



Empathy, dignity, and respect

Creating cultural safety for Aboriginal
people in urban health care



About the artist

To gather information for this report, the Health Council of Canada held a series of seven regional discussions across the country, facilitated by AMR Planning and Consulting Inc., an Aboriginal-owned consulting company based in Winnipeg. AMR associate and artist Leah Fontaine (Dakotah/Anishinaabe/Métis), created a visual representation of each meeting by listening to discussions and incorporating the themes she heard, along with culturally significant symbols, into her work. At each session, she invited participants to suggest images and/or to draw or write on the large illustration (four feet by four feet), which was mounted on a wall.

The resulting artwork of the seven regional discussions has been incorporated throughout this report, accompanied by the artist's descriptions. The image on the cover, commissioned separately for the report, symbolizes the balance between Western and Aboriginal perspectives and approaches to health and restoration.

Leah Fontaine has a BA (Theatre Design), a BFA (with Honors), and an MA (Native Studies). She connects her Dakotah/Anishinaabe/Métis heritage to intuitively attain the iconography and worldview that is displayed in her work. She lives in Winnipeg.

Ms. Fontaine would like to convey her heartfelt gratitude to the various Elders and her First Nations sisters and brothers she met on this project who assisted her with their First Nations ethos.

About the Health Council of Canada

Created by the *2003 First Ministers' Accord on Health Care Renewal*, the Health Council of Canada is an independent national agency that reports on the progress of health care renewal. The Council provides a system-wide perspective on health care reform in Canada, and disseminates information on innovative practices across the country. The Councillors are appointed by the participating provincial and territorial governments and the Government of Canada.

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It is well documented that many underlying factors negatively affect the health of Aboriginal people in Canada, including poverty and the intergenerational effects of colonization and residential schools. But one barrier to good health lies squarely in the lap of the health care system itself. Many Aboriginal people don't trust—and therefore don't use—mainstream health care services because they don't feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating.

Table of contents

Part 1: Commentary by the Health Council of Canada	3
Introduction	4
The value of cultural competency and safety	6
Why cultural competency and cultural safety are needed	8
The persistence of racism	8
An intimidating and alienating health care system	10
Cultural competency and safety in action	11
How it feels to Aboriginal people	11
Creating understanding and respect	11
Innovative practices across Canada	12
Concluding comments	15
References	16
 Part 2: Summary report: 2012 regional discussions on cultural competency and cultural safety for First Nations, Inuit, and Métis Peoples in urban health systems	 19
1. Introduction	21
2. The value of cultural competency and cultural safety	23
3. Practices in cultural competency and safety	27
System-wide transformation	28
Collaboration and partnership to build capacity	33
Increasing cultural awareness and competency among health professionals	37
Culturally based services that respond to community-identified needs	47
Research that enhances understanding, capacity, and accountability	58
4. Sustaining and building on positive change	63
 Appendix A: List of practices identified by participants	 67
Appendix B: References	72
Acknowledgements	74

Part 1

Commentary by the Health Council of Canada



Introduction

In the spring of 2012, the Health Council of Canada held a series of meetings across Canada with health care providers, managers, and researchers to learn about efforts to create *culturally competent* care and *culturally safe* environments for Aboriginal people in urban health care services.

It is well documented that many underlying factors negatively affect the health of Aboriginal people, including poverty and the intergenerational effects of colonization and residential schools.^{1,2} But as participants discussed at our meetings, one of the barriers to good health lies squarely in the lap of the health care system itself. They told us that many Aboriginal people don't trust—and therefore don't use—mainstream health care services because they don't feel safe from stereotyping and racism, and because the Western approach to health care can feel alienating and intimidating.

This is one of the reasons that many Aboriginal people are less likely to seek help when they have symptoms and more likely to be diagnosed at a later stage of disease than non-Aboriginal people, a delay that can make treatment more difficult or no longer possible.³ Others may go for care but then drop out of treatment. In addition, if the health system is not safe for Aboriginal people, they miss the benefits of preventive care such as immunizations and screening tests.

While these issues would be of concern for any population, they are of particular concern for Aboriginal people, who, as a group, have the poorest health and the shortest life expectancies of all Canadians.^{2,4}

Culturally competent care builds trust, increasing the likelihood that Aboriginal people will go for care and stay with their treatment. Although a number of research and government reports have discussed the need for increased cultural competency in health care,^{3,5,6} participants told us this issue is not widely known or understood in the health care field.

The goal of the 2012 Health Council meetings, held in Saskatoon, Winnipeg, Edmonton, Vancouver, Toronto, Montreal, and St. John's, was to hear first-hand accounts from people in the field about the need for cultural competency and safety, and to learn what innovative practices are working. The focus was on mainstream urban health care systems, as approximately half of Canada's 1.3 million Aboriginal people live in cities.⁷

Most of the participants in our sessions were First Nations, Inuit, or Métis people, and we asked for their professional and personal perspectives to help us answer two questions: What do cultural competency and cultural safety look and feel like in health care? What programs are working at the system level, in community health care and hospitals, and within professions to create welcoming and safe environments for Aboriginal people?

We learned that cultural competency and cultural safety are becoming top-of-mind topics in many governments, health regions, and hospitals. In addition to the innovative practices listed in this report, participants told us of other strategies that are currently in development and expected to roll out within the next few years. There was a sense of hope and anticipation among many participants.

In this commentary, we provide what we heard about the reasons why cultural competency and cultural safety are needed. It is intended to serve as a primer on the issue for health care providers and leaders, governments, and the Canadian public. Part 2 of this report provides descriptions of new and emerging programs and strategies, while selected in-depth case studies and a video are available online at healthcouncilcanada.ca.

Defining cultural competency and cultural safety

In lay terms, cultural competency is about creating a health care environment that is free of racism and stereotypes, where Aboriginal people are treated with empathy, dignity, and respect. Culturally competent health care providers are more likely to recognize the effects of history on Aboriginal people and to adapt the way care is provided to more effectively meet their patients' distinct needs. Cultural safety occurs when Aboriginal people feel they can trust their health care providers as a result of these culturally competent efforts.

The term *cultural safety* was developed in the 1980s in New Zealand in response to the Maori people's discontent with nursing care. Since then, cultural safety as a concept has extended beyond its origins and resonates with Indigenous people around the world. It has been explored extensively in academic literature, government reports, and professional studies, particularly in New Zealand, Australia, and Canada.^a

The following definitions are taken from work by the former National Aboriginal Health Organization (NAHO), which served as a guide for others, as well as from collaborative work by the Indigenous Physicians Association of Canada (IPAC), the Royal College of Physicians and Surgeons of Canada (RCPSC), and the Association of Faculties of Medicine of Canada (AFMC). These three

organizations collaborated on a new curriculum framework for undergraduate medical education and for family medicine residents and physicians.

Cultural safety

- ▶ is an outcome, defined and experienced by those who receive the service—they feel safe;
- ▶ is based on respectful engagement that can help patients find paths to well-being;
- ▶ is based on understanding the power differentials inherent in health service delivery, the institutional discrimination, and the need to fix these inequities through education and system change; and
- ▶ requires acknowledgement that we are all bearers of culture—there is self-reflection about one's own attitudes, beliefs, assumptions, and values.^{b,c}

Culturally safe care

- ▶ involves building trust with Aboriginal patients and recognizing the role of socioeconomic conditions, history, and politics in health;
- ▶ requires communicating respect for a patient's beliefs, behaviours, and values; and
- ▶ ensures the client or patient is a partner in decision-making.^{d,e}

The value of cultural competency and safety

While there is great diversity within and across the First Nations, Inuit, and Métis populations, as a group Aboriginal people generally have poorer health status and health outcomes than other Canadians. For example, Aboriginal people are more likely than other Canadians to live with chronic conditions and infectious diseases, and to die prematurely. The poorer health status and health outcomes found in the Aboriginal population are closely linked to determinants of health.¹ Aboriginal people are more likely than other Canadians to live in poverty, which, in turn, is associated with other conditions that negatively affect health, such as inadequate housing, poor nutrition, obesity, and physical and emotional stress.^{1,2,9}

Canadian health care managers have a responsibility to reach out to populations that are suffering from poor health and/or not using services, to find out why, and to adapt health care services to better meet their needs.

Cultural safety makes a significant difference to health. Aboriginal people are more likely to use health care services and follow treatment advice when they trust their health care providers.^{8,10,11} Efforts in cultural competency have shown it is an effective way for health care providers, institutions, and health regions to build bridges with Aboriginal communities and increase their use of health care services.^{2,8,10,11}

Cultural competency also benefits health care providers. They want their patients to do well, and it increases staff confidence and morale when patients follow treatment and their health improves, rather than returning in progressively worse condition at each visit (or not returning at all). This can lead to less staff turnover.^{10,12}



“There is growing recognition that if the mainstream health care system in Canada is to be effective in helping to improve the health of First Nations, Inuit, and Métis clients, it must provide culturally safe care.”

– Indigenous Physicians Association of Canada and the Royal College of Physicians and Surgeons of Canada, 2009.⁸

Emerging evidence shows positive results

Although our participants shared many anecdotal reports of positive changes that occurred as a result of cultural competency and safety in their organizations, the published evidence is still emerging.

Many participants commented on the importance of the Aboriginal Health Transition Fund (AHTF) (2005–2011), which seeded many new initiatives in cultural competency for Aboriginal people across the country. One approach to cultural competency that is showing positive effects is the role of Aboriginal Patient Navigator (also called liaison or support worker), many of which were first funded through the AHTF. This role is developing across all provinces and territories, and is an increasingly important part of adapting health care services for Aboriginal people. Evaluations are showing many benefits, including improved access to Western and traditional health services; increased quality of care; increased knowledge, understanding, and adherence to recommended treatments; improved trust of providers; and increased patient satisfaction.^{f,g,h}

An AHTF meta-evaluation and lessons learned can be found at <http://hc-sc.gc.ca/fniah-spnia/services/acces/oll-rlr-eng.php>. This information will guide the new Health Service Integration

Fund (HSIF), a five-year, \$80 million Aboriginal health initiative that will build on the AHTF with a focus on the integration of health services for Aboriginal Canadians.

Participants also discussed the Aboriginal Health Human Resources Initiative (AHHRI) (2005–2010; 2010–2014 renewed), designed to “lay the foundation for longer term systemic changes in the supply, demand and creation of supportive environments for First Nations, Inuit, and Métis health human resources, with the goal of improving health status, with a particular emphasis on increasing the numbers of Aboriginal health professionals.” Improving the cultural competency of non-Aboriginal health providers was part of this initiative. An evaluation showed that significant inroads have been made and many positive changes are taking place; for example, foundational work resulted in the development of cultural competency frameworks and curricula for the fields of nursing and medicine, which will serve as tools for other health professions.^{i,j} However, participants in the Health Council sessions stressed that much work still needs to be done to increase the numbers of Aboriginal health care professionals and ensure equitable representation of First Nations, Inuit, and Métis people.

Why cultural competency and cultural safety are needed

The persistence of racism

Many Aboriginal people do not like to use the mainstream health care system because, in the words of one session participant, “they have had experiences like being treated with contempt, judged, ignored, stereotyped, racialized, and minimized.” Negative stereotypes about Aboriginal people are deeply rooted in Canadian society, and much of what Aboriginal people experience in the health care system is an extension of this systemic racism.

The word *racism* makes many people uncomfortable, and that discomfort was sometimes palpable in the sessions; but a number of participants with significant experience in cultural competency programs asked us to “name the elephant in the room” in order to encourage open discussions about racism and accelerate efforts to create culturally safe health care services.

Participants shared many examples of racism, speaking sometimes as health care providers and sometimes as patients. They told stories of doctors who would not prescribe painkillers to Aboriginal people (even when they were in severe pain) because of a mistaken and racist belief that Aboriginal people are at high risk of becoming addicted, or a similarly racist assumption that they may already be engaging in prescription drug abuse. There were several

“Two primary objectives of the residential schools system were to remove and isolate children from the influence of their homes, families, traditions and cultures, and to assimilate them into the dominant culture. These objectives were based on the assumption [that] aboriginal cultures and spiritual beliefs were inferior and unequal...There is no place in Canada for the attitudes that inspired the Indian residential schools system to ever again prevail.”

— excerpts from the Government of Canada’s public apology to Aboriginal people for residential schools, Prime Minister Stephen Harper, June 11, 2008.¹³

stories of Aboriginal people who went to emergency departments with various ailments (one suffering from a diabetic coma, another from an injury) who were assumed to be under the influence of drugs or alcohol and not given proper assessments as a result.

Other examples of racism included a staff member who used a code word to signal dismissively to a colleague that the next patient was an Aboriginal person; a mother who learned that she and her newborn baby had been kept in the hospital for longer than expected because staff were assessing whether she would be a good parent; and an Aboriginal woman (and health care professional) who was told that she would not be included in the planning process for her family member's care because she "wouldn't understand."

One story exemplifies the type of racist assumptions that many Aboriginal people experience. An Aboriginal man who was beaten and bloodied was brought to an emergency department, where he was not allowed to lie on a bed. When a physician asked why the patient was not lying down, the nurse explained that the man was dirty, and would just return to the street after leaving the hospital to engage in the same risky behaviours that had landed him in emergency. In fact, the patient was employed, owned a home, and had been attacked on his way home from work.

Encounters with discrimination and racism negatively affect the quality of care that Aboriginal people receive, and cause a loss of confidence in mainstream health care. They often feel uncomfortable, fearful, or powerless when they attempt to use the health care system, and some avoid going for care, even when they are not well.

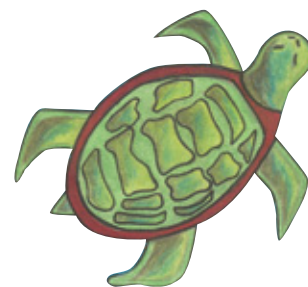
At a fundamental level, discrimination and racism can make it unsafe for Aboriginal people to use the health care system, which reduces opportunities for early intervention and prevention of health problems.

My grandmother was discriminated against in the health care system, so she didn't encourage me to go for help when I needed it. I grew up thinking the same thing. People have been turned off by the system, and this is totally preventable. If I feel [that] I'm going to be belittled or judged if I seek help, I won't seek help and I won't encourage my children or grandchildren to seek help. This will have terrible effects.

Aboriginal health care professionals in our sessions reported that they too are often subject to discrimination and racism, ranging from racial slurs to the frequent insinuation that they have been awarded their positions because they are Aboriginal, rather than because they have the skills and qualifications their positions require.

Racism and sexism have much in common. Both are not only inappropriate but also illegal and not to be tolerated; just as we need to remind men not to be sexually aggressive in the workplace, we need to be vigilant about stopping racism.

A number of participants noted that most health care professionals who behave this way are unaware that they are acting out deeply entrenched stereotypes of Aboriginal people. They make assumptions about Aboriginal people because they are not educated about Aboriginal history and issues.



An intimidating and alienating health care system

To some Aboriginal people, health care environments can feel alienating and providers can seem judgmental and arrogant. Reasons for this include the higher value placed on Western educational credentials and a lack of respect for traditional Aboriginal approaches to healing; the power differential and different communication styles between provider and patient; the use of complicated medical terminology instead of conversational language; the rapid pace at which health care operates; and the Western focus on disease rather than on the whole person and the life circumstances that may be affecting their overall health and subsequent treatment.

Many Aboriginal people take a more holistic approach that focuses on the integration of physical, emotional, mental, and spiritual well-being, an approach that participants said is often undervalued in mainstream health care systems. For many Aboriginal people, care for the spiritual aspects of health and well-being is based on ceremonies; although many health care organizations accommodate ceremonies, Aboriginal people don't always feel that traditional practices are welcome and understood.

Ceremonies are about celebration, healing, and destroying negativity. We sneak around to do them. A cultural room would tell us that there's space for ceremony, that no one would stop us.

Communication gaps and misunderstandings can also develop when health care professionals fail to speak in ways that recognize the other person as an equal in the conversation. This can be an issue for people who are fluent in English as much as for those who need an interpreter.

Education creates a power differential. All these big words! Why don't the different disciplines talk in a common, simpler language? It's not about "dumbing down." It's about making sure everyone can understand you.

In addition, although the health care system can be, in the words of one participant, "alienating to everyone," it is particularly so for some Aboriginal people. Health care providers need to be aware that the impact of the long history of discrimination and racism directed at First Nations, Inuit, and Métis people is still felt today. Aboriginal people—particularly those who were affected by the residential school experience—may have a heightened sensitivity to practices that are a routine part of hospital life.

Even when racism is absent, the typical downsides of Western health care, such as rushed appointments with impersonal providers, can feel like discrimination to Aboriginal people. As one example, several participants noted that the triage process in emergency departments can lead some Aboriginal people to think that non-Aboriginal people are seen ahead of them because of racism. Misunderstandings like this can be minimized by working with Aboriginal communities to find out what concerns exist and by ensuring there is clear communication in place to explain processes. Patience and understanding also make a difference.

Our people have always experienced racism and discrimination, so when they come into the system, they are likely to feel that—and feel defensive and angry. We need to be aware of that and respect the reasons for it. Stay open, accommodating, and kind.

Cultural competency and safety in action

How it feels to Aboriginal people

When asked, “How do cultural competency and safety feel?” participants said that the single most important factor in creating cultural safety was the attitude and behaviour of health care providers.

You can have cultural safety without someone knowing anything about your culture if they are really listening, as if what you say matters; treating you with respect; and treating you as an equal.

They said that Aboriginal people need to know that providers are interested in them as people, that they will be treated with dignity and respect, and that they will be considered partners in their care. In the words of one participant, health care providers need to be “the right kind of people, not just people with the right credentials.”

For providers, cultural competency starts with the understanding that they should not make assumptions about people’s culture. Culturally competent staff know to ask questions about what their patients need, find out how to get it, and are willing to advocate for it, such as a request to have a traditional ceremony or involve a traditional healer in care. They also recognize that Aboriginal communities have different beliefs, cultural practices, and languages, and that not all Aboriginal people are interested in following traditional ways.

Health care providers who are culturally competent also take a holistic approach to care (for physical, emotional, mental, and spiritual wellness) and consider how the circumstances of patients’ lives may be affecting their health. As one example, patients who fail to show for appointments or drop out of treatment are typically described as “non-compliant,” but a culturally competent health care professional would ask, “What is going on in this person’s life that is

making it difficult to care for their health?” With Aboriginal patients, poverty or a lack of resources often lies behind the behaviour.

If someone lacks a car or childcare to allow them to attend an appointment, that doesn’t make them non-compliant!

A culturally competent organization would figure out how to make its services meet the needs of Aboriginal patients instead of expecting patients to adapt to the services, and would do this in partnership with Aboriginal communities. One of the ways to improve services for Aboriginal people is to develop and enforce policies that support cultural competency training and ensure that racism will not be tolerated in the work place.

