
Indian and Inuit Nurses of Canada

BY JEAN CUTHAND GOODWILL

We, the Indian people of Canada, are approaching a turning point in our history. We are actively seeking ways to govern ourselves, to set our own standards and, ultimately, to be responsible for and to learn from both our achievements and mistakes.

The association of Indian and Inuit Nurses of Canada is part of this trend. This group, conceived in 1974 amid the preparation for International Women's Year, was originally called the Registered Nurses of Canadian Indian Ancestry, and was the first Native professional organization in Canada. From the beginning, we had a deep concern for the health status of Native people in Canada. As well, we were concerned with developing and maintaining a registry of Registered Nurses of Native ancestry, with attracting more Native students into nursing and other health professions, and with establishing a mechanism to work for and lobby on behalf of better health care in Indian and Inuit communities. Although these objectives have been refined and expanded (see below), these are still our main goals.

OBJECTIVES

- To act as an agent in promoting and striving for better health for the Indian and Inuit people (that is, a state of complete physical, mental, social and spiritual well-being).
- To conduct studies and maintain reporting, compiling information and publishing of material on Indian and Inuit health, medicine and culture.
- To offer assistance to government and private agencies in developing programs designed to improve health in Indian and Inuit communities.
- To maintain a consultative mechanism the association, bands, government, and other agencies concerned with Indian and Inuit health may utilize.
- To develop and encourage courses in the educational system of nursing and health professions on Indian and Inuit health and cross-cultural nursing.
- To develop general awareness of Native and non-Native communities of the special health needs of Indian and Inuit peoples.
- To generally encourage and facilitate Native control of Indian and Inuit health involvement and decision making in Indian and Inuit health care.

- To research cross-cultural medicine and develop and assemble material on Indian and Inuit health.
- To actively develop a means of recruiting more people of Indian and Inuit ancestry into the medical field and health professions.
- To generally develop and maintain on an on-going basis, a registry of Registered Nurses of Canadian Indian and Inuit ancestry.

BACKGROUND TO NATIVE HEALTH ISSUES

Since the implementation of the Medical Health Insurance Plan in 1967-68, the average Canadian has enjoyed and appreciated benefits envied by most developed and developing countries. Most Canadian citizens believe they have the right to the best available health care. To the Indian people of Canada, health care has always been a highly political issue, which stems from treaties signed with the federal government in most areas of the country during the 1800s. In particular, the Indian people have relied on a "Medicine Chest Clause" (*Assembly of First Nations*, 1979, p. 3) plus other promises concerning medical care. These were understood to mean, as part of the treaty agreements, that medical services would be provided to Indian people whenever they might need them. These services were to be provided to all Indians, and to be appropriate for the type of medical care available at the time. Canada's Native groups believe that this medicine chest clause should mean that a comprehensive health care plan, incorporating all aspects of present day health care should be available — curative, mental health care and preventive services, essential medications, hospital care, ambulance services, diagnostic services, optometric and dental care, and medical appliances — at least as widely as they are to other Canadians (*Assembly of First Nations*, p. 7).

Although this treaty clause has been interpreted differently by legal experts, federal bureaucrats, and Indian and non-Indian politicians, the Indian people maintain our right to health care is based on an historic belief that the government has an inherent legal responsibility to provide health services in lieu of the land and resources surrendered throughout this country. Interpretation of this clause remains a point of serious political dispute that affects the administration of health care.

What is not open to dispute is the fact that, by the beginning of

the 20th century, Indian people had been reduced to almost complete destitution and dependence.

The Medical Services Branch of Health and Welfare Canada has been responsible for administering to the medical needs of Native peoples. In terms of conventional diagnosis and treatments, the Medical Services Branch has achieved a notable measure of success. Many diseases that ravaged Native communities in the past have been brought under control — although not completely; for example, tuberculosis is by no means eradicated.

