportive care I think many women would make it but not make it well. Meaning that they might die earlier, they may end up losing their children forever (P.2, P. 10)*

This participant explains that without the right type of supportive care, a lot of women will keep living, but not in a good, healthy way that necessarily promotes any quality of life. It’s important to note that the word ‘supportive’ was often described by participants and often was used to describe how women felt that they could be safe in their identities in these type of care encounters whether they were poor, Aboriginal, or drug users. There was an understanding that

they would be given the best possible care to be as well as they could be in their particular circumstances. The previous quote also explicitly links the critical necessity of good preventive care for women as a means to help them get on the right road to a better life. `Working it through` is about service provider`s respecting and affirming Aboriginal women`s identity and meeting them where they are at as the first step to developing a trusting relationship. The following and final theme describes the implications that accessing good care that affirm Aboriginal women`s identity has for Aboriginal women, their families and communities.

### ***Aboriginal Women Leading and Transforming Care***

This major theme describes the courage which Aboriginal women demonstrated by developing the personal agency to seek out places where their identity was respected, where they received good care, and where their knowledge as mothers and of traditional ways were valued. A well-respected Aboriginal leader described Aboriginal women`s courage to change the way they and other Aboriginal people are treated within health care encounters. He said:

*Well I have to accredit some of our women; it takes an individual effort to make a choice, to make a change for themselves. I heard a late elder Arthur Solomon share a story some nineteen years ago and he had stated at the time that if the men didn't pick up their tools, meaning their learning the traditional ways, the values of the culture, then a lot would be put on the wayside but most importantly that our people begin to recognise how important retaining our culture, our identity, to recognise what's going to be most important for the future and those next generations to come... But what I get back to is the fact about women are making that initial stage in life to say enough is enough. I'm so proud that our women took that initial step forward to start making a verbal announcement to indicate that violence will not be tolerated any longer (P.4, P. 3-4)*

*Aboriginal women leading and transforming care* was not only about women taking pride in their identities, but was also about women resisting the negative identities imposed upon them by others, predominantly health care providers. The self-respect and resiliency exhibited by women was an important characteristic that was eloquently exhibited in women`s stories when they

spoke from their role as mothers and as individuals demanding the best care not only for themselves but also for their children.

*I think if you were to sit with a young mom, if she were to be able to articulate, I think she'd say, "I want to be involved in the change. I want to know, I don't have the resources to, but I really want to know and shape how my child is going to succeed in the next ten years." Every mom wants that. But when she's busy surviving she can't even think about that. She can only love and protect what she has at that moment with what she has (P. 2, P. 24).*

This theme was also about Aboriginal women demanding that their expertise as mothers be recognized. Mothers in the verification group described wanting to be respected and acknowledged for wanting to bring a child into the world and for trying to do this the very best way that they could despite being young, poor and Aboriginal.

These women demonstrate the courage, and often defiance, necessary to identify as an Aboriginal mother in light of such deep layers of discrimination. During the verification meeting, one young First Nations mother described the bravery she witnessed among local Aboriginal female leaders as *their ability to speak out on behalf of us*. This was with the understanding that not only did female leaders advocate and act as leaders for the local Aboriginal population, but these women also had their own lived experiences of discrimination and racism. Participants often described Aboriginal women as the community members who had "taken that initial step" to do things in a good way, not only for themselves, but for their children and their communities despite their own personal circumstances.

*If it wasn't for our women who are so strong and stand behind their way of life and their beliefs of who they are, they're the ones who create the opportunities (P.4, P. 6).*

These Aboriginal female leaders used the strength of their identity and lived experience to transform mainstream society's understanding of Aboriginal issues and advocate for safe care

places for Aboriginal people. Therefore “*Aboriginal women leading and transforming care*” is not only about individual woman preserving the strength of their identities, this is about women building community pride in their collective Aboriginal identity by drawing their efforts and strength together towards finding safe places to access care for their children, and by transforming and leading new models of providing high quality care for Aboriginal people.

## **IMPLICATIONS FOR NURSING**

Identity features as a very powerful force within Aboriginal people’s lives as a result of government policies such as the Indian Act that have tried to control and limit their identity as Aboriginal peoples as well as ongoing racism and discrimination that are a feature of many Aboriginal people’s everyday lives. When we spoke with an Elder about using an identity lens to examine issues of access for Aboriginal women, he pointed out that ever since the Indian Act whether one has access to health care or not has always been about identity for Aboriginal people. Furthermore, nursing needs to examine identity as a component of developing therapeutic relationships, and nurses need to particularly examine their own identity, values and biases and the implications their identity has for the therapeutic relationship. Boykin<sup>40</sup> notes that nursing knowledge cannot exist without nurses purposefully engaging with “the one nursed” in a meaningful manner to address their concerns. Attention is too often focused on marginalized populations and how to help *them* get the care they deserve, without realizing that this will not be possible without health care providers (including nurses) being attentive to what it is about *us* that makes it difficult for people to feel safe to access care. This is an important paradigm shift that needs to be incorporated into reflective practice, a professional nursing standard, which has implications for nurses’ ability to provide safe, culturally competent care to various populations.

Understanding the dynamics of nurses' identity within the therapeutic encounter needs to be incorporated as a critical component of any nurse's self-reflective exercise.<sup>41</sup>

Exploring the intersecting identities of both patients and nurses may also force a re-examination of how to practice in a culturally competent manner. Teaching and training around cultural competence often revolves around finding ways of incorporating individual's culture into the care that is provided without addressing the underlying power dynamics that are prevalent in issues of identity and "otherness".<sup>42</sup> Cultural safety was developed as a means of "taking us beyond" the skills, knowledge and attitude of nurses addressed in cultural competence, to helping nurses become action-oriented to address unequal power dynamics that underlie issues of racism and discrimination.<sup>42</sup> The results of this study indicate that an intersectionality paradigm as a way of looking at the world has the potential to help nurses specifically examine and address the myriad ways that power constitutes relationships with clients. Examining the influence of intersecting identities on care encounters is a useful concept for exploring how nursing can be more attentive to meeting the psychosocial needs of their clients as a component of 'culturally safety'. This more detailed examination offers a pragmatic approach to enabling us to reach in practice the emancipatory aims of nursing's caring moral position.

Acknowledging the unique role mothering may play in Aboriginal women's access to care has important implications for health care providers and for research devoted to studying women's issues. First of all, finding out one is pregnant and being a mother is a unique and critical time in a woman's life for accessing care, not only for her health and well-being but for that of the child she will bring into the world. Therefore every effort needs to be made to help women during this phase of life to feel safe and comfortable accessing care and to help develop



women's confidence and mastery in her role of mothering. Women need to be given the opportunity to define their identity within the encounter and the meaning that this has for how care is delivered to them. This is particularly true for women who may be marginalized or vulnerable on account of their interrelated social locations, not only because these women may be more isolated and lack the necessary supports, but also because as stated earlier, they often present at higher risk for discrimination, oppression, and poor access to the determinants of health, thereby increasing the likelihood of complications during and after their pregnancy.

The subtheme *working it through* described the importance of service providers acknowledging and reaffirming women's identities and their personal capacities, particularly their sense of mastery as mothers. However, as this study and others have indicated, Aboriginal mothers often encounter racism and discrimination while accessing care at mainstream organizations. This is evidence that nursing has a long way to go to getting to the point of 'reaffirming women's identity' rather than imposing their own value system. Nurses need to become aware that they need to make specific efforts to reaffirm Aboriginal women in their role as mothers, with a particular understanding of the intergenerational impact of residential schools and the centrality of the mothering role in many Aboriginal communities. In order to do so, nurses need to be particularly aware of the complexity of the mothering role as a result of these community values and historical experiences. *Working it through* describes nurses working with clients in a collaborative manner that promotes client decision making about their own health behaviours. This has implications for our understanding of how nurses can practice in a manner which is both culturally competent, but also client-centered.<sup>43</sup>

Nursing education plays an important role in helping nurses learn what it means and how to practice as a reflective practitioner, however schools of nursing need to take a more proactive

approach to dealing with the complexities of issues of identity with students. Literature has begun to explore the discrimination professors and students who are visible minorities encounter in the academic milieu with indications that those within academic settings need to find ways to make academic settings safer and more accessible places for professors and students from diverse backgrounds.<sup>44</sup> One important way of doing so is to encourage greater diversity within nursing faculty and students. Changes that are needed include antiracist and antidiscrimination policies as well as new methods of exploring the power dynamics of race, socioeconomic status, sexuality, gender, between professors, between professors and students, as well as in teaching nursing students how to be good nurses.<sup>41</sup>

Exploring the impact of Aboriginal women's interrelated identities indicates that more research is needed to understand how different events along the trajectory of Aboriginal women's lives influences access to health care. As well, the concept of identity has implications for our current understandings of nursing theories and reflective care and has the potential for further research and theorizing, with specific reference to our understandings of providing culturally competent care. Nursing policies, research and education needs to find ways to help nurses examine the identity politics that prevail not only their profession and its future, but also their therapeutic encounters. Finding ways to address this often contentious issue will reinforce not only the professionalism, intelligence, and critical perspective nursing brings to the health care team, but will also strengthen nursing's reputation as a trusted, compassionate group of individuals.

## CONCLUSION

This paper provided an introduction into the implications service provider's perception of Aboriginal women's identity has on Aboriginal women's experiences of accessing care in an urban setting. This paper reported on how Aboriginal women's role as mothers was perceived by service providers was the pivotal point at which their identities intersected to impact their care encounters. An exploration of these findings contribute to nursing discussions on developing therapeutic relationships with marginalized populations and highlight the need for nursing to further it's examination of the power dynamics that structure therapeutic relationships. By exploring the power relations of identity that shape issues of oppression and discrimination, this paper provided emancipatory knowledge on how nursing can move forward to address sustained injustices in "a good way".

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**Examining Our Privileges and Oppressions:  
Incorporating an Intersectionality Paradigm into Nursing**

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**Abstract:** This paper presents an intersectionality paradigm as a means by which nurses can attend to issues of oppression and privilege within their practice and profession. Intersectionality is introduced as an essential theory to help remove the hegemony of the “white, middle class” perspective that often directs nursing research, practice and education. An example of how an intersectionality paradigm using Essed’s gendered racism analysis was incorporated into research with Aboriginal women is included to explore the potential uses and benefits of this theoretical shift for nursing. Findings contribute to an increased understanding of the importance and necessity of attending to the power relations that dominate nursing care encounters and influence the way nurses provide care. By acknowledging and responding to the presence of privilege and oppression and the associated power dynamics within the therapeutic encounter, nursing can strive further in helping to alleviate social injustices and health disparities that arise from unequal power relations.

**Key Words:** Intersectionality, postcolonial feminism, identity, whiteness

As a practicing nurse and as a nurse researcher my interest has primarily been in looking at issues of social justice within nursing; how nurses can provide better care to those who have the least access to it and yet, most often, require it the most. It has been my experience that those who are marginalized within the health care system are often misunderstood, and as a result, a divide is created between provider and patient which results in patients’ receiving poor care that is unresponsive to who they are as human beings. This divide is the result of the dominance/subordination and privilege/oppression binaries associated with the biomedical model of health and the associated white, middle class perspective that often separates health care providers from the context of the lives of marginalized individuals to whom they provide care.

Although notions of cultural safety are sometimes touched upon within nursing education, nurses need to take personal initiative to further explore issues of power, privilege and oppression within their profession. As well, they must also have a previous personal awareness of the privilege afforded to the dominant biomedical model and the power afforded to their role as nurses. Without this personal awareness, nurses often will miss opportunities to be exposed to critical examination of the impact these concepts have on the care they provide. This is a crucial

gap within nursing education and nurses' professional development that has implications for our capacity to practice as safe and caring professionals<sup>11</sup>, affects who is perceived as a "good nurse" and has particular repercussions for the health and well-being of those for whom we provide care.

This paper argues for the incorporation of an intersectionality paradigm into nursing as a means to help remove the hegemony of the "white, middle class" perspective that governs nursing research, practice and education. Incorporating an intersectionality paradigm would be a progressive step forward for nursing in helping us to better attend and respond to issues of oppression and privilege and continue to advance our strong social justice ideals. I begin by describing intersectionality and how it has previously been used in nursing. This is followed by an account of the processes I used to incorporate an intersectionality paradigm into my research with Aboriginal women, as an example of how this way of thinking can be useful for nursing theory. I conclude with implications that the use of an intersectionality paradigm could have for nursing practice, education, research, and policy.

### **WHAT IS AN INTERSECTIONALITY PARADIGM?**

Intersectionality has previously been described as a lens, a theory, a tool and a paradigm; however I have chosen to incorporate intersectionality as a paradigm in my research as a way of thinking, understanding and acting as well as a method of analysis (Hancock, 2007). An intersectionality paradigm posits that "people's experiences are simultaneously the product of

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<sup>11</sup> As a Registered Nurse in the province of Ontario, Canada, when I refer to professional nursing I am specifically referring to the professional standards as set out by the College of Nurses of Ontario. However, it is my understanding that other provinces and countries would have similar guidelines and expectations of how nurses practice as professionals accountable to the public. For the particular purposes of this paper, relationships, both professional and therapeutic client encounters, are particularly important standards for the introduction of an intersectionality paradigm.

how they identify themselves, how they are seen by others, and how they interact with others” (Chow et. al 2009, 163). It arises from postcolonial feminism and other critical theories, and attends to, and uncovers the different voices and social-historical locations that have often been ignored or oppressed within healthcare discourses (Hancock, 2007). Postcolonial feminism “calls for a health care system that is responsive to the varied social locations of its clients” (Anderson 2002, 23). This includes critically examining the power structures that govern society and social relations and shape health care encounters by examining the “social, political, economic and cultural contexts” from which health inequities arise, including postcolonial and neo-colonial policies (Racine 2003, 92). An intersectionality paradigm extends postcolonial feminism’s theoretical bounds by recognizing that these influences come together in distinct ways and lead to distinct health outcomes for individuals/groups, providing context to health experiences and drawing attention to the dynamic interplay between different system levels (Guruge and Khanlou 2004).

Originally, intersectionality was introduced as a theoretical shift from thinking about social locations such as race and gender as separate categories, into a more inclusive framework that examined the interrelating “social relations of domination and oppression, and how they operate along different axes” (Anderson 2004, 243). Intersectionality has grown to incorporate other constructed identities such as sexuality, ethnicity, culture, socioeconomic status and ‘ableness’ and continues to be “concerned with the ways in which constructed identities interact to shape multiple selves or dimensions of persons” (Cramer and Plummer 2009, 163). This has important implications for nursing as Anderson (2000, 226) notes, “we need nursing scholarship that conceptualizes the intersection of class, racialization, gender relations, and other social

relations, because we experience our lives not solely as gendered persons, but as classed and racialized persons.”

