

**EXPLORING CULTURAL CARE: THE DEVELOPMENT OF  
CULTURALLY COMPETENT NURSE PRACTITIONERS FOR BRITISH  
COLUMBIA'S FIRST NATIONS COMMUNITIES**

by

**Bryan Schultz**

BScN, University of Victoria, 2001

PROJECT SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF  
MASTER OF SCIENCE  
IN  
NURSING  
(FAMILY NURSE PRACTITIONER)

UNIVERSITY OF NORTHERN BRITISH COLUMBIA

July 2012

© Bryan Schultz, 2012

## ABSTRACT

Aboriginal Canadians have historically suffered from barriers to health and healthcare. Racialism, colonialism, and culturalism continue to perpetuate the barriers to healthcare that enable health disparities between aboriginal and non-aboriginal Canadians. Cultural competency is recognized as a strategy to ameliorate the effects of health inequities that exist for First Nations populations. Moreover, nurse practitioners are currently emerging as primary care providers for marginalized and underserved populations of First Nations in British Columbia and are professionally required to provide culturally competent and culturally safe healthcare. This project asks what culturally competent interventions can be used by nurse practitioners to mitigate health disparities experienced by First Nations communities in Northern British Columbia, and finds that nurse practitioners must rely on expert opinion, including the views of First Nations patients and the professional standards.

## Table of Contents

<b>ABSTRACT</b>	<b>iii</b>
<b>LIST OF TABLE</b>	<b>vi</b>
<b>LIST OF FIGURES</b>	<b>vii</b>
<b>LIST OF ABBREVIATIONS</b>	<b>viii</b>
<b>INTRODUCTION</b>	<b>1</b>
<b>Chapter One</b>	<b>5</b>
<b>Canadian Aboriginal Identities</b>	<b>5</b>
<i>First Nations, Inuit, and Métis</i>	<i>5</i>
<i>Demographic Review of First Nations Populations in Northern British Columbia</i>	<i>6</i>
<i>Geographic Overview of First Nations Communities in Northern British Columbia</i>	<i>6</i>
<b>Chapter Two</b>	<b>9</b>
<b>What is Cultural Competency and Cultural Safety?</b>	<b>9</b>
<b>Chapter Three</b>	<b>12</b>
<b>Government, Professional, and Stakeholder Commitments to Cultural Competency and Safety</b>	<b>12</b>
<i>Provincial Agreements</i>	<i>13</i>
<i>Regional Health Authority</i>	<i>14</i>
<i>First Nations Stakeholders</i>	<i>15</i>
<b>Chapter Four</b>	<b>16</b>
<b>Health Disparities Experienced by First Nations of Northern British Columbia</b>	<b>16</b>



<i>The Divide in Health Indices</i>	16
<i>Infant Mortality</i>	17
<i>Potential Years of Life Lost</i>	18
<i>Life Expectancy at Birth</i>	19
<i>Social Political Barriers to Health</i>	19
<i>Poverty</i>	20
<i>Education</i>	21
<i>Perceived Barriers to Healthcare by First Nations Peoples in Northern British Columbia</i>	22
<b>Chapter Five</b>	<b>27</b>
<b>Theoretical Discussion of the Role of Cultural Competence in the Practice of Nurse Practitioners</b>	<b>27</b>
<i>Theoretical Foundations of Cross-Cultural Nursing and Cultural Competency</i>	27
<i>The Heritage of Colonialism and Racism as Explored through Critical Racial Theory</i>	29
<i>Critical Social Theory as an Underpinning for the Validity of CC in NP Practice</i>	30
<b>Chapter Six</b>	<b>32</b>
<b>Literature Review and Analysis</b>	<b>32</b>
<i>Meta-Analysis</i>	33
<i>Best Practice Guidelines</i>	35
<i>Implications for Practice</i>	38
<b>Chapter Seven</b>	<b>43</b>
<b>Conclusions and Recommendations</b>	<b>43</b>
<b>References</b>	<b>45</b>

## LIST OF TABLES

Table 1. <u>Overview of meta-analysis findings</u>	35
--	----

## LIST OF FIGURES

Figure 1.	First Nations Language Groups of Northern British Columbia	7
Figure 2.	First Nations Communities of Northern British Columbia	8
Figure 3.	Leininger's <i>Sunrise Enabler to Discover Culture Care Model</i> (Leininger, 2002)	28

## LIST OF ABBREVIATIONS

BC	British Columbia
BCPHO	British Columbia Public Health Officer
CC	Cultural Competency
CNA	Canadian Nurses Association
CRNBC	College of Registered Nurses of British Columbia
CRT	Critical Race Theory
CS	Cultural Safety
CST	Critical Social Theory
FN	First Nations
NHA	Northern Health Authority
NPs	Nurse practitioners
PYLL	Potential Years of Life Lost



## INTRODUCTION

Canadian nursing continues its professional progression during the opening of the 21<sup>st</sup> century, attaining a legislated role for nurse practitioners (NPs) in many provinces. Nurse practitioners provide primary care in a fashion that was previously delivered only by physicians. In British Columbia (BC) in 2005, the NP role was legislatively established through the Health Professions Act (CRNBC, 2010). The new health practitioner role was envisioned to provide primary care to populations underserved by the traditional physician-delivered primary care models (Burgess & Purkis, 2010; Canadian Nurse Practitioner Initiative, n.d.; Gardner & O'Keefe, 2003). Nurse practitioners provide care to underserved populations in BC, in new immigrant clinics, orphaned patient clinics, and in First Nations (FN) communities (Burgess & Purkis).

All healthcare professionals, including NPs, practice with cultural life-ways or culturalisms that are informed by their heritage education and community of origin. Culturalisms communicate values and meanings to patients and may include, but are not limited to, word use, meanings of health, social values, or gender relationships (Leninger, 2001). Nurse practitioners who practice in indigenous communities provide healthcare with culturalisms that may have a history of creating racist or colonialist experiences for indigenous patients (Hart-Wasekeesikaw, 2009a; Dhamoon, 2009; Wolfe, 2010). The residual dynamics of racialism and colonialism are prominent in the experiences of the indigenous populations of Canada (BCPHO, 2009). The term 'racialism' describes the unintentional racist, cultural, and colonial structures that favour the dominant Eurocentric demographics, while negatively affecting FN people (Ford & Airhihenbuwa, 2010; Kafele, 2004; Wolfe, 2010). 'Colonialism' is a cluster of systematic processes that have been used in the past to



assimilate Canada's indigenous population into the previously predominant Eurocentric culture and political structures (Browne, 2007; Browne 2009; Hart-Wasekeesikaw, 2009a; Holmes, Roy, & Perron, 2008; National Aboriginal Health Organization, 2002). Nurse practitioners who provide healthcare to marginalized and often remote populations of indigenous Canadians require specialized cultural competencies and strategies. Health services should be provided by NPs in a manner that meets the cultural needs of these populations, and helps them to overcome the experiences of racialism, colonialism, and culturalism (Hart-Wasekeesikaw, 2009a; Capell, Veenstra, & Dean, 2007; Dhamoon, 2009; Kafele, 2004; Wolfe, 2010 ).

The colonialist experiences of the FN of Northern BC were heralded by the Indian act of 1876. This legislation and its subsequent amendments have defined the caretaker relationship between the FN communities and the Federal Canadian Government, outlawed cultural practices such as the potlatch, denied rights of Canadian citizenship including the right to vote, and undermined the political structures of the FN through the institution of the Indian agent (Canadian Royal Commission on Aboriginal Peoples, 1996; Moss & Gardner-O'Toole, 1987). The Indian agent asserted bureaucratic control over many aspects of FN community and individual affairs in order to assimilate its culture into Eurocentric norms (Canadian Royal Commission on Aboriginal Peoples, 1996). In 1879, the Davin Report influenced the initiation of the residential school program by calling for the civilization of FN through education that separated children from the influences of their families and communities (Kelm, 1998; Kirmayer, Simpson, & Cargo, 2003). Laws prohibiting cultural ceremonies such as the potlatch were enforced in BC until 1951 (Kelm, 1998; Moss, & Gardner-O'Toole, 1987). The right of FN individuals to vote was not restored until 1967; the

last residential school officially closed in 1986 (Canadian Royal Commission on Aboriginal Peoples, 1996; Kelm, 1998; Kelm 2004; Moss & Gardner-O'Toole, 1987).

This history and the ongoing influence of marginalization create impaired access and barriers to healthcare that contribute to notable health disparities endured by indigenous Canadians (Assembly of First Nations, 2004; Browne & Talier, 2008; Campbell, 2002; Veenstra, 2009; Wardman, Clement, & Quantz, 2005). Individuals from underserved or marginalized communities are more likely to seek health care attention and comply with recommendations made by an NP when they feel culturally understood, accepted, and supported (Papps, 2005; Registered Nurses Organization of Ontario, 2007). Alternately, if members of a community feel misunderstood or culturally unknown by the NP, patients may be less likely to seek medical attention and education on issues of health, and be even less likely to comply with medical instruction (Kingi, 2007). This project asks what culturally competent interventions can be used by NPs to mitigate health disparities experienced by FN communities in Northern BC.

Cultural competency (CC) has become a prominent intervention strategy for NPs to meet the needs of culturally diverse or marginalized populations (CRNBC, 2011; Grote, 2008). The successful implementation of CC strategies may contribute to ameliorating the barriers to healthcare access, as a best practice of NPs providing primary healthcare services to FN populations (King, Smith, & Gracey, 2009; RNAO, 2007).

Professional organizations, governments, and FN stakeholders in BC recognize that healthcare professionals need to be responsive to the cultures of the populations they serve, and thus need to use CC. These organizations have adopted CC to meet this need for culturally diverse populations. Culturally competent care is fundamental in preventing



barriers that continue to result in poorer health outcomes for FN persons in BC (Adelson, 2005; Peters & Self, 2005).

This query begins with a discussion of the background and context for the importance of CC within the context of delivering primary care to FN communities. In this regard, this project discusses: the identification of indigenous peoples of Canada and BC; health disparities experienced by FN; professional literature describing the current experiences of indigenous Canadians in accessing healthcare services; the history of theoretical constructs of CC; and the current professional stake-holders and government commitments to culturally competent training for healthcare providers in BC.

Secondly, a review of published systematic reviews, meta-analyses, and best practice guidelines for CC outcomes and interventions will be presented. Finally, the CC best practices and outcome evidence, as it applies to NPs who practice in FN communities of Northern BC, will be synthesised.

## **Chapter One**

### **Canadian Aboriginal Identities**

#### **First Nations, Inuit, and Métis**

Aboriginal populations of Canada have been categorized into three main subgroups within the literature and law: the First Nations, Inuit, and Métis. These are not construed as being designations of cultural homogeneity, but rather as descriptions of ancestry and of relationships of diverse people groups to the Government of Canada. The identity of “being FN” is similar to “being European” or “being Asian”, as it refers to an aggregate of diverse cultures and nationalities. Therefore, cultural ways may differ in different FN communities. The Canadian federal government identifies FN people as having met some level of ancestral purity, in relationship to the pre-European inhabitants of North America.

Many FN people are, or have been, residents of reserves or identify with a tribe, band, or individual nation. First Nation persons are further categorized as either Status or non-Status. The differentiation is based on the relationship that an individual has with the federal government. Status FN individuals have full treaty rights and therefore have access to federal social and health programs as well as any treaty rights negotiated by their individual band or nation. Non-Status FN persons may have no less ancestral purity but because of historical occurrences such as land ownership or criminalized behavior by an ancestor, their claim to Status rights may have been expunged (Anderson, Smylie, Anderson, Sinclair, & Crengle, 2006). Status FN people are further designated as either on-reserve or off-reserve, depending on their primary residence.

The Métis have had a long historical struggle for official recognition and land claims. In recent years, Métis have made considerable gains in this regard via the courts. Aside from



recognized communities in Manitoba, the Métis largely belong to an invisible population in terms of aboriginal rights and demographic data collection (Waldram, Herring, & Young, 2006). The Inuit of the North West Territories, Nunavut, and Nunavik inhabit Canada's arctic. In these territories, health programs are managed by territorial governments, rather than by the federal government (Waldram, Herring, & Young, 2006).