Creating understanding and respect

Until recently, most Canadians learned very little about Aboriginal people in public school, and what they did learn was typically the European perspective on historic events such as the founding of Canada. They did not learn history from the point of view of Aboriginal people, which includes the forced relocation of Aboriginal peoples from their traditional territories to make way for settlers, the Indian Act, residential schools, and the placement of thousands of Aboriginal children in non-Aboriginal families for adoption (called the Sixties Scoop).¹⁴ Similarly, until recently, very little information about Aboriginal people was provided in the curriculum at medical schools and other post-secondary programs for health professionals.

Fortunately, public school systems and medical and other post-secondary programs are changing, and curricula now include more material on both the historic experiences and present-day realities of First Nations, Inuit, and Métis peoples. For Aboriginal people, the legacy of Canadian history includes persistent inequities in the determinants of health, health status, and health outcomes. For many people, this legacy also includes significant mistrust of non-Aboriginal people and those in authority, as well as governments, institutions, and public services, including the health care system.

Participants said that most providers are well-intentioned and want to care for their patients, but they may be unaware that their lack of cultural competency is causing a problem. They may not realize that they are the reason someone does not follow a treatment protocol or doesn't return for appointments. Practitioners who don't know the history of Aboriginal people may think they are treating all patients equally. Even if they don't exhibit any systemic racism, health care providers who don't know the historical context of Aboriginal people may make decisions that are not completely informed and may in fact do harm.

Participants noted that some Aboriginal people may feel unsafe because they have experienced trauma (such as abuse in residential school), and without knowing this a health care provider cannot help them appropriately. One participant shared the story of a patient whose hospitalization triggered memories of residential school, leaving him withdrawn and quiet. He was labelled "low functioning."

Health care providers don't need to know the details of someone's culture, but they should have enough understanding of the history of colonization and resulting intergenerational trauma to understand how these factors may affect someone's health and care, and be willing to work actively to gain someone's trust.

Many of the participants in our sessions said their organization or health region offered some sort of cultural awareness training, but the content varied significantly. A number of participants with experience in cultural competency training stressed that there is a benefit to a standardized curriculum that provides

what Canadians did not learn in school. But training should not focus just on facts, they said. Stories told directly by Aboriginal people about their experiences are an effective way to create understanding and empathy. Health care providers should also be encouraged to think about their own cultural beliefs and biases, their power and privilege, and how these might unconsciously play out in their interactions with Aboriginal people.

People think that learning the facts about Aboriginal people is enough, but what's really needed is a process of looking inside, self-reflection, and unpacking their own attitudes, understandings, and actions about Aboriginal people.


This type of training has the potential to generate real change in people's practices, and makes it possible for staff to say, "I want to know more."


Innovative practices across Canada

Across Canada, provinces and territories are at different stages of development in cultural competency efforts and are using multiple approaches. Overall, participants said that cultural safety needs to be established as a priority at the provincial/territorial level, in health regions, and in health service delivery, with changes to policies, guidelines, governance, accountability, education, and training.

Part 2 of this report describes more than 30 examples of innovative programs and strategies that address many of these elements of cultural competency and safety. Some are well established and nationally recognized, while others are just emerging. Although the practices in this report do not capture all of the activity in Canada in cultural competency and cultural safety, they do represent those that were top of mind to our participants and are of either regional or national interest.

Eight selected innovative practices are profiled on the Health Council's Health Innovation Portal (healthcouncilcanada.ca/innovation):

 Winnipeg has Canada's largest population of urban Aboriginal people, representing 10% of the population.¹⁵ The **Winnipeg Regional Health Authority (WRHA)** is increasing its efforts to embed cultural competency throughout the region. In 2011, the WRHA began to implement a **new framework for action in cultural proficiency and diversity**, which affects everything from policy to research. Components include cross-cultural training programs as well as activities that support the development of cultural and social knowledge, communications skills, and know-how regarding cultural health assessments. The WRHA has been recognized for the collaborative partnerships it has formed with First Nations, Inuit, and Métis organizations.


 In 2010, BC launched a facilitated online **Indigenous Cultural Competency Training** program, the first of its kind in Canada. The program **provides fundamental information and encourages self-reflection** about Aboriginal people, the history of colonization, cultural biases, and the importance of culturally safe health care. The online program, developed and operated by the Provincial Health Services Authority, serves as the foundation for additional cultural competency training about local communities that takes place in each health region. The program developed as a result of recommendations made in tripartite agreements between First Nations leadership, the provincial government, and the federal government. Both the 2006 *Transformative Change Accord* and the 2007 *Tripartite First Nations Health Plan* include this requirement: "First Nations and the Province will develop a curriculum for cultural competency in 2007/2008, and require health authorities to begin this training in 2008/09. Training will be mandatory for Ministry of Health and health authority staff, including executive and senior management."




BC's **Interior Health Authority (IHA)** has made significant changes to the way it plans, delivers and governs health services following through on a long-standing commitment to make health care services and programs more accessible and appropriate for Aboriginal people and improve their health status. IHA recognizes that the gap between the health status of Aboriginal people and other residents cannot be closed without also addressing inequities in health determinants, collaborating with Aboriginal people to identify and develop health care solutions that will meet their needs, and making changes across IHA's Care and Service Continuum. The organization, working in partnership with First Nations, Urban Aboriginal and Métis people, has developed and implemented the **Aboriginal Health & Wellness Strategy 2010-2014**.

Activities undertaken to move this strategy forward include:

- establishing core funding for the Aboriginal Health Program;
- implementing an Aboriginal Patient Navigator program to help Aboriginal patients access service;
- committing to Indigenous Cultural Competency Training;
- developing Aboriginal health human resources;
- undertaking an Aboriginal self-identification process for Aboriginal patients and staff members that provides data to support planning activities;
- establishing The Aboriginal Health & Wellness Advisory Committee; and
- developing Letters of Understanding with local First Nations.

 In Saskatchewan, the Regina Qu'Appelle Health Region (RQHR) Home Care, in partnership with the Eagle Moon Health Office, initiated an **Aboriginal Home Care Project** because RQHR Home Care recognized that Aboriginal people were not accessing home care. To understand why, the department assembled a working group with representation from First Nations, Métis, government, and home care. They identified key issues relating to a lack of case management and restrictive policies, and began to adapt home care services to make them more culturally relevant for First Nations and Métis people. A model of holistic care was developed for the project, offering services beyond what RQHR Home Care offers to the mainstream population and changing how practitioners do their work. RQHR Home Care created new staff positions and incorporated cultural practices into management. In the two years since it started, the program has increased access to home care. All Aboriginal patients using home care services now have case management and are linked to an Aboriginal liaison worker.

 Participants emphasized in our sessions that Aboriginal people often feel most comfortable and safe using mainstream health care services when they see Aboriginal staff, including someone who can help them navigate their way through the health system. **Aboriginal patient navigators** (sometimes called support workers or liaisons) provide support to individual patients, and break down barriers between health care providers and patients by serving as cultural interpreters. They also serve as a bridge to wary Aboriginal communities that are reluctant to use mainstream health care services, and provide cultural competency education to non-Aboriginal staff, both formally and informally through their day-to-day interactions. Evaluations show that Aboriginal patient navigators are highly effective.^{16,17,18} Two case studies show how this role functions in two different regions: in the **Southern Regional Health Authority in Manitoba** (formerly the Regional Health Authority in Central, Manitoba), and in the **St. John's Native Friendship Centre/Shanawdithit Shelter**, in partnership with Eastern Health.

 **Clinique Minowé**, opened in 2011 in the Val-d'Or Native Friendship Centre in the city of Val-d'Or, Quebec, offers **new approaches to integrate and adapt health and social services** for urban Aboriginal people. The Clinique offers the services of a nurse and a social worker in a culturally relevant environment, meeting patients' health care needs and helping them to address life circumstances (such as poverty, addictions, unemployment, or social problems) that are affecting their health and well-being. The Clinique Minowé concept originated in the Aboriginal community, initiated by people who were ready to create change. The provincial association of Friendship Centres and the Regroupement des centres d'amitié autochtones du Québec (RCAAQ) plan to roll out the clinic's model in other Quebec cities that have a friendship centre in place.

 The **All Nations Healing Hospital**, located on-reserve in the community of Fort Qu'Appelle, Saskatchewan, is a **community-driven hospital that provides programs and services to meet the needs and reflect the cultures and traditions of the communities it serves**. Traditional components are included in virtually all programs and activities. First Nations community members have been engaged from the start in the development of the hospital, but it does not serve only First Nations people—the hospital is open to everyone. All Nations has become a model for other health care organizations, recognized for its integration of services across different levels of government and funders. The hospital has agreements with First Nations, the federal government, and the provincial government to provide health services, establishing a new way to manage costs for services and straddle jurisdictions.

For more detailed information on the innovative practices described here, visit healthcouncilcanada.ca/innovation.

Concluding comments

Statistically, Aboriginal people have poorer health and shorter life expectancies than the broader Canadian population, although there are variations within and among the First Nations, Inuit and Métis communities. There is a missed opportunity for the mainstream health care system to play a role in improving their health outcomes, as many Aboriginal people don't trust the system enough to use it.

Their mistrust is based on a long and painful history of racism in Canadian society and efforts to eradicate their culture. This racism is also present in health care. While Aboriginal people may have access to care, racism creates a systemic barrier that contributes to their mistrust of the health care system. This history makes the experience and needs of Aboriginal people very different from those of other Canadians. Making specific efforts to ensure that the health care system works for Aboriginal people is important not only to improving their health, but as a concrete way to show respect and work towards reconciliation and justice.

Cultural competency is not merely a nice thing to do, or an add-on. It is about reform, based on acknowledging that a lack of culturally competent health care professionals and services keeps many Aboriginal people from seeking care and is negatively affecting their health. Cultural competency requires organizations and institutions to develop appropriate policies, structures, and processes to support and formalize it.

Health care leaders and providers, both in health care delivery and government, have the ability to create a culture shift that ensures First Nations, Inuit, and Métis people will feel welcome and safe in the health care system. Many are already rolling out new programs and strategies to make these changes. We commend their efforts and urge others to join them.



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We need to build an equitable system. Equity is missing. Cultural competency and safety can help toward this end.

Part 2

Summary report

2012 regional discussions on cultural competency
and cultural safety for First Nations, Inuit, and Métis
Peoples in urban health systems

A commissioned report prepared by AMR Planning
and Consulting Inc.





SASKATOON

Be the change

The Health Council's first meeting was in Saskatoon. Participants talked about the challenging balance between the Aboriginal holistic approach to health and the Western medical world view that is represented in the image by the two styles of medical attire, as well as a turtle rattle in one hand and a medicine bottle in the other. The tears show the hurt that happens when someone is not treated with empathy, dignity, and respect.

Braids in the person's hair represent the past, present, and future of Aboriginal peoples. The roots of the tree refer to how we are all rooted in a common experience.

Participants were invited at the end of the day to add words that were meaningful to them from the session. We are all treaty people. *Respect. Pride. Understanding. Empowerment. Humility. Equity. Be the change [you want to see in the world].*

1. Introduction

- ▶ While there are many organizations involved in exploring the gaps in health status between Aboriginal Peoples and the larger Canadian population, the Health Council of Canada is in a unique position with a mandate from federal, provincial, and territorial governments to report not only on the health status of First Nations, Inuit, and Métis people, but also on practices that are improving their access to care and health outcomes.

To fulfill this mandate, the Health Council embarked on a multi-year project to understand the issues affecting the health status of Aboriginal populations in Canada and to share what is learned with Canadians. The goals of this project are:

1. To improve Canadians' understanding of the issues that underlie disparities in health status and in access to health care between First Nations, Inuit, and Métis people and the larger Canadian population; and
2. To identify practices that are improving health status (in the broad sense of health, wellness, and community healing) and access to health care for First Nations, Inuit, and Métis people.

In 2011, the Health Council released a report titled *Understanding and Improving Aboriginal Maternal and Child Health in Canada* as the first project in the multi-year plan. To further explore the underlying reasons for disparities in access to health care and disparities in health outcomes, the Health Council's second project focuses on the importance of cultural competency and cultural safety for First Nations, Inuit, and Métis people who use or are a part of urban health systems.

For insight into the issues and to identify practices, the Health Council of Canada completed a series of regional discussions across Canada. Between April 26 and June 7, 2012, the Health Council visited seven cities (Saskatoon, SK; Winnipeg, MB; Edmonton, AB; Vancouver, BC; Toronto, ON; Montreal, QC; and St. John's, NL), bringing together Aboriginal and non-Aboriginal people representing organizations involved in the delivery of health care services to First Nations, Inuit, and Métis people in urban settings. Each one-day discussion explored the importance of cultural competency and cultural safety, along with practices that enhance cultural competency and cultural safety. More than 160 people participated in the discussions.

The regional discussions explored four overarching questions:

- ▶ Why are cultural competency and cultural safety important?
- ▶ What are some examples of practices that enhance cultural competency in urban health systems and cultural safety for First Nations, Inuit, and Métis people using those systems?
- ▶ How do cultural competency and cultural safety change health service delivery?
- ▶ Do cultural competency and cultural safety improve access to, quality of, or the overall experience of care, or improve health outcomes for First Nations, Inuit, and Métis people?

In the discussions, participants were asked to draw on their experiences as practitioners and professionals working in the health sector, and their personal experiences as people who have sought or used health services. The majority of the day was spent in small groups, with each group supported by a facilitator and a note taker. Referring, as needed, to a series of guiding questions designed to draw out relevant information, insights, and experiences, the facilitators worked with participants to develop a body of knowledge to help answer the overarching questions.

The facilitation process was designed and led by AMR Planning & Consulting Inc., an Aboriginal-owned consulting company based in Winnipeg. The process and structure of the regional discussions incorporated local cultural protocols. In each city, an Elder or Cultural Advisor/Helper opened and closed the day with a prayer. Before the closing prayer, participants gathered for a sharing circle where they were able to reflect on the day's activities. Participants' generous contributions of their insights, experience, and time were acknowledged with a gift. Proceedings were recorded in conventional ways by the note takers, but the Health Council also engaged Leah Fontaine, a First Nations artist, to graphically record proceedings at each regional discussion.

This summary report presents key findings from the regional discussions.

2. The value of cultural competency and cultural safety

- Each of the regional discussions began with the question, “Why are cultural competency and cultural safety important?” As many participants observed, First Nations, Inuit, and Métis people, as a group, do not access health services at the same rates that other Canadians do. To a large extent, this occurs because they have had experiences of being “treated with contempt, [of being] judged, ignored, stereotyped, racialized, and minimized” in the health care system and in broader Canadian society. This contributes to significant disparities between the health status of Aboriginal and non-Aboriginal Canadians. When people do not go for care, or do not return after a bad experience, they are less likely to have a good health outcome. Culturally competent health care services can improve both health care experiences and health outcomes for First Nations, Inuit, and Métis people.

Participants drew on both their personal and professional experiences in urban health care systems when responding to this question. They shared personal stories of encounters with service providers whose approaches and actions suggested significant gaps in knowledge, understanding, and experience of First Nations, Inuit, and Métis people, or whose approaches and actions reflected or seemed driven by racism. They also identified ways in which understandings of what constitutes health and wellness and how health and wellness should be cared for that prevail in urban health systems, as well as structural aspects of these systems (that is, the ways in which people and resources are organized, positioned, or managed within these systems) often impede access to and the quality of health care. Ultimately, these understandings affect health outcomes for First Nations, Inuit, and Métis people.

Participants were also asked to describe what cultural competency and cultural safety look and feel like. Their responses reveal the inseparability of cultural competency and cultural safety. When health services are provided in culturally competent ways, First Nations, Inuit, and Métis people using those services feel culturally safe:

- ▶ The physical and emotional environments feel familiar, welcoming, warm, and comfortable.
- ▶ First Nations, Inuit, and Métis people feel respected as equals and heard when accessing services—they can trust service providers, the providers are interested in them as people, and they are partners in their care. Aboriginal clients are more likely to feel respected when providers recognize or acknowledge them as Aboriginal people, recognize the impacts of history on the health and wellness of Aboriginal people, and actively work to gain their trust and help them feel safe in the system. This includes a willingness to change routine practice to accommodate culturally distinct needs or ways of being (for example, offering house calls rather than assuming that all clients can easily travel

to a service location), and a focus on shared objectives rather than areas of conflict. Practitioners or interpreters are available who are fluent in the languages spoken by the First Nations, Inuit, and Métis people they serve.

- ▶ There is balanced, mutually comfortable interaction between First Nations, Inuit, and Métis clients and service providers. Clients feel safe and comfortable, and providers feel that they understand the impacts of community or culture on their clients' health and wellness.
- ▶ Culturally safe health care services offer clients on-site access to both traditional holistic approaches and Western approaches to care. This might include a dedicated space for ceremony and access to Elders or healers.
- ▶ First Nations, Inuit, and Métis people may more easily feel that they belong and are respected, and that their values and practices are recognized and reflected in practice, when they access services at or through organizations that are operated by or under the control of First Nations, Inuit, and Métis people. It is usually easier for people to feel safe when they see themselves reflected in the organization that is providing services. The presence of Aboriginal providers, practitioners, and professionals supports cultural safety, as do mechanisms or processes for ongoing input from community members.
- ▶ For non-Aboriginal people working with Aboriginal people, "it should not always be about what [they] can do for First Nations, Inuit, or Métis people." In a culturally safe environment, non-Aboriginal people recognize and acknowledge that they too will learn and gain competency from their relationships with Aboriginal people: "We can't master it all and be proficient in all cultures, so we must listen and be open."
- ▶ Health professionals advocate for equitable and culturally safe care for the First Nations, Inuit, and Métis people they serve.

Participants' descriptions of a culturally safe health care environment can be summarized in terms that one group described as "the four Rs":

- ▶ **relationship**, in which both providers and patients recognize the limitations of biases they might have and think about their roles;
- ▶ **respect**, which includes the recognition of diversity among Aboriginal peoples;
- ▶ **reciprocity**, which involves living and learning from each other; and
- ▶ **reflection**, which involves ongoing reflection on our roles, both as patients and providers.

Why are cultural competency and cultural safety important?

DISPARITIES IN HEALTH DETERMINANTS, ACCESS TO HEALTH CARE SERVICES, AND HEALTH OUTCOMES

Significant disparities exist between access to health care services for First Nations, Inuit, and Métis people and other Canadians, and between socioeconomic health determinants (that is, factors such as income level and quality of housing) and health outcomes for these groups. A participant described the relationship between these disparities and the need to enhance cultural competency of health care services and systems for First Nations, Inuit, and Métis peoples using those systems:

We're aware of disparities and inequities related to health outcomes for our community. It's an important leadership responsibility for all of us who serve Aboriginal community members in any programming to work to address inequities, eliminate barriers to service provision, and improve health outcomes for Aboriginal community members. We need to work from a population health perspective [and] address determinants of health and how they impact Aboriginal people. ... If the system responds poorly to Aboriginal people, they do not come for health care or do not respond well to health care. As a result, communities have limited access. This, in turn, creates a negative response from the health care system, [a perception that] 'this is how they [Aboriginal people] are.' It reinforces and perpetuates misguided impressions on both sides. Unless one cog in the wheel changes, there will be no change. We need system change. We need to build an equitable system. Equity is missing. Cultural competency and safety can help toward this end.