Hulko (2009) has previously argued that it is necessary to describe the difference between social location and intersectionality and how they came about to be used theoretically. Social location “refers to the relative amount of privilege and oppression that individuals possess on the basis of specific identity constructs, such as race, ethnicity, social class, gender, sexual orientation, age, disability, and faith” (Hulko 2009, 48). Intersectionality, on the other hand, describes “the entanglement of identity categories that make up an individual, the differential attributions of power that result from such varied configurations, and the need to view intersectional beings holistically rather than try to tease apart different strands of identity” (Hulko 2009, 48). Therefore social location forms an integral part of an intersectionality framework.

Intersectionality attempts to account for the overlapping and interrelated aspects of individuals’ identity and their time contingent nature that contribute to experiences of health and illness. As Hulko (2009, 52) notes, “the ways in which identities intersect and oppressions interlock are fluid and varied because the meanings that are ascribed to identity categories and the power afforded or denied to specific social groups are based on the specific socio-cultural context in which these social processes occur.” For example, the way in which someone is perceived as being ‘sick’ very much depends on what location they are in (hospital vs. home), the cultural meanings ascribed to symptoms and definition of health, how the individual describes their own health, and how those around them (family, friends, coworkers, etc.) perceive their health as well as their developmental stage in life.

Attending to social location and interrelating identities is an important element that has begun to be examined within nursing research, but has yet to be taken up within other facets of nursing. However nursing as a whole needs scholarship that examines the implications of individuals' interrelated identities, service provider's perceptions of them, and how both of these factors impacts their expectations and experiences of care.

### **WHY AN INTERSECTIONALITY PARADIGM?**

Over the past decade, some nursing researchers and associations have become more interested in exploring methods to help nurses address cultural diversity within their nursing settings (Registered Nurses of Ontario (RNAO) 2007). Such methods often revolve around helping nurses acquire the necessary skills, attitudes, knowledge and behaviours to provide “culturally sensitive” care (Gustafson 2007). However, providing ‘culturally sensitive care’ can present as a politically correct way to overlook the discourses of race and racialisation that often take place within care encounters. As Allen (2006, 66) notes “most conversations about cultural ‘difference’ depend upon and reproduce a privileged white norm.”

Gustafson (2007) argues that nurses, and particularly white nurses, need to challenge these social discourses of privilege and oppression. Part of challenging these discourses needs to be a personal reflection on how one's own identity contributes to these normative discourses. For example, individuals are generally considered to be “white” unless someone acknowledges otherwise. Whiteness or being “white” has been socially constructed to mean that those individuals recognized as ‘white’ have more access to power, resulting in unearned privilege that does not require them to have to self-identify as any racial or ethnic identity. In a sense, being white means that you have the privilege of not having to reflect on your own identity. This is a

result of whiteness being presented in such a way as to invoke it as “the normative body and the normative location at the centre of a social system organized around race and other social differences” (Gustafson 2007, 155). However there are very few resources which help white nurses to recognize this unearned privilege or to be aware of the prevalence of ‘whiteness as normal’ within nursing practice. There are also very few tools available to help nurses address other types of power dynamics such as gender, socioeconomic status, ‘ableness’, and sexuality that occur within the profession, our therapeutic interactions, research and education (Gustafson 2007). The dominance of the white, middle class perspective has major implications not only for how nursing is practiced but also extends to who is recognized as a nurse, as nurses who are recognized as minorities often struggle during the process of becoming a nurse and finding employment.

Pharris (2009, 4) also recognizes this as a cause of concern, and notes that institutionalized racism is at play when professors consciously or unconsciously point students of colour towards “practical nursing programs while at the same time steering white students toward professional and graduate nursing programs.” Pauly, MacKinnon and Varcoe (2009) argue that further research is needed to explore the opportunities and barriers nursing students from ethnic minorities, low-income backgrounds, and those who identify as homosexual encounter. They argue that particular attention should be directed towards examining multiple and intersecting inequities as well as to the structural and institutional barriers that create and maintain these inequities both within academic institutions and as students enter the workforce.

The marginalization that occurs within nursing is particularly evident amongst the stratification of nursing positions along class and race lines. Gustafson (2007, 155) notes how institutionalized discrimination plays out in the nursing profession in the “historic concentration



of women of color and newcomer women in practice settings with less prestige, lower wages, less security, and less professional autonomy.” She also goes on to note that nurses need to examine institutionalized racism as a way of also explaining the disproportionate number of white men and women represented among nursing management, academia, research and other positions of esteem.

The dominance of white, Western, biomedical interpretations of health and illness also impacts how we nurse, what our care looks like. According to the Canadian Nursing Association’s Ethical Guidelines, as part of ethical practice nurses should treat everyone the same regardless of gender, race, culture, or sexuality (Canadian Nursing Association (CNA) 2008). However, unconsciously, nurses may be engaging in ‘normalizing’ discourses and racialized constructions in their clinical practice, which has serious implications for their patients as well as their colleagues (Anderson, 2004).

We need to examine the underlying dialogue that creates and sustains our understanding of medical and nursing diagnoses, and the role larger systemic issues such as racism and poverty play into these discourses (Racine 2003). For instance, why is it that Aboriginal people have higher rates of diabetes than non-Aboriginal people in the Canadian context? Oftentimes professional discussions focus on issues of compliance, while little acknowledgement is given to the difficulty of obtaining the expensive supplies needed to monitor blood sugar or to the lack of access to nutritional food that is the reality of living in many northern contexts. Rather than employing behaviour-based health promotion models which focus on individual choices, Registered Nurses need to critically analyze the interrelatedness of dominant discourses which structure our world (Pauly MacKinnon and Varcoe 2009). These include globalization, colonization, marginalization, race, and gender and class interactions that affect people’s ability

to make healthy choices for themselves and create inequities in health between different populations (Anderson 2000).

Issues such as racism, classism, sexism, etc. are often not considered domains with which nursing should be concerned; however they need to be (Racine 2003). Nursing needs a theoretical perspective that accounts for the multiple social locations of individuals and the social, historical, political and economical contexts of health and illness, while being attuned to how power, particularly oppression, can cause marginalized populations to have inequitable access and care outcomes. Without recognizing how the underlying social location of individuals affects their lived experiences and opportunities, nursing interventions will prove to be less effective, efficient or caring (Pauly MacKinnon and Varcoe 2009). Introducing an intersectionality paradigm into nursing provides an opportunity for nurses to engage in critical dialogue about their own oppression and privilege and the impact that this has on their ability to practice professionally. These discourses are powerful and political and affect our ability to recruit and retain a diverse workforce, as well as our ability to understand and respond to the complex needs of the multicultural society within which we practice (Kossman 2009).

### **HOW HAS AN INTERSECTIONALITY PARADIGM BEEN USED PREVIOUSLY?**

Intersectionality is a useful theoretical lens for nursing because it assists in examining the “relationship between different systems and structures in society and the ways in which these connections impact the lives of women” (Jones Bifulco and Gabe 2009, 286). For example, Cramer and Plummer (2009, 163) argue that an intersectionality framework is particularly valuable for exploring the help-seeking and help-receiving behaviours of people of colour with disabilities. They note that an intersectionality paradigm allows for an exploration of how

“people of colour with disabilities, representing multiple constructed selves, shape systems through their interactions with them, and in turn are shaped by these systems.”

Intersectionality has also been used to examine social phenomena in which power and oppression figure prominently. For example Mill et. al (2009) used an intersectionality lens to examine how stigma related to living with AIDS often was interlocked with other experiences of marginalization related to gender, socioeconomic status, culture, and sexuality. Cramer and Plummer (2009) synthesized how intersectionality has been used by several authors to examine intimate partner violence and how multiple dimensions such as race and gender influence the adequacy of structural and political responses to this issue. Varcoe and Dick (2008) explored how Aboriginal women`s experiences demonstrate how gender, rural living, poverty, racism and colonialism intersect to increase risk for health problems including increased exposure to sexually transmitted infections and HIV. Hulko (2009) argues that we also need to incorporate an understanding of how both time and context contribute to one`s social location, and how this may impact an intersectionality analysis over the course of a lifespan.

Exploring the intersections of race, gender and class and their impact on individual well-being has important implications for critically examining issues of justice and equity for marginalized populations (Pauly MacKinnon and Varcoe 2009). As Hulko (2009, 44) notes, intersectionality offers the potential to “engage in explorations of the subjective realm of oppression to gain a better understanding of the personal impact of structural relations of domination.” However, there are few examples demonstrating how nurses` could adopt and employ an intersectionality paradigm to understand and improve their research, education or professional practice.

## HOW I INCORPORATED AN INTERSECTIONALITY PARADIGM INTO MY NURSING RESEARCH

My research study, *Incorporating an Intersectionality Paradigm to Examine Aboriginal Women's Experiences of Access* (which for the purposes of this paper I will refer to as the *Examining Aboriginal Women's Experiences* study) is a secondary analysis of a larger research study titled *Improving Access to Preventive Services for Pregnant and Parenting Aboriginal Families Living in an Urban Context*<sup>12</sup> (which from now on will be referred to as the *Improving Access* study). While being heavily involved in conducting qualitative interviews for the *Improving Access* study, it became apparent that issues of identity, particularly around 'race', gender, and socioeconomic status and how they were perceived by service providers was problematic within health care encounters for the Aboriginal women whom I spoke with. An intersectionality paradigm appeared to be a natural fit in exploring how these identity categories interacted with one another to affect women's experiences of accessing care in both positive and negative ways.

As well, I considered an intersectionality paradigm particularly important for understanding and explicating Aboriginal women's experiences, whose stories have been shaped by the intersecting forces of colonization, confiscation of traditional land bases, forced assimilation, residential schools, patriarchy and the ongoing removal of Aboriginal children from their homes. I wanted to understand Aboriginal women's experiences as they described them from their own social, political, historical, economic, and geographical contexts and also the

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<sup>12</sup> Ethical approval for this study was obtained from the University of Ottawa and the participating Aboriginal and mainstream organizations.

variety of perspectives-young/old, single mother, married, ethnicity etc. and the intersections and relations between these identities. Table 1 summarizes the main steps in the process.

Although this approach was originally thought about for the research process, there are parts of it which I continue to find helpful and applicable to my nursing practice, particularly while exploring the power dynamics of therapeutic encounters I engage in. However it is important to note that although I share my methodology, it is not with the intention of generalizing this as the “way” in which to incorporate this paradigm, but instead is offered as an example, because there have been such little written about the practical use of intersectionality within nursing.

**Table A: Summary of Research Steps**

Step	Description
<b>Interviews</b>	Qualitative interviews with service providers, leaders, Elders and family members using a semi-structured interview guide (n=40).
<b>Immersion in data</b>	I conducted the majority of the interviews and continue to be involved in analyzing transcripts for the primary research study.
<b>Sampling</b>	Purposively selected 5 rich transcripts from the total sample (n=21) which explicitly talked about the specific needs of Aboriginal women while accessing care.
<b>Essed's Gendered Racism Analysis</b>	A 7 step process was used to help “identify how intertwining systems of domination are expressed and experienced” in the everyday lives of Aboriginal women (Essed n.d.). This process was beneficial in exploring how oppressions and privileges are reproduced largely through routine and taken-for-granted practices and procedures in everyday life (Essed n.d.).
<i>1. Situation: What has occurred?</i>	This included a brief description of a particular incident in time.
<i>2. Relation to the research question</i>	This component was included to keep the analysis focused on issues of access as particularly experienced by Aboriginal women.

3. <i>Context:</i>	Involves examining who was involved, where, and when the situation took place. This particular component of the analysis helps draw attention to the power dynamics of care encounters.
4. <i>Complication: Relation to Outcome of Care</i>	The complication is the turn of events, which Essed coined as “the unacceptable”, or what went wrong or was unjust about the situation (Essed n.d.). The author also included “the acceptable” to describe care situations in which women described accessing good care.
5. <i>Explanations: participants understanding of the situation and the outcome</i>	This part of the analysis looks at the particular reactions of the women involved in the situation and how they account for what occurred.
6. <i>Argument: relation to other similar experiences</i>	The argument component makes a broader statement about whether the event is unique or whether it reinforces systemic oppressions. This is done by linking stories with what the literature has previously found about this issue.
7. <i>Reaction: evaluation of outcomes</i>	This element examines what happened as a result of the ‘unacceptable’ situation. Was the situation dealt with accordingly? Was it just? Did the patient receive a level of care that was acceptable?
<b>Thematic Narrative Analysis</b>	Used to code all of the transcripts for themes relating to Aboriginal women’s experiences of accessing care, particularly focusing on the seven subcomponents found within the gendered analysis framework. After coding the transcripts for themes, they were further analyzed for patterns, consistencies and contradictions.
<b>Verification with Participants</b>	A verification meeting was organized with three service providers and three family members attending. The wording of the themes, subthemes, and explanations were discussed for issues of language, in order to help keep the writing as close as possible to the phrasing Aboriginal women chose to describe their experiences.
<b>Interpretation</b>	Done from a critical postcolonial feminist perspective.

### *Sampling and Preliminary Analysis*

My approach to incorporating an intersectionality paradigm continued as I immersed myself in the data. As I read through transcripts, I began to purposely select stories for inclusion

into my analysis. The analysis began with five transcripts considered ‘rich’ in data; those which plainly acknowledge that First Nations, Inuit and Métis women encounter particular barriers while accessing care or those transcripts which gave voice to the implications of women’s intersecting identities in their care experiences. These ‘rich’ transcripts proved useful as a starting point in framing how an intersectional paradigm would be used.

After choosing the five main transcripts, Essed’s ‘gendered racism’ analysis was used to help identify “how intertwining systems of domination are expressed and experienced” in the everyday lives of Aboriginal women (Essed n.d.). This analysis was helpful in practically applying an intersectionality paradigm to my research. Incorporating the seven very detailed stages involved in Essed’s analysis allowed me to pinpoint crucial moments in the women’s stories and to see clearly the ways in which perceptions of women’s identity, along with the feel of care spaces, and the design of health care delivery, can together impact the continuum between descriptions of negative and positive encounters. Essed (n.d.) developed this analysis in two cross-sectional studies of gendered everyday racism, in which she examined “how everyday racism operates through and interferes with gender and other systems of oppression. As a concept everyday racism has been useful in showing that systemic racism is reproduced largely through routine and taken-for-granted practices and procedures in everyday life.” The term has been expanded in this research to also incorporate multiple interrelated identities that may perpetuate inequities as experienced by women including socioeconomic status, age, ‘ableness’, sexuality, etc. In addition, Essed’s original gendered racism analytic approach was applied to identify positive as well as negative examples of women’s care experiences to explicate the different factors found between different types of care encounters.

