Educating Nurses to Address Socio-Cultural, Historical, and Contextual Determinants of Health among Aboriginal Peoples

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Aboriginal Nurses Association of Canada

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ABORIGINAL NURSES ASSOCIATION OF CANADA

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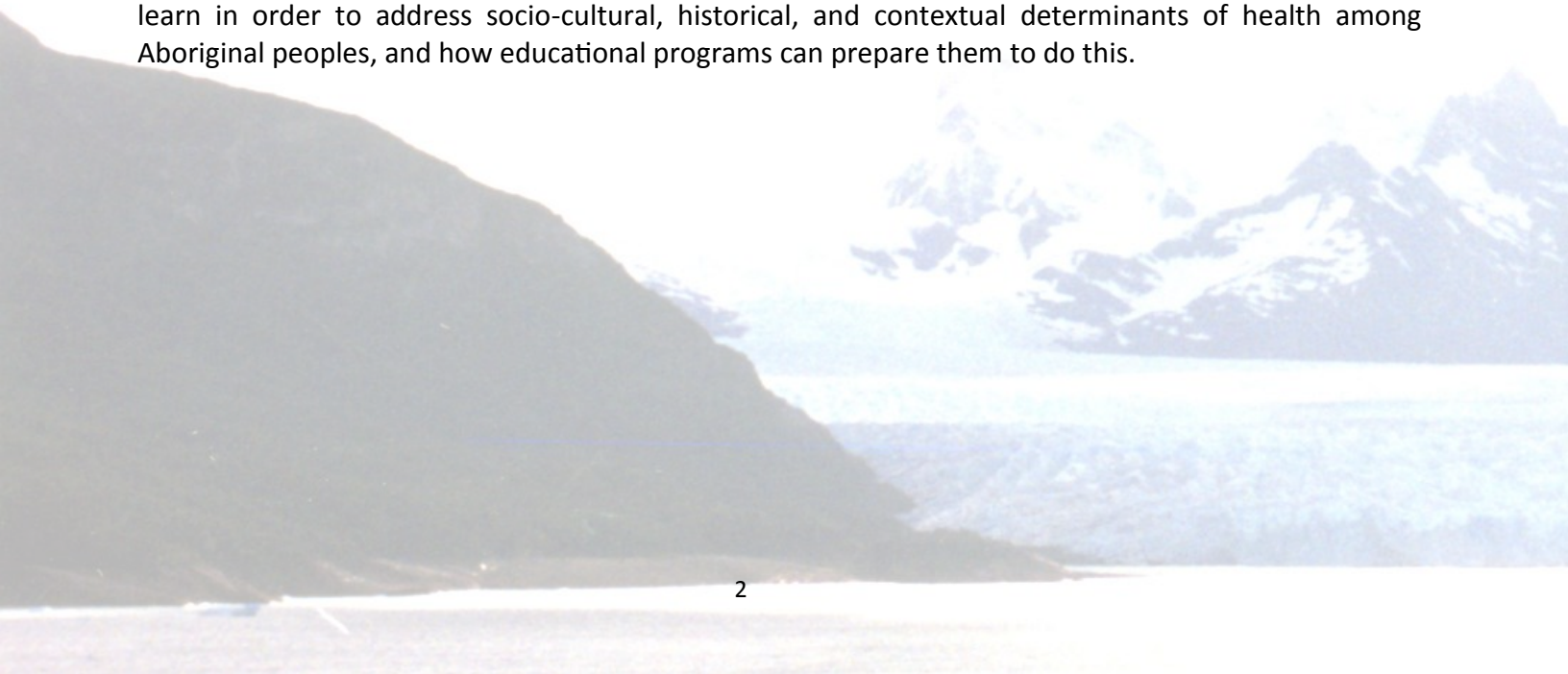
Introduction

There is international recognition that the pre-licensure education of health professionals must prepare graduates to respond appropriately to increasingly diverse populations (Wittig, 2004). Moreover, researchers have reported improved health outcomes when health-care providers are sensitive and responsive to cultural issues (Kirmayer, 2012). As a result, there have been initiatives in Canadian Schools of Nursing to incorporate the concepts of cultural competence and cultural safety into curricula, with a particular emphasis on the Aboriginal peoples in Canada. There have also been projects in nursing education to address an under-representation of Aboriginal health-care providers. In the Canadian context, Aboriginal peoples include First Nations, Inuit, and Métis populations (Royal Commission on Aboriginal Peoples, 1996).

