ACCESS TO HIV/AIDS TREATMENT SERVICES AMONG URBAN ABORIGINAL PEOPLES IN VANCOUVER, B.C.: A CULTURAL SAFETY PERSPECTIVE

by

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ABSTRACT

Disparities in health care access need to be addressed to help reduce health inequities among Aboriginal Canadians. A literature review examines the role cultural safety can play in reducing access barriers among urban Aboriginal peoples living with HIV/AIDS. Despite its aim to address power dynamics and structural inequities within the health care system this concept lacks methodological application at an institutional level. Key organizational initiatives to provide culturally appropriate health care in Vancouver are discussed in the context of this literature. While cultural competency terminology predominates, efforts exemplify some support and value in moving towards the concept of cultural safety that is well positioned to address the underlying mistrust and negative experiences that dissuade many Aboriginal people from accessing care. A preliminary organizational self-assessment tool is developed to invite discussion and application of cultural safety to strengthen best practice in providing culturally appropriate health care that ensures equitable access.

Keywords: cultural safety; access to health care; urban Aboriginal peoples; HIV/AIDS treatment services

DEDICATION

"The last six months I have been trying out doctors. I tried one and I missed two appointments and they sent me a letter saying they do not want to see me anymore. . . . The next doctor I tried out . . . it was a turnoff because as soon as I walked in—the baby was about a year old . . . All they said to me when I got there was "Well you know you are high risk we have to call [Children's] Aid." You know what I mean? They did not even ask me what have you been using for support, what have you been doing, where have you been . . . I did not like that approach so I just left. [I went to] another doctor close to where I live, and then . . . the nurse goes, "We don't give narcotics here, eh?" I said, "I haven't said anything yet, how do you know I want narcotics?"." (Mckoy, 2005, p.796)

"Cultural Safety developed from the experience of colonization and recognizes that the social, historical, political and economic diversity of a culture impacts on their contemporary health experience. Thus, structural influences, which have a significant impact on health status, cannot be ignored." (Ramsden, 2002, p.112)

This paper is dedicated to all Aboriginal peoples who share in similar demeaning or disempowering experiences when accessing health care and to all those who are working hard to address Aboriginal health inequities in Canada.

ACKNOWLEDGEMENTS

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1: INTRODUCTION

1.1 HIV/AIDS Treatment Services – Access Inequity

Aboriginal peoples are among the most historically disadvantaged groups in Canada and continue to experience significant health and socio-economic inequities (Royal Commission on Aboriginal Peoples, 1996). Poverty and a history of colonization and residential schools have resulted in intergenerational trauma, mental health and addiction problems, domestic violence, and other outcomes that place Aboriginals at increased vulnerability for HIV/AIDS and a host of other communicable and non-communicable diseases (Kelm, 1998; Kirmayer, Brass and Tait, 2000; RCAP, 1996; Adelson, 2000; Vernon, 2000). Disparities in health care access are seen often among marginalized populations, as they face upstream economic and social barriers to accessing care. Also, given the history that Aboriginal people have endured they have a unique need to feel comfortable and respected with their health care provider and services, safe from any physical emotional or psychological harm, and empowered to access and utilize mainstream health care. While access to health care is an outcome of a complex intersection of social determinants of health, it is also a determinant of health on its own. Many health care professionals believe that access inequity is central to the discrepancies in health status seen between ethnic populations and socio-economic groups (Andrulis, 1998; Ellison-Loschmann and Pearce, 2006). In the case of HIV/AIDS, Aboriginal British Columbians access HIV treatment less often than other populations in the province despite the proven effectiveness of Highly Active Anti-Retroviral Therapy (HAART) in improving health outcomes among people living with HIV/AIDS (Wood et al., 2003; Hogg, Strathdee, Kerr, Wood, and Remis, 2005).

Aboriginals also tend to seek treatment at a later stage of diagnosis than other ethnic groups (Barlow et al., 2008). Furthermore, HAART adherence rates are known to be poor among injection drug users, a population that Aboriginals tend to be overrepresented among (Kerr et al., 2004). These statistics speak to the fact that many access barriers deter Aboriginal people from utilizing health services and adhering to HIV/AIDS treatment. Therefore, it is critical that we further understand and prevent existing health care access barriers to adequately address the HIV epidemic and other health disparities experienced by Aboriginal Canadians. This paper will explore the value that cultural safety might bring to this public health problem.

1.2 Purpose of Paper

The purpose of this paper is to explore the academic literature and current application of cultural safety at an institutional level within the health care system in Vancouver to help inform best practice on addressing health care access inequities and strengthening HIV/AIDS prevention and treatment outcomes among urban Aboriginal populations in Canada. The paper aims to:

- Provide readers with a better understanding of the concept of cultural safety;

- Discuss current best practice initiatives in Aboriginal health in relation to the literature on cultural safety to determine where this concept might strengthen efforts to provide culturally appropriate care; and

- Use findings to develop a tool from which to foster future frameworks and discussion on operationalizing cultural safety.

This document is not an assessment of health programs or an appraisal of the ability of health authorities to oversee the provision of culturally safe services in Vancouver. Rather, it is a preliminary look at how cultural safety can be discussed in the context of organizational policies, programs, and structure and what this reflection invites beyond the concepts of cultural awareness and cultural competency in helping strengthen the provision of culturally appropriate health care services.

1.3 Background

1.3.1 Urbanization of Aboriginal Peoples

Aboriginal people residing in metropolitan areas have often been marginalized and ignored by the Canadian public as a whole. Historically, popularized images and public discourse saw Aboriginal people as incompatible with urban culture (Newhouse and Peters, 2003). As a result, it was believed that Aboriginal people in metropolitan areas had decided to assimilate into mainstream society and did not warrant any special consideration or room to retain their culture (Ibid.). Furthermore, due to historical legislation Canadian provinces have long viewed urban Aboriginal people as a federal responsibility, while the Canadian government has continued to articulate and focus their responsibility to on-reserve populations. This lack of government leadership pertaining to urban Aboriginal peoples has led to a policy vacuum in this area and decades of poor intergovernmental collaboration which has failed to address the many social and economic issues facing urban Aboriginal populations (Ibid.). Likewise, literature on the health of Aboriginal peoples in Canada has predominantly focused on rural on-reserve Aboriginal populations (Young, 2003). There is a pressing need for better knowledge and commitment to addressing the health of urban Aboriginal populations, especially given that the majority or 54% of Aboriginal peoples now live in urban centers (Statistics Canada, 2009). From 2001 to 2006, the Aboriginal population in Vancouver grew by

9%, yet the provision of health care to this population has yet to attract sufficient political will (Statistics Canada, 2010).

1.3.2 Marginalization and HIV Vulnerability

Moreover, the historical legacy of colonization, intergenerational trauma, and continued socio-economic marginalization have contributed to the overrepresentation of Aboriginals among the poor, the homeless, injection drug users, and sex trade workers residing in urban settings. These marginalized populations all face an increased vulnerability to HIV and have a greater chance of residing in economically poor neighbourhoods as historical marginalization is replicated frequently within cities (NAHO, 2009; Vernon, 2000). In fact, ten percent of Vancouver's Downtown Eastside (DTES) community identify as Aboriginal when they account for only 1.9% of Vancouver's population (City of Vancouver Central Area Planning Department, 2006; Statistics Canada, 2008). This area is well-known as the poorest postal address in Canada (Benoit and Carroll, 2001). Literature acknowledges that HIV vulnerability tends to follow patterns of social inequity (Larkin et al., 2007; Farmer, 1996). Therefore, it is not surprising that this neighbourhood has been noted to have had the highest rate of HIV/AIDS transmission in the Western hemisphere (TACCIT, 1999 as cited in Benoit and Carroll, 2001).

Surveillance data and seroprevalence studies show an alarmingly higher HIV prevalence and HIV infection rate among Aboriginal people than among other Canadians (Health Canada, 2004b). In British Columbia, Aboriginal people account for 15-17% of new HIV infections each year, yet they only constitute approximately 5% of the population (Provincial Health Officer's Annual Report, 2007). While there is a lack of epidemiological data on the differences in HIV prevalence between urban and rural Aboriginal populations, a community study of Vancouver's DTES indicated an 18%

prevalence rate in 2002 and the Vancouver Injection Drug Users Study (VIDUS) reports a HIV prevalence of 26% among male IDUs and 35% among female IDUs in this neighbourhood (Vancouver Coastal Health Authority, 2005; Spittal et al., 2002).

1.3.3 The Need to Expand HIV/AIDS Treatment

For over a decade, evidence based research has proven the efficacy of Highly Active Anti-Retroviral Therapy (HAART) in improving health outcomes and extending the lives of people living with HIV/AIDS (Wood et al., 2003). The expansion of HAART coverage within communities also has the potential to improve a population's health and well-being in the future by reducing stigma and disseminating knowledge on HIV/AIDS among family and friends, as more people begin to access health services (Mahajan et al., 2008). Furthermore, HAART can reliably prevent vertical HIV transmission and has shown to have a protective effect on HIV transmission among serodiscordant heterosexual couples in a number of studies (Volkow and Montaner, 2010). Research shows a marked reduction in new HIV cases after the introduction of HAART in various countries and settings (Ibid.). Despite HAART's therapeutic and preventative benefits, challenges remain in expanding HARRT to everyone who is eligible for HIV treatment, especially among Vancouver's marginalized Aboriginal population.

