

TUBERCULOSIS (TB) STORYTELLING:
IMPROVING COMMUNITY NURSING TB PROGRAM DELIVERY

by

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Abstract

This study explores the effectiveness of the traditional First Nations practice of storytelling as a tool in improving Community Health Nurse (CHN) continuing education, regarding tuberculosis (TB) programming in First Nations communities. The first part of this study involves a critical analysis of literature regarding the evolution of Canada's First Nations policies and health care, and the use of storytelling as a learning tool in Western and First Nations contexts. Informed by critical social justice as a theoretical lens, and decolonising perspectives in health care, the analysis of the literature focuses on (a) shifting factors and societal values shaping the evolution of health care policy and regimes in First Nations health, and (b) the use of storytelling as an educational tool for CHNs working in First Nations communities. The analysis indicates that generations of inequities have resulted in First Nations mistrust of the Western health care system and a widening gap between the health status of First Nations and that of the broader Canadian population. The analysis also reveals that storytelling is an essential component of traditional First Nations education. Finally, the literature shows that there is increasing recognition by current health care policy makers that narrowing the gap in health outcomes requires that First Nations health care programming reflects First Nations input and community needs.

The second part of this study evaluates the use of storytelling in CHN TB continuing education. TB continuing education sessions for CHNs included first person accounts by First Nations Elders, as part of the TB Tapestries Project, after which 70 CHNs were invited to provide written feedback. Thematic analysis of this feedback reveals increased appreciation for First Nations traditional storytelling as an important tool in provision of First Nations health care; recognition of the effectiveness of storytelling compared to other teaching methods; and a desire to change future TB programming by including storytelling. Based on the analysis of

literature and CHN responses to the TB continuing education sessions, the primary recommendation of this study is to incorporate storytelling into TB education sessions for CHNs and broader health care programming for First Nations communities.

Preface

This thesis is an original intellectual product of the author, April MacNaughton. Parts of Section II are adapted from previous unpublished term papers (MacNaughton 2013a, 2013b, 2013c) and referenced where applicable. Use of the TB continuing education questionnaire, reported in Section III, was approved as per UBC Behavioral Research Ethics Board Certificate Number: H15-00312.

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Tuberculosis (TB) Storytelling: Improving Community Nursing TB Program Delivery

Section I – Introduction

I didn't have TB, but members of my family did...Dad and uncle used to go down to visit Tommy in the dormitory (sani[torium]) when they could when he was young... Years later, when he felt he was getting unhealthy he would always sign up for treatment centers and go away...you talk about people being institutionalized and I think for Tommy there was comfort in a schedule, daily routine and all your needs being met like eating at this time and sleeping at that time...I remember he did tell me of the kids being tied to their beds because they were up and running around...in the back of my mind I think of the horror he must of felt being tied to his bed as a kid...it seemed extreme (TB Tapestries Project participant, 2013).

Background and Context

Despite best efforts to treat communicable disease in First Nations communities, there remains a wide gap between the health status of First Nations and of broader Canadian society. For example, with the introduction of Tuberculosis (TB) medications, the rates of TB have declined in BC First Nations but continue to be substantially higher than the overall BC population TB rates (Health Canada, 2012a). A significant factor contributing to this discrepancy in health status is historic health care and administrative regimes for First Nations in Canada, which have resulted in a high prevalence of fear and mistrust regarding disease and Western health care. This fear and mistrust exists in First Nations communities to this day, as discussed by Waldram, Herring, and Young (2007) and Kelm (1999). As community health nurses (CHNs) are often the most direct link between health care regimes and First Nations communities, these nurses have a crucial role in reducing the fear and mistrust of Western health

care. Research is needed to obtain a better understanding of ways in which CHNs can effectively exchange knowledge with First Nations community members. Literature indicates that the use of culturally appropriate methods results in increased knowledge exchange (Hodge, Pasqua, Marquez, and Geishirt-Cantrell, 2002). The traditional use of storytelling is one such knowledge exchange tool, but further research is needed.

The purpose of this thesis is to explore the ways in which the traditional practice of storytelling within First Nations communities, when added to CHN TB continuing education sessions, might impact CHNs intention to improve TB programming they deliver in First Nations communities. This work will draw on the perspectives and insights gained from (i) a critical review and synthesis of the literature and (ii) a thematic analysis of the data collected from a self-reflective questionnaire of nurses participating in TB continuing education sessions for CHNs working in BC First Nations communities. The questionnaire was designed to evaluate (i) the impact of including traditional storytelling in TB continuing education sessions and (ii) potential for further use of traditional storytelling practices in CHN TB continuing education sessions.

I realized the vital importance of this topic while working as the TB Nurse Specialist/Educator for the First Nations Health Authority (FNHA) in British Columbia (BC), formerly the First Nations Inuit Health Branch (FNIHB)¹. This role provided me opportunity to not only collaborate with First Nations communities in health care programming, but also to work closely with many other CHNs, both of First Nations and non-First Nations ancestry, seeing first-hand the challenges they face in attempting to integrate Western medicine, particularly TB programming, into First Nations communities. With a TB Nurse Educator colleague from the TB Services for Aboriginal Communities (TBSAC) Program, we designed and implemented the TB Tapestries Project, a First Nations community storytelling project.

¹ On October 1, 2013, all FNIHB First Nations health care services in British Columbia transferred to FNHA.

To collect stories for this project we visited community health centres and the homes of community members from a variety of First Nations communities throughout BC. Community members' stories were recorded in a variety of mediums (video, audio, and text), as per the preference of individual storytellers. The experience of being in the presence of these storytellers, as they shared their stories and their lived experiences, was humbling. Many of the stories had never been shared before, and the storytellers were clear that their intent in sharing was to gift to us stories to teach with, so that future health care workers could carry the learnings from the stories forward in their practice. The storytellers shared, in hope that these learnings would enable the health care workers to see the whole community and its history, helping to provide context and safety in nurse-client encounters.

The stories from the TB Tapestries Project were then, with storyteller's permission, integrated into the FNHA two-day TB continuing education sessions for nurses who work in First Nations communities in BC. These sessions were facilitated by FNHA and TBSAC TB Nurse Educators. Following the TB continuing education sessions, participating nurses were engaged in anonymous open ended, written questionnaires designed to elicit personal reflection on the use of storytelling in the sessions, and on the potential impact (if any) to their nursing practice. In this study I have analysed these questionnaire responses and reflections, with the goal of understanding the potential and impact of storytelling as a learning experience and teaching tool.

This thesis is organised into four sections. The remainder of Section I discusses the theoretical perspectives informing this research, the research question, and an overview of the methodology. In Section II, critical analysis is used to synthesize perspectives from the literature, focusing on: (a) the broader context and evolution of First Nations health care services in Canada; (b) how past health care practices impact the effectiveness of TB prevention and treatment programs today; and (c) how storytelling could contribute to improving health care

outcomes. In Section III, a thematic analysis of the CHNs' responses and reflections in the questionnaire is discussed, with a focus on considering whether the culturally appropriate use of storytelling influences CHNs' community TB practice. Recommendations and concluding comments are included in Section IV.

Theoretical Perspectives

The theoretical perspectives informing this research include: understandings of critical social justice, decolonizing approaches to health care, and the use of storytelling as an educational tool, as they relate to improved health outcomes in First Nations communities. These theoretical perspectives are used to synthesize and analyse the literature in Section II. Key readings informing my understanding of these theoretical concepts and perspectives include the following.

Critical social justice, in relation to health care, has been the focus of a number of academic studies. Critical social justice theory focuses on the root causes of inequities in health and health outcomes, rather than just on equal access to health care services. The critical social justice lens directs the analysis to focus on the inequities that result in poor health outcomes. It is important to focus on the root causes and how these causes impact the inequities that exist for First Nations communities. (Browne & Reimer-Kirkham, 2014; Reimer-Kirkham & Browne, 2006; Browne & Tarlier, 2008; Anderson et al., 2009; Racine & Petrucka, 2011). It is these inequities that influence, for example, the increased rates of TB in First Nations populations.