In March 2012, the Canadian Association of Schools of Nursing (CASN) and the Aboriginal Nurses Association of Canada (A.N.A.C.) sponsored a two-day Symposium in Toronto on Cultural Competence and Cultural Safety. Participants included faculty representatives from Schools of Nursing across the country, members of First Nations, Inuit, and Métis communities representing all regions of the country, and scholars with expertise in cultural diversity and Aboriginal health. This project was financially supported by the Health Canada Aboriginal Health Human Resources Initiative.

The Symposium included presentations of recently completed government-funded projects to integrate cultural competence and cultural safety into nursing curricula, panel discussions and dialogue examining the lessons learned from these projects, and a Knowledge Café to provide direction for the future.

The purpose of this paper is to disseminate the promising practices shared at the Symposium, and to present a Framework developed in the course of this national dialogue. Background literature is reviewed followed by a description of the innovative, government-funded projects presented. Discussion at the Symposium led participants to a broader and more nuanced conceptual understanding of culture, health, and health care. This broader perspective is described. The paper concludes with a presentation of a Framework that emerged for educating nurses to address socio-cultural, historical, and contextual determinants of health among Aboriginal peoples. It represents a synthesis of themes expressed in the Knowledge Café session, and reflects the broader conceptual understandings generated at the Symposium. The Framework identifies what nursing students need to learn in order to address socio-cultural, historical, and contextual determinants of health among Aboriginal peoples, and how educational programs can prepare them to do this.



Background

International, national, and provincial/territorial standards and frameworks currently inform the cultural content in nursing education programs [A.N.A.C., 2009a; Douglas et al., 2011; Doutrich, Arcus, Dekker, Spuck, & Pollock-Robinson, 2012; Mahara, Duncan, Whyte, & Brown, 2011; National Aboriginal Health Organization (NAHO), 2008]. The International Council of Nurses, for example, has published a position supporting "the integration of cultural care knowledge and training for cultural competence into all levels of nursing education" (Douglas et al., 2009, p. 264). At the national level in Canada, A.N.A.C. in partnership with CASN and the Canadian Nurses Association (CNA) developed a national framework of nursing education competencies for cultural competence and cultural safety in 2009 (A.N.A.C., 2009a). Provincial and territorial regulatory bodies also provide Canadian schools with curricular direction related to cultural diversity in their entry-to-practice requirements [Arnold, Appleby, & Heaton, 2008; College of Registered Nurses of British Columbia (CRNBC), 2009].

Projects presented at the Symposium were designed with the long-term objective of advancing the delivery of culturally competent and culturally safe care for First Nations, Inuit, and Métis, through education. Thus, cultural competence and cultural safety were key concepts guiding these initiatives.

Cultural Competence and Cultural Safety

Cultural competence refers to competence in understanding and responding appropriately to cultural norms, values, beliefs, and customs shared by members of an ethnocultural group. At the national level in Canada, CNA (2010) defines cultural competence as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals, and enables… [them] to work effectively in cross-cultural situations" (p. 1). The concept is based on the premise that culturally shared norms, values, beliefs, and customs influence health and determine clinically relevant health behaviours (Kirmayer, 2012). In contrast, the concept of cultural safety highlights the health risks experienced by members of cultural communities related to "power imbalances and inequitable social relationships in health care" (CNA, 2010, p. 1). Dion Stout and Downey (2006) point out that the cultural safety concept counters an emphasis on culture at the expense of other social determinants of health. Browne, Smye, and Varcoe (2005) argue that by looking at the "culture of health care" (p. 32), rather than cultural differences, one can see how widely accepted practices and policies have unwittingly created inequities in health-care service delivery that threaten the cultural safety of Aboriginal peoples.