*Gendered Racism Analysis*

A 'gendered racism' analysis incorporates seven components which are used to explicitly analyze the different elements involved in Aboriginal women's care encounters.

*Situation: what has occurred?* This is a brief description of a particular incident in time; in this research project, situations revolved around First Nations, Métis and Inuit women's experiences of accessing health care, social services and/or support. It also included particulars such as how these women identified themselves and what services they were accessing (mainstream vs. Aboriginal). For example: A young, pregnant First Nations woman who recently came to Ottawa from a small rural First Nations community goes to a mainstream health centre to get health care. She feels isolated and alone in a new city, does not have a lot of money, and is having a hard time obtaining enough to eat. The health centre is primarily concerned with her lack of prenatal care.

*Relation to the research question:* this component was included by the author to keep the analysis focused on issues of access as particularly experienced by Aboriginal women. What is the young women's experience of accessing care? Is she obtaining the services she requires?

*Context:* involves examining who was involved, where, and when the situation took place. This is the most important and in-depth component of the analysis as it involves closely examining the situation and the 'layered' identities involved. What identities are involved in the situation? Does it take place in a mainstream health organization or an Aboriginal health centre? Who funds the centre and what are the implications? Are there health care professionals involved? Are they male or female? Who is the Aboriginal woman involved? What specific components of her identity, both her understanding and the health care



professional/organizations' perception of her identity, are influential in this situation? This particular component of the analysis helps draw attention to the power dynamics of care encounters. This woman, pregnant and alone in an urban setting, is isolated from her social context and supports. She is concerned about her ability to obtain adequate housing and nutrition however this is not the concern of the doctor treating her, as he is not familiar with this context. He is a white, middle class male doctor who looks at health through the lens of the biomedical model. His major concern is that she will be obtaining prenatal care, receiving the necessary ultrasounds, and blood work.

*Complication: Relation to Outcome of Care:* the complication is the turn of events, which Essed coined as “the unacceptable”, or what went wrong in the situation (Essed 1991). This part of the analysis examines what occurred in the context of the care situation that affected whether the woman received the care she needed at that particular time. The “unacceptable” is what was wrong or unjust about the care situation from either the perspective of the Aboriginal women in the story, the perspective of the Aboriginal individual telling the story about Aboriginal women's experiences of accessing care, or from the perspective of the author. The author also included “the acceptable” to describe situations in which women described accessing good care. In this situation, the woman eventually stops accessing the doctor because she feels that he is judging her for being poor and so young, and becomes worried that he will have her child taken away by CAS.

*Explanations: participants understanding of the situation and the outcome.* This part of the analysis looks at the particular reactions of the women involved in the situation and the possible intersections of racism, sexism, classism, etc. What do they believe occurred in the situation? Do they feel that they were treated in an acceptable manner? Why do they believe that

they were treated in the way they were? What parts of their identity do they identify as contributing to the way in which they were treated? This part of the analysis is particularly telling of women's situations-do women feel as if they were treated badly, worse or differently than other women because of a particular component or combination of any of their identities? If they do, what do they do about it? If they don't, what meaning does this have for them as individuals, for the way care is given to them and in general, for their health and well-being? In positive care encounters, explanations examine why women feel that the encounter was positive and what contributed to this experience. In this specific encounter, the woman leaves without obtaining the supports she requires because she feels judged and is worried about the associated repercussions i.e. her child will be taken. She knows that this happened to her cousin who was in a similar situation and many other Aboriginal women and believes this is the only option to protect herself and her child.

*Argument: relation to other similar experiences.* The argument component takes a step away from the situation and makes a broader statement about whether the event is unique, whether it reinforces systemic oppressions, or whether it reflects best practices. This is done by linking this woman's experience with other Aboriginal women's experiences by examining what the literature has said about this issue. For example, we know that Aboriginal women's encounters with health care are often marked by discrimination, a lack of understanding of cultural practices and that fears about CAS often prevent women from accessing care in a timely manner (Stout, Kipling and Stout 2001).

*Reaction: evaluation of outcomes.* This element examines what happened as a result of the 'unacceptable' situation or as a result of women accessing good care. Did the women go back to the care place to receive health services? Did her health improve? Did they involve other

people in the situation? Did the health care professional recognize that the individual woman was happy/ not happy with the services provided? Did they care? Did the organization acknowledge that their mandate did/did not meet the particular needs of the individual? The woman does not have any further contact with the doctor. Eventually, late in her pregnancy, she accesses care from an Aboriginal organization and continues to go there after her daughter is born to access care.

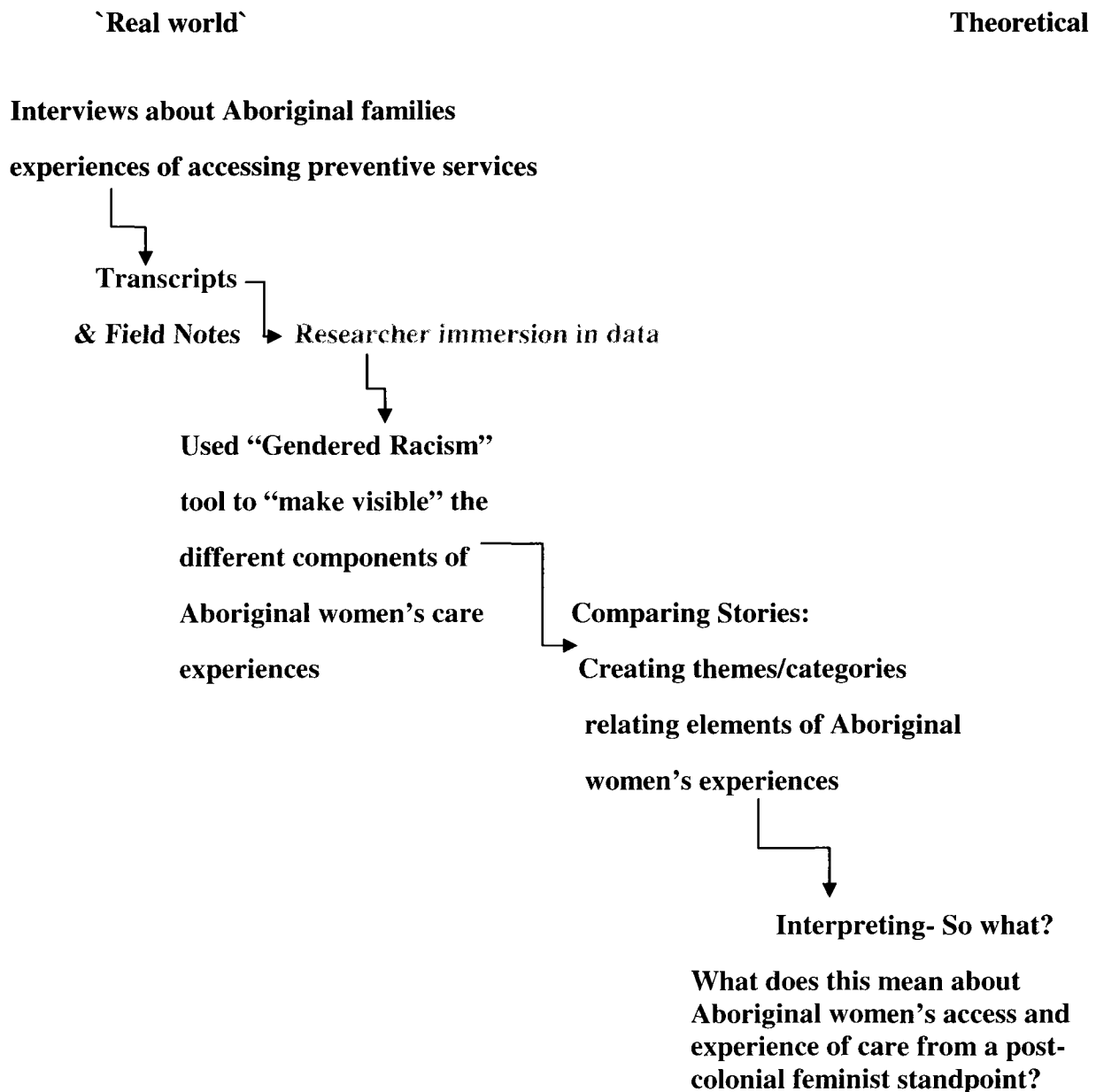
The gendered racism analysis was completed by writing up stories for each of the five purposefully selected transcripts as well as any other stories found within the larger body of transcripts (n=21).

### *Thematic Narrative Analysis*

A thematic narrative analysis was used to code all of the transcripts for exemplars of the themes explicated in the gendered racism analysis relating to Aboriginal women's experiences of accessing care. Although the results are not written in such a way as to divide them into the subcategories of the gendered racism analysis, these categories are represented within the major themes and subthemes found in the results. After coding the transcripts for themes they were further analyzed for patterns, consistencies and contradictions such as comparisons between First Nations, Inuit and Métis women's' stories, contrasting women's experiences at different care places, and examining how the identities of care providers were reflected in different encounters. Thematic narrative analysis was chosen because it gives voice to those who are often unheard by providing descriptions of individuals' "experiences, beliefs and perception" (Benoit, Carroll and Chaudhry 2003). This involved a continuous process of "finding relationships" among stories in order to show similarities between different experiences of accessing care, while also drawing

out small segments of individual stories to closely examine the nuances of the context and people involved (Benoit, Carroll and Chaudhry 2003). Alongside the raw interview data, descriptive field notes were used to provide context to the interview data. Figure 1 is a visual representation of what the data gathering and analysis process looked like in this study.

**Figure 1: Data Gathering and Analysis Process**



*Verification of Results with Participants*

After comparing stories and creating a list of themes and subthemes, a verification meeting was organized with members of the local Aboriginal community to share the initial results with them and to see if the way in which the results were being communicated made sense to them. Three service providers attended; one of whom was a First Nations woman who had encountered a lot of racism and prejudice during her life, another First Nations woman who worked with mothers and infants, as well as a non-Aboriginal service provider who had been working within the community since the centre had opened. Three family members attended the meeting; one First Nations grandmother, one Inuit grandmother and one First Nations mother.

The diversity of women's experiences reflected within the verification meeting was important to ensure that the results of this study resonated with different Aboriginal women's encounters. The women that attended the verification meeting came from reserve or rural areas, lived in urban areas but continued to have connections with their land bases, were First Nations and Inuit, were different ages and had had different experiences of accessing care. However, despite these differences, there were a lot of similarities between their stories of care encounters and the original research participants.<sup>13</sup> The wording of the themes, subthemes, and explanations were discussed for issues of language, and feedback was given to help keep the writing as close as possible to the phrasing Aboriginal women chose to describe their experiences.

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<sup>13</sup> Please note that some of the original research participants also participated in my verification meeting. However I also included other women from the community in order to ensure that my research continued to be relevant.

## **IMPLICATIONS FOR NURSING PRACTICE, RESEARCH, EDUCATION AND POLICY**

An intersectionality paradigm offers an avenue for nurses to travel upon that can improve individual practice, as well as broader professional arenas such as nursing education, research and policy. In the following sections I will explore the positive potential implications I have identified of introducing an intersectionality paradigm into these different components of nursing.

Intersectionality has major implications for clinical nursing practice. Exploring the interlocking social locations of one's self and the client should be incorporated into reflective practice as a way for nurses to examine the implications of privilege and oppression for the therapeutic encounter. Tang and Browne (2009, 124) argue that "even if a person does not intend to act in a discriminatory manner, his/her historical location as a member of a privileged group is implied by and implies the systemic and historical relations that sustain his/her existing location as a privileged member of society." Without being made aware of these power dynamics, nurses with all the right intentions run the risk of imposing dominant discourses onto marginalized populations, further ostracizing them within the care space.

An intersectionality paradigm "opens up a dialogic space for reflection on our socio-political *historical* positioning and how this shapes everyday realities. It calls upon everyone to reflect upon his or her positioning in history, the contexts of oppression, and the ways in which each one of us colludes in oppression" (Anderson, 2004, 245). An intersectionality paradigm helps nurses to attend to the power dynamics that are held not only by their gender, race, social class and sexuality but also how this interacts with their educational level. We cannot ignore that the knowledge we carry as health professionals is a form of power which has enormous

implications for the well-being of those that are cared for (Allen 2006). As Pauly, MacKinnon and Varcoe (2009, 122) note “nurses can and should see people and their health as embedded in the social locations and the material conditions of people’s lives.”

As well, examining the interlocking oppressions of race, gender, socioeconomic status, etc. forces a re-examination of the meaning of social justice within nursing. Pauly, MacKinnon and Varcoe (2009, 119) note that in order to address issues of equity and justice, nurses

“need to cast their gaze backwards or upstream to the conditions that perpetuate inequities... attention is required to structural injustices that act as barriers to healthcare services such as addressing the stigma and discrimination experienced when accessing healthcare services by those disadvantaged by their social positioning in relation to class, gender, ethnicity, and so on.”

Incorporating an intersectionality paradigm into nursing organizations and the institutional settings in which nurses work would be helpful in incorporating and acting out our ideals of social justice in a practical and meaningful way sense as described above.

The use of an intersectionality paradigm also has major implications for nursing research. Incorporating an intersectionality paradigm forces nursing researchers to examine who is being represented within nursing research and how issues are being examined. This also forces a re-examination of research topics for inclusion of critical appraisal of issues of privilege and oppression within nursing care, research and education. Pauly, MacKinnon and Varcoe (2009, 120) note that in order to address health equity nurse researchers need to be examining how to address

“those broader conditions that produce health inequities such as poverty, inadequate housing, racializing structures, criminalization of drug use, social exclusion, and violence... Thus, beyond examining how healthcare is provided we need to examine the ways that society is organized and the structural conditions that contribute to vulnerability, illness, and injury for groups in the population.”

Examining these issues of equity and how to address them begins in our nursing education. A nurse's education provides a powerful socializing experience into the roles and attitudes required of a nurse and universities' curricula and academic expectations shape who will be nurses and how they will nurse. The incorporation of an intersectionality paradigm offers our schools of nursing and our academics the opportunity to talk about the power dynamics associated with deciding who will be the face of the next generation of nurses, but also in teaching student nurses what it means to be a nurse.

Nurse educators need to be personally attending to the dynamics of educating students **from** multiple backgrounds before attempting to educate them about providing care **to** people from different backgrounds (Allen 2006). Pharris (2009, 6) notes the particular importance of white Professors taking the lead on addressing this important issue;

“white faculty can and should teach students that dismantling racism is an essential nursing intervention for health. This important work is often a new concept for white students, most of whom have not spent a great deal of time thinking about racism or their responsibility to identify and address it. The overwhelming whiteness of the nursing culture, if not critiqued, perpetuates this blindness.”

