APORIA

LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

2016: Volume 8, Numéro 2/ Volume 8, Issue 2. ISSN: 1918-1345

Sommaire/Content

2016: Vol.8, Numéro 2/Vol.8, Issue 2

Éditorial/Editorial

Suite à une rencontre récente incluant les éditeurs et le rédacteur-en-chef, l'équipe d'APORIA – La revue en sciences infirmières a décidé de publier deux numéros par année au lieu de quatre comme c'est le cas depuis janvier 2009. Obéissant à un souci constant de produire la meilleure qualité de journal possible cette décision importante permettra à l'équipe de travailler à la création d'une nouvelle structure qui verra le jour en janvier 2017, soit 8 ans après la création d'APORIA – La revue en sciences infirmières. Marilou Gagnon, Inf, PhD, professeure agrégée, se joindra à l'équipe actuelle composée des professeurs Dave Holmes, Inf, PhD (rédacteur-en-chef), Amélie Perron, Inf., PhD (éditrice), Isabelle St-Pierre (éditrice), et Patrick O'Byrne, Inf, PhD (éditeur responsable de la production) afin d'assumer le rôle d'éditrice pour APORIA – Livres/APORIA – Books.

En effet, la nouvelle structure, appelée Les presses APORIA/APORIA Press se déclinera en deux structures : APORIA – La revue en sciences infirmières/APORIA – The Nursing Journal et APORIA – Livres/APORIA – Books. Les mêmes principes directeurs qui ont fait la réputation d'APORIA – La revue en sciences infirmières seront à la base de cette nouvelle structure.

APORIA Press will be a peer-reviewed, bilingual, and open access publisher (journal and books) dedicated to scholarly debates in nursing and the health sciences. APORIA Press will be committed to a pluralistic view of science and to the blurring of boundaries between disciplines. APORIA Press will encourage the use of a wide range of epistemologies, philosophies, theoretical perspectives and research methodologies. In the critical analyses of health-related matters, APORIA Press will advocate and embraces a wide range of epistemologies, philosophies and theories including but not limited to: cultural studies, (post-) feminism(s), neo-marxism, postmodernism, poststructuralism, postcolonialism and queer studies.

APORIA Press will adhere to the following principles: freedom of speech, critical pedagogy, the role of the specific intellectual, recognition of local and marginal knowledge(s), critique of dominant discourses, the right of both the author and the reader to dispose of themselves and their ideas and finally, and the "committed" citizen.

C’est avec plaisir que nous invitons les lecteurs d’APORIA – La revue en sciences infirmières à explorer de nouvelles frontières dès janvier 2017.

Professeur Dave Holmes, Inf., PhD
Rédacteur-en-chef
Aporia – La revue en sciences infirmières

Abstract
Nurse Practitioners (NPs) are clinically effective and safe. They positively influence patient outcomes, and they increase access to care while decreasing health care costs. Despite these significant benefits, NPs can seldom practice to their full scope and often experience interprofessional tensions. The supposed lack of clarity around NPs' role is often cited as a barrier to seamless integration, despite clear legal and professional delineation. We suggest other factors are at play within the Canadian health care system that explain why, after almost four decades, NPs' full involvement as equal health care partners and their job satisfaction remain modest at best. New, critical frameworks are needed to uncover the various contingencies that mediate their integration process. This paper explores how Actor-Network Theory (ANT) can provide such a framework to analyze contemporary issues in advanced nursing practice. ANT's main concepts are explored along with their applicability to an examination of NPs' integration in the Canadian health care system.

Key Words actor-network theory, advanced practice nursing (APN), interprofessional collaboration, nurse practitioner, primary care, role integration

Exploring the Potential Contribution of Actor-Network Theory in Nursing Using the Integration of Nurse Practitioners as an Exemplar

ANNIE RIOUX-DUBOIS & AMÉLIE PERRON

Introduction

In North America and elsewhere, advanced practice nursing (APN) is at the heart of health restructuring and reforms. Despite emerging as a distinct specialty 45 years ago, and even though scientific studies have clearly established their effectiveness and efficiency, advanced practice nurses, which include nurse practitioners (NPs), are not used to the full extent of their knowledge, skills and capabilities.[1] Research consistently shows that NPs are clinically effective and safe; that they positively influence patients' health outcomes; that they increase access to quality care as well as decrease health care costs.[2] Despite these significant impacts, studies suggest that NPs often experience interprofessional conflicts within clinical settings, which often results in them not being able to practice to their full scope. According to two studies (one American, one Canadian), this has led to significant numbers (approximately a quarter) of NPs intending to leave their position due to dissatisfaction with professional growth, intrapractice partnerships, and collegiality.[3,4] In fact, according to the Canadian Nurse Practitioner Initiative[5], autonomy, support, clarity, collaboration and practicing at full scope are key elements for maintaining NPs' workplace satisfaction, and of great importance as they directly correlate with patient satisfaction.[6]

A number of studies have explored various models and processes for the successful integration of nurse practitioners (see for example [1,7,8,9]), yet significant issues remain, including a persistent belief that NP roles lack clarity, which purportedly explains the lack of NP integration and interprofessional conflicts. However, we contend

instead that professional role socialization, negotiation and integration are far too complex to be reduced to mere role ambiguity. Uncritical approaches to research on NPs have left us with linear explanations. Perhaps it is time to examine issues surrounding NP integration from a different angle.

APN is paradoxically positioned at the juncture of divergent, changing, and sometimes conflicting discourses focusing on professional scope of practice, access to health care, patient safety, economic benefits, and professional autonomy, which may explain why the integration of NPs across various health settings remains inconsistent. We suggest that a complex assembly of networks of actors and actants are formed and transformed through the integration process of NPs in primary health care. Actor Network Theory (ANT) has been proposed as being capable of delineating and describing such forces in action.

This manuscript will offer a detailed description of ANT, its main concepts, and its epistemological and ontological commitments. It will then present a preliminary application of ANT concepts to the issue of NP role integration in Canadian primary health care settings. A more detailed analysis will be published separately.

Frequently cited issues regarding nurse practitioners' roles and scope of practice

In the 70s, the Canadian federal government launched the NP role across most provinces, mainly in rural areas.[10] At the time, a few studies had already established the efficacy and safety of NPs' practice.[9,11,12] Despite this support, the next decade saw the near complete elimination of NPs, which some authors attribute to increased medical workforce and the lack of legislative support and political will on the part of decision makers.[10,13,14] The reinvigoration of primary health care (PHC) following the Lalonde[15] and Romanow[16] reports, as well as the creation of the Ottawa Charter[17] led to the adoption of concrete legislative measures and the reinstitution, in the mid to late 90s, of NPs in the Canadian health care system. Today, despite an ever growing number of studies that confirm NPs' contribution to health care, there remain multiple hurdles to their integration; their scope of practice varies greatly across provinces and settings; and a number of reports that discuss the future of Canada's health system do not include them as key players who contribute to its quality and sustainability (see for instance [18,19]). Some scholars also argue that their integration is heavily "dependent on the changing political agendas shaping the health-care system".[10 p6]

Though it is beyond the scope of this paper to review the detailed history of NPs in Canada, a cursory view suggests that such uneven implementation process reflects the extent to which NPs' position in the health care system is not assured, and they remain subject to shifting discourses, priorities, hopes and anxieties that at times create an environment that is conducive to NP integration, and at times less so. In this paper, NP integration refers to:

> the extent to which NPs within a program or team setting are enabled to fully enact the scope and intent of their role in order to contribute effectively to client care … NP role integration at the program–team level relies on collaborative efforts by the leadership and team members to constitute the NP role as essential to PHC delivery.[20 p100-101]

Several barriers to NP integration have been cited in the literature, including: lack of political frameworks to promote and safeguard NP autonomy, lack of monetary resources or incentives to support NP positions, role ambiguity, uneven acceptance and collaboration within teams, lack of performance indicators that specify NPs' contribution to health services, medical interference, and lack of administrators' involvement and will to address these issues.[9,20,21,22,23,24] Hamric[25] asserts that various matters, such as managerial aspects of care, political issues, remuneration schemes, organisational cultures, marketing strategies, laws, and credentialing issues, significantly affect APN. Such issues have been described in various ways. Here, we are interested in the organisational, discursive, political, and historical links that bind these issues together and create a particular reality for NPs.

The configuration of clinical settings is thought to strongly influence NP integration outcomes.[4] In Ontario, Canada, there exist four models of primary health care services: Fee-For-Service, Community Health Centers (CHC), Family Health Teams[26] and NP led-clinics (NPLC). Health services governance structure is typically physician-led. CHCs, however, are community-based, and NPLC are, as their name indicates, governed by NPs. Such organizations vary greatly in terms of management models, vision and mission, thereby shaping the range of NP practice and decision-making power. Furthermore, since their scope of practice can significantly overlap with that of family physicians' and some specialists', it has been suggested that the introduction of NPs in a clinical setting may lead to interprofessional conflicts arising from resistance to change and, in some cases, the maintenance of medical stronghold over decision making, particularly in physician-led institutions.[27] This perspective is influenced by the common view that nursing is a subordinate profession[28] and that health care systems

are hierarchical in nature.[29] NP role integration does not mean the sole development of a new professional role; it also involves the need to navigate a complex, sometimes positive, sometimes hostile, environment that can react in various ways to organisational and professional culture changes.[30]

In primary health care in particular, interprofessional teamwork is typically described as key to ensuring successful NP integration[29], hinging on strong collaborative ties that facilitate the negotiation of scopes of practice.[13,14,31] Yet, according to one Australian study, "total" collaborative relationships do not characterize most clinical settings[32], suggesting that health care teams continue to function according to particular, and sometimes antiquated, organizational structures and conventions.[29] Interestingly the concept of integrated teams is not necessarily problematized in such analyses, and they are often treated as an absolute entity.

NP integration within health systems is highly complex.[9] Yet this particular process is not studied extensively. Rather, outcomes of NP care, patient satisfaction and barriers to NP integration remain the most commonly researched topics relating to NP practice.[24] Integration is a longitudinal phenomenon subjected to forces that go well beyond the sole will, agency and subjectivity of individual players. The global and local realms are therefore closely connected across settings and across interactions. Examining the intricacies of these connections may provide additional insights into the way NP integration occurs (or not) in current health systems. Actor-Network Theory is specifically focused on the study of such interactions and relationships.

Theoretical considerations: Bruno Latour & actor-network theory

Actor-Network Theory (ANT), borne out of the sociology of science and technology, was proposed in the 1980s, not as a theory per se, but as a methodology for exploring the interplay of those domains that have come to be defined as "society" and "technology". It stems from the work of Bruno Latour, Michel Callon and John Law, who have proposed a relational epistemology that rejects the notion of a pre-existing, essential actor who acts on his own free will. The indeterminacy of the actors sets ANT apart in that it moves beyond usual considerations afforded by realism and social constructionism as distinct paradigms. ANT is defined as such:

> A disparate family of material-semiotic tools, sensibilities and methods of analysis that treat everything in the social and natural worlds as a continuously generated effect of the webs of relations within which they are located. It assumes that nothing has reality or form outside the enactment of those relations. Its studies explore and characterise the webs and the practices that carry them.[33 p141]

As an anti-essentialist frame, ANT rests on and defends a relational epistemology, according to which one cannot presuppose prior existence, purpose or functionality of any thing. As such, rather than use "social elements", such as race or gender, to explain phenomena, one should limit oneself to a description of what makes these elements "social" in the first place. Inspired by ethnomethodology, ANT aims for the description, rather than the explanation, of "society", whereby human, technological, and discursive actors come together in the form of complex and often far-reaching networks.[34]

ANT suggests that facts are engineered, thus repositioning conventional understandings about science, politics, society, technology, nature and modernity.[35] A fact is tied to its history of production that can be verified through historical and empirical studies, for example by collecting data about activities taking place within the confines of the laboratory whence it comes. Scientists therefore construct the social, historical and political world, a view that strongly contrasts with dominant discourses of philosophy of science.

ANT does not reproduce common ontological assumptions about taken-for-granted dualisms, such as subject/object, nature/culture, reason/emotion, self/other, etc.[34] A Latourian perspective makes it possible to bring together all of those entities, such as nature and society, that Modernism had carefully taken apart, without further emphasizing those differences that supposedly makes them incommensurable. To do this, Latour introduces the concept of hybridization, which runs counter to the modernist differentiation project. Through hybridization, elements are connected and networked into a complex interplay that forms the world, regardless of the nature of such elements (discursive, technological, human, etc.). The network rests on the reciprocal associations that bind these elements to one another. Such associations are the crux of ANT's relational ontology. In Latour's view, there is nothing other than networked collectives: no essence, no underlying factors or predispositions, no contexts.[35] The world is made up of nodes and connections laid out in a single plane, so much so that not one is more sociologically significant than the others. In order to better understand Latour's thinking, it is important to explain some of his core concepts, in particular: the social, actors/actants, network and translation.

The social

Commonly understood as the very foundation of sociology, the social is, according to Latour, everywhere and nowhere at the same time.[36] Latour critiques traditional sociology, which he names sociology of the social, because it typically targets social structures, social difference and social order notions that have dominated sociological theory since Émile Durkheim[35] as though they exist in and of themselves, as though they function with and respond to intrinsic rules and regulations. The problem with the term social, however, is that it automatically binds the reader or the researcher to normative discourses about, and representations of, what is "not social". Latour wishes specifically to eliminate the ensuing bias that dictates what is worth analyzing sociologically and what is not. As a result, he calls for a radical shift of perspectives, in the shape of what he calls the *sociology of associations*.

Sociology of associations turns conventional sociology on its head, namely by effectively circumventing habitual dichotomies that are deemed to be inevitable: macro/micro, agency/structure, technology/society, nature/culture, global/local, individual/group, etc. Such dichotomies restrict the realm of sociological analysis by excluding an array of elements from review. For example, discussing technology as an entity that is separate from society leaves out crucial details about how society forms, extends itself, and acquires meaning through technologies. Sociology of associations argues instead that technology does not exist outside of society, and that it is inherently 'social'. This view promotes an understanding of the world as a hybrid configuration of complex associations between entities that have historically been divorced and placed in opposition to one another. In this sense, Latour proposes a "flat ontology" where any and all actors occupy the same plane and where no nature, agency, structure, intention, animation, meaning or essence can be presumed. Any and all bear the same sense of existence, which boils down to their ability to generate relationships and connections with others and to react to these others.

The social now refers to "a movement, a displacement, a transformation, a translation, an enrollment. It is an association between entities which are in no way recognizable as being social in the ordinary manner, *except* during the brief moment when they are reshuffled together". [36 p64-65, italics in original] This notion of the social does not imply the fragmentation of society into individual actors, but rather the replacement of the term *society* with the notion of *collective*.[35] Latour[36] echoes Gabriel Tarde, who also remarked that society, on its own, explains nothing; instead, it should be the product of one's explanations. Society from a traditional sociological perspective predisposes one to an assumption of stability and naturalness, something that Latour vehemently opposes. In *Pandora's Hope*, he contends that:

> Unlike society, which is an artifact imposed by the modernist settlement, [collective] refers to associations of humans and nonhumans. While a division between nature and society renders invisible the political process by which the cosmos is collected in one livable whole, the word "collective" makes this process central.[37 p304]

To avoid the pitfalls of comfortable, convenient dualistic abstractions, Latour suggests using the terms actor and actant to keep open the descriptions about possible sources of actions.

Actor/actant

According to Latour[36 p71, italics in original], "any thing that does modify a state of affairs by making a difference is an actor". Conventional sociology would rather describe an actor as an individual, a corporation or a social unit capable of initiating and performing any form of action borne out of intention – a misleading designation according to Latour, since, in his view, an actor does not act; it is what is made to act:

> [In ANT] the word actor directs our attention to the complete dislocation of the action, warning us that it is not a coherent, controlled, well-rounded, and clean-edged affair. By definition, action is *dislocated*. Action is borrowed, distributed, suggested, influenced, dominated, betrayed, translated… it represents the major source of uncertainty about the origin of action.[36 p46, italics in original]

Actors, then, need not be animate; therefore, objects can be full-fledged actors, rather than mere props for social action. Whether entities are 'social', 'discursive', or 'technological' in nature is irrelevant: what matters is the shape and outcome of their action.[36] An actor reacts to something. Therefore, for Latour[36 p. 46], an actor is "not the source of an action but the *moving target* of a vast array of entities swarming toward it". Latour illustrates this point using the example of an artist on stage who cannot perform without spotlights, sound technicians, scripts, spectators, curtains, makeup, emotions, prompters, costumes, and so on. Latour[36] notes that one can (and should) follow the trail of non-human entities as long as one lets go of the ontological assumption that they are any different from humans. This does not mean however that their respective features are to be dismissed:

> Often in practice we bracket off non-human materials, assuming they have a status which differs from that of a human. So materials become resources or constraints; they are said to be passive; to be active only when they are mobilized by flesh and blood actors. But if the social is really materially heterogeneous then this asymmetry doesn't work very well. Yes, there are differences between conversations, texts, techniques and bodies. Of course. But why should we start out by assuming that some of these have no active role to play in social dynamics?[38 p168]

> In abandoning dualism our intent is not to … efface the distinct features of the various parts within the collective. …The name of the game is not to extend subjectivity to things, to treat humans like objects … but to avoid using the subject-object distinction at all in order to talk about the folding of humans and nonhumans. What the new picture seeks to capture are the moves by which any given collective extends its social fabric to other entities.[37 p193-194, italics in original]

Actors come into networked associations, which provide them with characterization, motivation, and subjectivity. They are inherently unspecified, with no a priori essence. It is through networks that they acquire substance, as well as the opportunity to act. They are not able to act if they are not part of a broader configuration (a network) of other entities that prompt and channel their actions. The network is a key component of ANT.

Network

A network is "a group of unspecified relationships among entities of which the nature itself is undetermined" [39 p263]. It is made of relationships and nodes, whereby nodes can be networks in and of themselves. It is important to reiterate the notion that actors cannot be 'actors' outside of a network configuration; similarly, networks are made of actors brought into relations with other actors. Actors and networks, then, need each other to constitute one another and confer meaning and substance to one another. The relationships that constitute any network are semiotically derived, giving networks a highly contingent and localized quality, yet their substance, meanings and effects can transcend space and time.

Though Latour was concerned about improper use of the term "network", he insisted that the concept is highly appropriate since it does not attempt to create relational hierarchies. The term network thus remains useful because

> It has no a priori order relation; it is not tied to the axiological myth of a top and of a bottom of society; it makes absolutely no assumption whether a specific locus is macro- or micro-.[40 p5]

Networks have no beginning and no end. They seek a certain degree of equilibrium, which provides longevity, yet they are subjected to continuous tension from within and without. They therefore undergo continuous de-forming and re-forming processes, which lend them a dynamic quality. The actor-network theorist's task, then, is to examine how networks come to be formed, how they enrol actors and bring them to endorse particular interests and objectives, how they acquire consistency, stability, functionality and purpose, and how they become indispensable. These features of the network are dependent upon what Latour calls translation processes.