Cultural safety has been linked to anti-racism. Paradies, Harris, and Anderson (2008) define racism as "avoidable and unfair actions that further disadvantage the disadvantaged or further advantage the advantaged", noting that it can be expressed through "stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices)" (p. 4). In Canadian society, stereotypes, and racist beliefs have been found to jeopardize the quality of the health-care services delivered to Aboriginal populations (Browne, Smye, & Varcoe, 2005). Moreover, as racism may be systemic, embedded in institutional practices, subtle, and even unintentional (McGibbon & Etowa, 2009), it can create insidious inequities in health-care service delivery to Aboriginal peoples, and contribute to persistent health disparities.

Cultural safety has also been closely tied to the history and legacy of colonialism. Indeed, the concept was originally developed by Maori nurse leaders to capture the negative impact of colonialism on health-care delivery services, and on the health-care status of the Maori people in post-colonial New Zealand (Papps & Ramsden, 1996). In Canada, researchers investigating cultural safety have found that social policies, reflective of a colonial past, have had deleterious effects on life opportunities and the overall health status of Aboriginal peoples, families, and communities (Browne, Smye, & Varcoe, 2005). The impact of the residential school system on Aboriginal communities has been particularly detrimental. Introduced by the Canadian Government in the mid-1800s to foster assimilation, it persisted throughout most of the twentieth century (Royal Commission on Aboriginal Peoples, 1996). Studies show deep-rooted, continuing intergenerational effects of the residential school system on mental, social, and physical health, resulting from the early parental separation, suppression of language and culture, every day humiliations, and widespread physical and sexual abuse experienced by the children (Smith, Varcoe, & Edwards, 2005).

Aboriginal Peoples of Canada

In the 2006 census, 1,172,790 people in Canada, almost 4% of the whole population, identified themselves as Aboriginal. Of these, 698,025 (60%) self-identified as First Nations, 50,485 (4%) as Inuit, 389,785 (33%) as Métis, and the remaining 34,495 placed themselves in a combination of these groups. Many Aboriginal peoples live in rural and remote parts of Canada. 77% of Canadian Inuit live in Inuit Nunangat (Statistics Canada, 2006), an area representing one third of Canada's total land mass (Statistics Canada, 2008). It is comprised of four regions: Nunatsiavut in northern Labrador, Nunavik in northern Québec, Nunavut, and the Inuvialuit Settlement Region in the Northwest Territories. Among those who self-identified as First Nations, 55% reported living in rural and remote areas, and 304,490 live on reserves. In contrast, 70% of self-identified Métis were urban dwellers (Statistics Canada, 2006).

There is a significant gap in income and employment rates for self-identified Aboriginal populations and non-Aboriginal identifying populations (Statistics Canada, 2006). These inequalities have compounded access issues related to geography in affecting the health status of these populations in Canada (Loppie Reading & Wien, 2009). Indeed, the persistence of significant health disparities experienced by the Aboriginal peoples of Canada has been linked to multiple social, historical, and contextual factors. This understanding has resulted in the identification of a unique subset of social determinants of health among Aboriginal peoples related to colonization, globalization, migration, cultural continuity, access to services, land rights, and self-determination (International Symposium on the Social Determinants of Indigenous Health, 2007; NAHO, 2006).

Cultural Competence and Cultural Safety Projects

Building on the project led by A.N.A.C. (2009a), "*Making it Happen: Strengthening First Nation, Inuit and Métis Nursing*", the 2012 CASN *Cultural Competence and Cultural Safety in Nursing Education: A Knowledge Translation Symposium*, began with reports of the government-funded projects. Six of the projects were conducted in existing nursing programs across Canada: University of Alberta Faculty of Nursing, Langara College Nursing Department, Nova Scotia Community College Practical Nursing Program, St. Francis Xavier School of Nursing, Trent/Fleming School of Nursing, and Laurentian University School of Nursing. In a seventh presentation, the *Nurses for Nunatsiavut* project was described as an innovative education program designed by Inuit for Inuit nursing students.