### **Demographic Review of First Nations Populations in Northern British Columbia**

As the focus of this project is on NP practice and patient experiences of healthcare in aboriginal communities of Northern BC, the term First Nations (FN) is used to identify the subject population. These peoples are largely, but not exclusively, FN members. In order to streamline the discussion, the term will be used to refer to all indigenous persons and communities in Northern BC, regardless of their actual racial or cultural origins (British Columbia Provincial Health Officer, 2009). According to the Canadian census, over 44,000 FN people lived in 80 communities across Northern BC in 2001.

### **Geographic Overview of First Nations Communities in Northern British Columbia**

Northern BC is populated by 14 language groups representing 37 different political entities and 80 communities (Figure 1). The majority of this population of over 44,000 (> 80%) live in reserve communities. First Nation political entities may be self-designated as nations, bands, or tribal councils. Each political entity may represent a single community, multiple communities, or the political cooperation of a group of nations or bands (Figure 2). For example, the Carrier Sekani Tribal Council represents 11 communities from two language groups that have become politically aligned (Carrier Sekani Family Services, n.d.).

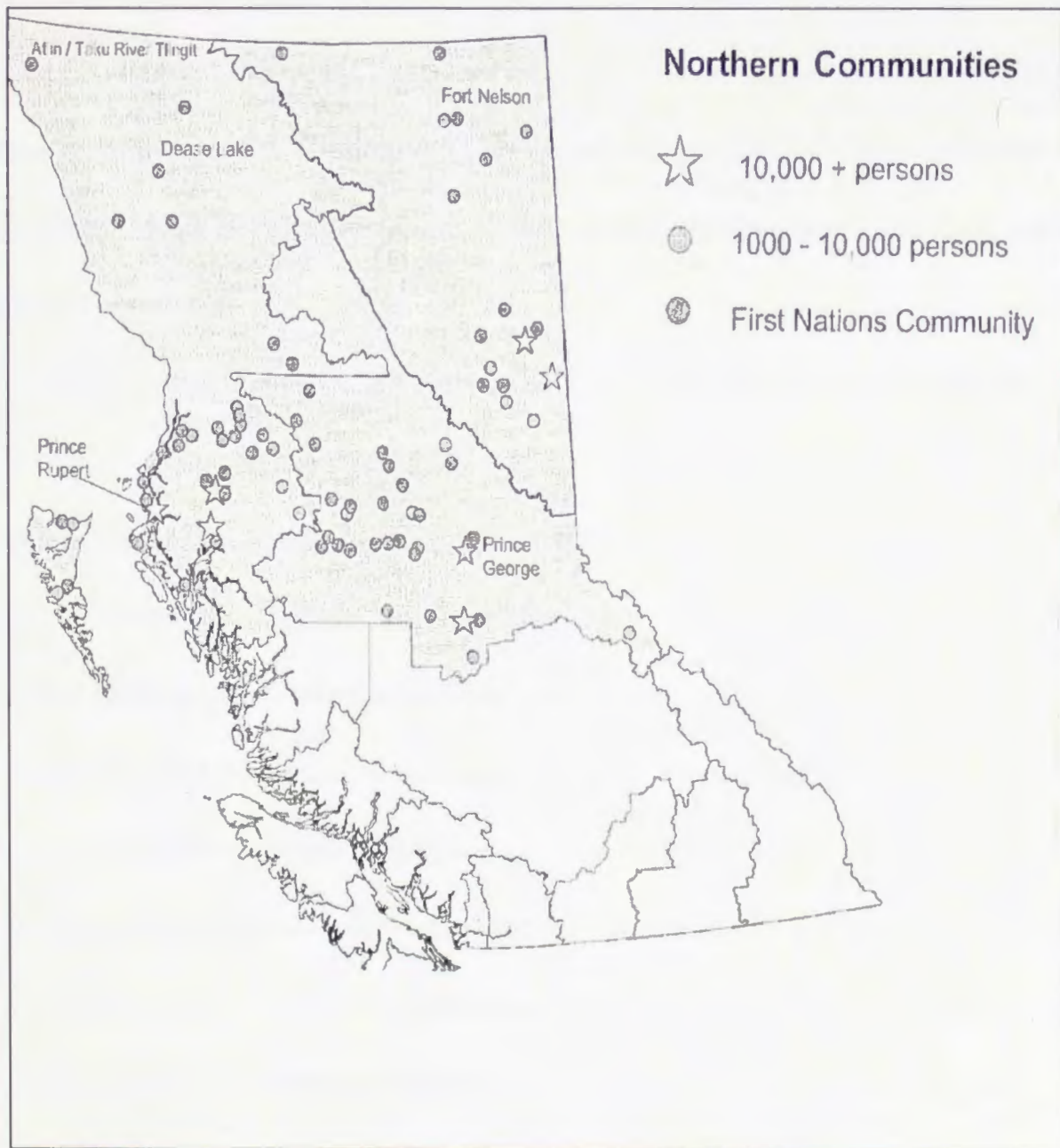


**Figure 1:** First Nations Language groups of Northern British Columbia. (Adapted from University of British Columbia Museum of Anthropology, 2004)

The FN of Northern BC have diverse cultures and ethnicity, similar to the diversity of cultural identity that can be found in Europe. The central Northern BC nations are the Takla, Skin-Tyee, Nee-Tahi Buhn, Cheslatta, Ts'il Kas Koh (Burns Lake), Tl'azt'en, Nak'azdli, Nadleh, Stelat'en, Saikuz, Lheidli Tenne'h, Nazko, Lhatko Dene, and Lh'oosk'uz Dene. The coastal and western nations are the Haida, Haisla, Tsimshian, Gitksan, Wetsuwet'en,



Nisga'a, Tahltan, Tlingit, and Daylu Dene nations. To the east, FN people belong to the Tsekani, Sauteaux, West Moberly, Dog River, Blueberry River, Halfway River, Kwadacha, Tsay Keh Dene, Prophet River, and Daylu-Dene nations (Tabobondung, 2007). This diversity of FN peoples may require that health professionals develop cultural competencies that are specific to each community.



**Figure 2:** First Nations communities of Northern British Columbia. (Adapted from Tabobondung, 2007).

## **Chapter Two**

### **What is Cultural Competency and Cultural Safety?**

As this project will review in the next chapter, NPs are mandated to provide culturally competent and culturally safe care to Northern BC FN communities. Although the definitions of these concepts can be vague and may seem to be interchangeable (Wolfe, 2009, professional bodies, including the Canadian Nurses Association (CNA), and the College of Registered Nurses of British Columbia (CRNBC) clearly require NPs to provide culturally safe care. At this point, these concepts need to be clearly differentiated and their implications to NP practice explored.

Cultural Competence (CC) is built on two sets of knowledge. First, cultural awareness is the knowledge of one's own culture, in contrast to other cultures (Grote, 2008). Nurse practitioners can recognize that the cultural identity and practices of others is equally valuable to their own, through the ability to identify the nature of culture and how different cultures exist and coexist in relation with each other (Grote, 2008), .

Secondly, the knowledge of cultural sensitivity builds upon cultural awareness, and is a grounded realization of the effect that one's own expression of culture may have in marginalizing patients that identify with a different culture. The NP's knowledge of the historical interaction of a dominant or colonial culture on other cultures is a form of cultural sensitivity (Kingi, 2007). Cultural competency, in the context of Northern BC, is a demonstrated awareness of historical and contemporary forces that have disempowered FN peoples (Browne & Talier, 2008; Campinha-Bacote, 1999). This awareness can then be used to recognize and deconstruct the hegemonies left in the wake of colonialism in healthcare and mitigate the ongoing effect of racialism (BCPHO, 2009; Hart-Wasekeesikaw, 2009a). Nurse



practitioners are culturally competent when they combine cultural sensitivity with a degree of fluency in the cultural norms of others. For example, cultural fluency can be demonstrated in learning the language or traditional healing norms of FN communities (Campinha-Bacote, 1999).

Nurse practitioners can acquire cultural understandings about family and community attachments that are strong predictors of self-assessed wellness for indigenous peoples (Hart-Wasekeesikaw, 2009a). Stated differently, relationships are a significant dimension of indigenous health. For policy-makers and healthcare providers, this knowledge implies that family and community relationships need to be supported in healthcare, just as spiritual health is supported with infrastructure in the form of a chapel and staff (i.e., a pastor) (Richmond, Ross, & Egeland, 2007). Further examples of cultural understanding for NPs who serve FN communities were outlined in an orientation document created for health professionals by the Aboriginal Health Improvement Committee of the Thompson, Cariboo, Shuswap Health Service Delivery Area (2005). The document lists actions that would improve cultural understanding, such as: learning the indigenous language, referring to traditional healing practices in care plans, supporting and attending cultural activities, accessing elders to act as guides for social protocol and tradition, acquiring knowledge of the seasonal activities, such as hunting and gathering, and supporting traditional foods in dietary teaching. The document offers further direction as to how health professionals may become culturally competent in particular FN communities and, more importantly, indicates the standards of CC, by which health professionals should be measured.

Cultural safety (CS), as a concept, arose in the 1980s out of a Maori treaty with the New Zealand government that codified expectations for healthcare services that were to be

culturally appropriate for the indigenous population (Hart-Wasekeesikaw, 2009a; Kingi, 2007; Papps, 2005). Cultural safety in its inception was intended to support a patient's experience of health care that was empowering, respectful and inclusive of their cultural identity by focusing on the indigenous patient's perceptions of culturally appropriate care (Kingi, 2007; NAHO, 2008).

In practice, NPs combine the components of CC to provide CS by recognizing and ameliorating actions, attitudes, and policies that diminish, disempower, or demean the culture of clients (Grote, 2008; Papps, 2005). Culturally competent NPs can support the CS of FN clients by instituting practices that recognize, respect, and participate in a culture of healing (Aboriginal Health Improvement Committee of the Thompson, Cariboo, Shuswap Health Service Delivery Area, 2005; Peiris, Brown, & Cass, 2008).

Nurse practitioners who practice both CC and CS share the role of expert and, therefore, power with FN patients (Hart-Wasekeesikaw, 2009a; Richardson & Williams, 2007; Wolfe, 2009). As indicated by Leininger (2001), culturally competent health practitioners apply a body of cultural knowledge to the clinical relationship. In addition, NPs who practice in a culturally safe manner must rely on FN clients as experts holding not only cultural knowledge but the measure of whether their cultural identity is supported by the clinical relationship (Hart-Wasekeesikaw, 2009a). This inversion of the hegemony between expert and client enables NPs to be sensitive to inequities created by culturalism, colonialism, or racialism (Browne & Varcoe, 2006; Hart-Wasekeesikaw 2009a).



## **Chapter Three**

### **Government, Professional, and Stakeholder Commitments to Cultural Competency and Safety**

The Canadian Nurses Association (CNA) is the national professional body for Canadian nurses. This body produces national professional standards and ethics for registered nurses. The CNA Code of Ethics requires the following:

When providing care, nurses do not discriminate on the basis of a person's race, ethnicity, culture, political and spiritual beliefs, social or marital status, gender, sexual orientation, age, health status, place of origin, lifestyle, mental or physical ability or socio-economic status or any other attribute (Canadian Nurses Association, 2008, p. 17).

The specific prohibition against discrimination is supported by affirming principles of justice, human rights, equality, and fairness in the practice of nurses. The Code of Ethics obligates NPs to employ values of justice to advocate for fairness, equity, and the promotion of the public good for FN patients and the communities in which they live. Cultural competence promotes justice in the practice of NPs by supporting awareness of the historical roots and cultural dynamics of social inequality and health disparity (Canadian Nurses Association, 2008; Registered Nurses Association of Ontario, 2007; Scott, Stern, Sanders, Reagon, & Mathews, 2008).

A CNA (2004) position statement clearly states that all domains of nursing are responsible for acquiring and utilizing CC in all aspects of care. The CNA also addresses education, government, healthcare organizations, and regulatory bodies with suggested roles

for practitioners in promoting culturally competent care. In a document outlining the core competencies of NPs, the CNA (2010) states that NPs “will incorporate knowledge of diversity and cultural safety and determinants of health in the assessment diagnosis and therapeutic management of clients and in the evaluation of outcomes” (p. 17). Additionally, the CNA defines unsafe cultural care as those practices which are demeaning, disempowering, or diminishing of a client’s cultural life ways.