Translation

Translation is understood as the displacement of actors and interests in such a way that an actor can act for another or for a collective.[41] Through translation, actors are mobilized and brought together. Their interests, which may have been disparate and unrelated initially, may converge and become aligned, thus providing further stability to the network. Translation is key in understanding how supposedly commonsensical, essential distinctions between certain realms are groundless. Latour[37] illustrates this point by describing how seemingly unconnected decision makers and atomic particles are actually tightly bound and share common grounds and objectives. No definition of the social in any traditional sociology text can accommodate these disparate entities together in one statement. Yet, as Latour explains, in the years prior to World War II, complex dealings leading to the invention of the atomic bomb brought together politicians, who made public funds available for this project, and complex chain reactions that led to the splitting of an atomic nucleus, without which no fission bomb could be created. Translation movements are what makes possible the joining of two apparently heterogeneous and distant realms: in this case, the 'political' and the 'scientific'. According to Latour[37 p88], "[t]o call the first ambition "purely political" and the second "purely scientific" is completely pointless, because it is the "impurity" alone that will allow both goals to be attained". Translation, then, rests on mobilization and enrolment of diverse actors and actants. As translation progresses, actors transform and configure one another, co-opt one another in the delineation or defense of particular objectives, which then in turn modifies and configures the network. Alignment of interests through translation therefore allows the network to become consistent and intelligible, despite the heterogeneity of its components. Rather than assuming and studying the existence of any network (e.g. person, group, organization), the task of the sociologist of

translation is to outline these processes of translation.

Examining the concept of translation, and the accompanying reshuffling of entities, motivations, interests, and identities, helps to further understand why, in Latour's view, traditional definitions of the social are not adequate:

> Another notion of social has to be devised. It has to be much wider than what is usually called by that name, yet strictly limited to the tracing of new associations and to the designing of their assemblages. This is the reason why I am going to define the social not as a special domain, a specific realm, or a particular sort of thing, but only as a very peculiar movement of re-association and reassembling.[36 p7]

'Reassembling the social', as Latour[36] calls it, involves tracing the making and unmaking of an infinite number of networks that are understood as playing a 'social' role, whether 'political', 'scientific' or 'technological'. Such networks extend and connect to other (often black-boxed) networks through multiple (discursive, physical, biological, chemical, etc.) connections and translations, rather than entities that exist and acquire meaning in and of themselves. Such expansive configurations confer increased stability and durability to networks, as well as an ability to generate far-reaching effects. The stability, rather than the power, of a network is therefore explained by its scope, rather than some presumed macrosystem that holds it in place.

ANT moves beyond traditional sociological constructs, such as micro- and macrosystems, and inhibits the mental construction of so-called social strata, systems or hierarchies that fragment and compartmentalize the world according to particular ontological features. Latour suggests instead that we localize the global: "Instead of having to choose between the local and the global view, the notion of network allows us to think of a global entity – a highly connected one – which remains nevertheless continuously local".[40 p5] The notion of networks allows for renewed malleability and fluidity of sociological analyses that is hindered if the use of dualisms (micro/macro, local/global, etc.) persists.

Latour critiques the tendency for social explanation and promotes instead descriptions of the social. Though widely considered as an unsophisticated, insufficient and somewhat useless approach by many researchers, funding bodies, policymakers, and scientific journals, the description of the social is precisely where traditional sociology has failed, according to Latour, because sociologists "have simply confused what they should explain with the explanation. They begin with society or other social aggregates, whereas one should end with them".[36 p8]. This means that, rather than use certain 'explanatory' concepts such as violence, hope or knowledge, sociologists should work to describe these notions and what bestows a 'social' quality upon them. This is so, because social explanations involve the imposition of the researcher's own representations on particular matters, thereby stunting social movements. Social description, on the other hand, allows these movements to occur and produce social effects. One should be wary, then, of any presumed intellectual dominance of researchers over the very matters and persons they seek to investigate. This caution extends to critical researchers as well. In this sense, Latour seeks to reconcile constructivism (rather than social constructionism), critical social theory and what could be termed the "participatory paradigm".

As mentioned earlier, Latour criticizes those perspectives that discredit non-human entities by portraying them as "visibly invisible" and, therefore, unimportant. According to him, such entities "act" to the same *degree* (though not in the same *way*) as humans do, because they can enable (and disable) action. There is therefore a social compatibility between persons, technological and semiotic entities. Echoing Latour, Karsenti and Porter[42] argue that technologies, much like science, evolve in their own world, filled with organisations, negotiations and even morality. Scientific investigations, then, cannot afford to dismiss them. Since categorizing social structures is no longer relevant, other questions must then be asked by researchers who wish to unravel the ways in which the social comes into being:

> Which agencies are invoked? Which figurations are they endowed with? Through which mode of action are they engaged? Are we talking about causes and their intermediaries or about a concatenation of mediators?[36 p62]

Latour's approach undoubtedly opens up new research possibilities. It has been used as a framework in studies from various disciplines other than sociology, including information technology, accounting, and biology, to name those few. Despite being widely used in other disciplines, ANT is not common in nursing scholarship. Very few authors have applied the theory effectively to explore issues of importance to nursing. For example, Mary Ellen Purkis[43] has used ANT to examine the managerial practices that shape home nursing care, showing the means by which some practices are made visible and other invisible. Clinton Betts[44] has used ANT as a philosophical alternative to postpositivist epistemology in the context of illicit drug use and harm reduction in nursing, arguing for a political ontology of nursing: 'the reality is political (…) and constructed by (democratic) due process rather that short circuited (…) by a modernist use of things like knowledge, evidence,

research, science, efficiency, effectiveness'.[44 p270] More recently, Thomas Foth[45] rendered a complex and interesting portrayal of the interplay of different entities, such as patient records, in the networks of psychiatric practices in 1931-1945 Germany, thus enlightening the normalization process that led nurses to partake in acts of killing. In the field of medical sociology, Annemarie Mol[46] explored the ethnographic applications of ANT to provide multiple readings of the body and bodily ailments that are generally thought of as commonplace.[46,47] Vicky Singleton has explored the ambiguity and ambivalence of various actors in public health programmes directed at women.[48] These examples show how ANT has had fruitful applications within critical health studies and how it could contribute to nursing scholarship. The scarce use of ANT in nursing is unfortunate, given that nursing scholars have all endeavoured, one way or another, to conceptualize, describe, model, explain, theorize, and represent various aspects of nursing care using social constructs, such as groups (e.g. at-risk youth; palliative patients) or concepts (e.g. resilience, race, stigma, health care organizations). Furthermore, ANT was developed in order to reconcile those entities that have traditionally been cast in different ontological categories, such as humans and technology. Given nursing's proximity with technology, nursing research questions lend themselves particularly well to innovative analyses using ANT. This, however, does not preclude the possibility of investigating nursing issues in which technology plays a less prominent role, though one quickly realizes that technology – any technology – mediates much, if not most, of "health work". ANT is useful for a range of topics that problematize traditional historical, social, and ontological distinctions in health-related matters. However, it has not yet been put to work to understand issues arising from NP integration efforts. In the next section, we wish to suggest ways is which ANT could be applied in exploring PHC NP nurse practitioners' integration.

Using ANT to explore NP role integration in primary health care

Various models and processes have been used for the successful integration of nurse practitioners (see for example [1,8,9,30]). Research to date on NPs integration within a healthcare system has therefore favoured organisational and social explanations, especially as regards facilitators and barriers to integration. However, ANT affords a very different kind of sensibility – or relation – to nurses and nursing. Researchers have not yet considered using the concept of network to *describe* (rather than *explain*) how various entities come together to form what is socially understood as a "health care system", "multidisciplinary teams" and "advanced practice nursing". As such, ANT offers a way to seek the means by which primary care organization are produced and what it is about NPs (themselves an effect of actor-networks) that mediates their articulation with these organizational processes and practices.

Unlike other frameworks, such as ecological or systems theory, which are decidedly static, ANT can capture the dynamic and ever changing quality of the network, understood as a moving target of hybrid relationships that make up the "health care collective". It is more responsive to complex and morphing patterns of associations and can therefore accommodate unstable and shifting frames of references.[36] ANT is relevant "whenever things accelerate; innovations proliferate; boundaries between groups are blurred; and the number of entities in the collective multiply".[35 p106]. Primary health care (PHC), interprofessional teams, health networks and role negotiation are just some of the many heterogeneous entities in a constant state of flux that may be better understood through the concept of translation. Actors include persons, such as nurses, patients, various health professionals and administrators, but also non-living beings, such as policies, standards of practice, computers, rumours, pathogens, media accounts, statistics, medications, and patient charts.

Interdisciplinary collaborations, local health networks, primary health care agencies, computer networks, policy networks, advocacy or consumer groups, teaching institutions, and research groups are just some of the networks that NPs can be enrolled in in the context of their professional practice. NPs can establish connections with a number of larger, distant networks, without losing their specificity as actors. A nurse practitioner is a network in and of herself, shaped and made to act by an elaborate arrangement of relationships and interests. In the context of health reforms that seek to employ more NPs, successful alignment of various entities such as position statements and research evidence, can create "hard facts" about NPs' purpose, competency, and contribution to health care, and through this alignment create a context favorable to their integration. Despite successful alignment, the nurse practitioner can be construed as a disturbance in the "PHC network" that disrupts existing relationships and creates new ones, while enrolling new actors in the process. Yet we contend that the NP can also be considered a stabilizing force inasmuch as she supports the attainment of particular "organizational" goals, such as improving access to health services and treatments, patient outcomes and cost effectiveness of services.[49,50]

As such, much like electronic records, diagnostic imaging systems, patient databases, telehealth and mobile devices, all of which are touted to drive modern health care, advance practice nurses appear to be likened to a form of technology (in a broad sense) that can also transform the face of health care, by improving continuity of care, increasing access to services, reducing costs, streamlining certain services or programs, and optimizing existing resources (for example, by making it possible for physicians to focus on more complex cases). These notions however rest on a set of assumptions. For example, it assumes that NPs constitute an ontologically discrete group that can exist outside of technological devices, separate from health policies, and distinct from what are conceptualized as 'other' professional groups, and that can be 'inserted' unproblematically into equally clear-cut 'contexts' (e.g. primary health care) and organizational structures (e.g. integrated teams, PHC clinics).

In keeping with Latour's approach, investigating NP integration in PHC settings would involve the examination of the ways in which clinical settings and related actors and actants are assembled and configured. Such configurations may involve entities as diverse as office spaces, diagnostic equipment, and chronically ill patients, and they set boundaries in terms of what actions will be possible over the course of time[51], which in turn impacts the steadiness of associations and the network itself. Associations then shift, move, dissolve and re-form in ways that are not entirely anticipated. For example, while the literature reports that interprofessional collaboration and NP integration yield excellent patient outcomes, some of the entities involved do not necessarily act in the required way to achieve these results. Configuration of the setting serves to reduce the likelihood of this scenario. For such configuration to take place, 'preparatory work' may occur so that events and processes unfold in ways that are consistent with the network's purpose and function. In the context of NP integration, perhaps this involves notifications being made, bulletin boards being updated, newsletters being released, office space challenges being sorted out, narratives being uttered about the implementation of a new player in the clinical setting.. All these contribute to the configuration of those entities that will come into contact with NPs and will, in turn, configure NPs themselves. Analyzing the configuration of actors, at the heart of which are ongoing translation processes, becomes a key task of the investigator.

As actors themselves, NPs embody, and are subjected to, certain codes, discourses, meanings and concerns that also *make them* act in certain ways in the course of their practice and provide their actions with social significance. For example, such codes and concerns are crystalized in part in provincial, regional and institutional protocols that govern the scope of practice and day-to-day activities of NPs (and, consequently, of other professionals). Such protocols mediate interprofessional interactions (e.g. team meetings, consultation processes, delegation schemes, etc.) but also a range of non-human entities, such as space organization and use of time. These protocols therefore establish certain conventions and requirements through and by which NPs integrate the PHC network. They outline specific 'organizational competencies' that support the purpose of the network and, as such, they serve as an extension of broader meanings and interests. They also work to remove, reduce or manage possible unpredictable events (which could further destabilize the network and jeopardize its existence), by standardizing and routinizing decisions and practices. While NPs can constitute a perturbation in the PHC network, they mobilize a range of entities (e.g. protocols) that can offset (partly at least) the ensuing disturbances. The reciprocity of NPs and protocols provides just one of many examples of the way human and non-human elements configure one another and set the parameters for each other's existence. For NPs to accept and abide by these conventions and regulations, they must perceive a high enough level of alignment between these and their own narratives about advanced nursing practice in PHC. The ongoing constitution of these narratives, from the time nurses undertake their graduate studies to the present day, mobilizes further actors and actants that are themselves part of other networks (e.g. universities, regulatory bodies, clinical placement settings, ministry of health, etc.), thereby connecting NPs to both local and distant/global entities and neutralizing any presumption of geographic/spatial figuration. As such, though it is highly counter-intuitive, NPs cannot be conceived of as pre-existing, essential actors who act on their own initiative; they should rather be conceptualized as entities that respond to various contingencies and that are therefore constantly being made and re-made.

Throughout this section, we have suggested some of the ways ANT may support the production of new accounts about NP practice and role implementation. It provides a robust basis for envisioning the ways in which NP integration rests on multifarious associations and networks and requires the involvement of numerous entities, both tangible and intangible, both human and non-human, both material and semiotic. These may include care delivery models, medical technologies, laws, media outlets, diagnoses, chronic illnesses, professional socialization processes, budgets, managers, research evidence, office desks and computers,

all of which shape, and are shaped by, nurse practitioners. Such an approach remains flexible when attempting to understand the success or failure of role integration, as particular associations, rather than specific persons, come under scrutiny.

Latour states that, in order to understand the formation and re-formation of associations that make up the "social world", one needs to follow the *controversies* – those brief moments when disruptions occur that allow a glimpse into the complex, and sometimes fragile, workings of the network. In PHC, such disruptions may take the form of an epidemic, the introduction of new clinical guidelines or medical technology, budget cuts, or a change in institutional policy or corporate objectives. We suggest that the introduction of NPs in a given setting may constitute such a disruption in the PHC network, a disruption that brings into light the actions of the actors as they work to re-stabilize the PHC network. As seen earlier, current literature suggests that NP role integration often generates tensions, confusion, frustration and conflict. Along with Latour, we believe that the examination of group formations, as it occurs when a nurse practitioner enters a new setting and seeks to establish new collaborations, can lead to a fresh understanding of APN role deployment that is not reduced to mere role confusion.

Conclusion

ANT has much to offer with regards to nursing research, because it takes into account the hybrid nature of the world and the performance of non-human entities that shape events and processes, and contribute to their "social" quality. It also considers the importance of technology in social matters and works to eliminate traditional ontological categories. Central to an analysis of health care issues using ANT is the exploration of the ways actor mobilization occurs and interests and purposes are reconfigured and provided with convergence. Understanding the way actors negotiate relationships with all kinds of entities in their environment (including policies and technological devices) is key in understanding the way subjective positions are formed, negotiated and mediated—a core issue in the context of nurse practitioner integration.

ANT is not meant to provide ready-made answers to the tricky issue of proper NP integration in health care structures. It does, however, allow for new understandings and insights to emerge. Policies and legislation that support NP practice are clearly insufficient to dispel what are commonly perceived as barriers to implementation, such as misunderstandings of NPs' roles in health care. ANT can be of use to critically examine the kinds of dynamics, discourses, subjectivities and meanings that emerge from, and in turn shape NPs' interactions with other entities (semiotic, technological, human, etc.) along a multitude of network relationships that shape PHC NPs' professional trajectories.

References

1.Institute of Medicine Executive Office. The Future of Nursing: Leading Change, Advancing Health. 2011. Available from URL: http://www.nap.edu/read/12956/chapter/2. Accessed 15 May 2016.

2.Canadian Nurses Association. Advanced Nursing Practice: A National Framework. Ottawa: Author, 2008.

3.De Milt DG, Fizpatrick JJ, McNulty SR. Nurse practitioners' job satisfaction and intent to leave current positions, the nursing profession, and the nurse practitioner role as a direct care provider. Journal of the American Academy of Nurse Practitioners 2011; 23: 42-50.

4.Sullivan-Bentz M, Humbert J, Cragg B, Legault F, Laflamme C, Bailey PH, Doucette S. Supporting primary health care nurse practitioners' transition to practice. Canadian Family Physician 2010; 56: 1176-1182.

5.Canadian Nurse Practitioner Initiative. Health and human resource planning- recruitment and retention of primary health care nurse practitioners in Canada. Ottawa: Tom Murphy Consulting, 2003.

6.Misener TR, Haddock KS, Gleaton JU, Abu Ajamieh AR. Toward an international measure of job satisfaction. Nursing Research 1996; 45: 87–91.

7.Burgess J, Martin A, Senner W. A Framework to Assess Nurse Practitioner Role Integration in Primary Health Care. Canadian Journal of Nursing Research 2011; 43: 22-40.

8.Reay T, Patterson EM, Halma L, Steed WB. Introducing a nurse practitioner: experiences in a rural Alberta family practice clinic. Canadian Journal of Rural Medicine 2006; 11: 101-107.

9.Sangster-Gormley E, Martin-Misener R, Downe-Wamboldt B, DiCenso A. Factors affecting nurse practitioner role implementation in Canadian practice settings: an integrative review. Journal of Advanced Nursing 2011; 67: 1178-1190.

10.DiCenso A, Bryant-Lukosius D. The Long and Winding Road : Integration of Nurse Practitioners and Clinical Nurse Specialists Into the Canadian Health-Care System. Canadian Journal of Nursing Research 2010; 42: 3-8.

11.Spitzer W, Sackett D, Sibley J, Roberts R, Gent M, Kergin

D, Hackett B, Olynich A. The Burlington randomized trial of the nurse practitioner. New England Journal of Medicine 1974; 290: 251–256.

12.Spitzer W, Kergin D, Yoshida M, Russell W, Hackett B, Goldsmith C. Nurse practitioners in primary care: the southern Ontario randomized trial. Health Care Dimensions 1975; Spring: 105–119.

13.Donald F, Mohide EA, DiCenso A, Brazil K, Stephenson M, Akhtar-Danesh N. Nurse Practitioner and Physician Collaboration in Long-Term Care Homes: Survey Results. Canadian Journal on Aging 2009; 28: 77–87.

14.Donald F, Martin-Misener R, Bryant-Lukosisus D, Kilpatrick K, Kaasalainen S, Carter N, Harbman P, Bourgeault I, Dicenso A. The Primary Healthcare Nurse Practitioner Role in Canada. Nursing Leadership 2010; 23: 88-113.

15.Lalonde M. Nouvelle perspective de la santé des Canadiens. Ottawa: Information Canada, 1974.

16.Romanow RJ. Building on Values: The Future of Health Care in Canada. 2002. Available from URL: http://publications.gc.ca/collections/Collection/CP32-85-2002E.pdf. Accessed 15 June 2016.

17.World Health Organization. Ottawa Charter for Health Promotion. 1986. Available from URL: http://www.euro.who.int/__data/assets/pdf_file/0004/129532/Ottawa_Charter.pdf. Accessed 15 June 2016.

18.Canadian Nurse Practitioner Initiative. Implementation and Evaluation Toolkit for Nurse Practitioners in Canada. Ottawa: Canadian Nurses Association, 2006.