REASONS FOR CONCERN ABOUT NATIVE HEALTH CARE

- The loss of whole generations, the enfeeblement of those who remained, the fear of demographic destruction, the loss of faith in their own institutions and values has resulted in a demoralization and sense of powerlessness in Indian communities throughout this country (Berger, 1980, pp. 2-3).
 - Neonatal mortality on Indian reserves is one-third higher than that experienced by a comparable non-reserve population; post-neonatal mortality is almost four times higher, with the causes attributed to infective and parasitic diseases, pneumonia, Sudden Infant Death Syndrome, and fires (Morrison et al., 1986, p. 269).
 - Mortality rates on Indian reserves for violent deaths are three to four times higher than Canadian rates in general. Violent deaths account for half of all deaths to residents of Indian reserves (Mao et al., p. 267).
 - Suicides account for 35% of accidental deaths in the 15-24 ages group, a rate of almost three times that of the national rate for suicides in this age group (Indian Affairs, 1980, p. 19).
 - Indian children and even adults, like their Third World counterparts, excessively suffer the effects of infective and parasitic disease, such as meningitis, otitis media, and tuberculosis (Postl, 1986, p. 253).
- Native leaders, espe-

cially during the last two decades, have taken an increasingly active role in trying to improve the status of their peoples. For example, most Indian reserves in Canada have their own government structure with a chief, a council, and an administrator who conducts the business of a community. Apart from the Band councils, there are tribal and district councils to advance common interests, provincial and territorial councils, and an Ottawa-based national body, the Assembly of First Nations. At the band level, health is only one aspect of a whole range of issues and is often not a priority. However, because health issues can lead to crises, such as epidemics, violence related to alcohol or drug abuse, or medical emergencies, it can quickly become a hot political issue.

These political realities, coupled with the health care problems outlined previously, have put those who work in Native health care in uniquely sensitive political positions not ordinarily experienced by those who work in the general health care system. If nurses working in Native communities go about their duties with side blinders and do not know how to look beyond their daily routine of clinical care or community health, they will never be able to appreciate why the job so quickly becomes frustrating, is filled with misunderstandings, and leads to quick "burn-out."

THE ROLE OF THE IINC

These realities have also put increasing pressure on Native nurses to take a more active role. Most members of the Indian and Inuit Nurses of Canada have experi-

enced the rigors of life on reserves, have faced discrimination and lack of support in the Canadian education and health care system, and can recognize problems associated with the need to meet increasingly high standards in health care and in education. Some of the difficulties arise from within the nursing profession itself, such as the emphasis on the baccalaureate for entry when many young Native men and women are having difficulty in achieving and financing higher education.

Members of the association have been aware of and active in all these and many other political areas since its inception — listening, watching, and working in whatever capacity required within our profession, yet ever mindful of what is happening to families, friends, and nursing colleagues. A vital role has been the support for young Native men and women to gain entry to the health professions.

The Registered Nurses of Canadian Indian Ancestry (RNCIA) was launched with the help of several nursing colleagues. Our first and most difficult task was to identify other nurses of Indian ancestry to find potential members for a support group. The name was chosen deliberately so that the group would include both status and non-status Indians, a matter that, at the time, involved considerable political dissension (*Indian and Inuit Nurses of Canada*, 1984).

Despite a lack of support and even active discouragement from some government officials, we eventually identified 80 potential members with the help of some non-Native colleagues. In August of 1975, a group of 40 met in Montreal to launch the association.

The first chairman was Tom Dignan, a Mohawk who had been in the United States Marines before becoming a nurse and later achieving a baccalaureate. The election of a male president during International Women's Year was questioned by feminists, but we persevered because we believed he had the qualities the group wished in a leader.

We continued to stress the need to establish networks for ourselves on the



photograph GEORGE JOHNSTON

common grounds of education, cultural background, and mutual concerns. After a rocky start, our group became especially vulnerable in 1978, but was saved when the Manitoba Indian Nurses Association (MINA) formed as a provincial body and the late Grace Easter of MINA also took on the presidency of the national group.

Financial backing was a major problem, with a national Indian political group blocking one early federal funding initiative. Initial funding was obtained from Native Women's Program, Native Citizens Directorate of the Secretary of State — even though a program officer in a department objected to the inclusion of a male nurse. Tom Dignan went on to attend medical school and to obtain his medical degree, but the association continued to welcome male nurses rather than compromise its professional status to achieve funding. The Secretary of State's office continued to provide regular annual funding for the first decade, enough for one board meeting and a national conference yearly. In the early 1980s, financial support was received from the Medical Services Branch of Health and Welfare Canada for special projects and later for administrative and staff costs.