The College of Registered Nurses of British Columbia (CRNBC, 2011), the licensing body for nurses in the Province of BC, provides a similar statement: The NP “incorporates knowledge of diversity, cultural safety and the determinants of health in assessment, diagnosis and therapeutic management of the client and the evaluation of outcomes” (p. 9). The CRNBC mandates NPs to practice in FN communities in a manner that identifies and affirms the culture needs of patients.

### **Provincial Agreements**

A memorandum of understanding was signed in 2006 between the Government of Canada, the Province of British Columbia, and British Columbian First Nations stakeholder groups, with the following commitments:

The Parties seek to provide equitable access to health services that meet the needs of First Nations communities, and ensure that these services are culturally sensitive.

B.C. and Canada recognize that First Nations need to be partners in the design and delivery of health programs and services for First Nations (First Nation Health Plan, 2006, Sect. 3.1(c)).



The memorandum clearly commits both the Canadian federal government and the BC provincial government to the provision of culturally sensitive care. This tripartite agreement is referred to in the 2007 annual report by the BC Public Health Officer (BCPHO, 2009). Included in the report was an \$8.5 million commitment to implementing the agreement by supporting CC initiatives for healthcare professionals. The funding was to be made available over a three-year period to adapt health services to the needs of FN communities and individuals.

### **Regional Health Authority**

The Northern Health Authority (NHA), which serves the sparsely populated northern half of BC, has well-developed vision, mission, and value statements to guide the development of cultural health initiatives. The vision of the NHA is to be a model of excellence in rural healthcare. Specifically, the mission of the NHA is to build and strengthen the health of communities, relationships, and all people in Northern BC. Moreover, the NHA lists the following values: a commitment to improving the health of all people of Northern BC through a spirit of collaboration, strengthening communities, accountable decision-making, honesty, integrity, a culture of respect, learning, innovation, and continuous improvement. The overall long-term goal of this initiative is to orient and equip NHA personnel to deliver quality services to people of Northern BC, including indigenous individuals, families, and communities, and other culturally different health ‘consumers’ (Mussel, 2006; Northern Health Authority, 2007).

**First Nations Stakeholders**

The Assembly of First Nations (2004) clearly recognized barriers to primary healthcare in an action plan for FN health initiatives. In the action plan, FN people were noted to be especially susceptible to culturally inappropriate or even hostile healthcare providers. The Assembly of First Nations also noted that accessing services required FN to accept inflexible programs or providers that did not meet their cultural needs. Among the suggested solutions in the document were participatory inputs into healthcare service provision and the training of culturally appropriate health service providers.

In the statements, the governing bodies that fund healthcare services and the Health Care Authority for Northern BC made a commitment to the provision of culturally competent healthcare. In addition, the CNA and the CRNBC have recognized the important role of culturally competent care to meet the needs of FN communities. Lastly, the National Assembly of First Nations recognized the role that culturally competent training can play in improving the healthcare provision to FN.



## **Chapter Four**

### **Health Disparities Experienced by First Nations of Northern British Columbia**

The FN of Northern BC are ethnically and culturally diverse, which makes it difficult to provide general statements with regards to culture. Nevertheless, the health disparities experienced by the indigenous peoples are much more homogeneous. Health disparities experienced by the FN of Northern BC are in the areas of experience, health indices, and determinants of health, which separate them from the greater Canadian population (Fisher, Burnet, Huang, Chin, & Cagney, 2007; Peiris, Brown, & Cass, 2008). It is important for the NP practicing in FN communities in Northern BC to have an understanding of the magnitude of the health disparities. This understanding then provides direction to the practice of NPs by highlighting the professional imperative to utilize culturally competent interventions to reduce health disparities.

#### **The Divide in Health Indices**

This overview of the indigenous indices of health uses data from: Census Canada, various researchers, and the Vital Statistics Agency of British Columbia, as reported by the BCPHO. The data sets for review were identified in a report by the BCPHO (2007) as benchmark indices that indicated the magnitude of the health disparity experienced by FN British Columbians. The health indices include infant mortality, life expectancies at birth, potential years of life lost, and a few notable disease prevalence rates.

The source of some of the data was the Canadian federal government. The indices generated from the Census Canada data are populated nationally and therefore may not

accurately represent the disparities of the smaller, specific populations of Northern BC. The data has been criticized historically for under-reporting health disparities experienced by FN communities (Smylie, Anderson, Ratima, Crengle, & Anderson, 2006, p. 13). In their report on the health data sets in post colonial countries, Smylie, Anderson, Ratima, Crengle and Anderson (2006) compared various countries and noted that the data collected in Canada for FN issues was impaired by a conflict of interest, since federal organizations were reporting on the efficacy of their own health programs. This criticism could also be generalized to provincial statistics where the same conflict of interest may exist. Young (2003) found that research on health issues experienced by Canadian aboriginals was lacking in many areas of morbidity and mortality.

### **Infant Mortality**

Infant mortality is a strong indicator of the effectiveness of health systems (Smylie et al., 2006). This health indicator states the number of deaths in the first year of life per 1,000 births (BCPHO, 2009). Adelson (2005) noted that in 1999, Canadians as a whole experienced an infant mortality of 5.5 per 1,000, while the rate was 8 deaths per 1,000 for FN live births. Thus, from a national perspective, a FN infant in 1999 would have been nearly 30% more likely to die before its first birthday, compared to other Canadian infants (Canadian Institute for Health Information, 2004).

In BC, a study that tracked infant mortality across 19 years found an interesting trend in health disparity. On-reserve FN babies experienced a greater decline in infant mortality, compared to FN babies in urban areas. The numbers are clear, with urban FN people experiencing an infant mortality rate of 7.2, and their non-FN urban neighbours having an infant mortality rate of less than 2.5 per 1,000 live births (Frohlich, Ross, & Richmond,



2006). Between 2000 and 2004, the BCPHO reported a province-wide aggregate infant mortality rate of 8.6 for Status FN and 3.7 for other residents (BCPHO, 2007). This greater than two-fold increase in infant mortality for FN residents of BC may be appreciated against the background of rising disparity in the race-based infant mortality gap since 1997 (BCPHO, 2007). In the 2007 interim report by the BCPHO (2007), the gap was noted to have grown by 23% in the 5 years preceding 2004, with 5-year aggregate infant mortality rates reported to be 7.3 (1997 to 2001), which increased to 8.6 (2000 to 2004), while the rate for non-FN British Columbians remained at 3.7 during the same period.

### **Potential Years of Life Lost**

Potential years of life lost (PYLL) is an indicator based on mean life expectancy at birth for a population that is corrected for actual years lived per 1,000 individuals (World Health Organization, 2007). In 1999, non-aboriginal males lost 62.5 years of life per 1,000 individuals, while Status FN males lost 158.3 years of life (Martens, Sanderson, & Jebamani, 2005). This is a greater than two-fold increase (disparity) in terms of years of life lost for this group of aboriginal males, compared to the greater Canadian population of males. In BC, even though overall PYLL is less, the magnitude of the disparity is similar. In 2006, PYLL for all causes for Status FN was 97.0, compared to 41.5 for other British Columbians (BCPHO, 2009).

The BCPHO (2007) offers insight into the health disparity experienced by FN, using the PYLL to understand the burden of individual diseases in the population. The effect of suicide and motor vehicle accidents is three times greater in the FN population, which leads to a PYLL of 12, as compared to less than four for other British Columbians. The burden of human immunodeficiency virus is nearly seven times greater in the FN population than in the

general BC population (4.7 and 0.7, respectively), expressed aggregately for the years 2000 through 2004 (BCPHO, p. 13). Diabetes, which has a 40% higher prevalence rate for Status FN British Columbians (BCPHO, Chap. 4) also has a PYLL of 2.1 years, which is 2.5 times greater than that of other British Columbians (BCPHO, p. 11).

The BCPHO (2009) compiles statistics that track the number of deaths from diseases for which medical treatments exist that would be reasonably expected to prevent death. The statistics describe a population that has failed to receive full access to healthcare due to some sort of barrier. In 2006, Status FN experienced a mortality rate from medically treatable disease of 1.5 per 10,000. Other British Columbians experienced a rate that was 500% lower (0.3 deaths per 10,000). This statistic captures the effect that barriers to healthcare have in increasing the mortality rates for Status FN in BC (BCPHO,).

### **Life Expectancy at Birth**

In BC, the BCPHO (2009, p. xxxix) reported an aggregate life expectancy for all Status FN, from 2002 to 2006, of 74.9, as compared to 80.7 for other British Columbians during that same period. The aggregate life expectancy at birth for female Status FN (2002 to 2006) was 77.0, compared to 83.0 for other British Columbian females. The same index for FN males was 73.0, while the rate was 78.4 for other British Columbian males. These results indicated that the FN men experienced a 5.4 year penalty and FN women had a 6 year penalty (BCPHO, 2009, p. 108).

### **Social Political Barriers to Health**

The barriers to healthcare experienced by FN people are often rooted in the encompassing determinants of health. Both objective and subjective evidence will be used



here in exploring the marginalizing experience of FN people in accessing healthcare. The socio-economic barriers of poverty, lack of education, and racialism will be explored as they are an important context for understanding adaptations of culture and the underlying health needs of the FN population (Foster, 2006). Nurse practitioners need to understand that the patient perception of healthcare is an important target of the CC interventions aimed at reducing health disparities in FN communities. This is especially relevant to the discussion of CC, given that culturally competent skills are primarily concerned with creating behavioral outcomes in healthcare providers, in order to eliminate barriers for the minority populations being served (King, Smith, & Gracey, 2009; Veenstra, 2009).

### **Poverty**

Poverty is a foundational determinant of health that creates disadvantages correlated with poorer population performance, as captured by the above health indices. The disadvantages of isolation, poor housing, lack of adequate sewer systems, poor water quality, and the impact of domestic violence are all vestiges of poverty experienced by on-reserve FN populations (Burns, Bruce, & Marli, 2007; NAHO, 2002; Noël & Larocque, 2009). These socioeconomic conditions are well documented by the Canadian media and are part of the common knowledge of Canadians. Poverty compounds the effects of chronic diseases, such as Type II Diabetes (Campbell, 2002; Martens, Martin, O'Neil, & MacKinnon, 2007), and is significantly correlated with poor health (BCPHO, 2009).

BC Stats (2009) published economic data for each Health Authority, based on the 2006 census. Although no household income data is available, some other metrics indicate the disparity of poverty experienced by FN communities. Over one-third (36.1%) of on-reserve homes in the NHA were in need of major repairs, compared to 9.0% for non-FN

homes. On reserve homes in the NHA were more likely to have crowding of more than one person to a bedroom than were non-FN homes (5.6% and 0.8%, respectively). The average income for FN persons 25-34 years of age, living on reserve in the NHA, was \$16,203; this figure rose to \$23,158 for those 35-54 years of age. On average, non-FN persons earned more than twice these amounts (\$35,864 for 25-34 year olds; and \$48,133 for 35-54 year olds). Unemployment is also seen as contributing to poverty on reserve (Anderson et al., 2006). In May 2006, 33.1% of the FN persons living on reserve were unemployed, in contrast to 7.1% of non-FN persons in the NHA (BC Stats, 2009).

## **Education**

In a discussion paper prepared for the Assembly of First Nations (Reading, Kmetz, & Gideon, 2007), poor access to quality education was noted as a barrier to healthcare. Individuals in Inuit and FN communities regularly find that adult illiteracy and limited English fluency impede their efforts to receive and understand health teaching. Written instructions for medication, diet, and self-care are not available in the indigenous languages that many FN people speak. For older adults who do not speak English or French, the language barriers separating them from healthcare providers is exacerbated by the loss of bilingual speakers, resulting in communities in which access to translators for healthcare visits is increasingly difficult (Rosenberg, Wilson, Abonyi, Wiebe, & Beach, 2008).

Higher educational levels are also positively associated with health indices such as life expectancy; education is also linked to higher incomes, decreasing levels of poverty, and the effects of chronic disease. The BCPHO (2009) states that high school graduates benefit from nearly a 10-year increase in life expectancy. In the 2005/2006 school year, only 50.9%



of FN students graduated from high school, as compared to 78.4% of other British Columbians (BCPHO).