However, it is important to note that in incorporating an intersectionality paradigm, nursing professors should not only be attending to racism, but also to interlocking issues of gender, class, sexual identity, ableness and other identity factors which have implications for helping nursing students to also avoid marginalizing these identities and contribute to their understandings of providing client-centered, reflective care.

Incorporating an intersectionality approach into nursing policy also provides the opportunity to create meaningful systemic change. An intersectionality paradigm could be used to appraise and create more inclusive and equitable policies that govern nurses' organizations,



research funding bodies, and universities by looking at nursing hiring policies, or policies around diversity, for example (Gustafson 2007).

## CONCLUSION

Before closing, it is important to offer perhaps a word of warning that although this paper promotes the use of an intersectional approach within nursing as a means by which to address inequities, the author in no way wants to promote this lens as the only way in which to address this problem. Issues of inequity and justice are complex and require the work of multiple scholars; therefore this paper is only meant to introduce intersectionality as one approach that could prove useful and offers only one way of introducing such a paradigm.

This paper is written with the intention of bringing awareness to the necessity of including ‘othered’ voices in the creation and development of nursing education, research, and policy in the hopes of moving the nursing profession closer towards its goal of social justice and equity for all (Anderson 2000). Often in the current health care environment of efficiency, with the limited time and resources within which many nurses work, including myself, it feels like there is little time to really understand where our patients are coming from. However we need to question a system that puts more emphasis on money and efficiency than giving us the time, education, and resources we need as nurses to be able to provide the type of care that not only have we been trained to do and which our profession requires of us, but which as dedicated and compassionate human beings we want to be able to provide.

As Tang and Browne (2009, 124) concluded; “we recognize an urgent need to bring to the open what might have been taken for granted, and question the unequal power relations that organize not only the experiences of injustice, but also the interpretation of those experiences by people coming from different historical and socio-political locations.” This paper draws attention

to the importance and necessity of nursing attending to its own social location through the use of an intersectionality paradigm to “unearth” the unequal power relations within our profession and within our engagements with our clients. Without recognizing the narrow lens through which our personal social location affords our view of the world, we miss the opportunity of engaging with people in a real, genuine way and of furthering our profession as the caring, dedicated individuals we pride ourselves on being.

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## CHAPTER 3: IMPLICATIONS FOR NURSING

The final chapter explores the implications of the “*Exploring Aboriginal Women’s Experiences of Accessing Care*” study and outlines the particular connotations for nursing practice, education, research and policy. The following sections examine how the concept of identity was developed in the study, and discusses the potential contributions to nursing and our understanding of developing therapeutic relationships, particularly with marginalized populations. It also delineates how the use of an intersectionality paradigm was beneficial in exploring issues of identity in this research, and the potential this paradigm offers nursing as an emancipatory means of addressing the power dynamics that infiltrate therapeutic encounters.

### Review of the Results

This research study explored Aboriginal women’s experiences of accessing care, and specifically investigated how the meanings attributed to women’s identity by service providers influenced their care encounters. An intersectionality paradigm incorporating Essed’s gendered racism analysis was used to identify one major overarching theme and four subthemes associated with Aboriginal women’s descriptions of their care experiences.

Aboriginal women’s identity as *mothers* was found to be the overriding focal point at which the intersections of women’s identities (including gender, ethnicity, race, class, and marital status) influenced the ways in which they saw themselves perceived and treated by service providers within care encounters. The mothering identity was the intersecting point at which women described facing heavy stereotyping and discrimination as a result of service providers perceptions of women’s identities and how mothers should ‘behave.’ Aboriginal women described negative experiences of accessing care that were marked by discrimination and

racism in which they felt disrespected and unsafe. These experiences were described in the subtheme the “*impositions of presumed superiority of Western models of mothering*.” The views imposed by service providers often led Aboriginal women to fear that their children would be apprehended, demonstrating the impact of historical experiences onto current everyday encounters.

Positive care encounters also revolved around Aboriginal women’s identities, as these were care places and encounters in which efforts were made to *reaffirm Aboriginal women’s identity*. Three subthemes described different elements of care places and encounters that *reaffirmed Aboriginal women’s identity* as mothers. Aboriginal women described the importance of care places ensuring *safety and a sense of belonging*, particularly as a result of previous negative experiences they had encountered while accessing care. Developing non-judgmental, trusting therapeutic relationships with service providers in which women’s identities were perceived positively was another important element of Aboriginal women’s positive descriptions of accessing care, described in the subtheme *service providers ‘working it through’ with Aboriginal mothers to provide care in “a good way”*. In the final subtheme Aboriginal women described themselves and each other as *leading and transforming care*. This subtheme was about Aboriginal women taking pride in their identity as Aboriginal women, building their capacity to do things in a good way for themselves, their families, and their community, by leading and transforming how care is delivered to Aboriginal people in an urban setting.

### Implications for Nursing

The following section explores the implications of the results of this study for nursing practice, education, research and policy.

*Nursing Practice*

The results of this study had several important implications for nursing practice which will be described in the subsections *identity and forming trusting relationships* and *affirming the strength of mothers*.

*Identity and Forming Trusting Relationships.*

According to the Canadian Nursing Association Code of Ethics (2008), nurses practice in an ethical manner when they “build trustworthy relationships as the foundation of meaningful communication, recognizing that building these relationships requires conscious effort. Such relationships are critical to understanding people’s needs and concerns.” Examination of how Aboriginal women’s interrelated identities contributed to their care experiences draws attention to the importance of acknowledging the psychosocial and historical elements of care as central to building trusting relationships. How women defined themselves and how they were perceived within the care encounter was the result of both historical and contemporary influences and was central to how they interpreted their care experiences.

Though nursing contends that the therapeutic milieu is critical to effective practice, this study’s results illustrate that Aboriginal women, one of the most marginalized populations in Canada, continue to encounter discrimination, racism, and oppression while accessing care on account of how their identities are perceived. Thus, though in theory nursing argues that the psychosocial and relational elements of care are important, these results show that in practice, we may not be incorporating this critical element of care very well, particularly while working with marginalized populations (Harkreader, Hogan & Thobabem, 2007). For example, participants recounted instances in which their psychosocial needs were not met, and often felt that service



providers (including nurses) often did not understand the context within which they lived, or respect or acknowledge their culture or traditions. Even worse, many Aboriginal women described encountering racism and discrimination within their care encounters, indicating that some nurses are ill-prepared or not willing to practice in a manner that promotes respect and safety for the identity of clients that they are required to engage within the very center of nursing care, the therapeutic relationship.

Furthermore, the Canadian Nursing Association's (2008) Code of Ethics contends that as part of ethical practice, nurses "question and intervene to address unsafe, non-compassionate, unethical or incompetent practice or conditions that interfere with their ability to provide safe, compassionate, competent, and ethical care to those to whom they are providing care, and they support those who do the same." The results of this study indicate that some nurses are unaware that their attitudes and the way in which they engage in care does not make their clients feel safe, that they do not feel a sense of compassion for the lived experience of clients they encounter, or that they are not able to practice with a level of competency that promotes the safe and ethical care of human beings. Furthermore at this time it is nurses who are the ones to evaluate whether the therapeutic relationship is a trusting one. Nursing has not yet evolved methods or knowledge to a) develop relationships that clients deem trustworthy or b) understand how nurses can assess/understand client's evaluation of a trusting relationship. This is where cultural safety is advancing knowledge, but perhaps has not yet widely been taken up. Examining the concept of identity and how nurses' perception of the identity of their client influences the care encounters of marginalized populations is particularly important for exploring how nurses can work towards building safe, trusting relationships with marginalized populations to promote ethical and compassionate practice.

*Affirming the Strength of Mothers*

Acknowledging the importance of Aboriginal women's identities and strengths as mothers within care encounters has important implications for nursing care. Motherhood is a unique and critical time in a woman's life for accessing care, not only for her health and well-being but for that of her fetus, children, and family. In the subtheme, the "*imposition of the presumed superiority of Western models of mothering*," Aboriginal mothers talked about how destructive it was to their identity when they encountered stereotyping, racism, and discrimination while accessing care, particularly in their role as mothers. They also recounted very real fears of their children being taken away by social services as a result of how their mothering abilities and identities were judged by health care professionals.

As a result of residential schools and the associated loss of parenting skills, the historical impact of the sixties scoop and the ongoing disproportionate removal of Aboriginal children from their families by Children's Aid Services, Aboriginal mothers experience substantial fear and an increased level of vulnerability about how their skills as mothers will be judged within the therapeutic encounter and the associated repercussions (Cull, 2006). This, alongside the lived experience of markedly increased rates of poverty, violence, inadequate housing, isolation, racism and discrimination, form a strong underlying current within many Aboriginal women's lives (Jacobs, & Williams, 2008). As caring professionals, nurses need to be attuned to these underlying socio-historical elements that structure the power dynamics within care encounters with Aboriginal mothers. Nurses need to understand that this marked vulnerability experienced by Aboriginal women as well as their own lived experiences of being parented may impact how they understand being a parent. So rather than judging their parenting abilities, they need to understand where these abilities have arisen from. Even more importantly, nurses need to

become attentive to how their own identity and understanding of mothers and mothering shapes how they respond to and understand Aboriginal women's experiences. By becoming attuned to their own identity and experience of mothering, nurses may become attuned to their own privileges and oppressions and be more reflective of how this impacts their perceptions while working with mothers.

Chase and Rogers (2001) argue that as health care providers, nurses need to be involved in critically analyzing how Aboriginal women are constructed as 'bad' mothers within health care discourses,

"whenever we hear the charge of bad mothering, we need to pause to consider what is going on. What are the social and historical conditions shaping these women's lives? What are the ideologies and cultural assumptions shaping public perceptions of them? And most important of all, what is at stake and for whom, in their social construction as bad mothers? More often than not, 'bad' mothers function as scapegoats, as diversions from the horrendous social problems of our time: persistent poverty, and pervasive racism, sexism and heterosexism" (p. 47).

Mothering has always been a very public spectacle, however within the past twenty to thirty years the media has increasingly played a pronounced role in defining social norms, particularly around the "ideal mother" and in perpetuating the pressures put on women to act out this social role. Intense strain is put on women in their role as mothers, "everyone watches us, we watch ourselves and other mothers, and we watch ourselves watching ourselves...motherhood has become a psychological police state" (Douglas and Michaels, 2004, p.6). Douglas and Michaels go on to note that "the new momism is a highly romanticized and yet demanding view of motherhood in which the standards for success are impossible to meet" (2004, p.4). However if privileged white, middle-class women with supportive partners feel inadequate in their ability to mother according to the standards set out by the dominant society, how are women who are

persistently “othered” in the dominant discourse, such as Aboriginal women, supposed to cope? Nursing needs to examine how we contribute to the othering discourses through our racially based education and interventions. We need to move towards becoming strong advocates for women in their role as mothers and examine how we can support and empower women in this role, educate the public about the lived reality of mothering (particularly as a single female) and change public policy to meet the multiple needs of different groups of women.

During our interviews with Aboriginal women and service providers, we often heard that there is a very different type of parenting amongst Aboriginal families, particularly Inuit families or families that come from the north or remote areas. This type of parenting was often described as being “looser” and allowing children to be more “free” and learn through experience. Service providers spoke about having to teach parents about how to live within the 9am to 5 pm child care and schooling schedule that dominates many western societies. Parents and service providers also spoke about how this type of parenting was often judged as being neglectful or not caring because of different cultural understandings of parenting.

Nursing needs to recognize that there are different cultural understandings of parenting, and that the social construction of women as ‘bad’ or ‘unfit’ mothers and the associated “isms” that accompany these discourses (such as racism) have implications for marginalized women, particularly Aboriginal women. Recently, the *Canadian Feminist Alliance for International Action* (2010) argued that the Canadian government is not doing enough to help marginalized women and their children living in poverty and is not attending to the alarming rates of violence and murder against Aboriginal women. Rather than coming to conclusions based on dominant discourses on the disparities between Aboriginal mothers and “the ideal” mother, Chase and Rogers (2001) argue that understanding these issues of oppression within Aboriginal mother’s

lives should be an important element of providing nursing care. “Understanding the social construction of bad mothers should be an essential part of the education of lawmakers, policymakers, prosecutors, doctors, educators, child welfare professionals-everyone who has the power to affect the lives of mothers and their children” (p. 47).

Examining the mothering identity as a pronounced period of vulnerability for Aboriginal women should force nurses to become attentive to the power dynamics that they hold in the therapeutic encounter by their gender, race, class, sexuality as well as how these identities interact with the knowledge that they carry as health professionals (Allen, 2006). As Pauly, MacKinnon and Varcoe (2009) note, “nurses can and should see people and their health as embedded in social locations and the material conditions of people’s lives” (p. 122). Rather than using a “victim-blaming approach” or ignoring the particular context within which marginalized women live, nurses need to continue to incorporate a critical and political lens into their work and examine how issues that they attend to at the bedside are part of larger systemic issues that affect certain women disproportionately.

The results of this study indicate that part of learning to practice in a culturally safe manner should be the incorporation of how different social roles, such as motherhood, differ across cultures and historical experiences. Nursing needs to be attentive to the power dynamics afforded to different groups of mothers and as a result, the resources these mothers have at their disposal. Chase and Rogers (2001) argue that “a mother’s age, race, ethnicity, social class, sexual orientation, and abilities or disabilities make a big difference to the challenges she faces as she goes about her everyday life, the kinds of resources and support that she is able to draw on for mothering, and the social expectations concerning her motherhood” (p. xv). Nursing needs to continue to find ways to attend to the specific strengths of clients who come from different

backgrounds and views on health, while accessing care in a system that may discriminate against multiple aspects of their identity and values. For example, our results suggest that while providing care to Aboriginal women, nurses could invite and assist women to explore and incorporate traditional Aboriginal reproductive, pregnancy, and birthing knowledge into the care they provide, and the incorporation of different culturally relevant roles, such as midwives (NWAC, 2007b).

Incorporating traditional knowledge and roles as per clients' wishes is a powerful means of conveying respect and acknowledging the identity and values of women. Incorporating traditional knowledge is one aspect of practicing in a culturally safe manner that addresses the power dynamics that pervade Aboriginal women's encounters with a health care system that often does not acknowledge or respect different ways of knowing about pregnancy and motherhood (Hart-Wasekeesikaw, 2009). The importance of addressing traditional and cultural knowledge will increase within nursing as Canada's population becomes increasingly diverse.

Another important aspect of providing safe and responsive care to Aboriginal women is having an understanding of the context within which they are attempting to parent. In the subtheme "*service providers 'working it through' with Aboriginal mothers to provide care in "a good way"*", an important part of the way that service providers gave care to Aboriginal women was that they supported them with an understanding of the context within which they were living. For many women living in poverty or as single mothers, this included providing them with food and with social support, rather than with a sense of judgment for these mothers' poverty and lack of access to food to feed their children.