19.Hutchison B, Abelson J, Lavis J. Primary care in Canada: So much innovation, so little change. Health Affairs 2001; 20: 116-131.

20.Burgess J, Sawchenko L. Community of Practice: A Nurse Practitioner Collaborative Model. Nursing Research 2011; 24: 99-112.

21.Gould O, Johnstone D, Wasylkiw L. Nurse Practitioners in Canada: Beginnings, Benefits and Barriers. American Academy of Nurse Practitioners 2007; 19: 165–171.

22.Irvine D, Sidani S, Porter H, O'Brien-Pallas L, Simpson B, McGillis Hall L, Graydon J, DiCenso A, Rederlmeir D, Nagel L. Organizational Factors Influencing Nurse Practitioners' Role Implementation in Acute Care Settings. Canadian Journal of Nursing Leadership 2000; 13: 28–35.

23.Jones L, Way D. Delivering Primary Health Care to Canadians: Nurse Practitioners and Physicians in Collaboration. Ottawa: Canadian Nurses Association & Canadian Nurse Practitioner Initiative, 2004.

24.Sangster-Gormley E. Nurse practitioner-sensitive outcomes. Halifax: College of Registered Nurses of Nova Scotia, 2007.

25.Hamric AB. A Definition of Advanced Practice Nursing. In: Hamric AB (ed). Advanced Practice Nursing: An Integrative Approach. St. Louis: Saunders Elsevier, 2005; 85-108.

26.Mayo-Bruinsma L. Family-centered care delivery: Comparing models of primary care service delivery in Ontario. 2011. Available from URL: http://www.ruor.uottawa.ca/fr/bitstream/handle/10393/19952/MayoBruinsma_Liesha_2011_thesis.pdf?sequence=1. Accessed 11 June 2016.

27.Registered Nurses Association of Ontario. Primary Solutions for Primary Care: Maximizing and Expanding the Role of the Primary Care Nurse in Ontario. Toronto: Author, 2012.

28.Nairn S. A critical realist approach to knowledge: implications for evidence-based practice in and beyond nursing. Nursing Inquiry 2012; 19: 6-17.

29.Kilpatrick K, Lavoie-Tremblay M, Ritchie JA, Lamothe L. Advanced Practice Nursing, Health Care Teams, and Perceptions of Team Effectiveness. The Health Care Manager 2011; 30: 215-226.

30.Burgess J, Martin A, Senner W. A Framework to Assess Nurse Practitioner Role Integration in Primary Health Care. Canadian Journal of Nursing Research 2011; 43: 22-40.

31.Burgess J, Purkis ME. The power and politics of collaboration in nurse practitioner role development. Nursing Inquiry 2010; 17: 297-308.

32.Wilson K, Coulon L, Hillege S, Swann W. Nurse Practitioners' experiences of working collaboratively with general practitioners and allied health professional in New South Wales, Australia. Australian Journal of Advanced Nursing 2005; 23: 22-27.

33.Law J. Actor network theory and material semiotics. In: Turner BS (ed). The New Blackwell Companion to Social Theory. Malden: Wiley-Blackwell, 2009; 141-158.

34.Stalder F, Clement A. Actor-Network-Theory and Communication Networks: Toward Convergence. 1997. Available from URL: http://felix.openflows.com/html/Network_Theory.html. Accessed 10 May 2016.

35.Blok A, Jensen TE. Bruno Latour: Hybrid thoughts in a

hybrid world. New York: Routledge, 2011.

36.Latour B. Reassembling the Social: An Introduction to Actor-Network-Theory. Oxford: Oxford University Press, 2005.

37.Latour B. Pandora's Hope. Essays on the Reality of Science Studies. Cambridge: Harvard University Press, 1999.

38.Callon M, Law J. After the Individual in Society: Lessons on Collectivity from Science, Technology and Society. Canadian Journal of Sociology 1997; 22: 165-182.

39.Callon M. Variety and Irreversibility in Networks of Technique Conception and Adoption. In: Foray D (ed). Technology and the Wealth of Nations: The Dynamics of Constructed Advantage. London: Pinter, 1993; 232-268.

40.Latour B. On actor-network theory: A few clarifications plus more than a few complications. 1997. Available from URL: www.bruno-latour.fr/sites/default/files/P-67 ACTOR-NETWORK.pdf. Accessed 25 June 2016.

41.Callon M, Latour B. Unscrewing the big Leviathan: how actors macrostructure reality and how sociologists help them to do so. In: Knorr-Cetina KD (ed). Advances in Social Theory and Methodology. Toward an Integration of Micro and Macro Sociologies. Boston: Routledge & Kegan Paul, 1981; 277–303.

42.Karsenti B, Porter C. Biography of an Investigation: On a Book about Modes of Existence. 2012. Available from URL: http://www.bruno-latour.fr/sites/default/files/downloads/126-KARSENTI-AIME-BIO-GB..pdf. Accessed 18 May 2016.

43.Purkis ME. Managing home nursing care: visibility, accountability and exclusion. Nursing Inquiry 2001; 8: 141-150.

44.Betts CE. Nursing and the reality of politics. Nursing Inquiry 2009; 16: 261-272.

45.Foth T. Nurse, medical records and the killing of sick persons before, during and after the Nazi regime in Germany. Nursing Inquiry 2013; 20: 93-100.

46.Mol, A. The Body Multiple: Ontology in Medical Practice. Durham: Duke University Press, 2002.

47.Mol, A, Law, J. Embodied Action, Enacted Bodies. The Example of Hypoglycaemia. Body & Society 2004; 10: 43-62.

48.Singleton V, Michael M. Actor-networks and Ambivalence: General Practitioners in the UK Cervical Screening Programme. Social Studies of Science 1993; 23: 227-264.

49.American Academy of Nurse Practitioners. Quality of Nurse Practitioner Practice. Austin: Author, 2010.

50.American Academy of Nurse Practitioners. Nurse Practitioner Cost-Effectiveness. Austin: Author, 2010.

51.Woolgar S. Configuring the user: the case of usability trials. In: Law J (ed). A Sociology of Monsters: Essays on Power, Technology and Domination. London: Routledge, 1991; 57-99.

To Contact the Authors:
Annie Rioux-Dubois, PHC NP, PhD(cand)
University of Ottawa
School of Nursing
451 Smyth Road
Ottawa, Ontario
K1H 8M5
Canada
Email: ariou013@uottawa.ca

Amélie Perron, RN, PhD
Associate Professor
University of Ottawa
School of Nursing

2

Abstract
This paper presents a conceptual framework and model that merges Anishinaabe and non-Anishinaabe perspectives regarding balance promotion for health. Inspired by Freire's concept of liberating education and Antonovsky's concept of salutogenesis, the conceptual framework and the model incorporate the Anishinaabe view of health as rooted in cultural, spiritual and philosophical values that focus on balance to attain and maintain health at the individual and community level. Hypothetical examples of health issues are presented with accompanying questions designed to launch an emancipating dialogue with Anishinaabe clients, which may also be suitable for other Aboriginal clients. The model and questions target three major areas of balance promotion for health: overcoming stereotypes, restoring a sense of belonging, and developing resilience and adaptive behaviours. To counteract the harms provoked by stereotypes and marginalization, the type of dialogue suggested by the model builds on Anishinaabe strengths to develop and mobilize community assets and to achieve a meaningful and coherent health perspective.

Keywords Anishinaabe, balance promotion for health, Canada, emancipation, salutogenesis

An Emancipating-salutogenesis conceptual framework & model of Anishinaabe balance promotion for health

MARGARETH SANTOS ZANCHETTA, MELISSA STEVENSON, VERA NENADOVIC, MICHEL PERREAULT, CARMEN JAMES HENRY & NEWTON LEONG

Introduction

The conceptual model presented in this paper originated in discussion among nurses and social scientists on how to advance nursing knowledge of promoting health in Aboriginal communities in ways that are humanistic, culturally, politically and morally sensitive. Our ideas coalesced around exploring the appropriateness of the application of Freire's ideas of emancipatory pedagogy[1] in combination with Antonovsky's concept of salutogenesis[2] (the latter being adopted worldwide by researchers in the field of health promotion) to the context of health promotion in Canadian Aboriginal communities.

This paper aims to show the transferability of both Freire's and Antonovsky's ideas to the design of a new perspective on promoting Aboriginal health in ways that are intended to counteract the deleterious effects on Canadian Aboriginal peoples of historical oppression and ongoing marginalization. Through examples of how the model could be used in practice, we demonstrate how an Anishinaabe community could be supported to contribute to health services, redesign their own health education, and transcend the current lack of solutions to their issues. The advantage of adopting a salutogenesis orientation to health initiatives is that social vulnerabilities can be transformed into strengths, thereby positively impacting both short- and long-term health outcomes.

Both the framework and model were created in an intellectual

partnership between a graduate nurse of Anishinaabe descent (MS) and nursing and sociology professors. The key principles from Anishnaabe culture are that balance is necessary for health, and that health is achieved through connection with others; the philosophical contributions from Freire's and Antonovsky's view of health as a metaphor for liberation and change (emancipation) and focus on factors that support human health and well-being (salutogenesis). Both conceptual tools were inspired by the experiential health knowledge of MS, as developed and practiced in her own Anishinaabe community (in Toronto, Canada); they are culture-bound and can be applied to initiatives in the area of health education for Anishinaabe (and likely other Aboriginal) individuals, families and communities.

We sought to establish the epistemological adequacy of the model by confirmation from a cultural insider's perception of the Anishinaabe health reality. This means that health is understood as a process that respects the Anishnaabe community life trajectory and acknowledges the historic roots of current health issues and social vulnerabilities. We acknowledge those social vulnerabilities as reflections of the harm done to individuals, groups, relationships, and community resources — all of which, in turn, damage community capital and provoke social disorganization.[3]

We drew on Freire's emancipating pedagogy[1] to expand our understanding of education for health and to counteract the current health inequities and challenges experienced by Anishinaabe and other Aboriginal communities. We adopted Antonovsky's salutogenesis model of health,[2] which emphasizes the sources of risks, vulnerabilities, as well as potential strengths, to sustain the promotion of initiatives towards health in a broad, holistic perspective.[2] We posit health as a state of balance that promotes individual and collective empowerment and resilience. We believe that promoting Aboriginal people's sense of integrity, equilibrium, and well-being may provide an appropriate health perspective to address a wide range of health issues, transcend limitations, and support the self-management of health and life issues.

Definition of terms

Anishinaabe: composed of Aboriginal people of the Algonquin, Chippewa, Delaware, Mississaugi, Ojibway-Cree, Ojibway, Ojibwa, Odawa, and Potowatomi tribal groups or First Nations. In Canada, they live in the provinces of Alberta, Manitoba, Ontario, and Quebec.[4] They originate from the Great Lakes region and are considered to be one of the largest Indigenous nations in North America.[5] They are noted for having an intense spirituality and being deeply independent. The particular Anishinaabe community that inspired and supported this project is part of the 63 First Nations located in the province of Manitoba,[6] with a population of approximately 7,200 individuals living on reserve and in urban areas.

Balance for health: the empirical definition, as adopted in this paper, is grounded in Anishinaabe Medicine Wheel knowledge. Balanced health results from a complex interaction between one's life, other individuals, and all of creation (e.g., the environment, living beings, and inanimate things); it is a four-dimensional state including mind, body, spirit, and emotion, as embedded in the Seven Grandfathers Teachings and the Medicine Wheel.

Conceptual framework: an abstraction, a mental image[7] displaying a logical grouping of concepts into a knowledge form within the empirics pattern,[8] linked in sets of propositions.[9] The concepts composing a framework may originate from one or more theories, previous research results, or the researcher's own experiences.[9] Explanation of the relationship between concepts may be presented in a less well-developed structure than for a theoretical framework.[10] A conceptual framework acts as a background or foundation for a study with a presentation of related concepts in a logical manner by the researcher.[10] Overall, as a basic conceptual structure (e.g., including assumptions, concepts, values and practices), it constitutes a way of solving or addressing complex issues.

Conceptual model: a conception of reality[7] composed by "a set of abstract and general concepts and propositions that provides a distinctive frame of reference for the phenomenon of interest to a discipline" and that implies a disciplinary matrix or a paradigm.[11 p83] By containing all variables of a subject matter and describing reality more fully,[9] a conceptual model uses a set of concepts and propositions integrated into a meaningful configuration. Therefore, a conceptual model provides a systematic structure and rationale for activities, including the search for relevant questions about phenomena, and indicates solutions to practical problems.[12] By being highly abstract, a conceptual model serves as a "set of lenses" to view reality, thus assisting the description, explanation and understanding of a given phenomenon of interest.[13]

Considerations of qualitative modelling

As a systemic view of the complex health reality of Anishinaabe people, the proposed conceptual model acknowledges a

structural complexity while respecting its essential features to inspire courses of action based on simplicity. The health reality of Anishnaabe people is complicated by the forces that limit the improvement of community capacity. These forces include a range of historic and ongoing unresolved issues and traumas, grounded in experiences of exploitation and oppression, and current legal and political dependence that fosters mistrust of authorities, as well as collective feelings of powerlessness and compromised self-esteem. Multiple social determinants of health (e.g., geographic and social isolation, childhood development, poor housing, coping mechanisms, gender) contribute to health inequities between Anishnaabe and other Canadian populations. A simple course of action could be to restore their believed sources of health and self-determination, and to acknowledge their roles as responsible citizens by supporting the mobilization of their self-agency and honouring their values and beliefs in the appropriate care and protection of their people, families, and communities.

This stance resonates with the scientific paradigm of complexity — wherein complexity and simplicity are at play[14] — that currently challenges researchers to propose new understandings and responses to intriguing questions and conflicting ideas. The proposed conceptual model represents the occurring modifications, variations, or configuration about the elements that compose the phenomenon under modelling.[15] It also represents an existing system with functional and structural properties.[16-18] Moreover, this model acts fundamentally by reducing the phenomenon of interest to its more significant characteristics.[19] Using a model archetype's features,[14] the model identifies the phenomenon of interest and differentiates it in the surrounding environment; it designs the phenomenon's active nature, the phenomenon's self-regulation and internal stability, the phenomenon's operational mode to information-gathering within its own environment, as well as the way the phenomenon's mode of conduct functions through the elaboration of decisions about actions.

We want to inspire readers to see through our proposed conceptual lens, a joint work with Anishinaabe people to promote balance for health as feasible and compatible within the three aforementioned perspectives. Our aim is to re-frame the concept of health as a matter of balance in Anishinaabe people's life, within a holistic paradigm of life in balance, as it is embedded in all forms of their teachings. This approach is reflected in Freire's perspective of an emancipating philosophy and in Antonosvky's perspective of promoting resilience and adaptation. We propose an amalgamation of Anishnaabe and Western forms of knowledge and philosophies to create an innovative lens with which to explore health promotion; neither of the aforementioned perspectives emerges as the dominant one in the proposed conceptual tools.

Literature review

This section briefly outlines current views of Aboriginal health by international and national health organizations, as well as the scope for Aboriginal autonomy in designing and implementing health-related initiatives in Canada. An Anishinaabe approach to achieving balance for health, as shown in Figure 1, incorporates multiple dimensions; all must be addressed to adequately deal with the deleterious effects of colonization and marginalization of Aboriginal peoples. (It is beyond the scope of this paper to include literature on the historic roots of Aboriginal oppression in Canada or the current range of issues regarding Aboriginal health status and self-government.) This section also presents the Anishinaabe's view of balance for health that inspires this paper.

Worldwide issues regarding Aboriginal health

An estimated 370 million Indigenous individuals live in more than 70 countries worldwide, in developing and industrialized countries alike, but across the board, their health status varies greatly from that of their non-Indigenous counterparts.[20] The current health status of the Canadian Aboriginal population reflects significant health inequities; their life expectancy, for both men and women, is five to ten years lower than for other Canadians.[21] These inequities are closely related to the social determinants of health, notably low socioeconomic status and adverse political factors that are linked to the historic oppression of Aboriginal peoples.[22,23] The Aboriginal population in Canada faces poor health outcomes according to almost every indicator used to assess health outcomes.[24]

Autonomy for health related initiatives in Canada

The historic neglect of Aboriginal population health care in Canada is linked to major issues and disputes regarding who is responsible for tackling health disparities.[25] Aboriginal dependence on the federal government has undermined initiatives to improve Aboriginal quality of life.[26] A critical issue is that Aboriginal communities have lost self-determination in policy development for their own people.[27] As a strategy to promote self-determination, governments, policy makers, practitioners and researchers are urged to seek Aboriginal input on their communities' concerns, needs, and possible solutions,[26,27] especially in the creation of culturally appropriate mental health recovery

services.[28]

Aboriginal autonomy also relates to the ability to navigate the Canadian health system since the Aboriginal population also faces problems with accessibility to health services. Despite the establishment of provincial and federal support policies, the current education structure (including the health-specific one) does not prepare Aboriginal individuals to fit within the mainstream society. One of the most damaging adverse consequences of historic oppression of Indigenous peoples is the development of feelings of shame rather than respect for their ancestral culture.[29] Adopting a critical perspective and understanding of the politics, culture, and history that underpin Aboriginal communities' current struggles to live in health, while respecting their culture in its enormous diversity,[30] is a necessary and promising avenue to their improved health.

Health promotion opportunities

Health promotion projects that recognize and honour Aboriginal people's history and celebrate their traditional ways are needed to help with the healing process.[23] For Aboriginals living off-reserve, such projects could nourish their sense of belonging and connect them to their culture.

Health Canada recently adopted a new research direction for projects that fit the balance model of health. A success-focused approach in the First Nations and Inuit Health Branch claims to support the "positively focused aspirations of Canadian Indigenous communities". The current focus is on the generation of hypotheses and research questions that will "strengthen First Nations' capacity to apprehend, anticipate, and heighten positive potential".[31 p1] First Nations peoples are known to share traditional values such as balance, harmony and interconnectedness as part of their Aboriginal culture.[32] This acknowledgement of a culturally appropriate, preventative, holistic, and strength-based approach corroborates the suitability of our emancipating-salutogenesis conceptual framework and model which recognizes the need to honour the voice and potential of Anishinaabe communities to achieve balance for health.