The BC Center for Excellence in HIV/AIDS (BC-CfE) recently launched a $48 million project entitled *Seek and Treat for Optimal Prevention of HIV/AIDS* (*STOP HIV/AIDS*) which aims to actively locate undiagnosed and untreated marginalized people living with HIV/AIDS in the urban areas of Vancouver and Prince George. This initiative further highlights the importance that reaching marginalized populations who are not currently utilizing HIV/AIDS treatment services will play in curbing this epidemic on a larger scale. It is based on a new approach to combating HIV/AIDS termed "treatment as prevention" that stems from evidence indicating that expanding HAART coverage will

decrease viral load within populations thereby reducing transmission and theoretically

optimizing the prevention of HIV/AIDS (British Columbia Center for Excellence in

HIV/AIDS, 2010). While it is too early in the planning stage to include a discussion of the

Seek and Treat program in this paper, the findings may prove useful for this program to

consider when working to expand HAART coverage and sustainably improve treatment

adherence among marginalized urban Aboriginal populations.

1.3.4 Barriers to Expanding HAART Coverage

"There is growing evidence that a high proportion of the ongoing AIDS mortality

in the developed world is due to poor access to therapy among disadvantaged or

marginalized populations" (Wood et al., 2003, p.2420). The accessibility of health care

is commonly seen as a geographical problem that concerns northern and rural

Aboriginal communities rather than being an important issue in large metropolitan cities

where health and social services are abundant for the general public. However, this

frequent conclusion fails to ask whether urban Aboriginals are indeed accessing these

services and overlooks the structural and social environments which may inhibit

equitable health care utilization by Aboriginal people within Canadian cities. This paper

embraces the broadest definition of access that includes a desire for care, the initiation

or entry into care, and the continued use of care with an implicit link to health outcomes

(Goldsmith, 2007).

HIV/AIDS is already a highly stigmatized disease, making it difficult for the

average person to seek treatment or disclose their HIV/AIDS status. This stigma can

only be compounded for those urban Aboriginal peoples who are marginalized by social

and structural inequity. Many of the urban Aboriginal peoples living with HIV/AIDS in the

DTES have been displaced from their reserve communities and left with no social

support due to a lack of understanding and stigma against this disease in their home

communities (Adelson, 2005; Benoit and Carroll, 2001). Urban Aboriginals may also be facing the added challenge of navigating a new and unfamiliar health care system and complexities in health coverage depending on their legal status (Status, Non-Status, Band member) (Peach, 2004).

A deep distrust in the health care system has been ingrained in many Aboriginal peoples due to the historical injustices their people faced at the hands of a colonial government; from the experimental treatments at Indian Hospitals, to the Sexual Sterilization Act, and the physical and emotional abuse at residential schools (Kelm, 1998; BC Association of Community Living, n.d.;Lux, 2007; Bucharski, Reutter, and Ogilvie, 2006). In addition, experiences of continued racism or cultural ignorance during interactions with health care practitioners can further this distrust and under utilization of mainstream health care (Browne and Fiske, 2001). In some cases, doctors do not accept urban Aboriginal patients due to negative stereotypes they hold or an avoidance of patients who use drugs, creating difficulties among this population with securing a primary care doctor in the city (Mckoy, 2005). Many Aboriginal people are located in socially marginalized positions and have been subjugated by authority figures under the colonial government or within residential schools. This history may result in Aboriginal people receiving poor quality treatment from practitioners, as these individuals may not feel safe in raising questions or clarifying medical instructions with their doctor (Browne and Fiske, 2001). Furthermore, doctors may not acknowledge the reality of their patients' lives when providing information and treatment instructions (Browne and Fiske, 2001; Mckoy, 2005). Homelessness, drug use, lack of adequate housing, psychiatric health issues, and general social instability all makes access to HIV care and treatment even more challenging, and safe health care interactions even more pertinent (Barlow et al., 2008). Therefore, this paper aims to explore how health care services in Vancouver

can better provide culturally safe care in order to address the access barriers discussed above.

1.3.5 The Role of Cultural Safety

Culture is viewed in this paper as "a complex network of meanings enmeshed within historical, social, economic and political processes. It is not therefore reduced to an easily identifiable set of characteristics, nor is it a politically neutral concept." (Anderson and Reimer Kirkham, 1999 as cited in Browne, and Varcoe, 2006, p.157). However, western society tends to view culture as the "values, beliefs, knowledge, and customs [of different ethnic groups] that exist in a timeless and unchangeable vacuum outside of patriarchy, racism, imperialism, and colonialism" an understanding which makes it easy to pinpoint 'culture' as the issue behind social problems or health differences seen between groups of people (Razack, 1998 as cited by Browne and Varcoe , 2006, p.157). Cultural safety moves beyond cultural sensitivity and cultural competency which tend to hold narrow definitions of culture. Most definitions of cultural competency are concerned with the application of knowledge about a culture to improve practices that will in turn improve health outcomes (Tripartite First Nations Health Plan, 2007). Instead, the term cultural safety focuses on analyzing and addressing power imbalances, colonial/post-colonial relationships and institutional discrimination that can contribute to access deterrents (Smye et al., 2010). It involves changing attitudes and the continued self-reflection of providers and institutions on their own culture that they bring to their practice, as well as recognition of the historical, social, political, and economic determinants of health inequities. Thus, the concept of cultural safety is well positioned to address the many access barriers that stem from structural inequities and disempowering attitudes towards Aboriginal peoples within the health care system (Note: cultural safety is further defined in Section 3.1).

Many of the health care access barriers discussed above could be mitigated theoretically through self-reflexivity and an acknowledgment of the history and power imbalances that have shaped Aboriginal peoples health outcomes today. For instance, practitioners' negative perceptions and stereotyping, their authoritative aura, or their disregard for the history and social context of their patients lives are some of the root causes of these deterrents to accessing health care. Furthermore, the intergenerational distrust and attitudes that many Aboriginal peoples have developed of the health care system needs to be alleviated through safe care that goes beyond standard quality care if healing from the past few centuries is to occur to enable trust to be built between health care institutions and Aboriginal peoples.

Many urban Aboriginal people are very transient as they maintain connections to rural communities which they frequently visit or return to or their social instability necessitates migration within Vancouver to secure housing or employment (Newhouse and Peters, 2003;NAHO,2009). This mobility poses challenges for HAART adherence (Lima et al., 2009). Thus, migration speaks to the need for culturally appropriate HIV/AIDS treatment services and continuity of care throughout British Columbia, in both rural and urban localities to help prevent treatment default. Urban migration, drug use, incarceration, or the socio-economic context of Aboriginal peoples' lives may also prevent stable adherence to HARRT. Building a positive connection and allowing safe communication between clients and practitioners is the first step in solving these challenges.

2: METHODS

A critical literature review on cultural safety will inform an exploratory review of key efforts by an Aboriginal health centre and health authorities in Vancouver to provide appropriate services to urban Aboriginal peoples living with HIV/AIDS. Key articles were located from NAHO's (2006) annotated bibliography list on cultural safety as well as the reference list from Smye, Browne, and Josewski's (2010) cultural safety report. Literature on health care access barriers faced by urban Aboriginal peoples was reviewed in previous coursework and provided the background needed to inform this paper's argument for strengthening the provision of culturally safe health care.

Following the literature review, meetings were arranged with key informants from Vancouver Native Health Society (VNHS), Vancouver Coastal Health (VCH), Fraser Health (FH), and the Provincial Health Services Authority (PHSA) in order to obtain program description and policy documents, as well as garner insight on the organizational familiarity and challenges, for implementing concepts of cultural safety within their respective organizations. Also, the official websites of these health institutions were reviewed for information on the provision and oversight of culturally competent and safe health care. Principles of cultural safety highlighted by the literature review are then discussed in relation to the current initiatives reviewed and the paper provides recommendations to move forward in improving health care utilization by urban Aboriginals, particularly for those living with HIV/AIDS.

3: LITERATURE REVIEW

3.1 Defining Cultural Safety

The majority of literature on cultural safety originates in New Zealand where the term was first introduced by Maori nurses in the late 1980s (Smye, Josewski, and Kendall, 2010). Ramsden (1990; 2002) was the first scholar to develop the concept of cultural safety as a critical lens to examine health care interactions. The term was based on the belief that challenging the structural inequities and power imbalances in patient-provider interactions could help address the Maori under-utilization of mainstream health care services that are linked to the poor health outcomes experienced by indigenous populations (Smye et al., 2010). The notion of cultural safety emerged as public awareness surrounding the long term impact of colonization grew and activists called for recognition and action on the rights of Maori to health under the Treaty of Waitangi, as well as in response to the state's disregard for indigenous health belief systems (Ramsden, 2002). In 1992, the Nursing Council of New Zealand developed curriculum guidelines and incorporated cultural safety into their nursing education curriculum (Wepa, 2003). The concept has since permeated other health fields apart from nursing and the application of the concept to health care in Canada has been explored by a number of academics (Ibid.). Still it is a relatively new concept and the vast majority of literature on culturally appropriate health care focuses on constructs such as cultural awareness, cultural sensitivity, and cultural competency.

