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# Cultural Competence and Cultural Safety in First Nations, Inuit and Métis Nursing Education: An Integrated Review of the Literature

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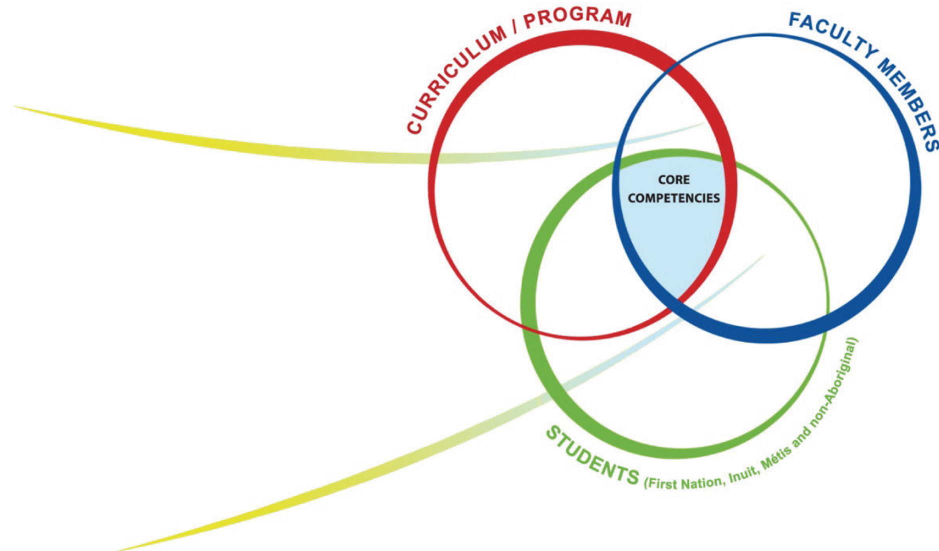


# Cultural Competence and Cultural Safety in First Nations, Inuit and Métis Nursing Education

## An Integrated Review of the Literature

Aboriginal Nurses Association of Canada

Canadian Association of Schools of Nursing

Canadian Nurses Association

**Cultural Competence & Cultural Safety in First Nations, Inuit and Métis Nursing Education AN INTEGRATED REVIEW OF THE LITERATURE**

***Making it Happen:***
***Strengthening First Nation, Inuit and Métis Health Human Resources***

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## *Executive Summary*

There is a pressing and moral need to redress the health, economic, and social inequities experienced by the First Nations, Inuit and Métis people of Canada. Education is integral to the future of Canada's Aboriginal people. Nursing has the opportunity to actively educate First Nations, Inuit and Métis students at the baccalaureate, master's and doctoral levels. Ensuring safe passage through these programs entails, in part, the inclusion of indigenous worldviews, academic and personal supports for students, and curricula which foster competence among Aboriginal and non-Aboriginal graduates in the provision of care to Aboriginal peoples.

The First Nations, Inuit and Métis youth population is a significant and potential human resource to address the national and global nursing shortage. Unfortunately, Aboriginal youth remain mostly marginalized from nursing programs in Canada. Increasing their numbers is the first challenge for nursing education; beyond admissions, retaining First Nation, Inuit and Métis students warrant action. There is at present sufficient evidence for *best practices* regarding the education of First Nation, Inuit, and Métis nursing students. Programs adopting these best practices not only foster success among Aboriginal students, but create safe learning environments for all nursing students. Moreover, graduates of these programs are educated in the provision of culturally safe care to the Aboriginal peoples of Canada.

The purpose of this document is to address these nursing education challenges by integrating the literature and consequently developing a best practice framework. This framework will assist educators to foster cultural competence and safety among students and particularly in relation to First Nations, Inuit and Métis contexts.

The Aboriginal Nurses Association of Canada (A.N.A.C.) in partnership with the Canadian Association of Schools of Nursing (CASN), and the Canadian Nurses Association (CNA) are working to strengthen First Nation, Inuit and Métis health human resources in Canada. Funding for the development of this document and the subsequent nursing education framework is provided by the Aboriginal Health Human Resources Initiative (AHHRI) of Health Canada.

**Evidence of the Need for Cultural Competence Framework in Nursing Education**

The evidence of the need for cultural competence in nursing education--as it relates to First Nation, Inuit and Métis students—is presented to provide context in which to situate the cultural competency framework. The areas covered are: colonization; health disparities; health inequities; diversity of First Nations, Inuit and Métis people; historic trauma transmission; nursing education and potential First Nation, Inuit and Métis student candidates; number of Aboriginal nursing students in Canada; and, nursing education and First Nation, Inuit and Métis students. Best practices are listed at the end of each topic area. As an example, a briefing on the "Diversity of First Nations, Inuit and Métis and Health" is presented as follows:

> Statistical data about Aboriginal populations provides insightful information to reducing both the inequities and the disparities of health; however, the interpretation of this information requires a cautionary note. Cultural, historical, linguistic and social contexts

among and between First Nations, Inuit and Métis are unique. Additional factors, and according to population health are key determinants of health, can serve as guides to develop understandings about the diversity of Aboriginal people and their health. In other words, the ability to effectively reduce both the inequities and the disparities of health requires being cognizant of the "very real" cultural and social barriers which may exist between First Nation, Inuit and Métis individuals and health service providers in communities and urban centres.