Anishnaabe balance for health

The synchrony between the external, social and cultural environments in Anishnaabe worldviews highlights the Aboriginal emphasis on the necessity to maintain a connection with 'Mother Earth'.[23] It is expressed in the idea of balance and harmony within and among the domains of social, spiritual, emotional and physical health. The concept of balance relates to the whole of creation and, ultimately, to health and wellness. Everything that Aboriginal people interact with in their daily lives is considered to be alive and to have a spirit.[33] The use of traditional ways of maintaining health and provision of culturally-focused care are important to Aboriginal people since both emphasize the importance of respect for all life. Appreciation for interdependence is also important for balance since it situates human relationships as a better source and reflection of well-being than material wealth or status.[34]

For Anishinaabe people, the cultural image of balance comes from the Medicine Wheel.[5] Balance involves each aspect of being in connection with the four directions and incorporates associations with plants, spirits, animals, colors, minerals, and the lifecycle. Balance must exist between the spiritual, physical, mental, and emotional dimensions for individual good health. Balance impacts health through an individual's participation in traditional activities, and with the establishment of significant relationships. Balance includes the observance of 'seven generations teaching' which places a high value on respecting ancestors and accepting stewardship on behalf of future generations.[23] Such cultural practices can mitigate the harmful consequences of loss of culture and language, discrimination, injustice, poverty, and social inequality.[35]

Inspirational conceptual frameworks and the design of conceptual tools

Freire's emancipating pedagogy[1,36} and Antonovsky's salutogenesis model[2,37,38] framed the development of the conceptual tools (i.e., a framework and a model) that we integrated for an Anishinaabe perspective of emancipating-salutogenesis balance for health. Freire's pedagogy espouses social justice, equality, freedom and democracy through the development of critical consciousness, resulting in emancipation, a state of awareness and conscientization about one's potentialities and agency. For Freire,[1] education must stimulate a desire for action that addresses inequality and oppression. Since traditional forms of education tend to support the status quo in terms of social and political structure, it is essential that education be reoriented towards promoting social change. In Freire's pedagogy, learners are encouraged to reflect on their own experiences in life and on the individual and collective injustices encountered. They are then asked to reflect on the underlying reasons for these problems and to identify prominent ideas that would foster a change in their social reality. Liberation from oppressive forces can be achieved by framing one's reality through "seeing-judging-acting" in the world.[39] For Freire,

the best way to help others to identify and become aware that a problem exists, as well as understand it, is through developing critical judgment from which solutions can be formulated. It is through an understanding of their specific and broad issues that individuals can develop critical consciousness and solutions to their problems.

Antonovsky's conceives salutogenesis[38] as the origins of health,[2] particularly with respect to how people deal with the inevitable challenges of life, or pressures toward entropy as human life unfolds in an open system. Within this perspective of health, the emphasis is on the individual's ability to cope with stress, the deciding factor to withstand any pathogens or trauma. Antonovsky[2] defines a sense of coherence as "a global orientation that expresses the extent to which one has a pervasive, enduring though dynamic feeling of confidence that one's internal and external environments are predictable and that there is a high probability that things will work out as well as can reasonably be expected"[p3] Moreover, a sense of coherence is formed by life experiences whose meanings depend on social position and culture, type of work, family structure, gender, ethnicity, chance and genetics. Experiences are determined by consistency, load balance, and participation in socially valued decision-making processes.

The focus is on the human capacity to generate health by mobilizing the factors that promote a healthy state. Initiatives for health promotion support the individual's progress toward this goal. An individual uses generalized resistance resources that are the "property of a person, a collective or a situation which, as evidence or logic has indicated, successful coping with the inherent stressors of human existence".[38 p15] The major concept in Antonovsky's model is a sense of coherence: making sense of the world through comprehensibility, manageability and meaningfulness, as well as human resilience in the face of adversity. These features are described by Antonovsky[38 p15] as: "the wish to be motivated to cope (meaningfulness); belief that the challenge is understood (comprehensibility); and belief that resources to cope are available (manageability)".

Freire's and Antonovsky's conceptual perspectives are compatible with the Anishinaabe idea that balance for health implies resilience and empowerment. Both of these perspectives would encourage and sustain critical awareness of the possible connections between Western scientific thought and traditional Anishinaabe knowledge, in consonance with Anishinaabe people's dreams and goals to recreate dignifying life perspectives for current and future generations.

An emancipating-salutogenesis conceptual framework for Anishinaabe balance promotion for health

Freire's and Antonovsky's ideas resonate with the Anishinaabe view of ecology, rooted in traditional knowledge thousands of years old.[40] As a way of life and a way of knowing,[41] it is action-oriented, dynamic, and adaptive to changes. It encompasses spiritual experience and relationships with the land and religious dimensions. This approach to ecology can be understood by outsiders through the exploration of four interrelated levels of knowledge and management systems. The first level is localized and is cross-culturally accepted in terms of local knowledge of land and animals. The following layers are land and resource management systems, social institutions, and lastly, world view. Each layer encompasses the previous and provides interpretation of the underlying layers.

The meaning of the land or ecology to Aboriginal people is tied to "living a good life" since it is culturally and spiritually based on the way Indigenous people relate to their ecosystem.[40] This idea of "living a good life" is evident in every traditional teaching, directly linked to people's spirituality, and is widespread within Indigenous pedagogy. Another relevant aspect of critical Indigenous pedagogies is the Native American view of "exist[ing] in in-between, border, marginal, and liminal spaces, the crossroads where colonializing and decolonializing frameworks intersect and come into conflict with one another.[42 p211] This pedagogy enacts politics of liberation and empowerment, as well as spaces of engagement; creates sacred spaces;[42] and reinforces Native intellectualism, identity, self-determination and sovereignty.[43] As Indigenous knowledge conceptualizes the resilience and self-reliance of their people and emphasizes the importance of their philosophies, heritages and educational processes,[44] it can become instrumental in reaffirming collective capacities to overcome oppressing poverty and support sustainable development.

We need to appreciate and respect the Indigenous view that everything on Mother Earth has a purpose. Their environment is important to them as the provider of the basis for life (medicines, food, and shelter). Aboriginal people's connections to the land are both practical and sacred, and deeply meaningful.

From an Anishinaabe perspective, the following concepts in the conceptual framework are all interconnected: resilience, individual and collective empowerment, self-determination, holism, interdependence and support, sense of coherence,

security, and cultural identity. These concepts can inspire transformative health education initiatives that aim to create a meaning of health compatible with traditional native health knowledge. There is a dynamic connectivity between the intellectual, spiritual, emotional and physical aspects of Aboriginal identity and worldview,[33] which is reinforced by traditional teachings. The Aboriginal identity incorporates a positive self-image and a healthy cultural identity.[22]

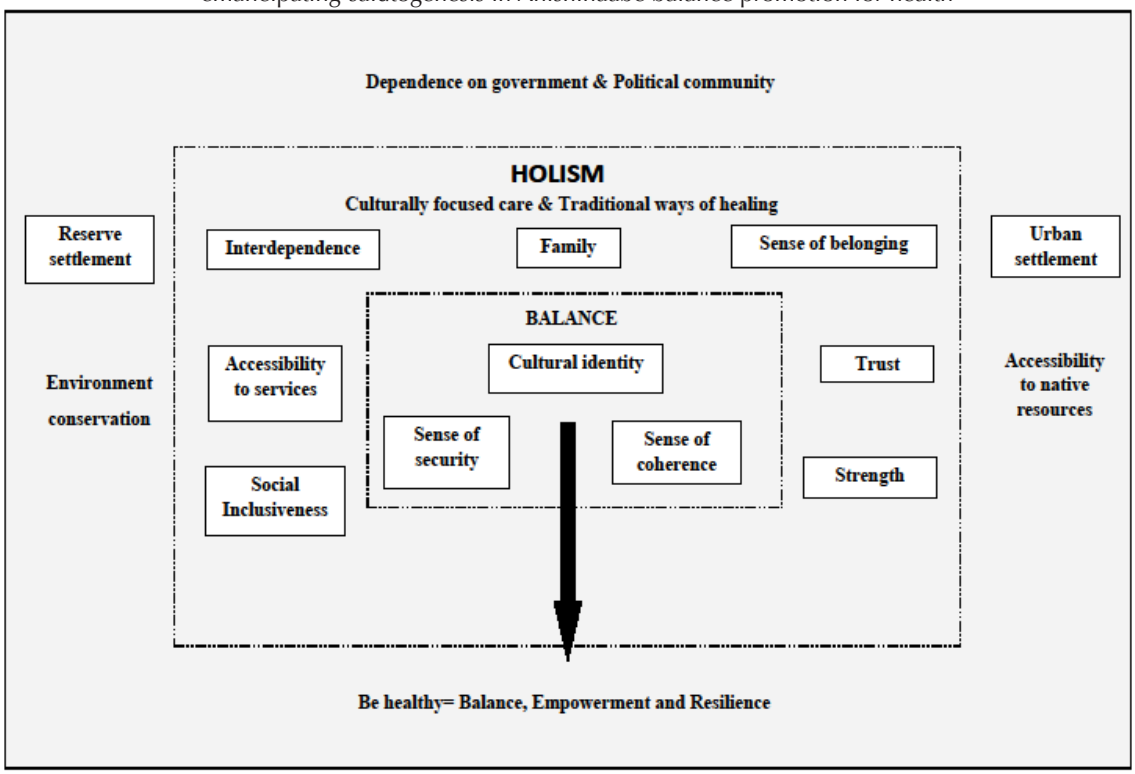
Based on the Anishinaabe view of balance, the proposed conceptual framework integrates traditional teachings and philosophy within a macro level, ecological perspective of living. The emancipating-salutogenesis conceptual framework we propose for Anishinaabe balance for health promotion operates at three levels:

-A macro-societal level where political relations between levels of government and the Aboriginal community determine health conditions related to physical and social environments. The reserve or urban context will shape target emancipating actions related to the environment, accessibility to Absoriginal services, and governance issues regarding land claims and conservation. These elements relate to Aboriginal people's sense of coherence.[26]

-A meso-community level where processes of emancipation and salutogenesis are rooted in Aboriginal culture and traditional healing. Social inclusion and accessibility to health and social services are interlinked, while interdependence among community members reinforces trust. Living in balance with self and others is rooted in the sense of belonging, and psychological strengths are instilled within the family unit. The family is considered to be one of the most influential sources of nourishing feelings of love, affection, and belonging, all of which are symbols of Aboriginal safety, strength and comfort.[45] Healthy family relations also contribute to the development of a positive cultural identity, spirituality, and resilience by promoting a holistic view of life, resistance against forces of oppression, and forgiveness, all of which, in turn, can help communities to overcome longstanding silence.[46]

-A micro-individual level, where a sense of security, coherence, and cultural identity are expected to reinforce the development and consolidation of balance. Balance embodies notions of action to prevail in one's motives to achieve psychological and spiritual resilience. Resilience also refers to the community and cultural contexts, as well as to positive adaptation in facing adversity and navigating life well.[47] Balance that is rooted in security, coherence, and cultural identity involves resilience through self-transcendence and faith that is rooted in Aboriginal cultural identity and spirituality.

Figure 1: Features of the conceptual framework displaying the processs of emancipating-salutogenesis in Anishinaabe balance promotion for health



Harmonizing Western and Anishinaabe ideas in the conceptual model

Our conceptual model amalgamates Anishinaabe philosophy with Freire's and Antonovsky's ideas to inspire native and non-native individuals to marshal their assets to rebuilding an alliance for health within the process of balance promotion. We identified a philosophical alignment between Freire's and Antonovsky's ideas with the Seven Grandfathers and Medicine Wheel Teachings, particularly in that each approach values knowledge, courage, harmony, self-coherence, and respect for a natural flow of life events that honours the sacred essence and dignity of individuals. Freire based his thinking on the Brazilian people's experiences of social oppression and resistance; Antonovsky based his thinking on resilience and well-being in the face of stress and trauma. So, both authors explored ways for people to thrive in the face of extreme forms of suffering, oppression and extermination. Anishinaabe experiences and ideas recall equally painful memories, but like the Western authors, celebrate individuals' and communities' strengths, possibilities, and assets to overcome difficulties.

Among Aboriginal nations, the Medicine Wheel is known as a post-colonial teaching to explain to non-Indigenous people their way of life, not their culturally specific traits. The Medicine Wheel's major ideas vary from Indigenous culture to culture, including those conceived and embraced by Anishinaabe people. Since each tribal nation can use this tool in a distinctive way, the relevance of the Medicine Wheel relies on the existence of trans-tribal concepts (sacred medicines, seasons, directions, stages of life, and aspects of a person). Anishinaabe people also rely on Seven Grandfathers' Teachings while outline the seven characteristics that constitute the good life: living life with courage, truth, honesty, wisdom, respect, love and humility. In other words, it is a way to traditionally live one's life in balance with oneself and one's surroundings.

By transmitting knowledge about man's wholeness in the world, the Aboriginal life paradigm goes beyond the sacred dimensions[48] to embody the political dimension of living with constant experiences of marginalization, oppression and injustice, which have been widely documented by Aboriginal and non-Aboriginal scholars. Since the Western and Aboriginal ideas introduced in this paper both address living with adversity, their similarities can be identified to inspire a synergy of ideas.

Freire's dialogical learning approach based on educator-learner dialogue was considered integral to a revolutionary critical praxis by Grande,[48] who also emphasized that despite its profound, participatory and creative nature, Freire's critical pedagogy could be in tension with Indigenous knowledge and praxis. Our disagreement about this is supported by pointing to the historical roots of Freire's pedagogy for liberation, which evolved from his literacy work with Brazilian rural workers deprived of rights to land and who had struggled for decades with powerful landlords and suffered generational inequities resulting in hunger, extreme poverty and illiteracy.[1] We note the similarities between a human misery lived in a Western, middle income country and the social inequities that Canadian Aboriginal people face in their high income home country. In both social contexts, life, human dignity, suffering, health and death have similar moral meanings.

Re-focusing on the application of Freire's ideas to Aboriginal health promotion initiatives, and seeing Aboriginal individuals as learners for health, we reaffirm the appropriateness of emancipatory ideas from Freire's critical pedagogy. According to Freire, the learner becomes a political agent in his/her own world in that "…critical pedagogy encourages students to learn to perceive the tolerable as intolerable, as well as to take risks in creating the conditions for forms of individual and social agency that are conducive to a substantive democracy".[49 p186] In a critical pedagogy context, learners are assisted to confront the threat of fundamentalist and accepted ideas to imagine and formulate different ways to intervene in their private and public life. So, as a matter of living life with courage, truth, and honesty, the politically aware Aboriginal learner can see balance for health as an individual project for well-being that has a collective benefit by having a balanced person in the community.

Furthermore, Freire's ideas refocus the core of a teaching-learning process on the learner's dreams instead of on the teacher's goals,[1] and on the teacher's audacity and courage to challenge the systemic oppression sustained by educational institutions.[50] By doing so, the teacher becomes aware of his/her fears to counteract the injustice faced by learners. These ideas are transferrable to the context of health education and health promotion initiatives and programs that, intentionally or not, impose non-Aboriginal teachings in a new form of imposition of dominant culture and knowledge.

The source for agency and energy to confront oppressive, non-liberating forces is informed by Antonovsky's ideas of resilience, in consonance with Aboriginal teachings on matters of wisdom, respect, love and humility. These teachings

can help an individual to find a way to be resilient and find the "other". Moreover, the traditional mode of talking circles and humble acceptance of advice based on the wisdom of Indigenous elders can be understood as strategies for a narrative resilience,[51] where one's discourse translates the affective value of sharing thoughts and concerns with other individuals in a perceived safe context. The purposeful dialogue within an affective and cultural context among Aboriginal individuals and with non-Aboriginal professionals can exemplify an integration of Antonovsky's ideas related to mental strength to confront adversity. Dialogue as a strategy for building resilience allows the verbalization of a narrative truth from the individual's point of view that may not be exactly the historical truth (from a collective point of view).

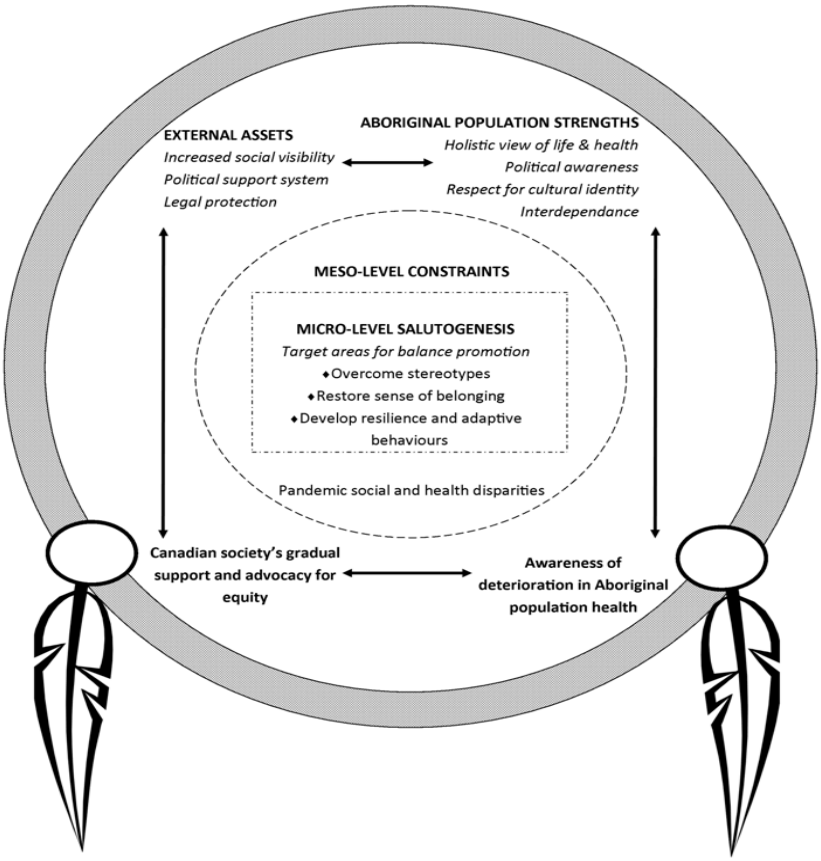
Within such a space of disclosure, dialogue, and conscientization, it is possible to foresee a process of healing taking place, as stated by the Aboriginal Medicine Wheel paradigm. The traditional teachings see the individual as a free and responsible agent who chooses whether and how to use and incorporate the teachings in their life. It is possible to say that the sources of elements for wellness and health are identifiable to Aboriginal individuals by their affective and spiritual proximity.

Ultimately, individual resilience can also foster community resilience, for instance when Aboriginal families and groups or communities resist oppressive forces and bring about positive outcomes, such as "strengthening social capital, networks and support; revitalization of language, enhancing cultural identity and spirituality; supporting families and parents to insure healthy child development; enhancing local control and collective efficacy; building infrastructure (material, human and informational); increasing economic opportunity and diversification; and respecting human diversity.[52 p62]

An emancipating-salutogenesis conceptual model on Anishinaabe balance promotion for health

In this section, we introduce the design features of the proposed conceptual model and decode the model's language to show a feasible course of action to promote balance for health for Anishinaabe people.

Figure 2: An emancipating-salutogenesis conceptual model on Anishinaabe balance promotion for health



The model

The model acknowledges Aboriginal people's strengths regarding their life and political philosophies, as well as Canadian society's gradually increasing support and advocacy for equity for Aboriginals. The co-existence of these strengths, support and advocacy may be seen as key components of the systemic social environment where the process of balance promotion for health will unfold.

The model refers to a progression in critical awareness, recognizing that individuals can range from being largely unaware of the implications of their daily reality, to being more engaged in the world, to finally reaching a stage of reflexivity and action.[53] External factors, such as external governance of Aboriginal policies or even the inappropriate actions of a band council, will not diminish or even jeopardize the progression of individual or collective critical consciousness leading to empowerment. This is because a community's political emancipation will lead inevitably to a quest for freedom to act on internal issues of management (or mismanagement), as well as influence efforts at change at the level of federal, provincial, and territorial governments.