A nursing student in New Zealand first coined the term when she questioned, "You talk about legal safety and you talk about ethical safety. But what about cultural safety?" (Pere, 1997, p.45 as cited in Wepa, 2003). The term subsequently evolved,

although ambiguity remains surrounding its meaning as scholars have varied slightly in how they have conceptualized and explained the term (Polaschek, 1998). Literature on cultural safety most commonly begins by defining culturally unsafe care as "any actions which diminish, demean, or disempower the cultural identity and well-being of an individual" (Whanau Kawa Whakaruruhau, 1997, p.7 as cited in Smye et al. (2010); NAHO (2008); Polaschek, 1998). Thus, culturally safe care has been defined as "actions which recognize, respect, and nurture the unique cultural identity of the Tangata Whenua [or other indigenous populations] and safely meet their needs, expectations and rights" (Whanau Kawa Whakaruruhau, 1991, p.7 as cited in Smye et al., 2010). The meaning of this term then tends to be constructed based on what other concepts of culturally appropriate care lack (Polaschek, 1998). For instance, cultural competency can reinforce paternalistic care and racism by simplifying "culture" and creating experts or technical skills in Indigenous cultures that in fact demean or disempower recipients of care (Bruni, 1988 as cited in Smye et al., 2010; Hart-Wasekeesikaw, 2009). Likewise, cultural sensitivity implies that we need to respect difference and treat everyone the same irrespective of gender, race, religion, or sexual orientation rather than treating people in a way that recognizes the historical and social processes that define them today (Coup, 1996; Ramsden, 2002). Therefore, cultural safety is about more than being knowledgeable about different cultural practices, it is about recognizing how certain groups are positioned, perceived and treated in society (Polaschek, 1998).

The original cultural safety objectives outlined for nursing education in New Zealand involved four core components: educating nurses to be self-reflective of their own cultural realities and attitudes; teaching them to be open minded and flexible towards differing views and cultures; preventing victim blaming for the historical and social processes that have shaped Aboriginal peoples' plight today; and producing a

workforce that recipients of care define as culturally safe (Ramsden and Spoonley, 1994). Five main principles of cultural safety emerged from this literature review that reflect these original objectives. First, the concept attempts to challenge power inequity and discrimination embedded in institutions and patient provider interactions due to ongoing colonial and neo-colonial processes. Second, it calls for an understanding of the social, political and economic histories and government practices that have contributed to health inequities among Aboriginal populations. Third, it is achieved through a self-reflexive process on the part of health practitioners. Fourth, following these key tenets will promote the recognition and value of Aboriginal practices and ways of knowing. Fifth, this process must be participatory and bring voice to the marginalized, as only they can determine whether their care is culturally safe (NAHO, 2008; Smye et al., 2010; Ramsden, 2002; Ramsden and Spoonley, 1994; Hart-Wasekeesikaw, 2009;; Wepa, 2003; Browne et al., 2009; Polaschek, 1998).

In essence cultural safety attempts to change attitudes among health professionals that will serve to deconstruct power differentials within the health care delivery system that put clients at cultural risk. Creating positive health care interactions that support Aboriginal people in accessing health care services goes beyond being aware and respectful of the diversity of Aboriginal cultures. It requires the rebuilding of trust by recognizing and fostering healing from the history of mistreatment and discrimination that continue to be reflected in the health inequities seen today.

3.2 Theoretical Foundations and Practical Implications

At its foundation, cultural safety is linked to post-colonial theorizing, as it attempts to unmask neo-colonial relations and practices (Anderson et al., 2003). Literature also

connects the concept of cultural safety to a Critical Theory paradigm, as its purpose is to unveil the social, political and economic forces behind health inequities and shift the status quo (Smye et al., 2010). Browne et al.'s (2009) document on the practical implications of cultural safety look at the term as a tool for social justice, arguing that the concept should be translated into practice in health care settings through practitioners' active engagement with a social justice lens.

The Nursing Council of New Zealand provided the first document or blueprint for cultural safety in which it was viewed along a continuum of appropriate care that started with cultural awareness and then cultural sensitivity before reaching cultural safety (Wepa, 2003). Consistent with other literature, Hart-Wasekeesikaw (2009) explains cultural awareness as "the beginning step toward understanding that there is difference" and cultural sensitivity as the expression of "behaviours that are considered polite and respectful by the other" (p.21). However, both these terms view "culture" as an exotic phenomenon that belongs to the "other" and they do not challenge the ethnocentric practices of the health care system, social structures, or the providers own perspectives which affect the care that Aboriginals and other ethnic minorities experience (Ibid.). Cultural competence definitions do involve the practitioner recognizing their own attitudes, and having the skills and knowledge to deliver "quality" care to different cultures, but these current definitions run the risk of reducing competence to technical skills rather than engaging the practitioner in purposeful self-reflection and action. The way in which cultural competency has been taken up has been criticized because of the tendency to homogenize Aboriginal culture and promote a paternalistic and ethnocentric approach, as practitioners become experts or qualified practitioners in treating Aboriginal people (Bruni, 1988 as cited in Smye, Josewski and Kendall, 2010). For example, practitioners may make efforts without consultation to accommodate a cultural practice

that is not practiced by their patient's culture or for an individual who does not identify

with Aboriginal spirituality. Creating experts in Aboriginal cultures is 'unsafe' or

disempowering in itself, as many Aboriginal people have lost knowledge of their culture

due to colonial processes (Ramsden, 1990). Some literature provides examples of how

cultural awareness can exacerbate racism and paternalistic care, as "simplistic

representations of culture reinforce negative stereotypical conceptualizations of the

"other" and divert attention from the structural inequities that disadvantage certain

groups of people based upon their culture" (Smye, Josewski, and Kendall, 2010, p.6).

The Transcultural Theory is a model that has been commonly used in nursing

since the 1950s for providing culturally competent care (Leininger, 1999). Cultural safety

supporters have criticized it, since it is based on practitioners learning and

understanding other cultures in order to predict their clients' health needs and ensuring

the care administered fits with their cultural beliefs (Ramsden, 2002; Leininger, 1999).

Conversely, Smye et al. (2010) outline the central tenants or core competencies that

health care providers need to provide culturally safe care. These tenets include an

understanding of colonization and post-colonial forces on the health of populations;

relationship building and collaboration which embodies principles such as respect,

inclusivity, and self-determination; safe communication and language; and the valued

recognition of indigenous practices and ways of knowing (Ibid.).

The concept of cultural safety has received its share of criticism in the New

Zealand media and within some academic literature (Ramsden and Spoonley, 1994;

Smye et al., 2010). Polaschek's (1998) article reviews many of the arguments and

limitations that emerge in discussions on cultural safety. First, the literature focuses on

changing attitudes of individual nurses rather than taking action to change the broader

societal structures which influence and form practitioners' attitudes and beliefs

concerning indigenous populations (Polaschek, 1998). The argument suggests that large scale change will not incur unless cultural safety moves beyond nurses' individual interactions with their patients, to examine health policies, health care settings and structural inequalities at the societal level. However, the term is still evolving and has more recently been exported to other contexts. For example, Smye and Browne (2002) analyze Aboriginal mental health policy in Canada from a cultural safety lens. Likewise, Smye et al. (2010) recognize that everyone involved in health care needs to embrace cultural safety. Therefore, their article moves beyond nursing education and clinical implications to discuss the practice of cultural safety in policy and research as well. Dion-Stout and Downey (2006) speak to the need for both a bottom up and top-down approach to institutionalizing cultural safety into the health care system. This argument further supports this paper in its assessment of cultural safety at an organizational level where top-level decision makers determine how institutions approach culturally appropriate services.

Ramsden (2002) and subsequent authors argue that cultural safety is based on biculturalism, or the structures and exchanges that operate between the dominant, white Anglo-Saxon population and Indigenous groups. It is important to note that there is much greater diversity of Aboriginal languages and peoples in Canada than New Zealand and more treaties and power differentials to negotiate with the government. However, the definition and concept of cultural safety still applies to Canadian Aboriginal people. Also, Canadian literature has explored its applicability to multicultural contexts and other minority groups (Smye et al., 2010; Baker, 2007). Nevertheless, the literature does continue to focus on Indigenous peoples, as they arguably possess a unique place within Canadian society and history that warrants cultural safe practices that are not simply best practice for all recipients of health care. Another concern, especially given

the principles of cultural safety, is the fact that little is known about how Aboriginals in Canada perceive this concept (Ibid.). Anderson, 2004 (as cited in Smye et al., 2010, p.20) argues that although cultural safety was born from indigenous nurses, unless it is "turned into a methodology 'for the marginalized, by the marginalized rather than a scholarship that informs both margin and centre' it will be rendered impotent as a tool for social change." However, it is the dominant culture that sits in a position to change many of the structural inequities cultural safety aims to challenge.