These service providers demonstrated an alternative positive way of being for women that did not further oppress them, but instead celebrated their strengths and their gifts and provided a strong counter-narrative to the dominant discourses of the “ideal” mother placed on Aboriginal women. These service providers developed supportive relationships with Aboriginal women that nurtured them and helped to develop their personal agency and mastery as mothers is a positive example of how nurses can be involved in debunking the ‘new momism’ and can help to provide marginalized women with the tools and supports they need to feel confident in their role as mothers. DeLashmutt (2007) argues that developing these types of supportive, compassionate and trusting relationships between nurses and marginalized women can create an opportunity to ameliorate the negative impacts of poverty and to improve childbearing outcomes.

Nursing needs to be more proactively involved in providing this counter-narrative to marginalized women, in providing the tools and resources to help women feel confident in their role, to let them know that they are going to be okay, to give them an alternative to the stereotypes placed on marginalized women in their mothering role, to help women and their children lead strong, healthy, and productive lives. Rather than focusing on a deficit-based approach or a needs based approach, nurses needs to continue to build upon the strengths, capacities and resources available to the women they work with. In a study of marginalized mothers accessing care in Australia, Short (2005) notes that “women’s motherwork at the margins emerges as a set of practices deeply connected to singular identities of strength. Their capacities for self-reliance, risk taking, and endurance sustained them and enabled survival in extreme circumstances” (p. 211). By recognizing and building on the strengths and supports women have, nurses can help women who may be marginalized on account of their social location use their strengths to help them be attentive to their health and well-being. As

DeLashmutt (2007) notes, “nursing presence has a direct effect on health, relationships, trust, hope, esteem, and sense of self” (p. 184).

### *Nursing Education*

This section explores the implications of this research for nursing education by examining curriculum content and formats and the composition of nursing students and professors within nursing faculties. In her important document on developing a culturally safe nursing curricula to help retain First Nations, Inuit and Métis nursing students, Hart-Wasekeesikaw (2009) argues that “the ability to effectively reduce both the inequities and the disparities of health requires being cognizant of the ‘very real’ cultural and social barriers which may exist between First Nations, Inuit and Métis individuals and health service providers in communities and urban centres” (p. 2). The results of this study provide an empirical example of the “cultural and social barriers” that exist between Aboriginal peoples and health care providers as a result of the privilege and oppression associated with each person’s identity within the care encounter and particularly service providers imposing their own, often negative, perceptions of women’s identities, making women feel unsafe within the care encounter. The following section will explore how nursing education can help student nurses to be aware of issues of privilege and oppression as they are socialized into nursing; and address how nursing can acknowledge issues of identity within nursing faculty and the nursing student population.

### *Socialization of Nursing Students*

Examining identity and issues of privilege and oppression while students are becoming socialized into nurses is an important step in developing future nurses who are able to practice competently, compassionately, with increased self awareness, and with an understanding of their



role in alleviating social injustice. Cultural safety is a promising framework to help guide nursing in addressing these power dynamics. Cultural safety goes beyond cultural sensitivity's emphasis on respecting difference, and cultural competence's focus on developing skills and attitudes of health care professionals. Rather, cultural safety includes cultural sensitivity and competence, but invites nurses to examine and "understand the power differentials inherent in health service delivery and redress these inequities through educational processes" (Hart-Wasekeesikaw, 2009, p. 2). Cultural safety enables nurses to actively address disparities by acknowledging issues of racism and discrimination, examining the historical, political and social contexts of care, and understanding that what is considered to be culturally safe care is determined by the one receiving care (Hart-Wasekeesikaw, 2009).

Use of the term 'culture' within the title of a concept may imply that this concept is only associated with locating power differentials between people of different cultures, and could possibly be extended to issues of ethnicity and race. However, the Nursing Council of New Zealand's (2005) definition suggests that cultural safety also incorporates multiple aspects of identity including "age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability" (p.3). The results of this study indicate that cultural safety should incorporate these aspects of identity and an understanding of the interrelationships between these identities. Incorporating these different components of identity would go a long way in helping to reduce stereotypes by acknowledging the different power differentials associated with different identities. For instance, nursing students could be presented with case studies about two different Aboriginal women accessing care; one is a young Inuit women arriving in an urban centre from Nunavut to deliver her baby. She is very poor, speaks Inuktitut, and is with her sister while her husband and large extended

family remain in the north. The other case study is a young First Nations mother, a professional who works as a manager at the local Aboriginal health centre, middle-class, and interested in having a homebirth. How would culturally safe care look different for these two women and their personal circumstances? Asking nursing students these types of questions would provoke discussion about how possible assumptions about these different identities and the impact they have for the type of care that nurses would deliver.

### *Acknowledging the Importance of Identity within Nursing Education*

Acknowledging the diversity of people's experiences reflected in their identities, personal histories, and the political, economic and social context within which they live, needs to be an integral part of the way nurses think about providing care. However in order to make this a reality, it is necessary that the nursing workforce begins to reflect this diversity (Jacob, 2008). The Canadian Nurses Association (CNA) (2009) points out that the profession of nursing does not represent the diversity reflected in the demographics of the general Canadian population. For instance, in 2006 they reported that there were 252,948 registered nurses in Canada, with only 5.6 percent being males (while in the general Canadian population, men account for 49.6% of the population), with an average age of 45 years (versus 39.5 years in Canada's general population), and 7.9 percent had been internationally educated (meanwhile immigrants account for 18.5% of the Canadian population) (Statistics Canada, 2010; The Institute of Chartered Accountants of Ontario, 2008).

In order to help develop a more representative nursing workforce, schools of nursing need to make efforts to recruit and retain nursing faculty and nursing students that represent the diversity of identities reflected in the populations they serve (Jacob, 2008). This view is

consistent across a number of different nursing organizations in countries including Canada, Australia and New Zealand, who all are attempting to address how to recruit and retain more Aboriginal students (Turale & Miller, 2006). Hart-Wasekeesikaw (2009) notes the benefits of having a more diverse academic and student population;

“developing culturally safe learning environments benefits students, educators, educational institutions, and education systems. Students are more likely to respond positively to the learning encounter when they feel safe, respected and able to voice their perspective. An educator is more likely to experience more job satisfaction when attendance is better, when the quality of scholarship is good, and when the classroom is an environment of equal engagement between different ways of knowing. This comes from an educator creating a culturally safe learning environment and delivering culturally safe curriculum” (p.3).

In particular, efforts need to be made within schools of nursing to incorporate professors from diverse backgrounds who represent different identities and worldviews. Representing diversity in academia promotes a broader range of subject matter and expertise within nursing faculty, and may help minority students feel more comfortable and find a place of belonging in predominantly “white” academic institutions (Jacob, 2008). However, in order to ensure that nursing faculty from diverse backgrounds are able to bring their experiences and knowledge forward into their research and educational pursuits, efforts need to be made to ensure that these faculty feel safe, welcomed and that they are able to represent themselves and their experiences within the classroom and their research (Davis-Dick, 2009).

Just as schools of nursing must value and work towards addressing diversity within their faculty, they must also acknowledge the need to encourage diversity among nursing students (Labun, 2002). Hart-Wasekeesikaw (2009) argues that “professional image, gender, race and power in nursing are all variables that impact recruitment of non-traditional candidates into Canadian nursing and merit our attention” (p. 13). Students from diverse backgrounds may face a

range of barriers that prevent them from applying to schools of nursing, or once accepted, continuing on in the program. Some barriers that have been previously found include

“negative views of faculty and other students about the abilities of such students, racism in nursing curricula and textbooks, and bias in evaluation of student performance...in addition, faculty may not be well prepared to teach transcultural concepts or may not have the time or expertise to help students with financial issues and continuing family obligations, an overwhelming sense of isolation, and fear of academic failure” (Evans, 2007, p. 354).

Greater efforts need to be made within schools of nursing and by nursing faculty to encourage students to feel safe and comfortable to share their opinions and worldviews within nursing education, while supporting them to be attentive to their own power, privileges and oppressions. The Registered Nurses Association of Ontario (RNAO) (2007) points out the lack of acknowledgement and voice many nursing students encounter within the confines of the professional education setting; “combining with faculty that also are overwhelmingly female and white, the textbooks, journals, pictures in hallways and so on can all combine to feel unwelcoming to anyone who is not part of that demographic” (p.52).

Faculty need to make personal efforts to attend to the dynamics of educating people of different identities, before attempting to educate them about how to provide care to people with different identities (Allen, 2006). The RNAO (2007) recommends that in order for academics to help students practice as culturally safe professionals, they need to “incorporate diverse learning styles and strategies into the development and delivery of the curriculum” as well as “identify and meet the specific learning needs of the growing population of culturally diverse students coming into nursing programs” (p. 47). For example, in an opinion piece by Australian nursing scholars Turale and Miller (2006), they note recommendations that have been made within Australia to help recruit and retain more Indigenous students including compulsory content on

Indigenous history, teachings and traditions, building better working relationships between Indigenous communities and schools of nursing and increasing the education of nursing professors in regards to Indigenous ways of being.

Another important aspect of retaining students from diverse backgrounds and for teaching students about providing care to different populations is that nursing faculty should be attending not only to issues of race in the classroom, but also to interlocking issues of gender, class, sexual identity, ‘ableness’ and other identities which have implications for nursing students understandings of providing client-centered, reflective care to marginalized populations. This is particularly important for those who come from very privileged backgrounds. As Pharris (2009) notes;

“White faculty can and should teach students that dismantling racism is an essential nursing intervention for health. This important work is often a new concept for White students, most of whom have not spent a great deal of time thinking about racism or their responsibility to identify and address it. The overwhelming Whiteness of the nursing culture, if not critiqued, perpetuates this blindness” (p.6).

Professors need to incorporate discussions around identity and systemic oppression while examining cultural competence and safety so that nursing students are exposed to, and critically reflect upon the prevalent “whiteness” that underlies societal structures and marginalizes different populations from equitable access and health outcomes.

Incorporating the concept of cultural safety, as well as increased diversity among nursing faculty and nursing students “can increase the understanding and sensitivity of nurses and positively affect the way they provide care to their patients” (Jacob, 2008, p. 217). The results of this study indicate that as nurses we need to move beyond addressing notions of meeting people’s “cultural needs” and address how identity impacts care. By ensuring that nursing

faculty, nursing students and the education of future nurses is geared towards increased inclusivity and awareness of the power dynamics that structure our social relationships (including relationships between professors and students, and between nurses and patients), nursing can work towards examining and addressing systemically ingrained inequities and move forward with increased consciousness of the larger world around us and our valued place within it as a caring profession.

### *Nursing Research*

The following section will explore the implications of this study's results as well as the implications of the research methodology employed within this study for future nursing research. It summarizes the different concepts and theories within my thesis that require further examination and probing within nursing research.

The concept of identity, and particularly interrelated identities, requires further research within nursing. This study introduced a definition of identity that could be useful for nursing and examined how identity featured within Aboriginal women's' experiences of care. However, since the results suggest that identity needs to be considered a core concept of nursing, further research is required to examine and develop the use of this sociological definition of identity across different populations and settings. Further research is also needed to understand the features of care places and encounters that feel 'safe' for different populations. For example, the notion of 'safety' and how it can be brought into the design and delivery of health care for marginalized populations needs to be examined across different populations and different health service delivery models. Examining 'safety' could potentially have implications not only for nurses' understanding of providing culturally safe care and the therapeutic encounter, but also

have implications for health care staffing, the design of care organizations, and the development of health care policies.

Considering the importance of the mothering identity in the results of this study, it would be of benefit for nursing researchers to examine different steps along trajectories in a women's life, such as motherhood, which have major biological, emotional, social and spiritual components. How do women's layered identities change along this trajectory, and how does this influence their access to care? Similarly, as women get older, and their physical and mental functioning may change, how does this contribute to their access to care? How do women's experiences of power and oppression change along their life trajectory, and what influences these changes?

The results of this research indicate that health care providers need to have a better base of understanding about identity and how it relates to issues of privilege and oppression within health care encounters. Examining the concept of identity within nursing research forces a reexamination of who is being represented and how they are being represented. The RNAO (2007) argues that in order to help nurses develop the knowledge to practice in a culturally safe manner, researchers need to "make every effort to include diverse populations as subjects of research" (p. 48). However I would push this even further and argue that research also needs to incorporate issues related to privilege and oppression within nursing.

Furthermore, postcolonial feminism critically analyzes what is valued as knowledge, and asks nurses to move beyond including marginalized populations as 'subjects' of knowledge, to have participants actively involved in creating new knowledge (Khan, McDonald, Baumbusch, Kirkham, Tan & Anderson, 2007, p. 229). Within research, nursing needs to continue to

incorporate and develop methodologies, paradigms and research questions, such as postcolonial feminism and intersectionality, which bring to light injustices that are being sustained by maintaining the status quo. Incorporating a postcolonial feminist lens into nursing research and practice helps nurses to move away from victim blaming, to critically analyzing how such health disparities have arose. Incorporating the concept of identity into further nursing research will expose the “identity politics” which plague the delivery of health care, leading to health disparities for marginalized populations. By developing emancipatory action-oriented knowledge to address these concerns, nursing researchers can pave the way towards a health care system that is more inclusive, fair, and just.

### *Nursing Policy*

This section will highlight the most notable policy issues related to access to preventive care for Aboriginal women, from among the broad range of topics explored which have some impact for nursing policy.

The subtheme *ensuring safety and a sense of belonging* examined the implications of identity for the design of care structures. Health care organizations need to recognize that the design of health care structures and the space in which health care is delivered impacts whether people feel that they belong there, that they are safe, and that they are comfortable. Within this study, Aboriginal organizations designed their care spaces to be attentive to the needs of Aboriginal people, particularly women, understanding that women were the most likely to access care for themselves and their families. However when participants described their experiences at mainstream health care organizations, they often described them as cold or unwelcoming,



because they did not see themselves reflected in the art on the walls, or were not greeted warmly by the secretary at the front desk as they entered the facility.

As health care providers are mandated by professional standards to practice in a culturally safe manner, it needs to also become the responsibility and policy of leaders at the organizations where they work to make the necessary efforts to ensure that organizations are designed to be culturally safe for both employees and patients. The RNAO (2007) argues in their Best Practice Guideline for promoting cultural competence in the workplace;

“in working towards the goals of quality care and professional satisfaction, employers and unions must co-create work environments that provide support for cultural competence in care delivery and staff relationships. Employers and unions alike must value diversity in order to establish the policies and procedures needed for the people in the organization to develop and “live” cultural competence. At the most basic level they must choose to engage deeply in the diversity agenda if real change is to happen for the next generation of nurses and other health care workers. Engaging in the diversity agenda in the workplace involves creating an inclusive environment in which our diverse skills, cultural perspectives and backgrounds are recognized and valued” (p. 35).