WINNIPEG

Hope

Many words were written on this illustration, including *no more lip service*, *no more excuses*, and *stop racism*, which was a big topic of discussion at the session. At the top, overseeing everything, is *hope*.

The joined heads at the top of this illustration represent male and female, as well as the past, present, and future. Their arms reach around the picture to join together creating a circle, which author Donald Fixico describes as “**Indian Thinking**,” “seeing things” from a perspective emphasizing that circles and cycles are central to the world and that all are connected to the universe.

The colour purple was chosen for the background because it represents Aboriginal cultural restoration; that is, Aboriginal nations are re-learning their inherent rights of culture. There was a lot of talk at this session about restoring the system in assisting towards bridging the cultural gap that is prevalent in Canada.

The scales in the centre of the picture symbolize balance between Western and Aboriginal approaches. The tree on the right of the picture represents the importance of listening to youth, which was another topic discussed in Winnipeg. The youth are coming out from behind the tree, saying “Listen to us.”

3. Practices in cultural competency and safety

- In the regional discussions, the Health Council of Canada learned about many programs, initiatives, organizations, strategies, and policies designed to enhance cultural competency within urban health systems and support cultural safety for First Nations, Inuit, and Métis people who use or are part of those systems. While the range and scope of these activities vary widely, they all involve change in at least one of the following areas of action: 1) system-wide transformation; 2) collaboration that builds capacity; 3) knowledge that transforms practice; 4) culturally based services that respond to community-identified needs; and 5) research that enhances capacity and evidence-based decision-making.

This section presents selected examples of practices within each area of action. Although there are many efforts across Canada to increase cultural competency in health care—and in other fields as well—in this report we discuss only those provincial, territorial, and regional efforts that were mentioned by participants. The programs, initiatives, and strategies put forward by participants reflect their own knowledge and experience, and are not intended to serve as a comprehensive list of activities across Canada.

The descriptions in this section draw on information shared by participants in the regional discussions, supplemented by information available online about the programs and initiatives.

Appendix A provides a full list of practices discussed in the sessions.

System-wide transformation

Transforming a health care system to enhance the cultural competency of practitioners and organizations and support the cultural safety of First Nations, Inuit, and Métis people who use or are part of that system requires leadership and a demonstrated commitment to change.

In British Columbia and Saskatchewan, formal agreements between Aboriginal governments or leadership, provincial governments, and/or the Government of Canada furthered cultural competency initiatives. In other provinces, such as Ontario, governments have demonstrated leadership and commitment by establishing specific strategic directions relating to Aboriginal health. In Alberta, which in 2008 established a province-wide, fully integrated health system (Alberta Health Services, AHS), leadership and commitment are provided through AHS's Aboriginal Health Program. At a more local level, the Winnipeg Regional Health Authority in Manitoba has implemented a systemic strategy to support change at organizational, structural, and clinical levels, with the goal of establishing a culturally proficient health care system.

Tripartite First Nations Health Plan, British Columbia

In British Columbia, the First Nations Leadership Council (representing the BC Assembly of First Nations, the First Nations Summit, and the Union of BC Indian Chiefs), the Government of Canada, and the Province of British Columbia formalized their commitment to close the health status gap between First Nations people and other British Columbians in a series of agreements: the 2006 *Transformative Change Accord: First Nations Health Plan*; the 2006 *Tripartite First Nations Health Plan Memorandum of Understanding* (MOU), and the 2007 *Tripartite First Nations Health Plan*.

The 2006 *Transformative Change Accord: First Nations Health Plan* (TCA:FNHP), negotiated by the First Nations Leadership Council and the Province of British Columbia, identified 29 actions in four key areas that would help close the health status gaps, addressing priorities jointly developed by the Leadership Council and the Province.

The First Nations Leadership Council, the Government of Canada, and the Province of British Columbia are signatories to the 2006 MOU. The MOU's purpose was to formally acknowledge the need to improve health programs and services, to establish and define a collaborative and coordinated partnership between the three parties, and to establish a framework for development of a tripartite 10-year First Nations health plan. The MOU reaffirmed the four areas for collaboration agreed upon in the TCA:FNHP:

- 1) governance, relationships, and accountability (to increase First Nations participation in decision-making, and to establish mechanisms to support collaborative action);
- 2) health promotion / disease and injury prevention (to reduce levels of preventable diseases and injuries);
- 3) health services (to provide equitable access to culturally sensitive services that meet community-identified needs); and
- 4) performance tracking (using specific performance indicators to track progress on closing gaps in health outcomes).

The 2007 *Tripartite First Nations Health Plan* built upon the 2006 agreements. In the 2007 Plan, the First Nations Leadership Council, the Government of Canada, and the Province of British Columbia

committed to a 10-year plan that: 1) creates fundamental change, 2) defines founding principles to guide change, and 3) establishes goals for the plan. The 2007 agreement also described the collective vision of the parties: to improve the health and well-being of First Nations; to close gaps in health; and to support the full participation of First Nations in decision-making related to the health of their people. The plan's guiding principles refer to respect and recognition; a commitment to action and nurturing relationships; reciprocal accountability; and transparency. The parties also committed to develop a new structure for governance of First Nations health services in British Columbia, affirmed the four priority areas for action laid out in the 2006 agreements, and included statements committing appropriate levels of funding from the federal and provincial governments to support and sustain implementation of the plan.

These three agreements have provided a strategic framework that is transforming the delivery of health services for First Nations people in British Columbia. For example, the agreements have enabled and supported the development of the nationally recognized Indigenous Cultural Competency Online Training Program of the Provincial Health Services Authority, discussed later in this document. The 2006 *Transformative Change Accord: First Nations Health Plan* included the statement "First Nations and the Province will develop a curriculum for cultural competency in 2007/2008, and require health authorities to begin this training in 2008/09. Training will be mandatory for Ministry of Health and health authority staff, including executive and senior management."

Memorandum of Understanding on First Nations Health and Well-Being in Saskatchewan

In 2008, the Federation of Saskatchewan Indian Nations (FSIN), Government of Canada, and Saskatchewan Ministry of Health signed a *Memorandum of Understanding (MOU) on First Nations Health and Well-Being in Saskatchewan* (Government of Saskatchewan, 2010). The MOU established a formal partnership between the parties, focused

on their shared goal of closing gaps and eliminating disparities between the health status of First Nations people and other Saskatchewan residents. The purpose of the MOU also included: 1) adapting and integrating programs in all jurisdictions; 2) improving First Nations people's participation in the health care workforce; 3) establishing a collaborative and coordinated tripartite partnership; and 4) establishing a planning process for a 10-year First Nations health and wellness plan. The MOU authorized the formation of a tripartite steering committee to provide leadership and oversee implementation of activities, and established that the MOU would be reviewed by the parties every two years.

Since the signature of the MOU, the three parties have worked together to build relationships of trust and have identified eight priority areas for collaboration: chronic disease prevention and management; long-term care; mental health and addictions; health human resources; health care experience; intake-discharge; e-health; and relationships and partnerships. The MOU partners identified the priority areas through a process that engaged First Nations communities, health care providers, and other stakeholders.

Developing and implementing a cultural framework is an important foundational initiative under the MOU. A Project Advisory Team, established to inform the development of the framework, has representation from First Nations (including Elders, cultural advisors, and health directors), regional health authorities, and the College of Medicine/Nursing. The Federation of Saskatchewan Indian Nations, Health Canada—First Nations Inuit Health Branch, and the provincial Ministry of Health sit as ex-officio members of this team.

Ontario Aboriginal Healing and Wellness Strategy

Ontario was the first province in Canada to develop a strategic framework to promote healthy Aboriginal communities. The province's Aboriginal Healing and Wellness Strategy, launched in 1994, is a joint program between five Ontario government ministries (Health and Long-Term Care, Aboriginal Affairs, Community and Social Services, Children and Youth Services, and the Ontario Women's Directorate) and

First Nations and Aboriginal organizations (Queen's Printer for Ontario, 2012). The strategy signals the partners' commitment to work together on culturally appropriate programming and ongoing collaboration to improve health outcomes for Aboriginal people and communities. The ministries renewed their commitment to the Strategy in 2010, emphasizing the importance of First Nations, Métis, and Inuit design, delivery, and management of programs that serve their community members.

The Strategy focuses on improving access to health care, enhancing services to address family violence, and building the capacity of First Nations, Métis, and Inuit communities. The Strategy establishes a system-wide approach and supports a combination of traditional and mainstream community-based programs. Importantly, the Strategy supports activities both on- and off-reserve, enabling the province to take action to bridge jurisdictional gaps. The Strategy has continued to support the work of two Aboriginal Community Health Centres (including Misiway Milopemahtesewin Community Health Centre in Timmins), 10 Aboriginal Health Access Centres (including De dwa da dehs nye>s Aboriginal Health Centre in Hamilton and Brantford), and six Aboriginal health authorities (including Noojimawin Health Authority in Toronto).

What do cultural competency and cultural safety look and feel like?

STRUCTURING HEALTH SYSTEMS TO SUPPORT CULTURAL COMPETENCY AND CULTURAL SAFETY

Participants at one regional discussion suggested that cultural competency and cultural safety for First Nations, Inuit, and Métis people are most likely to occur in health care systems where: 1) First Nations, Inuit, and Métis people are part of decision-making in areas that affect them; 2) First Nations, Inuit, and Métis people have access to the tools they need to care for their health and wellness; this includes learning about their own cultures, understandings, and practices relating to health and wellness, which strengthens competency and safety as well as identity, and empowers people to take more control of their care; and 3) health care systems are aware of the resources and needs of Aboriginal people and incorporate into practice culturally distinct understandings and practices relating to health and wellness.

Aboriginal Health Program, Alberta Health Services

Alberta Health Services (AHS), through its Aboriginal Health Programs, is in the process of reinvigorating its approach to Aboriginal health throughout the province. Alberta Health Services itself is a relatively new organization, formed in 2009 when nine regional health authorities (RHAs) and other provincially mandated boards and commissions were amalgamated into a single entity. Prior to amalgamation, Aboriginal programs and services were widely varied across the RHAs. The two largest RHAs in the province (serving Calgary and Edmonton) had built up significant infrastructure to support Aboriginal health. Alberta Health Services is now consolidating these activities into the province-wide Aboriginal Health Program.

The Aboriginal Health Program focuses on engagement and relationship building to address five priorities: 1) enhancing cultural competencies; 2) improving access to health services; 3) customizing approaches to specific health challenges; 4) addressing addiction and mental health; and 5) monitoring the health of Aboriginal Albertans. The Program provides direct supports to Aboriginal patients and families. Aboriginal Care Coordinators, Aboriginal Cultural Helpers, and Aboriginal Hospital Liaisons help patients and families to connect with services and programs, and offer cultural and spiritual support. The Program also delivers several services customized for the Aboriginal population, including the Aboriginal Diabetes Wellness Program located in Edmonton.

The Aboriginal Health Program has been able to build upon successes that were underway prior to the formation of Alberta Health Services, including the Elbow River Healing Lodge at the Sheldon M. Chumir Health Centre in Calgary's inner city. Elbow River, which was established in 2006, incorporates care for physical, mental, emotional, and spiritual wellness in its approach to Aboriginal health. Programs and services available at Elbow River include triage and assessment; education and lifestyle counselling; health examinations; coaching for self-care; Elder consultation; prenatal care; immunization; and foot and wound care. It is also one of the sites for a province-wide Aboriginal mental health program. In addition, Elbow River provides space (currently under renovation) for ceremonies and other cultural activities. Elbow River's programs and services, which are available only to Aboriginal people, are currently being used by approximately 2,000 clients. The Lodge features a primary health care clinic with a multidisciplinary team whose staff members include an Aboriginal Liaison Advocate, an Aboriginal mental health worker, a physician, a nurse, and a Traditional Wellness Counsellor. All staff members (a group that includes both Aboriginal and non-Aboriginal practitioners) participate in training and orientation activities designed to enhance their cultural capacity.

Other programs in development at Elbow River include a chronic disease program (which will bring an additional RN and a registered dietitian to the site);

a prenatal/women's health program; foot care and wound care; street outreach (in which an Aboriginal Liaison will connect with community members and social resources and assist with navigation of service systems); and holistic traditional healing services. The traditional healing services are being developed with extensive consultation with Elders. Elbow River also provides customized services, including support for an Aboriginal Diabetes and Wellness Program in Edmonton.

Alberta Health Services is developing a Health Equity Framework, with the goal of establishing a coordinated approach that will help ensure consistency, equity, and equal access to programs and services for all Albertans. A new position has been established in the Aboriginal Health Program for an Aboriginal Health Specialist in Cultural Competency. The Specialist facilitates cultural competency training for health practitioners, and is also responsible for helping to develop a competency framework and an action plan for health service organizations throughout the province. In the early stages of this project, the Specialist will visit communities to learn about their visions of health care, a process that will help build accountability into the framework implementation process. AHS is also in the process of establishing a Wisdom Council, which will assume an advisory role.

Cultural Proficiency & Diversity: Framework for Action, Winnipeg Regional Health Authority, Manitoba

The Winnipeg Regional Health Authority (WRHA) has a long-standing strategic commitment to improve its ability to respond to the needs of the Aboriginal community. Reflecting this, recent activities include the development and implementation of Cultural Proficiency & Diversity: Framework for Action, a collaborative project of the organization's Aboriginal Health Programs, Human Resources, Research and Applied Learning, and Primary Health Care and Chronic Disease departments. The framework, which was completed in 2011 and has been approved by the WRHA board, was developed with the understanding that cultural proficiency can enable a health care system to deliver the highest quality of care to every

person, regardless of their race, ethnicity, culture, or language proficiency. Research studies have confirmed the links between racial and cultural identity, socio-cultural factors, and disparities in access to health care services, quality of care, and health outcomes. The populations of both Winnipeg and Manitoba are increasingly diverse, and WRHA recognizes that an appropriate response to this change is to work to increase cultural proficiency within its organization. The framework enables the integration of existing and future initiatives that respond to the increasing diversity of the communities it serves.

The framework provides a system strategy that focuses on organizational, structural, and clinical interventions, engages community partners, and enhances health care experiences and outcomes for First Nations, Inuit, and Métis people, as well as immigrant and refugee communities, the French Canadian community, and other community members who otherwise might face language barriers when seeking services. The framework incorporates a process to analyze the current state of cultural competency and proficiency in specific areas, giving consideration to the core components of cultural proficiency: values and attitudes; structures and policies; practices; training and staff development; and evaluation and research.

Organizational interventions undertaken through the framework are designed to promote leadership and a workforce that represent the ethnically and culturally diverse population WRHA serves, and include diversity and minority recruitment initiatives. Structural interventions are designed to make processes within the health care system more client-friendly and culturally appropriate, with the goal of ensuring that patients and clients have full access to quality health care. Interventions in this area include activities that support communication competency, design and functioning of the health care system, socio-cultural assessment of the population WRHA serves, community development and participation, and collaborative partnerships. Clinical interventions are designed to equip health care providers with an understanding of the impacts of socio-cultural factors on health, and to provide them with tools and skills to manage socio-cultural factors in clinical encounters. Interventions in this area include cross-cultural training

programs and activities that support the development of cross-cutting cultural and social knowledge, communications skills, and know-how concerning cultural health assessments.

Innovative practices associated with the framework include:

- ▶ Collaborative partnerships with First Nations, Inuit, and Métis organizations in Manitoba and Winnipeg – These relationships provide WRHA with insight, knowledge, experiences, and anecdotal information that demonstrate and clarify the importance and value of culturally proficient care.
- ▶ Inclusion of interests and experiences of diverse populations – Examples include the development of BridgeCare Clinic (which supports health access for refugees) and the participation of community members in advisory councils that report directly to the WRHA Board and that provide valuable input into community stakeholder reports.
- ▶ Services specifically designed to support the distinct cultural and linguistic needs of patients – These services include interpreters' support in 29 languages; Aboriginal language interpreters; Aboriginal advocacy supports; and discharge coordination supports for complex situations involving Aboriginal patients.

As noted above, WRHA's Aboriginal Health Programs (AHP) is a partner in the framework. AHP, which began in 2001 and was established as a Regional Program in 2010, has had strong support from senior management, including WRHA's former CEO (in place when AHP began) and the current Vice President of Population and Aboriginal Health (a position established relatively recently). AHP oversees coordinated programming in three areas: Health Services, Workforce Development, and Health Education (Winnipeg Regional Health Authority, n.d.). Working in partnership with tribal organizations, government departments and programs, post-secondary education and training institutions, and human resource development initiatives, AHP provides a broad range of supports to patients and practitioners within WRHA, to the organization as a whole, and to the broader community.

AHP offers direct supports to First Nations, Métis, and Inuit patients. These include interpretation/translation, patient advocacy, discharge planning, and spiritual/cultural care at hospitals throughout the region. Aboriginal patients, their families, and staff can access a Traditional Wellness Clinic (in a centrally located hospital), which is run by an Elder who is trained both as a traditional healer and a nurse. Patients and staff can also connect with on-staff Spiritual/Cultural Care Providers for ceremonies or to access traditional medicines. In addition, AHP assists as a member of the health care team in complex discharges. WRHA provides interpretation services in the three most widely used Indigenous languages in the region, an activity that has been recognized by Accreditation Canada as a leading practice.

WRHA has a Preferred Aboriginal Hiring philosophy, and both existing employees and new applicants can voluntarily self-declare their Aboriginal identity. The organization has adopted a respectful workplace policy, and AHP's workforce development and health education activities include ongoing delivery of two-day Aboriginal cultural awareness workshops for WRHA and partner organizations, as well as CME-accredited courses in Aboriginal health policy and palliative care from an Aboriginal perspective. CME-accreditation increases buy-in from practitioners.

AHP also provides training that enhances managers' ability to work well with Aboriginal staff, an activity that serves as capacity development for managers and supports the cultural safety of Aboriginal employees. AHP actively recruits Aboriginal employees with outreach activities that begin in the public school system, include community-based organizations, and extend to post-secondary institutions. Retention activities include working with Aboriginal employees to develop communication and conflict resolution tools and skills that can help them address micro-aggression in the workplace, and wellness sharing circles for staff members that are facilitated by a cultural worker associated with the program.

Other departments and entities within WRHA consult frequently with AHP. AHP staff members are involved in external partnerships and collaborate with a wide

variety of community organizations, sharing knowledge about traditional understandings and practices of health and wellness, and working to build and strengthen partnerships with community organizations.

Collaboration and partnership to build capacity

Collaboration and partnerships between First Nations, Inuit, and Métis leadership and organizations, along with other health care entities, can increase all partners' capacity to enhance the cultural competency and cultural safety of health care service delivery and systems. Collaboration and partnership are key features of practices in system-wide transformation, as shown by the examples mentioned in the previous section.