The fact that cultural safety has "yet to be articulated with great methodological rigour by its proponents" is perhaps its largest constraint in addressing structural inequities and creating change within the health care system (Polaschek, 1998, p.455). Both Smye et al.'s (2010) article and the guidelines released by the National Aboriginal Health Organization (NAHO) in 2008 are useful in discussing how to apply cultural safety into clinical practice and educational institutions. For instance, NAHO's guidelines on practicing cultural safety are based on the following domains which were established by the Tikanga Best Practice Guidelines in New Zealand (NAHO, 2008, p.21-25):

1. Create Aboriginal Rooms: First Nations, Inuit, Métis
2. Ceremony, Song and Prayers
3. Sacred/Ceremonial Items
4. Information and Support
5. Family Support
6. Food, Toiletries and Constitutions
7. Body Parts/Tissues/Substances
8. Pending and Following Death

NAHO's document advises that the guidelines for the above domains need to be incorporated into all levels of an organization to be effective. However, beyond mentioning that rooms which are designated for Aboriginal use should not be marginalized within health institutions, little instruction on how organizations can support

culturally appropriate action in these domains is provided. Furthermore, these guidelines simply focus on practitioners' behaviour in a clinical setting and how they can accommodate traditional practices and values in a manner that patients will perceive as 'safe', respectful, and inclusive. However, rather than attempting to make patients feel safe, empowered, and involved in decision-making only through the inclusion of traditional practices and values, the concept of cultural safety should invite reflection on: practitioners' attitudes towards Aboriginal patients which may override these practices; the power dynamics within health care relationships; the diversity of Aboriginal cultures and how assumed knowledge of traditions can perpetuate stereotypes and racism; and whether aboriginal ways of knowing are systematically acknowledged and valued or if certain practices that conveniently fit within a biomedical model are merely being incorporated. Examining how organizational policies, planning, programs and overarching attitudes can structurally enable or prevent this approach to cultural safety is essential. Thus, this paper will move beyond NAHO's guidelines for practitioners to discuss the five principles of cultural safety identified earlier in this literature at an institutional level.

In conclusion, while there are criticisms and limitations to the methodological application of cultural safety, this relatively new concept does move us beyond earlier definitions of cultural awareness and cultural sensitivity, to recognize the "social, structural, and power inequities that underpin health inequities/disparities" (Smye et al., 2010, p.ii). It is a very useful platform from which to reflect critically on attitudes and practices that continue to marginalize and perpetuate disempowering post-colonial relations. Given its purchase as a concept to be used in organizations, I now move on to discuss the cultural safety literature at the organizational and policy level, in an attempt to strengthen the application of cultural safety in order to better address the HIV/AIDS

epidemic and general health status of urban Aboriginal populations residing in Vancouver.

3.3 Cultural Safety within Canada

In addition to the Assembly of First Nations (AFN) and NAHO's endorsement of cultural safety there have been efforts to introduce this concept into the educational curriculum of health care professionals in Canada (Smye et al., 2010). The Aboriginal Nurses Association of Canada (A.N.A.C) along with the Canadian Association of Schools of Nursing (CASN), and the Canadian Nurses Association (CNA) developed a framework for cultural competence and cultural safety which was launched in 2009 with the aim of "enabling all nurses to provide optimal care for First Nations, Inuit, and Métis clients" (Aboriginal Nurses Association of Canada, n.d.). As part of phase two of this project, six Canadian nursing schools are currently developing methods for integrating the presented framework into their educational curriculum (Ibid.). In addition, the University of Victoria's School of Nursing has taken the initiative to provide three online learning modules on cultural safety which are accessible and free to the public (http://web2.uvcs.uvic.ca/courses/csafety/mod1/).

The Indigenous Physicians Association of Canada, along with The Royal College of Physicians and Surgeons of Canada (RCPSC) developed core competencies on First Nations, Inuit and Métis health in which having a working knowledge and definition of cultural safety is a core component of medical education programs (IPAC-RCPSC, 2009b). A core curriculum in Indigenous health is now being piloted in select health programs such as Obstetrics, Family Medicine, and Psychiatry (IPAC-RCPSC, 2009b). These efforts have largely been funded through Health Canada's Aboriginal Health

Human Resources Initiative (AHHRI) (Smye et al., 2010). While it is a lengthy process to reach consensus and develop and implement cultural safety curriculum into all medicine and nursing schools, it is promising that certain health professional programs have begun to incorporate this concept, providing future opportunity for all health professionals in Canada to understand and act out cultural safety.

Many of these initiatives emphasize the importance of understanding Aboriginal conceptual approaches to health and healing. The medicine wheel is a traditional Aboriginal health belief model used by many though not all Aboriginal cultures, where health is viewed as attaining balance between four quadrants of the self: emotional, physical, mental, and spiritual, as well as being interconnected with your community and mother earth (Twigg and Hengen, 2009). This perspective is consistent with holistic care which is an important means of addressing some of the economic and social conditions and mental health issues that are manifested in a complex interplay of factors which often result in treatment default or health care access barriers.

The Mental Health Commission of Canada (MHCC) aims to bring an integrated mental health system to the country by being a catalyst for reform of mental health policies and services, disseminating evidence based information, and working to diminish the stigma and discrimination faced by Canadians with mental illness (Mental Health Commission of Canada, n.d.). The Commission's First Nations, Inuit, and Métis advisory committee is committed to ensuring cultural safety is a pillar of the MHCC anti-stigma campaign (Ibid.). The scope of the MHCC and the role that mental health issues play in HIV vulnerability and access to health care makes the MHCC's endorsement of cultural safety a significant step forward for this concept.

Nevertheless, despite advances in education curriculum and the uptake of cultural safety by the MHCC, Smye et al. (2010), state that very few health authorities in

Canada have adopted cultural safety frameworks even though there appears to be

considerable support for its integration. Therefore, several of the main initiatives by

health authorities and an Aboriginal health centre to provide culturally appropriate care in

Vancouver will be explored now in the context of HIV/AIDS treatment services to assess

how the application of cultural safety might be strengthened.

4: REVIEW OF CULTURAL COMPETENCY/SAFETY INITIATIVES IN VANCOUVER

As the conception of cultural safety occurred among nurses and focuses on health care provider interactions with clients, the methodological literature on applying the concept of cultural safety in practice is concentrated on addressing access barriers and reducing health inequities through educational processes in nursing schools. The literature review reveals that the methodological application of the concept of cultural safety focuses at the level of the individual health care interactions. However, given its underlying concern with challenging the social structures and power imbalances that create cultural risk, it seems evident that there is a great deal of value in moving beyond what educational institutions can do, to also apply this concept at the organizational level. Therefore, this paper seeks to focus on the role that health authorities and community organizations can play in changing institutional attitudes and practices that play a role in improving clients' interactions with the health care system.

4.1 Aboriginal Specific HIV/AIDS Services – Vancouver Native Health Society

Vancouver Native Health Society (VNHS) is the only health centre providing HIV/AIDS treatment services specifically to Aboriginal populations in the Greater Vancouver Area. Healing our Spirit in Vancouver and Kla'how'eya Healing Place in Surrey provide "holistic and culturally appropriate" HIV/AIDS prevention education and support services to people living with HIV/AIDS, though they do not administer antiretroviral therapy (Healing Our Spirit, 2010; Kla'how'eya Aboriginal Centre, 2010).

Therefore, this section will focus on the practices and policies at VNHS and how their organizational approach to service provision embodies and helps foster a culturally safe health care environment.

The organizational philosophy and model of care at VNHS serves to redress power imbalances and discrimination that their clients have historically faced and continue to encounter within the health care system. Individual interactions at VNHS begin with the health care staff asking their clients "Where you from" which is one 'Aboriginal way of greeting someone'; a way that some feel locates the person and legitimates their family background (Doreen Littlejohn, personal communication, June 1st 2010). Staff at VNHS then take the time to learn their client's story or invite them in for a coffee, rather than pushing a particular treatment agenda (Ibid.). Part of learning their story involves understanding the colonial and post-colonial forces that have shaped their health and well-being as well as their perceptions and behaviour that have emerged from past health care interactions. It is important that we learn individual stories and are mindful of the differences across Aboriginal peoples, while we find ways to recognize the collective colonial history and neo-colonial practices that have bound Aboriginal groups together and act on these structural processes that perpetuate socio-economic and health inequities.

Next, VNHS health care providers offer to walk with the person on their "Health Care Journey," recognizing their story and the trauma or violence they may have faced in order not to retrigger trauma or perpetuate negative experiences that will dissuade them from returning to seek health care. This terminology and practice of "walking alongside" the client is a perfect example of how the hierarchical power dynamic between health provider and patient is shifted and these individuals become collaborators in care, which helps to build trust, empower clients' voices, and counteract

negative neo-colonial relations. For urban Aboriginals living with HIV/AIDS who have left

rural communities and or face daily stigma and a lack of social support in Vancouver,

this act of reassuring patients that their doctor will walk alongside of them on a level

playing field and support them throughout their health care experience may provide the

trust and recognition that encourages them to return to health care appointments.