Despite setbacks and opposition, however, the association continued to put forth its ideas on better health care for Native peoples and to encourage Native men and women to enter the profession. It repeatedly lobbied government departments, using the knowledge gained from members' nursing experiences, to describe health conditions and to recommend new approaches to health care for Native communities. In 1979, the federal government adopted a new Indian Health Policy by which it is committed to involve more Native people in the planning, budgeting, and delivery of health care programs — recently, in line with this policy, the federal government is in the process of transferring health services into the hands of Indian people to allow more client control.

In 1982, the Registered Nurses of Canadian Indian Ancestry moved its head office to Ottawa; in

1983, the name was changed to Indian and Inuit Nurses of Canada (IINC) and the membership was opened to Inuit nurses.

As IINC grew and established its reputation as a professional organization, support came first of all from other organizations of health professionals, such as the Canadian Nurses Association (which in 1987 was in the process of granting IINC status as a Special Interest Group), the Canadian Association of University Schools of Nursing, various provincial nurses' associations, the Canadian Public Health Association, the Indian and Inuit Health Committee of the Canadian Pediatric Society.

THE IINC SINCE 1987

The Indian and Inuit Nurses of Canada is governed by an elected three-member executive (president, vice-president, and secretary-treasurer) and a 13-member board (representatives from Northern and Southern Ontario and one from each of the other nine provinces and two territories). Elections are carried out every two years at an annual meeting, which also includes sessions on nursing education and on Indian and Inuit health issues. These meetings are held in a different centre each year, preferably at or near a Native community.

Potential membership has now grown to approximately 300 Native nurses. Associate membership, approved in 1986, allows participation by nurses who are not of Canadian Indian or Inuit ancestry but who support the objectives of the association; associate members cannot vote, however.

The association has an executive director and one other staff person in Ottawa to manage day-to-day affairs. Communication is carried out through a newsletter published twice a year and through distribution of reports on special workshops held throughout the year. This keeps members abreast of new educational programs for Native nurses, of community-based programs looking for Native health care workers, and of concerns related to health care of Canada's indigenous peoples.

Funding comes from membership fees and from grants and donations to the association. Baxter Corporation of Toronto provides an annual scholarship for two Native nursing students who wish to pursue a career in northern communities. Members also raise money for the organization through sale of promotional material such as sweatshirts, T-shirts, and pins, and through raffles and other activities throughout the year.

Only one province — Manitoba — has a provincial association, although some initial meetings have been held in Saskatchewan and Executive and board members frequently act as advisors or resource persons to other organizations and groups, such as the Assembly of First Nations' Health Commission and to Bands on request. As well, they meet regularly with representatives of government departments and agencies, and with other professional associations.

In particular, the IINC has been working closely with university and college nursing programs across Canada to help with entry of Native students. As well, the association supports programs such as the

Indigenous People's Access Program to Nursing at the University of Saskatchewan and the Indian Health Careers Program at SIFC, University of Regina.

Because of their role as advocates both for an improved health care system in Native communities and for increased numbers of Native professionals, IINC members must be aware of the political implications and also keep abreast of current issues.



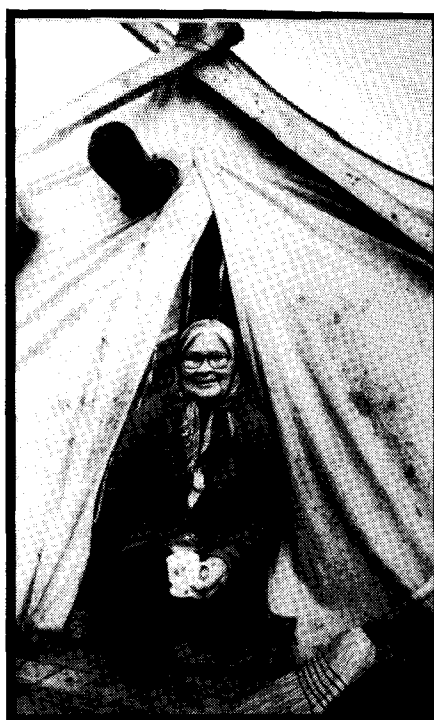
The equal opportunity provision in the civil service hiring regulations, introduced in the late 1970s, increased the number of Native workers hired by the Medical Services Branch for positions in headquarters and in the field. Before this provision, a training program for community Health representatives had provided a number of Native paraprofessional workers for Native communities. A recent evaluation found that, although many of these community health representatives provided a necessary and useful service, some were relegated to positions of translators or "gophers" for non-Native nurses and had little hope of advancement or recognition for their services.