Much has been written with regard to the need to overcome the ongoing impacts of colonialism on equity for Indigenous peoples, referred to as decolonizing health care. The process of decolonizing systems such as health care and education requires the production and use of culturally appropriate materials, based on Indigenous knowledge and culture, and continued opposition to colonizing attitudes. (Battiste, Bell & Findlay, 2002; Stansfield & Browne, 2013; McGibbon, Mulaudzi, Didham, Barton, & Sochan, 2014). This decolonizing

perspective supports this research using an indigenous methodology approach to decolonize nursing practice with regards to TB education.

Storytelling, in its most basic definition, is the oral communication of information through stories. The use of storytelling as a tool for information sharing and education in both Western and First Nations contexts is an established phenomenon. The use of storytelling in education has been documented as a successful way to connect learners to the subject matter (Rossiter, 2002; Hodge et al., 2002). Although Western and First Nations storytelling contexts share similarities, there are also significant differences in the structure and intent of the storytelling process. For example, in both Western and First Nations contexts, storytelling provides an emotional connection to the subject matter, which can make the messaging easier to retain. Western storytelling, however, has traditionally been focussed more on attaining an emotional effect, whether as entertainment or illustration, as opposed to serious life lessons to be delivered by First Nations storytelling. The structure of Western storytelling is generally point-driven, with a structure leading to one specific conclusion that is easily obtained by the listener at the end of the story. First Nations storytelling, on the other hand, often utilizes a more nebulous structure, which requires reflection by the listener, after the storytelling session, to arrive at his or her own conclusions regarding the message of the story. (Rossiter, 2002; Fisher & Ball, 2005; Hodge et al., 2002; Hurst & Nader, 2006; Piquemal, 2003). Western storytelling, when used for obtaining knowledge, often involves the recording of stories followed by the extraction of desired facts to meet empirical academic needs, with any remaining superfluous data being set aside. In this process, the storyteller is silenced and the story itself is lost (Kovach, 2009). In contrast, First Nations storytelling values the whole story and the storytelling process, including the storyteller, the audience, and the context, as integral parts of the story. Recognizing the similarities and differences between Western and First Nations storytelling, in terms of purpose,

use, style, and context, could facilitate the use of storytelling by CHNs working in First Nations communities, for improved health outcomes.

Research Question

How can traditional First Nations storytelling be used as an effective tool in community health nurse education, to improve delivery of TB prevention and treatment programs?

Sub-questions:

1. How does the literature inform our understanding of:
 - a. The evolution of First Nations health care as a factor in current TB programming?
 - b. The use of storytelling in current practice today?
2. How do CHNs respond regarding the inclusion of storytelling in TB continuing education in terms of:
 - a. Informing their understanding of First Nations peoples' experiences with the health care system?
 - b. The use and impact of storytelling in TB educational sessions for CHNs working in First Nations communities?
 - c. How making space for individual and community stories about TB might inform CHNs' delivery of future TB programming?
3. What are the implications and recommendations for incorporating TB storytelling in TB continuing education for CHNs and community health nursing practice?

Overview of Methodology

The methodology includes critical analysis of the literature and a thematic analysis of CHNs' responses in the TB continuing education session self-reflective questionnaire.

Specifically, the aim is to:

1. Conduct a review and synthesis of relevant literature, including Canada's First Nations historic and current policies and health care, changing societal values and

perspectives, and the traditional and current use of storytelling in Western and First Nations contexts.

2. Conduct a thematic analysis of community health nurses' responses to the self-reflection questionnaire, administered post-education session, to address the research questions. These questionnaires were designed to evaluate the usefulness of incorporating traditional storytelling into TB continuing education sessions for community health nurses who deliver TB prevention and treatment programs in First Nations communities.

Section II - Analysis and Synthesis of Literature

Background to First Nations Health Care Policy in Canada

I had to take the medication for a long time. I was a kid then, and I remember they used to give me the pills at the school...it was really hard because the other kids wanted to know why I had to leave the classroom and had to take pills, and what was this disease?...I didn't know anything about TB at that time...and I felt ashamed about it...called a dirty little Indian because I had a disease...kids were mean...it was really hard (TB Tapestries Project Participant, 2013).

Chronology of Canada's First Nations policies and health care.

This review of Canada's evolving First Nations policies and health care provides the context in which CHNs currently practice tuberculosis health care programs. Knowing the history of First Nations health care can provide key insights into why current health care providers experience the challenges that they do, in garnering uptake in First Nations communities.

As discussed by MacNaughton (2013c), government policies related to First Nations in Canada have evolved over the past 250 years, commencing with the Royal Proclamation of 1763 (Maton, 2009), by King George III, regarding lands held by the Dominion from Quebec to Florida. This proclamation outlined the procedure for interacting with First Nations regarding land and trade, guaranteeing protection of Crown Lands for First Nations, and preventing colonist occupation or purchase of land from First Nations, or trade with First Nations, without permission from the Crown. The proclamation was, however, limited to those First Nations that were connected to, and therefore under the protection of, the Dominion (i.e. Eastern North America). The American Revolution (1775 - 1783) resulted in the Dominion lands being divided between Britain and the United States. As such, First Nations communities within the Dominion fell under separate jurisdictions, greatly reducing the scope of the 1763 Royal Proclamation.

A number of key documents regarding First Nations in Canada were produced following Confederation. The Constitution Act (formerly the British North America Act) of 1867 placed health care under provincial jurisdiction, but placed the general care of Indians² under federal jurisdiction. As discussed by Speck (1989), this distinction led to a debate over whether ‘Indian health’ should be considered a ‘health’ problem, or an ‘Indian’ problem, as each would fall under a separate government jurisdiction. As a result, neither government accepted full responsibility for Indian health. An Act was passed by the Government of Canada in 1869 (An Act for the gradual enfranchisement of Indians, the better management of Indian affairs, and to extend the provisions of the Act 31st Victoria, Chapter 42, S.C., 1869 c. 6). Although not specific to health care, the Act is indicative of the government policy of encouraging enfranchisement, or assimilation, of First Nations into the general population of Canada. This policy of enfranchisement, or assimilation, was more overtly outlined in the Indian Act of 1876 (An Act to amend and consolidate the laws respecting Indians, S.C., 1876, c. 18), and successive amendments from 1881 through 1961, which encouraged First Nations to renounce their Indian status and traditional cultures, to become homogenous with broader Canadian society.

More specific to health care, the Indian Act was amended in 1884, resulting in the legislation of a system of Indian Residential Schools administered by Christian churches, whose responsibility evolved to include Indian Hospitals. Over the next 20 years, the responsibility for Indian Hospitals was assumed by the Department of Indian Affairs. By 1920, Residential School attendance was compulsory for all First Nations children from the age of seven years. Indian Residential Schools greatly exacerbated the incidence of TB in First Nations communities, as children were kept in close and constant contact, resulting in a very high infection rate. The result was the complete tuberculization of the second generation of First Nations following

² Note that that term “Indian” is used throughout this text, in reference to First Nations, as per the context of historic legal documents and the language used within those documents.

forced relocation to reserves (Moore, 1961). The mortality rate for First Nations children from TB was 75% or higher, in some schools.

The era of TB sanatoriums in Canada began in 1896, with the first being constructed in Ontario for treatment of TB in non-Indians (Canadian Lung Association, 2013). By the end of World War I in 1917, the Government of Canada built TB sanatoriums in every province, as a result of thousands of soldiers returning from overseas and infected with TB. First Nations people were not admitted to these sanatoriums, however, as overcrowding was an issue.

The Department of Indian Affairs was pressured by TB associations, such as the Canadian Lung Association, through the 1920's, to address TB control in First Nations, primarily stemming from the fear of rampant infection in First Nations communities spreading to non-First Nations populations (Kelm, 1998; Lux, 1998). As such, a limited number of First Nations patients were admitted to the Fort Qu'Appelle Sanatorium in 1924, on a research basis. The economic depression of the 1930's led to increased budget cuts and cost-saving measures in First Nations health care, with services often limited to those required for immediate 'life, limb, or essential function' (Kelm, 1998), precluding TB surveys and admission to sanatoriums.