As the project descriptions show (see Table 1), innovative practices include the involvement of Aboriginal community members in curriculum design and in teaching students, faculty development in cultural competence and cultural safety, the creation of contextualized educational materials such as case studies, and clinical placements of students in Aboriginal communities. The projects also tested valuable new approaches to support Aboriginal student recruitment, retention, and completion rates, such as involving Aboriginal advisors and recognizing diverse patterns of knowing.

Table 1
Cultural Competence and Cultural Safety Projects

University of Alberta Faculty of Nursing
In 2010-2011, a team of 11 nursing students and faculty within the Faculty of Nursing at the University of Alberta, and community members introduced "Embracing Indigenous Ways of Knowing", in order to integrate the A.N.A.C., CASN, and CNA Cultural Competence and Cultural Safety in Nursing Education Framework (A.N.A.C., 2009a) into the baccalaureate curriculum. The goal was to transform how students learn about culture in the program. Besides conference presentations and guest lectures, activities undertaken involved Aboriginal community projects and faculty research programs. Previous Aboriginal initiatives within the Faculty of Nursing strengthened the integration of the key concepts of cultural competence and cultural safety into the nursing curriculum. As a result of the project, faculty were able to carry out other activities to support faculty development and student learning opportunities in both coursework and clinical practice.
Langara College Nursing Department
Faculty of the Langara College Nursing Department in British Columbia set out to enhance cultural safety through the development of their curriculum, educational materials, a repository of Aboriginal resources for faculty, and partnerships with surrounding First Nations and Métis communities. Specific activities of this project included the creation of an external Advisory Committee, the use of post-colonialism theory as a framework for curriculum development, the integration of a case study reflecting cultural safety in the program from term one through term nine, and the incorporation of the A.N.A.C., CASN, and CNA Cultural Competence and Cultural Safety in Nursing Education Framework (A.N.A.C., 2009a) into the decision-making framework that students are taught.
Nova Scotia Community College Practical Nursing Program
In Nova Scotia, the province-wide Nova Scotia Community College offered a course dedicated to cultural competence and cultural safety for Practical Nursing Students. The faculty designed the course to further Practical Nursing Students' understanding of Mi'kmaq culture, and to build competencies of inclusivity, respect, and indigenous knowledge to care for First Nations clients. The course included clinical learning opportunities for students in a Mi'kmaq Community Health Centre and instruction from community Elders.

St. Francis Xavier School of Nursing

Faculty at St Francis Xavier and the Nova Scotia Community College held a workshop for nursing educators on cultural competence and cultural safety. Participants concluded that retention and course completion were priority areas needing attention. The approaches that participants identified included employment of Aboriginal faculty, relationships with Elders, valuing traditional knowledge, self-reflection on colonialism, post-colonialism and unequal power relations, recognition that culture is situated in a broader socio-economic context, and methods to support Aboriginal students' completion of the programs (i.e. a strong Aboriginal student advisor office).

Trent/Fleming School of Nursing

In Ontario, core competencies were integrated into the Trent/Fleming Baccalaureate Nursing Program in course outlines laddered throughout the four-year curriculum. The core curricular themes are comprised of the following: leadership, rural health, elder care, safety, and knowledge transfer. In addition, students may take courses jointly with the Faculty of Indigenous Studies. A new Aboriginal Enrolment Advisor and Aboriginal Cultural Advisors are now available to students, and guest lecturers are invited to discuss topics related to Aboriginal health, such as the impact of the residential school system. Following up on the project initiatives, the school became a Registered Nurses Association of Ontario (RNAO) Best Practice Spotlight Organization in 2012 to implement the Healthy Work Environments Best Practice Guideline - Embracing Cultural Diversity in Health Care: Developing Cultural Competence (RNAO, 2007).