Efforts by the IINC were at least partially responsible for the Indian and Inuit Health Careers Program that was launched by the Medical Services Branch in 1984, and there has been an effort to refocus the programs from paraprofessional to professional training. Some community health representatives now are taking advantage of health careers programs, particularly nursing programs.

However, this may create a new rift among front-line health-care workers. In some communities, Chiefs are asking whether Indian students in Health Careers Programs are developing into an elite group who may not wish to return to their communities — and who may not be accepted back. Although it was never presumed nor anticipated that all students in Health Careers Programs would return to their home reserves, there has always been a hope that many would do so in time.

As members have become more visible and have come to be recognized for their abilities, the demand for our services and expertise has increased dramatically. We do not have the numbers to meet all the requests from chiefs for their communities, from academic institutions, and from urban and rural health-care agencies for well-prepared Native nurses. In particular, managers of health service delivery programs are looking for qualified personnel with the ability to cross the cultural barriers that have always posed a major challenge to effective health care in Native communities.

With this in mind, IINC has made a conscious effort to focus on transcultural nursing in recent, on-going educational efforts for members. At the 1986 annual



assembly in Victoria, B.C. for example, we sponsored a day-long seminar based on the work of Madeline Leininger. Leininger argued that the health status of Indian communities will never approach that of the non-Native population unless transcultural concepts are incorporated in the delivery of health services, so that a community's cultural beliefs and values remain intact.

With our work on transcultural nursing, and our continuing support for these new developments across the country, we have continued to demonstrate our commitment to an improved health system delivered by and for the Indian communities. What we have not been willing to do is to take a political stand on such issues as the transfer of Indian health services to Band Administration. We are always aware of the need to support Indian governments and the decisions of Chiefs and Councils, but we must also uphold our professional standing and maintain a healthy working relationship with the colleagues and clients whom we serve.

Today's nurses in Indian health services are confronted with a range of very serious issues. In recent years, Indian people have become increasingly aware of their right to effective, culturally appropriate health care, in line with a growing demand for meaningful political rights. There is an air of uncertainty prevailing in Indian communities as the federal gov-

ernment moves toward the transfer of Indian health services and programs into the administration of the Bands. Regarding this transfer, we have worked closely with officials in the Medical Services Branch. It will not be sufficient to leave Bands with a messy and ambiguous health-care situation and then declare that "it's out of the department's hands."

Community education is also needed. Indian people often find it difficult to differentiate between a nurse and a community health representative — to distinguish their respective duties, responsibilities, and reporting relationships. This has become even more difficult with the emergence of alcohol and drug abuse workers and mental health paraprofessionals on reserves.

These developments suggest that it is time for a new generation of Indian trainees to enter the health professions, bringing with them a commitment to gaining acceptance in Native communities, rather than being perceived as a professionally trained elitist group. However, these students must maintain a presence in their communities, so that they do not emerge as strangers after years of study in an institution. We all know that Indian students need support which includes peers, parents, and members of the communities who, in turn, must be made to understand why it takes so long to become community health nurses.

Increased recognition and appreciation for tradition and culture in the curricula of a number of newly established Health Career Programs for Native students is most gratifying. Native nurses also need a grasp of the differences in values and customs among the many tribes and regions in North America. Traditional practices in the United States are not applicable in Canada, and beliefs and practices of the Iroquois and other eastern tribes in Canada may not correspond to those on the Prairies and West Coast.

Our most fervent hope is that a growing number of graduate Indian health professionals will be in a position to fill the cultural gap that tends to be one of the main causes of the misunderstandings and of the difficulties we have had with Western medical practices.