In 1941, the Coqualeetza Residential School was converted to Coqualeetza Hospital, the first TB sanatorium for First Nations in B.C, which was in operation until 1968. Two more First Nations TB sanatoriums were opened in BC, one at Miller Bay and the Nanaimo Indian Hospital. National Health and Welfare assumed control of Indian Health Services in 1944, and after World War II, TB control became the primary function of Indian Health policy (Kelm, 1998). Consequently, funding for TB control continued to increase through the 1950's and 1960's. Improvements in the use of medications gradually allowed for the treatment of TB patients in their own homes, resulting in most TB sanatoriums being closed down as the 1960's came to a close.

A prevailing trend throughout the evolution of First Nations health care programs is the lack of inclusion of First Nations communities as participants in the consultation, design, or delivery methods for services that directly affected them. This trend is in stark contrast to the policies and mission statements that guide patient care for most health authorities today, which reflect patient rights and autonomy as key components.

TB sanatoriums are no longer utilized in Canada today, but their legacy persists in the memory of former patients and their families. Many First Nations community members who were admitted to sanatoriums, and to residential schools, however, are still highly apprehensive regarding their past treatment, or lack thereof, associated with TB. As discussed by Waldram et al. (2007), tuberculosis treatment and prevention methods that were successfully used in the non-First Nations population were often not employed in First Nations tuberculosis programs, due to lack of funding. The treatment that was made available to First Nations was often highly invasive and insensitive, including forced evacuations from communities to hospitals, and segregation of First Nations patients from non-First Nations people. Many First Nations patients taken from communities for treatment never saw their families again, particularly if they were taken from communities at great distance from the hospitals. These practices led to a great amount of fear and mistrust of Western health care and stigma of TB in First Nations communities, which continues to the present day. The persistent fear among First Nations community members of being taken from their home, to be treated in isolation, results in many cases of TB going unreported, which makes the planning and delivery of TB prevention and treatment programs a real challenge.

I have latent TB. I got the germ from my sister in-law. Unfortunately my sister in-law did not know she had TB. I noticed that her health was slowly deteriorating and she coughed continuously, but she refused to go to the hospital or seek medical help. She was afraid to

go the doctor. She would stop by for tea and a visit. As she became sicker, her “flu” became worse. All summer she went about her business and I did not see her much. One day she called me over to her house to make her lunch. I was not prepared for what I saw, a woman who was nothing but skin and bones, coughing and so sick. She eventually had to be taken out of the home and hospitalized. I got the news that she had TB (TB Tapestries Project participant, 2013).

These concerns about TB and its treatment combined with, for many, social determinants of health that increase individuals’ susceptibility to the disease, has resulted in TB remaining prevalent in many First Nations communities. In 2008, the First Nations on-reserve TB rate was 29.4 times higher than the TB rate for the broader Canadian populous (Health Canada, 2012a).

Reflection on key factors, societal values, and perspectives affecting First Nations health care policies.

As discussed by MacNaughton (2013c), the evolution of policy and attitudes regarding First Nations health care from the late 1700’s to the present day is reflective of shifting values, politics, and structure of the Canadian government, and society as a whole.

Since the Royal Proclamation of 1763, the administration of Canada has categorized First Nations people as separate from broader Canadian society. Historically, Canada unjustly did not recognise that First Nations peoples possessed their own effective traditional methods of promoting health and treating illness. It could be argued that instead the government generalised their view of First Nations peoples, based on conditions observed only after populations had been decimated by disease resulting from European contact, as discussed by Kelm (1998). This simplistic view was reflected in the language of the Royal Proclamation of 1763, and subsequent Acts, determining First Nations to be dependants of Canada, not treated on equal footing and as a separate society. From that time, and to lessening degrees since, First Nations health care has

been managed through an approach of condescending support, or patronage, of peoples who were deemed unable to care for themselves. Examining this general attitude towards First Nations health care, and the Government of Canada approach specifically, is key in our striving for critical social justice. It is widely recognised that there exists a dichotomy between the health status of First Nations and non-First Nations in Canada. By determining the root causes of this dichotomy, we can work to achieve equality in health outcomes for First Nations, rather than merely achieving equal opportunity for access to health care.

A number of key conflicting values have been in play with regard to First Nations health care regimes throughout Canadian history. An overwhelmingly powerful perspective is that of colonialism, whereby a colonizing force subjugates another group of people by imposing itself upon the other through positional superiority (Racine & Petrucka, 2011). European interests were expanded to North America to gain control of its lands and resources, despite the fact that another society was already in possession of these lands. The subjugation of First Nations would likely have been justified in European societal perspective by an attitude of superiority, assuming that First Nations would benefit from European medicine and health care practices. This assumption would have been especially strengthened given the health conditions witnessed in First Nations communities by early colonists, resulting from European diseases. Ironically, although the Europeans introduced disease which decimated the First Nations communities, the early colonists considered First Nations to be a people unable to persevere without intervening Western science and administration; the essence of patronage. This paternalistic attitude ensured a condescending system of health care, where First Nations would be provided for, but not collaborated with. Services were provided ‘to’, not ‘with’. Various Acts for dealing with First Nations, such as those of 1869, regarding enfranchisement, and the 1876 Indian Act, emphasized another key administrative value; that of assimilation. This value gave rise to Indian Residential

Schools, designed to remove the inherent First Nations cultures and customs that were deemed to prevent effective assimilation of First Nations people into Canadian society.

It was eventually determined that, despite best efforts to treat First Nations through patronage and assimilation, there remained, and remains, a wide gap between the health status of First Nations and of broader Canadian society (First Nations Health Council, 2011). New, enlightened ideals, centred on empowerment and self-determination, have now emerged, and are central to the perspective of decolonising health care. As discussed in MacNaughton (2013c), the ideals of self-determination and empowerment of marginalized voices represent the values associated with postcolonial feminism, as opposed to colonialism. Postcolonial feminism is a theoretical perspective whereby subjugated non-Western knowledge is voiced and given value to the benefit of non-Western peoples (Racine & Petrucka, 2011).

There has been a gradual acknowledgement that First Nations societies are aware of their own priorities, and have critical insights into how health services can be delivered most effectively in their own communities. It is now clear that collaborating with First Nations in a lateral fashion enables the promotion of health care from within communities. Those responsible for First Nations health care and governance policy are realizing that embracing traditional knowledge and culture, rather than viewing it as an impediment, fosters trusting relationships and more effective health and social outcomes (Fiske & Browne, 2006; Lavoie, Forget & Browne, 2010). A key aspect in embracing traditional knowledge and culture in health care is the use of storytelling in education. Stories in First Nations culture embody the collective memory of a community with regard to traditional knowledge, and are an important tool for delivering health care messaging.

Storytelling

This section will review relevant literature with two aims in mind. The first aim is to compare and contrast the traditional use of storytelling as an educational and health care tool, in Western and First Nations contexts. The second is to describe how storytelling is currently being used in TB continuing education.

Storytelling is a complex phenomenon of broad definition, with meanings as diverse as human cultures themselves. This section examines the concept of storytelling in the contexts of First Nations and Western education and health care, comparing and contrasting the two perspectives. This examination primarily focuses on how storytelling is construed and utilized and how it can be a useful instrument in First Nations community health programs.

As described by MacNaughton (2013b), storytelling, in its most basic definition, is the oral communication of information through stories. The use of storytelling as a tool for information sharing and education in both Western and First Nations contexts is an established phenomenon. Although there are similarities, there are also significant differences in the structure and intent of the storytelling process, between the two storytelling contexts.

Storytelling holds considerable transformational power, for a number of reasons. Not only is it widely acclaimed and evidenced for its healing capacities for individuals and families, it also lends itself to strengthening culture, identity and relationships in fragmented communities. Through telling of their own stories, people may discover new self-perceptions, new strengths that fall outside previous “problem saturated” or negative constructs, held either by themselves or others. Storytellers also grow as the story is re-told. Story-telling is a method for building trust and connection between people through identifying similarities, sameness, belonging, a finding a connection that binds. Story-telling can be used as a method to challenge dominant social structures or improving community work practice. It is a cost effective method for engagement (Archibald, 2008; Waldram et al., 2007).