### **Perceived Barriers to Healthcare by First Nations Peoples in Northern British Columbia**

The health services that are offered to FN persons in BC are descended from Eurocentric colonial social structures that previously enacted racially biased policies (Adelson, 2005; Hart-Wasekeesikaw, 2009a; Kafele, 2004; Peiris, Brown, & Cass, 2008). The most glaring racially biased policy that captured the attention of Canadian media and inspired an apology from the Prime Minister of Canada was the residential schools. The schools were mostly administrated by churches with the express intention of cultural assimilation of Canada's indigenous population (National Aboriginal Health Organization, 2002). In their health plan for aboriginals, the NHA (2007) recognized that colonization was a systematic process that devastated the communities and cultures of the FN of Northern BC (Hart-Wasekeesikaw, 2009a).

Although many of the overt racially biased and colonial policies have been shed, postcolonial healthcare is still Eurocentric (Lancillotti, 2008). Healthcare is delivered in ways that meet the needs of the dominant culture and that are often blind to the cultural needs of the indigenous peoples of Canada (Browne, 2009). Vickers (2008) and Hart-Wasekeesikaw (2009b) recognized the effects of the status quo post-colonial racialism in nursing curricula. Vickers found that nursing education was largely blind to the colonial culturalisms that pervade nursing theory. Wolfe (2009) described racialism in nursing theory and educational discourses as the domination of Eurocentric values of health that required non-dominant cultures to negotiate for legitimization. For example, Eurocentric nursing theories describe

health as belonging to the individual, whereas, many FN communities identify health in relation to the extended family (Boutain, 2005). Thus, one is only healthy while in relationship with one's family. The result is a system that echoes the marginalizing effects of previous times when colonial and racist policies were openly accepted (Kafele, 2004).

Kelm (2004) identified that even when FN people have self-governed healthcare, such as the Nisga'a, it required an ongoing struggle against the colonial nature of Western healthcare systems and the Eurocentric health professionals that operated within those systems. Kelms coined the term, 'medical colonialism', to describe the dynamics between Westernized healthcare and traditional healing.

The medical model of healthcare, which informs NP practice to a greater degree than it does other nurses (Dicenso & Bryant-Lukosius, 2010), is construed by Holmes, Roy, and Perron (2008) to have a residual colonial influence. In the context of FN healthcare, the biomedical approach to health remains in Eurocentric opposition to traditional modalities of healing, such as the topical use of plant products to promote healing (Hart-Wasekeesikaw, 2009b).

Ford and Airhihenbuwa (2010), in a study of race as a determinant of health, suggest that racialism is ubiquitous in healthcare systems. Anderson et al. (2006) summarily define colonial structures in healthcare as all those structures that are not reflective of the cultural ways of indigenous peoples. In this light, nearly all healthcare, including the primary care role of NPs, can be seen as being imposed on FN communities by governments that are nearly indiscernible from the colonial structure that preceded them.

In the NHA, the Hazelton Memorial Hospital that provides healthcare services to the Gitsaan peoples, is still owned and operated by the United Church of Canada (United Church



of Canada, 2009). This organization was once the Methodist church, which delivered missionary health services to the costal indigenous peoples of BC. In Hazelton, the classic colonial structure of churches providing government services still exists in the same physical structures as they did in the 1930s. The work of NPs in this community is intended to provide outreach clinics in the FN communities that neighbour Hazelton. As a reasonable assumption, a FN person might view the new NP role as a mere extension of the surviving colonial healthcare infrastructure.

The tertiary hospital of the NHA in Prince George (central BC), University Hospital of Northern British Columbia [UHNBC] is situated in the middle of the traditional Carrier Sekani First Nations territory. In 2001, 9% of the residents of Prince George identified themselves as aboriginal (Cook & Daniele, 2006). From personal observation, however, the Carrier culture is not significantly represented in the art, language, or architecture of the hospital that serves them. FN individuals who are accessing healthcare in Northern BC would find themselves entering buildings that either echo the colonial experiences of the past or are mute to the present existence of their culture. NPs need to be sensitive to the barriers that may exist in the infrastructure when providing healthcare, which may represent a lack of cultural safety for their FN patients.

In exploring the experiences of FN women with healthcare in BC, Browne and Fiske (2001) identified three recurrent themes. The women who were interviewed spoke about their experiences of racism, discrimination, and marginalization. In another BC study, more than 80% of a sample group of FN persons reported avoiding accessing healthcare services due to a fear of racism (Wardman, Clement, & Quantz, 2005). The same number of respondents reported feeling very uncomfortable in BC health facilities (Wardman, Clement, & Quantz,

2005). Browne (2007) studied the discourses between FN women in BC and nurses providing emergency healthcare. In the study, themes of culturalism and racialism were prevalent in the views expressed by the nurses. Browne recommended that researchers and nurses need to begin applying a critical approach to explore the manner in which racialism may be influencing the nursing care received by FN women. Guilfoyle, Kelly, and Pierre-Hansen (2008) used more direct language to suggest that healthcare professionals and institutions must begin developing tools to measure the prejudices of care providers that create barriers to healthcare for FN Canadians.

Another study, describing disparities in health services, examined Canadian neonatal intensive care units. The authors found that aboriginal neonates were given fewer treatments, medications, life support, and nutrition, compared to non-aboriginal patients (Reime, Tu, & Lee, 2007). The authors suggested that more research was needed to explore the relationships between ethnicity and denial or refusal of treatment. This evidence of healthcare disparity does not describe a causal relationship between racialism and health outcomes. Nevertheless, it suggests that FN patients encounter greater barriers to healthcare, suggesting that differences in race and culture between healthcare providers and patients may act as a determinant of health.

Data collected by the NHA (2006) from FN focus groups identified a number of themes with regards to healthcare staff. In particular, the staff lacked cultural awareness or sensitivity, did not support relationship- or trust-building, caused experiences of racism and discrimination, used stereotypes, were not responsive to language barriers, elicited fear in the interactions with healthcare staff, reinforced the effects of colonization, and had interactions that were affected by the historical memory of racism, leading to disempowerment or the



taking away of aboriginal voices from the medical decision-making (Mussell, 2006; Northern Health Authority, 2006).

## **Chapter Five**

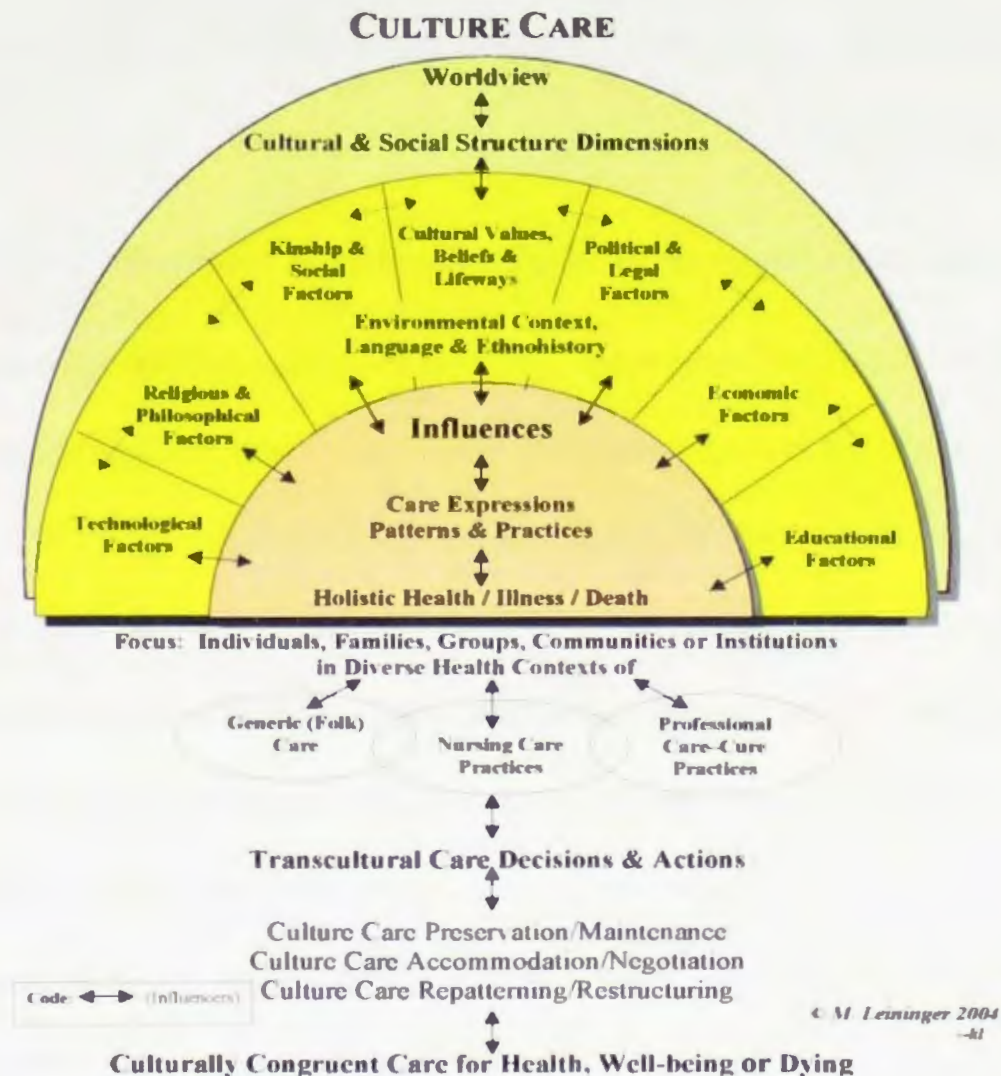
### **Theoretical Discussion of the Role of Cultural Competence in the Practice of Nurse Practitioners**

#### **Theoretical Foundations of Cross-Cultural Nursing and Cultural Competency**

In the 1950s, Leininger wrote about the overlap between anthropology and nursing theory (Leininger, 2002). By 1968, the result was the concept of culturally congruent care, which led to the publishing of the theory of transcultural nursing in 1970. In 1991, Leininger further elucidated her transcultural nursing theory in culture care diversity and universality. Leininger's work firmly entrenched the importance of culture as a dimension of nursing, noting that culturally-based care is fundamental to promoting health and understanding wellness. Leininger further recognized that specialized skills and knowledge were necessary to enable nurses to work with patients from different cultures. This area of nursing study has become known as transcultural nursing.

The primary focus of transcultural nursing is the provision of culturally congruent care, which requires nurses to apply cultural knowledge regarding a patient in a manner that delivers care to meet the patient's holistic needs (Leininger, 1978). In Leininger's Sunrise model (2006), the holistic care needs of patients are influenced by their worldview, cultural and social structures, environmental context, life ways, kinship, spirituality, education, and patterns or practices of receiving care (Figure 3). Transcultural nurses provide culturally competent care through preservation, accommodation, or restructuring of either the expectations of the patient or the delivery of care. The result of these actions would ideally be the availability of culturally congruent care that supports the patient's holistic health needs.





**Figure 3:** Leininger's sunrise enabler to discover culture care model (Leininger, 2002)

Leininger (2001) explored the concept of universal cultural norms and diverse cultural norms. Universal norms are the life ways or meanings that are held in common between the nurse and the client. Diverse cultural norms are the cultural differences between the nurse and the ethnically or culturally different patient. To guide nurses, Leininger provided an overview of the diverse needs of over 23 distinct cultures.

Leininger's foundational work on transcultural nursing has inspired theoretical writings and health system initiatives that focus on client-centered cultural training in CC strategies. The CC strategies require nurses to use specific knowledge, attitudes, and

behaviors to provide culturally congruent care to specific ethnic groups (Leininger, 2002; Wolfe, 2010).

### **The Heritage of Colonialism and Racism as Explored through Critical Racial Theory**

Nursing has dear traditions, ways of knowing, and ways of being that have pre-existed its own theoretical discourse. Many of the traditions remain in the practise of nursing and are at the base of the arising discourse of the profession (Warelow, Edward, & Vinek, 2008); culturalism and colonialism are good examples of this (Browne & Varcoe, 2006). Cultures that predominate in nursing are blind to their own imposition of cultural norms of health onto patients from other cultures that may have different cultural approaches to achieving wellness (Wolfe, 2009). The unexplored professional characteristics cause othering, disenfranchisement, and marginalization of minority cultures and races (Peiris, Brown, & Cass, 2008). The empowered position of NPs, as experts, can lead to a discourse of meaning that disempowers patients, possibly unintentionally undermining or demeaning the cultural ways of FN health consumers (Browne, 2007; Browne & Varcoe, 2006; Richardson, & Williams, 2007).