The practices described in this section have developed new and unusual models for collaboration and partnership. The All Nations Healing Hospital, located on-reserve in the town of Fort Qu'Appelle in Saskatchewan and serving both Aboriginal and non-Aboriginal clients, has worked around the jurisdictional constraints that typically separate service delivery to on- and off-reserve populations by collaborating with various levels of government and funders. Clinique Minowé, which provides services to pregnant women and children under five years of age on-site at the Native Friendship Centre in Val-d'Or, Quebec, was formed through a unique and innovative partnership between the Friendship Centre, le Centre de santé et de service sociaux de Vallée-de-l'Or (CSSS), and the Centre jeunesse de l'Abitibi-Témiscamingue. The Eagle Moon Health Office, serving the Regina Qu'Appelle Health Region in Saskatchewan (where Aboriginal health has been identified as a strategic priority), incorporates both internal and external partnerships into its activities. The Saint Elizabeth First Nations, Inuit, and Métis Program works exclusively in partnership with Aboriginal organizations, ensuring that their Aboriginal partners take leadership and are meaningfully engaged throughout each project.

All Nations Healing Hospital, Fort Qu'Appelle, Saskatchewan

All Nations Healing Hospital (ANHH) is an accredited hospital located on-reserve in the community of Fort Qu'Appelle, Saskatchewan (File Hills Qu'Appelle Tribal Council, n.d.). ANHH includes 13 acute care beds, a palliative care bed, and a large outpatient and diagnostic area, and provides a full range of services to Fort Qu'Appelle and surrounding communities. The hospital is open to everyone, whether they live on- or off-reserve, whether they are First Nations (with or without status or band membership), Métis, or non-Aboriginal. The hospital has become a model for other health care organizations, recognized for its integration of services across different levels of government and funders. ANHH is owned and operated by the File Hills Qu'Appelle Tribal council and Touchwood Agency Tribal Council, and is affiliated with and receives funding through an operating agreement with the Regina Qu'Appelle Health Region. The hospital has agreements with First Nations, the federal government, and the provincial government to provide health services, establishing a new way to manage costs for services and straddle jurisdictions.

All Nations replaced the aging Fort Qu'Appelle Indian Hospital, and much of the work to establish the new hospital was done by a board led by the File Hills Tribal Council. During the development phase, the board had to work to overcome resistance and lack of trust from some non-First Nations people. The perseverance and dedicated leadership of the board members was crucial to the success of the project.

All Nations is a community-driven health care organization that provides responsive, patient-driven care and supports self-determination for patients. First Nations community members have been engaged from the start in the development of the hospital. Their input and direction, along with input and direction from medical professionals and other stakeholders, were sought in the earliest stages of planning. The hospital provides programs, services, and supports that meet the needs and reflect the cultures and traditions of the

communities it serves. Traditional components are included in virtually all programs and activities. Core programs and activities at All Nations include a Women's Health Centre, which was developed in response to a community-identified need for a program to support women's sexual health. The Centre began with a single nurse practitioner and an administrative assistant; it now has two full-time and additional part-time nurse practitioners on staff. This has enabled them to offer midwifery services to the First Nations communities (as well as others). In addition, there are plans to open a low-risk birthing centre (2013).

All Nations has also brought in two psychologists to help support women, along with a Women's Helper, a key staff member. Reflecting a traditional role for helpers in local First Nations communities, the Women's Helper acts as an ally and advocate, connecting women with services, providing ongoing support, and bringing a solutions- and strength-based approach to their interactions with clients. The hospital is the site of the White Raven Healing Centre, which offers mental health services and a spiritual cultural program. Staff at the Centre include an on-site Elder and First Nations counsellors.

Clinique Minowé, Val-d'Or Native Friendship Centre, Quebec

Clinique Minowé opened recently in the Val-d'Or Native Friendship Centre. The clinic was established through a unique and innovative partnership between the Centre de santé et de service sociaux de la Vallée-de-l'Or (CSSS), Centre jeunesse de l'Abitibi-Témiscamingue, and the Val-d'Or Native Friendship Centre. It provides complementary health and social services to urban Aboriginal women who are pregnant and to children younger than five years of age.

Clinique Minowé offers new approaches to integrating and adapting health and social services for urban Aboriginal people in Val-d'Or. Since January 2011, the clinic has provided community members with access to the services of a nurse and a social worker in a culturally relevant environment. The clinic works to:

- ▶ improve access to psychosocial services;
- ▶ identify solutions to social problems and issues (addictions, juvenile delinquency, school dropout rate, homelessness, self-esteem, unemployment, poverty, etc.);
- ▶ offer prevention activities (healthy lifestyle habits, child development, parenting skills, academic success, youths experiencing difficulties, etc.);
- ▶ accompany and support children and families in vulnerable situations; and
- ▶ reduce the number of cases reported to Youth Protection.

The clinic's approach includes a focus on innovative ways of collaborating, thinking, and meeting service goals (including, where appropriate, sharing data) within the health and social services system. As an example, in the past, when staff at the Centre jeunesse felt that a child might be troubled or at risk, they typically contacted child prevention services, which in turn contacted the child's family. This process did not necessarily encourage families to access services. Clinique Minowé enables a very different response. If a child has a problem, the Centre jeunesse connects with staff at the Friendship Centre. A Friendship Centre support worker and/or a nurse from the clinic, in turn, connect with the family, often through a home visit. The staff and family review services and supports available through Clinique Minowé, the Friendship Centre, and CSSS, and identify which services might be most appropriate and helpful to the child and family. By meeting the family and reviewing options with them (rather than arranging a formal intervention), the staff members signal to the child and family that their well-being matters to them personally, ensure they understand the services and supports available to them, and empower the family to take some control in the process of positive change. The families

and children reached through this process are less likely to become involved with child protection services or to visit the hospital's emergency department.

The clinic will soon begin offering developmental assessments of children at age three. Currently, the majority of these assessments are completed at a local community services centre (CLSCs). Aboriginal families, however, have relatively high rates of relocation and many do not bring their children to the CLSCs for assessment. Having nurses at the clinic trained to do the assessments is expected to enhance access for Aboriginal families in Val-d'Or. Offering this service at the Friendship Centre will also facilitate families' access to another on-site activity, the early childhood stimulation program.

Clinique Minowé is gathering practical lessons about what culturally competent and culturally safe care looks like. For example, when the Clinique began to offer contraceptive supports, a nurse associated with the project recommended that they offer Depo-Provera, a contraceptive that stops women's menstruations. Others on the project team knew that, in many Aboriginal cultures, menstruation is seen as important and is understood to be a type of cleansing, and that it would be important to attend to this culturally distinct understanding.

Clinique Minowé was developed in response to a community-identified need. Findings from a recent study indicated that 60 per cent of respondents would like to have access to psychosocial and health care services that are culturally relevant and that fit their real-life experiences. Anecdotal data suggest that since the clinic has opened, the number of Aboriginal people who have visited the emergency department at the local hospital has declined. The clinic has also had positive outcomes for families and children. In the first 18 months of operation, seven families were able to connect with Clinique Minowé and avoid child protection services.

Clinique Minowé was "do-able" within the current health care environment; it did not require any modifications to existing legal or policy context. The model it uses can provide a foundation on which to develop other activities. The model is particularly valuable because

it has been built from the bottom up, rather than the top down. The Clinique Minowé project has moved forward, in part, because it began in the community and was initiated by people from the community who were ready to create change and believed that they could make it happen.

The project is rooted in a commitment to collective effort. In the conventional Western health care system, patients often feel isolated and alone, and the focus of care is treating the disease or condition rather than supporting individual patients. At Clinique Minowé, aspects of Western medical practice remain—for example, the medical procedures involved in vaccinations or diabetes screening have not changed—but the ways in which medicine is practised, and the conditions in which it is being practised, have changed. This includes the collective effort behind the development of the Clinique; the relocation of services to the Friendship Centre site; the holistic, client-centred approach used at the Clinique; a focus on prevention; and the sense of belonging and collective responsibility demonstrated by staff.

The Clinique Minowé project team members recognize the importance of carefully monitoring the progress of the project and of measuring and recording (as quantitative and qualitative data) outcomes. The provincial association of Friendship Centres, the Regroupement des centres d'amitié autochtones du Québec (RCAAQ), plans to deploy the clinic's health and social services model in other Quebec cities.

Eagle Moon Health Office, Regina Qu'Appelle Health Region, Saskatchewan

The Regina Qu'Appelle Health Region (RQHR) Eagle Moon Health Office works to increase understanding between practitioners and providers in the health region and First Nations and Métis people and communities. It also aims to make space within the health system for Aboriginal traditional medicinal ways and practices, including culturally distinct ways of understanding and caring for health and wellness (Regina Qu'Appelle Health Region, n.d.).

Eagle Moon approaches health holistically, understanding that wellness encompasses the physical, emotional, mental, and spiritual aspects of who we are. Its attention is focused on areas of health that are of particular concern for First Nations and Métis people: mental health and addictions; women and children's health; home care; diabetes and foot care; and primary health care and chronic disease. Eagle Moon prioritizes activities that strengthen relationship building, communication, community development, education, and access to Western and Traditional Elders and medicine knowledge keepers, culture, and spirituality.

Eagle Moon has identified key approaches, practices, and principles that help health care systems better meet the needs of First Nations and Métis people. These include, for example, recognizing and acknowledging diversity within the Aboriginal community; valuing traditional and cultural understandings of and approaches to health and wellness as equal to Western understandings and approaches; offering access to a holistic continuum of health care services and supports (including traditional and cultural services and supports); building flexibility into service provision (so that services adapt to fit patients rather than patients changing to fit services); and working with patients to identify their needs and priorities and then putting those needs first. Each of these practices can enhance the accessibility of Traditional and Western health services and improve the quality of the care experience for Aboriginal patients.

Eagle Moon is a relatively small office, but it makes the most of its resources by engaging with community members and partnering with specific departments within RQHR and with community organizations. This practice has contributed to the success of RQHR's Aboriginal Home Care Project (profiled elsewhere in this report).

First Nations, Inuit, and Métis Program, Saint Elizabeth Health Care

The Saint Elizabeth First Nations, Inuit, and Métis (FNIM) Program works in partnership with First Nations, Inuit, and Métis communities and organizations to enrich the knowledge base and supports available to community-based health care providers (Saint Elizabeth Health Care, 2011). Activities undertaken through the FNIM Program include partnership, action-based research, online learning, knowledge exchange, and mobilization. Recognizing that First Nations, Inuit, and Métis communities best understand the issues that affect health care delivery at the local level, as well as how to address those issues effectively, Saint Elizabeth follows the lead of its FNIM partners and maintains meaningful engagement with them throughout projects. Saint Elizabeth identifies this equitable partnership model, which supports capacity-building of First Nations, Inuit, and Métis partners, as one of its most significant achievements.

Other significant achievements of the FNIM Program include:

- ▶ The participation of more than 1,200 health care providers from over 325 communities and organizations in various knowledge exchange activities, including online health-related courses, e-learning events, and a web-based portal for community sharing of best practices and information.
- ▶ The development and implementation of a patient wait times guarantee framework for the prevention, treatment, and care of diabetic foot ulcers. This project, which was a joint initiative between the Assembly of Manitoba Chiefs and Saint Elizabeth, was developed in response to the high rate of amputations for First Nations people living with diabetes in Manitoba.
- ▶ Working in partnership with rural, remote, and isolated First Nations communities across Canada to better understand and improve pathways that connect community members with cancer care.

Currently, the Saint Elizabeth FNIM Program is leading the Sharing Knowledge, Strengthening Connections Project. This national project is designed to reconnect First Nations, Inuit, and Métis Elders and youth using

social media (a Facebook fan page, a Twitter account, and YouTube videos) to foster and communicate discussions and teachings around sexual health in an appropriate and respectful manner.

The FNIM Program offers services at no cost to communities or participants. The program is funded through charitable donations and a mix of government and non-government grants and contributions, and Saint Elizabeth has made an ongoing commitment to sustainability.

Increasing cultural awareness and competency among health professionals

A frequently repeated theme in the regional discussions was the importance of training activities that fill in the considerable gaps in knowledge, understanding, and experience that most Canadians have in relation to First Nations, Inuit, and Métis people, cultures, and communities. Participants presented a number of education and training activities at the regional sessions. The training typically involves three components: developing knowledge and understanding about the historic and present-day experiences of First Nations, Inuit, and Métis people; engaging in activities that help participants understand the impacts that their own perceptions of Aboriginal people might have on their practice and, ultimately, on health outcomes for Aboriginal patients; and developing understanding and skills that will help them engage with Aboriginal people in ways that support their cultural safety.



Humility

In Edmonton, cultural humility was a big topic of conversation: one participant added the word at the top of the illustration. Others added *heart, humankind, sacred place, connectedness, tears, and foundation*. Another large theme at the meeting was the need to make sure that health care is holistic and incorporates all four aspects of life: the mental, physical, emotional, and spiritual. The Western medical doctor and Aboriginal medicine woman who are holding a medicine wheel together, which portrays a sense of interconnectedness, also represent this.

The snakes in the centre of the picture are symbols of healing. The stethoscope with beads, which is used by some doctors, represents the integration of Western and Aboriginal approaches to health. The mouse in the centre comes from a story told by the Elder at the session. He said we could learn from the mouse, a sacred animal which is always sensitive to its surroundings. People would benefit from also taking time to feel, sense, and understand what is going on around us. *Be the spirit of the mouse.*

In this section we provide information about a ground-breaking program in BC, the online Indigenous Cultural Competency Training Program, as well as the activities of one of the province's regional health authorities, Interior Health. Other programs are underway to reach health care professionals during their training. The Indigenous Physicians Association of Canada, in partnership with the Association of Faculties of Medicine of Canada, has developed a framework for cultural competency training that is being incorporated into the curriculum for students in medical schools. The Aboriginal Nursing Initiative at the University of New Brunswick has introduced activities that enhance cultural competency into its program. And Anishnawbe Health in Toronto has stepped up to develop and deliver cultural competency training modules in health-related post-secondary programs in Ontario. In other organizations, such as New Brunswick's Department of Health, individual employees have stepped into roles in which they share information and skills with their peers and associates. The IWK Health Centre in Halifax is working to strengthen diversity and inclusion within its facility, making a clear statement of its commitment to culturally competent care and identifying actions it will undertake to support that. A guide by the Society of Obstetricians and Gynecologists of Canada provides action-based recommendations to help health professionals with the steps they can take to become more culturally competent.

Indigenous Cultural Competency Training Program, Provincial Health Services Authority, British Columbia

The Aboriginal Health Program (AHP) of the Provincial Health Services Authority (PHSA) in British Columbia has developed and implemented an Indigenous Cultural Competency Training Program (Provincial Health Services Authority in British Columbia, n.d.). The training was developed in response to the Transformative Change Accord First Nations Health Plan's requirement that health authorities increase their cultural competency. The Plan also includes a commitment from First Nations and the province to collaborate in the development of cultural competency curriculum for the authorities.

The Indigenous Cultural Competency (ICC) Training Program provides facilitator-supported online training, including training that all employees within the province's health authorities and Ministry of Health are required to complete. For participants, ICC training can enhance: 1) knowledge and understanding about the socio-historical context of Aboriginal peoples' present-day experiences; 2) their ability to engage in self-reflection about how they understand, respond, and relate to Aboriginal people; and 3) skills that will improve practice.

PHSA ICC training is thoroughly researched and evidence-based. There is plenty of evidence that a training program such as ICC is needed (including, for example, constraints on Aboriginal people's access to health services or Aboriginal people's feelings or experiences of being unsafe when seeking health services). One of the first actions taken in developing the course was to ask Aboriginal community members what they would like non-Aboriginal practitioners to know about Aboriginal people. A pilot version of the course was tested for a year, and revised significantly during that time.

ICC now offers three online courses: the basic training course is an 8–10-hour module; a shorter version provides core training in a 5-hour module; and a new 9–11-hour module focuses on mental health. The ICC Core Health training is accredited, making it more attractive to practitioners.

The online ICC courses are designed as foundational training, part of a three-tiered framework for lifelong learning. In addition to the foundational ICC courses, the regional health authorities in the province provide training that reflects regional learning needs about local First Nations and Métis communities. The RHAs are able to set their own targets for staff participation in this training and may, for example, focus on strategic areas of practice. Tertiary organizations associated with the PHSA may provide an additional level of training that reflects more local needs. Lifelong learning for practitioners also includes developing meaningful relationships with the Indigenous peoples upon whose territories they live and work.

In the required foundational ICC training, participants complete 8–10 hours of training over an eight-week period, working in cohorts of approximately 25 people. The training begins with a welcoming video, incorporates a variety of teaching methods, and is non-judgmental and interactive.

In the two years that the program has been up and running, over 9,000 of the 100,000 health employees in the province of British Columbia have participated in ICC training. PHSA is now developing new modules in ICC training, including a training module specifically for Indigenous learners and a module that examines the dominant cultural narratives about Indigenous people. Also in development is training for Indigenous youth wellness, to be delivered by PHSA in partnership with Aboriginal communities, which will provide participating youth with in-community culture-based positive supports during learning sessions.

The ICC training has strong executive support. The online format of ICC training reduces costs and increases accessibility. To date, completion rates for training have ranged around 85 per cent. The training has undergone significant evaluation, with results indicating that participants have significant knowledge gain. Anecdotal evidence also suggests that people do things differently after completing the training. ICC facilitators have also witnessed “aha moments,” as participants examine how knowledge and awareness gained through ICC learning can enhance their practice.

Interior Health Authority Aboriginal Health & Wellness Strategy 2010–2014, British Columbia

The Interior Health Authority (IH) in British Columbia has made and demonstrated its commitment to transforming the ways in which health care services for Aboriginal people are delivered and governed. IH serves a large region in the southeastern corner of the province, a region that is home to nearly 750,000 people (7 per cent of whom are Aboriginal people) and encompasses 55 First Nations communities, 13 Métis Chartered communities, and 58 municipalities. As elsewhere in Canada, significant disparities exist between the health status of Aboriginal people and that of other residents, and IH has long focused on

addressing those disparities. It recently issued the Aboriginal Health & Wellness Strategy 2010–2014, which lays out strategies for a renewed approach:

1. Develop a sustainable Aboriginal Health Program.
2. Ensure Aboriginal people's access to integrated services.
3. Deliver culturally safe services across the care and service continuum.
4. Develop an information, monitoring, and evaluation approach for Aboriginal health.
5. Ensure ongoing meaningful Aboriginal participation in health care planning.