Use of storytelling or narrative in Western health care and education.

In the Western context, storytelling is used to deliver messages through organized point-driven stories, involving the relation of anecdotes that are applicable to a given situation, with the intent of providing a ‘take-home’ message or practical lesson (Davidhizar & Lonser, 2003).

Western society may demonstrate reluctance to the consideration of storytelling as a serious instrument of knowledge transfer, of scientific value, or component of health care and community wellbeing, as it has traditionally been focussed more on attaining an emotional effect, whether as entertainment or illustration. There is, however, a growing trend in health care in which storytelling is gaining prominence as a valuable tool for holistic patient care (Davidhizar & Lonser, 2003). In the health care context, storytelling is often referred to as narrative.

The dominance of technology and empirical data collection has resulted in health care becoming more impersonal. In response, storytelling provides an opportunity for emotional connection between clients and caregivers, and between health care providers themselves, and is becoming an increasingly important component of health care provision (Davidhizar & Lonser, 2003). The importance of storytelling or narrative in nursing, to connect with patients in a holistic manner, as people and not just cases, is corroborated by Gaydos (2005), Sandelowski (1994), and Skott (2001)). When nurses communicate with, and listen to, patients through narration, a trusting relationship develops, as does a nurse’s professional skills. Likewise, in terms of education, Davidhizar and Lonser (2003) state that in moving away from traditional lecture-style nursing education, storytelling can be effective in maintaining student engagement and encouraging critical thinking.

The concept of narrative in conducting research is further refined by Hall and Powell (2011), who state that narratives are a communication of time-ordered events, structured together as a logical, coherent whole. Narratives can be separated into a variety of categories, such as narratives of self, of illness, and of trauma. Utilizing narratives in research can encourage clients

to share their own stories with nurses, revealing cultural or background information, which is helpful in planning and providing appropriate health care.

Use of storytelling in First Nations health care and education.

Storytelling is of utmost importance as a societal construct in First Nations cultures. It provides the foundation for the transfer of information, historical documentation, community building, and problem solving. Stories are the means by which significant lessons are transmitted from one generation to the next (Schanche Hodge, Pasqua, Marquez, & Geishirt–Cantrell, 2002; Kovach, 2009). Stories are used to teach the difference between positive and negative choices and behaviours (Reich & Michaels, 2012).

As discussed by Drees (2013), First Nations storytellers share their personal experiences through stories, as teaching moments. Elders explain that the learning process using stories is deliberately slow and emphasise that full understanding of a story requires repeated listening and an open-minded listener to absorb a story's many meanings and lessons. As Drees (2013) states, stories of others' experiences are not just historical facts. Rather, the storytelling process is a priceless opportunity to gain an understanding of a period of time or a community aspect that would not otherwise have been possible. Traditional storytelling is meant to help and to teach people. The sharing of stories is a powerful tool for achieving personal insight and developing relationships. It establishes a cultural connection and sense of belonging, and ownership or pride of these stories, and sharing in them is considered a privilege.

An example of the significant use of stories in First Nations culture is one of being a witness, as seen in give-away or potlatch ceremonies by Coast Salish First Nations. The purpose is for the observer to remember and pass on the story, affirming that it happened, as a witness to the significant event. This significant use of storytelling demonstrates how storytelling was, and is, a responsibility. Without these stories, valuable information, lessons, customs, and laws would be lost, as Indigenous languages/stories are living and outside of written language.

The use of storytelling in First Nations health care has been studied extensively. As discussed in MacNaughton (2013a), storytelling as a teaching method has been demonstrated to be an effective method for removing cultural boundaries between health care providers and First Nations communities (Fisher & Ball, 2005). Schanche Hodge et al. (2002) advocate for the use of storytelling as an educational tool in First Nations communities. They found storytelling to be effective in generating introspection and engagement on the part of the listener, and that health care models based on storytelling result in greater acceptance of physicians and nurses by local communities.

Comparison of storytelling in Western and First Nations contexts.

The use of storytelling in the Western health care context is structured and implemented differently than the use of storytelling in First Nations health care (Table 1). As described by Piquemal (2003), Western education advocates for the use of storytelling as a tool for teaching explicit moral lessons and practical knowledge. The process used to accomplish this is based in Western thinking. The storyteller sets up a specific message, communicated through a thread of logic, relating a story containing conflict, crisis, and resolution, with a key message or moral at the end. In contrast, in traditional First Nations storytelling, the stories are meant to be living oral documents, which adapt and unfold through time. There is no definitive ending to the story. The moral or intended message is not explicitly stated, but rather embedded within the story, to be drawn out by each individual in the audience, upon long-term reflection. In this way, the message or teaching is likely to have resonating meaning for the recipient.

The use of stories to elicit information for health care has been used in both Western and First Nations health settings. Drees (2013) documented a wide range of stories from First Nations people regarding their experiences with Western medicine and Indian Health Services in Canada. This practice is similar to the use of narratives in Western health care, as described in the previous section of this paper. The long-term process of using stories as a method for eliciting

information and building trusting relationships is corroborated by Dixon and Iron (2006), where they recognise that this type of communication requires time. Information may only be offered after the relationship is adequately developed. A fundamental difference between Western and First Nations storytelling is the expected result and structure of each context. Western storytelling, or narrative, involves a logical order and specifically prescribed outcome of the story or narrative, which are not present in First Nations storytelling.

Table 1. Comparison of Storytelling in Western and First Nations Contexts*

This table summarises key points from references listed throughout this section.

Aspect of Storytelling	Western Health Care Context	First Nations Health Care Context
Primary purpose of stories	Specific lessons and practices are taught.	General lessons are taught.
	Querying	Sharing
How stories are used	A message, concept or patient situation is conveyed.	Long-term change and positive outcomes are sought.
	A particular story might only be used once.	The use of a particular story is ongoing.
Style of stories	Stories are: <ul style="list-style-type: none"> - Structured - Practical - Pointed - Logical and science based - Oriented to immediate lessons 	Stories are: <ul style="list-style-type: none"> - Adaptive - Embedded with meanings - Learned from upon lengthy reflection - Embodied with ritual and myth
Benefits	Patient and/or caregiver creates personal meaning	Patient and/or caregiver creates personal meaning
	Relationship building	Relationship building
	Logical progression allows for quick learning	Community engagement
		Reflective learning is retained
Context	Used within a variety of specific settings or groups (e.g. nursing students)	Used within a First Nation community context
	Used to achieve a specific end result	Messages are often general, i.e. holistic message of health (physical, emotional, mental, spiritual)

*Adapted from MacNaughton (2013b)

Refining the use of storytelling in First Nations health care provision.

As described by MacNaughton (2013b), storytelling is a powerful tool for delivering information, including health care messages, to First Nations communities. Health care planners who employ this approach may strategize with communities to determine the most appropriate setting for available communication methods. Various education and health care options, including storytelling and narratives, can be viewed as tools in a large, well-equipped toolbox. Each tool is useful in its own appropriate context.

For instance, storytelling in the traditional First Nations way has the potential to be a highly effective tool for delivering health care services, provided that the educator does not expect a similar audience response or the immediate effect that is achieved through Western narrative teachings. Rather, storytelling in First Nations is a long-term process, where meaning is often transferred after repeat listening. For this reason, storytelling would not be an appropriate tool for detail-dependant instruction, such as in clinical process or specific policy/legal requirements. Storytelling is, however, ideal as a vehicle for general or specific health promotion practices, how people manage health and illness, and how the contexts of people's lives shape their health and access to services. A storytelling model of health care messaging, even if limited to promoting wellness as a value, could encourage community engagement in more formal health care programs and detail-dependent instruction.

Audience engagement achieved through storytelling and subsequent critical reflection on the underlying message of the story, could result in greater long-term buy-in to health promotion initiatives, rather than from simply reciting facts and dictating procedure to communities. Having communities involved in the storytelling process, led by a respected community Elder, would contribute to community-led health initiatives, with improved long-term commitment from community members. Working with First Nations through community members is an important consideration, as each community will have its own storytelling protocols that must be respected.