Laurentian University School of Nursing

Faculty at the Laurentian University School of Nursing developed learning resources for baccalaureate nursing students with the aim of enhancing the quality of health care provided to Aboriginal populations in Northern Ontario. A literature review was conducted as part of this project, and the six A.N.A.C., CASN, and CNA competencies in the Cultural Competence and Cultural Safety in Nursing Education Framework (A.N.A.C., 2009a), were integrated into the curriculum. The resource "Nursing Practice with Aboriginal Peoples: A Nursing Student's Guide to Cultural Competence and Cultural Safety" was the end product, and is made up of five modules: 1) Historical Context of Aboriginal Peoples in Canada; 2) Relating to Aboriginal Peoples-Effective & Culturally Safe Communications; 3) Explorations of Racism; 4) Improving Nursing Practice; and 5) Strengthening Relationships with Aboriginal Communities (A.N.A.C., 2009b).

Nurses for Nunatsiavut

The Nurses for Nunatsiavut project, an innovative nursing education program, was designed by Inuit for Inuit nursing students. The program provided students with a culturally competent curriculum and a culturally safe environment. It was a positive, life transforming experience for most students who enrolled in the program, and a number excelled. Completion rates, however, were not high because of the barriers students faced related to geography and insufficient academic preparation for university study.

Broadening the Conceptual Lens

The projects demonstrated that partnerships with Aboriginal communities may enhance the integration of relevant First Nations, Inuit, and Métis content into nursing education programs. In addition, the verbal evidence presented at the Symposium indicated that they were successful in fostering a climate of greater cultural sensitivity among faculty and students. Despite the clear successes that were presented, some inherent difficulties with the application of the concepts of cultural competence and cultural safety emerged in the panel presentations and discussions that followed. Academic scholars and educators reported that the concepts are often difficult to define for students in a meaningful way, which reduces their usefulness. In addition, they do not sufficiently capture geographical and historical determinants of health that are linked with, but are separate from, culture.

Society, Culture, and Change

Society versus culture and stability versus change lie at the heart of the difficulties in using the concepts in real life situations. As noted, cultural competence is concerned with competence in understanding and responding to differences in the beliefs, values, attitudes, and customs of the person receiving care. Cultural safety, on the other hand, centres on eliminating the harm entailed in power differentials between the cultural group of the caregiver and the cultural group of the recipient. Both concepts, however, imply a relatively fixed normative world where “a culture” is an identifiable, circumscribed “society” of people.

Definitions of society refer to social organization, social relationships, power differences, and equality/inequality among, between, and within groups, the target domain of cultural safety (Loppie Reading & Wien, 2009). Definitions of culture refer to a symbolic realm of shared knowledge, ideas, values, beliefs, and customs that members of a given social group learn, representing the target domain of cultural competence (Kirmayer, 2012).

Society and culture may be distinguished conceptually or used interchangeably. In reality, the phenomena they represent overlap and interact, but are rarely aligned completely with one another. Moreover, in modern, complex societies, culture rarely coincides with a given, geographically located “people”. In addition, there is a recognition that multiple layers or levels of culture exist and interact, and that these layers increase along with societal complexity (Kirmayer, 2012).

Furthermore, both society and culture are dynamic, fluid, and continuously changing; in contrast, culture is often portrayed in the health literature as a fixed and static phenomenon (Gregory, Harrowing, Lee, Doolittle, & O’Sullivan, 2010). This stems in part from earlier conceptualizations that emphasized a generational transmission of culture, often resulting in an artificial perception of culture as a set of fixed cultural traits characterizing a particular people. Later definitions of culture recognize an ongoing process of creating and re-creating culture through social interactions and social relationships, as well as transmission through other social processes (Browne & Varcoe, 2006). Nevertheless, the idea of culture as a fixed set of traits persists.