IH has undertaken a broad range of activities to move the strategy forward, including:

- ▶ **The establishment of core funding for the Aboriginal Health Program, one of five core programs delivered through IH's Community Integration Portfolio.** The Aboriginal Health Program works collaboratively with First Nations and Métis communities, and with other health programs, to close the health status gap.
- ▶ **Aboriginal Patient Navigators (APNs), whose primary responsibility is to assist Aboriginal patients to access services.** The APNs are an invaluable resource both for Aboriginal patients and their families, and for health care providers. APNs play a vital role in the provision of culturally sensitive health care. The APN position first appeared as part of an Aboriginal Health Transition Fund (AHTF)–supported pilot project, but since then, IH has established seven positions for APNs at various locations throughout the region. Core funding has been allocated to support their employment.
- ▶ **Indigenous Cultural Competency Training, provided online by the Provincial Health Services Authority.** IH has made participation in this training compulsory for all employees. Training has been taken up more quickly by IH employees than it has been by employees in any of the province's other regions.

Why are cultural competency and cultural safety important?

THE PERSISTENCE OF RACISM

First Nations, Inuit, and Métis people's present-day experiences of racism are inseparable from the experience of colonization. Canada's colonial history includes actions such as the forced relocation of Aboriginal Peoples from their traditional territories, the imposition of the Indian Act, the Residential School System, the Sixties Scoop, and today, the overrepresentation of Aboriginal children and families in the child welfare system. The impacts of these experiences are still felt today, lingering in the form of intergenerational trauma, and directly (as emotional and physical effects) and indirectly (as determinants of health). These impacts affect the health and wellness of First Nations, Inuit, and Métis people, families, communities, and Nations.

One legacy of these historical experiences is that many First Nations, Inuit, and Métis people mistrust non-Aboriginal people, institutions, systems, or governments. Aboriginal people's present-day encounters with discrimination and racism from individual health care practitioners also feed distrust. Over and over in the regional discussions, participants shared stories about these encounters, speaking sometimes as practitioners and sometimes as patients in the health care system. Each story was unique, but each referred to degrading stereotypes and racist characterizations that are well-known to most First Nations, Inuit, and Métis people—and to most Canadians. One story exemplifies many of these: An Aboriginal man who arrived bloodied and beaten at an emergency department was not allowed to lie on a bed by the nurse attending him. When a physician asked why the patient was in a chair, the nurse stated that he was dirty, and that, in any case, when he left the hospital, he would return to the street and engage in the same risky behaviours that had landed him in emergency.

The nurse was wrong. The patient was employed and owned his own home; he had been assaulted on his way home from work.

Encounters with discrimination and racism negatively affect the quality of care that First Nations, Inuit, and Métis people receive and the quality of their care experience. Participants observed that Aboriginal people who experience discrimination and racism easily lose confidence in the health care system. They often feel uncomfortable, fearful, or powerless when they attempt to access care, and some may avoid getting care, even when they are not feeling well. At a fundamental level, discrimination and racism can make it unsafe for First Nations, Inuit, and Métis people to access regular care, which, in turn, reduces opportunities for early intervention and prevention of health problems.

Racism, participants acknowledged, is often deeply engrained and can come from an unconscious place: "Whatever is said, you unpack it and it's racism. It's not always apparent and can't always be detected in the language a person uses, but it's apparent in the way they treat you as a provider or as patients. How to get people to see that their lens is not culturally proficient? This is a huge challenge... The health care system has so much stereotyping and racism that it's overwhelming." Participants also reported that, as Aboriginal people working in health care organizations, they too are often subject to discrimination and racism, ranging from explicit behaviours such as racial slurs to more covert racism and micro-aggression. In particular, there is a too-frequent insinuation that they have been awarded their positions because they are Aboriginal, rather than because they have the skills and qualifications their position requires.

- ▶ **Aboriginal health human resources (HHR) development.** IH is committed to a representative workforce and is using baseline data from employees to develop an evidence-based Aboriginal HHR strategy.
- ▶ **Aboriginal self-identification process for both Aboriginal patients and staff members.** IH began collecting Aboriginal self-identification information at selected hospitals, health care centres, and mental health sites in 2011, and now has implemented the self-identification process at nearly all these health sites in the region. The voluntary process enables patients and the APNs to connect more easily. Data gathered through this process supports planning activities. For patients, this includes both hospital planning activities and planning activities of First Nations communities who may be able to access anonymized patient data. Data gathered from staff will be used to develop and assess strategies that support the development of a representative workforce.
- ▶ **The Aboriginal Health and Wellness Advisory Committee (AHWAC), a sub-committee of IH's Board of Governors.** The AHWAC is a health planning advisory body with representation from First Nations communities, Friendship Centres, the Métis Nation BC, IH's Board of Directors, and the Aboriginal Health Program. AHWAC makes an ongoing contribution to IH's planning processes and provides a vehicle for IH to liaise with Aboriginal communities.
- ▶ **Letters of Understanding (LOU) with local First Nations.** The LOUs act as relationship documents, acknowledging the inherent rights of First Nations people and empowering each Nation's chief to speak directly with IH. Within the next year, IH expects to have signed LOUs with all seven First Nations in its region, and also expects to establish a partnership with the First Nations Regional Table that is being established in the region.

While IH has already made significant changes to its practices, it anticipates even more change in the near future. In 2013, a new provincial First Nations Health Authority (the first in the country) will assume control

of programs, services, and budgets currently delivered by First Nations Inuit Health – BC Region. This governance shift reflects the rapidly shifting landscape of Aboriginal health policy in BC where, in 2007, the First Nations Leadership Council, Province of British Columbia, and the Government of Canada agreed to the Tripartite First Nations Health Plan (discussed in more detail elsewhere in this document).

Core Competencies Framework, Indigenous Physicians Association and Association of Faculties of Medicine of Canada

The Indigenous Physicians Association of Canada (IPAC, which represents First Nations, Inuit, and Métis physicians and medical students), in partnership with the Association of Faculties of Medicine of Canada (AFMC), and through a consultation process with stakeholders, has developed the *First Nations, Inuit, and Métis Health Core Competencies: A Curriculum Framework for Undergraduate Medical Education* (The Association of Faculties of Medicine of Canada, n.d.). The competencies framework focuses on increasing cultural competency and safety between First Nations, Inuit, and Métis people who are in post-secondary medical programs or health systems and non-Aboriginal peers or practitioners. The Royal College of Physicians and Surgeons of Canada (RCPSC) has used the competencies framework to support its own development of post-graduate and CME curricula. IPAC, AFMC, and RCPSC established a working group with membership from each relevant university to determine how this curriculum (with accompanying objectives linked to core competencies to support culturally safe practice) might be implemented. The partners expect implementation within the next few years.

The College of Medicine at the University of Saskatchewan will be among the first to implement the IPAC curriculum. Saskatchewan has one of the highest populations of Aboriginal peoples in Canada, and the University would like to contribute to reducing health-related disparities between this population and other Canadians. An increasing number of Aboriginal students are participating in medical school, and many have reported not receiving adequate training.

The College's implementation of the IPAC curriculum, which will be introduced in 2013, will transform the medical program. The curriculum is designed to ensure that medical students get the right information about Aboriginal people from the right people, taught in the right ways. Students will learn about both positive and negative aspects of the historic and present-day experiences of Aboriginal people. The curriculum was developed with input from the community and students. It incorporates multiple learning opportunities, methods, and strategies that will appeal to a broad range of learners, and includes experience-based components in which students will live in Aboriginal communities and learn how to interact with the community.

The Faculty of Medicine at the University of Manitoba has also begun to adapt and incorporate modules drawn from the RCPSC curriculum to teach undergraduate students the core competencies they need to work well with Aboriginal people. Teaching activities have included small group work to help undergraduate students understand how their actions affect cultural safety for patients, and dramatic monologues to show how racism impacts care. The goal is to teach—in a non-threatening but powerful way that enables students to connect emotionally with the subject—about the history of Aboriginal peoples, including colonization and residential schools. The Faculty has also initiated an Indigenous Health Lecture Series.

The University of Manitoba's Faculty of Medicine is currently undergoing a complete curriculum renewal, including a redevelopment of the four-year program. The revised program will replace what had been 10 hours over the entire four years with curriculum that will embed teaching about cultural safety and Indigenous health in mandatory coursework throughout the program.

Key success factors for the University of Manitoba's initiative have included getting support from the national organization of medical school deans and the current dean at the University of Manitoba Faculty of Medicine; the recruitment of Indigenous faculty members at the medical school; structures and funding that were put in place to support this initiative; and the establishment

of the competencies framework as core curriculum (i.e., all students in the Faculty of Medicine are required to take it).

Aboriginal Nursing Initiative, University of New Brunswick and Mi'kmaq-Maliseet Institute

The University of New Brunswick, in partnership with the bridging program at the Mi'kmaq-Maliseet Institute, has established an Aboriginal Nursing Initiative designed to increase the number of Aboriginal students who enter and graduate from UNB's nursing program. The goals of the initiative are to recruit and retain Aboriginal students; to develop and implement curriculum that strengthens cultural competence and cultural safety for Aboriginal people and reflects social justice; to provide opportunities for nursing faculty to develop cultural competence; and to develop a course in Aboriginal Health, along with a cooperative learning option in Aboriginal health nursing. Because the initiative includes learning opportunities for both faculty and staff, it is expected to create sustainable change within the institution.

The initiative involves actively recruiting Aboriginal students into the nursing program. A culturally appropriate DVD and brochure were developed to support recruitment, and program representatives travel to communities to connect with potential students. The program reserves five designated seats for Aboriginal students, and students may also enter through a bridging program and a competitive application process. A database has been established to track students who apply and inquire. To support retention, the initiative has introduced two positions for Aboriginal support people, and students may also connect with Elders associated with the initiative. An orientation for incoming Aboriginal students is hosted one week prior to the start of classes, and students can access additional supports such as laptop lending, tutoring, and peer mentoring throughout their program.

Changes to curriculum include the introduction of curriculum on Aboriginal health, social justice, cultural competence, and cultural safety, threaded throughout the four-year program. An Aboriginal Health Issues

nursing course (taught by a First Nations nursing faculty member) is now available, and a theory course and placement in an Aboriginal community will be available as of the fall of 2012. Workshops and faculty development sessions (designed to increase awareness of Aboriginal people and understanding of cultural competence and safety and social justice) are available to nursing faculty and, in some cases, to the broader university community.

The Aboriginal Nursing Initiative was developed with guidance from an advisory team, with representation from Aboriginal partners. Since the initiative's implementation in 2008, the number of Aboriginal students enrolled in the nursing program has increased from one or two each year to 10 to 15 per year. In 2012, seven Aboriginal students will graduate from the program. In evaluations, faculty members reported gains in knowledge and awareness of Aboriginal culture since the initiative began. Activities of the Aboriginal Nursing Initiative at UNB are supported through the Aboriginal Health Human Resources Initiative (AHHRI).

Aboriginal Cultural Safety Initiative, Anishnawbe Health Toronto

The Aboriginal Cultural Safety Initiative of Anishnawbe Health Toronto (AHT) was designed to prepare Ontario's health sciences students to practise within their respective health care professions in ways that are culturally safe for Aboriginal clients. An environment scan done by AHT revealed that while some nursing and medical schools incorporate cultural competency training into their programs, prior to the development of this initiative there was little content in post-secondary training in this area for the 57,000 students in health-related programs in Ontario (Anishnawbe Health Toronto, 2011). The post-secondary institutions that deliver health sciences programs attributed the absence of cultural competency training with Aboriginal populations to a lack of time in the curriculum, and a lack of Aboriginal faculty to teach the content. When Anishnawbe Health asked post-secondary institutions, "If we were to provide Aboriginal faculty to teach Aboriginal cultural safety to your students, would you offer it?" the majority answered that they would.

With support from the Trillium Foundation and the Ontario Ministry of Training, Colleges, and Universities, Anishnawbe Health developed a three-hour cultural competency training module for students. The training draws on the Indigenous Physicians Association of Canada's curriculum framework for continuing medical education and explores the impacts of colonization, health determinants and the health status of Aboriginal people, gaps in mainstream health services for Aboriginal people, and the concept of health and healing in Aboriginal communities. The initiative targets students in all of the various health sciences programs, with the understanding that practitioners do not need to be experts in Aboriginal history and health, but they do need to be sensitized to this information if they are to work with Aboriginal clients. Anishnawbe Health has trained 35 Aboriginal people as Preceptors to deliver the training, and invites colleges and universities to bring Preceptors into classrooms to host these training sessions. The Aboriginal Preceptors strengthen the training experience for participants by sharing personal stories and describing their own processes of self-reflection and self-awareness, a critical step in the development of cultural competency and cultural safety.

To date, over 15 health sciences programs have participated in the program and 1,200 students and health professionals have gone through the training. Evaluations indicate that participants have an increased awareness of these topics, and an increased interest in learning more about the history of First Nations, Inuit, and Métis people in Canada. The Aboriginal Cultural Safety Initiative is running on a three-year grant from the Trillium Foundation, as well as additional funding support from the Ontario Ministry of Training, Colleges, and Universities.

Building Cultural Competency, Department of Health, New Brunswick

The New Brunswick Department of Health is working to enhance cultural competency within its own organization and within the larger health system in the province. New Brunswick has established a two-day cultural competency training program for the public service and is working toward the development of a cultural competency framework.

The province has established a position for a First Nations Health Liaison Coordinator. The Coordinator's role focuses primarily on breaking down barriers by educating and translating meaning (rather than languages) for both Aboriginal and non-Aboriginal people who are part of the health system. The Coordinator has, for example, accompanied the province's Chief Oncologist to communities where they presented programs on screening and cancer

awareness, and introduced information about the impacts of smallpox, the Spanish flu, residential schools, and the Sixties Scoop into a mental-health focused project. The Department recognizes the importance of building relationships with First Nations peoples. Wherever possible, the Coordinator brings First Nations people with appropriate expertise in to do presentations and help educate people across all public sectors.

Why are cultural competency and cultural safety important?

GAPS IN KNOWLEDGE, UNDERSTANDING, AND EXPERIENCE

As many participants pointed out, if health practitioners are to provide the best possible care—or even care that is on par with that available to most Canadians—they need to understand the historical context of Aboriginal people's present-day health and wellness. A participant put it simply: "You don't need to know everything about First Nations, Inuit, or Métis people, but you do need to be aware that there was and is a colonial process, and recognize that this has impacts on health." The majority of non-Aboriginal Canadians have limited awareness, knowledge, and understanding of First Nations, Inuit, and Métis people. Until very recently, First Nations, Inuit, and Métis peoples' histories and their foundational role in the development of Canada have only rarely been acknowledged or explored in public school curricula. Similarly, until recently, Aboriginal people have been absent from curricula at medical schools and other post-secondary programs for health professionals.

The gaps in awareness, knowledge, and basic understanding generated by gaps in academic curriculum are compounded by non-Aboriginal people's frequent lack of connection to or relationships with First Nations, Inuit, and Métis people. A participant who teaches health professionals described an exercise he does with students. The teacher first asks students to list stereotypes they have about Aboriginal people. He then asks the students, "How many of you have Aboriginal family members? Aboriginal friends? How many of you have gone to their homes? Had lunch with them?" Only a few students answer positively, and those who do not answer positively typically identify the media as the primary source of their stereotypical perceptions of Aboriginal people. Experience, on the other hand, can be a powerful teacher. Non-Aboriginal people who have relationships or meaningful engagement with Aboriginal people are less likely to fall into stereotypical perceptions of or racist behaviour towards First Nations, Inuit, or Métis people.

Strengthening Diversity, Inclusion, and Cultural Competency, IWK Health Centre, Halifax, Nova Scotia

The IWK Health Centre is a tertiary health centre for women and families in the Maritimes. Over the last three years, IWK has taken action to strengthen diversity, inclusion, and cultural competency within the organization (IWK Health Centre, 2009). The initiative began with consultations with community stakeholders representing various groups in the centre's catchment area, including First Nations people. Following the consultations, IWK included diversity and inclusion in its strategic plan. IWK issued a position statement that declares its commitment to provide culturally competent care (defined as recognition and respect for the cultural and personal values of patients, families, staff, and all who interact with IWK), to create a welcoming and inclusive environment, and to respect, embrace, and value diversity in all statements and actions. The statement also identifies specific actions and approaches to follow through on this commitment. IWK developed and distributed a Diversity and Inclusion Lens Tool to help staff members consider diversity and inclusion as they plan, implement, and evaluate programs, policies, and practices. The tool provides 12 questions to guide staff through this analytic process. Cultural competency training is now included in orientation activities for new staff members, and other employees are also encouraged to complete the training.

Other activities are designed specifically to enhance cultural competency and cultural safety for First Nations, Inuit, and Métis people. IWK is participating in the province of Nova Scotia's Building Cultural Safety Project. IWK will be a pilot site for cultural safety training, currently under development in the Project, and has also used opportunities presented in the project to strengthen relationships with Mi'kmaq people and organizations that have partnered on the project. IWK has undertaken health promotion and education activities that draw on its enriched understanding of the culturally distinct needs of Aboriginal people.

Society of Obstetricians and Gynecologists of Canada (SOGC), Aboriginal Health Initiative, Guide for Health Professionals working with First Nations, Inuit, and Métis

Between December 2000 and March 2001, the Society of Obstetricians and Gynecologists of Canada (SOGC) issued a policy statement entitled *A Guide for Health Professionals Working with Aboriginal Peoples* to provide information and recommendations regarding Aboriginal health. The Guide provides clear, action-based recommendations to assist health professionals with steps they can take to become more culturally competent, and is widely recognized among health professionals as a ground-breaking document.

In early 2013, the SOGC will release a new Guide that will further assist health professionals who work with First Nations, Inuit, and Métis women and their families by guiding them through a process of understanding the social determinants of health, colonization, and key sexual and reproductive health issues. The Guide will feature evidence-based recommendations, case studies, and clinical tips to support health professionals in their ability to offer culturally safe care. To produce this Guide, members of the SOGC's Aboriginal Health Initiative Committee—many of whom are Aboriginal—are working with partner organizations such as the former National Aboriginal Health Organization (NAHO), Inuit Tapiriit Kanatami (ITK), the National Aboriginal Council of Midwives, Pauktuutit Inuit Women of Canada, the Aboriginal Nurses Association of Canada, the Indigenous Physicians Association of Canada, and the Métis National Council, among others.

Committee members have conducted extensive consultations with Aboriginal and non-Aboriginal health professionals over the last 12 months to better understand the health needs, challenges, and strengths of First Nations, Inuit, and Métis people. As a result, this Guide will be grounded in the experiences of health practitioners and will offer tips for relevant change to provide culturally safe care. It is intended to help bridge theory and practice. The process has also been defined by the opportunity for genuine collaboration and consensus building, and the

SOGC remains incredibly grateful to all its partners for their support in this initiative. The main audience is the SOGC's 3,500 members, including obstetricians, gynaecologists, family doctors, nurses, and midwives. The members receive continuing medical education (CME) credits for attending regional meetings (which are accredited sessions), and this Guide will be a much-anticipated presentation in 2013 and beyond. The Guide will be published alongside a compendium that will feature key messages of the Guide in an accessible format for widespread distribution through the SOGC and Aboriginal Health websites (sogc.org; aboriginalsexualhealth.ca).