The organization also takes a medicine wheel approach to health; holistically

attending to the emotional, physical, spiritual and mental health of their clients that

operates within the context of community health (VNHS, 2009; Doreen Littlejohn,

personal communication, June 1st 2010). Countering paternalistic care by recognizing

indigenous ways of knowing begins with acknowledging Aboriginal definitions of health,

which generally incorporate spiritual, mental, physical and family/community health

(Ramsden, 2002). This inclusion of clients' community in the definition of health is also

in line with addressing an access barrier commonly discussed in the literature; that

doctors do not acknowledge the reality of their patients' lives when providing information

and treatment instructions (Browne and Fiske, 2001; McKoy, 2005). This is particularly

important for people enrolled on HAART, as the interruption or discontinuation of ARVs

can lead to drug resistance and treatment failure. Also, limited access to HAART may

be attributed to practitioners' reluctance to initiate persons of lower socio-economic

status based on assumptions about their lives and ability to adhere to therapy (Wood et

al., 2003).

Practitioner's failure to recognize their patient's community in the context of their

treatment can dissuade patients from accessing care, as their encounter may be seen

as a waste of time if they are unable to benefit from the doctors' advice and they may

view clinics as only serving "others" who are, for example, more affluent than

themselves. A community health perspective also speaks to the socio-economic

vulnerability of residents in the DTES. Smye et al. (2010, p.15) claim that "cultural safe practitioners have to move beyond the critical self-reflective to engage in actions that address the broader socio-political and economic determinants of Indigenous health and challenge the taken for granted processes and practices that continue to marginalize indigenous voices and needs". Key staff members at VNHS are also community advocates and political activists in fighting for better socio-economic conditions in the DTES, thereby challenging inequities that create barriers to health care access, increase HIV vulnerability, and contribute to disease progression. For example, they advocate for increased social housing and have protested against the closing of St.James' Cottage Hospice and other government actions which further marginalize residents of the DTES. However, in taking on responsibility to challenge the structural inequities that perpetuate health inequities, VNHS makes itself vulnerable to backlash from funders and institutions that maintain the status quo. Although, this organization may represent current best practice in the provision of culturally appropriate care, in some ways they are rendered powerless and can only help advance the provision of culturally safe health care services in Vancouver with the collaboration and action of mainstream health authorities.

VNHS staff also advocate for clients at other health institutions, demonstrating their commitment to challenging racial discrimination and providing safe care for their clients on a continuum beyond their Centre. The literature reports that Aboriginal people tend to over utilize hospital emergency rooms because they lack primary health care and stories where Aboriginals are turned away, ignored, or maltreated in emergency rooms continue to appear in the media (Kerr et al., 2004b). Health institutions are often hostile environments for Aboriginal peoples. For instance, the brick building that is St.Paul's Hospital may trigger memories of residential schools for some individuals (Doreen Littlejohn, personal communication, June 1st, 2010). Therefore, VNHS staff may

accompany clients to St. Paul's hospital if they have had negative health care encounters in the past or they visit patients from the Centre's community who are admitted into the HIV/AIDS ward.

A holistic and welcoming philosophy of care is upheld by the VNHS staff. The VNHS has a policy to hire Aboriginal staff first and seek people who understand the colonial history, intergenerational trauma, and current social and political context of marginalized peoples' lives in the downtown eastside (Doreen Littlejohn, personal communication, June 1st, 2010). Long-term staff members have helped provide continuity of care and maintain the trust and respect that has been built over twenty years of operation. A safe atmosphere is also built by having staff take time to learn each other's life stories. The VNHS Centre is also a welcoming home for Aboriginal peoples, as cultural values and practices are part of everyday operations at the Centre. For example, food is a central part of meetings, as the Centre is a home in which it is custom to share and come together over food. Joking and laughter is another common value in many Aboriginal cultures which is fostered at VNHS. Also, prayers are held before meetings and elders are often invited to talk at the Centre (Doreen Littlejohn, personal communication, June 1st, 2010).

VNHS also embraces participatory practices and owns their own research by only engaging in participatory studies with their clinic and its clients. Also, community volunteers help run the Centre's programs and have the opportunity to sit on the community committee for VNHS or in peer support groups within the Positive Outlook (HIV/AIDS) Program. These activities likely help give the recipients of care a voice in the Centre's operations as well as a sense of belonging at the centre and perhaps empowerment to help others in their community.

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Cultural safety as a self-reflexive process where health providers examine their own culture, attitudes, presumptions, and the world view they bring to their practice, may not be explicitly carried out by staff at VNHS. However, the values held by the organization do foster many aspects of cultural safety such as levelling out power imbalances, including participatory processes, incorporating Aboriginal cultural practices and healing models, and a knowledge and recognition of their clients' lives and socio-political history. Future research could explore or foster the self-reflexive process of cultural safety among staff at VNHS and provide participatory knowledge on whether the clients would define the care they receive as safe.

There is some initial evidence supporting the fact that VNHS provides culturally safe care to urban Aboriginals living with HIV/AIDS. The Aboriginal clientele in the Positive Outlook Program has gone from around 15% identifying as Aboriginal to over 80% of the people accessing their HIV services, highlighting the safe care which is attracting marginalized populations to access health services (Doreen Littlejohn, personal communication, June 1st, 2010). In addition, a study by Tu et al. (2009) found that Aboriginal peoples enrolled in HIV care at Vancouver Native Health Society "achieved similar rates of HIV care engagement, ARV uptake and virological suppression compared to non-Aboriginals" (Abstract, ¶5). The article hypothesizes that this unexpected equitable result is related to the "culturally safe" environment that VNHS provides to its clients (Ibid.).

4.2 Mainstream Health Services – Health Authorities within the Greater Vancouver Area

While Vancouver Native Health Society may currently be an example of best practice in providing culturally safe services and successfully attracting many Aboriginal

clients into a primary health care centre, at some point people living with HIV/AIDS need to access health services beyond the primary care provided at VNHS. The need for a continuum of care along with the value of preventing the development of a segregated health care system, make it important that mainstream health services also provide culturally safe environments. This paper will now review the approach and initiatives surrounding culturally appropriate care by health authorities who oversee the delivery of mainstream HIV/AIDS health services in the Greater Vancouver Area.

4.2.1 Provincial Health Services Authority

The Provincial Health Services Authority mandate is to provide British Columbia residents with a coordinated network of health services; as such, it plans, coordinates and evaluates specialized health services while working with other regional health authorities in the province. PHSA operates eight provincial health agencies such as BC Children's Hospital and BC Cancer Society and oversees specialized health care services like cancer treatment and cardiac care (PHSA, 2010).

The development of a cultural competency curriculum was mandated under the Transformative Change Accord: First Nations Health Plan which identified actions to close the health gap between First Nations people and other British Columbians in 2006 (Tripartite First Nations Health Plan, 2007). The PHSA has since developed and launched an online Indigenous Cultural Competency training in 2010 (Cheryl Ward, personal communication, June 10th, 2010). This training is introduced and delivered based on the understanding that cultural competency necessitates self-awareness in addition to 'knowledge, attitudes, and skills' to work effectively in cross-cultural nursing environments. It also emphasizes cultural competency as a continual learning process and practice rather than something that is achieved at some point in time. While the training does not clearly engage with the concept of cultural safety, the content does in

fact embrace a number of cultural safety principles. This may partly be due to the ambiguity in terminology and or the planning 'think tank's' time constraints and interest in developing consensus on a term and definition for this training.

The online curriculum attempts to move beyond teaching about different Aboriginal cultures, instead recognizing that cultural competency should start with an understanding of the historical context and an awareness of what practitioners bring to a health care interaction with Aboriginals or other marginalized groups. After providing a socio-historical foundation to the health disparities seen today, the training challenges attitudes and stereotypes, develops clinical communication and relationship building skills, and promotes the recognition and integration of both bio-medical and traditional models of healing in health care practice. The third module on enhancing self-awareness looks at the principle of self-reflexivity and the culture that health care professionals bring to their work, which is a key tenet of cultural safety. This module also touches upon the social position held by the training participant and the resulting advantages/privileges or disadvantages they encounter during their life. However, this notion of social group membership is primarily discussed in the context of deepening personal self-awareness of social identity and how it shapes the practitioner's values and interaction with others. The training could mention or have you reflect on how your educational training and on how your organization of employment shapes your values and approach to providing health care.

A cultural safety approach might extend the third module's focus on communication styles and situational awareness in clinical encounters to examine the power dynamics present within patient provider encounters or within health care institutions. For instance, the quietness of Aboriginal patients is often acknowledged as a culturally specific way of conveying respect (Browne and Varcoe, 2006). While this

may be true in some cases, this assumption does not recognize that a behaviour that has cultural roots has been exploited and reinforced by residential school staff to enforce conformity and reduce assertiveness among Aboriginal children who attended these schools. Thus, while this behaviour has cultural roots it has been strongly shaped by processes of power and paternalism (Ibid.). In the context of dealing with Aboriginal patients with HIV who may have faced domestic violence and sexual abuse, a practitioner's exertion of power is likely to be as strong a force in silencing their voice as any cultural sign of respect.