In order to follow such guidelines, organizations are required to examine their mandate and values, the design and layout of preventive health care environments and how ‘safe’ it is for different populations, the diversity reflected in staffing, and the training and education opportunities provided. In doing so, organizations can improve the level of patient care they deliver, the satisfaction of their employees, and the overall environment of the care organization, as the RNAO (2007) notes;

“there are many benefits for patients and staff when employers and unions work together towards cultural competence. When professionals are culturally competent, they establish positive, helping relationships that engage the client/patient and improve the quality of services that are provided. As a

recruitment and retention factor, improved job satisfaction and commitment through greater opportunity for participation in decision making together with the flexibility to better balance work and personal commitments are key. Improved performance and greater innovation are possible through harnessing the creativity that comes from cooperation within diverse groups. For patients/clients and residents, this means better and more responsive services that builds on our diversity” (p. 35).

Examining the dynamics of underlying historical and socio-politically embedded values that govern the way care is provided gives institutions, researchers and health care professionals a deeper understanding of the disparities in access to services for Aboriginal women and their families. By examining issues of identity and marginality at the different system levels we come to understand how oppression and disparities are perpetuated and as a result of our increased knowledge, are able to take the steps needed to promote positive change. Examining identity, privilege and oppression also broadens our understandings of social justice to incorporate a

“gaze backwards or upstream to the conditions that perpetuate inequities... attention is required to structural injustices that act as barriers to healthcare services such as addressing the stigma and discrimination experienced when accessing healthcare services by those disadvantaged by their social positioning in relation to class, gender, ethnicity, and so on” (Pauly, McKinnon & Varcoe, 2009, p. 119).

Although our profession has historically described itself as having a strong consciousness towards addressing social justice issues, at times we have also been involved in perpetuating oppression. By creating policy that acknowledges and incorporates the voices of the marginalized and attempts to reflect our population diversity within our health care organizations, we can move forward in a positive way with our agenda for achieving social justice. In order to build upon the idea of “safety” within nursing policy, nursing need to continue to make efforts to make it “safe” for Aboriginal people and other marginalized groups

to be involved in creating healthy policies at an organizational and systems level perspective in order to help to continue to draw attention to pressing social justice issues.

### Identity as a Useful Concept in Nursing

This section describes some of the particular implications the concept of identity has for nursing and possibly other fields of study.

#### *Fluidity of identity: The importance of self-definition*

The subtheme *fluidity of identity* has important implications for health care provision. As was described in Chapter 2, fluidity refers to both the shifts in people's identity over time, as well as the scope and subtle variations in how they used the concept of identity, which are not captured in 'mainstream' identity categories. It also refers to Aboriginal people changing how they choose to self-identify according to the situation, according to events or life stages, according to changes such as progress along a healing path. Poor understanding of the diverse and fluid identities of Canada's Aboriginal people from both historical and contemporary perspectives is a significant barrier to meaningful care, and potentiates deeply embedded patterns of discrimination and oppression.

As health care organizations become more aware of the need to improve access to preventive services for Aboriginal people, there is an increased need for understanding that there is not one way to provide care to Aboriginal people. Health care providers and organizations need to recognize the fluidity of Aboriginal people's identities and how this contributes to their care encounters. Examples of how fluidity may impact access to care include: what type of formal identification documentation they have as a result of moving between urban and rural

settings or between provinces; where they feel safe to access preventive health care; and what expectations they may have of care (e.g. traditional medicines vs. biomedicine).

Poor understanding of the fluidity of Aboriginal people's identity in the urban setting impedes nurses' understanding of what culturally safe care might look like when providing care to an urban Aboriginal population. The *Aboriginal Women's Experiences of Accessing Care* study results showed that care spaces and places need to be designed and developed in such a way as to make Aboriginal people feel safe and comfortable to, first of all, access them. But, once they have that sense of safety and comfort accessing care, it is also necessary that they feel that they belong there, and that the fluidity of their identity is acknowledged and respected. This might mean incorporating traditional teachings and cultural practices, it may be as simple as finding a place to access primary health care where families do not face discrimination and stereotyping on account of their identity; or it could mean feeling safe to explore how their life experiences impact their identity and feelings about changing identity (e.g. as in the case of an Elder telling her story about not identifying as an Aboriginal woman for most of her life until she began to recognize the impact of the residential school experience and went through a healing journey coming to a place where her Aboriginal identity is a critical point of pride in her life).

What is important is for health care providers to recognize that it is the client's right to be able to define how they self-identify within the care encounter and to not have their identity imposed on them by providers. Care providers also need to recognize the links between identity and wellbeing, and that such shifts in how people identify are normal and healthy.

*Multiple Identities: Service Providers Roles within Urban Settings*

The multiple roles Aboriginal service providers took on within the organization and Aboriginal community was an important part of their ability to develop trusting, mutually engaging relationships with their clients. Participants often spoke about their relationships with service providers as being on a more personal level that helped to defuse unequal power dynamics that often exist between service providers and clients. Participants also spoke about feeling safe accessing care from someone who “looked like them”, spoke the same language or had similar values and traditions, which helped to facilitate a sense of familiarity and establish a therapeutic encounter. Participants often made it clear that optimally they would be receiving preventive care from an Aboriginal person. However, as stated earlier, although nursing organizations have recognized that there is a need to recruit and retain more Aboriginal nurses at this particular time there remains a shortage of Aboriginal nurses or health centres to attend to such a need.

The multiple roles of Aboriginal service providers within organization and the local Aboriginal community contributed to their ability to create a safe environment and affirm the identities’ of clients. Yet this expanded role challenges current social constructions of the objective nurse who is ‘removed’ from patients by their level of knowledge about client conditions, as well as by professional standards that impose certain boundaries to prevent nurses from engaging with clients on a more social or subjective level (College of Nurses of Ontario (CNO), 2006). Although Aboriginal service providers also must establish boundaries in their relationships with their patients these boundaries are very different and poorly understood from this ‘objective professional’ standpoint. One participant described the sense of connection she feels with clients that connotes a different way of maintaining healthy boundaries: “they are not

my friends, but they are my family.” She attempted to describe the level of responsibility of engaging with people on a more personal level, rather than just attending to clients as biophysical beings. For example, this might include being interested in hearing how the rest of the family is doing, what they are eating, where they are sleeping that night, or talking about what happened at last weekend’s Pow Wow. This level of engagement affirms peoples’ identities, and communicates care for them in a holistic fashion.

Engaging and attending to personhood is essential to healthy, health-promoting and healing relationships, and an example of nursing’s caring approach that is present in many nursing theorists work such as Watson and Parse (Meleis, 2007). However it would seem evident in the care encounters recounted by Aboriginal participants that perhaps nursing is not moving this type of caring into practice at the same level as what clients described experiencing in Aboriginal health care environments. It could be argued that nursing is constrained from developing these types of relationships as a result of western biomedical understanding of boundaries, and that it may be necessary for nursing to establish partnerships with scholars who are strong in other paradigm ways of knowing/being. This is a potential area of research for nursing, particularly around issues of boundaries and what this looks like in different cultural contexts of providing care.

Understanding that Aboriginal service providers play multiple roles in their community gives nurses and other health care providers a deeper understanding of a different way of engaging that may need to occur between service providers and Aboriginal clients. At a surface level, nurses need to have an awareness of certain cultural nuances such as the importance of non-verbal communication among Aboriginal peoples and ways of conveying respect. However at a deeper level, they need to also be aware that working with Aboriginal people and other

marginalized populations may require nurses to be more personally invested and make efforts to have a better holistic understanding of the community and current events. This may include attending community celebrations or learning traditional teachings from elders. It also means being strong about one's own identity, which is a whole new level of challenge as a nurse.

### *Leveraging Identity: Aboriginal Female Leaders*

In this study context, executive directors at all of the Aboriginal organizations were women. During our interviews with these female leaders, their answers often focused on meeting the needs of women and children and helping to make Aboriginal mothers feel safe to access care. As a result of their focus on making care spaces and places safe and evoking a sense of belonging for Aboriginal mothers, they have helped improve access to culturally relevant services for Aboriginal people in the urban context. It is apparent that in the urban setting in which our research took place, having Aboriginal women as executive directors has made a difference for care delivery for Aboriginal mothers accessing care.

However besides leading Aboriginal service organizations in urban settings, it could be argued that these Aboriginal female leaders are also directing a movement advocating for the rights and well-being of Aboriginal people within urban settings. These women tirelessly work as activists on behalf of Aboriginal people while collaborating with other mainstream service organizations, engaging with local politicians, academics and policy-makers, and at an international level, in their education about racism and discrimination against Indigenous peoples.

In these roles, these women have served to act as role models for nurses and for how we can act as leaders in fighting for issues of social justice and in being involved in the political

realm of delivering care. According to the College of Nurses of Ontario “Standards of Practice”, nurses demonstrate leadership “by providing, facilitating and promoting the best possible care/service to the public” (CNO, 2009, p. 10). As a traditionally female-dominated profession, nurses have played important roles as women’s leaders, and these Aboriginal female leaders (although not nurses), continue a tradition of leadership for women within healthcare. These women demonstrate the tenacity, drive, and courage needed to sustain the fight to have Aboriginal people’s health disparities acknowledged and the will to keep talking about these serious issues. Using their personal experiences not only as Aboriginal people, but also as service providers who have seen the issues firsthand while caring for the community, they have drawn upon these stories in their advocacy work. Nursing can take a lot from these women’s examples of leadership; we need to be taking the stories that we encounter at the bedside to our political leaders to make the changes needed to promote a more sustainable, equal and inclusive health care system. It has been widely acknowledged within nursing that nurses need to move from talking about social justice issues to acting on them (Boutain, 2005; Canadian Nurses Association, 2005). Drevdahl, Kneipp, Canales and Dorce argue that “although we may speak the words of social justice, it is how we act that clearly demonstrates our philosophy” (2001, p. 29).

### *Implications of Identity for Nursing Knowledge/Theory*

This study used and developed empirical evidence to support the utility of a more robust understanding of identity in theory and practice. Alcoff’s definition of identity helped to account for the interplay between how societal structures impose certain restrictions and privileges onto people based on their identity, as well as how a person’s identity is constructed in relation to how they see themselves and their family, community and social relationships. Shield (2008)



identifies that these social identities may mutually constitute one another, reinforce one another or naturalize each other. Yet, how can and should nursing develop a notion of identity that will enable better care based on a clearer understanding of the dimensions and nuances of identity in caring encounters? Several issues arose in the study suggesting ways in which nursing theory could be developed, such as mutually constituting categories; naturalizing processes; fluidity and multiple identities; and the primal importance of self-identification.

‘Mutually constitute’ refers to the idea that one category of identity may understand its meaning in relation to another category. For example, Aboriginal women may construct their meaning of what it is to be a mother in relation to a cultural understanding of women’s roles in Aboriginal society. When an individual ‘reinforces’ their identity, they engage in a dynamic process whereby the individual actively constructs, deconstructs or maintains the categories with which one identifies. This component of identity may have particular implications for nursing encounters as this study showed that when Aboriginal women felt that care providers were reinforcing the strengths associated with their identity, they felt a sense of safety and belonging while accessing care.

An individual may also ‘naturalize’ their identity; by identifying with one category they come to naturally identify with another category (Shield, 2008). This study identified that this potentially had negative connotations when other people were involved in “naturalizing” participants’ identity. For example, when participants described encountering stereotyping, they often described service providers automatically putting labels on them about their substance use because they were identified as being Aboriginal.

Although Shield does not directly mention it in her framework, it is also necessary to talk about marginality as there are many ‘grey’ areas in describing identity, in which one may self-identify within one category but not be recognized as such by the larger society. These neglected points of intersection may force a re-examination of the social construction of race, gender, and class and require further examination in nursing interactions and in our understanding of identity (Olsvik, 2007). For example, grey areas of identity were involved when describing the multiple ethnicities and worldviews that comprised many of the participants’ families we spoke with; how did they identify and who did they identify with? These neglected points not only have implications for the way in which one interacts with the world, but also have powerful implications for the way one sees themselves in relation to the world and to the way in which health care is provided. By examining the grey areas of identity, nursing and other health care providers may be able to come to a better understanding of people’s healthcare-seeking behaviors, as well as the attributes of care places that help appeal to different components of people’s identities. Nursing can be more proactive at helping to address the “othering” discourses that occur in care by becoming more aware and inclusive of different parts of people’s identities within health care interactions and the design and delivery of care.

In conclusion, the concept of identity is a basic component of nursing interactions, and as such, needs to be incorporated into nursing theory in a more explicit fashion. The concepts of “client-centered care” and “culturally safe care”, which are both important topics that continue to be a source of major discourse within nursing, actually revolve around discussions of identity without actually touching upon how care is impacted by our own identity and the identity of those we care for. This study indicates that acknowledging and addressing the identity of Aboriginal women in our care in a way that does not invoke harm, is respectful, non-judgmental,

and supportive is necessary in order to help them feel safe and comfortable to access care. This is about the importance of creating a space and place for Aboriginal women within the therapeutic encounter to feel safe to self-identify, for health care providers to take on the responsibility of asking them who they are, and not imposing their own view of women's identities. Once health care providers have an understanding of how clients identify themselves, they can then work towards creating a plan of care that responds to their client, rather than their own perceptions of the client, in order to provide client-centered care. We need to overlook our "political correctness" and call racism and discrimination for what they are. We need to challenge the predominant discourses in nursing and health care that "other" marginalized populations, and instead find ways of celebrating and drawing on the strengths of our diversity.

Without addressing the importance and usefulness of identity in our care, we are missing out; not only on examining how we can provide better care to our clients, but also in creating a more diverse and sustainable workforce, and in personally reflecting on how we identify ourselves as nurses and the implications that this has for the care we provide.

### Implications of Incorporating an Intersectionality Paradigm

The following section will explore the implications of incorporating Essed's gendered racism analysis as well as how intersectionality could be a potentially helpful paradigm for nursing research, education, practice and policy.

#### *Implications of Incorporating Essed's Gendered Racism Framework*

Incorporating Essed's gendered racism framework was a helpful analytical tool in explicating the different factors which impact Aboriginal women's access to care. The analysis of women's verbal reconstructions of experiences provided a rich

“basis for the analysis of the simultaneous impact of racism in different sites and in different social relations. Accounts of racism locate the narrators as well as their experiences in the social context of their everyday lives, give specificity and detail to events, and invite the narrator to carefully qualify subtle experiences of racism” (Essed, 1991, p. 4-5).