The core of the conceptual model is composed of three major areas for individual and collective change as a result of health education initiatives: overcoming stereotypes, restoring a sense of belonging and developing resilience and adaptive behaviours. Applying an emancipating-salutogenesis conceptual model to suggest and guide actions in partnership with Anishinaabe communities can potentially promote innovative critical health initiatives. These initiatives could mobilize community awareness of emancipation as a pathway to promote health through improved social conditions.

The key significance of this model derives from the origin of its components. The components of the conceptual framework emerged from the Aboriginal co-author's experiences and assumptions about the balance promotion for health. The elements of the conceptual model are based on the integration of two Western theoretical/conceptual approaches, amalgamated with Indigenous knowledge about balance for health, sources of health, and emancipation for health.

Exploring the prospective contribution to practice

Initially, the professional contribution of the proposed emancipating-salutogenesis conceptual framework was confirmed by a nursing professor who has ten years of experience as a nurse practitioner with Anishinaabe clients. This confirmation resulted from a review of several clinical cases and her professional interventions on a reserve located in the province of Ontario. This corroborated the pertinence of the concepts presented in the conceptual framework. Further, we followed qualitative research procedures for trustworthiness and verification by presenting the conceptual framework to Canadian nursing professionals and educators, composed of approximately 50 practitioners, scholars, faculty members, and decision-makers who attended four Canadian nursing research and community health conferences (in 2010, 2011, and 2012). The model's validity was corroborated by conference participants who reported having expertise in Aboriginal health.

We aimed to apply other testing criteria and procedures of trustworthiness, in case the scientific meetings did not allow us to select or even identify audience members as Aboriginal individuals and confirm their status as cultural insiders or professional experts. Such methodological limitations were attenuated by having only Aboriginal reviewers for the early draft of this paper. Aware of the meaning of validity as synonymous with verisimilitude, identified in the levels of accuracy and truthfulness in the findings, we also targeted the criteria of epistemological and catalytic validity, addressed by issues of text verisimilitude.[54] That is, our presentation of the model provided an incitement to discourse[55] in the form of comments from key informants and auditing by external examiners;[56] the model's interpretative validity was reflected in how it responded to different audiences about issues of culture, ideology, gender, textual language, relevance, advocacy, and standards or respectability.[57] Using feedback from external, professional examiners and their auditing, we verified the framework's incitement to critical discourse with external audiences. Trustworthiness was established by the criteria of credibility and transferability, based on the opinions of various contacts in the field with natural experts (including an Anishinaabe elder and Aboriginal professionals), member checks, and similar conclusions by other researchers and experts. Later, an Anishinaable elder reviewed and corroborated the validity of a primary Anishinaabe outline of the conceptual model in a discussion with the Anishinaabe co-author.

Discussion

As Indigenous knowledge and pedagogy are trans- and inter-cultural, they allow for a multi-disciplinary convergence of sources of systemic knowledge;[44] and they allow for the examination of similarities with non-Indigenous systems of

knowledge. More specifically, there is a logical congruency between the ideas of critical pedagogy and Indigenous learning styles. The application of critical pedagogy with Australian Aboriginal learners was found to the be culturally sensitive.[58] As a human-centred pedagogy, it should observe teaching approaches that are culturally sensitive and inclusive responding to Aboriginal identity. Teaching is expected to address the whole meaning of holistic learning: the role of the images and imagination as learning tools through unstructured thoughts, images and experiences; tactile, experiential learning; communal, collective learning experience; contextual-specific learning; and a person-centred approach involving family and personal relationships. Hence, teachers and learners should integrate into any health promotion initiative an adequate locus to learn about balance for health promotion.

Kryzanowski and McIntyre have noted that the concept of balance in the Medicine Wheel ignores some of the key recognized social determinants of health;[59] they suggested that their Community Life Indicators be added to the centre of the Wheel to incorporate a wider range of the determinants of health. Their Integrated Life Course and Social Determinants Model of Aboriginal Health includes life stages, and categorizes the determinants of health as proximal, intermediate and distal, according to the level of influence on the individual. Their Holistic Model for the Selection of Indigenous Environmental Assessment Indicators includes an environmental assessment of health, not included in previous models. Within the individual, community, and external context levels of the models, specific indicators for each determinant of Indigenous health can be identified.

Our proposed conceptual framework also highlights the roots of balance from multiple social determinants of health, including geographic location, social support, access to health services, and coping strategies. To adequately address the social determinants of Anishinaabe health, health promotion initiatives for their communities as well as education for health could be envisioned as a form of liberation to overcome a hegemonic, biomedical form of health knowledge. Through educational initiatives connecting both scientific and traditional health knowledge, a holistic health practice is already present in native-focused health centres. Such practice brings together a multidisciplinary team that is made up of traditional and modern science-based healthcare professionals. Anishinaabe communities could further develop their assets to become powerful partners in healthcare planning, delivery and evaluation. Critical awareness could facilitate partnerships in knowledge development following what Freire[1] stated is the ultimate goal of an educational process: the achievement of learners' dreams and goals. Acting on the principle of respect for Aboriginal diversity (e.g., generational differences, differences among various groups including First Nations, Inuit, Métis) could provide opportunities for Aboriginal communities to evaluate and critique their own health issues using their own philosophical lenses, and be the basis for culturally sensitive and meaningful decisions and actions.

The applicability of the proposed framework for Anishinaabe balance for health promotion is corroborated by the positive results from a project which promoted 'living in balance' with a group of youth; those who increased their physical activity and spent less time watching television.[60] The authors concluded that prevention should focus on youth development and empowerment to effect positive developmental outcomes such as improved self-esteem, participatory competence, and enhanced learning outcomes.

Within our framework, health promotion involves strengthening the health potential of Anishinaabe communities to achieve balance by involving those affected, thereby increasing their autonomy.[23] Community- and culturally-based Aboriginal models of care should guide the development of evidence-based practice.[61] Respect for Aboriginal traditional culture and cultural activities sensitizes individuals to loss and protects them from the reminders of loss.[47] Appreciation of Aboriginal cultural and spiritual orientation helps to anchor and ground groups to prevent self-destructive ideation, suicide attempts, and alcohol and substance abuse.

Critical to the process of salutogenesis, as perceived by Aboriginal communities, is recognition of the deleterious effects of colonization (e.g., stereotypes and racism) that compromise the social adjustment and participation of Aboriginal people in our multicultural society.[30] An understanding and awareness of salutogenesis features can lead to effective knowledge for social change and a shift of social attitudes toward reducing social and health inequities.[35]

Contributions to health promotion practice and research

With the intention of assessing the feasibility of the proposed conceptual tools to contribute to health promotion practice, we have presented them at nursing scientific meetings. The framework was also used by MS to guide her professional practice as a diabetes nurse educator for almost 4 years. Use of the framework revealed promising avenues for wider

Table 1: Examples of questions to initiate an emancipating dialogue towards

Examples of situational sense of coherence	Target area: Overcome stereotypes	Target area: Restore sense of belonging	Target area: Develop resilience and adaptive behaviours, balance promotion for health
Example A A newly diagnosed young male adult with type 2 diabetes	•How does the client understand his sacredness in creation, which ensures self-care and the ability to overcome stereotypes of the Aboriginal victim of diabetes? •How does he perceive self-caring as a means to live in balance in all quadrants (e.g., tackling stereotypes)? •To what extent does the current discourse on health disparities within Aboriginal individuals influence his awareness of the strengths required to make needed changes?	•How much importance does the client attribute to his sense of belonging? •Who will help him to feel accepted as part of a new social sub-population of men living with diabetes? •What are the expected or perceived benefits of belonging to social and support networks?	•To what extent does he feel supported to adopt needed lifestyle and diet changes after a diagnosis of diabetes? •How does the client perceive his ability to make the changes needed to live a healthier lifestyle? •What and who would help him to manage glycaemia and promote a good quality of life?
Example B A request for guidance to create a self-help group with female teens to battle sexual violence	•How do the dynamics of the perceived image of sexual violence victims affect family and social relations? •To what extent does the client view the social, political and economic environment as supportive, and what personal changes are required to ensure a balanced way of living? •What are the group's goals with respect to changing the community's perception of their abilities for self-recovery?	•To what extent do the teens see their community reflecting a subculture of sexual violence against Aboriginal women? •How will the teens in the self-help group discuss their issues in the face of disrespect for traditional teachings and values, and create social bonds of protection? •How important is the creation of a self-help group to sustain psychological endurance, personal empowerment, and abilities for self-protection?	•What is the impact of participation in the group on decreasing sexual violence? •How does the perception of empowerment and sharing among Aboriginal women influence teens' adaptability? •How do the teens perceive their ability to make changes needed to live a healthy lifestyle, and in what time frame?
Example C A parents' group to address increasing rates of obesity among toddlers in a rural community	•How do cultural and historical perceptions of health, diet, growth, and weight promote social acceptance of obesity? •How do community members perceive their potential to act on underlying economic barriers to following a traditional diet and prevent childhood obesity? •How has the community accepted child obesity as a result of imbalance in children's development?	•How does the psychological environment of the community enable parents' expression of issues and concerns about childhood obesity? •What are the achievable outcomes of implementing a community project targeting the development of parental networks to counteract historical and economic inequities? •What questions could parents ask of themselves and the community to create the changes required to implement healthy diets throughout pregnancy and childhood?	•Who is deemed to have the power to redress inequities in accessing healthy foods? •How much consensus exists among community members with respect to this assessment? •What are the perceived social determinants of community capacity in managing childhood obesity? •How does the community foresee goal-oriented health intervention to adopt a new lifestyle related to food and exercising? In what time frame?

application and practice guidance. An important feature is how cultural identity is directly linked to the need for healing from historic trauma in the Aboriginal population due to the history of colonialism and dependency on government.[62]

In Table 1, we provide three examples of fictitious clients in

situations related to their sense of coherence (as inspired by Antonovsky's ideas) to show how questions can be derived from application of the model to inspire an emancipating dialogue (according to Freire's ideas) between health educators and Anishinaabe clients (and probably with other Aboriginal clients). The questions are intended to foster clients' awareness about their own plan to achieve multidimensional health (inspired by Anishinaabe philosophies). The questions address the major areas of balance promotion for health within the perspective of a sense of coherence (a main feature in the salutogenesis approach). The resulting dialogue is meant to focus clients' actions on feasible lifestyle choices and plans for change, according to an optimistic but realistic continuum of health.

Use of the proposed conceptual tools is meant to inspire health educators, stakeholders, and communities to explore the qualitative impacts of their incorporation to practice. We recommend process and outcome evaluation studies that will be particularly important to document the underlying philosophies, assess the actual application by clients and professionals, and determine whether and how implementation of this innovative process improves Anishinaabe well-being. Such evaluation is needed for services and programs for health promotion with the Aboriginal population,[63] especially by organizations seeking new solutions to their practice-related problems. The documentation and follow-up of impacts, consequences, and influences provoked by such dialogues in individual and community practices could be the object of studies using a variety of methodological designs.

Furthermore, the conceptual model may be applicable in other countries that are dealing with vulnerable populations such as Aboriginal populations around the globe.[64,65] As in Canada, their vulnerability may be expressed by a high incidence and prevalence of chronic, degenerative diseases in all age groups; compromised adaptation to changes in their social and physical environment; lack of access to societal goods, resulting in exacerbated frustration and increased mental illnesses;[66] and limited opportunities to liberate themselves from negative stereotypes that are related to trans-generational moral and spiritual suffering.[67]

Concluding remarks

The relevance of the concept of balance for health as lived by Anishinaabe may be relevant as well for other Aboriginal populations since it relies on positive social constructions.[68] The basis for healthful balance can be offset by imbalances caused by stereotypes, racism, oppression, or marginalization.[27] To bring innovation to practice through the incorporation of new conceptual frameworks and models targeting education for Anishinaabe health, we should integrate philosophical ideas about freedom to recreate healthy, dignifying life conditions for their communities, especially in dealing with chronic or acute health conditions. We should focus on Anishinaabe strengths to guide reciprocal relations with community and professional stakeholders, and take macroscopic points of view on balance promotion for health. In sum, we argue that balance promotion is a precursor, holistic stage to the achievement of health promotion for Aboriginal individuals and communities, as well as to their education for health as a practice of freedom.[39] The social relevance of such innovation relies on its potential to contribute to new responses to the community health challenges facing by the majority of Aboriginal people who live in Canadian urban areas.[69]

References

1.Freire P. Education for Critical Consciousness. New York: Continuum, 1973.

2.Antonovsky A. Health, Stress and Coping. San Francisco: Jossey Bass, 1979.

3.Mechanic D., Tanner J. Vulnerable people, groups, and populations: Societal view. Health Affairs 2007; 26: 1220-1230.

4.Indigenous and Northern Affairs of Canada. Anishinabek Nation Agreement-in-Principle with Respect to governance. Available from URL: https://www.aadnc-aandc.gc.ca/eng/1309200193324/1309200275975 Accessed 7 July 2016.

5.Turton C. Ways of knowing about health: an Aboriginal perspective. Advances in Nursing Science 1997, 19: 28-36.

6.Indigenous and Northern Affairs of Canada. First Nation community listing, Manitoba region 2012-2013. Available from URL: https://www.aadnc-aandc.gc.ca/eng/1100100020539/1100100020544 Accessed 7 July 2016

7.Adams E. Toward more clarity in terminology: frameworks, theories and models. Journal of Nursing Education 1985, 24: 151-5.

8.Chinn PL, Kramer MK. Integrated Knowledge Development in Nursing. 6th ed. St. Louis: Mosby, 2004.

9.Meleis AI. Theoretical Nursing: Development & Progress. Philadelphia: J. B. Lippincott, 1991.

10.Nieswiadomy RM. Foundations of Nursing Research. Upper Saddle River: Prentice Hall, 2002.

11.Fawcett J, Downs FS. The Relationship of Theory and Research. East Norwalk: Appleton-Century-Crofts, 1986.

12.Fawcett J. Analysis and Evaluation of Conceptual Models in Nursing. 2nd ed. Philadelphia: F. A. Davis, 1989.

13.Moody LE. Advancing Nursing Science Through Research. Vol. 1. Newbury Park: Sage, 1990

14.Le Moigne J.-L. La Modélisation des Systèmes Complexes. Paris: Dunod, 1990.

15.Bruter CP. Sur le formalisme différentiel. In: Thellier, PDM (ed.). Élaboration et Justification des Modèles: Application en Biologie (Vol. I). Paris: Maloine-Doin, 1980; 83-92.

16.Hawes LC. Pragmatics of Analoguing: Theory and Model Construction in Communication. USA: Addison-Wesley, 1975.

17.Willett, G. La modélisation. In: Willett, G. La Communication Modélisée: Une Introduction aux Concepts, Modèles et aux Théories. Ottawa: Éditions du Renouveau Pédagogique, 1992; 24-47.

18.Willett, G. La notion de d'information,. In: Willett, G. La Communication Modélisée: Une Introduction aux Concepts, Modèles et aux Théories. Ottawa: Éditions du Renouveau Pédagogique, 1992; 157-178.

19.Mucchielli A. Dictionnaire des Méthodes Qualitatives en Sciences Humaines et Sociales. Paris: Armand Colin, 1996.

20.World Health Organization. 2007. Health of indigenous peoples. Available from URL: http://www.who.int/mediacentre/factsheets/fs326/en/index.html. Accessed 20 April 2012.

21.Macauly A. Improving aboriginal health: how can healthcare professionals contribute? Canadian Family Physician 2009, 55: 334-336.

22.King M., Smith A., Gracey M. Indigenous health part 2: the underlying causes of the health gap. The Lancet 2009, 274: 76-85.

23.Mundel E., Chapman G. A decolonizing approach to health promotion in Canada: the case of the urban Aboriginal community kitchen garden project. Health Promotion International 2010, 25: 166-173.

24.Lemstra M., Neudorf C. Health disparity in Saskatoon: Analysis to intervention. Saskatoon: Saskatoon Health Region, 2008. Available from URL: http://www.caledoninst.org/Special%20Projects/CG-COP/Docs/HealthDisparityRept-complete.pdf. Accessed 20 April 2012.

25.Health Council of Canada. 2005. The health status of Canada's First Nation, Metis & Inuit Peoples. Available from URL: http://www.healthcouncilcanada.ca/tree/2.03-BkgrdHealthyCdnsENG.pdf. Accessed 10 November 2011.

26.Minore B., Katt M. Aboriginal health care in northern Ontario: Impacts of self-determination and culture. Institute for Research on Public Policy 2007, 13: 1-22.

27.Reading J. 2009. A life course approach to the social determinants of health for Aboriginal peoples. Available from URL: http://www.parl.gc.ca/Content/SEN/Committee/402/popu/rep/appendixAjun09-e.pdf Accessed 20 April 2012.

28.Lavallée LF., Poole JM. Beyond recovery: colonization, health and healing for Indigenous People in Canada. International Journal of Mental Health and Addiction 2010, 8: 271-281.

29.Baskin C. Aboriginal youth talk about structural determinants as the causes of their homelessness. First Peoples Child & Family Welfare Review 2007, 3: 31-42.

30.Browne A., Varcoe C. Critical cultural perspectives and health care involving Aboriginal peoples. Contemporary Nurse 2006, 22: 155-167.

31.Kishk Anaquot Health Research. 2007. Successful indigenous community in Canada. Available from URL: http://fnbc.info/sites/default/files/documents/200706_scott_kim.pdf. Accessed 19 September 2011.

32.Government of Alberta. Understanding health and wellness from the perspective of Aboriginal peoples in Canada. Available from URL: http://www.healthyalberta.com/699.htm. Accessed 19 January 2014.

33.AwoTaan Healing Lodge Society. 2007. Aboriginal frameworks for healing & wellness manual. Available from URL: http://www.awotaan.org/publications/Manuals/Awo_Taan_Manual_FINAL_May_30_2007.pdf. Accessed 14 May 2011.

34.Stewart S. Promoting indigenous mental health: Cultural perspectives on health from Native counsellors in Canada. International Journal of Health Promotion & Education 2008, 46: 12-19.

35.Browne A., Smye V., Varcoe C. The relevance of postcolonial theoretical perspectives to research in Aboriginal health. Canadian Journal of Nursing Research 2005, 37: 16-37.

36.Freire P. Educação e Mudança [Education and Change], 23rd ed. Rio de Janeiro: Paz e Terra, 1991.

37.Antonovsky A. Unravelling the Mystery of Health, How People Manage Stress and Stay Well. San Francisco: Jossey Bass, 1987.

38.Antonovsky A. The salutogenic model as a theory to guide health promotion. Health Promotion International 1996, 11: 11-18.

39.Freire P. Educação como Prática da Liberdade [Education as Practice of Freedom], 23rd ed. Rio de Janeiro: Paz e Terra, 1999.

40.McGregor D. Traditional ecological knowledge: an Anishnabe woman's perspective. Atlantis 2005, 29: 1-10.

41.Berkes F. Sacred Ecology, 2nd ed., New York: Routledge, 2008.

42.Denzin NK, Lincoln YS, Smith LT. Critical and Indigenous pedagogies. In: Denzin NK, Lincoln YS, Smith LT (eds). Handbook of Critical and Indigenous Methodologies. Thousand Oaks: Sage, 2008; 211-215.