Critical race theory (CRT) owes its origins to legal theorists of the 1980s. Writers such as Bell (1973) began a discourse regarding possible frameworks that might explain seemingly inherent race disparities in American legal outcomes. Delgado and Stephancic (2000) extended the discussion of CRT, borrowing from critical social theory (CST) and feminist theory to explore racial influences on institutions and relationships of power. Browne (2001), in applying CRT to mental healthcare, noted that the theoretical framework offered the advantage of exploring the complex relationship between race and health



outcomes and the creation of a lexicon for discussion and research of the emotional impacts of individuals experiencing racial inequalities.

CRT offers a lens for investigating racialism in an organizational context. Two principles of the theory provide the underpinnings for studies of CC. First, CRT emphasizes the importance of the subjective narrative of a population to describe the effects of racialism. Second, the discourse identifies the permanence of racialism as the amplitude of inequality decreasing through time. This notion of a permanent, but lessening, effect of racialism is thematically synonymous with the experience of colonialism by FN peoples (DeCuir & Dixon, 2004).

Previous meta-theories and paradigms of nursing, at best, fail to recognize this criticism or, at worst, enable power differentials intended to impose assimilation (Kushner & Morrow, 2003). The exploration of this social power exercised by nurses is implicit in CST (Browne, 2001; Kushner & Morrow, 2003).

### **Critical Social Theory as an Underpinning for the Validity of CC in NP Practice**

Nursing, as a profession, has often been required to amalgamate various traditions and disciplines of thought. Nurse practitioners have the expanded responsibility of medical diagnosis and treatment, which traditionally has been the role of medical practitioners; the need to adapt to and embrace new theories and practice becomes an additional intrinsic role of NPs. This requires comprehensive NP theories to be either sufficiently elastic to join disparate concepts, or to act as the substrate for other theories (Wolfe, 2009).

CST is a substrate for various theories and ways of knowing (Mohammed, 2006). In considering CST as a meta-theory, it is based on postmodernism, contextualization, and the subjective exploration of knowledge that allows different narratives to be self-legitimized.

The legitimization of its meaning allows concepts to be critiqued for their efficacy within the social construct that CST offers NPs, like a smorgasbord of theories, paradigms, and concepts. At the same time, it provides the tools for judging the capacity of each component for empowering patients to progress towards health. Furthermore, NPs are called upon to provide a service to persons wherever they are in the cultural, experiential, or meaningfulness of humankind (Cohen & Gregory, 2009). This role of nurses means that higher level theories must be robust enough to support the diversity of personhood found in practice. Many early nursing theories and discourses were challenged by a heavy cultural or paradigm bias to Judaeo-Christian influenced positivism (Wolfe, 2009). The bias was marginalizing for many as it devalued any meaning or concept that it found contradictory to its own norms. CST values subjective narrative and personal meaning over objective or quantitative discourses (Browne, 2001). As well, CST can be self-critiquing on a level that was never available to previous systems of knowledge development while at the same time allowing what were once positivist truths to stand as valuable narratives (Boulos & Rajacich, 2003).

Critical race theory, along with CST, offers a theoretical paradigm for the deep professional practices of racialism (Dahmoon, 2009; Wolfe, 2009). These theories inform this discussion of CC by offering a theoretical construct that in some measure explores and explains the causational attitudes and cultural norms of health institutions that have led to the experiential data being captured by the NHA (2006).



## **Chapter Six**

### **Literature Review and Analysis**

#### **Sources and Search Process**

The CRNBC, CNA, FN stakeholders, the Government of Canada, the Provincial Government of BC, and health regions are committed to the role of CC / CS as a body of professional knowledge for NPs to ameliorate the effects of health inequities that exist for FN. Cultural competency includes a set of understandings that enable health professionals and health systems to recognise and respond to the needs of individuals that may have cultural norms that differ from those of the predominant culture in a given population (Capell, Veenstra, & Dean, 2007). Cultural safety is the sense of clients being supported in their cultural health needs. In this project, evidence has been explored for the health disparities and marginalization affecting the indigenous peoples of Canada, and specifically, the FN of Northern BC.

A systematic search was performed of the electronic databases of Pubmed and CINAHL, using the following terms: cultural competency, cultural safety, cultural sensitivity, transcultural nursing, health disparity, First Nations, British Columbia, Indian, North American Indian, and inequality. The search resulted in 69 articles from CINAHL and 148 articles from Pubmed.

The abstracts were then sorted according to their level of evidence (Melnik & Fineout-Overholt, 2005). Preference was given to meta-analyses, best practice guidelines, and Canadian content. Fineout-Overholt, Melnik, and Schultz (2005) organized research into the following seven-level hierarchy of evidence with level 1 evidence being the strongest. Level 1 represents meta-analysis and review studies of randomized control studies

(RCTs); Level 2 includes practice guidelines based upon meta-analysis, review studies, and RCTs; Level 3 has individual RCTs; Level 4 is populated with non-randomized controlled or cohort studies; Level 5 represents review studies of qualitative and descriptive studies; Level 6 includes individual qualitative and descriptive studies; and, Level 7 includes authoritative opinion and expert committee statements. The search led to four evidence level 4 and 5 meta-analyses and four evidence level 7 practice guidelines. Individual studies were also selected if they had not been included in a meta-analysis paper. No studies conducted within BC were found.

Various sources were consulted to obtain practice guidelines, including the Registered Nurses Association of Ontario, the New Zealand Guideline Group, the Cochrane Library, the Guideline Clearing House, the Canadian Medical Association Infobase, and various nongovernment organizations. This search yielded five practice guidelines for CC / CS.

### **Meta-Analysis**

The review of the meta-analyses provided a rigorous overview of the available CC / CS literature. The five selected studies used different investigational lenses to give a more complete sense of the state of the CC / CS literature.

Beach et al. (2006) reviewed studies reporting the outcome effectiveness, and included cost comparisons of health interventions that were intended to address racial or ethnic disparities. In this evidence level 4 study, the authors reviewed 27 studies, with 19 being focused on primary care. The authors' analysis rated interventions and grouped them into eight sub-sets, from "A" for the most highly recommended to "D" for not recommended. Only two studies looked at provider attributes of CC. The authors designated these



interventions with a C, due to the lack of quantity of studies. Of the eight intervention subsets, only one received an A rating, and the rest were either C or D. The A rating was given to an automatic recall strategy for patient follow-up. In their conclusion, the authors noted that the body of literature had too few rigorous studies to adequately assess the effectiveness of cultural interventions for alleviating health disparities.

Betancourt (2006) provided an evidence level 4 meta-study comparing quality improvement efforts directed at ethnic health disparities with CC initiatives. The author did not mention a methodology; however, the analysis rated interventions based on evidence or hypotheses. FN health liaisons that assisted patients through the healthcare system, also known as navigators and interpreters, were given a rating of A. The rating was based on evidence demonstrating that navigators reduced the health disparities of their target population. The author noted that, based on the literature, the CC attitudes of healthcare providers failed to affect health disparity outcomes. Betancourt also noted the lack of research that would validate CC as efficacious, and that practitioners relied on expert opinion.

Anderson, Scrimshaw, Fullilove, Fielding, and Normand (2003) looked at CC from a systems perspective. Implementations of healthcare organizations, priority hiring of ethnic minorities, use of interpreters, CC training for staff, use of culturally appropriate printed material, and ethnically specific clinics were evaluated for targeted quality improvements and decreases in health disparity outcomes. The authors reviewed 157 papers, and concluded that, even though the literature offers professional opinions that support CC, the evidence for support was absent. In this evidence level 5 study, the authors found no substantial research-based evidence to support the five CC healthcare initiatives.

Fisher, Burnet, Huang, Chin, and Cagney (2007) reviewed 38 papers. Their inclusion criteria mentioned: interventions with outcomes that modified the behaviors of the target population, and increased access to healthcare or made system changes that benefited visible minorities. Their findings were made clear by the statement, "None of the studies was designed to examine the impact of an intervention on health disparities" (Fisher et al., 2007, p. 8). This study data was ranked at evidence level 5.

---

**Table 1.** Overview of meta-analysis findings

Meta-analysis Finding
No rigorously supported evidence exists for CC interventions
None of the meta-analyses discussed cultural safety as an intervention
None of the cited studies were specific to any Canadian population
Employing lay staff from the community may help reduce the barriers to healthcare (Fisher et al., 2007).
Quality improvement initiatives, such as patient call-backs, may positively affect health disparities (Fisher et al., 2007).

---

Of the reviewed interventions, the only successful intervention included lay workers that belonged to the target culture (Fisher et al., 2007). The authors stated that the relationships created between members of the visible minority and health workers of the same minority facilitated better access to healthcare. In their conclusion, the authors recommended that health system managers should focus on quality improvement initiatives and community health workers who specifically target ethnic minorities. In regards to CC education for practitioners, the authors found a modest improvement in attitudes, but no evidence that the intervention reduced health disparity.

### Best Practice Guidelines

McFarland and Eipperle (2008) offered an NP-focused best practice guideline. The guideline is firmly based on Leininger's Theory of Culture Care, and is very theoretical in its



content. NPs are directed to rely on culturally specific knowledge, combined with the nursing ethic of caring, to create trust and consensus with patients of different cultures.

*A cultural competence guide for primary health care professionals in Nova Scotia* (Nova Scotia Department of Health, Primary Health Care Section, 2005) is a practice guideline developed as the result of a multicultural care initiative by the Nova Scotia Ministry of Health. The conceptual structuring of this guideline closely resembles the McFarland and Eipperle guideline (2008) with a focus on CC as a set of skills and attitudes brought to the clinical environment by the NP. The Nova Scotia guideline offers an overview of selected cultural characteristics, such as: French Canadian, Indigenous, and new immigrant Canadians to be understood by the primary care provider, a set of scripted questions for multicultural client encounters, as well as a CC self assessment tool. A strong and repeated emphasis in this guideline is placed upon a discussion of racism and oppression including systemic racism. Systemic racism is described in the guideline as unconscious actions or policies that adversely affect individuals from the non-dominate race or culture. This discussion of institutional racism is introduced in the context of hegemonies exorcized by healthcare providers that belong to the dominant cultural group. While the Nova Scotia guideline offers NPs a very well developed application of CC skills and attitudes, it makes no reference to cultural safety.

The National Aboriginal Health Organization (NAHO, 2008), funded by Health Canada, has created a best practice guideline for CC / CS. This important document clearly delineates the differences between CC and CS, which is overlooked in some of the other literature reviewed in this project (Wolfe, 2009). The NAHO guideline is explicitly based on the New Zealand best practice guideline, designed by and for the Maori.

Cultural safety is the response of the patient to culturally competent care provision. Some of the hallmarks of this care are that it is empowering, respectful, and inclusive of the patient's cultural identity. The greatest difference between the end focus of the Maori model of cultural safety and of Leininger's model is the recognition of the historicity of cultural meanings and the focus on patient perceptions that are the substrate of cultural safety, versus, predetermined attitudes and cultural knowledge of health professionals that constitute cultural competency (Hart-Wasekeesikaw, 2009a; NAHO, 2008).

The NAHO (2008) document directs NPs toward cultural interactions including language acquisition, and attendance to ceremony and cultural events. In adopting CS models, NPs have become known to the FN in ways that level the power differentials, such as requiring the abandonment of the clinic for the feast hall, respecting the elders' table and the grave site. These culturally competent actions are prescribed by the FN community, not by health professionals or the health system.

The RNAO (2007) published a Canadian guideline that has been cited as a reference by the CNA (2010) and by the CRNBC (2010), with NP competency documents as a best practice resource for NPs. The document offers definitions of CC and CS. Cultural safety is defined partly as a recognition of the inequalities of power between minorities and dominant cultures. The RNAO definition (YEAR) does not go as far as to define CS as a response of patients, but rather, as a more sophisticated nuanced extension of CC.