The importance of narratives, as interpreted in the Western context, should not be overlooked as useful tools in First Nations health care. In both the Western and First Nations health care contexts, narratives provide an opportunity to develop a holistic picture of patient health through open-ended questioning, where specific answers are needed. The personal contact and individual respect involved with eliciting narratives, or stories, from First Nations community members, is the best possible opportunity to gather critical information, while developing a trusting relationship (MacNaughton, 2013b).

It must be noted that as useful as Western medical practices are, culture and community-specific needs, as identified by communities, are critical to success (Hurst & Nader, 2006). The key to successful health care delivery in First Nations communities lies in finding the appropriate combination of Western and First Nations approaches. First Nations and Western storytelling approaches can be combined to meet multiple needs, develop trust, deliver information, and elicit feedback. Trial studies in American Indian communities, reported by Schanche Hodge et al. (2002), demonstrated that an effective combination of the two approaches is achievable through careful facilitation of storytelling sessions blended with specific health messages.

Current State of First Nations Health Care

Health care governance structure.

Evolving political trends are reflected in the structure of health care governance in Canada. British Columbia is on the forefront of this structural transformation. As discussed in MacNaughton (2013c), BC is the first province to have First Nations assume responsibility for federally funded health care, through the creation of a First Nations Health Authority (FNHA). This Health Authority is the result of a tripartite governance process between First Nations, the Government of Canada, and the Province of British Columbia, through the Transformative Accord of 2005. The Accord is a commitment for the three parties to work together in closing social and economic gaps between First Nations and other British Columbians (First Nations

Health Council, 2005). In 2011, the BC Tripartite Framework Agreement of First Nation Health, a legal agreement, was completed, the product of a long relationship building and negotiation process. The shift to First Nations-directed health care from the traditional government-directed health care is indicative of significant evolution in administrative structure and decision-making. The administrative structure for health care shown in the traditional First Nations – Federal government relationship was based on Government-driven, top-down, command and control actions, as an extension of past societal values and politics (MacNaughton, 2013c).

With changing values and politics in Canadian society, there is willingness to endorse increased self-determination, with First Nations being empowered to make decisions and administer health care in their communities. The significant changes in societal values, political trends, and governance structures over the past 250 years indicate a shift in attitudes toward First Nations at a Canadian societal and political level. This evolution has been a significant factor in how health care has and will be delivered in First Nations communities.

Changing roles, responsibilities, and practices for health care providers.

Historically the provision of health care services to First Nations people occurred in isolation from that of broader Canadian society. Given that First Nations were deemed to be the responsibility of the Federal government, the provinces were not required to provide services which were provided to non-First Nations people. Jurisdictional divisions over the provision of health care has resulted in a significant dichotomy of care between First Nations and non-First Nations people in Canada (Browne, McDonald, & Elliott, 2009). While non-First Nations were given care in provincially funded hospitals, First Nations hospitals were functions of Christian churches, with very little funding available. As a result, First Nations health care programs did not evolve at the same rate as provincial programs for non-First Nations. Even today, although all Canadians have access to universal health care, as per the Canada Health Act (1985), the Federal government is still responsible for a significant portion of First Nations health care. This

includes the placement of community health and home care nursing programs and health promotion programs, such as dental health, nutrition services, mental health and alcohol and drug programs on Indian Reserves. It is important to note that these Federal programs and services were developed and implemented with little input from First Nations and as such are designed for the non-First Nations health care client (Adelson, 2005).

Adapting health care programs over time, to develop increased relevancy to First Nations, is within the capacity of health care providers, in conjunction with First Nations communities. Health care providers contribute to the development of new policies and implementation procedures in First Nations communities, facilitating the process whereby specific communities work to determine their own best practices. First Nations communities require the on-going support, expertise and services provided by health care providers, as advocates for community members navigating the health care system and, where appropriate, providing input to the development of health care policies. The evolution of First Nations health care policies and programs does not negate the need for services that are currently provided. Health care providers in First Nations communities play a critical role in recognizing the value and limitations of current services while fostering a more culturally appropriate system of health care.

Moving forward in First Nations health care.

A high level of mistrust persists amongst First Nations, a result of past experiences associated with participation in Western health care (Browne & Fiske, 2001). The context within which health care is now being provided is, therefore, critical in determining when, where, and from whom First Nations community members will seek care, if they seek it at all. The inclusion of First Nations as an equal stakeholder in health care policy determination is key in establishing appropriate cultural context. The recognised necessity for this inclusion is evident in the establishment of the tripartite First Nations Health Authority (FNHA) in British Columbia, with First Nations involvement at the macro, meso, and micro level.

TB programming is in effect an example of this new relationship. TB programs will continue to be delivered as per national and provincial TB strategies (macro level). Both of these strategies: Health Canada's Strategy Against Tuberculosis On-Reserve (Health Canada, 2012b), and the British Columbia Strategic Plan for Tuberculosis Prevention Treatment and Control (British Columbia Centre for Disease Control, 2013) were developed in consultation with key stakeholders at all levels, including federal and provincial governments, health care workers, and First Nations community members. While BC on-reserve programming strives to achieve strategic targets, it is important to note that the direction guiding TB programming is not limited to these strategies. First Nations and Inuit Health Branch (FNIHB), TB Services for Aboriginal Communities (TBSAC) and the FNHA, at the meso level, as well as First Nations communities, at the micro level, participate in the planning and implementation of on-reserve TB programming. First Nations communities are engaged in program development through the community TB team.

Community TB teams include not only Community Health Care Workers (CHWs), but also community TB Champions. TB Champions are community members who have been affected by tuberculosis in the past and work with the CHWs, sharing their stories and knowledge of the community's experience with TB and the health care system. Active community participation in the development and delivery of community TB programming is key to ensuring that programming is tailored to the cultures and circumstances particular to a given community. This community 'ownership' model of TB program development helps to engage communities and raise TB awareness, decreasing fear and stigma, and improving access to health care.

To be successful, new arrangements in health governance, such as the tripartite FNHA, will require new approaches to health care delivery. These approaches must be adaptive, with

flexibility built in to allow for continual improvement. The result could be increased potential for First Nations participation than was historically achieved.

As discussed by MacNaughton (2013c), this is a dynamic time in the evolution of First Nations health care governance, policy and delivery. The key influence at play appears to be the relationship between policy and the problem that it is intended to address. Historically, the ‘issue’ was deemed to be that First Nations people, with their cultures and customs, did not ‘fit’ with the health care programming designed for broader Canadian society. As a result, policy makers planned to assimilate First Nations by removing their culture and customs, to make them fit with Western health care programming, and society in general. We have now arrived at a point in time where the paradigm, and thus the policy, has shifted. There is now recognition that the problem is actually the nature of health care programming, not the nature of the people. By shifting the changeable component of the issue from the people to the program, policy is beginning to concentrate on adapting health care programming to fit the needs of First Nations communities. This shift in policy is in its infant stages, but has potential to be of great benefit in narrowing the gap in health outcomes between First Nations and broader Canadian society. The use of storytelling in education is one potential component of adapting health care programming to community needs. An important aspect of this process will be the education of CHNs, as health care workers who have direct relations with First Nations communities, regarding the importance of storytelling.

Section III: Analysis of CHN Responses to Continuing Education Sessions on the Use of Storytelling in TB Programming

Conceptualizing the TB Tapestries Project: Gathering the Stories

The incorporation of storytelling into TB continuing education for CHNs in First Nations communities is in process in BC. One current initiative is the TB Tapestries Project, which is being implemented through the First Nations Health Authority. TB Tapestries is a storytelling project that weaves together a collection of lived experiences and truths gathered from individuals whose lives have been impacted by TB. These stories were gifted by the storytellers, to Nurse Educators, with the goal of educating health care workers. The concept of the TB Tapestries Project evolved from a number of key observations that were noted by FNHA and TBSAC TB Nurse Educators working in First Nations communities. One observation was that they routinely heard at least one TB story from a client at each community TB screening event. Many of these stories had never been shared before. Another observation by Nurse Educators was that in evaluating TB education sessions, CHNs regularly commented on how they greatly valued listening to the casual stories that Nurse Educators interjected into TB history lessons. With these observations, the Nurse Educators realised the potential value of formally incorporating stories into CHN education curriculum. While these stories had always existed with TB clients and health care workers, they had not been utilised as a formal component of the teaching process. As described in Section II, people value stories, because they provide substance – eliciting all manner of emotions that appeal to the human spirit, and make the listener want to know more. This prompted the Nurse Educators to more intentionally and explicitly integrate storytelling into the continuing education sessions.