43.Grande S. American Indian identity and intellectualism: the quest for a new red pedagogy. International Journal of Qualitative Studies in Education, 13: 343-59.

44.Battiste M. Indigenous knowledge: foundations for First Nations. Available from URL: http://142.25.103.249/integratedplanning/documents/IndegenousKnowledgePaperbyMarieBattistecopy.pdf Accessed July 5 2016.

45.Richmond C., Ross N. Social support of material circumstance and health behaviour: influences on health in First Nation and Inuit communities of Canada. Social Science & Medicine 2008, 67: 1423-1433.

46.Tousignan M., Sioui N. Resilience and Aboriginal communities in crisis: theory and interventions. Journal of Aboriginal Health 2009, 5: 43-61.

47.Fleming J., Ledogar RJ. Resilience and indigenous spirituality: a literature review. Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 2008, 6:47-64.

48.Grande S. Red pedagogy: the un-methodology. In: Denzin NK, Lincoln YS, Smith LT (eds). Handbook of Critical and Indigenous Methodologies. Thousand Oaks: Sage, 2008; 233-254.

49.Giroux HA, Giroux SS. Challenging neoliberalism's new world order: the promise of critical pedagogy. In: Denzin NK, Lincoln YS, Smith LT (eds). Handbook of Critical and Indigenous Methodologies. Thousand Oaks: Sage, 2008; 181-189.

50.Shor I, Freire, P. Medo e Ousadia: O Cotidiano do pProfessor. (Fear and Audacity: The Teacher's Daily Work. Rio de Janeiro: Paz e Terra, 1986.

51.Cyrulnik B, Jorland G. Résilience- Connaissances de Base. Paris: Odile Jacob, 2012.

52.Kirmayer LJ, Sehdev M, Whitley R, Dandeneau, SF, Isaac C. Community resilience: models, metaphors and measures. Journal of Aboriginal Health, 2009, 5: 62-117.

53.Morrow RA., Torres CA. Reading Freire and Habermas: Critical Pedagogy and Transformative Social Change. New York: Teacher College Press, 2002.

54.Lincoln Y, Guba E. Establishing trustworthiness. In: Bryman A, Burgess RG (eds.). Qualitative Research. Vol III. Thousand Oaks: Sage, 1999; 397-444.

55.Creswell JW. Qualitative Inquiry and Research Design: Choosing among Five Traditions. (2nd ed.) Thousand Oaks, CA: Sage, 2007.

56.Miles MB, Huberman AM, Saldaña S. (2014). Qualitative Data Analysis: A Methods Sourcebook (3rd ed.). Thousand Oaks: Sage, 2014.

57.Altheide DL, Johnson JM. Criteria for assessing interpretative validity in qualitative research. In: Denzin NK, Lincoln YS (eds.). Collecting and Interpreting Qualitative Materials. Thousand Oaks: Sage, 1998; 283-312.

58.Main D, Nichol R, Fennell R. Reconciling pedagogy and health sciences to promote Indigenous health. Australian and New Zealand Journal of Public Health, 2000, 24: 211-213.

59.Kryzanowski J., McIntyre L. A holistic model for the selection of environmental assessment indicators to assess the impact of industrialization on indigenous health. Canadian Journal of Public Health 2011, 102: 112-117.

60.Cargo M., Peterson L., Levesque L., Macaulau A. Perceived wholistic health and physical activity in kanien'keh:ka youth. Primatisiwin: A Journal of Aboriginal and Indigenous Community Health 2007, 5: 87-109.

61.Maar MA, Seymour A., Sanderson B., Boesch L. Reaching agreement for an Aboriginal e-health research agenda: the Aboriginal telehealth knowledge circle consensus method. Rural and Remote Health Journal 2010, 10, 1299. Epub 2010 Jan 27.

62.Alfred GT. Colonialism and state dependency. Journal of Aboriginal Health 2009, 5: 42-60.

63.McCalman J., Tsey K., Clifford A., Earles W., Shakeshaft A., Bainbridge R. Applying what works: a systematic search of the transfer and implementation of promising Indigenous Australian health services and programs. BMC Public Health 2012, 12: 1-7.

64.Mikkonen J., Raphael D. 2010. Social determinants of health: the Canadian facts. Available from URL: http://www.thecanadianfacts.org/The_Canadian_Facts.pdf. Accessed 6 March 2013.

65.World Health Organization. 2008. Closing the gap in a generation. Available from URL: http://whqlibdoc.who.int/hq/2008/WHO_IER_CSDH_08.1_eng.pdf. Accessed 20 April 2012.

66.Canadian Health Services Research Foundation. 2012. Harkness Canadian health policy briefing tour backgrounder. Available from URL: http://www.chsrf.ca/Libraries/Harkness/2012HarknessBackgrounder-EN.sflb.ashx Accessed 5 January 2013.

67.World Health Organization. 2010. Equity, social determinants and public health programmes. Available from URL: Http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf. Accessed 20 April 2012.

68.Reading C. Wien F. 2009. Health inequities and social determinants of Aboriginal peoples' health. National Collaborating Centre for Aboriginal Health. Available from URL: http://www.nccah-ccnsa.ca/docs/social%20determinates/NCCAH-Loppie-Wien_Report.pdf. Accessed 20 April 2012.

69.Indigenous and Northern Affairs of Canada. Urban Aboriginal peoples. Available from URL: http://www.aadnc-aandc.gc.ca/eng/1100100014265/1369225120949 Accessed 7 July 2016.

Acknowledgments
Chi Meegwetch to Colin Mousseau, an Anishinaabe healer from Winnipeg, Canada who has been talking to and supporting M. S. throughout the several months while our conceptual work was done. We thank Sylvia Novac for editing an early draft of the manuscript, Zulfikar Adamji for model design, as well as, Lyle W. Frank (Saulteaux Health Centre), and Suman Bavi (Anishnawbe Health Toronto) for providing criticisms that helped to refine the manuscript.

Funding
This work was supported by Ryerson University Faculty of Community Services with a student conference support grant awarded to Melissa Stevenson that allowed her to present the preliminary draft of the conceptual framework and model at the 5th National Community Health Nurses Conference (Halifax, Canada, 2011), and to the multidisciplinary scientific community at Ryerson University Teaching & Learning Conference and York University, School of Nursing 4th Annual Research Day (Toronto, 2011), where the authors were able to 'member check' our framework and model. Publication financial assistance was provided by Ryerson University, Faculty of Community Services Publication Grant awarded to Margareth Zanchetta.

To Contact the Authors:
Margareth Santos Zanchetta, RN, Ph.D.
Associate Professor
Ryerson University
Faculty of Community Services
Daphne Cockwell School of Nursing,
350 Victoria St.
Toronto, ON M5B 2K3
Canada
Email: mzanchet@ryerson.ca

Melissa Stevenson, RN, BScN
Anishnawbe Health Toronto

Vera Nenadovic, RN, NP, PhD
Independent practice
Adjunt Professor
University of Toronto
Lawrence Bloomberg School of Nursing

Michel Perreault, PhD
Université de Montréal
Faculté des sciences infirmières

Carmen James Henry, RN, MSc
Director, Hospital Operations
St Michael's Hospital

Newton Leong, RN, BScN
St Michael's Hospital- Sumac Creek Health Centre

Commentaire/Commentary

Quelques enjeux entourant la prévention des ITSS/VIH/SIDA, tels que vécus lors de recherches doctorales auprès des jeunes des Premières Nations du Québec

SERGE DJOSSA ADOUN

Mise en contexte : nos recherches

La démarche de recherche sur laquelle porte cet article s'inscrit dans le cadre de notre thèse de doctorat en santé communautaire à l'Université Laval. Ce projet de thèse fut motivé par notre sensibilité aux inégalités sociales de santé (ISS) et notre désir de contribuer à leur réduction. Les ISS résultent de l'inégale répartition des facteurs (ou déterminants) sociaux qui influencent la santé des populations. Elles réfèrent aux écarts systématiques qui existent dans l'état de santé des groupes socioéconomiques.[1] Nos travaux visant à contribuer à la réduction des ISS en matière de santé sexuelle et reproductive (SSR) remontent à nos recherches au cycle de maitrise en santé communautaire. Nous avions alors évalué un programme de promotion de la SSR auprès des adolescents et jeunes adultes du Bénin, un pays en développement. La recherche de moyens novateurs pour l'amélioration de l'impact des interventions dans cette population nous a déterminé à nous inscrire aux études doctorales. Toutefois, il était difficile pour nous de trouver un financement pour faire nos recherches terrain au Bénin. Dans le même temps, le programme catalyseur des Instituts de recherche en santé du Canada (IRSC) offrait une opportunité de subvention pour de la recherche communautaire dans le domaine du VIH/SIDA auprès des Autochtones[a]. Le projet de recherche que nos directeurs de thèses et nous avons soumis, en collaboration avec la CSSSPNQL, obtint ladite subvention, ce qui nous amena à changer pour un terrain chez les Premières Nations.

Selon le Centre de recherche sur les inégalités sociales de

santé de Montréal Léa-Roback, les ISS observées au Canada sont relatives au genre, au fait d'être d'origine autochtone, et à l'éducation.[2] La répartition des taux de prévalence de l'infection au VIH/SIDA au Canada présente une grande inégalité entre les différents groupes socioculturels. Bien que représentant seulement que 3,3% de la population totale canadienne, les Autochtones comptaient pour près de 5% à 8% de la prévalence d'infections au VIH et près de 15% des cas incidents.[3,4] De 1998 à 2006, les personnes âgées de 0 à 29 ans représentaient jusqu'à 32,4% de tous les diagnostics de séropositivité chez les Autochtones, comparativement à 21% pour les diagnostics non autochtones.[55 Cette situation souligne la nécessité de développer des interventions pour réduire les inégalités qui existent à cet égard.

La stratégie autochtone sur le VIH/SIDA estime que pour être efficaces, les interventions visant la prévention du VIH/SIDA doivent cibler divers groupes, en particulier les jeunes Autochtones. En ce sens, la familiarité des jeunes générations avec la technologie positionne l'utilisation des technologies de l'information et de la communication (TIC) comme une avenue fortement prometteuse dans le domaine de la prévention des ITSS/VIH/SIDA chez les adolescents et jeunes adultes. Suite à ces constats, notre projet de recherche doctorale s'articulait autour de l'utilisation des TIC pour la prévention des ITSS/VIH/SIDA et la promotion de la santé sexuelle et reproductive auprès des adolescents et jeunes adultes des Premières Nations (PN). Rappelons que les PN sont l'un des groupes de populations qui constituent les Autochtones du Canada[b]. Suivant les objectifs spécifiques de notre projet de thèse, trois phases sont à distinguer, à savoir : une synthèse de connaissances sur les interventions utilisant les TIC pour la promotion de la santé sexuelle, une étude de faisabilité, et une étude des facteurs sous-jacents du port du condom chez des adolescents de 13-18 ans de communautés des PN du Québec.

La revue systématique sur l'efficacité des TIC pour la promotion de la santé sexuelle chez les jeunes est en cours, dont le protocole a été publié.[6] Par la suite, l'étude de faisabilité qui fit l'objet d'un partenariat avec la CSSSPNQL visait à objectiver l'applicabilité des TIC au domaine de la prévention des ITSS et du VIH/SIDA dans le contexte des Premières Nations de Québec. Au cours de cette évaluation de la faisabilité, nous avons, entre autres, documenté les habitudes et préférences des adolescents et jeunes adultes de communautés des Premières Nations du Québec en lien avec les TIC, ainsi que les implications possibles de leur utilisation pour la promotion de la santé sexuelle.[7] Les résultats de ce sondage, ajoutés à l'analyse de contenu des entrevues réalisées auprès de différents acteurs du domaine de la promotion de la santé sexuelle, suggèrent que le contexte actuel des communautés des PN enquêtées est favorable à l'utilisation des TIC pour intervenir auprès des jeunes en vue de la prévention des ITSS/VIH/SIDA.

Au-delà de l'évaluation de faisabilité, le projet avait également pour objectif d'explorer les dimensions fondamentales constituant une intervention basée sur les TIC et visant l'amélioration de la santé sexuelle des adolescents et jeunes adultes des PN. Cela requérait de documenter les facteurs sous-jacents aux déterminants de la santé sexuelle au sein de cette cible particulière afin d'organiser le contenu d'éventuelles interventions. Ce sont ces prérogatives qui justifièrent l'étude de facteurs sous-jacents au port de condom. La conception de la santé sexuelle qui s'est dégagée de l'enquête réalisée auprès de ces jeunes permet de croire que ces derniers seraient réceptifs à des interventions visant la promotion de l'utilisation du condom. À titre d'illustration, les deux énoncés ci-après font partie de ceux les plus mentionnés dans leur définition de la santé sexuelle : «Ne pas avoir d'infections (ITSS, SIDA, etc.)» et «Avoir des relations sexuelles sans crainte d'attraper des maladies».

Dans ce sens, nous avons identifié des croyances saillantes relatives à l'utilisation du condom chez des adolescents et jeunes adultes des PN. Ces croyances pourront être prises en compte lors de l'élaboration d'interventions à l'endroit de cette cible en vue d'une meilleure santé sexuelle.

Telles sont les grandes lignes de la démarche de recherche que nous proposons d'analyser sous les angles politique, méthodologique et éthique.

Enjeux politiques entourant la recherche visant à alimenter le processus d'élaboration d'interventions utilisant les TIC pour la prévention des ITSS/VIH/SIDA chez les jeunes de communautés des PN du Québec.

La recherche avec les Premières Nations

Le contexte de la recherche chez les PN ne peut être abordé en dehors de son histoire. Depuis les premiers contacts des peuples autochtones avec les missionnaires et agents de colonisation européens, les PN ont fait l'objet d'une multitude de recherches, aussi bien pour des fins de gouvernance (par les différents paliers gouvernementaux) que pour des fins académiques, mais très peu de ces recherches peuvent « s'enorgueillir d'avoir consulté les peuples des Premières Nations sur leurs priorité et leurs besoins en termes de recherche » .[8 p12] À ce sujet, l'Énoncé de politique des

trois conseils (EPTC) a reconnu un manque de respect dans ces travaux de recherche, lequel s'expliquerait par le fait que le chercheur provenait d'une culture différente.[8] En effet, ces travaux, qui n'étaient pas nécessairement bénéfiques aux peuples ou communautés autochtones, ont été principalement été définis et réalisés par des chercheurs non autochtones, utilisant des méthodes qui ne prenaient généralement pas compte de la conception du monde par les Autochtones.[9] Au nombre des auteurs qui se sont intéressés à l'analyse historique de la relation de recherche autochtone-allochtone, Lachapelle et Puana ont relevé un héritage culturel colonial ethnocentrique et discriminatoire.[10] Par ailleurs, nombre des travaux antérieurs d'anthropologues, de sociologues et d'ethnohistoriens ont eu des répercussions politiques et identitaires néfastes pour des Nations Autochtones.[11] Dans cette relation historique communauté-recherche où les populations des PN constituaient le plus souvent des objets d'étude, de nombreuses plaintes et préoccupations ont été enregistrées au sein des différentes communautés. À ce propos, voici quelques exemples de commentaires répertoriés dans le Protocole de recherche des Premières Nations du Québec et du Labrador[12]: «- Les Premières Nations firent l'objet de trop nombreuses recherches ; - Les chercheurs choisirent des thématiques représentant un intérêt personnel, théorique ou d'intérêt pour la société en général, sans se préoccuper des priorités des Autochtones ; - Les gouvernements et les chercheurs analysèrent et interprétèrent des données sur les Premières Nations et produisirent des rapports sans obtenir le consentement, l'autorisation, l'examen ou les commentaires des représentants des Premières Nations ; - La recherche ne respecta pas la dignité humaine fondamentale des participants ou leurs croyances religieuses, spirituelles ou culturelles ; - Des chercheurs firent preuve d'irresponsabilité en dramatisant les problèmes existant au sein des Premières Nations, sans égard à l'impact sur les communautés ou aux intérêts sociaux et politiques de ces dernières ; etc.».[p13] Face à cette situation, l'Assemblée des Premières Nations du Québec et du Labrador (APNQL) a affiché sa position à travers le développement d'un protocole de recherche pour encadrer les activités de recherche sur les territoires des PN.

S'il est vrai que, historiquement, des recherches menées en milieu autochtone ont contribué aux dynamiques coloniales, d'autres, par contre, ont contribué à l'émancipation de la parole PN. Plusieurs chercheurs se sont inscrits dans une perspective post colonialiste et ont contribué à l'émancipation des peuples autochtones, comme c'est le cas dans le Réseau DIALOG. Au cours d'une entrevue[c] où elle relatait les circonstances dans lesquelles naquit DIALOG, la directrice du Réseau, Carole Lévesque, expliquait comment la Commission royale sur les peuples autochtones[d] changea fondamentalement le domaine de la recherche relative aux Autochtones. Selon Madame Lévesque, cette commission favorisa la prise de parole par les Autochtones, une plus grande ouverture des Autochtones à l'académie et aux études supérieures, ainsi qu'une augmentation de l'intérêt pour la recherche relative aux Autochtones. Il s'en suivit de nouvelles orientations dans de ce domaine avec l'implication de plus en plus active de chercheurs Autochtones. Ces changements socio-structurels constituèrent un terreau fertile où germa l'initiative DIALOG qui se voulait un espace commun de rencontre des acteurs de la recherche – étudiants, chercheurs, partenaires autochtones – mais qui visait d'abord à créer un dialogue entre ces acteurs autour de la recherche et de la connaissance.

Créé en 2001 et ancré à l'Institut de la recherche scientifique, DIALOG réunit plus de cent cinquante personnes issues du milieu universitaire et du milieu autochtone et à l'œuvre au Québec, au Canada, dans les Amériques, en Océanie, en Europe et en Asie, et partageant l'objectif de mettre en valeur, de diffuser et de renouveler la recherche relative aux peuples autochtones. Pour se faire, le Réseau DIALOG s'est donné pour mandat, entre autres, de « développer une meilleure compréhension des réalités historiques, sociales, culturelles, économiques et politiques du monde autochtone, des enjeux contemporains et des relations entre Autochtones et non-Autochtones en misant sur la co-construction des connaissances et en favorisant la prise en compte des besoins, perspectives et approches des Autochtones en matière de recherche et de politiques publiques ».[13]

Des lignes directrices ont été élaborées dans le but de « protéger les communautés, les générations futures ainsi que les ressources environnementales, culturelles et humaines » .[8 p22] Le protocole de recherche des PN se veut un guide de référence visant à « promouvoir une recherche éthique précise et bien informée, dont le déroulement respecte la volonté des PN impliquées » .[8 p5] L'APNQL postule ici que les communautés des PN devraient s'impliquer davantage dans les recherches en participant activement au développement de ses objectifs et finalités. L'une des approches suggérée pour y parvenir est l'établissement de partenariat de recherche. Le partenariat est conçu ici comme une démarche dynamique de répartition éclairée, souple et négociée du pouvoir entre les parties prenantes, ce qui nécessite une collaboration et une consultation constantes et continues.[12] L'APNQL estime qu'une bonne entente se met en place entre une communauté et des chercheurs

lorsqu'elle promeut une collaboration au sein d'un cadre de travail favorisant la confiance mutuelle et la coopération. Pour ce faire, les chercheurs sont appelés à travailler avec les membres de la communauté dès les premières étapes de la planification de leurs propositions de recherche.