Using Essed’s framework, I was able to examine not only race, but also other social locations such as gender, class, ethnicity, and marital status and how they were interrelated to affect Aboriginal women’s care encounters. I was also able to analyze how women’s experiences were related with the interrelated identities of their care provider, and care provider’s perceptions of their identities, and the design and delivery of care within the organizations women accessed. *This is new knowledge and should be explored further in the future.*

Incorporating the different components of the analysis also provided a larger understanding of how individual women’s experiences were related to each other and how they were part of a larger story of systemic racism and discrimination against Aboriginal women. This included examining the historical backdrop of how inequities in access to care as experienced by Aboriginal people, particularly women, have developed. This also included exploring how racism and discrimination are perpetuated within societal structures, specifically within the health care system.

The use of Essed’s framework in this study helped make sense of a way to incorporate an intersectionality paradigm into my research design. This was important, because there are very few frameworks which examine or provide tools to help nurses incorporate such complicated paradigms. However, because I was not able to ask questions specifically related to Aboriginal women’s experiences, the use of Essed’s framework was limited because I was not able to garner specific details about women’s experiences. Therefore it would be of future benefit for nursing research to incorporate Essed’s framework into the collection of original research.

Overall, Essed's framework is a useful analytical tool for nursing to incorporate as a means to examine how everyday racism, as well as sexism, classism, and homophobia operate in care encounters, how these systemic oppressions function to exclude particular populations from health care discourses, and what needs to be changed in order to help marginalized populations obtain the level of care they deserve. Nursing may want to continue to explore how to incorporate Essed's framework as a workable model into our care to explore how we can work towards addressing everyday racism and discrimination within the design of care spaces and within the dynamics of care encounters.

### *Intersectionality as an Important Paradigm Shift for Nursing*

Intersectionality has been identified as a lens, a perspective, a tool, a paradigm, and a theory and is described differently depending on the author and their perspective. I chose to define intersectionality as a paradigm in my research with the understanding that a paradigm is both a method of analysis and a way of looking at the world. In being both, intersectionality as a paradigm generates a wealth of questions, yet also can be used as a method to examine such questions at a level of detail that could otherwise not be attained (Hancock, 2007a). I have used an intersectionality paradigm as a way of approaching social identity that values and recognizes multiplicity and is neither additive nor reductive (therefore we are not simply adding on or taking away an identity construct, but rather exploring how different identities are interrelated with one another) (Hulko, 2009).

My decision to include intersectionality as a paradigm came about both from a personal understanding that this was a lens through which to view the world, but also because within social science research, there has been a recent move to recognize intersectionality as a paradigm

(Hancock, 2007a). This move towards acknowledging intersectionality as a paradigm may be a result of what Kuhn describes as a predictable scientific process, in which scientists begin by exploring the creative possibilities of a new way of thinking, and then begin to agree upon language, methods and tools to conduct research, before entering the final phase in which there is a recognized need for new concepts and thought processes; opening the door to further scientific inquiry (Greenhalgh, Robert, Macfarlane, Bate, Kyriakidou, & Peacock, 2005). From this perspective, an intersectionality paradigm responds to the need to better understand social justice issues and often deepening disparities within society. At this point in time scientists within various fields including nursing and population health are now attempting to begin to develop language, methods and tools to ‘do intersectionality research and analysis.’

Hancock argues that we need to conceive of intersectionality as a paradigm rather than as “a content specialization” because it refers to both a way of being as well as an approach to doing research (2007a). She argues that “the keys to intersectionality in the future involve an emphasis on research design and enhanced data collection” (Hancock, 2007b, p. 253). Viewing intersectionality as a paradigm, enables nursing to “take up” and explore the different dimension of this paradigm including the conceptual (what are the objects of study, what are the problems nursing needs to investigate?), theoretical (how are these objects related to one another and to the larger world around them?), methodological (how is nursing going to solve these problems?) and instrumental (what tools/techniques will we use to solve these issues?) (Greenhalgh et. al, 2005). See the following page for a table of examples.

Table 3: Use of an Intersectionality Paradigm in Nursing

The following table explores the different components of incorporating an intersectionality paradigm into nursing. Using this research study as an example, the table explores how an intersectionality paradigm could enhance nurses' understanding of how identity and perceptions of identity influence access to care for Aboriginal women living in an urban centre.

Paradigm Dimension	Focus	Example from this study
Conceptual	What are the objects of study?  What are the problems nursing needs to investigate?	This study explored Aboriginal women and their experiences of accessing care. The problem nursing needs to investigate is what is it about women's care experiences that make them less likely to access care?
Theoretical	How are these objects related to each other and to the larger world around them?	The study attempted to look at how women's identities were perceived within the care encounter by service providers and whether perceptions of women's identity contributed to their experiences of accessing care. By exploring service provider's perceptions of Aboriginal women's identities, we also attempted to locate these perceptions within larger systemic issues of racism, discrimination, and colonialism.
Methodological	How is nursing going to solve these problems?	We talked with women about what their experiences were to get an understanding of what they had to say about this issue and what they thought needed to be done to fix it.
Instrumental	What tools/techniques do we use to solve these problems?	Using a gendered racism analysis tool, we attempted to locate issues of access within larger systemic issues of racism, discrimination which pervade our social systems.

My aim with incorporating an intersectionality paradigm and encouraging myself and other nurses to explore the power differentials in the therapeutic encounter is not to encourage

binary thinking (nurse/patient, black/white, etc): it is actually quite the opposite. In exploring the power differentials that nurses and patients hold within different contexts based on how identities are perceived and imposed, use of an intersectionality paradigm enables greater awareness of the power nurses hold in certain situations and the implications this has for patients. The power we hold as nurses is not necessarily bad. For instance I often use my title as a registered nurse to help advocate for my patients to obtain the level of care they deserve while accessing care at other facilities. Recognition of our power, our weaknesses and sources of oppression will enable nurses to be fully engaged in the therapeutic encounter and provide culturally safe care that is responsive to the needs of patients.

Incorporating a postcolonial feminist lens and intersectionality paradigm into my thesis has personally also helped me become aware of the power of language and of using ‘normative’ language to describe patients and their health behaviours. I became aware during the process of writing this thesis of my socialization into a nurse, of the prevalent ‘whiteness’ of nursing, and of how this influences the way nurses are taught to think about health and well-being (Gustafson, 2007). For instance, while conducting this research I became very aware of how dominant the biomedical perspective of health is and how this influences First Nations, Inuit and Métis people access to traditional sources of wellness. My sub-theme, the “*impositions of the presumed superiority of Western Models of mothering*” relates very closely to what Browne, Fiske & Thomas (2000) found in their study of on-reserve Aboriginal women accessing care. They described Aboriginal women feeling the need to “transform themselves into credible medical subjects.” Both of these studies indicate that service providers felt the need to impose their own sense of what was normal onto Aboriginal women, which is a very powerful discourse within a health care interaction. The ‘othering’ of Aboriginal women within the care encounter is a



discourse that maintains power differentials, invalidates Aboriginal women's knowledge, and legitimizes medical authority and the biomedical model, placing Aboriginal women on the margins of the health care system.

As a result, incorporating an intersectionality paradigm has challenged me to incorporate language that is client centered; rather than imposing my own normative values, I ask my clients, "what is normal for them?" This has been enormously helpful in understanding different cultural understandings of health and wellness among Aboriginal peoples and other marginalized populations. For example in my work as a street nurse, although I may not use crack, understanding the intersections of histories of childhood sexual abuse, poverty, mental illness and addiction has helped me to incorporate harm reduction into my work with homeless clientele to help keep them as safe as possible while they are engaging in risky behaviours. Incorporating an intersectionality paradigm has been an important exercise in trying to find a language of commonalities in my nursing orientation, instead of a language that falsely and negatively separates and differentiates myself from other people. I reject language that makes people less than human and continue to work on incorporating a language that is inclusive and welcoming.

### Limitations

The following section will describe the limitations of this study by going step-by-step through the research process to describe what could have been done better or what I would change if I could do the study again.

#### *Sampling Limitations*

*Exploring Aboriginal Women's Experiences of Accessing Care* came about as a result of my involvement in the *Improving Access* study as was described in the introductory chapter.

While designing this study, I invited the same two Aboriginal organizations to participate as had been involved in the *Improving Access* study. However only one Aboriginal organization chose to participate. This may have been because I had well established relationships with leaders and service providers at one of the participating Aboriginal organizations (which I will call organization A to keep things clear) as a result of working with them for a year to evaluate their Homeless Outreach program. However I had only begun to develop a relationship with the other Aboriginal organization (organization B) involved as I began to conduct interviews for the *Improving Access* study. Not being able to use the transcripts from our interviews with organization B was a limitation because this organization is particularly geared towards meeting the needs of Aboriginal women who have encountered violence and abuse. Therefore transcripts from service providers and family members at this organization would have helped to highlight some of the unique needs of Aboriginal women, especially women encountering violence.

#### *Data Collection Limitations*

Since previously collected data was used to answer the research question, I was not able to directly ask participants about my research questions, specifically about how they felt that their identity contributed to their care experience or their experiences of how service providers' perceptions of their identity had contributed to care encounters. Rather, I incorporated those identity features which were explicitly stated in their descriptions. Therefore the data is very much limited to the identities which women accounted for while recounting their care experiences. In addition, I was not able to probe and direct the dialogue to further explore issues of identity and the details of care encounters. For example, little acknowledgement was given towards how perceptions of women's sexuality or 'ableness' contributed to Aboriginal women's care experiences in this study (Grenier, 2005). However during my verification meeting when I

talked to women about the different social locations that I heard mentioned as most often contributing to Aboriginal women's experiences (gender, race, ethnicity, class, marital status, age), they also mentioned these identities in their stories as well.

Although using a secondary analysis was particularly beneficial in trying to keep within the timeline afforded to complete a master's thesis, it would have been beneficial to have been able to talk with Aboriginal women directly about their care experiences and how they felt that their care encounters were marked by issues of identity, and specifically what components of their identity they felt contributed to their care encounters. Future work can now build on this initial research to further explore the definition of identity used in this research as well as other methods of exploring the impact of identity for women's care encounters.

#### *Data Analysis Limitations*

I chose to incorporate Essed's gendered racism framework as a tool to help me integrate an intersectionality paradigm into my secondary analysis. However since I was not able to directly ask women about their care encounters, it was sometimes difficult for me to elicit the different components of Essed's framework from participants' stories. As a result, I was not able to always garner the minute details of care encounters that may have been helpful in understanding what needs to change within care encounters to help make care more accessible for Aboriginal women.

It took me quite some length of time to develop a list of themes and subthemes which I felt reflected what participants had told me that I then used to take to the verification meeting. After the verification meeting I modified some of my wording according to what participants thought was more conducive to what they wanted people reading my work to understand about

Aboriginal women's care experiences. However after the verification meeting as analysis and writing evolved the results continued to change. It would have been ideal to return to the community for further verification, but was beyond the resources available for this study.

In general, it would have been beneficial to have had another consultation with a community member during the final stages of writing to ensure that the writing continued to remain oriented towards the community. My situation was unique because although I have been fortunate enough to have an Algonquin member on my committee, due to time constraints and other duties, I was not always able to utilize her in this role. The overextension of Aboriginal people in leadership often means they have multiple demands on their time. Ideally, I would have found someone in the Aboriginal community at the very beginning of the research process who would have been interested in filling this role, potentially even as a paid, casual position. However, final results were viewed and supported by a senior Aboriginal women leader.

#### *Limitations of Conducting this Research as a White Academic*

It would be a major oversight to not address that the power dynamic I held as a white, female academic which was a limitation throughout the research process. This was my first time conducting research of any sort, and conducting research with a marginalized population to whom I did not belong, made it that much more challenging. I often felt like I did not have enough experience in conducting research or knowledge and use of postcolonialism, feminism and critical theory to be doing this level of academia. However I attempted to address my limitation of lack of experience by having an Aboriginal female leader on my thesis committee to guide me during the different steps of the research process. As well the other members of my

thesis committee were experts in postcolonial and feminist research and I often consulted with them as I was conducting my analysis of the results.

My identity as a white researcher meant that it took a lot of time and effort to develop relationships with the Aboriginal organizations who were involved. While completing my analysis using an intersectionality paradigm, I often felt very uncomfortable interpreting women's stories and particularly how service provider's perceptions of their identity contributed to their stories. It is impossible to ignore or overlook that no matter how much you may want to bring marginalized voices into the research narrative, these voices are still used with your interpretation as a researcher. I addressed this limitation by meeting regularly with an Aboriginal female leader to talk about how I was interpreting the results. I also expressed my concerns about this in my regular meetings with my thesis committee, who were reviewing my writing.

Although I have been engaged in collaboration and conversation about my research with a number of different Aboriginal women over the course of the research process, it would have been beneficial to have been able to pay a member of the local Aboriginal community to be engaged in the research process with me. I think that this would have been beneficial in teaching me more about culturally appropriate ways of conducting research as well as helping to keep the research within the local community. By working as a team with a member of the local community, I could have brought my skills and knowledge forward of the research process along with her lived experience as an Aboriginal woman and her knowledge of culturally relevant ways of approaching the community. I also think that working intensely alongside an Aboriginal woman would have been particularly helpful while I was inductively and deductively sorting through women's stories and using my voice to make sense of what Aboriginal women were

saying. I believe that participants and the local Aboriginal community would have felt safer and that they were being better represented and given voice by a member of their own community. As researchers working with populations that we do not belong to, we need to continue to find innovative ways of having community members involved in conducting the research and being part of the knowledge creation process, to help bring back the knowledge to the community and keep it relevant to the community.

However it is important to acknowledge that as a researcher I have a voice, and it is not my responsibility to be an Aboriginal person but to be transparent about who I am, and to enable all voices to be heard within the research process. Researchers can do this by explicitly acknowledging who they are, both within the research process, but also in their presentation of the results of research studies.

### Conclusion

This study, *“Exploring Aboriginal Women’s Experiences of Accessing Care”* examined Aboriginal women’s experiences of accessing care using an intersectionality paradigm. The results of this study indicate that how Aboriginal women’s identity as mothers are treated and perceived by service providers impacts their care encounters, with both positive and negative ramifications. Within negative care encounters, Aboriginal women described encountering the *“impositions of presumed superiority of Western models of mothering”* in which their knowledge and identity were not acknowledged or respected. However, within positive care encounters when women described that their identity was reaffirmed, Aboriginal women described encountering *safety and a sense of belonging*, service providers *‘working it through’* with Aboriginal mothers to provide care in *“a good way”* that respected women’s identities, and

Aboriginal women “*transforming and leading care*” to take pride in their identity, developing personal agency, transforming care relations, and leading new ways of providing care.

The results of this study indicate that identity is an important concept for nursing, particularly for developing therapeutic relationships with marginalized populations. Attending to issues of interrelated identities within the therapeutic encounter should be considered an important element of providing culturally safe care, and is important in attending to issues of privilege and oppression within the care dynamic. In order to provide care to marginalized populations, nursing needs to adapt to include a paradigm that makes space for the inclusion of “othered” voices within nursing faculty and within the nursing profession itself.