I know how TB is... I was in the Coqualeetza when I was younger. To this day I cringe when I am around people who are coughing...it scares me. That is why I became like a

recluse, I didn't want to go out into public places...I am a bit better about it today, but I spent many years at home... (TB Tapestries Project participant, 2013).

Through interactions and nursing care in community, TB Nurse Educators prompted dialogue regarding TB in communities. As educators, it can be difficult to start conversations about TB and even more difficult for community people to talk about TB, treatments, and research, given the fear and stigma associated with the disease. Considering this, the Nurse Educators began simply by asking community members to describe their level of knowledge and experience with TB. This was a breakthrough moment, where the Nurse Educators learned to journey wherever people led them in their stories. During these storytelling sessions, the teaching and learning moments occurred in a reciprocal manner, where the nurse and the client alternated between teaching and learning. Because each were part of the teaching and learning, they were both more fulfilled and satisfied with the experience, and motivated to learn more about TB. In most cases the nurse was afforded glimpses of people's health history that the client thought of as not important, not interesting, or hidden, but was in fact important. Stories are able to cross individual, cultural and educational barriers more powerfully than other types of information. Below, I provide an analysis of the impact of sharing the stories from the TB Tapestries Project with a group of CHNs.

Assessing the Impact of Stories within the Continuing Education Sessions

The First Nations Health Authority regularly sponsors continuing education sessions on TB for CHNs working within First Nations communities, conducted by Nurse Educators. The Nurse Educators realised that these continuing education sessions provide an ideal opportunity to formally incorporate the traditional practice of storytelling into CHN TB education. The stories gathered through the TB Tapestries Project were first incorporated into CHN TB education sessions in 2014 and 2015. Following four of these TB continuing education sessions, which included storytelling as an educational tool for TB prevention and treatment, a questionnaire was completed by the participating CHNs to evaluate the utility of the storytelling component to their educational experience. The questions were open-ended and focussed on personal reflections of how the storytelling component might affect the CHNs' TB programming and patient/nurse relationships, how the storytelling affected them in general, and how the storytelling impacted their learning process at the TB continuing education session. This section will explore how these responses reflected a change in the CHNs' perspectives and awareness of TB history and how current TB program delivery in First Nations communities may be enhanced through storytelling.

A total of 70 CHNs completed an anonymous open-ended written self-reflective questionnaire following TB continuing education sessions in January and June of 2014 and 2015. Cueing questions were provided to elicit reflections (see Appendix A). The CHNs had all experienced the same phenomenon, having attended the same TB continuing education session, and were able and willing to describe the experience and possible changes to their practice via anonymous questionnaire completion. Typically, the completed questionnaires were one page in length, with responses varying from point-form to small paragraphs. All questionnaire respondents were CHNs working in First Nations communities in British Columbia.

Methods of analysing the CHN responses.

The CHNs responses were transcribed from individual handwritten responses to the questionnaire. These transcribed data were then grouped according to items posed in the questionnaire (see Appendix A). A thematic analysis of each group of responses was conducted to examine the range of insights, reflections and understandings that the CHNs derived from the use of storytelling in the TB continuing education programs. As discussed by Braun and Clarke (2006), thematic analysis involves looking across responses for both common and divergent patterns in the data. Using a thematic analysis approach, I looked for concepts or categories generally representative of the responses of the participants, regarding their understanding of First Nations peoples' experiences with the health care system, the use and impact of storytelling in TB educational sessions for CHNs, and how the use of stories might inform CHNs' delivery of future TB programming. This process consisted of familiarization with the response data through careful reading and re-reading, and continuously comparing responses. Patterns and dissimilarities within the data were noted in codes, and these codes were then used to further analyze the full set of CHNs responses. After collating the coded responses, key themes were identified and reviewed for possible gaps and their overall representativeness in relation to the entire data set. The results are discussed below.

Themes in Responses

Analysis of the 70 anonymous self-reflective questionnaires revealed three themes that represent key aspects of the CHNs responses in their questionnaires.

Theme One: Increased appreciation for storytelling.

When asked for their general reflections on the TB stories and dialogue component of their TB continuing education session, all respondents indicated a greater appreciation for storytelling as an important tool in provision of First Nations health care. This enhanced appreciation manifested in a number of ways. Most respondents indicated that storytelling would be of high importance to their health care practice. Examples of reflections:

I truly believe that the stories from Elders and community members are an amazing learning tool about the communities. These stories that were shared at the workshop touched my heart and will always [be] a reminder to treat your client as a person, not a number or a stat (TB education session participant, 2015).

I really enjoyed these stories and I think they are an important part in this training session to help recognize and reduce the complexities of stigma, judgements, discrimination (TB education session participant, 2015).

Remembering that the person is in the center of education, stories, past, testing, treatment...never put the disease in the center (TB education session participant, 2014).

The CHN respondents overwhelmingly identified the TB Tapestries Project stories as a rich and extremely helpful addition to their learning. As predicted by Schanche Hodge et al. (2002), the use of storytelling as an educational tool was identified by participants as effective in generating deeper thought and engagement on the part of the listener, with CHNs describing the stories in words like “important”, “enjoy”, and “touched my heart”. As the participants quoted above

noted, the stories served to facilitate the removal of cultural boundaries between themselves and the storyteller (Fisher & Ball, 2005), creating a holistic connection and reminding the nurse to continually adjust programs and practice to acknowledge each client's personhood and to keep the person at the center of the care delivered (Gaydos, 2005; Sandelowski, 1994; Skott, 2001).

Theme Two: Effectiveness of storytelling compared to other methods.

CHNs were asked to describe the effectiveness of their learning experience involving storytelling, in contrast with traditional text or didactic learning.

Hearing from people, rather than books, and being presented by the interviewer who can add context is so powerful and brings home the message about the importance of cultural competence (TB education session participant, 2015).

Text books give physical data only whereas stories open up areas of emotional, mental, spiritual health (TB education session participant, 2014).

True stories are always very powerful ways to learn about a subject. They are real and not like words on a page. True stories demand to be considered, thought about and remembered (TB education session participant, 2014).

Most CHNs reported that they found that storytelling made the subject matter more relevant, retainable, interactive, and engaging, as seen in the work of Davidhizar and Lonser (2003). They found that storytelling resulted in a much richer understanding of the topic, rather than just the objective facts. Some CHNs reported that learning through storytelling was much more subjective, and each CHN might come away from the process with a different perspective, as opposed to text-based learning, which relays the message in an objective, clear manner. This

learning perfectly reflects the traditional intent of First Nations storytelling in that the message and ending are not explicit, but rather are to be reflected upon and drawn out by each individual listener (Drees, 2013). When the listener considers the story and determines for themselves the learnings, that learning is likely to have a deeper meaning for listener over time. It can be argued that this combination of storytelling and factual information provides the most informed picture of an issue, rather than the picture provided by one or the other in isolation (Schanche Hodge et al., 2002).

Theme Three: Desire to change future TB programming.

CHNs were asked how their TB programs and health care patient/nurse relationships might change as a result of listening to the TB tapestry project stories. Some CHNs indicated that they would be modifying their practice immediately, to incorporate storytelling as a tool. Other CHNs expressed an interest in receiving further education on the subject of storytelling, prior to implementation in their practices. These CHNs related that the stories encouraged them:

To stop; reflect and make sure the whole picture/history of the client is looked at (TB education session participant, 2014).

Ensuring that there are opportunities for my patient to share their stories so that I can find a way to make my practice more patient-centred, individualized (TB education session participant, 2015).

Everything we do/say to client can have lasting effects on their lives & future relations with health care (TB education session participant, 2014).