Culturally based services that respond to community-identified needs

Encouragingly, the majority of practices identified by participants in the regional discussions are culturally based services designed to respond to community-identified needs. The examples of practices presented in this section include several that were created in the context of activities designed to create system-wide transformation. Ontario's Aboriginal Healing and Wellness Strategy supports the work of the Misiway Milopemahtesewin Community Health Centre in Timmins, De dwa da dehs nye>s Aboriginal Health Centre in Hamilton, and the Traditional Healing Program at Southwest Ontario Aboriginal Health Access Centre. The First Nations Health Programs at Whitehorse General Hospital in the Yukon was developed in the context of the transfer of responsibility for health services from the federal government to the territorial government. Other activities, such as Aboriginal Health Services at the Southern Regional Health Authority in Manitoba (formerly Regional Health Authority Central MB) and the Aboriginal Home Care Project of Regina Qu'Appelle Health Region, were developed in close collaboration with First Nations, Inuit, and Métis organizations.

Activities of the Nuu-chah-nulth Tribal Council Nursing Program in British Columbia (which restructured its framework for service delivery, taking guiding principles from the First Nations communities it serves), the Centre for Addiction and Mental Health in Ontario, Cancer Care Ontario, and the Alberta branch of the Canadian Paraplegic Association were developed because these organizations recognized that their services were not working for Aboriginal people and they sought out Aboriginal partners to implement change. The Tungasuvvingat Inuit Family Health Team Medical Centre in Ottawa provides community access to a comprehensive team of health providers. In addition, the Ottawa Health Services Network and the St. John's Native Friendship Centre developed practices focused on coordinating services and supports to meet the needs of an often overlooked group, Aboriginal people who must travel into urban centres to access health care services.

Many participants mentioned the value of Aboriginal patient navigators/liaisons as cultural bridges between First Nations, Inuit, and Métis people and non-Aboriginal health care professionals.

Misiway Milopemahtesewin Community Health Centre, Timmins, Ontario

The Misiway Milopemahtesewin Community Health Centre in Timmins is one of three Aboriginal Community Health Centres in Ontario. Roughly 95 per cent of the Centre's clients are First Nations people. The Centre offers quality programs and services that honour, respect, and support Aboriginal culture, values, and healing practices, complemented by Western approaches to primary health care, in a culturally and physically safe space. The Centre's practitioners invest time in building relationships with the people who use their services, allocating up to an hour for initial appointments with new patients.



XWEE-NUT-SA (We are all one)

The two main images in this illustration are contrasts. On the right, a person is holding the shield of a Long House, representing cultural safety at home. On the left, a person is holding a prison with a hospital inside it, representing how hospitals do not feel culturally safe and can feel like prisons, also a reminder to Aboriginal peoples of the residential school experiences many have encountered. The image of the two heads and the two snakes in the centre of the illustration represent unity and healing.

The bear on the longhouse shield represents the importance of bear medicine to the people. A participant drew the illustration below the bear of a body with a heart. Participants requested an image of moccasins ("walk in somebody else's moccasins") and a bee, which represents community. They added words such as *social justice*, *open mind*, *reach out*, and the title, *We are all one*.

In 2011, the Centre began delivering a traditional program that connects clients with Elders and the land. The program was developed in response to an identified need in the community and has grown quickly. The Centre, which already had a psychotherapist on staff, added a traditional counsellor who was initially engaged for only a few days each month. The demand for the traditional counsellor's services has been overwhelming, and the Centre has added two more traditional counsellors to its staff. The Centre's traditional activities also include land-based activities, such as camps that offer traditional healing to children and youth.

The Centre carefully selects the traditional healers it brings on staff. Traditional healers are not formally credentialed, so the Centre recruits healers through an informal credentialing process, asking Elders with whom they have existing relationships to refer healers they know, trust, and can work with. The Centre recognizes the value of having people on staff who understand the culture and ways of being of the Aboriginal people they serve and, wherever possible and appropriate, hires Aboriginal people.

The Centre also reaches out to the larger community it serves. It collaborates with local high schools and community organizations on health education activities, and partners with other service delivery organizations. The Centre is mandated to provide services within 160 kilometres of Timmins. In partnership with the Wabano Tribal Council, the Centre is taking a mobile diabetes screening program and other services to nearby communities. The Centre has also been contracted to provide home care services for the Community Care Access Centre.

De dwa da dehs nye>s Aboriginal Health Centre, Hamilton and Brantford, Ontario

De dwa da dehs nye>s Aboriginal Health Centre in Hamilton is one of 10 Aboriginal Health Access Centres established under Ontario's Aboriginal Healing and Wellness Strategy. The Centre offers culturally appropriate health care programs and services, including primary health care (providing access to physicians, nurse practitioners, and traditional healers); mental health supports; and advocacy, outreach, and health promotion and education services in the community (De dwa da dehs nye>s Aboriginal Health Centre, 2012). The Health Centre serves all Aboriginal people, regardless of status, and offers assistance to outside service organizations to provide care in a culturally appropriate way. Its catchment area includes the urban centres of Hamilton and Brantford, as well as the local Six Nations community.

The Health Centre primary health care and traditional health care teams approach care holistically. Patient scheduling allows adequate time during appointments for practitioners and patients to build relationships based on trust. The Centre also has a Patient Advocate on staff, who works on- and off-site at the local hospital and other organizations, providing supports that benefit both patients and practitioners. The Centre's traditional healing and primary health care teams work together as equals and must be open to learning from each other. Basic orientation for staff members includes information about culturally distinct ways of understanding and caring for health and wellness, and cultural differences that may affect the care relationship. The Centre looks to its traditional healers and other Aboriginal people on staff for guidance and input on knowledge and information that should be shared to enhance the cultural capacity of non-Aboriginal staff members.

As with other organizations that provide traditional healing services, many of the Elders who work with the Centre do not have formal education, but have tremendous knowledge. The Health Centre recognizes the importance of trusting the value and integrity of Elders' knowledge and of trusting their skills as practitioners, in the same way as the Centre recognizes the skills of other professionals that provide services at the centre.

The Health Centre is in the process of establishing a traditional medicine dispensary. The dispensary will offer traditional medicines that patients frequently request (at no charge), along with teachings and sharing of information about alternatives to or interactions with Western medicines. The Centre is also establishing rapid HIV testing services and plans to bring basic dental services on-site. Both HIV testing and dental services are activities that people often have misunderstandings or missed knowledge about or feel uncomfortable accessing; it is expected that by making these services accessible on-site, Aboriginal clients will feel more comfortable about using them.

The Health Centre works in partnership with other Aboriginal service providers, including, for example, the local Friendship Centre and the Southern Ontario Aboriginal Diabetes Initiative. These partnerships extend the reach of the Centre's services, enabling it to provide services to people in locations such as Niagara Falls, Brantford, London, and Guelph. The Centre has also established partnerships with child and family service agencies (so that Aboriginal children in care who have been placed with non-Aboriginal families can learn about traditional ways and cultural teachings) and with a breast cancer organization (to bring together Aboriginal women for testing, a task that the organization had not been able to do on its own).

Traditional Healing Program, Southwest Ontario Aboriginal Health Access Centre, London and Muncney, Ontario

The Southwest Ontario Aboriginal Health Access Centre (like De dwa da dehs nye>s in Hamilton) was established under the province's Aboriginal Healing and Wellness Strategy. The Centre's Traditional Health Program brings a traditional, holistic approach to individual, family, and community health and wellness. Services available through the Program include one-on-one healing sessions with traditional healers; access to traditional ceremonies and workshops; information on natural medicines and traditional ceremonies; stress management workshops; and cultural awareness training (Southwest Ontario Aboriginal Health Access Centre, 2012). The program serves a diverse population, representing various First Nations, speaking different languages, and interested in a range of healing practices.

The traditional healing program was developed in response to community-identified needs and has grown rapidly. Traditional healers are available only twice a month; demand for their services is growing quickly, and currently clients who request their services are put on a waiting list. The program also connects clients with herbalists who teach them about traditional medicines and may take them out on the land to show them how and where to gather medicines.

The Traditional Healing Program works to bridge and build understanding between traditional and mainstream Western healers, and provide opportunities for them to learn from each other. The Program works directly with individual practitioners at local hospitals to teach them about the roles of healers and traditional ceremonies. Practitioners can also contact the program to learn more about interactions between traditional medicines and Western medications, the properties of the medicines, and the importance of traditional medicines and ceremonies to Aboriginal people.

Why are cultural competency and cultural safety important?

FIRST NATIONS, INUIT, AND MÉTIS PEOPLE UNDERSTAND AND CARE FOR HEALTH AND WELLNESS IN CULTURALLY DISTINCT WAYS

In the mainstream Western medical system, doctors and other health professionals are produced by formal universities and other post-secondary institutions. As Aboriginal people, we have our own ways of learning and sharing knowledge, our own informal universities that produce our medical practitioners who practise from our own knowledge and understandings about wellness. We're trying to build a bridge between those knowledge systems, ways of understanding and practising health and wellness, and to set up ways that people will have the freedom to go where they need to go to care for their health and wellness.

Participants emphasized the importance of holistic approaches to health and wellness in Aboriginal communities, and of addressing the underlying causes of unhealthy conditions rather than just the symptoms. Many Aboriginal people are very spiritual and have lives based on ceremony; a holistic approach includes attending to the spiritual (as well as physical, emotional, and mental) aspects of health and wellness. A participant called for more understanding of the healing power of traditional medicine, offering the story of a girl who recovered from leukemia after participating in traditional ceremonies and using traditional medicines. Participants cautioned that there must be “a careful balance” to ensure that Aboriginal people do not lose control of traditional healing and that it does not get drawn into profit-making.

First Nations Health Programs, Whitehorse General Hospital, Yukon

The First Nations Health Programs (FNHP) at the Whitehorse General Hospital were established in 1992 in response to needs identified in consultations with First Nations leadership undertaken by the territorial government in the Yukon when it assumed responsibility for health from the federal government. Whitehorse General is the only acute care hospital in the Yukon and FNHP provides support for all 14 First Nations in the territory. Services provided through FNHP include Health and Social Liaison Workers, traditional healing supports, and cultural supports.

FNHP's six Liaison Workers are trained in Aboriginal health and social work, and visit all self-identified First Nations, Inuit, and Métis patients admitted to the hospital. FNHP has allocated one of these positions to the emergency department, ready to greet Aboriginal patients as they arrive. The Liaison Workers advocate

for First Nations, Inuit, and Métis patients and help raise awareness among hospital staff. FNHP is represented on discharge planning teams, and the Liaison Worker assigned to this position can coordinate outpatient services for discharging patients, act as a social support and advocate, and connect with the Non-Insured Benefits program to arrange transportation or other benefits as needed.

FNHP's Traditional Medicine Coordinator is available for consultation within the hospital and will assist patients and their families to access traditional healing. Part of the role of FNHP is to interpret cultural understandings and practices, teach these to other medical practitioners, and, ultimately, work to a place of collaboration. Patients and their families may access the Na'Ku healing room, attached to the hospital, for prayer, ceremony, or other healing activities. The room is open to everyone, regardless of their spiritual practice, and staff members often use the space as part of their own self-care activities.

Cultural supports include interpreter services and a Traditional Diet Program. This program enables the hospital to offer traditional foods to Aboriginal patients, a service that is made possible only through the support of First Nations leadership, the territorial government, and community members, who help harvest the food.

FNHP has developed and delivers a two-day cultural competency training program, which is now mandatory for all employees of Yukon Hospitals, as well as certified training designed specifically for palliative care practitioners.

Aboriginal Health Services, Southern Regional Health Authority in Manitoba (formerly Regional Health Authority (RHA) Central MB)

In 2008, the former RHA-Central, working in partnership with local Aboriginal leadership, initiated a major project to better meet the self-defined needs of the Aboriginal people and communities it serves. The project, which was supported by the Aboriginal Health Transition Fund, included institutional self-reflection pieces with a system-wide analysis to assess the cultural safety of programs and facilities, and a series of consultations to learn from Aboriginal community members about their experiences accessing care.

The most critical component of the health authority's initiative may be the establishment of the Aboriginal Support Worker positions in the RHA's Aboriginal Health Services (AHS) department. The AHS department is relatively small, but it has had significant impact within the hospital and the region. Aboriginal Support Workers are based in the Portage District General Hospital and are highly visible since their office is in a high traffic area. They spend much of their time in the emergency department, but also work throughout the hospital and region and in every area of service, available seven days a week to support First Nations, Métis, and Inuit clients from their arrival at the front desk of the hospital throughout the length of their stay. Aboriginal Support Workers help clients fill out paperwork and navigate through and within the health system services. They make weekly visits to local Personal Care homes, connecting residents with the community and offering sharing circles, cultural

healing, and traditional culturally competent care. Aboriginal Health Services provides interpretation and translation services in local Aboriginal languages, offers smudge ceremonies within the health authority facilities, and has developed a protocol that enables health practitioners to arrange for provision of the ceremony with very little lead time. AHS may also bring in Elders to support cultural and healing activities for clients and staff.

Aboriginal Health Services provides extensive assistance at the hospital and within the region. AHS staff model culturally competent and culturally safe behaviour in all their interactions. They seek out engagement with other staff members, joining the morning huddle with department heads, participating in committees, going out of their way to interact with physicians, and consulting with housekeeping and kitchen staff about the culturally distinct needs of their clients. Health Practitioners connect with AHS staff to ask questions or to share information. These activities have opened up new lines of communication between health practitioners and Aboriginal clients, and give AHS staff and health practitioners unusual insight into the needs of Aboriginal patients.

The Aboriginal Health Services initiative has gained support and momentum by making a positive difference and achieving promised outcomes. Initially, Aboriginal Support Workers had to work to convince many health authority staff members that they added value to the organization. Today, they are recognized, appreciated, supported, accepted, and respected by clients, health staff, physicians, and the organization's board, senior management, and CEO. Aboriginal Health Services staff members are seeing changes in staff attitudes and behaviour that enhance cultural safety, and the community also recognizes that the presence of Aboriginal Support Workers helps the regional health authority be more accountable to the First Nations, Métis, and Inuit people it serves.

What do cultural competency and cultural safety look and feel like?

GETTING IT RIGHT!

At one regional discussion, a participant shared a story that demonstrates how a hospital in Goose Bay modified practice to give the best possible care to an elderly Innu patient. The Elder had terminal cancer and was in the in-patient ward for a long-term stay. The family asked if they could set up a tent outside the health centre. The tent would be located behind the centre, on the centre's property but not visible from the road. The family wanted to be able to spend time with the Elder in a context that was familiar and comfortable to him, but that was also as close to the hospital as possible. The hospital gave consent, and the family set up a tent, equipped with a wood stove and hospital bed. The family brought the patient out to the tent each day and, if his condition permitted, stayed there with him until the evening, at which time they took him back into the hospital. Within a few days, the hospital's nurses and physicians were visiting the tent to monitor their patient's condition. Because the Elder was highly respected, at any given time there were as many as 50 people there to visit him. The family added two more tents to the encampment, in part to accommodate people visiting from other communities. The Elder and his family spent about 10 days like this.

Aboriginal Home Care Project, Regina Qu'Appelle Health Region, Saskatchewan

The Aboriginal Home Care Project began as a highly successful initiative undertaken by the Regina Qu'Appelle Health Region (RQHR) Home Care, in partnership with the Eagle Moon Health Office. The project was initiated because RQHR Home Care recognized that Aboriginal people were not accessing home care. To understand why, the department assembled a working group with representation from First Nations, Métis, government, and home care to analyze gaps in services. The working group identified key issues relating to lack of case management and restrictive policies that limited access. For example, a nurse might not understand that Aboriginal patients' inability to manage their diabetes effectively was linked to their inability to afford or access nutritional food. Another example related to how the home care system responded to missed appointments, identifying patients who were not at home when a home care worker arrived as "non-compliant" and screening them off the program, rather than considering what might have been going in their lives to make them miss their appointment.

After identifying these issues, RQHR, with the support of funding from the Aboriginal Health Transition fund, began to adapt home care services to make them more culturally relevant for First Nations and Métis people. A steering group was struck to support the project, and members of the project team were hand-picked and moved into space reserved for the project. A model of holistic care was developed for the project, offering services beyond what RQHR Home Care offers to the mainstream population and changing how practitioners do their work. More flexibility was built into service delivery so that home care workers are able to reschedule with patients who miss appointments. RQHR Home Care created new staff positions, including a Community Support Worker (who helps patients with transportation), an Aboriginal Liaison Worker (who helps patients bridge services), and access to a Traditional Healer (employed by Eagle Moon Health Office but working part-time in the Home Care office). The project team also includes an Elder.

Project team members are provided with training to enhance their cultural capacity. Cultural practices are incorporated into management, including the practice of beginning all weekly meetings with a talking circle.

Development of the Aboriginal Home Care project took four years, and it has now been in operation for two years. The program has increased access to home care. All Aboriginal patients using home care services now have case management, and all are linked to an Aboriginal liaison worker. The project team is now working with emergency departments to identify patients who are frequent users of these services and then develop and implement chronic disease management plans to reduce their need to access emergency services.

Nuu-chah-nulth Tribal Council Nursing Program, Tseshah First Nation, British Columbia

The Nuu-chah-nulth Tribal Council Nursing Program (NTC), based in the Tseshah First Nation outside the city of Port Alberni, is a transferred health program, operating in the territories of the Nuu-chah-nulth First Nations on Vancouver Island. When health programs were transferred to the Nuu-chah-nulth Tribal Council in 1988, the nursing program recognized both the need and the opportunity to transform their program. They knew change was needed because, in a region where birth rates are very high, very few pregnant women accessed any services.

As a community health nursing program, NTC seeks to deliver professional, ethical, culturally sensitive, and responsible care (Nuu-chah-nulth Tribal Council, n.d.). NTC's goal in the transformation process was to develop a program that would put First Nations' community members' needs first without compromising the practice needs of the nursing staff. A first step was to connect and work with members of the communities NTC serves. Based on findings from these consultations, NTC developed a framework based on four fundamental beliefs of the communities:

- 1) Each life is a precious journey;
- 2) Each life connects;
- 3) Each life seeks fulfillment; and
- 4) Each life completes its cycle.

With the framework beliefs in place, NTC then considered how the program could fulfill needs identified by both community members and the nursing staff. NTC identified specific nursing-related responsibilities and associated them with each belief. NTC also developed an approach in which practitioners work with patients to identify, recognize, and explore ways to meet their needs throughout their interactions. This approach is strengths-based and culture-based. It looks at where people come from, acknowledges their resilience, strengths, and capacity, and works with them to move their wellness forward in ways that they are comfortable with.