The RNAO (2007) also commented on the state of evidence for CC. The guideline suggested that CC cannot be rigorously researched, and therefore, a lower level of evidence would be necessary to accept it as best practice.



### **Implications for Practice**

Practice guidelines identify that the culturally competent NP in practice applies the foundational skills of cultural awareness and cultural sensitivity (McFarland and Eipperle, 2008; NAHO, 2008; Nova Scotia Ministry of Health, 2005; RNAO, 2007) . In the context of the FN communities in northern BC, culturally aware NPs are able to identify their own cultural life ways of being, and discern similarities and differences from FN ways of being. NPs should be able to value both cultural systems of being as equal. With cultural awareness, NPs can build an understanding of FN cultural sensitivity, which includes not only a historical, but a contemporary perspective of the interactions between the dominant culture of BC and FN peoples. Culturally sensitive knowledge is community-specific and includes an awareness of the general themes of the destructive colonial influences that may be experienced by FN peoples. Culturally-aware NPs will also be able to identify surviving vestiges of colonialisms, culturalisms, and racialisms that continue to affect FN peoples contribute to profound health disparities (Browne & Talier, 2008; Browne & Varcoe, 2006). NPs will become culturally competent as they demonstrate specific knowledge of cultural customs, language, values, and life ways.

Of the practice guidelines reviewed, only the NAHO (2008) and RNAO (2007) guidelines reflect the professional mandate for NPs to practice in a manner reflective of CS. These guidelines offer specific definitions of CS, both built upon CC. However, the RNAO document does not offer a fully developed construct of CS. The works of Hart-Wasekeesikaw (2009a; 2009b) and the NAHO document expound upon the CC skills required to provide culturally safe care to FN populations. Cultural safety is the experience of FN patients and their community. Nurse practitioners will recognize that in order to provide

culturally safe care they are interdependent with FN patients who provide an assessment of their experience of care which in turn informs the development and provision of culturally safe NP care. Building upon CC care, NPs in their practices working in Northern BC communities modify the delivery of primary care by instituting and maintaining communication that fosters feedback from FN patients and communities to ensure that culturally affirming and empowering care is being delivered.

The meta-analyses all indicated that, as yet, no rigorously supported evidence exists for CC interventions. None of the cited studies were specific to any Canadian population. The findings that may be generalized to Northern BC FN communities are: no currently applicable studies of CC have been conducted; employing lay staff from the community may help reduce the barriers to healthcare; and quality improvement initiatives, such as patient callbacks, may positively affect health disparities. None of the meta-analyses discussed CS as an intervention.

As NPs assume new practice roles in Northern BC FN communities, they will be mandated to provide culturally competent and culturally safe care. These NPs will be supported by expert opinion, rather than by thoroughly researched evidence. The NAHO practice guideline and Hart-Wasekeesikaw's (2009a) development of the concept of cultural competence will provide a model for other authors as further CS research is conducted within the FN context.

Nurse practitioners may face challenges because of systemic racism and colonialism, without available support due to lack of guidance from the literature. Their practice will benefit from a critical awareness of systemic inequalities, and from having historical insight of the cultural sensitivities. With an understanding and emphasis on CS,



NPs can be sensitized to the FN perceptions of demeaning or disempowering cultural practices. Finally, as NPs provide culturally safe care, FN patients will be empowered to be their own cultural experts, so that NPs can customize their CCs for the specific needs of the patient population.

The culturally competent NP working in FN communities will apply learned skills, knowledge and attitudes that support the development of cultural sensitivity that will be specific to the community and individuals for whom they provide care. The NP will then build upon culturally competent practices by inviting the FN communities and individuals to provide feedback based on their experience of care. The NP's response to this feedback will again be measured by the FN patients creating a feedback loop that acts as a measure of CS. Therefore, the initial indicator of the success of culturally competent interventions in mitigating health disparities will be the improvements in the FN patient's subjective experiences of care. The logical extension of this application of CS is that improved subjective experiences of healthcare may reduce perceived barriers to healthcare resulting in improved healthcare access for FN peoples.

Implementation into practice of the CC skills reviewed above will require further educational preparation for NPs prior to entering practice. The skill sets that will support culturally competent and safe NP practice will require graduate NP education programs to place greater emphasis on the required competencies of CC and CS. Hart-Wasekeesikaw (2009a) proposes that graduating NPs be equipped with core CC skills from educational programs that have undergone certification by aboriginal stakeholder groups. The core competencies which focus on the development of both CC and culturally safe practice include: understanding the historical and ongoing effects of colonialism, practising culturally

safe communication, demonstrating respect for the values of indigenous peoples, and understanding indigenous systems of knowledge (Hart-Wasekeesikaw).

Hart-Wasekeesikaw (2009a) further describes the need for a CC framework in nursing education to impart the understanding that providing Aboriginal Canadians with culturally safe healthcare experiences results in the reduction of the barriers to healthcare that foster health disparities. The recommendation of this author is that a focus on CS education would also create the expectation by students that CS is determined by the patient's experience.

The NAHO (2008) guideline recommends that CS education curricula focus on: the historical and social causes of health disparity, the diversity of aboriginal peoples each having unique cultural identities, awareness of hegemonies between care providers and indigenous patients, and, creating educational organizations that foster culturally safe environments for staff and students. The RNAO (2007) practice guideline calls for the implementation of CC curriculum for nursing education. The RNAO falls short of offering any recommendation for curriculum content but rather focuses on the need for nursing education organizations to offer culturally safe environments for staff and students. All the guidelines recognized the imperative need for nursing education to focus on creating culturally safe environments that supported the success of FN nursing candidates whose successful graduations would allow the profession of nursing to reflect the demographics of the aboriginal peoples it serves (Hart-Wasekeesikaw, 2009a; NAHO, 2008; RNAO, 2007).

The implication for future research is to provide the professional community with a body of literature built on robust methodologies; researchers should examine CC and CS.



Further investigation of the relationship between FN ethnicity and the barriers to healthcare would also support NPs in addressing the health disparities.

Until this research can be completed, NPs must rely on the expert feedback from the FN communities in which they are working. The most significant CC interventions will be focused on receiving communication on whether or not the healthcare delivered by NPs is affirming of the culture of the FN clients. By facilitating the discourse, and being sensitive to the opinions and direction from FN clients and communities, culturally competent NPs will be exercising cultural safety.

## Chapter Seven

### • Conclusions and Recommendations

This project asked what culturally competent interventions can be used by NPs to mitigate health disparities experienced by FN communities in Northern BC. The literature reviewed in this project was ranked by level of evidence and included Level 4 (non-randomized controlled or cohort studies), Level 5 (review studies of qualitative and descriptive studies), and Level 7 (authoritative opinion and expert committee statements evidence) studies (Fineout-Overholt, Melnyk, & Schultz, 2005). The overall lack of rigorous research included in the evidence level 4 and 5 articles regarding the effect of CC interventions, precludes any research based determination being made regarding the impact that these studied interventions might have in reducing the health disparities experienced by FN peoples in Northern BC. Although, the literature does not provide rigorously constructed research studies an evidence-based approach to CC practice at this time is supported by Level 7 evidence. Nurse practitioners should rely on expert opinion to shape their practice. Expert opinion should be gleaned not only from practice guidelines, but also from the FN clients and community members, since they are recognized as the holders of expert knowledge on their cultural health needs. Cultural competency practice guidelines should be selected for an emphasis on the development of the concept of cultural safety in practice. The theories reviewed here (i.e., CST and CRT) provide a foundational discourse for informing the constructs and models to apply CC and to uphold the role of FN experts in evaluating culturally competent and safe healthcare provided by NPs.

The expert opinions gleaned in this project offer clear direction for developing culturally competent NP practitioners to provide primary care in FN communities. Nurse



practitioner graduate programs will be obligated to develop culturally competent curricula in order to prepare NPs for practice. The culturally competent NP will require culturally competent knowledge, attitudes, and skills that may be specialized to individual communities and individual patients. However, the complexities of culturally competent practise may not be condensed into set of measurable parameters that are easily identified; the dynamic construct of CS will enable NPs to be responsive to the expressed subjective experience of FN patients, providing an indication of the cultural appropriateness of their healthcare experience. The desired outcome of culturally safe practice is the improvement in the subjective cultural experiences of FN peoples. Nurse practitioners who tailor their actions in such a manner to offer a culturally safe experience of healthcare may measurably reduce barriers to healthcare for FN patients.

## References

- Aboriginal Health Improvement Committee of the Thompson, Cariboo, Shuswap Health Service Delivery Area. (2005). Role of the community health nurse in aboriginal communities of the Thompson, Cariboo, Shuswap Health Delivery Area. Retrieved from [http://www.interiorhealth.ca/uploadedFiles/Health\\_Services/Aboriginal\\_Health/RoleofCHN.pdf](http://www.interiorhealth.ca/uploadedFiles/Health_Services/Aboriginal_Health/RoleofCHN.pdf)
- Adelson, N. (2005) The embodiment of inequity: Health disparities in aboriginal Canada. *Canadian Journal of Public Health*, 96(2 Suppl), 45S-61S.
- Anderson, M. L., Scrimshaw, S.C., Fullilove, M.T., Fielding, J. E., & Normand, J. (2003). Culturally competent healthcare systems: A systematic review. *American Journal of Preventative Medicine* 24(3 Suppl), 68S-79S. doi:10.1016/S0749-3797(02)00657-8
- Anderson, M., Smylie, J., Anderson, I., Sinclair, R., & Crengle S. (2006). First Nations, Métis, and Inuit health indicators in Canada: A background paper for the project "Action oriented indicators of health and health systems: Development for Indigenous peoples in Australia, Canada, and New Zealand." *Indigenous Peoples Health Research*. Retrieved from [http://www.medicine.uottawa.ca/SIM/Data/Images/Aboriginal\\_health\\_indicators.pdf](http://www.medicine.uottawa.ca/SIM/Data/Images/Aboriginal_health_indicators.pdf)
- Assembly of First Nations. (2004). First Nations action plan. Retrieved from: <http://www.afn.ca/cmslib/general/Action-Plan-2.pdf>
- BC Stats (2009). Northern Health Authority-5: Statistical profile of aboriginal peoples 2006 with emphasis on children, labour market and post-secondary education issues health. Retrieved from <http://www.bcstats.gov.bc.ca/StatisticsBySubject/AboriginalPeoples/CensusProfiles/2006Census.aspx>
- Beach, M.C., Gary, T.L., Price, E.G., Robison, K., Gozu, A., & Palacio, A. (2006). Improving health care for racial/ethnic minorities: A systematic review of the best evidence regarding provider and organization interventions, *Public Health*, 6(104), 123-134. doi:10.1186/1471-2458-6-104. Retrieved from <http://www.biomedcentral.com/1471-2458/6/104>
- Bell, D. (1973). *Race, Racism and American Law*. New York: Little Brown & Co.
- Betancourt, J.R. (2006). Improving quality and achieving equity: The role of cultural competence in reducing racial and ethnic disparities in health care. Boston: *The Commonwealth Fund*. Retrieved from [http://web01.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Oct/Improving%20Quality%20and%20Achieving%20Equity%20%20The%20Role%20of%20Cultural%20Competence%20in%20Reducing%20Racial%20and%20Ethnic/Betancourt\\_improvingqualityachievingequity\\_961%20pdf.pdf](http://web01.commonwealthfund.org/~media/Files/Publications/Fund%20Report/2006/Oct/Improving%20Quality%20and%20Achieving%20Equity%20%20The%20Role%20of%20Cultural%20Competence%20in%20Reducing%20Racial%20and%20Ethnic/Betancourt_improvingqualityachievingequity_961%20pdf.pdf)
- Boulos, P., & Rajacich, D. (2003). Critical theory as a philosophical base for nursing science. *Guidance & Counseling*, 19(1), 37-44.