Then Native students can have the best of all possible worlds by combining the strengths of traditional and Western medicine.

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Jean Cuthand Goodwill was a founding member of the Indian and Inuit Nurses of Canada (IINC) in 1974 and has served as president since 1983. A Plains Cree born on the Little Pine Reserve in Saskatchewan and a registered nurse, she first worked as a nurse with Indian and Northern Health Services in northern Saskatchewan and a hospital in Bermuda. On her return to Canada, she continued to nurse but became increasingly involved in the development of organizations to improve Indian health care.

She has been employed in various capacities in government departments. In 1980, she was appointed Special Advisor to the Minister of National Health and Welfare. In 1986, she received an honorary doctorate of law from Queen's University, and later that fall was re-elected for another term as President of IINC. She recently accepted a position as Head of the Indian Health Studies Department, Saskatchewan Indian Federated College, University of Regina.

Profiles

Jean Cuthand Goodwill



The President of I.I.N.C., Jean Goodwill is a Plains Cree born on Little Pine Reserve in Saskatchewan. Possessed with the dynamic energy inherited from her 85 year-old father, John Tootoosis, and buoyed with continuous support from the Cuthands, her adoptive family, she has accumulated a wealth of experience and knowledge from a variety of careers.

Her interest in nursing was instilled during a hospitalization in her teen years, and her interest grew after a brief stint as a Nurses' Aide in Saskatoon. She graduated from the Holy Family Hospital in Prince Albert and was subsequently employed at the Indian Hospital in Fort Qu'Appelle. As Nurse-in-Charge of the La Ronge Nursing Station, (Indian and Northern Health Services), she coped with working conditions where many emergency situations arose and resources and professional assistance were either minimal or unavailable. After two years in this challenging job, she travelled to Bermuda and worked at the King Edward Memorial Hospital. She returned to Canada and continued to nurse, but she became increasingly involved in the development of Indian organizations. As a result, she accepted the position of Executive Director of the Winnipeg Indian and Metis Friendship Centre.

In 1966 Jean and her husband, Ken Goodwill, moved to Ottawa and they maintained their ties with Indian organizations by working for them when they were not employed in various capacities in government departments. Her involve-

ment with the World Council of Indigenous People has enabled Jean to travel extensively to places in Europe, U.S.A., North and South America, Australia and New Zealand.

In 1978 she assumed the position of Nurse Consultant at Medical Services Branch, and became advisor on Native Affairs to the Assistant Deputy Minister, Dr. Lyall Black. From there she moved into the rarified atmosphere of a Minister's office as the Special Advisor on Indian Health to the former Minister of National Health and Welfare, the Honourable Monique Bégin.

Other activities had her involved in editing a book, *Speaking Together*, which is a collection of profiles of outstanding Canadian Indian and Inuit women. She assisted in the production of an NFB film, *Mother of Many Children*. She also co-authored a biography of John Tootoosis, with Norma Sluman.

In 1981 the Manitoba Indian Nurses Association initiated the Jean Goodwill Award which is meant to honour members of I.I.N.C. for outstanding contributions to the health care and advancement of Native people. Jean was the first

recipient of the award and since then she has had occasions to award deserving colleagues with the medal which was originally struck in recognition of her dedication to her people.

Kathy Bird

Kathy is of Cree-Dakota heritage and originally from Norway House Indian Reserve, Manitoba, although she is now a Peguis Band member. She became interested in nursing while working as a dental assistant at Percy E. Moore Hospital in Hodgson, Manitoba. Although she applied for admittance into an L.P.N. course, she decided instead to try for the R.N. Diploma. She had been taking her children for immunizations to the Health Centre, and felt strongly that her own people should be holding those positions as Public Health Nurses. She was accepted into the Brandon General Hospital School of Nursing in 1978. Originally she wanted to work in an isolated Cree community, but she went back for one year for Medical Services Branch at the Hodgson Hospital, then transferred to the Peguis Reserve Health Centre. She has worked there for the past five years, is presently Nurse-In-Charge, and derives a great deal of satisfaction from her work on the reserve. "When working with your own people," Kathy says, "you have that knowledge that you are where you belong and that you are doing something for your people and yourself. I wouldn't want it any other way."