The first area in which this approach was implemented was maternal and child health. A standard screening and assessment tool that focused on problems (with a checklist that included questions such as, "When was your last drink?") was replaced with an approach that uses open-ended guiding questions through which women can explore what is important for them in their world and practitioners can gather information needed for assessment. This approach, called The Mother's Story Care Model, opens with questions that invite women to talk about their health and explore what they want, need, and hope will happen, and then moves on to develop practical ways to meet those needs and achieve those hopes. Nurses and their patients assess available supports, determine what level of care would meet both their needs, set goals they can work towards together, and, finally, review a checklist based on maternal guidelines developed by the Ministry of Health. The checklist is not a medical assessment, but rather is a teaching tool that provides an opportunity to share information about ways to support the health and wellness of both mother and child. The Mother's Story Care Model also guides practice after a baby comes into the world. Nurses invite their patients to share the stories of their birth experiences, a process that gives mothers a chance to talk safely about their experiences and gives nurses a chance to understand and support mothers as new parents. The nurses also use the first visit with a new mother to welcome the baby into the world in a traditional way, wrapping the baby in a blanket to ready him or her for the journey through life.

NTC has introduced other important changes to support cultural safety. They have staff in an advocate/ liaison role at the local hospital. NTC has also developed and implemented a charting system that follows the nursing framework. In this model, nurses make sure that their computer screen is visible to clients during their interactions, and nurses do the actual charting with their patients.

Aboriginal Services, Canadian Paraplegic Association, Alberta

The Canadian Paraplegic Association (CPA Alberta) assists persons with spinal cord injuries and other physical disabilities to achieve independence, self-reliance, and full community participation (Canadian Paraplegic Association (Alberta), n.d.). CPA Alberta established Aboriginal Services approximately 25 years ago, and now has Aboriginal Client Coordinators in each of its six regional offices in the province. One-quarter of CPA Alberta's clients served in 2011 were Aboriginal, and, of these, approximately three-quarters live outside Calgary and Edmonton. The Coordinators work with clients from intake, travelling to reserves to see those who have significant physical access barriers. Aboriginal Services offers a peer program in which clients are matched with a peer who has a similar injury. Connecting with another person who can share their experiences creates comfort for clients and helps them through their experiences.

CPA Alberta's Aboriginal Services are unique in that they work across jurisdictions (First Nations, federal, and provincial) and manage the fiscal responsibilities and constraints associated with the jurisdictions. CPA is one of the only non-profit organizations that serve the on-reserve population. The program was developed in recognition of the rapidly growing Aboriginal population and, more specifically, to address identified gaps in programs and services.

21-Day Treatment Cycle, Centre for Addiction and Mental Health, Ontario

The 21-Day Treatment Cycle program for men and women is available through the Aboriginal Service of the Centre for Addiction and Mental Health (CAMH). It was developed because Aboriginal staff

members had seen their "brothers and sisters" on the street and recognized the need to develop services that worked for those community members. CAMH has assigned four clinical staff and an Elder to the initiative, supplemented by the work of program leadership, administrative support staff, and health professionals from elsewhere in the Addictions Program that houses the Aboriginal Service.

The 21-Day initiative relies on collaboration between CAMH and eight other Aboriginal and non-Aboriginal organizations, including St. Christopher's, Na-Me-Res, and Native Child and Family Services of Toronto. Through close collaboration and relationships of trust with community organizations, CAMH is often able to negotiate care and advocate for clients who would typically be refused care (such as clients with a criminal background) at health care organizations.

The 21-Day initiative was started with funding from the federal Aboriginal Health Transition Fund and the provincial Ministry of Health and Long-Term Care. These funding bodies provided invaluable foundational support for a project based on innovative collaboration and change. Since then, CAMH has committed funding to sustain the program, reflecting the support of the organization's senior leadership.

Program activities have been evaluated, including a formal evaluation by service users. A significant indicator of success is that it has a very high program completion rate of around 88 per cent.

Aboriginal Patient Navigator, Cancer Care Ontario and Juravinski Cancer Centre, Ontario

Cancer Care Ontario recently established an Aboriginal Patient Navigator program modelled after the Navigator program at the Juravinski Cancer Centre in Hamilton. The Navigator provides culturally sensitive support and advocacy services for Aboriginal patients with cancer and their families (Accreditation Canada, n.d.). The Navigator ensures access to best care through the provision of support, advocacy, and community networking with Aboriginal and non-Aboriginal health groups and organizations, and by addressing cultural needs.

The Navigator helps Aboriginal patients and their families by providing support at clinic visits; helping patients and families communicate with doctors and nurses; arranging language and cultural translation services; helping patients and families find services; and helping them connect with traditional Aboriginal healers (Juravinski Cancer Centre, n.d.). These services (which may be delivered on-site at the Juravinski Cancer Centre or within the patient's own community)

are available throughout the patient's healing journey, including prevention, screening, early detection, diagnosis, treatment, remission, recurrence, palliation, and end-of-life care. Cancer Care Ontario recognizes the value of a patient-centred approach to help Aboriginal patients through the cancer experience and is now developing a business case for additional Aboriginal liaisons.

What do cultural competency and cultural safety look and feel like?

(KNOWLEDGE + SELF-REFLECTION) x COURAGE TO CHANGE = CULTURAL COMPETENCY

When I was fresh out of university, I was so excited to be working in First Nations, using what I had learned. I had seven pregnant women I was doing my first prenatal classes with. I had prepared for first class. They all showed up and I was so happy. My travelling companion, a First Nations man and a cultural counsellor, asked me after the class how it had gone. I thought it went well. He asked if any of the participants had interacted with me. I said no, but maybe that's because it was the first session and they were getting to know me. He asked if I thought they'd come back. I said that I thought they would. He also had told me that some people showed up because they got food vouchers. He waited a bit and then told me he wanted to share part of the community's history: 'Our people have always taken really good care of our pregnant women and babies. And it was hard for me to observe you teaching our women because of this.' It wasn't about me. He was sad because something his people had done so beautifully for so long I was telling them how to do it now. He said this in a kind way.

I went home and self-reflecting—and I cried. I didn't want to be the person telling people what they need to do, when they already know how to do it. On the next trip to the community, I asked for his advice. He told me to start talking to the women Elders in the community, and to learn from them about traditional ways of caring for pregnant women and babies. I did that. Without naming it, I was learning how to be more culturally competent and provide care that was more culturally safe. I was providing care that met their needs as pregnant women, rather than my needs as a professional. The program began to shift so that it focused on strengths women had, instead of what we thought they should do. I began trusting that First Nations people have the expertise to decide what they need for prenatal care. Cultural competency, I realized, is people being able to openly access care in the way that they feel safe, not the way that I think they should be. It's about connecting at a heart level and believing in our clients' capacities to know what's best for their children and families.

Ottawa Health Services Network Inc., Ontario

The Ottawa Health Services Network Inc. (OHSNI) is a not-for-profit organization, established in 1997, that coordinates specialist and tertiary health care in Ottawa and Iqaluit for residents of the Baffin region of Nunavut (Aboriginal Health Services Network, n.d.). OHSNI's practice is guided by founding beliefs that include: 1) keep care as close to home as possible; and 2) all people in the North have the right to equitable care.

OHSNI helps its clients participate in their care and understand the options available to them in the North and the South. When clients are referred to their office, staff members coordinate their care, attending to their distinct needs such as setting up their appointment for an MRI on the same day as their doctor's appointment so that they can return to their home communities as quickly as possible. Clients who do need to stay in the city typically use Larga Baffin, a boarding home specifically for Inuit coming into the city for medical services. Larga is available to people during and after care, and, in addition to residential services, also provides cultural activities. OHSNI has a close working relationship with Larga, coordinating services with the boarding home as needed and appropriate.

Cultural interpreters provide crucial supports to OHSNI clients. These include interpreter services, but they also help clients understand, for example, issues relating to their care or the hospital environment. The interpreters help ensure that clients and their doctors and other service providers understand each other, assist patients to navigate the hospital and health care system, and provide information to support decision-making processes. They work in partnership with OHSNI's Nursing Case Managers, a partnership that has helped change the behaviour of some service providers. The interpreters are well-known and trusted by hospital staff. They have built good working relationships with the doctors, who rely heavily on them. The interpreters are also accepted and valued by the Inuit people who use their services because they are there to provide services that meet clients' needs.

Tungasuvvingat Inuit Family Health Team Medical Centre, Ottawa, Ontario

Tungasuvvingat Inuit, a community-based counselling and resource centre for Inuit people in Ottawa, recently opened the Inuit Family Health Team Medical Centre (Tungasuvvingat Inuit, n.d.). The Centre seeks to bring effective primary care services to Inuit community members and provides community access to a comprehensive team of medical practitioners, registered nurses, interpreters or case managers, midwives, and traditional healers.

Aboriginal Patient Navigator Program and Shanawdithit Shelter, St. John's Native Friendship Centre, Newfoundland and Labrador

Like the Ottawa Health Services Network described above, the St. John's Native Friendship Centre is developing a continuum of supports for First Nations, Inuit, and Métis people who travel to St. John's to access health care services. The project is evidence based, addressing a need identified in a research project (conducted by faculty at the medical school at Memorial University) that explored the health needs of urban Aboriginal people in the region. Friendship Centre staff also visited a program in Ontario that provides similar supports to gather lessons learned.

To provide much-needed supports to this sector of the community, the Friendship Centre has undertaken two projects: the provision of Aboriginal Patient Navigators at a local hospital, and the establishment of a shelter that offers temporary housing.

The Centre, in partnership with Eastern Health and with support from the Aboriginal Health Transition fund, has introduced two staff positions for Aboriginal Patient Navigators. The Navigators are on site at the city's Health Science Centre and are embedded in a multidisciplinary team that provides health care services to Aboriginal people in culturally specific and sensitive ways. The Navigators connect with patients either through referral by hospital staff, self-referrals, or by simply introducing themselves to patients and telling them about the services they provide. The navigators act as interpreters, for languages, concepts, ideologies, and practices. They might, for example, interpret between English and Inuktitut so patients understand

what a physician is saying, or they might interpret between non-Aboriginal and Aboriginal ways of knowing and being to help patients better understand what is happening to them in the health care system. The navigators help break barriers between physicians and patients. They consult with social workers in health facilities, make sure that patients have the equipment they need, and assist with discharge planning so that when patients return home, they will have whatever level of ongoing care they might need. A resource guide with information on health-related services has been developed for distribution to patients.

The Centre also operates the Shanawdithit Shelter. The shelter has 10 rooms, can accommodate up to 23 people, and offers temporary housing in a safe and secure setting. The shelter is comfortable and well-appointed, can accommodate either short- or long-term stays, and is the only shelter in the city that accommodates families. Staff members include a cook, and meals are provided to clients at no additional costs, offering food that is healthy and as traditional as possible.

The shelter's services are geared primarily to Aboriginal people who are visiting St. John's and include transportation and laundry services for community members who are in or are caring for those in hospital. When arranging services, the shelter typically deals directly with either Aboriginal organizations or Health Canada. Because the shelter does not have outside funding to support its activities, it operates on a fee-for-service basis, and recently restructured rates to ensure that their services are accessible to community members. The shelter also has a partnership with the provincial government in which the shelter takes social services clients when it can, an arrangement that helps stabilize the shelter financially.

The new programs have enabled the Friendship Centre to offer a surprisingly comprehensive range of supports to First Nations, Inuit, and Métis people who travel to the city for health care. The centre arranges for staff to meet people at the airport, transports them to where they need to be, and, if needed, arranges appointments for them. Clients can also be brought to the shelter, where their accommodation needs are

taken care of. The Friendship Centre provides wrap-around services and supports to clients, enabling them to focus on their health and wellness needs.

Community response to the Friendship Centre's programming has been extremely positive. Clients report that they feel more comfortable staying at the shelter than anywhere else and prefer to travel in the shelter's van over other transportation options. People who must travel to the city for medical services are typically stressed and vulnerable, and must work to navigate cultural gaps. With support from the shelter, they make it to appointments on time, have a relatively good experience, and are likely to return. In this way, the centre's services support patient compliance.

Understandably, demand for the centre's services is high. The organization gives over 900 rides each month and, for the last year, the shelter has been continuously full, with many clients booking in advance. Aboriginal people are given priority. When the shelter is full, staff members take an extra step and try to find alternate accommodations for people it cannot accommodate.

A key contributor to the success of the Friendship Centre's activities is the level of coordination, which enables the Centre to provide wrap-around services. It has also proven important to have the "right people" in place, people who have the personality, skills, and ability to make clients feel as comfortable as possible through a typically stressful time.

Research that enhances understanding, capacity, and accountability

The majority of participants in the regional discussions represented organizations that are directly involved in service delivery. While issues came up in the regional discussions that pointed to the need for research in specific areas (such as the need to develop effective ways to measure qualitative outcomes from activities, or the need to develop a process and policy that will enable Aboriginal people to safely self-identify in the intake process), only a few participants referred to research activities in the discussions of practices.

It should be noted, however, that during the period in which the regional discussions took place, the National Aboriginal Health Organization and its affiliates learned that they would no longer receive funding from Health Canada. Concern about the closure of NAHO and the loss of its research capacity was expressed at several of the regional discussions.

Noojimawin Health Authority, profiled in this section, may be unique in Canada. It is a provincially funded agency with a mandate focused on research, knowledge sharing, and planning to support community health programs and services for Aboriginal people. Other Aboriginal organizations have partnered with research centres to develop data and an evidence base for interventions that address the distinct needs of the populations they serve or represent. These include De Dwa Dah Dehs Ney's Aboriginal Health Centre, the Ontario Federation of Indian Friendship Centres, Hamilton Executive Directors' Aboriginal Coalition (partnering with the Centre for Research and Inner City Health at St. Michael's Hospital in Toronto), the Manitoba Métis Federation (partnering with the Manitoba Centre for Health Policy), and the Métis Nation of Alberta (Alberta Health and Wellness, Public Health Agency of Canada, and the University of Alberta School of Public Health in Edmonton). Accreditation Canada, a national, not-for-profit, independent organization that provides health care organizations with an external peer review process to assess and improve the quality of services they provide, has established specific standards in community health and rehabilitation for First Nations, Inuit, and Métis service providers.

Noojimawin Health Authority, Toronto, Ontario

The Noojimawin Health Authority, established in 1997 through the province's Aboriginal Healing and Wellness Strategy, is one of five Aboriginal health planning authorities in Ontario, and the only one that serves both an urban and a rural population (Noojimawin Health Authority, n.d.). Noojimawin's mandate focuses on health planning, health research, data collection and analysis, and communication and information sharing.

Noojimawin's recent projects include a health equity initiative entitled "Enhancing the Health Equity in Health Care Settings: Engagement, Solutions, Policies, and Implementation." This research project was undertaken in partnership with the youth group Equiteam Health Force. Stakeholders included Local Health Integration Networks in the Greater Toronto Area (GTA LHINs), the Toronto Central LHIN Hospital Collaborative on Marginalized Populations, Native Women's Resource Centre, Anishnawbe Health Toronto, and Andayaun Women's Shelter. The project explored Aboriginal people's encounters with racism in health settings, using sharing circles to gather information directly from Aboriginal community members. The project also included a literature and document review. Noojimawin is now in the final reporting stages of this project, but already has been approached by hospitals that participated in the project with requests for cultural competency training.

Other recent projects have included providing guidance on protocols for Aboriginal community engagement for an LHIN that serves a region that includes both an urban centre and a First Nation community; a project that looked at accountability of care and brought together health providers, the LHIN, and Aboriginal community members to explore ways to work together to enhance health outcomes; and the facilitation of cultural competency workshops for LHIN and hospital staff.

Noojimawin has undertaken several activities to build the capacity of Aboriginal youth, including youth on their research team. Noojimawin also secured funding to train youth in facilitation, life skills, and traditional ways. Participants in this program then went out into the community to provide workshops to other youth on issues pertinent to youth today. Over a three-month period, the youth facilitators held over 20 workshops for approximately 150 youth participants.

Our Health Counts Urban Aboriginal Health Database, Centre for Research and Inner City Health (St. Michael's Hospital), De Dwa Dah Dehs Ney>s Aboriginal Health Centre, Ontario Federation of Indian Friendship Centres, and Hamilton Executive Directors' Aboriginal Coalition, Hamilton, Ontario

The Our Health Counts Urban Aboriginal Health Database project was undertaken to fill gaps in Aboriginal health information and to improve understanding of health issues and challenges faced by this population (St. Michael's Hospital, 2011; Smylie, et al., n.d.). Working in partnership with urban First Nations organizations and community members, a research team associated with the Centre for Research on Inner City Health at St. Michael's Hospital in Toronto gathered data on social determinants of health, such as poverty, illness, and income for Hamilton's First Nations population. The study found significant health inequities in the region. Key findings include:

- ▶ First Nations people living in Hamilton experience very high levels of poverty as well as significant challenges in linked social determinants of health, such as housing and food security.
- ▶ First Nations people in Hamilton also experience very high rates of chronic disease and disability. For example, rates of asthma for First Nations children are twice as high as those in the general Canadian population.
- ▶ First Nations people living in Hamilton experience substantial barriers in accessing health care and have much higher rates of admission to emergency (for both acute and non-acute illness) than the general population of Hamilton and Ontario.
- ▶ First Nations people living in Hamilton demonstrate remarkable cultural continuity and resilience.

The researchers used an innovative sampling technique to recruit participants, offering participants who completed interviews cash incentives to recruit additional participants. This process enabled the researchers to connect with community members who might typically be missed, for example, in the census.

The research report from the project calls for increased and meaningful participation (with appropriate resourcing) of urban Aboriginal communities and organizations in the planning, design, delivery, and governance of activities to address critical inequities relating to determinants of health, rates of chronic disease and disability, and access to equitable care and services. The report also recommends the development and expansion of culturally competent and culturally safe health care services, including community-based health centres, programs, and services delivered by Aboriginal people.

In addition to the Hamilton research project, Our Health Counts team members have also undertaken similar studies for the Inuit and Métis populations in Ottawa and will release reports on these research projects.

Profile of Métis Health Status and Healthcare Utilization in Manitoba: A Population-Based Study, Manitoba Centre for Health Policy and Manitoba Métis Federation

The Profile of Métis Health Status and Healthcare Utilization in Manitoba: A Population-Based Study examines population-based indicators of the health status, health care use, and social determinants of health of Métis people in Manitoba (Martens, et al., 2010). The study, undertaken by the Manitoba Centre for Health Policy in collaboration with the Manitoba Métis Federation (MMF), explores whether there are significant differences within the Métis population and between Métis and all other Manitobans at several geographic areas (at the provincial level, by regional health authorities, by larger rural areas, by seven MMF regions, and by 12 Community Areas of Winnipeg). At a provincial level, key findings from the study include:

- ▶ The Métis population is younger than the population of Manitoba as a whole.
- ▶ The prevalence of most chronic disease conditions is greater in the Métis population than in the overall population; the prevalence of mental illness conditions is similar or higher.