As noted by Rossiter (2002) and Hodge et al. (2002), participants connected deeply with the lessons contained in these stories. CHNs further stated that as a result of this connection, they were able to reflect on their current practice, noted areas that could be strengthened, and came to view practice change as an acceptable and desirable outcome of listening to them. Specifically, respondents indicated that in future they would become more intentional in encouraging clients to relay stories and would make efforts to listen in a more focused way when clients were speaking, mindfully connecting those stories to potential barriers and concerns that clients may have in regard to health care, specifically care related to TB. The CHNs reported that they had come to view developing a relationship with the client as key when planning and delivering TB programs. After listening to the stories, the CHNs related that they understood the historical context of TB better and would focus on getting to know the client holistically and within the context of their personal and community history of TB, as opposed to concentrating solely on the individual client's objective health status. Each client may have had a different experience with the health care system, which CHNs need to elicit and then adapt individual treatment to. Some indicated that they would be encouraging education for others in their department, regarding storytelling, particularly as regards TB history. Others noted that they would be taking greater care when promoting TB programming, realising that there are many sensitivities to the disease in First Nations communities.

Theme Discussion

Strong support was found in the literature for theme one and theme two identified from CHNs responses. The concurrence between these findings and the literature indicates that the body of evidence supporting the use of storytelling is applicable to CHNs working in First Nations communities and therefore supports the continued use of storytelling in this context. The identification of theme three, a desire to change future programming, moves beyond the outcomes identified in the critical analysis of the literature, demonstrating that the inclusion of

storytelling in TB education sessions can support CHNs to reflect on their current practice and identify opportunities for practice improvement and be a catalyst, leading CHNs to express a desire to put these opportunities into action.

Using TB stories for educational purposes models for CHNs the importance of stories within health care and provides an opportunity to listen, learn and generate ideas for how to improve their TB program simply by learning how to initiate and provide space for community and individual storytelling. Based on an analysis of the CHNs responses, there is great value in using people's TB stories for community sharing and participation.

Section IV: Implications and Recommendations

Incorporation of Storytelling in Broader Health Care Programming

Nurses working in First Nations communities hear a plethora of stories, but without an understanding of the importance of stories in First Nations communities it can be difficult for a nurse to recognize the importance of being grounded in the moment with patients and venture through the patients' lived experience. Stories provide moments and opportunities to connect with patients, given adequate time and reflection. Nurses need opportunities to learn this skill. Listening to the stories in TB education sessions provided opportunity to recognize that practicing empathy requires listening not only to the verbal cues, but the physical, emotional, and spiritual ones.

Stories have a purpose and importance for First Nation peoples as an oral and linguistic expression of culture. Stories are used to teach about life ways, creation, origins, lessons, courage, humility, relationships, traditions, and practical matters, such as how and when to collect foods and medicines. These teachings are becoming increasingly important as First Nations populations work to decolonize and restore cultural values. In order for nurses to work with community to decolonize health care, they must learn to understand the value and messages within patient and community stories.

Aboriginal story telling is the traditional learning tool within their culture. It has worked for 10,000 years + (TB education session participant, 2014).

As demonstrated in previous studies, and evidenced in the nursing questionnaire noted in this paper, an effective way to reach learners with educational messages is in, and through, narrative stories and experiences. To think *with* a story is to experience it affecting one's own life and to find in that effect a certain truth of one's life and empathy (Rossiter, 2002).

Yes, the stories that are part of the TB program or part of the nursing program stay with the nurse throughout their career...As I can always relate it to my practice with different stories (TB education session participant, 2014).

Stories are increasingly being used in nursing education as a vehicle to facilitate learning, rather than merely imparting knowledge (Davidhizar & Lonser, 2003). Stories explore ethics, chronic illness, emergency care, suffering and other critical information on diagnosis, conditions and patient care.

Stories give a voice to an experience that medicine cannot describe. These stories tell us how people change and reconstruct their life map. People's lives change course constantly, due to good and bad experiences, especially with health care. People may not seek care, or seek care with only a select few, or may constantly seek care, but there is always a story or experience behind these behaviours. Nurses strive for the best possible outcomes for clients. They advocate for and affect change required to improve health care delivery. Incorporating the use of stories into health care practice supports this. However, a more in-depth understanding of the specific use of stories within First Nations culture is important for nurses delivering safe care.

I connect more with oral storytelling because this is the way of First Nations people. Our ancestors have taught us the teachings through storytelling. One story can have so many teachings that is applicable to a certain circumstance (TB education session participant, 2014).

Lessons Learned: Examples of Storytelling to Incorporate into the Nursing Process Through TB Stories

The TB stories educational session models and demonstrates to CHNs how to incorporate stories into the nursing process. CHNs are encouraged to utilize critical thinking, clinical reasoning and decision making when reflecting on the stories presented, and how hearing this story will impact the future care they deliver. Participating CHNs are instructed that listening to stories should result in the adaptation of care plans to better address individual client needs, which are revealed in the stories. As the CHN listens to the stories and comes to understand what aspects of the client need to be addressed, be it physical, mental, emotional or spiritual she adds this information into her nursing assessment. Importantly, through the TB education stories, the CHN also learns to be aware of cues that a patient may need to share a story, and how to make a safe space in the nurse-client interaction for the story to be told. The following story shows how this might look:

One day, during an immunization clinic, I had an older gentleman come into my office. He was there for his flu shot. I recall idle chit chat, and the gentleman pulling his shirt sleeve up for the shot. He sat there visibly sweating, pale and nervous. Something just seemed off about this situation, this moment. I stopped just before I was going to administer the shot...I sat back and said to the gentleman, "I can't give you this immunization today, I can see how much stress this is causing for you...what is going on for you and what can I do to help?" The gentleman broke down and began weeping...he quietly said you are the first person to ever ask me. He then went on to share his fears and past experiences with health care, he carried numerous scars on his body (TB education session participant, 2014).

This story illustrates how a CHN can successfully incorporate story telling into the nursing process. Having learned to value and make space for stories, the CHN did the following:

- **Assessment:** Recognized non-verbal cues (sweating, pale and nervous) that the gentleman's action of raising his sleeve was not enough to demonstrate consent to immunization. The CHN furthermore recognised that there was likely a story that the client would benefit from sharing; one that would have priority over the planned immunization.
- **Diagnosis:** Once the CHN determined that the client needed to share, she postponed the immunization, establishing a safe space in which to deeply engage the client to solicit his story. Instead, she used the nursing encounter to build trust and rapport with client, creating the groundwork for future successful health care encounters.
- **Planning:** The nurse immediately planned to discontinue the immunization in order to listen and fully engage with the client and hear his story.
- **Implementation:** This nurse put her plan into action immediately with this client. She also widely shared this story with other nurses, demonstrating how to engage with stories successfully, and modelling how an overt focus on getting a nursing task completed can be detrimental to building a quality long-term relationship. Much more can be achieved to promote client health and lead to improved health outcomes in the future by the effective building of trust. She stated that this encounter reinforced the value of the story and that she would incorporate this in other client encounters.
- **Evaluation:** The nurse evaluated the success of this practice change immediately as the client immediately stated that he valued being heard. Her sharing of this story with other CHNs is evidence that she evaluated this practice and found it to be successful.

Evaluation of nurses' reflections on the stories presented at the TB continuing education sessions clearly demonstrates that the CHNs attending had an improved understanding of the value of story-telling and further, that they intend to use this in future use of the nursing process.

I will put more thought into how I present treatment and diagnostic options (TB education session participant, 2014).

Integrating TB Stories into Continuing Education for Nurses, to Enhance Nursing Practice

TB nurses working in community can gain much insight, respect, and skill in listening to and learning about the people they work for, if they are provided the opportunity to learn more about the value of stories, and how to recognize the messages that may lay within them. TB nurses work for First Nations people to decrease, or eliminate TB, and they recognize that First Nations Peoples must lead, have a voice, and play an integral part in TB programming. These are their stories and truths, which cannot be denied, and deserve their rightful place in education curriculum for physicians and nurses. Each time these stories are used as a teaching tool to help health care professionals learn and grow, the storytellers, and the stories they have gifted, are honoured.