In order for health authorities to move towards cultural safety at an organizational level as well as within patient provider interactions, it is essential that non-clinical staff and directors undergo the training. This is in fact being done, and PHSA has noticed that in agencies where high leadership staff have taken the training the corresponding institution has portrayed more interest, inquiry, and commitment to training all their staff members (Leslie Varley, personal communication, July 14th, 2010). The training curriculum should also reflect the importance of cultural competency or cultural safety beyond clinical health care settings. Coincidentally, PHSA has received feedback on the training and is already looking to remove the module that focuses on improving skills and relationship building in clinical scenarios (Ibid.). Instead of being removed, perhaps this module could retain its content, but in the context and provision of videos and scenarios where relationship building and communication is examined with colleagues in your organization and with Aboriginal community stakeholders.

The importance of levelling the power imbalances between marginalized Aboriginal peoples and health providers operating in the dominant culture should be extended into the domain of health research. Promoting participatory research and empowering Indigenous voice (i.e. from those receiving care) is essential to the concept

of cultural safety. PHSA is interested in evaluating their cultural competency training course in a community with high levels of racial tension, by conducting a baseline and post-training assessment of service provision from community members that are receiving care, as well as practitioners' self-assessed learning and behaviour post-training (Leslie Varley, personal communication, July 14th, 2010). This will allow for the recipients of care to define whether PHSA's Indigenous Cultural Competency training is successful at preventing unsafe care and increasing the utilization of mainstream health services.

Finally, the director of Aboriginal Health at PHSA suggests that PHSA is open to and better positioned to address issues relating to Aboriginal health care, as other Aboriginal health departments sit on their own within their respective health authorities (Leslie Varley, personal communication, July 14th, 2010). On the other hand, the director at PHSA sits on an advisory committee that meets with the heads of other health agencies in Vancouver, creating greater opportunity for dialogue and collaboration on Aboriginal health initiatives across a wider spectrum of services. This is a noteworthy observation from a cultural safety perspective, as it has potential implications for improving the structure and positioning of other Aboriginal health departments.

4.2.2 First Nations Health Governing Body

The Tripartite First Nations Health Plan is a new governance structure for the health of First Nations peoples in British Columbia originating from the Transformative Change Accord (Tripartite First Nations Health Plan, 2007). This tripartite agreement between Health Canada, the Province of British Columbia, and the First Nations Leadership Council is the first initiative of its kind to create an Aboriginal health governing body with major control over "the design, delivery, and evaluation of health services" (Tripartite First Nations Health Plan, 2007, p.1). It is designed primarily to take

over services provided through the First Nations and Inuit Health (FNIH) branch of Health Canada that serves on-reserve First Nations and Inuit communities. Thus, the majority of Aboriginal people who now live in urban areas will not directly benefit from this initiative. However, efforts to increase the number of Aboriginal health professionals and or develop a more culturally competent health workforce will benefit the entire health care system. There are approximately twenty-two Aboriginal reserves within the Greater Vancouver Area (GVA) whose urban residents will only benefit from initiatives by this health authority, if they access services on reserve rather than at mainstream health facilities in the GVA (Greater Vancouver Regional District, 2003). Nevertheless, the control provided to First Nations under the Tripartite Plan is a significant step towards giving Aboriginal peoples a voice and power in determining and operationalizing culturally appropriate care, but it is important that urban Aboriginal communities are not overlooked by this significant move forward in Aboriginal self-determination.

4.2.3 Fraser Health Authority

The Aboriginal Health Department is a small component of Fraser Health Authority with approximately twenty staff and five nurses (Laurel Jebamani, personal communication, June 14th, 2010). It is difficult for this department to leverage commitment and leadership towards improving Aboriginal health care from other departments within FH, especially in the context of budget cuts (Ibid.). Again, a cultural safety perspective would call for the positioning of Aboriginal health within an institution to be examined to ensure the department and its initiatives are not marginalized.

In addition to funding aboriginal specific health programs, the Fraser Health Aboriginal Health department recognizes the need for mainstream health providers to recognize the unique needs of Aboriginal clients. Therefore, the department is promoting the PHSA Cultural Competency training to Fraser Health employees and

hopes to have 500 staff members voluntarily trained by the end of 2010. Also, different training and mentorship programs are offered periodically by FH Aboriginal Health department staff or by community elders to clinical staff (Laurel Jebamani, personal communication, June 14th, 2010). One example, although outside Vancouver's metropolitan area, was the Chehalis Indian Band who hosted a daylong gathering to discuss cultural awareness and death protocols last April, to which Fraser Health service providers were invited (Garner, 2010). Engaging Aboriginal leaders and elders in the concept of cultural safety would provide a venue for understanding how Canadian Indigenous populations perceive this term and may be a valuable concept for them to consider during the cultural awareness trainings they offer to mainstream health providers.

Each of the four health regions within Fraser Health Authority has one health liaison and one mental health liaison (Aboriginal Patient Navigators) whose job is to connect with Aboriginal people and corresponding service providers to ensure patients receive culturally safe and appropriate care when accessing services at a hospital or in the community (Laurel Jebamani, personal communication, June 14th, 2010). As mentioned earlier, complexities in legal categories have created challenges for migrating Aboriginals who must navigate a new and unfamiliar urban health care system (Peach, 2004). These Aboriginal Patient Navigators (APNs) are able to address this access barrier by helping patients understand and navigate the system as well as educating practitioners on providing safe and appropriate care (Fraser Health, 2009). Future research with APNs could provide a clearer sense of how they promote safe and appropriate care and whether they endorse principles of cultural safety, such as self-reflexivity or challenging power dynamics when working with health practitioners. Also, information on whether marginalized urban Aboriginals living with HIV are accessing and

benefiting from this service would be beneficial data when looking to improve access to HIV treatment services.

Unfortunately, FH has found it difficult to fill its APN staff positions, illuminating the widespread shortage of qualified Aboriginal health workers. Hart-Wasekeesikaw (2009) discusses how difficulty in attracting and retaining Aboriginal nurses is due to the hostile or discouraging institutional environments of nursing schools. She argues that the education system needs to be culturally safe by recognizing Aboriginal student's culture and values, providing Aboriginal student supports, nurturing reciprocal relationships that allow two-way learning between Aboriginal students and faculty, and including Aboriginal epistemologies in curriculum theory and practice (Ibid.). It is clear that cultural safety needs to be applied across health education systems, research, policy development, and institutional operations to have the greatest impact on addressing Aboriginal health inequities.

Through personal communication and upon review of Fraser Health's "Guidelines for Health Care Professionals" pamphlet and "Partners in Care: Respecting Diversity" it appears that Fraser Health Authority takes a multicultural approach to providing culturally appropriate care to clients in its jurisdiction. The first of these pamphlets articulates aspects of cultural safety by emphasizing open communication and the patients' right to voice their concerns. However, the wording of the pamphlet puts the onus on patients' to voice their concerns, ignoring the power dynamic and the position of the patient, which necessitates an empowering approach to elicit their voice. This may be important especially when patients are asked to talk about sensitive topics like HIV, sexual abuse, domestic violence, sex trade work, or injection drug use. The latter pamphlet follows a Transcultural theory approach to understanding and being 'sensitive' to the beliefs and spiritual practices of a number of "other" cultures including native

spirituality. Thus, the literature produced by FH to guide culturally appropriate service provision portrays an approach that concentrates on multiculturalism and cultural sensitivity running the risk of enabling culturalism and ignoring structural inequities.

While multiculturalism is justly promoted and legislated within Canada, some academics in the field of cultural safety would argue that the term "multiculturalism" masks "unequal power relations and the impact of dominant culture positions" by bringing attention to the plethora of different cultures rather than the institutional discrimination resulting from the dominant culture's position of power (Browne et al., 2009, p.169; Ramsden and Spoonley, 1994). While the application of the concept of cultural safety to health care interactions between the dominant culture and other cultural minorities has been explored, it is justifiable as part of affirmative action philosophy to have health care departments, policies, and philosophies that recognize the unique historical position of indigenous peoples and warrants special attention to deconstructing colonialism and the power differentials between the dominant peoples and Aboriginal Canadians. While the Aboriginal Health Department and its initiatives to build a culturally competent workforce is a step in this direction, it might be beneficial if Fraser Health in its entirety recognized and created policies surrounding the provision of safe care to Aboriginal populations beyond the current multicultural approach their literature portrays.

5: FINDINGS

While there is merit in changing attitudes and behaviour towards Aboriginal peoples at the individual level of the health practitioner through educational curriculum, these health workers are often constrained by the organizational values, structure, and policies that they work in. Furthermore, a critical literature review reveals how the concept of cultural safety; i) lacks methodological application, ii) attempts to challenge societal power and structural inequities, yet continues to focuses on the level of the individual, and iii) is gaining support within nursing and physician training curriculum and is endorsed by NAHO and AFN, but has yet to be adopted by most health authorities. This review of key Aboriginal health initiatives by VNHS, FH, and PHSA further supports the value of applying a cultural safety approach to organizational operations.