Both society and culture have a great deal to do with health status and health-care delivery; indeed, as noted in the background context, both have been identified as important social determinants of health (Loppie Reading & Wien, 2009). Symposium participants stressed, however, that society and culture represent a far more fluid, unbounded, and complex reality than is captured by the concepts of cultural competence and cultural safety. Moreover, as Bourque Bearskin (2011) has pointed out, caution is required in interpreting numerous reports investigating health disparities of Aboriginal peoples because they fail to reflect cultural and social diversity within these populations.

Geographical Context

In pre-industrial societies, culture, society, and geographical location were often closely tied to one another. A people typically inhabited a given location, and their culture often reflected elements derived from that particular geographical context; even peoples who were nomadic moved within a circumscribed region. However, urbanization, industrialization, globalization, and national and international mobility have altered this relationship between geography, society, and culture. As noted earlier, First Nations, Inuit, and Métis peoples live in urban centres, rural areas, and remote, sparsely populated northern communities; thus, there are significant variations in geographical factors affecting the health status and health-care delivery, both among and within the three Aboriginal groups.

The presentations and discussions at the Symposium underscored the importance of geographical contexts and their effects on health status and access to health-care delivery. It was evident that geography posed a formidable barrier to the recruitment and retention of students in the *Nurses for Nunatsiavut* project. Urban living, however, may also be providing significant geographical challenges of a different order to health care and health service delivery to Aboriginal peoples. In cultural competence and cultural safety frameworks, the geographical dimension tends to be subsumed under culture. Like society, however, culture and geography are not necessarily closely aligned and geography needs greater attention.

History

While culture and society are clearly shaped by the past, they both represent contemporary phenomena. Thus, the concept of cultural competence targets current culture even though there is often the assumption that current culture has been handed down by past generations. Similarly, cultural safety is concerned with vulnerabilities that stem from contemporary power imbalances, despite a recognition that these are rooted in historical relationships. Historical events themselves, however, may have a powerful and continuing effect on the current health status of a given population. Moreover, Paul Farmer (2004), a physician and anthropologist, has shown how “erasing history” is often an invisible, socially embedded health threat that serves the powerful and further disadvantages the historically disadvantaged. Participants at the Symposium stressed the need to separate history from culture, and to educate nurses to take into account the long-term effects of past circumstances on the health of First Nations, Inuit, and Métis peoples when providing care.

Synthesis Framework for Nursing Education

The project presentations, and the broader perspective that emerged in the discussions, provided an excellent foundation for the Knowledge Café session at the Symposium. Each of the participants discussed two of the following four questions in small groups:

1) What are the most important things health practitioners need to know about caring for First Nations, Inuit, and Métis populations?
2) What is the next level of thinking in relation to the concepts of cultural competence and cultural safety that would take these concepts further?
3) What are the best approaches for integrating concepts of cultural competence and cultural safety into nursing curricula? and
4) What are the facilitators and barriers for educators engaged in the process of integrating concepts related to cultural competence, cultural safety, and equity?

A thematic synthesis and analysis of participant responses was carried out and developed into a Framework: *Educating Nurses to Address Socio-Cultural, Historical, and Contextual Determinants of Health among Aboriginal Peoples*. This Framework offers educators direction for future curricular development.

Two key elements that future nurses need to learn related to the social, cultural, and contextual determinants of health are highlighted within the Framework: 1) build respectful relationships and 2) promote social justice and equity when providing care. Two key program approaches to achieve this are also identified: 1) bring society, culture, history, and context alive throughout the program and 2) create a safe and supportive classroom environment for students.