Madeleine Dion-Stout

Madeleine proudly claims that she began her nursing training as a small child. During her formative years she learned some ingredients of success for her chosen career. Her grandfather was an early role model and mentor, and as a young child, she followed him around while he went about his daily work. It was the eloquence of his example which cultivated a work ethic, perseverance, a striving of excellence and knowledge and discipline in her character. Although she is quick to say that she does not personify the epitome of these attributes, she does credit her family and the environment in which she was nurtured as very real sources of inspiration and support for her personal development.

Madeleine is Cree speaking and was born and raised on the Kehewin Indian Reserve in Alberta as a member in a family of twelve. She graduated from the Edmonton General Hospital in 1968 and worked as a staff nurse for the next nine years. Most of this time was spent working for Medical Services Branch in Edmonton at the Charles Camsell Hospital. In 1977, a family move to Southern Alberta launched her into community health nursing on the Peigan Indian Reserve in Brocket, Alberta.

This latter employment experience provided the impetus Madeleine required to pursue and obtain a Bachelor's Degree in Nursing from the university of Lethbridge in 1982. After a short return to community health nursing, an opportunity to work on the Community Health Demonstration Project within Medical Services Branch was offered to her. She accepted it and the proviso that she relocate to Edmonton

Five months later, she moved again. This time to Ottawa to replace Jean Cuthand Goodwill as Special Advisor to the Honourable Monique Bégin, then Minister of National Health and Welfare. In September 1984 Madeleine returned to Medical Services Branch to assist in the administration of the newly established Indian and Inuit Professional Health Careers Program, where she remains. It is no accident that Madeleine's employment history reflects a gravitation to and an alliance with those institutions which concern themselves with Native peoples' health, for she has long adopted this as her cause. Madeleine's further career plans include gaining a Master's degree in a health-related field in order that she can teach and do research. Her ultimate dream is to garner the skills and knowledge that would be useful to Native communities to which, she states, she shall return.

Madeleine believes in the objectives of I.I.N.C. and recognizes that as an organization it provides solidarity and a sense of collective purpose for its members, and it underscores their professionalism.

Madeleine's personal life revolves around her husband Bob, an information systems scientist, and her two daughters, Tamara and Roberta. Although her energies are directed to her family, Madeleine values and appreciates social time with friends, antiquing and flea market so-

journs, sewing sprees and Indian and Inuit Art.

Teresa Fox

A Blackfoot, born on the Blood Indian Reserve in southern Alberta, Teresa began school at the age of seven and had to learn English at the same time. She decided to become a nurse because it was one way she could get an education, while remaining close to her home and family. She graduated from St. Michael's School of Nursing in nearby Lethbridge, then qualified as a Community Health Nurse serving at Standoff Health Centre. She was on the Blood Band Council in 1978-80, during which time she helped to develop a report on the need for a Health Clinic on the reserve. A modern well-equipped clinic was opened there in July 1985. She believes that Indian and Inuit people should administer and operate their own health services, and she also believes, as a matter of principle, that the present bilingual bonus should be available not only to Native nurses who can speak English and/or French, but their own Native language as well. Teresa is convinced that reliance on the federal bureaucracy leads to too much "red-tape" and by the time funds are filtered down to the reserve level they are practically non-existent. She is a member of the Canadian Nurses Association and one of the original I.I.N.C. members. She has six children and two grandchildren.

Carol Prince

Carol was welcomed into the world by the midwife on the Nelson House Reserve, Manitoba and is of Cree ancestry. Her Indian name means "Woman with Energy," and the giver of this name must have had a very accurate premonition of her future.

She was impressed by nurses at a very early age. The two nurses on her reserve used to come around regularly with their little black bags and, as soon as Carol and the other children saw them coming, they all ran and hid! Carol's mother was a Community Health Representative, and may have influenced her to choose a health career.