Below is an example of one story used in TB education sessions, followed by guiding questions for reflection and learning. These reflection questions were carefully developed by the Nurse Educators to encourage reflection and awareness of the meaning and implications of the story, behind the actual words.

When I was asked if I wanted to come and share for this TB session, I thought oh this will be short...TB was so long ago and nobody gets it anymore...but wow, I never expected the stories that came from me...the experiences that came up were what it represented for me at the time...My mom used to work at Sardis (Coqualeetza) and that is

how she met my dad. She ended up with TB and had to go back down there. I was 15 or 16 years old at the time...when my mom left, I was on my own, my dad did his thing and was never home or came back occasionally...I had to get a job to make some money, nobody checked on me, no aunts or uncles. Sometimes I would hitchhike to Vancouver to see her every 2 or 3 weeks if I could. I remember seeing her and I saw healing in her face...I think she liked the structure of the hospital; she had a nice little room and had a sweet little old elder as a roommate. They got along good and a lot of the healing she got was from the quietness of that place and that elder lady. I think it gave my mom a chance to look at her life while she was there and see how hard her life was here...my dad was an alcoholic and he was so mean...so down there (Sardis) she had her needs met, she had good food, she had quiet and peace, she had beautiful grounds to walk on. I worried about her coming home, home wasn't a good place...she had nothing to come home to. I have a lot of anxiety" (TB Tapestries Project participant, 2014).

Reflection:

1. In this story, TB represented many things to this lady and her family. What would a holistic care plan look like for this client?
2. Reflecting on the story, describe why it is important that we listen to each person's unique story about their experience with TB?

This one example demonstrates how important it is to listen to the stories, reflect on the messages within them, and engage with patients. Following the use of this story in a TB continuing education session, one CHN shared that she gained insight into the importance of "understanding [that] each individual has a historical context and [that] their experience often affects their relationship with disease and health care". Within relationships with patients, CHNs need to take the time to listen, to have their ears, minds, and hearts open to what is said. Even

short visits provide opportunities to listen for the untold and unfolding story. Any visit gives CHNs a chance to realize that the story told is an ongoing one. Because of the ongoing nature of the story, it is important for CHNs to recognize and appreciate that there is value in inviting the patient back for subsequent visits. As visits continue, more and new aspects of the story might be shared. All the visits with patients, no matter the amount of time, are accumulating trust, encouraging CHNs to ask the right questions, leave space for answers, and attend to what is said and not said.

Conclusion

A critical analysis of the literature makes it clear that telling and listening to stories is an essential tool in delivering health care in First Nations communities. Generations of inequities in the health care system have led to increased rates of TB in First Nations populations. These same inequities have created mistrust of the Western health care system, which poses a substantial barrier to engagement with health care providers, particularly in non-emergent situations, such as TB screening and programs. Storytelling is foundational to First Nations culture, and provides a window for understanding between communities and the CHNs serving them. Thematic analysis of responses regarding the use of Elder's stories in the TB Tapestries Project, in CHN TB continuing education, clearly reflected the findings from the literature analysis. Listening to these stories allowed nurses to reflect on inequities that may be impacting their practice and current client and community decisions around engagement with existing TB programming. Expanding on the conclusions found in the literature analysis, CHNs further expressed that the inclusion of these stories led to a desire to expand their practice to make space for client and community stories, and to allow these stories to direct improvements to their TB program and approaches to client care.

Telling stories is as helpful for others as it is for oneself, particularly in health care contexts. Undeniably, there is reciprocity in storytelling. If people are able to share their story, and a part of themselves that is vulnerable, they are giving a gift to the listener who bears witness to their truth. CHNs who learn to value and make space in their programs for the client's story to be told receive this gift from community members, and in turn reciprocate by listening and using the learnings from each story in improving their programs.

The findings of this thesis, regarding inequities in health care outcomes and the potential for the use of storytelling in First Nations health care programming, are directly linked to the theoretical perspectives described in Section I. The value-added in drawing on the critical theoretical perspectives discussed in Section I is that they help to remind us of the history of First Nations healthcare in Canada and the impact it has had on today's programming and the potential of where it can go, and how it can be improved. Decolonizing and critical perspectives also remind us not to forget the impact of history, and what is possible in order to move forward. For example, barriers to First Nations engagement with health care providers, resulting in part from colonizing and negative experiences by First Nations with Western health care, are a root cause of health inequity. Focussing on and addressing this root cause is a practical application of critical social justice theory. Advocating for and encouraging active engagement of First Nations people in the development and implementation of their own health care program content and delivery, supports a decolonizing approach to health care (Battiste, Bell & Findlay, 2002; Stansfield & Browne, 2013).

Future Directions

Successful expansion and use of stories for improved health care outcomes in First Nations communities requires both Western and First Nations storytelling components. Once individual client level TB health care encounters have been adapted to create a respectful space for each person's story, and the principles of those stories have been incorporated into nursing assessment and practice, this could be taken further. As an example, in tuberculosis prevention programming, a facilitated session could begin with an Elder relating a traditional story about wellness, to set the stage and engage the community members, followed by a personal story about tuberculosis, which reflects the traditional story. This would encourage receptiveness to subsequent factual health information regarding disease prevention and treatment. The CHN would model respectfulness and demonstrate a willingness to work with communities in a way

that acknowledges and is responsive to the socio-cultural characteristics of the population. In keeping with First Nations storytelling practices, long-term engagement of communities, through regular sessions and repeated listening, would be necessary.

Traditional First Nations storytelling relies on repeat listening and long-term critical reflection by the audience before individual listeners attain the intended message, which is not stated outright. Utilising this type of storytelling as a tool for community health therefore requires a shift in traditional health education techniques and expectations. The educator needs to be prepared for a long-term process of message delivery, but with potential for greater uptake in the First Nations community than has been achieved through Western health care practices (MacNaughton, 2013b). Engagement of both traditional First Nations and Western health care practices will allow First Nations to take advantage of the best that both contexts have to offer, with increased community health outcomes.

Storytelling is an important instrument to help CHNs understand and engage with community members in the delivery of local health care. Storytelling provides the presentation of information in a manner that community members connect with. CHNs' willingness to engage through storytelling personifies and acknowledges the history of colonizing health care behavior, and signifies the importance of meeting the community where they are at, without forcing the Western model of health care inappropriately into a community.

It is hoped that future research will demonstrate that engaging in this respectful manner will help build bridges with communities, acknowledging the justifiable mistrust of the Western health care system based on colonializing practices, enhancing the health care experience, and eventually health outcomes, of community members. This is critical, as the comfort with which community members engage with health care providers will often determine when they will seek care, where they will seek care, and who they will seek care from, if they seek care at all (MacNaughton, 2013b).

A message from a Story-teller:

I don't know if I like this new system (health care)...they (doctors) don't know how to talk to me or know my history and what could be wrong with me...they rush out so fast now...I used to have confidence in them. Today they don't hardly look at you. We have a new health center being built and I just love our nurse there, she takes the time to listen to me...better than any doctor I ever had! She knows me, she knows my family, she knows my health history... I just love her (Elder Mary-Jane, 2014).

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Appendix

Appendix A: Open-ended Questions for CHNs Who Completed TB Continuing Education Session

First Nations TB Tapestry Stories: TB 101 Education

Background:

The FNHA/TB Services for Aboriginal Communities (TBSAC) program began a collection of TB tapestry stories from First Nations perspectives last year. Within the TB 101 workshops, we re-tell these stories and create dialogue around these experiences for educational purposes. To help us understand how these stories may impact on your learning (or not), please answer the following questions. With consent, some of your responses/answers may be used to inform larger audiences about this tapestry project. Thank you for your time and responses!

1. (a) Listening to TB stories and dialogue, what reflections (if any) have you made about your nursing practice in terms of TB programming?
(b) What changes would you make or like to see within your TB program?
2. How have /or will these stories and narratives impact on your patient/nurse relationship?
3. What have you learned about yourself (if any) from these First Nations TB stories that you will take away?
4. How is learning by storytelling/dialogue about TB and First Nations different than traditional text book learning for you?
5. Do you have any last comments to make about learning of TB and First Nations from stories that you think are important to consider?