As was stated in the introduction of Chapter 1 of this thesis paper, knowledge is not owned, but is passed on and freely shared. It is my hope that the knowledge that I have gained will be of some benefit to nurses, whatever their practice looks like and wherever it may be. It has been my experience in writing this paper, in conducting the research, and in my daily life as a nurse that nursing needs to be attending to the implications of own interrelated identities and how this impacts the care we provide. We need to find ways to be more inclusive, to be more humane and empathetic. We need to find ways to attend to people’s lived experience within the care encounter, and to explore how this influences their health. By exploring people’s identities, how they define themselves, and how we define ourselves as nurses, we open the possibility of providing care in a more humane, inclusive, holistic fashion that is really about caring for people, about caring for and respecting ourselves, and about exploring the possibilities that is born out of engaging in that dynamic process together.

## STATEMENT OF CONTRIBUTORS

This part of the thesis provides a statement of the contributions of those involved in this project. It was written in accordance with the guidelines of the Faculty of Graduate and Postdoctoral Studies at the University of Ottawa. Contributions of supervisory committee members and Advisory Board members in the development and implementation of the study, preparation of manuscripts, and the final thesis document are described.

The MScN candidate, Kim Van Herk, designed, implemented and led all aspects of the study as part of the fulfillment of the requirements of the Masters in the Science of Nursing degree at the University of Ottawa. The MScN candidate made all submissions for ethical review, developed relationships with the participating organizations, analyzed all data, and wrote all documents and manuscripts included in this thesis.

Thesis committee members included Dr. Dawn Smith as supervisor, and Caroline Andrew and Claudette Commanda Cote as committee members. Dr. Smith led the primary study from which this secondary analysis arose, and was therefore instrumental in helping the candidate develop relationships with the organizations involved, as well as in helping to provide feedback on the conceptualization and design of the thesis study. The supervisor and committee members provided support and consultation during analysis and interpretation, and contributed to the development of the manuscripts reporting study results. Co-authors for manuscripts, and order of co-authors, were identified based on the authorship guidelines of the Faculty of Graduate and Postdoctoral Studies. Co-authors contributed to interpretation of data by providing feedback during committee meetings or through one-to-one dialogue. They also were involved in critically reviewing manuscripts, and approved the final version of manuscripts submitted for publication.



A leader from the participating Aboriginal organization also was helpful in guiding the design of the thesis study and contributed to interpretation of data by providing feedback on initial review of the results and by providing comments on the manuscripts.

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## Appendix A: Improving Access Study Consent Form

### Consent Form-Individual Interviews



uOttawa

Université d'Ottawa  
Faculté des sciences  
de la santé

École des sciences  
infirmières

University of Ottawa  
Faculty of Health  
Sciences

School of Nursing

The research project entitled *Improving Access to Preventive Childhood Services for Urban Aboriginal Families* is under the supervision of Dr. Dawn Smith who is a professor in the School of Nursing at the University of Ottawa. Objectives are to:

1. Examine provider, organizational and system-level factors influencing access to safe and responsive preventive early childhood services for urban Aboriginal families;
2. Identify potential intervention strategies and priorities for change to increase access to safe and responsive preventive services for urban Aboriginal families.

You have indicated you are willing to participate in an individual interview. This interview will take about 45-60 minutes. In this interview, you will be asked to share your ideas about preventive health services for Aboriginal families living in cities, and how to make it better.

With your permission the interviews will be audio taped and will be scheduled at a time and place convenient for you. You will be assigned a number to your file so that your name will not appear on any transcript. The information you will share will be used only for research purposes and remain strictly confidential. The audiotapes and transcripts of the interviews will be stored in the office of Dr. Dawn Smith for 10 years and will be destroyed in April 2018. Only the research team will have access to the data.

**Benefits of this study:** Your answers may help improve how care is given to you and other users of preventive services for families.

**Potential risks involved:** The risks for this study are not higher than those lived in everyday life.

The interviews will be conducted in your choice of English or French. Family and Elder participants will be offered a small token of appreciation (\$25.00) and the costs of travel and childcare required to participate in the study.



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Faculté des sciences  
de la santé

École des sciences  
infirmières

University of Ottawa  
Faculty of Health  
Sciences

School of Nursing

Consent of Participant:

I, \_\_\_\_\_ have read the above information and understand this consent form. I have also had the chance to ask questions and they have been answered to my satisfaction. I agree to participate in this study and that participation will not pose any serious risk. I understand the purpose of this study is to gain information on my experiences in providing or delivering preventive services to Aboriginal families.

I am also aware that the results of this study will be presented to research peers at the University of Ottawa, at conferences and/or published in journals on health care but that my name will not be mentioned at any time. I understand that I am free to withdraw from the project at any time, including before or during the interview without any consequences or prejudice.

Any information requests or complaints about the ethical conduct of the project may be addressed to the protocol officer for ethics in research, 550 Cumberland, room 159, University of Ottawa, Ottawa, Ontario, Canada, K1N 6N5, (613) 562-5387 or [ethics@uottawa.ca](mailto:ethics@uottawa.ca).

I consent to the interview being audio-taped : ☐ Yes ☐ No

Researcher's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Participant's signature: \_\_\_\_\_ Date: \_\_\_\_\_

I wish to receive a summary of the research findings: ☐ Yes ☐ No

Mailing address or contact information:

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Should you have any questions regarding this research, please contact:

Dr. Dawn Smith, School of Nursing, University of Ottawa

Email

## Appendix B: Interview Guidelines

### For Leaders and Providers

#### Background/Rapport

1. Tell me a little about yourself (*personally/work history in provider/leader*) (*probe for past experience in health/social care*)
2. Tell me about your experience in Aboriginal health/social care

#### Describe good care during pregnancy and parenting for Aboriginal families

3. How would you describe 'good' care for Aboriginal families? (*obtain view on safe and responsive care*)
4. What are your views on strengths and needs of Aboriginal families during pregnancy and parenting? (*probe for similarities and differences with strengths and needs of other families and any relationship to safety and responsiveness of care*)
5. In Ottawa, where do Aboriginal families get care during pregnancy and parenting?
6. What is your organization's role r/t care for Aboriginal families (if any)?

#### Factors influencing access to safe and responsive care for Aboriginal families

7. What do you see as barriers to care for Aboriginal families in Ottawa? (*probe: community level, system level, organizational level, provider level*)
8. What do you see as facilitators to care for Aboriginal families in Ottawa? (*probe: community level, system level, organizational level, provider level*)
9. What strategies/action would help reduce barriers/improve access to care for Aboriginal families? (*probe for provider level, organizational level, system level, community level*)

#### Specific characteristics of interventions (training, program/policy assessment, program/policy change management)

10. What would be most helpful in improving capacity to provide safe and responsive care for Aboriginal families in Ottawa? (*probe for targets (e.g. individuals, policy/program guidelines; environment/space); methods (e.g. guidelines, training modules, mentoring, appraisal tools), as well as dose (e.g. how much, how often), participants (e.g. specific provider, leader groups, agencies, programs), and desired outcomes.*)
11. Other comments/suggestions: re: improving access to safe and responsive care for Aboriginal families in Ottawa

**For Aboriginal Family Members and Elders**Background/Rapport

1. Tell me a little about yourself (*personally/work history as provider/leader*) (*probe for past experience in health/social care*)
2. Tell me about your experience with pregnancy and parenting.

Describing good care during pregnancy and parenting for Aboriginal families

3. In your opinion, what is 'good care' for Aboriginal families? (*probe for views on safety and responsiveness in urban settings*)
4. What are your views on strengths and needs of Aboriginal families during pregnancy and parenting? (*probe for similarities and differences with strengths and needs of other families*)
5. In Ottawa, where do Aboriginal families get preventive services during pregnancy and parenting until kids go to school?

Factors influencing access to safe and responsive care for Aboriginal families

6. What makes it harder for Aboriginal families to get good support during pregnancy and parenting in Ottawa? (*probe: community level, system level, organizational level, provider level*)
7. What makes it easier for Aboriginal families to get good support during pregnancy and parenting in Ottawa? (*probe: community level, system level, organizational level, provider level*)
8. What could be done to improve care for Aboriginal families in Ottawa? (*probe for provider level, organizational level, system level, community level*)
9. Other comments/suggestions: re: improving access to safe and responsive care for Aboriginal families in Ottawa?

**Appendix C: Ethics Approval from the University of Ottawa Research Ethics Board**

Appendix D: Gendered Racism Analysis Chart

SITUATION	RELATION TO RESEARCH	CONTEXT	ACCEPTABLE/UNACCEPTABLE	EXPLANATION	ARGUMENT	REACTION
What happened?		Where, when and who is involved	What went well about the care encounter? What was wrong about the care encounter?	Reaction of Aboriginal women	Link with other literature	What happened as a result of situation?

## Appendix E: Example of how Gendered Racism Analysis Chart was used

SITUATION	RELATION TO RESEARCH	CONTEXT	ACCEPTABLE/UNACCEPTABLE	EXPLANATION	ARGUMENT	REACTION
What happened?		Where, when and who is involved	What went well about the care encounter? What was wrong about the care encounter?	Reaction of Aboriginal women	Link with other literature	What happened as a result of situation?
A young (under 15) half naked, Inuit girl is observed by an onlooker coming out of a car yelling. She is obviously intoxicated, may have been drugged up and is asking for help, stating she has been raped. The onlooker calls the police and they arrive but do not do a thorough investigation, stating "well that's usual for	Accessing emergency room and police services, which have both been designed to protect and attend to the health and well-being of people.	Where- major Canadian urban centre  When- this occurred within the past two years  Who is involved- young Inuit girl, onlooker, police officers, service providers at hospital	-What went wrong about the care encounter was that the young Inuit girl was treated in a discriminatory and racist manner by both the police officers and service providers attending to her. The police officers did not attend to the girl as a victim of sexual assault but talked about her as though she had asked to be raped or brought this on herself. The care providers did not provide good treatment by not using a rape kit to protect the girl in case she wanted to bring the perpetrator to court. Instead of acknowledging her as a victim of sexualized and racialized violence, they acknowledge that for "cultural" issues she does not want to get the perpetrator in trouble. There is no attempt to understand the safety risks of why the young female may not feel safe identifying the perpetrator. They also did not attend to the recent trauma she had endured and were not sensitive to her	Does not go into great detail, however story indicates that young Inuit girl does not want to get the perpetrator in trouble. The person telling the story indicates that because of the girl's youth, it could be expected that she did not want to get the perpetrator in trouble and that the system (police and care providers) should have done more to protect her and respond to the situation.	There is lots of literature to support the fact that Aboriginal women face substantially higher amounts of violence as compared to other Canadian women. The Native Women's Association of Canada along with Amnesty International has led an international campaign examining the large numbers	Leaders in the Aboriginal community were made aware of situation and responded by advocating to the chief of police and staff within emergency rooms for an end to discrimination against Aboriginal peoples and demanded that more attempts be made to protect and respond

these Inuit girls". When the girl is taken to the hospital she receives poor, discriminatory care. She is not given a rape test because the Inuit girl tells the service providers that she does not want to get the perpetrator in trouble.			needs as a recent victim of a horrible assault.		of missing and murdered Aboriginal women whose perpetrators have never been brought to justice. There is a systemic issue of Aboriginal women experiencing large amounts of violence that are not dealt with appropriately by either police officers, the law or care providers.	appropriately to the needs of Aboriginal people.
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**Appendix F: Log of Community Events**

<b>Date</b>	<b>Type of Event</b>
<b>November 2<sup>nd</sup>, 2007</b>	<b>Annual General Meeting at participating Aboriginal organization-involves local community members, features local artists, musicians, dancers</b>
<b>November 26<sup>th</sup>, 2007</b>	<b>Eradicating Poverty Dinner featuring Phil Fontaine</b>
<b>May 21<sup>st</sup>, 2008</b>	<b>Attended Research Team Cultural Sensitization Event at Local Aboriginal Organization</b>
<b>October 1<sup>st</sup>, 2008</b>	<b>Fundraising Gala for Local Aboriginal Organization featuring local Aboriginal Art, hoop dancers, and singers</b>
<b>October 31<sup>st</sup>, 2008</b>	<b>Halloween Dance at Local Aboriginal Organization, participated in dancing, family activities</b>
<b>November 7<sup>th</sup>, 2008</b>	<b>Annual General Meeting at participating Aboriginal organization-involves local community members, features local artists, musicians, dancers</b>
<b>February 11<sup>th</sup>, 2009</b>	<b>Attended education session on Two Spirit issues and impact of Colonialism at University of Ottawa</b>
<b>September 16<sup>th</sup>, 2009</b>	<b>Attended film screening on two documentaries related to violence against Aboriginal Women</b>

**Appendix G: Demographic Forms****Demographic Questions for Aboriginal Parents and Elders**

1. Role: specify all relevant-( e.g. Elder, mother, father, grandparent, aunt/uncle)
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2. Gender (circle one):                      M        F

3. Age (check one):

- ☐ < 20 years
- ☐ 20-30 years
- ☐ 31-40 years
- ☐ 41-60 years
- ☐ > 60 years

4. Educational attainment (check one):

- ☐ < high school
- ☐ High school diploma
- ☐ some post secondary college or university
- ☐ college degree
- ☐ undergraduate degree
- ☐ graduate degree

5. Marital status

- ☐ Never married
- ☐ Married
- ☐ Living with partner
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

6. Number of family members/roommates living in your household:

- a. Number of adults (> 18 years) : \_\_\_\_\_
- b. Age of children living in your household: \_\_\_\_\_

**Demographic Questions for Leaders and Providers**

Participant #: \_\_\_\_\_

Organization #: A      B      C      D      Other: \_\_\_\_\_

## 1. Role:

- ☐ leader- (specify program): \_\_\_\_\_  
(Specify role/discipline): \_\_\_\_\_
- ☐ provider (specify program): \_\_\_\_\_  
(Specify role/discipline): \_\_\_\_\_

2. Years in role stated above: (circle one):                      &lt; 5                      5-10                      &gt; 10

3. Years with current organization (circle one):                      &lt; 5;                      5-10;                      &gt; 10

4. Years in health/social care (circle one):      never                      &lt; 5;                      5-10;                      &gt; 10

5. Years in Aboriginal health /social care (circle one): never      &lt; 5;                      5-10;                      &gt; 10

6. Gender (circle one):                      M                      F

## 7. Age (check one):

- ☐ < 20 years
- ☐ 20-30 years
- ☐ 31-40 years
- ☐ 41-60 years
- ☐ > 60 years

## 8. Educational attainment (check one):

- ☐ < high school
- ☐ high school diploma
- ☐ some post secondary college or university
- ☐ college degree
- ☐ undergraduate degree
- ☐ graduate degree