- Boutain, D.M. (2005). Social justice as a framework for professional nursing. *Journal of Nursing Education*, 44(9), 404-408.
- British Columbia Provincial Health Officer. [BCPHO]. (2007). The health and wellbeing of the aboriginal population in British Columbia. Retrieved from [http://www.health.gov.bc.ca/pho/pdf/Interim\\_report\\_Final.pdf](http://www.health.gov.bc.ca/pho/pdf/Interim_report_Final.pdf)
- British Columbia Provincial Health Officer. [BCPHO]. (2009). *Pathways to healing: Second report on the health and wellbeing of aboriginal people in British Columbia*. Provincial Health Officers Annual Report 2007. Victoria, BC: Ministry of Healthy Living and Sport.
- Brown, T.N. (2003). Critical race theory speaks to the sociology of mental health: Mental health problems produced by racial stratification. *Journal of Health and Social Behaviour*, 44(9), 292-301.
- Browne, A.J. (2001). The influence of liberal political ideology on nursing science. *Nursing Inquiry*, 8(2), 118-129. doi: 10.1046/j.1440-1800.2001.00095.x
- Browne, A.J. (2007). Clinical encounters between nurses and First Nations women in a Western Canadian hospital. *Social Science & Medicine*, 64(10), 2165-2176. doi: 10.1016/j.socscimed.2007.02.006
- Browne, A.J. (2009). Discourses influencing nurses' perceptions of First Nations patients. *Canadian Journal of Nursing Research*, 41(1), 166-91. Retrieved from <http://docserver.ingentaconnect.com/deliver/connect/mcgill/08445621/v37n4/s5.pdf?expires=1343505091&id=69856809&titleid=6601&acname=Guest+User&checksum=FE8F3894029DB6934754CE8E68C580E9>. (Reprinted from *Canadian Journal of Nursing Research*, 37(4), 62-87(2005)
- Browne, A.J., & Fiske, J. (2001). First Nations women's encounters with mainstream health care services. *Western Journal of Nursing Research*, 23(2), 126-147. doi: 10.1177/019394590102300203
- Browne, A.J., & Talier, D.S. (2008). Examining the potential of nurse practitioner from a critical social justice perspective. *Nursing Inquiry*, 15(2), 83-93. doi: 10.1111/j.1440-1800.2008.00411.x
- Browne, A.J., & Varcoe, C. (2006). Critical cultural perspectives and health care involving aboriginal peoples. *Contemporary Nurse*, 22(2), 155-167.
- Burgess, J., Purkis, M., E. (2010). The power and politics of collaboration in nursing practitioner role development. *Nursing Inquiry*, 17(4), 297-308. doi: 10.1111/j.1440-1800.2010.00505.x
- Burns, A., Bruce, D., & Marli, A. (2006). Rural poverty discussion paper. Rural Secretariat Agriculture and Agri-food Canada Government of Canada. Retrieved from [http://www4.agr.gc.ca/resources/prod/rural/doc/poverty\\_pauvrete\\_e.pdf](http://www4.agr.gc.ca/resources/prod/rural/doc/poverty_pauvrete_e.pdf)



- Campbell, A. (2002). Type 2 diabetes and children in aboriginal communities: the array of factors that shape health and access to health care. *Health Law J* 10: 147-68.
- Campinha-Bacote, J. (1999). A model and instrument for addressing cultural competence in health care. *Journal of Nursing Education*, 38(4), 203-207.
- Canadian Institute for Health Information (2004). Aboriginal people's health (Chap. 4) in Improving the health of Canadians. Ottawa: Canadian Institute for Health Information. Retrieved from [http://secure.cihi.ca/cihiweb/products/IHC2004\\_ch4\\_e.pdf](http://secure.cihi.ca/cihiweb/products/IHC2004_ch4_e.pdf)
- Canadian Nurse Practitioner Initiative, (n.d.) Human health resource component literature review: Health and human resource planning/ modeling activities for primary health care nurse practitioners. Retrieved from [http://www.cnaaiic.ca/CNA/documents/pdf/publications/cnpi/techreport/section4/03\\_HHR\\_AppendixB.pdf](http://www.cnaaiic.ca/CNA/documents/pdf/publications/cnpi/techreport/section4/03_HHR_AppendixB.pdf)
- Canadian Nurses Association. (2004). Position statement: Promoting culturally competent care. Retrieved from [http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS73\\_Promoting\\_Culturally\\_Competent\\_Care\\_March\\_2004\\_e.pdf](http://www.cna-aiic.ca/CNA/documents/pdf/publications/PS73_Promoting_Culturally_Competent_Care_March_2004_e.pdf)
- Canadian Nurses Association. (2008). Code of ethics for registered nurses 2008. Centennial Edition. Retrieved from [http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Code\\_of\\_Ethics\\_2008\\_e.pdf](http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Code_of_Ethics_2008_e.pdf)
- Canadian Nurses Association (2010). Canadian nurse practitioner: Core competency framework. Retrieved from: <http://www.cna-aiic.ca>
- Canadian Royal Commission on Aboriginal Peoples. (1996). Looking forward looking back: Part one the relationship in historical perspective (Vol. 1). Ottawa, ON: Ministry of Supply and Services Canada.
- Capell, J., Veenstra, G., & Dean, E. (2007). Cultural competence in healthcare: Critical analysis of the construct, its assessment and implications. *Journal of Theory Construction and Testing*, 11(1), 30-36.
- Carrier Sekanni Family Services (n.d.). Mandate and mission statement. Retrieved from <http://www.csfs.org/pages/about/about.html>
- Cohen, B.E. & Gregory, D. (2009). Community health clinical education in Canada: Part 2- Developing competencies to address social justice, equity and the social determinants of health. *International Journal of Nursing Education Scholarship*, 6(1), 1-15.
- College of Registered Nurses of British Columbia. (2010). Nurse practitioner. What do nurses do? Retrieved from <https://www.crnbc.ca/WhatNursesDo/TypesOfNurses/Pages/NursePractitioner.aspx>
- College of Registered Nurses of British Columbia. (2011). Competencies required for nurse practitioners in British Columbia. Retrieved from <https://www.crnbc.ca/Registration/Lists/RegistrationResources/416CompetenciesNPs.pdf>



- Cook, E., & Daniele, B. (2006). Migration theories and First Nations mobility: Towards a systems perspective. *Review of Sociology & Canadian Review of Sociology & Anthropology*, 43(2), 141-164. doi: 10.1111/j.1755-618X.2006.tb02217.x
- DeCuir, J.T., & Dixon, A.D. (2004). So when it comes out, they aren't that surprised that it is there": Using critical race theory as a tool of analysis of race and racism in education. *Educational Researcher*, 33(5), 26-31.
- Delgado, R., & Stefancic, J. (Eds). (2000). *Critical race theory: The cutting edge* (2<sup>nd</sup> edition). Philadelphia: New York University Press.
- Dhamoon, R. (2009). Critical race theory: Toward a post-essentialist form of social critique. In S.P. Hier, D. Lett, & S. Bolaria (Eds.), *Racism and justice: Critical dialogue on the politics of identity, inequality and change* (pp. 24-41). Black Point, NS: Fernwood Books.
- Dicenso, A., & Bryant-Lukosius, D. (2010). Clinical nurse specialists and nurse practitioners in Canada: A Decision Support Synthesis 2010. Canadian Health Services Research Foundation. Retrieved from <http://www.chsrf.ca/PublicationsAndResources/ResearchReports/CommissionedResearch/10-06-01/b9cb9576-6140-4954-aa57-2b81c1350936.aspx>
- First Nations Health Plan Memorandum of Understanding between the First Nations Leadership Council Representing the BC Assembly of First Nations, the First Nations Summit and the Union of BC Indian Chiefs and Government of Canada and Government of British Columbia. (2006). Retrieved from [http://www.health.gov.bc.ca/library/publications/year/2006/first\\_nations\\_mou.pdf](http://www.health.gov.bc.ca/library/publications/year/2006/first_nations_mou.pdf)
- Fisher, L.T., Burnet, D.L., Huang, E.S., Chin, M.H., & Cagney, K. (2007). Cultural leverage: Interventions using culture to narrow racial disparities in health care. *Medical Care Research and Review*, 64(5 Suppl), 243S-282S. doi: 10.1177/1077558707305414
- Fineout-Overholt, E., Melnyk, B.M., & Schultz, A. (2005). Transforming Health Care from the inside out: Advancing evidence-based practice in the 21<sup>st</sup> century. *Journal Of Professional Nursing*, 21(6), 335-344. doi: 10.1016/j.profnurs.2005.10.005
- Ford, C.L., & Airhihenbuwa, C.O. (2010). Critical race theory, race equity, and public health: Toward antiracism praxis. *American Journal of Public Health*, 100(S1), S30-S35. doi: 10.2105/AJPH.2009.171058
- Foster, C.H. (2006). What nurses should know when working in aboriginal communities. *Canadian Nurse*, 102(4), 28-31.
- Frohlich, K., Ross, N., & Richmond, C. (2006). Health disparities in Canada today: Some evidence and a theoretical framework. *Health Policy*, 79(2-3), 132-143.
- Gardner, G., & O'Keefe, E. (2003). Researching the sexual health nurse practitioner scope of practice: A blueprint for autonomy. *Australian Journal of Advanced Nursing*, 21(2), 33-41.



- Grote, E. (2008). Principles and practices of cultural competency: A review of the literature. Retrieved from <http://www.deewr.gov.au/Indigenous/HigherEducation/Programs/IHEAC/Documents/PrinciplePracCulturalComp.pdf>
- Guilfoyle, J., Kelly, L., & St Pierre-Hansen, N. (2008). Prejudice in medicine: Our role in creating health care disparities. *Canadian Family Physician*, 54(11), 1511-1513. Retrieved from <http://www.cfp.ca/content/54/11/1511.full.pdf+html>
- Hart-Wasekeesikaw, F. (2009a). (Principal author). Cultural competence and cultural safety in First Nations, Inuit, and Metis nursing education: An integrated review of the literature. Aboriginal Nurses Association of Canada. Retrieved from [http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Review\\_of\\_Literature\\_e.pdf](http://www2.cna-aiic.ca/CNA/documents/pdf/publications/Review_of_Literature_e.pdf)
- Hart-Wasekeesikaw, F. (2009b). (Principal author). Cultural competence and cultural safety in First Nations, Inuit, and Métis nursing education: A framework for First Nations, Inuit and Métis Nursing. Retrieved from [http://www.uleth.ca/dspace/bitstream/10133/719/1/A\\_Framework\\_for\\_First\\_Nations\\_Inuit\\_and\\_Metis\\_Nursing.pdf](http://www.uleth.ca/dspace/bitstream/10133/719/1/A_Framework_for_First_Nations_Inuit_and_Metis_Nursing.pdf)
- Health Professions Act, RSBC § 183 (2010). Canada.
- Holmes, D., Roy, B., & Perron, A. (2008). The use of postcolonialism in the nursing domain: Colonial patronage, conversion and resistance. *Advances in Nursing Science*, 31(1), 42-51. doi: 10.1097/01.ANS.0000311528.73564.83
- Indian Act, S.C. 1876. Canada.
- Kafele, K. (2004). Racial discrimination and mental health: Racialised and Aboriginal communities. Race Policy Dialogue Conference Paper. Toronto, ON: Ontario Human Rights Commission. Retrieved from <http://www.ohrc.on.ca/en/racial-discrimination-and-mental-health-racialized-and-aboriginal-communities>
- Kelm, M. (1998). Colonizing bodies: Aboriginal health and healing in British Columbia 1900–50. Vancouver: University of British Columbia Press.
- Kelm, M.-E. (2004). Wilp Wa'ums: Colonial encounter, decolonization and medical care among the Nisga'a. *Social Science and Medicine* 59(6), 335-349. doi: [10.1016/j.socscimed.2003.10.024](https://doi.org/10.1016/j.socscimed.2003.10.024),
- Kirmayer, L., Simpson, C., & Cargo, M. (2003). Healing traditions: Culture community and mental health promotion with Aboriginal peoples. *Australasian Psychiatry* 11(Suppl 1), S15-S23. doi: 10.1046/j.1038-5282.2003.02010.x
- King, M., Smith, A., & Gracey, M. (2009). Indigenous health, part 2: The underlying causes of the health gap. *Lancet*, 374(9683), 76-85. doi: [10.1016/S0140-6736\(09\)60827-8](https://doi.org/10.1016/S0140-6736(09)60827-8)
- Kingi, T.K.R. (2007). The Treaty of Waitangi: A framework for Māori health development. *New Zealand Journal of Occupational Therapy*, 54(1), 4-10.