She graduated in 1965 in Psychiatric Nursing from the Selkirk Hospital for Mental Diseases and was married that

same year to Fred Prince from Peguis Reserve. She worked as a psychiatric nurse in various Manitoba Hospitals. She then earned her R.N. diploma at the Misericordia Hospital, Winnipeg, in 1972 then she went to work for Medical Services Branch as a general duty nurse at the Fisher River Indian Hospital. That was followed by a stint of Outpost Northern Nursing at the Nelson House Nursing Station. From there she travelled to Ruttan Leaf Rapids, where she worked as the Occupational Health Nurse for the Sherritt Gordon Mines. She left her native province then to work as a Community Health Nurse at Battleford's Indian Health Centre in Saskatchewan. It was while she was there that she received an unexpected phone call, asking if she would be interested in the position of Special Advisor on Native Affairs to the Assistant Deputy Minister in Medical Services Branch. Carol accepted and went to Ottawa, where she remained in that position for four years.

In spite of the fact that Carol has four lively children, three boys and a girl, she is now in her second year, working toward her B.Sc.N. degree. She still spends the occasional weekend working at the Royal Ottawa Hospital. She has been a very active member of I.I.N.C. for nine years, and somehow she still has time for her hobbies, quilting, beading and her art work. Carol designed the logo for I.I.N.C.

Donna Rear

Donna was born and raised in the Yukon Territory and is a Northern Tutchone Indian. As she was growing up her father became very ill with cancer, and she became interested in nursing because she wanted to be able to look after him. She was a certified Nursing Assistant at Whitehorse General Hospital for seven years, then was sponsored for her Registered Nurse course by the Northern Careers Program of Whitehorse, which is available to Native government employees in the northern Yukon. She moved to Edmonton and entered nursing studies at Grant McEwan College, and upon graduation became the second Indian registered nurse in the Yukon. She has been working at the Whitehorse General Hospital for the past three years. She first heard about I.I.N.C. from Marilyn Van Bibber, an

other Yukon member. She has served on the board of the association for three years and reports that she enjoys the I.I.N.C. newsletter very much.

Claudette Smith



Claudette comes from Maniwaki, Quebec. An Algonquin, her involvement in a health career began when a community Health Nurse asked her if she would like to be a Community Health Representative. Since this was a new position in the area and permanent positions were scarce, she readily accepted. Within six weeks, armed with a Home Nursing Certificate and St. John's Ambulance First Aid course, she worked in that capacity for six years. She found this work limiting, and in 1980 she entered Algonquin College and earned her R.N. Diploma. She worked as an office nurse at a Pediatrician's office in Ottawa, until she received an offer of employment from the Children's Hospital of Eastern Ontario. Then Medical Services Branch offered her the position of Community Health Nurse in Maniwaki. In order to qualify she attended the Community Health Nurse in-service training in Ottawa, where she got her certificate in Public Health Nursing. She became a member of I.I.N.C. in 1983, attended the Vancouver conference and was elected as Quebec representative for the association. She firmly believes in I.I.N.C.: "We Native nurses can share our problems, support and encourage one another and try to overcome the many health problems our Native brothers and sisters are experiencing in Canada." Following her recent move to Ottawa she is working as a Program Officer at the I.I.N.C. national office.

Fran Williams



Fran is an Inuit born in Hopedale, Labrador where she attained her primary grades. She attended high school at Northwest River, Labrador. She worked as a Nursing Assistant at the Hopedale Nursing Station in 1962-63. From there she went into nursing, and received her R.N. Diploma from the Grace General Hospital, St. John's Newfoundland, in 1967.

After graduation, Fran worked as a Pediatric Nurse at Gander, Newfoundland for five years (1968-73). General Duty Nursing found her working next at different communities: Northwest River, Labrador and St. Anthony's, Newfoundland. Like many of her colleagues, she took on new interests, and became a Community Development Worker for the company of Young Canadians (1973-75), and a member of the Status of Women Council in 1975-76. She was also an Inuit Specialist for the division of Adult and Continuing Education. In 1981 she was elected as the first Inuit woman to the Presidency of the Labrador Inuit Association.

Fran was one of the guest speakers at the I.I.N.C. annual conference held in 1983 in Brantford, Ontario, where she gave a good perspective on the life and struggle of the Inuit in Labrador and her personal concerns. She applauds I.I.N.C. because it provides an opportunity for Inuit nurses to become active members and become aware of the benefits of health programs and services for Inuit people.

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