Le cadre théorique – l'Intervention Mapping de Bartholomew et col.[14][e] - adopté pour la conduite de nos travaux de doctorat met de l'avant l'implication des parties prenantes comme étant une étape primordiale de la mise sur pied d'une intervention qui se veut efficace dans le domaine de la promotion de la santé. Aussi, suite à leur expérience avec le Kahnawake Schools Diabetes Prevention Project au Canada, des chercheurs ont élaboré quatre principes devant servir de fondement pour l'établissement d'une bonne relation de recherche avec des communautés autochtones. Le premier de ces principes, celui duquel découlent les autres, stipule l'intégration des membres des communautés autochtones comme partenaires, d'égal à égal avec les autres chercheurs (universitaires ou autres), à chaque étape de la recherche (integration of community people and researchers as equal partners in every phase of the project).[14] Il apparait donc clairement qu'au-delà de l'importance d'une problématique et de la pertinence de s'y pencher, d'autres paramètres sont requis pour enclencher une démarche de recherche avec des communautés des PN. Dans le cas du présent projet, il a fallu confronter l'objet de recherche aux problématiques prioritaires des PN en matière de santé puis proposer un plan partenarial pour la conduite de la recherche.

Mise en place d'un partenariat de recherche

Un bon partenariat de recherche engendre la confiance et le respect mutuel, deux éléments indispensables à la mise en place de conditions propices à une recherche participative susceptible de produire de multiples retombées. La recherche participative est une approche systématique de production de connaissances scientifiques qui consiste en l'engagement dans la conception et la conduite de la recherche des acteurs concernés par l'objet de recherche.[15] Les types d'acteurs et d'engagements peuvent varier dépendamment des relations de chaque acteur ou groupe d'acteurs avec l'objet de recherche. Construire un espace participatif adéquat nécessite de répondre aux questions relatives à l'étendue de la participation (qui participe ?), à l'ampleur de la participation (à quelles étapes de production de la recherche ?), ainsi qu'au degré d'engagement (qui contrôle la décision ?) dans la recherche.[15]

La Commission de santé et des services sociaux des Premières Nations du Québec et du Labrador (CSSSPNQL) fut le principal acteur de ce processus participatif. C'est avec ce partenaire que chaque décision fut négociée à toutes les étapes de notre démarche.

L'importance de la problématique des ITSS/VIH/SIDA pour les communautés des PN du Québec a amené la CSSSPNQL à adhérer à notre projet de recherche. En effet, l'organisme ayant identifié clairement les ITSS/VIH/SIDA, comme problématique de santé prioritaire dans le Plan directeur de la santé et des services sociaux des Premières Nations du Québec 2007-2017.[16] L'intérêt de la CSSSPNQL pour le projet proposé résidait aussi dans le fait que l'organisme travaillait depuis quelques temps à mettre sur pied un cadre stratégique pour le développement de la télémédecine et la santé électronique. Enfin, la CSSSPNQL trouvait dans ce projet l'occasion d'ouvrir éventuellement sur d'autres interventions de promotion de santé utilisant les TIC pour aborder d'autres problématiques que la santé sexuelle. De plus, la pertinence de la démarche projetée pour la recherche, la clarté et la teneur de notre offre de collaboration et le fait que la demande de partenarial conséquent passait par les canaux de la CSSSPNQL – posture d'autorité – a facilité la mise en place d'un espace participatif favorable à notre recherche.

Une première ébauche de projet de recherche fut acheminée à la direction de la CSSSPNQL. Cette ébauche était accompagnée d'une lettre explicative des intentions de notre équipe ainsi que les retombées potentielles du projet pour la CSSSPNQL et, par la suite, pour les communautés des Premières Nations. La CSSSPNQL était ainsi un acteur incontournable avec lequel il fallait composer pour peaufiner le projet de recherche, du fait de sa connaissance du milieu et de ses expériences de recherches avec les communautés. Ainsi, il y avait été mentionné clairement que le contenu de l'ébauche de projet n'était constitué que des idées que nous avions lancées et que les choix méthodologiques ainsi que la mise en œuvre du projet étaient à discuter avec la CSSSPNQL. Cette ébauche indiquait également combien la démarche projetée se conformerait au Protocole de recherche des PN. Nous avions enfin souligné notre engagement à faire en sorte que le projet ne vienne pas surcharger l'agenda ni bousculer le bon déroulement des activités habituelles de l'organisme. À l'issue de nos premières rencontres, plusieurs aspects du partenariat naissant furent discutés : la participation de chacun des acteurs en présence ainsi que les investissements en termes de temps, de finance et de matériel à chaque étape du projet, etc. En gros, la CSSSPNQL voulait bien du partenariat et du projet qui se développait tant que le temps et les ressources matérielles (et éventuellement financières) que

cela nécessiterait ne bousculent pas le cahier de charge de son personnel. Par ailleurs, il était aussi clair que l'aventure se poursuivrait seulement si le financement que nous visions pour la conduite du projet était accordé. Le projet développé à travers ce partenariat a obtenu le financement des Instituts de recherche en santé du Canada, dans le cadre du concours de l'automne 2010 de la Subvention catalyseur-VIH/sida (recherche communautaire).

Nous avons sélectionné conjointement avec la CSSSPNQL deux communautés pour la phase terrain du projet. La CSSSPNQL a joué un rôle capital dans l'établissement des contacts et dans le maintien des communications avec les acteurs communautaire des communautés retenues.

En somme, la démarche que nous avons adoptée dans notre recherche rejoignait l'approche partenariale mise de l'avant par l'APNQL. Elle met dans une telle collaboration une association d'égal à égal entre individus aux expertises et connaissances complémentaires, basée sur le respect mutuel et le partage des responsabilités en vue de résultats satisfaisants pour tous les partenaires. Toutefois, il a été facile de constater que le partenariat établi avec la CSSSPNQL était loin d'être une relation d'égal à égal, tel que expérimentée et aussi recommandée par collaborateurs.[15] Dans le cas du Kahnawake Schools Diabetes Prevention, l'on a assisté la mise en place d'une telle relation de travail où les intérêts spécifiques des acteurs en présence furent discutés et modulés. Ainsi, la partie universitaire a ainsi pu clairement exprimer ses attentes et mettre certaines balises dès le début du partenariat. Dans notre cas, la CSSSPNQL accepta notre projet du fait que notre objet de recherche s'inscrivait dans les priorités de sa planification stratégique. De ce fait, les résultats qui découleraient de nos travaux contribueraient aux réflexions de la CSSSPNQL. Nous avions à cœur la réalisation de nos travaux de recherche dans le respect des communautés des PN concernées, tout en prenant en compte leurs priorités. De plus, notre condition particulière d'étudiant étranger inscrit au cycle doctoral, avec des capacités financières précaires, ajoutée à notre innocente ambition de contribuer à la réduction des ISS en matière de SSR, nous plaçait en posture de dominé face à la CSSSPNQL. A ce stade de notre démarche, nous avions sous-estimé les répercussions potentielles d'une telle attitude sur le déroulement du projet, tel que nous le discuterons dans les enjeux méthodologiques.

Enjeux méthodologiques

L'APNQL accorde une importance capitale à la co-organisation de la recherche avec des acteurs des PN parce qu'elle considère la collecte de l'information et son utilisation ultérieure comme intrinsèquement politiques, dans le sens où elles représentent les principales sources de pouvoir et de contrôle.[12] La recherche participative mise de l'avant dans le protocole de recherche de l'APNQL faisait écho à l'approche partenariale que nous désirions adopter dans notre projet. L'APNQL conçoit la recherche participative comme un processus de production de connaissances au moyen d'une enquête systématique conjointe, en collaboration avec des individus spécifiquement touchés par les thématiques à l'étude.[12]

Une fois le principe et les différents aspects du partenariat établis avec la CSSSPNQL, les rencontres et échanges qui suivirent ont permis de confronter la problématique de santé sexuelle ciblée aux priorités des PN dans ce domaine afin de préciser l'orientation de notre recherche. Les choix méthodologiques ont été discutés avec les collaborateurs désignés par la CSSSPNQL. Par la suite, les outils de collecte de données élaborés en collaboration avec la CSSSPNQL ont été révisés, par les acteurs communautaires associés, notamment le directeur/la directrice à la santé et les intervenants du domaine de la santé sexuelle.

Au cours du processus de planification de la collecte de données, la collaboration avec la CSSSPNQL et nos partenaires communautaires nous permit d'anticiper la nécessité de personne-ressources pour recruter les adolescents et les jeunes adultes. L'identification de personne-ressources constituait un véritable défi, considérant le sujet à l'étude et population ciblée. Il s'agissait de trouver une personne crédible et reconnue des participants potentiels pour qu'elle puisse inviter ces derniers à discuter des questions sur la sexualité avec des membres de l'équipe de recherche. L'identification de personne-ressources dans les communautés a été possible grâce à l'implication de nos partenaires des milieux, les directions de santé et les directions des écoles secondaires.

Ainsi, l'approche partenariale adoptée dès le début de notre démarche a favorisé la participation active d'acteurs clés des PN, de même qu'elle a permis de veiller à la conformité des aspects méthodologiques de notre démarche avec le protocole de recherche des PN du Québec et du Labrador. Notre méthodologie de recherche a été élaborée en collaboration avec la CSSSPNQL. Notre partenariat s'est ensuite étendu à l'échelle communautaire. À ce niveau, nous avons premièrement associé les directions de santé de chacune des communautés participantes afin de valider avec elle notre approche méthodologique et réviser nos outils de collecte de données. Une fois, la méthodologie peaufinée,

nous avons soumis le projet de recherche aux Chefs de conseil de bande. Ceci a été fait par l'entremise d'un protocole d'entente lequel, une fois signé par l'ensemble des partenaires, légitimait le déroulement de nos activités de recherche dans chacune des communautés. Enfin, puisque la population à l'étude était constituée d'étudiants de niveau secondaire, les directions des écoles secondaires furent également associées au projet pour qu'elles puissent, entre autres, nous supporter dans l'organisation de la collecte de données.

Répercussions du "type" de partenariat établi avec la CSSSPNQL

À postériori, nous estimons que le partenariat établi avec la CSSSPNQL occulta une dimension importante, à savoir que cette recherche s'inscrivait dans un projet de thèse doctorale. En effet, nous avions un statut d'étudiant étranger inscrit au programme de doctorat en santé communautaire à l'Université Laval, un programme de trois ans d'études, avec une capacité financière limitée et donc convaincu de la nécessité de finaliser dans des délais raisonnables un processus menant à un diplôme. L'objet de cette recherche partenariale avec les PN s'inscrivait au cœur de notre thèse. L'analyse de notre parcours doctoral, entrepris dans une démarche collaborative, nous porte à croire, aujourd'hui, que notre appartenance au monde universitaire, et donc à ses obligations, n'a pas été réellement prise en compte par les acteurs clefs de la CSSSPNQL.

D'abord, au stade de la définition des objectifs du projet, il apparaissait clairement que nos visées, en tant qu'étudiant-chercheur, ne concordaient pas exactement avec les attentes (en termes de retombées) des acteurs communautaires. En effet, pour un doctorant, la production et la diffusion de connaissances scientifiques sont un point important. Dans ce sens, il était crucial que l'orientation donnée au projet soit justifiée et documentée, afin d'assurer au projet une certaine reconnaissance scientifique. La CSSSPNQL s'attendait plutôt à une intervention rapide auprès de la population cible par le biais des TIC pour améliorer la santé sexuelle. Plusieurs reformulations furent faites afin d'en arriver à une orientation du protocole de recherche qui répondait tant aux exigences académiques qu'aux préoccupations de nos partenaires. Le but ultime de notre travail était désormais la formulation de recommandations pour l'élaboration d'intervention utilisant les TIC basée sur les données probantes et adaptée au contexte des communautés des PN en vue de l'amélioration de la santé sexuelle chez les adolescents et jeunes adultes.

Bien que notre statut d'étudiant au doctorat ainsi que nos attentes furent clairement explicités dès le départ, la CSSSPNQL aura maintenu sa position. Une telle attitude pourrait se comprendre aisément quand on considère ce qui a été mentionné lors de nos discussions par un de nos interlocuteurs de la CSSSPNQL : « Notre mandat est de travailler pour l'amélioration de la santé des Premières Nations, et non de servir la cause universitaire ». Ainsi, le partenariat était acceptable tant et aussi longtemps que nos activités ne bousculaient pas l'agenda de la CSSSPNQL. Ceci constitua un enjeu majeur à chaque étape du projet : rencontres avec les collaborateurs PN, élaboration de la méthodologie, révision des outils de collectes de données, organisation de la collecte d'information dans les communautés, etc.

Si la posture de la CSSSPNQL en regard de la recherche se comprend politiquement, n'occulte-t-elle pas de grands pans de l'histoire et des dernières avancées dans le domaine (avec le Réseau DIALOG, l'expérience de Kanawaké, etc.)? Par ailleurs, une telle posture ne va-t-elle pas à l'encontre des principes d'un partenariat d'égal à égal aussi mis de l'avant par l'APNQL?

Avec notre profil, décrit un peu plus tôt, d'étudiant étranger – et doublement étranger en territoire autochtone – nous nous retrouvions en situation d'assujettissement et dans l'impossibilité de réagir outre mesure, au risque de compromettre la poursuite du projet. L'aboutissement du projet nous tenait aussi à cœur, car nous croyions en son potentiel de contribuer à la réduction des inégalités sociales de santé présentes chez les peuples autochtones en matière de santé sexuelle et reproductive.

Ces différents aspects du partenariat nous imposèrent de suivre le rythme des PN (CSSSPNQL et acteurs communautaires) dans le déploiement du projet. Réussir à concilier ce rythme avec le calendrier et les exigences universitaires constituait un grand défi. Il a fallu user d'une aptitude constante à s'ajuster afin d'accélérer dans les travaux quand il y a une ouverture sur le terrain et s'occuper à autre chose lorsque la cadence ralentit.

Enjeux éthiques

Le partenariat entre la CSSSPNQL (et les acteurs communautaires associés) et l'équipe de chercheurs de l'Université Laval visaient à mettre à contribution dans une même démarche de recherche des acteurs aux expertises variées afin d'obtenir des résultats potentiellement utilisables dans la lutte contre le VIH/SIDA et dans l'amélioration de la santé sexuelle et reproductive des jeunes des PN. Le projet

mis sur pied à travers ce partenariat fait aussi partie d'une recherche doctorale, ce qui implique l'observance d'un certain nombre prérogatives universitaires comme les règles et procédures éthiques de la recherche.

La "divergence" entre les visions éthiques

Les principes directeurs des PN pour la recherche postulent que le code d'éthique de chacune des Premières Nations doit être pris en considération afin d'assurer la pertinence du processus de collecte de données et son harmonisation à la réalité et au contexte de la communauté concernée.[12] À cet égard, il est important de souligner que l'implication plus active d'acteurs du secteur de la recherche de la CSSSPNQL dans l'élaboration de la méthodologie de notre projet de recherche visait à favoriser l'application du protocole de recherche des Premières Nations à chaque étape de la démarche. C'est dire que les considérations éthiques étaient présentes dès les premiers instants du processus d'élaboration de ce projet. Ce point a d'ailleurs été positivement apprécié par le Comité d'éthique de la recherche de l'Université Laval (CÉRUL). Les difficultés rencontrées dans l'obtention de l'approbation du CÉRUL étaient essentiellement relatives à la forme des documents soumis. En effet, le CÉRUL propose des modèles de formulaire de consentement différents de ceux adoptés par le secteur de la recherche de la CSSSPNQL.

Le protocole de recherche de l'APNQL reconnaît que lorsque divers groupes collaborent sur un même projet, il peut y avoir des problèmes de gestion et de compatibilité en ce qui concerne les aspects éthiques. Lorsque de telles situations surviennent, l'APNQL recommande que les acteurs en jeu établissent un dialogue afin de parvenir à un consensus.[12] En se basant sur ses expériences passées en matière de recherche avec les PN, la CSSSPNQL insistait pour que les formulaires de consentement soient présentés suivant un modèle auquel les PN auraient été habituées. Cette situation avait créé une certaine impasse, car le modèle de la CSSSPNQL était différent de celui du CÉRUL qui devrait donner l'approbation requise pour les recherches réalisées par chercheurs de l'Université Laval. Pour dissiper cette divergence (plutôt apparente), la partie universitaire a suggéré à la CSSSPNQL d'adresser une correspondance au CÉRUL pour appuyer certaines modifications dans la présentation des formulaires de consentement. En effet, en termes de contenu, l'APNQL et l'Université Laval se rejoignaient en ce qui concerne les considérations éthiques relatives au consentement éclairé des individus participants à la recherche. Les préoccupations éthiques mises de l'avant par le CERUL et l'APNQL trouvent leur fondement dans les trois principes directeurs qui sous-tendent le cadre éthique élaboré dans l'Énoncé de politique des trois conseils (EPTC), à savoir : - le respect des personnes ; - la préoccupation pour le bienêtre ; - la justice.[10] Fondé sur des normes éthiques reconnues à l'échelle internationale, l'EPTC se veut un guide pour encadrer la recherche réalisée par les chercheurs canadiens avec des êtres humains au Canada ou à l'étranger.[9]

Enjeux liés aux particularités de la population à l'étude

L'autre point important que nous désirons discuter dans ce volet éthique concerne l'obtention du consentement parental pour les répondants mineurs désireux de participer à l'étude. Notre démarche de recherche prévoyait deux "contacts" avec les adolescents et les jeunes adultes des communautés participantes. Au premier contact, les participants étaient invités compléter un sondage électronique visant à documenter leurs habitudes et préférences en termes d'utilisation des technologies de l'information et de la communication. La participation au sondage était volontaire. Aucune donnée personnelle (exemple : nom, coordonnées) ne fut recueillie. Le simple fait d'accepter de compléter le questionnaire était considéré comme l'expression du consentement.

La deuxième phase de ce processus avait pour but d'étudier les facteurs sous-jacents à un comportement relatif à la santé sexuelle, en l'occurrence le port de condom, chez les sujets participants. Cette autre étape requérait un consentement formel des participants âgés de 18 ans, et l'autorisation des parents pour les personnes mineures. Cette dernière catégorie constituait la majorité de note clientèle cible. Entre ces deux phases, le taux de participation diminua de 61%, malgré tous les efforts déployés.

En effet, pour nous assurer la réussite de la deuxième phase de collecte de données, et suivant les recommandations des partenaires, une personne-ressource fut mise à notre disposition par l'école secondaire de la première communauté participante afin de nous supporter dans la préparation et la réalisation de terrain. Notre arrivée à l'école fut annoncée aux étudiants la semaine précédant notre arrivée, et le but de l'étude leur fut présenté. De même, un horaire fut établi avec les enseignants afin de faciliter le déroulement de la collecte. A notre arrivée, nous avons rencontré, en classe, tous les étudiants. Notre équipe leur rappela la pertinence, le but et les retombées de l'étude. Nous leur avons signifié notre disponibilité à répondre aux questions. Par la suite, les formulaires de consentement et des feuillets d'information furent distribués à tous les étudiants ayant manifesté un intérêt à participer. Il fut clairement énoncé que les étudiants

de moins de 16 ans devaient faire signer le formulaire par un de leur partent et le rapporter en classe le lendemain.