- Kushner, K.E., & Morrow, R. (2003). Grounded theory, feminist theory, critical theory: Toward theoretical triangulation. *Advances in Nursing Science*, 26(1), 30-43.
- Lancellotti, K. (2008). Culture care theory: A framework for expanding awareness of diversity and racism in nursing education. *Journal of Professional Nursing*, 24(3), 179-183. doi: [10.1016/j.profnurs.2007.10.007](https://doi.org/10.1016/j.profnurs.2007.10.007)
- Leininger, M. M. (1978). *Transcultural nursing*. Thorofare, NJ: Slak.
- Leininger, M.M. (Ed.). (2001). *Culture care diversity and universality: A theory of nursing*. Boston: Jones and Bartlett Publishers.
- Leininger, M. (2002). Culture care theory: A major contribution to advance transcultural nursing knowledge and practices. *Journal of Transcultural Nursing*, 13(3), 189-192. doi: [10.1177/10459602013003005](https://doi.org/10.1177/10459602013003005)
- Leininger, M.M., & McFarland, M.R. (Eds.). (2006). *Culture care diversity and universality: A worldwide nursing theory* (2<sup>nd</sup> ed.) Boston: Jones and Bartlett Publishers.
- Martens, P.J., Martin, B.D., O'Neil, J.D., & MacKinnon, M. (2007). Diabetes and adverse outcomes in a First Nations population: Associations with healthcare access, and socioeconomic and geographical factors. *Canadian Journal of Diabetes*, 31(3): 223-232.
- Martens, P.J., Sanderson, D., & Jebamani, L.S. (2005). Mortality comparisons of First Nations to all other Manitobans: A provincial population-based look at health inequalities by region and gender. *Canadian Journal of Public Health*, 96(Supp), s33-s38.
- McFarland, M.M., & Eipperle, M.K. (2008). Culture care theory: A proposed practice theory guide for nurse practitioners in primary care settings. *Contemporary Nurse*, 28(1-2), 48-63. doi: [10.5172/conu.673.28.1-2.48](https://doi.org/10.5172/conu.673.28.1-2.48)
- Melnyk, B.M. & Fineout-Overholt, E. (2005). *Evidence based practice in nursing & healthcare*. Philadelphia: Lippincott, Williams & Wilkins.
- Mohammed, S. A. (2006). Scientific inquiry. *Journal for Specialists in Pediatric Nursing*, 11(1), 68-71. DOI: [10.1111/j.1744-6155.2006.00045.x](https://doi.org/10.1111/j.1744-6155.2006.00045.x)
- Moss, W., Gardner-O'Toole, E. (1987). Aboriginal people: History of discriminatory Laws (Rev. 1991). Government of Canada Publication. Retrieved from <http://dsp-psd.pwgsc.gc.ca/Collection-R/LoPBdP/BP/bp175-e.htm>
- Mussell, W.J. (2006). *Evaluation AHIP projects: Northern Health Authority*. Retrieved from [http://northernhealth.ca/Your\\_Health/Programs/Aboriginal\\_Health/Documents/AHIPEvaluation-FINALREPORT\\_000.pdf](http://northernhealth.ca/Your_Health/Programs/Aboriginal_Health/Documents/AHIPEvaluation-FINALREPORT_000.pdf)
- National Aboriginal Health Organization [NAHO]. (2002). Improving population health, health promotion, disease prevention and health protection services and programs for aboriginal people: Recommendations for NAHO activities. Retrieved from: [http://blogs.usask.ca/SHORE/research\\_pop\\_health.pdf](http://blogs.usask.ca/SHORE/research_pop_health.pdf)



- National Aboriginal Health Organization [NAHO]. (2008). Cultural competency and safety: A guide for health care administrators, providers and educators. Retrieved from: <http://www.naho.ca/documents/naho/publications/culturalCompetency.pdf>
- Noël, A., & Larocque, F. (2009, August). Aboriginal peoples and poverty in Canada: Can provincial governments make a difference? Paper presented at the Annual Meeting of the International Sociological Associations' Research Committee 19 (RC19), Montréal, Canada. Retrieved from [http://www.cccg.umontreal.ca/RC19/PDF/Noel-A\\_Rc192009.pdf](http://www.cccg.umontreal.ca/RC19/PDF/Noel-A_Rc192009.pdf)
- Northern Health Authority [NHA]. (2006). Aboriginal health conferences – Verbatim notes from small group work. Retrieved from: [http://www.northernhealth.ca/Your\\_Health/Programs/Aboriginal\\_Health/Documents/02-07-07AHConferencesVerbatimSmallGroupWork.pdf](http://www.northernhealth.ca/Your_Health/Programs/Aboriginal_Health/Documents/02-07-07AHConferencesVerbatimSmallGroupWork.pdf)
- Northern Health Authority [NHA]. (2007). Aboriginal health services plan 2007-2010. Retrieved from: [http://northernhealth.ca/Portals/0/Your\\_Health/Programs/Aboriginal\\_Health/documents/July3-2007-2010AboriginalHealthServicesPlan\\_000.pdf](http://northernhealth.ca/Portals/0/Your_Health/Programs/Aboriginal_Health/documents/July3-2007-2010AboriginalHealthServicesPlan_000.pdf)
- Nova Scotia Department of Health, Primary Health Care Section. (2005). A cultural competence guide for primary health care professionals in Nova Scotia. Retrieved from [http://www.healthteamnovascotia.ca/cultural\\_competence/Cultural\\_Competence\\_guide\\_for\\_Primary\\_Health\\_Care\\_Professionals.pdf](http://www.healthteamnovascotia.ca/cultural_competence/Cultural_Competence_guide_for_Primary_Health_Care_Professionals.pdf)
- Papps, E. (2005). Cultural safety: Daring to be different. In D. Wepa (Ed.), *Cultural safety in Aotearoa New Zealand* (pp. 20-28). Auckland, NZ: Pearson Education.
- Peiris, D., Brown, A., & Cass, A. (2008). Commentary. Addressing inequities in access to quality health care for indigenous people. *Canadian Medical Association Journal*, 179(10), 985-986. doi: 10.1503/cmaj.081445.
- Peters, H., & Self, B. (2011). Colonialism, Resistance and the First Nations Health Liaison Program. *Currents: Scholarship In The Human Services*, 4(1). Retrieved from <http://currents.synergiesprairies.ca/currents/index.php/currents/article/view/62>
- Reading, J., L., Kmetz, A., & Gideon, V. (2007). First Nations wholistic Policy and Planning Model: Discussion paper prepared for the World Health Organization Commission on Social Determinants of Health. Retrieved from [http://ahrnets.ca/files/2011/02/AFN\\_Paper\\_2007.pdf](http://ahrnets.ca/files/2011/02/AFN_Paper_2007.pdf)
- Registered Nurses Association of Ontario. [RNAO]. (2007). Embracing cultural diversity in health care: Developing cultural competence. From: Healthy Work Environments. Best Practice Guidelines. Retrieved from <http://rnao.ca/bpg/guidelines/embracing-cultural-diversity-health-care-developing-cultural-competence>



- Reime, B., Tu, A. W., Lee, S. K. and the Canadian Neonatal Network (2007), Treatment differences between Aboriginal and white infants admitted to Canadian neonatal intensive care units. *Paediatric and Perinatal Epidemiology*, 21: 532–540. doi: 10.1111/j.1365-3016.2007.00874.x
- Richardson, S. & Williams, T. (2007). Why is cultural safety essential in health care? *Medicine and Law*, 26(4). 699-707.
- Richmond, C.A.M., Ross, N.A., & Egeland, G.M. (2007). Social support and thriving health: A new approach to understanding the health of indigenous Canadians. *American Journal of Public Health*, 97(10), 1827-1833. doi: 10.2105/AJPH.2006.096917
- Rosenberg, M.W., Wilson, K., Abonyi, S., Wiebe, A., Beach, K., & Lovelace, R. (2009, September). Older aboriginal peoples in Canada – demographics, health status, and access to health care. Social and Economic Dimensions of an Aging Population Research Papers 249, McMaster University.
- Scott, V., Stern, R., Sanders, D., Reagon, G., & Mathews, V. (2008). Research to action to address inequities: The experience of the Cape Town Equity Gauge. *International Journal for Equity in Health*, 7(6), 6-14. doi:10.1186/1475-9276-7-6. Retrieved from <http://www.equityhealthj.com/content/7/1/6>
- Smylie, J., Anderson, I., Ratima, M., Crengle, S., & Anderson, M. (2006). Indigenous health performance measurement systems in Canada, Australia, and New Zealand. *Lancet*, 367(9527): 2029-31. doi:10.1016/S0140-6736(06)68893-4
- Statistics Canada. (2006). *2006 Census reference material: Notes – Incompletely Enumerated Indian Reserves and Indian Settlements*, Ottawa, Statistics Canada. Retrieved from: <http://www12.statcan.ca/census-recensement/2006/ref/notes/aboriginal-autochtoneseng.cfm>.
- Statistics Canada. (n.d.). Aboriginal peoples of Canada. In analysis series. Retrieved from: <http://www12.statcan.ca/english/census01/Products/Analytic/companion/abor/canada.cfm>
- Tabobondung, L. (2007). Aboriginal health services plan 2007-2010. Retrieved from: [http://www.northernhealth.ca/Portals/0/Your\\_Health/Programs/Aboriginal\\_Health/documents/July3-2007-2010AboriginalHealthServicesPlan\\_000.pdf](http://www.northernhealth.ca/Portals/0/Your_Health/Programs/Aboriginal_Health/documents/July3-2007-2010AboriginalHealthServicesPlan_000.pdf)
- United Church Of Canada. (2009). Minutes for Missions. Retrieved from <http://www.united-church.ca/sales/publications/minutes>
- University of British Columbia Museum of Anthropology. (2004). First Nations languages of British Columbia (Rev. 2006). Retrieved from [http://www.moa.ubc.ca/pdf/FN\\_Lang\\_map.pdf](http://www.moa.ubc.ca/pdf/FN_Lang_map.pdf)
- Vickers, D.A. (2008). Social justice: A concept for undergraduate nursing curricula? *Southern Online Journal of Nursing Research*, 8(1). Retrieved from <http://www.snrs.org>
- Waldram, J. B. Herring, D. A., & Young, T. K. (2006). *Aboriginal health in Canada: Historical, cultural and epidemiological perspectives*. (2<sup>nd</sup> edition). Toronto: University of Toronto Press.

- Wardman, D., Clement, K., & Quantz, D. (2005). Access and utilization of health services by British Columbia's rural Aboriginal population. *Leadership in Health Services*, 18(2), 26-31. doi: [10.1108/13660750510594864](https://doi.org/10.1108/13660750510594864)
- Warelow, P., Edward, K.-L., & Vinek, J. (2008). Care: What nurses say and what nurses do. *Holistic Nursing Practice*, 22(3), 146-153. doi: 10.1097/01.HNP.0000318023.53151.33
- Wilson, K., & Rosenberg, M.W. (2002). Exploring the determinants of health for First Nations peoples in Canada: Can existing frameworks accommodate traditional activities? *Social Science & Medicine*, 55(11): 2017-2031. doi: [10.1016/S0277-9536\(01\)00342-2](https://doi.org/10.1016/S0277-9536(01)00342-2)
- Wolfe, R.R. (2009). Working (in) the gap: A critical examination of the race/culture divide in human services (Doctoral dissertation). Retrieved from: [http://gateway.proquest.com/openurl%3furl\\_ver=Z39.88-2004%26res\\_dat=xri:pqdiss%26rft\\_val\\_fmt=info:ofi/fmt:kev:mtx:dissertation%26rft\\_dat=xri:pqdiss:NR62893](http://gateway.proquest.com/openurl%3furl_ver=Z39.88-2004%26res_dat=xri:pqdiss%26rft_val_fmt=info:ofi/fmt:kev:mtx:dissertation%26rft_dat=xri:pqdiss:NR62893)
- World Health Organization (2007). Health statistics and health information systems. Retrieved from <http://www.who.int/healthinfo/boddaly/en/index.html>
- Young, T. K. (2003). Review of research on aboriginal populations in Canada: Relevance to their health needs. *British Medical Journal*, 327(4), 419-422. doi: 10.1136/bmj.327.7412.419