The example of care provided by VNHS, illustrates how institutional philosophies, policies, and practices can help create culturally safe environments and successfully attract Aboriginal people to access HIV treatment services. The Indigenous Cultural Competency curriculum developed by PHSA is already embracing some principles of cultural safety, illustrating an openness and support to moving towards this concept in order to provide culturally appropriate health services that improve health care utilization and health outcomes. Finally, the discussion of Fraser Health's policies and initiatives from a cultural safety lens illuminates areas where culturally appropriate care can be strengthened beyond issues which cultural competency identifies. It is important to reiterate that this document is not an assessment of health authorities or organizations and their initiatives. Rather, it is a discussion around how to promote an organizational environment that helps strengthen the provision of culturally appropriate care.

The terminology and meaning behind cultural safety may not yet be fully understood or used by people in the health care field because of: the ambiguous nature of this term; a lack of time to engage in the literature and history of the term; resistance or complacency to a new term, as there are already many similar terms and different First Nations people have different understanding of these culturally appropriate care terms; and public opposition to addressing institutional racism and discrimination. Ultimately, it is the care that is received that matters, but in many ways, cultural safety is better positioned to focus on the care that is given, as its key tenet is that it is defined by the recipient of care. A Report on Aboriginal Health Strategies in British Columbia (Internal Audit and Advisory Services, 2007) notes that one of the barriers to moving forward in providing culturally competent Aboriginal health services is that the cultural diversity of Aboriginal communities creates less support for common training throughout the province. The concept of cultural safety acknowledges this diversity and provides a notion of culture that is not static, but is tied to social, political and economic histories. Thus moving towards a culturally safe curriculum would diminish local concerns around cultural relevance, by focusing on the power dynamics and structural inequities that are embedded within health care provider interactions with their clients. Therefore, embracing the cultural safety definition and concept could help us move past differing understandings of cultural competency, to focus on the underlying structural inequities and relationship dynamics that are crucial to creating empowering experiences of care that encourage rather than discourage clients from accessing health care in the future.

Clearly, there is a need to develop a methodological framework for further analysis on the applicability of cultural safety at the organizational level. In the next section, I present a draft cultural safety tool based on the findings of this paper's literature review and discussion of Aboriginal health initiatives.

5.1 Organizational Cultural Safety Self-Assessment Tool

A self-assessment tool that engages organizations to reflect on their institutional practices and identify areas where they could strengthen cultural safety may be a beneficial approach to addressing the structural inequities that deter urban Aboriginal peoples from accessing health care. Existing cultural competency frameworks such as the Purnell Model tend to focus on providing guidelines to clinicians (Purnell, 2002). While there are some valuable tools that explicitly focus on assessing organizational cultural competency (e.g. Ngo, 2008; Ngo, 2000), a cultural safety lens at the organizational level would broaden the criteria examined to include principles of self-reflexivity, power relationships, and the structural recognition of Aboriginal health models and the socio-historical determinants of health. Thus, a draft self-assessment checklist has been developed based on the five key principles of cultural safety that the literature review identified. It consists of a series of questions based on the issues that emerged from the discussion of key Aboriginal health initiatives by VNHS, PHSA, and FH's from a cultural safety perspective. It is hoped that this initial tool will serve as a starting point from which to conceptualize a framework for the application of cultural safety principles at an institutional level and contribute to discussions by Aboriginal scholars about how to strengthen culturally appropriate services through a cultural safety perspective (see Appendix 1).

6: RECOMMENDATIONS

The implementation of a cultural safety tool necessitates particular attention, as cultural safety is as much a process as it is an outcome that recipients of health care define. People in time constrained working environments where efficiency is valued, often regard a checklist as a quick tool that can be attended to and then disregarded. The best use of a tool will be one that is able to invite discussion and dialogue that cultivates continual critical reflection on institutional practices and policies that may contribute to structural inequities and unsafe care.

Challenging the status quo and encouraging people to reflect on their attitudes and assumptions without backlash requires engagement and dialogue in a positive and safe environment. Browne et al. (2009) discuss how the use of the words 'culture' and 'safety' have the risk of being interpreted narrowly like the terms cultural sensitivity and cultural competency which cultural safety attempts to move away from. Also, the article asks whether we are using cultural safety as a less contentious term to address social justice issues. Furthermore, since the concept of cultural safety "cannot be neatly packaged.....as a concrete set of standards for practice" the article suggests that a 'social justice lens for practice' might better enable nursing students to engage in the philosophical basis of cultural safety and foster critical inquiry and self-reflection in practice settings, that would advance the equity goals sought by the concept of cultural safety (Browne et al., 2009). While this idea has merit, trainings and workshops on cultural sensitivity or competency are already promoted within health authorities making the introduction of another term that is grounded in the health care experience of cultural

groups, but with broader social equity goals a potentially more serviceable idea to adopt and deliver to employees.

This paper recommends that a cultural safety tool or framework, such as the one developed in this paper, would be best implemented through organizational workshops or trainings that engage employees and facilitate dialogue. As mentioned earlier, the last module of PHSA's Cultural Competency training currently focuses on developing skills for communicating and interacting with patients in clinical settings and could perhaps provide organizational scenarios for administrative and managerial staff to consider. This might prove a great place to pilot an organizational cultural safety self-assessment tool, first as an individual exercise for non-clinical staff to reflect on how their organization could better support the provision of culturally safe care and challenge practices that place indigenous peoples at risk of discrimination and health inequities. This exercise could be followed by a facilitated teleconference call surrounding this activity that would provide a safe medium for dialogue and discussion with colleagues on addressing structural inequities within health authorities in British Columbia. Finally, periodic organizational workshops could provide an ongoing platform for reflection and mediated discussion on topics such as institutional discrimination, power dynamics, organizational values and indigenous ways of knowing. In addition, a cultural safety tool could be introduced within organizational workshops to facilitate discussion, emphasize critical reflection, and brainstorm ways to change policies and practices to help us work towards health equity. This cultural safety tool could be piloted and evaluated through an Appreciative Inquiry study with organizational staff on how they engaged with the tool and what attitudes, practices, or policies changed within the organization as a result of these cultural safety workshops. A qualitative pre-assessment on how recipients of care view the cultural safety of the health care provided to them by specific health authorities,

followed by a post-assessment several years after the organizational tool is implemented

could provide additional information on the value of an organizational cultural safety tool

or framework.

7: DISSCUSSION

The concept of cultural safety is well positioned to address current health care access barriers faced by Aboriginal people that negatively affect their health outcomes across a broad range of diseases and health conditions. In the case of HIV/AIDS, cultural safety could be taken up in the field of public health in a number of ways. First, public health programs tend to focus on individual risk behaviour in both health promotion and prevention strategies. This approach ignores the historical and social determinants of health, and assigns blame to individuals that although not intended creates stigma and judgement that can dissuade Aboriginal people from accessing HIV care. Bucharski, Reutter, and Ogilvie's (2006) qualitative study on "Canadian Aboriginal Women's Perspectives on Culturally Appropriate HIV Counselling and Testing" suggests that a harm-reduction approach would be a value-neutral stance that would oblige practitioners to provide options to patients on how to reduce their risk of HIV or future personal harm in the context of their life experiences which may not currently enable them to abstain from high-risk behaviours.

Second, epidemiological research that focuses on risk factors and the high HIV seroprevalence among Aboriginal populations, constructs an image of sick and dependent peoples that can reinforce unequal power relationships (O'Neil, Reading, and Leader, 1998). Surveillance data that does not acknowledge the historical and social determinants of health runs the risk that Aboriginal people and communities will internalize blame for their poor health, further disempowering individuals living with HIV/AIDS or other health conditions (Ibid.). Perhaps all surveillance reports that are produced by health institutions should be mandated to include a disclaimer on the

colonial and neo-colonial processes that increase Aboriginal peoples' vulnerability to HIV, to illicit greater reflection and recognition of structural inequities by health professionals and the Canadian public. All research conducted by mainstream health institutions that involves Aboriginal people should follow and value First Nations' Ownership, Control, Access, and Possession (OCAP) research principles as they promote some of the key tenets of cultural safety and allow for participatory research that gives greater voice to Aboriginal recipients of care. The OCAP principles provide an opportunity for self-determination and prevents the production of research that is 'one-sided' or conducted through the lens of the dominant society without benefit to the Aboriginal community. A parallel could be drawn between the philosophical basis of OCAP principles and culturally safe health care interactions, by viewing the patient as having ownership and control of their health information and the practitioner as being available not to extract data or place judgement on the patient, but to assist them with knowledge that empowers and builds their capacity to manage their health.

Finally, holistic programs that provide patients with greater choice of traditional and non-traditional treatment options and advocate for improved social conditions would better serve the needs expressed by urban Aboriginal people living with HIV/AIDS in a number of qualitative studies and from a cultural safety perspective (Benoit and Carroll, 2001; Bucharski et al., 2006; Tu et al., 2009). While organizations like VNHS may be providing current best practice in culturally safe HIV/AIDS care, they currently exist outside mainstream health care services. Public health professionals need to be open to working with Aboriginal health organizations to explore the applicability of their organizational practices to health authorities serving the Greater Vancouver Area.