A. What Future Nurses Need to Learn:

KEY ELEMENT 1	Build respectful relationships
Fostered through:	**Self-knowledge** • Recognition of one's personal location in society; and • Recognition of one's cultural beliefs, values, norms, and customs related to health, wellness, and well-being. **Cultural knowledge** • Recognition that cultural values, beliefs, knowledge, and customs influence behaviours and the meaning of health; • Recognition that health has different meanings across cultures; • Recognition that behaviours have multiple and different meanings across cultures; • Recognition that there are levels of culture; • Recognition that there are within-group cultural similarities and within-group cultural differences among people; • Recognition that respectful relationships are more important than trying to fully understand the person's culture; • Recognition that one is more than the culture one is born into; and • Recognition that the health care setting also has an organizational culture with subcultures such as a nursing culture and medical culture within it. **Critical societal knowledge** • Recognition of societal threats to health and health relevant behaviours including social inequality and inequity, power imbalances, racism, and stereotyping; • Recognition of short-term and long-term historical influences on health such as Aboriginal land claim history, the Indian Act, and residential schools; and • Recognition that multiple disadvantaging forces related to gender, poverty, race, culture, and geography may intersect and compound health disparities. **Contextual knowledge** • Recognition of environmental influences on health status, health behaviours, and health-care services including poverty and a lack of financial, social, and material resources; and • Recognition of geographical influences on health status, health behaviours, and health-care services. **Relational practice** • Recognition of commonalities among all human beings; • Adoption of a stance of inquiry, curiosity, and openness and "unknowing" to learn from clients; • Watching and learning from clients; and • Use of "intentionality" to learn about the client's culture, societal, historical, and environmental context.

KEY ELEMENT 2	Promote social justice and equity when providing care
Fostered through:	**Socially responsible care** • Commitment to citizenship with an allegiance to humanity and actions that improve social well-being; • Recognition of stereotyping, stigma, and unintentional and systemic racism; • Provision of socially inclusive care; • Recognition and support of client and community strengths; and • Community capacity building to address health disparities. **Action to redress injustice and inequity** • Recognition of injustice and social and contextual inequities affecting health; • Advocacy and support for clients; • Initiatives to level inequitable circumstances affecting health when possible; • Advocacy for multi-sectoral investment in health; and • Initiatives to improve health-care access through cultural and social responsiveness, including provision of interpretive services.

B. Program Approaches to Facilitate this Learning

KEY PROGRAM APPROACH 1	Bring society, culture, history, and context alive throughout the program
Fostered through:	**Experiential learning** • Guidance from an Advisory Committee with Aboriginal representatives to develop learning opportunities; • Use of narratives and case studies; • Indigenous knowledge holders teaching students; and • Clinical experiences among First Nations, Inuit, and Métis peoples. **Curricular threading** • Conceptual threads related to the socio-cultural, historical and contextual determinants of Aboriginal health in the curriculum; • Faculty development, such as workshops to support the threading; • Teaching and learning resources available for faculty; and • Faculty champions for curricular integration of society, culture, history, and geographical context.

KEY PROGRAM APPROACH 2	Create a safe and supportive classroom environment for students
Fostered through:	**Faculty role models** • Open and socially inclusive faculty; • Faculty recognition that guilt, defensiveness, and anger among students are easily evoked when inequities/ racism are discussed; and • Collegial support of Aboriginal faculty. **Program policies and position statements** • Formal school statements promoting respectful relations, social justice, and equity for students; • Formal school statements promoting respectful relations, social justice, and equity for faculty; and • Equity-based recruitment policies for Aboriginal faculty.

Summary and Conclusion

The national dialogue and exchange among nurse educators, members of Aboriginal communities, and scholars with expertise in cultural competence and cultural safety, resulted in the development of a broad Framework that schools may use to guide the integration of culture, society, and historical and contemporary contexts into nursing education. This Framework first identifies what nursing students need to learn to do: build respectful relationships with diverse clients, and promote social justice and equitable care. Secondly, it identifies how nursing education programs can prepare students to do this by bringing society, culture, history, and context alive, and by creating a safe and supportive environment in the classroom for students.

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Photograph

(Cover) Charles Gimpel Library and Archives Canada R10187 229 6 E Five Inuit boys playing on ice [graphic material].

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