- ▶ While some health indicators show that Métis children have similar experiences to other Manitoba children, breastfeeding rates are lower, and teen pregnancy, child injury mortality, and ADHD prevalence are higher.
- ▶ Métis people are more or equally likely to use physician services, but are less likely to have good continuity of care than other Manitobans. Métis people are also more likely to be hospitalized (reflecting an overall poorer health status) and are more likely to access some high profile surgical and diagnostic services.
- ▶ Métis people have higher home care and personal care home use rates than other Manitobans.
- ▶ Prescription drug use in the Métis population is significantly higher than that of other Manitobans.
- ▶ Métis and other Manitobans receive similar quality of care with respect to some important indicators, but a few areas of concern remain, in particular, high rates of prescribing antidepressant medications to older Métis people.
- ▶ While the self-rated health of Métis people is poorer than that of other Manitobans, they report similar levels of life satisfaction, emotional well-being, and self-perceived stress. Métis people have lower consumption of fruits and vegetables, much higher smoking rates, and are more likely to be overweight than other Manitobans, but Métis people have higher total physical activity levels.
- ▶ Education and social service outcomes for Métis people tend to be poorer than that of other Manitobans, and Métis children are twice as likely as other Manitobans to be in families receiving provincial income assistance and are more likely to be under the care of Child and Family Services.

By spotlighting key differences between Métis people and other Manitobans, and providing data that can be disaggregated to regional and community levels, the study supports the development of health plans to address the distinct and localized needs of Métis people in Manitoba (Houlden, 2010). The MMF, regional health authorities, and provincial planners will be able to use these findings to identify where

new policies and programs are needed, and will have an evidence base from which to identify health care successes. The MMF has developed a wellness-oriented holistic process that will be used to interpret study results.

First Nations, Inuit, and Métis Standards, Accreditation Canada

Approximately 50 years ago, Accreditation Canada began developing standards for acute care hospitals. Today, it has standards for services in mental health, community health, rehabilitation, and long-term care. In 1999, Accreditation Canada established specific standards in community health and in rehabilitation (with a focus on addiction rehabilitation) for First Nations, Inuit, and Métis service providers.

To develop and implement accreditation for First Nations-, Inuit-, and Métis-specific standards, the organization worked in partnership with Health Canada and an advisory committee whose members represent organizations across Canada (Accreditation Canada, n.d.). Health Canada approached Accreditation Canada with a request that the organization develop culturally specific standards addressing, for example, holistic care, the role and importance of Elders, traditional and cultural practices, and cultural safety. Participation in the program is voluntary and both Aboriginal and Aboriginal-serving organizations have used the culturally specific standards.

Accreditation Canada's clients report that participation in the program and use of the culturally specific standards have helped their organization reach standards of excellence equal to those anywhere in Canada. This, in turn, increases community members' confidence in the organization's ability to meet their health and wellness needs and, it can be argued, helps people and communities take charge of their health and health needs. Clients also report that the process of accreditation, in and of itself, improved the quality of the services they provide. Accreditation can also help organizations feel "comfortable at the table" with other community health service organizations.



TORONTO

We are all human

The large wolf eyes in the top background of this picture are a symbol of humility, meaning that we all have to face each other with respect in both worlds in an unbalanced society. *We are all human*. The doctor with the funnel in his ear represents the need for the Western health care system to listen to Aboriginal peoples, who are shown as people of four stages of life: a baby, youth, adult, and Elder.

The “no cell phones” image represents a discussion about technology, and how people need to turn it off to reconnect with the wisdom of Elders. The birch bark scrolls, also recognized as Midewiwin Scrolls, are pictographs of the Anishinaabe ways of knowing that have been revered and recorded by our ancient ones.

The “no Band-Aid” image represents a discussion about the fact that there are no Band-Aid solutions to improve health care for Aboriginal peoples. The moccasins were requested by a participant to encourage thoughts of empathy: “Walk a mile in my shoes.”

4. Sustaining and building on positive change

- The final question presented to participants at the regional discussions asked them to consider what needs to be in place to sustain and build upon practices to enhance cultural competency and cultural safety for First Nations, Inuit, and Métis people in urban health systems.

Responses emphasized the important contributions that can be made by all stakeholders in the delivery of health services to First Nations, Inuit, and Métis people. These include:

Front-line staff and health practitioners:

- ▶ Be a champion for cultural competency and cultural safety.
- ▶ Work to enhance your own cultural competency, a process that requires ongoing self-reflection, lifelong readiness to learn, and a willingness to change.
- ▶ Engage with patients, clients, and colleagues in ways that are respectful and caring, that acknowledge and affirm their distinct cultural identities, and that support the development of trust and mutually empowered relationships.
- ▶ Provide patient-centred care that meets patient-identified needs.
- ▶ Look for and create opportunities for partnership and collaboration that will enhance cultural safety for First Nations, Inuit, and Métis people.
- ▶ Record and share successes and lessons learned.

Senior management in urban health systems:

- ▶ Be a champion for cultural competency and cultural safety. Raise awareness both inside and outside your organizations about the value and importance of cultural competency and cultural safety.
- ▶ Work to enhance your own cultural competency and the cultural competency of your organization, a process that requires leadership, a demonstrated commitment, policy instruments, and appropriate allocation of resources.
- ▶ Look for and create opportunities for partnership and collaboration that will increase your organization's capacity to provide culturally competent services and enhance cultural safety for First Nations, Inuit, and Métis people who engage with your organization.

- ▶ Ensure that First Nations, Inuit, and Métis people participate meaningfully in planning, policy-making, advisory and governance activities, and other contexts in which they can influence or make decisions on matters that affect them.
- ▶ Take leadership from First Nations, Inuit, and Métis people and acknowledge their expertise with respect to the identification of their individual and collective needs, capabilities, strengths, and opportunities. Value and acknowledge the knowledge, expertise, and skills of traditional healers, counsellors, teachers, and other traditional knowledge keepers and practitioners.
- ▶ Develop policies and initiatives that will support the recruitment and retention of Aboriginal employees at all levels of your organization.
- ▶ Establish a zero-tolerance approach to stereotyping, discrimination, and racism in your organization. Hire the right people, i.e., people who are respectful and empathetic, and who have the right credentials.

Researchers and program evaluators:

- ▶ Develop methodologies that can be used to assess qualitative outcomes of activities that enhance cultural competency and cultural safety.

Educators:

- ▶ Be a champion for cultural competency and cultural safety.
- ▶ Develop and deliver curriculum that enhances students' cultural competency and their ability to provide culturally safe care to First Nations, Inuit, and Métis people.

Government:

- ▶ Make a public and formal commitment to address disparities between health outcomes for First Nations, Inuit, and Métis people and other Canadians, and take meaningful action to follow through on that commitment.

- ▶ Provide adequate and sustained funding and other resources to support the development, maintenance, and enhancement of activities that support cultural competency and cultural safety.
- ▶ Establish, implement, and enforce policies that support, maintain, and enhance cultural competency and cultural safety, including mandatory cultural competency training within and across all government sectors.
- ▶ Consult and collaborate with First Nations, Inuit, and Métis people to learn firsthand about their needs, capabilities, strengths, and opportunities.
- ▶ Ensure that First Nations, Inuit, and Métis leadership is at the table for planning, policy-making, advisory and governance activities, and other activities in which they might be able to influence or make decisions on matters that affect their community members.

First Nation, Inuit, and Métis leadership:

- ▶ Be a champion for cultural competency and cultural safety.
- ▶ Use collaboration and partnership opportunities to enhance the cultural competency of urban health systems and cultural safety for First Nations, Inuit, and Métis community members using those systems.
- ▶ Demand participation in planning, policy-making, advisory and governance activities, i.e., in any context in which you might be able to influence or make decisions on matters that affect your communities and community members.



Freedom

In the middle of this image is Skywoman, who is part of the Creation Story of Haundenosaunee Nations (Iroquoian peoples/Six Nations). The green background is part of this creation theme, which represents our Mother Earth. Blue is also another woman's symbol for water, which is depicted inside Skywoman's arms.

The three stars represent the cultural importance of the Three Sisters, (corn, squash, and beans). A participant requested the image of a baby with a cradle board (just above the turtle) to show the importance of providing support to young children, one of the topics discussed at the session. On the left is an Inuit woman and her baby, in honour of the Inuit participants at the session. The image of the city represents the focus on urban health care for Aboriginal people.

Appendix A: List of practices identified by participants

Below is a list of all practices or organizations identified by participants in the Health Council's regional discussions. A selection of practices are available on the Health Council of Canada's Health Innovation Portal at healthcouncilcanada.ca/innovation.

Canada

- ▶ Aboriginal Health Human Resource Initiative, Health Canada
- ▶ Aboriginal Health Transition Fund and Health Services Integration Fund, Health Canada
- ▶ Collaboration with First Nations, Inuit, and Métis Peoples, Canadian Partnership Against Cancer
- ▶ Core Competencies Framework, Indigenous Physicians Association, and Association of Faculties of Medicine of Canada
- ▶ Guide for Health Professionals Working with Aboriginal Peoples, Society of Obstetricians and Gynaecologists of Canada
- ▶ First Nations, Inuit, and Métis Program, Saint Elizabeth Health Care
- ▶ Cultural Awareness training, Nechi Training, Research and Health Promotions Institute
- ▶ Elbow River Healing Lodge, Sheldon M. Chumir Health Centre, Calgary
- ▶ Holistic Approach to Health and Wellness, Native Counselling Services of Alberta
- ▶ Improving Access to Health Services for First Nations People, Maskwacis Health Services and the David Thompson Health Region, Hobbema
- ▶ Integrated Mental Health and Addiction Services, Community Wellness, Bigstone Cree Nation Health Commission, Wabasca
- ▶ New in Town Aboriginal Welcome Services, Bent Arrow Traditional Healing Services, Edmonton
- ▶ Northern Alberta HIV Program, University of Alberta Hospital, Edmonton
- ▶ Poundmaker's Lodge Treatment Centres, Edmonton

Alberta

- ▶ Aboriginal Health Careers Bursary program
- ▶ Aboriginal Health Program, Alberta Health Services
- ▶ Aboriginal Liaisons (various locations), Alberta Health Services
- ▶ Aboriginal Services, Canadian Paraplegic Association (Alberta)
- ▶ Alberta Aboriginal Diabetes Wellness Program, Alberta Health Services
- ▶ Calgary Urban Project Society (CUPS) Health and Education Centres
- ▶ Community Health Representatives (various locations), First Nation communities

British Columbia

- ▶ Aboriginal Doula Initiative
- ▶ Aboriginal Health, Vancouver Coastal Health
- ▶ Aboriginal Liaison and Cultural Competency Training, Fraser Health Authority
- ▶ Aboriginal Liaison Nurse and Peer Navigators, St. Paul's Hospital, Vancouver
- ▶ Changes to organizational culture and workplace support for cultural competency, Interior Health
- ▶ Downtown Eastside Aboriginal Health Improvement Committee, Vancouver
- ▶ First Nations Health Authority
- ▶ Harm Reduction Activities, Portland Housing Society Community Services Society
- ▶ Hul'qumi'num' Health Hub, Duncan

British Columbia (continued)

- ▶ Indigenous Cultural Competency Online Training Program, Provincial Health Services Authority
- ▶ Kackaamin Family Development Centre, Port Alberni
- ▶ Nuu-chah-nulth Tribal Council Nursing Program, Tseshah First Nation
- ▶ Qul-Aun Program, Tsow-Tun Le Lum Society Substance and Abuse Treatment Centre, Lantzville
- ▶ SheWay pregnancy outreach program, Vancouver
- ▶ Ts'ewulhtun Health Centre, Cowichan Tribes, Duncan
- ▶ Workshop on impacts of intergenerational trauma on brain development, Centre for Counselling and Community Safety, New Westminster

Manitoba

- ▶ Aboriginal Healing and Wellness Partnership, Brandon Friendship Centre and Brandon Regional Health Authority
- ▶ Aboriginal Health and Wellness Centre, Winnipeg
- ▶ Aboriginal Health Programs, Winnipeg Regional Health Authority
- ▶ Aboriginal Health Services, Regional Health Authority Central
- ▶ Dream Catchers, Klinik, Winnipeg
- ▶ Recruitment and retention of Aboriginal employees, Brandon RHA
- ▶ First Nations Patient Wait Time Guarantee Pilot Project, Saint Elizabeth and Assembly of Manitoba Chiefs
- ▶ Standards in Performance Management Framework, Assembly of Manitoba Chiefs
- ▶ White Wolf Speaking, Sexuality Education Resource Centre, Winnipeg

New Brunswick

- ▶ Aboriginal Nursing Initiative, University of New Brunswick and Mi'kmaq-Maliseet Institute
- ▶ Activities to Build Cultural Competency, New Brunswick Department of Health
- ▶ Process for Aboriginal Self-identification, Miramichi Regional Hospital

Newfoundland and Labrador

- ▶ Aboriginal Patient Navigator Program and Shanawdithit Shelter, St. John's Native Friendship Centre
- ▶ Miawpukek First Nation Conne River Health and Social Services, Conne River
- ▶ Supports to Aboriginal students in health-related programs, Memorial University, St. John's
- ▶ Land-Based Family Treatment Program, Sheshatshiu Innu First Nation

Nova Scotia

- ▶ Strengthening Diversity, Inclusion and Cultural Competency, IWK Health Centre, Halifax
- ▶ Transforming How We Deliver Care: Building Cultural Safety in the Health Care System, Nova Scotia Department of Health and Wellness, Native Council of Nova Scotia; Confederacy of Mainland Mi'kmaq; Union of Nova Scotia Indians; Atlantic Policy Congress of First Nations Chiefs; and IWK Health Centre

Ontario

- ▶ Aboriginal Cultural Safety Initiative, Anishnawbe Health, Toronto
- ▶ Aboriginal Health Policy and Aboriginal Healing and Wellness Strategy, Province of Ontario
- ▶ Aboriginal Patient Navigator, Cancer Care Ontario and Juravinski Cancer Centre, Hamilton
- ▶ Anishnawbe Health Toronto
- ▶ Changes to Electronic Medical Records, Association of Community Health Centres

- ▶ Chronic Disease Surveillance Project, Métis Nation of Ontario
- ▶ Cultural Competency Initiative, Toronto Central Local Health Integration Network, Ontario Federation of Indian Friendship Centres, and Anishnawbe Health Toronto
- ▶ Cultural competency training for employees, Ontario Breast Screening Program
- ▶ Culturally enriched programs and services, Ontario Native Women's Association
- ▶ De dwa da dehs nye>s Aboriginal Health Centre, Hamilton and Brantford
- ▶ First Nations, Inuit, and Métis Standards, Accreditation Canada
- ▶ Interpreter Services, Cree Patient Services
- ▶ Meno Ya Win Health Centre, Sioux Lookout
- ▶ Misiway Milopemahtesewin Community Health Centre, Timmins
- ▶ Noojimawin Health Authority
- ▶ Nursing services for remote communities, Nishnawbe Aski Nation
- ▶ Ontario Aboriginal Health Advocacy Initiative, Ontario Federation of Indian Friendship Centres
- ▶ Ottawa Health Services Network Inc.
- ▶ Palliative care for First Nations community members, Treaty 3 Grand Council and Lakehead University
- ▶ Toronto Central Community Care Access Centre
- ▶ Traditional Healing Program, Southwest Ontario Aboriginal Health Access Centre, London and Muncey
- ▶ Tungasuvvingat Inuit Family Health Team Medical Centre, Ottawa
- ▶ Wabano Centre for Aboriginal Health, Ottawa
- ▶ 21-Day Treatment Cycle, Aboriginal Service, Centre for Addiction and Mental Health, Toronto

Quebec

- ▶ Adapter nos interventions à la réalité autochtone, First Nations of Quebec and Labrador Health and Social Services Commission
- ▶ Clinique Minowé, Val-d'Or Native Friendship Centre
- ▶ In-community internships, McGill Medical School
- ▶ Model for culturally competent care, Kahnawake Shakotia'takenhas Community Services, Kahnawake
- ▶ Diabetes Prevention Project, Centre d'amitié autochtone de la Tuque
- ▶ First Nations and Inuit Suicide Prevention Association of Quebec and Labrador, Montreal
- ▶ Montreal Urban Aboriginal Health Committee
- ▶ Post-Secondary Training to Support the Development of Early Childhood Prevention Services, First Nations of Quebec and Labrador Health and Social Services Commission
- ▶ Support to clients needing medical services, Native Women's Shelter, Montreal

Saskatchewan

- ▶ Aboriginal Health Curriculum, College of Medicine, University of Saskatchewan
- ▶ Aboriginal Home Care Project, Regina Qu'Appelle Health Region
- ▶ Addictions counsellors in public high schools, Prince Albert Regional Health Authority
- ▶ All Nations Healing Hospital, Fort Qu'Appelle
- ▶ Building Health Equity Project, Our Neighbourhood Health Centre, Saskatoon Health Region
- ▶ Eagle Moon Health Office, Regina Qu'Appelle Health Region
- ▶ Four Directions Community Health Centre, Regina Qu'Appelle Health Region
- ▶ Inclusion of Aboriginal history and issues in mandatory curriculum for K-12 schools



Peace

The brown in this image represents being rooted, an important aspect for the Mi'kmaq people who are becoming re-rooted toward rebuilding their culture. The Eagle at the top represents vision, foresight, and taking care of people who the Eagle loves, while the wolf represents the importance of humility.

People came from various Atlantic provinces to participate in the St. John's sessions. The involvement of Inuit people is represented through the Inukshuk and the Ulu, an Inuit woman's knife, shown here as a large semicircle in the middle of the picture. One participant from New Brunswick asked to add fiddleheads, an important element used for medicine.

Many people came up and asked for images from their business cards to be incorporated into the picture to illustrate joining and working together towards a balanced holistic health care system. This was a positive theme throughout the session.

Saskatchewan (continued)

- ▶ Medical Training Program, Northern Medical Services, University of Saskatchewan
- ▶ Memorandum of Understanding for Improved Health and Well-Being for Aboriginal People Served by the Saskatoon Health Region, Saskatoon Regional Health Authority, and the Aboriginal Health Council
- ▶ Memorandum of Understanding on First Nations Health and Well-Being in Saskatchewan
- ▶ Northern Labour Market Strategy, Aboriginal Health Human Resources Initiative
- ▶ Prioritizing relationships with First Nations communities, Prairie North Regional Health Authority
- ▶ Step into Health Careers program
- ▶ Westside Clinic, Saskatoon Health Region

Yukon

- ▶ Cultural Orientation Protocols Toolkit, First Nations Health and Social Development Commission
- ▶ First Nations Health Programs, Whitehorse General Hospital

Concepts and Tools

- ▶ Intercultural Development Inventory, used for self-assessment
- ▶ Métis Life Promotion Framework, Dr. Judith Bartlett
- ▶ Social Return on Investment template, which supports both social and business sides of activities
- ▶ Transtheoretical Model of Change (Prochaska & DiClemente), used in mental health and addictions
- ▶ Two-Eyed Seeing (Etuaptmumk) Teaching, Elder Albert Marshall, the practice of simultaneously drawing on both Indigenous and Western knowledges and ways of knowing

Appendix B: References

The descriptions of practices presented in this document are based on information provided by participants in the regional discussions. To ensure accuracy, many of the descriptions also incorporate information found in internal documents provided by participants, as well as the websites of organizations involved in the practices. These supplementary sources are listed below.

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