8: LIMITATIONS

This paper has several limitations. First, although information pertaining to VNHS, PHSA, and FH was obtained through key informants, an exhaustive review and analysis of all policy documents and services provided by these institutions was beyond the scope of this paper. Second, the information obtained through personal communication was not validated by other staff members or through primary research. Furthermore, while culturally safe care is defined by the recipients of care, this paper's assessment of the extent to which HIV health care services in Vancouver are governed by principles of cultural safety is removed from those receiving care and should involve participatory discussions and research to appropriately determine where cultural safety stands. Therefore, this document's discussion on how to work towards equitable health care access through the concept of cultural safety can only serve as a guideline and platform for further analysis and reflection on best practice.

Unfortunately, this paper excluded a discussion of key initiatives by Vancouver Coastal Health Authority to provide culturally appropriate care within mainstream health services. This is a serious drawback given that VCH oversees the majority of health services in the GVA and has jurisdiction over Vancouver's DTES where a significant portion of the marginalized urban Aboriginal population living with HIV/AIDS resides. VCH initiatives were omitted from this paper due to the challenge of scheduling a meeting with a key informant in time to include a discussion of their efforts prior to this projects' deadline.

Despite this document's portrayal of Vancouver Native Health Centre as current best practice, some literature points to the challenges and areas where VNHS may not

be providing culturally safe services. For example, female Aboriginal participants in

Benoit and Carroll's (2001) article expressed concern for security and anonymity at

VNHS, suggesting that they associated the presence of social workers and child welfare

workers with child apprehension. Given the historical trauma surrounding child

apprehension in Aboriginal communities, perhaps further effort needs to be made by

these social workers to help clients feel culturally safe. Health institutions could support

this by: ensuring their social workers are exposed to cultural safety training and are

critically aware of the history attached to their position; creating policies surrounding the

presence of social workers at HIV testing sites; distributing literature to patients

acknowledging their potential apprehension and explaining the roles and protocols that

social workers will follow; and working with Child Welfare to better support families rather

than apprehending children. A larger concern which emerged was that although

elements of Aboriginal culture are incorporated into programs at VNHS it appeared to

some clients that there is no overarching attempt to integrate traditional models of health

into the bio-medical approach that dominates services at the centre. The article

suggests that this may in part be due to the fact that the centre is tailored to meet the

needs of all peoples in the DTES whether Aboriginal or non-Aboriginal (Ibid.). Thus,

these criticisms bring up difficult questions surrounding how best to integrate traditional

ways of knowing and health belief models into the bio-medical health care system and

appropriately respond to the voices of marginalized populations.

Critics of cultural safety have claimed that the institutional change this concept

promotes is too idealistic (Polaschek, 1998). This paper might appear to be jumping too

far ahead of where health services stand today with respect to providing culturally

appropriate care. In other words, more could be done in terms of providing room for

cultural services and practices in health care settings or recruiting and retaining

Aboriginal health professionals before structural inequities and institutional attitudes are challenged. However, I would argue that these need to be done simultaneously to be effective. Moving forward with culturally appropriate care requires different cultural practices and beliefs to be accommodated in health institutions, but in a sensitive manner which also provides a critical lens of power inequities to ensure that power dynamics and discriminatory practices are not perpetuated. Cultural safety is essential to work towards healing from the history and legacy of colonialism, promote self-determination, and equitable socio-economic and health statuses among Aboriginal Canadians.

9: CRITICAL REFLECTION

Upon initiating this Master's Project, my background in this subject matter was limited and not informed by a rich practicum experience in Aboriginal health services. I recognize that stronger insight might be brought to this paper by someone with work experience in the Aboriginal health care field who has observed the lived experiences of Aboriginal clients and made clinical observations of the principles discussed by the cultural safety literature. Therefore, I took the initiative to complete the PHSA Indigenous Online Cultural Competency training to strengthen my historical background knowledge on Aboriginal peoples, familiarize myself with current cultural competency training, and to truly embrace the concept of cultural safety that this paper promotes.

The training helped me engage in a self-reflexive process and consider my own social location when writing this paper. As a Caucasian member of the dominant culture in Canada, I often felt it was not my place to express how the provision of health care services could better meet the needs of Aboriginal people, as this ultimately should be dictated by Aboriginal voices. On the other hand, I feel it is partly my responsibility to seek to address health inequities between Aboriginal and non-Aboriginal Canadians. Still, as a privileged individual who has not personally experienced racism and discrimination, I found it extremely difficult to locate and provide examples of the structural inequities the concept of culture safety seeks to address and critically reflect on my attitudes and assumptions towards Aboriginal people. Nevertheless, having felt disempowered in health care interactions where I perceived that I was rushed, not listened to, or that my reports of pain were dismissed I can relate to the notion of cultural safety and a system that does not empower patients' well-being and good health.

Although, negative health care experiences for many Aboriginal individuals have a far greater significance and impact on their access to care than for members of the dominant culture in Canada, due to the colonial and neo-colonial discrimination Aboriginal people have experienced.

I am aware of my advantage as a non-Aboriginal to express my opinions on racism and discrimination without the risk of being seen as overly sensitive or playing the 'race card'. I am in a social position as a Master's in public health candidate to make my opinions on the provision of culturally appropriate health care heard and possibly published. As mentioned earlier in the context of VNHS, it is the people who are in a position of power who currently have the ability to truly challenge structural inequities and transfer power to Indigenous peoples. Culture is a relational process and as such the most important step forward is to build collaborative relationships where we are all critically self-reflexive and people can challenge each other's attitudes without fear of reprisal or the allocation of judgement, so that we can collectively seek to address the system that has created and perpetuates social and health inequities today. Thus, I openly encourage critiques or comments in response to this paper.

Regardless of where my career in public health takes me, I have gained a deeper understanding of how marginalization and structural inequities can shape the health disparities seen within Canada and beyond. I hope the process of writing this paper and my continual self-reflexivity will better enable me to safely and respectfully communicate and work with Aboriginal peoples in the future. I will carry forward a deeper sense of responsibility to address the health inequities faced by Aboriginal Canadians given the privileged social position I hold and the MPH degree that this document has helped me attain.

It is my hope that the literature review will better inform readers on cultural safety and help clarify the differentiation between cultural buzz words commonly used in public health practice. The paper will hopefully inspire readers to self-reflect on their own stereotypes, attitudes and culture and how these affect their interactions with others in a health care setting. In addition, it is the intention of this document to invoke further discussion among health care institutions and Aboriginal scholars on strengthening best practice in Aboriginal health care through the concept of cultural safety and the development of an organizational cultural safety framework.

Appendices

Appendix 1: Cultural Safety Framework: Self-Assessment Checklist

PRINCIPLE 1: Challenging Power Dynamics and Discrimination

1) How is your Aboriginal Health department or advisory committee positioned within your organization? Is it marginalized in any way?

2) Is there a feedback loop and or safety net in place to allow Aboriginal staff or recipients of care to report disempowering or discriminatory behaviour they experience within your organization?

3) Does your organization take action against discriminatory conduct?

4) Does your organization have a strategy to attract, support, and retain Aboriginal staff?

PRINCIPLE 2: Recognizing the Socio-Historical Context of Disparities

5) Does your health organization promote training or educational courses that enables all staff to understand Aboriginal health disparities in the context of the colonial history and government practices which have contributed to their marginalized position and poor health status?

6) Do your policies recognize the unique history of Aboriginal peoples and view them as an important diversity stakeholder who warrant particular attention?

7) Does your organization advocate for community programs or government initiatives which address the broader social and economical determinants of health?

PRINCIPLE 3: Self-Reflection

8) Does your managerial staff take the time to reflect on their attitudes, culture and behaviour towards Aboriginal colleagues, the Aboriginal Health department, or Aboriginal health programs?

9) Are organizational learning workshops or employee self-assessment evaluations conducted that incorporate assessments or discussion on discrimination within your organization?

PRINCIPLE 4: Recognition of Aboriginal Ways of Knowing

10) Does your organization support the health centres under your umbrella to follow the National Aboriginal Health Organization's (NAHO) cultural safety guidelines which allow for Aboriginal practices and values to be recognized and accommodated within health clinics?

11) Do your policies recognize traditional Aboriginal health models and worldviews as valuable additions or alternatives to bio-medical care?

12) Does your organization value holistic health care? Is your organizational culture and values discussed in relation to acknowledging and respecting Aboriginal ways of knowing?

PRINCIPLE 5: Defined as a Safe Organization by Aboriginals

13) Does your organization mandate that all research conducted on Aboriginal peoples employ Ownership, Control, Access, Possession (OCAP) principles? Do your evaluations of Aboriginal programs consider client perspectives?

14) Does your organization involve the Aboriginal community and give them voice in program planning and decision making?

15) Is your organization recognized by the community as being culturally safe?

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