Le lendemain, l'équipe retourna dans chacune des classes afin de recueillir les formulaires de consentement signé. Notre planification fut fortement ébranlée en constatant que moins de 5% des formulaires fut retourné. La rigueur, la complexité, les structures et processus des instances éthiques de notre institution universitaires, considérant les réalités prévalant dans les communautés ciblées par notre recherche nous sont apparus en profonde dissonance. Cela occasionnait de nouveaux délais à notre démarche doctorale qui dépassait déjà largement notre planification initiale. Il fallait absolument envisager une solution. En effet, ce volet de notre recherche était important pour identifier des pistes d'intervention tirées des réponses (basées sur des expériences réelles) des adolescents et jeunes adultes concernés. Avec l'agent de planification chargé du programme VIH/SIDA au niveau de la CSSSPNQL qui constituait notre coéquipier sur le terrain, nous avons dû entreprendre une réflexion rapide pour arriver à une décision. Nous avons alors annoncé aux étudiants qu'ils pouvaient compléter le questionnaire, s'ils désiraient participer. Toutefois, si et seulement si nous recevions le formulaire signé par un de leur parent, nous serions en mesure de considérer leur questionnaire complété. Nous avons invité les répondants concernés à inscrire à l'endos de leur questionnaire un signe qu'il serait en mesure de reconnaître puisque leur nom n'était pas inscrit sur le feuillet. En nous rapportant le formulaire signé par leur parent le répondant serait invité à identifier son questionnaire complété à l'aide du signe inscrit à l'endos. Nous avons fait diffuser des messages de rappel à la pause-midi et à la fin de la journée, ainsi que les trois jours suivants, en mentionnant chaque fois notre incitatif (prix de participation à faire tirer parmi les répondants). À la fin de cette période, le nombre total de répondants ne dépassait pas les 40% du bassin de participants potentiels.

Ce taux était évidemment en-dessous de ce que nous espérions. Dans le but d'obtenir une meilleure participation dans la deuxième communauté, nous avons entrepris d'envoyer les formulaires de consentement la semaine précédant notre arrivée à l'école secondaire. Ceci, pensions-nous, donnerait plus de temps aux étudiants (mineurs) pour obtenir le consentement parental. Cependant, cette initiative et l'annonce et les multiples rappels par la personne-ressource n'ont pas réussi à produire un meilleur taux de participation.

Ces résultats ne semblaient pas surprendre nos collaborateurs du secteur de la recherche de la CSSSPNQL qui ont eu des taux de participation relativement semblables (voir plus bas) dans une étude récemment menée sur les comportements sexuels dans huit communautés des Premières Nations du Québec, dont les deux retenues pour notre projet. Cette situation impose des limites à notre étude et soulève d'importants questionnements quant à la portée de nos résultats. Quel poids auraient les résultats obtenus dans notre démarche quand on considère qu'ils sont destinés à alimenter un processus d'élaboration d'intervention ?

Ces constatations réalisées au cours de notre démarche nous portent à croire que de sérieuses réflexions devraient être menées au sujet des aspects éthiques de la recherche faite auprès des adolescents de communautés des Premières Nations du Québec. Dans notre cas, environ 60% des répondants potentiels de moins de 18 ans n'ont pu participer à l'étude faute de consentement par leur parent. Cet état des choses soulève quelques questionnements auxquels il serait important que de futures recherches s'intéressent :

-Les jeunes ont-ils oublié ou volontairement omis de présenter les formulaires de consentement à leurs parents ?

-Était-il inconfortable pour eux d'aborder le sujet avec leurs parents ?

-L'attitude des jeunes avait-elle quelque chose à voir avec un quelconque tabou autour de la sexualité ?

-Les parents ont-ils refusé de signer le formulaire de consentement ?

-Les parents ont-ils refusé aux jeunes de participer à l'étude du fait du sujet de la sexualité ?

-Pourrait-il s'agir d'un désintérêt parental concernant la vie scolaire de leur jeune?

-Cette attitude des parents est-elle un symptôme des «abus» attribués par les organisations des PN au monde de la recherche?

Dans une étude portant sur l'utilisation de condom chez les adolescents ruraux sexuellement actifs d'école secondaire, l'approche adoptée constituait à envoyer aux parents par courrier l'information concernant la recherche en leur donnant l'opportunité de restreindre la participation de leur enfant, s'ils le désiraient.[17] Toutefois, cette approche peut-elle s'appliquer dans des recherches universitaires ? Dans quelles mesures le « qui ne dit rien, consent » est-il vraiment éthique dans un contexte comme celui des PN? Quelles autres alternatives les étudiant-chercheurs ont-ils pour répondre aux exigences reliées à la recherche académique et aux règles éthiques qui régissent la recherche auprès des PN,

tout en tenant compte de la réalité que constitue le contexte socio-culturel des jeunes des communautés autochtones ?

Selon des données recueillies récemment dans dix communautés des PN du Québec, incluant les communautés participant à notre étude, auprès de 179 jeunes de 12 à 18 ans fréquentant des écoles secondaires, 11,3 % des jeunes de 12 à 14 ans, 51,7 % des 15-17 ans et 75,7 % des 18-20 ans ont déclaré avoir eu des relations sexuelles au cours des douze derniers mois (18). Ceci démontre qu'une forte proportion des adolescents des communautés enquêtées est sexuellement active. Or, faute de consentement parental, plusieurs d'entre eux n'ont pu partager leurs opinions en regard de la sexualité notamment concernant l'utilisation du condom afin d'éclairer d'éventuelle élaboration de programme de promotion concernant la santé sexuelle et la prévention des ITSS/VIH/SIDA.

L'éthique est-elle toujours éthique lorsqu'elle fait obstacle à la recherche et à l'intervention auprès d'une population à risque ? En effet, les données rapportées ci-dessus démontrent que les adolescents et jeunes adultes des communautés des PN s'exposent à des risques élevés en matière de SSR. Notre projet visant à produire des données pouvant alimenter le processus de mise sur pied d'intervention pour la prévention d'ITSS et la promotion de la SSR aura été limité pour des considérations éthiques totalement dissociées des réalités du terrain, surtout, vu toutes les préoccupations éthiques et les mesures que nous avons prises pour assurer l'anonymat des participants et la confidentialité de leurs réponses.

Plusieurs autres questions méritent d'être soulevées, notamment en lien avec :

-la pertinence des recherches qui sont – pratiquement toujours – pensées et élaborées à l'extérieur des communautés ;

-le fait que les experts problématisent des situations et des réalités qui, localement, ne sont pas considérées comme des problèmes ;

-le grand nombre de recherches faites chez les PN, leur validité, leur portée.

Nous soulevons ici de nombreuses questions sans pour autant apporter de réponses. Toutefois, nous estimons important de réfléchir et de débattre avec ouverture et respect autour de ces questionnements dans l'intérêt de l'avancement des connaissances et, du coup, de l'amélioration du bien-être des populations.

Conclusion

Les ITSS/VIH/SIDA constituent une problématique de santé réelle et prioritaire pour les PN du Québec. Toutefois, ce n'est pas suffisant de mettre en évidence leur plus forte prévalence au sein de la population autochtone du Canada. Des actions plus concrètes sont nécessaires pour alléger le fardeau des ITSS et du VIH/SIDA pour les communautés autochtones. Dans ce sens, la recherche partenariale apparaît comme une approche pouvant habiliter ces communautés à lutter plus efficacement contre les ITSS/VIH/SIDA et contribuer à la réduction des inégalités en lien avec la santé sexuelle et reproductive. Au cours des recherches présentées dans cet article, notre équipe a rencontré plusieurs défis qu'il n'aurait pas été possible de relever sans le soutien de la CSSSPNQL et la collaboration des communautés des PN concernées. Toutefois, nous estimons que cette collaboration aurait donné lieu à des expériences plus conviviales, plus enrichissantes et certainement plus fructueuses si elle était fondée sur un partenariat plus balancé. Éviter l'instrumentalisation de la recherche et de l'intervention en santé à des fins politiques favoriserait la mise en œuvre, chez les PN, d'action plus susceptible d'améliorer la santé des populations aux prises avec des problématiques sérieuses de santé (santé sexuelle et reproductive, en l'occurrence). De même, les considérations éthiques entourant la recherche dans ce domaine méritent encore une réflexion profonde pour éviter qu'elles constituent un obstacle à la mise sur pied d'interventions fondées sur des données probantes en vue de la prévention des ITSS/VIH/SIDA et la promotion de la santé sexuelle auprès des adolescents.

Footnotes

[a] Le terme « autochtone » réfère, au sens de l'article 35 de la Loi constitutionnelle du Canada, à l'ensemble des premiers habitants du Canada ainsi que leurs descendants et comprend trois groupes : les Premières Nations, les Métis et les Inuits. Cette définition est celle utilisée par l'Assemblée des Premières Nations et par la CSSSPNQL.

[b] La définition retenue pour « Premières Nations » est l'ensemble des indigènes du Canada qui ne sont ni Inuits, ni Métis. Cette définition est celle utilisée par l'Assemblée des Premières Nations et par la CSSSPNQL.

[c] Entrevue avec Carole Lévesque du réseau DIALOG. Entrevue réalisée par Bernard Roy, PhD, professeur agrégé, Faculté des Sciences Infirmières, Université Laval.

[d] La Commission royale sur les peuples autochtones aussi connue sous le nom de Commission Erasmus-Dussault est une commission royale d'enquête mise sur pied par le Parlement du Canada le 26 août 1991. Les 16 paramètres de

la commission sont élaborés à partir du rapport commandé par le gouvernement à l'ancien juge en chef Brian Dickson à la suite de la Crise d'Oka survenue au Québec à l'été de 1990. (Wikipedia)

[e] Bartholomew L, Parcel G, kok G, Gottlieb N, Fernandez M. Planning health promotion programs: an Intervention Mapping approach. Third Edition ed: Jossey-Bass; 2011.

Référence

1.Le Blanc M-F, Raynault M-F, Lessard R. Rapport du directeur de santé publique 2011. Les inégalités sociales de la santé à Montréal: Le chemin parcouru. 2e édition: Direction de santé publique

Agence de la santé et des services sociaux de Montréal2012.

2.Léa-Roback C. Les inégalités sociales de santé : Qu'est-ce que c'est ? 2007; Available from: http://www.centrelearoback.ca/coup_d_oeil.

3.Agence de la santé publique du Canada. Le point sur la pandémie de VIH/sida. 2005 [cited 2011 october, 18th]; Available from: http://www.phac-aspc.gc.ca/media/nr-rp/2005/2005_1bk2-fra.php.

4.Santé Canada. Profil statistique de la santé des Premières Nations au Canada.2005.

5.Réseau canadien autochtone du sida. Stratégie Autochtone sur le VIH/sida au Canada II : pour les Premières nations, les Inuit et les Métis de 2009 à 20142009 Contract No.: January, 18th.

6.Djossa-Adoun M, Gagnon M-P, Godin G, et al. Information and communication technologies (ICT) for promoting sexual and reproductive health (SRH) and preventing HIV infection in adolescents and young adults (Protocol). Cochrane Database of Systematic Reviews 2011(2).

7.Djossa-Adoun M, Roy B, Gros-Louis McHugh N, Caron M-N, Gagnon M-P. Les technologies de l'information et de la communication (TIC) et la promotion de la santé sexuelle chez les jeunes autochtones du Qébec. Recherches amérindiennes au Québec 2013;XLIII(2-3):9.

8.Fortier J-F. Recherche, éthique et Autochtones. Regard exploratoire sur les dilemmes éthiques de la recherche en milieu autochtone. Inditerra. 2010(2):1-14.

9.Conseil de recherches en sciences humaines du Canada, Conseil de recherches en sciences naturelles et en génie du Canada, Instituts de recherche en santé du Canada. Énoncé de politique des trois Conseils : Éthique de la recherche avec des êtres humains. 2010.

10.Lachapelle L, Puana Sd. Mamu minu-tutamutau. Bien faire ensemble. L'éthique collaborative et la relation de recherche. Éthique publique [serial on the Internet]. 2012; 14(1): Available from: http://ethiquepublique.revues.org/951.

11.Éthier B. Terrain de recherche en milieu autochtone: la participation radicale du chercheur à l'ère de la recherche collaborative. Altérités. 2010;7(2):118-35.

12.APNQL [Assemblée des Premières Nations du Québec et du Labrador]. Protocole de recherche des Premières Nations du Québec et du Labrador. 2005.

13.Réseau DIALOG. Réseau DiALOG - Présentation - Mission. 2010; Available from: http://www.reseaudialog.ca/fr/reseau-dialog/mission/ - sthash.kSSGWrnp.dpuf.

14.Potvin L, Cargo M, McComber AM, Delormier T, Macaulay AC. Implementing participatory intervention and research in communities: lessons from the Kahnawake Schools Diabetes Prevention Project in Canada. Social Science & Medicine. 2003;56(6):1295-305.

15.Bilodeau Angèle, Gendron Sylvie, Bédard Johanne, Couturier Yves, Bernier Jocelyne, Lefebvre Chantal. Les opérations de la recherche participative et leurs finalités : trois cas de recherche interventionnelle. In: Francois Aubry, Potvin Louise, editors. Construire l'espace sociosanitaire Expériences et pratiques de recherche dans la production locale de la santé. Montréal: Les Presses de l'Université de Montréal; 2012. p. 45-74.

16.CSSSPNQL. Plan directeur de la santé et des services sociaux des Premières Nations du Québec, 2007-2017: Remédier aux disparités...Accélérer le changement. 2007; Available from: http://www.cssspnql.com/fr/nouvelles/documents/Plan directeur.pdf.

17.Haley T, Puskar K, Terhorst L, Terry MA, Charron-Prochownik D. Condom Use Among Sexually Active Rural High School Adolescents Personal, Environmental, and Behavioral Predictors. The Journal of School Nursing. 2013 June 1, 2013;29(3):212-24.

18.CSSSPNQL. Étude sur le comportement sexuel, les attitudes et comportements sexuels en lien avec les ITSS chez les jeunes et adultes des communautés des Premières Nations de la région de Québec. Document de travail inédit en attente de publication: CSSSPNQL [Commission de la santé et des services sociaux des Premières Nations du Québec et du Labrador]2011.

Remerciements
Le présent article a été initié dans le cadre du séminaire de rédaction pour jeunes chercheurs francophones dans le domaine du VIH/SIDA. Nous aimerions adressés nos remerciements :
-Aux initiatrices et chercheur(e)s, (Viviane Namaste, Ph.D ; Marilou Gagnon, RN, PhD; Nathalie Duchesne, RN, Ph.D (Cand), Vinh-Kihm Nguyen, Ph.D) impliqués dans l'organisation et la réalisation du séminaire
-Aux jeunes chercheurs participants au séminaire dont les commentaires ont énormément nourri nos réflexions durant la rédaction de cet article
-À University Without Walls pour le financement du séminaire
Nous aimerions souligner l'importante contribution des conseils et commentaires de nos deux co-directeurs de thèse Bernard Roy, Ph.D et Marie-Pierre Gagnon, Ph.D. Nous les en remercions. Nous remercions également la CSSSPNQL ainsi que les communautés des PN participantes pour leur précieuse collaboration.

Pour contacter l'auteur:
Serge Djossa Adoun, Ph.D (cand)
Université Laval
Faculté des sciences infirmières,
1723, rue de Bergerville, Québec, G1S 1J2
Canada
Courriel : medetongnon-alfred-serge.djossa-adoun.1@ulaval.ca

APORIA
LA REVUE EN SCIENCES INFIRMIÈRES • THE NURSING JOURNAL

ABOUT APORIA

Aporia is a peer-reviewed, bilingual, and open access journal dedicated to scholarly debates in nursing and the health sciences. The journal is committed to a pluralistic view of science and to the blurring of boundaries between disciplines. Therefore the editorial team welcomes critical manuscripts in the fields of nursing and the health sciences that include critique of dominant discourses related to the evidence-based movement, best practice guidelines, knowledge translation, managerialism, nursing and health care practices, ethics, politics of health care and policies, technology, bioethics, biopedagogies, biopolitics etc. Research results in nursing and health-related disciplines are also welcome. *Aporia* encourages the use of various epistemologies, philosophies, theoretical perspectives and research methodologies. In the critical analyses of health-related matters, *Aporia* embraces a wide range of epistemologies, philosophies and theories including cultural studies, feminism(s), neo-marxism, post-structuralism, postcolonialism and queer studies.

While the public already pays to fund health research, it is inconceivable that the public should be required to pay yet again, to gain access to research results. Subscription to scientific journals can sometimes reach up to thousands of dollars that are paid directly from public funds. Aporia inscribes itself along the margins of this practice by allowing for a definite fracture to take place within the current trends in the field of scientific publication, which constitute the dominant model for the diffusion of knowledge. *Aporia* is, therefore, a free online journal. Following the footsteps of Deleuze and Guattari, the *Aporia* team firmly believes that freedom is only made possible in the margin; an autonomous space that is controversial, sometimes polemical and without censorship that does not sacrifice scientific and academic rigor. As such, the objective is to encourage access to scientific knowledge and to give the reader an opportunity to actively position himself/herself regarding the written words in order to give a plurality of meanings to the text.

Therefore, *Aporia* adheres to the following principles:

-Freedom of speech
-Critical pedagogy
-Recognition of local knowledge(s)
-Critique of dominant discourses.

SUBMISSION

Research manuscripts, theoretical and philosophical pieces must not exceed 7,000 words. Commentaries and responses related to published articles must not exceed 3,000 words. Manuscripts and the cover letter should be submitted to aporia@uottawa.ca.

Cover Letter

Papers are accepted for publication in the Journal on the understanding that the content has not been published or submitted for publication elsewhere. This must be stated in the cover letter, which should be sent with the manuscript. The cover letter must contain an acknowledgement that all authors have contributed significantly, and that all authors are in agreement with the content of the manuscript. When applicable, it should be stated that the protocol for the research project has been approved by a suitable and relevant Research Ethics Board. All investigations involving human subjects must include a statement that subjects provided informed consent and anonymity should be preserved. Authors should declare any financial support or relationships that may cause conflicts of interest.

Authorship Credit

Each author should have participated sufficiently in the work. Authorship creditsshould be based on substantial contributions to:

-conception and design, or analysis and interpretation of data;
-drafting the article or revising it critically for important
-intellectual content; and
-final approval of the version to be published.

Preparation of the Manuscript

Research manuscripts, theoretical and philosophical pieces must not exceed 7,000 words. Commentaries and responses related to published articles must not exceed 3,000 words. Submissions should be prepared in word-processing software using Arial 11. The text file should be double-spaced and set with top, bottom and side margins of 2.5cm or 1 inch.

For more information, please visit Aporia online at http://www.oa.uottawa.ca/journals/aporia/index.jsp?lang=.