- Nursing students, both Aboriginal and non-Aboriginal, must understand:

  i. That unique histories, cultures, languages, and social circumstances are manifested in the diversity of First Nation, Métis, and Inuit peoples, and;

  ii. That Aboriginal peoples will not access a health care system (and its practitioners) when they do not feel safe doing so—and where encountering the health care system places them at risk for cultural harm.

## Guiding Principles

These guiding principles are meant to enhance nursing curricula as they originate from the perspective of the First Nation, Inuit and Métis communities[1]. Emphasis is placed on: the need for respecting Aboriginal students for who they are; programming and curriculum content that is *relevant* to their view of the world; *reciprocity* in their relationship with others, and; assisting students to exercise *responsibility* over their own lives.

## Concepts

A number of concepts are described and these include: culture, cultural awareness, cultural sensitivity, and cultural competence. With the exception of the concept of culture, the strengths and limitations of these concepts are included. *Cultural safety* takes us beyond cultural awareness, the acknowledgement of difference; cultural sensitivity, the recognition of the importance of respecting difference; and, cultural competence, which focuses on skills, knowledge, and attitudes of practitioners.

Cultural safety is predicted on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes. Addressing inequities, through the lens of cultural safety, enables care providers to:

- Improve health care access for clients or individuals, aggregates, and populations;
- Acknowledge that we are all bearers of culture;
- Expose the social, political, and historical contexts of health care;
- Enable practitioners to consider difficult concepts such as racism, discrimination, and prejudice;

---

[1] This terminology is to be understood in the broadest context and encompasses all communities where Aboriginal People live, be it urban, rural or within traditional territories.

- Understand that cultural safety is determined by those to whom nurses provide care;
- Understand the limitations of "culture" in terms of having people access and safely move through health care systems and encounters with care providers; and,
- Challenge unequal power relations.

Culture is more than beliefs, practices, and values, and nursing curricula need to assist nursing students to understand the limitations of essentialist view of culture. Students require assistance to develop a constructivist understanding of culture. Awareness, sensitivity, and competence provide students and faculty with a beginning place in which to develop an appreciation of the complexity of "culture." Cultural safety presents opportunities in which unequal power relations are exposed and managed. Cultural safety is action orientated and is in alignment with the advocacy role of nurses and the nursing profession.

According to the National Aboriginal Health Organization (2008), the need for culturally safe care for First Nations, Inuit and Métis people is matched by the need for *culturally safe learning* to improve educational outcomes for Aboriginal students.

> Developing culturally safe learning environments benefit students, educators, educational institutions, and education systems. Students are more likely to respond positively to the learning encounter when they feel safe, respected and able to voice their perspective. An educator is more likely to experience more job satisfaction when attendance is better, when the quality of scholarship is good, and when the classroom is an environment of equal engagement between different ways of knowing. This comes from an educator creating a culturally safe learning environment and delivering culturally safe curriculum. High retention rates of an Aboriginal population can be interpreted as a reflection of an educational institute's commitment to such an environment, as well as their commitment to human rights and race relations. Such institutions produce more graduates, which attracts more students and thereby increases enrolment.

The Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada have endorsed cultural safety in the document, *First Nations, Inuit, Métis Health Core Competencies. A Curriculum Framework for Undergraduate Medical Education.*

## INTRODUCTION

There is a pressing and moral need to redress the health, economic, and social inequities experienced by the First Nations, Inuit and Métis of Canada. Education is integral to the future of Canada's Aboriginal people. Nursing has the opportunity to actively educate First Nation, Inuit and Métis nursing students at the baccalaureate, master's and doctoral levels. Ensuring safe passage through these programs entails, in part, the inclusion of indigenous worldviews, academic and personal supports for students, and curricula which foster competence among Aboriginal and non-Aboriginal graduates in the provision of care to Aboriginal peoples.

The First Nations, Inuit and Métis youth population is a significant and potential human resource to address the national and global nursing shortage. Unfortunately, Aboriginal youth remain mostly marginalized from nursing programs in Canada. Increasing their numbers is the first challenge for nursing education; beyond admissions, retaining First Nation, Inuit and Métis students warrant action. There is at present sufficient evidence for *best practices* regarding the education of First Nation, Inuit, and Métis nursing students. Programs adopting these best practices not only foster success among Aboriginal students, but create safe learning environments for all nursing students. Moreover, graduates of these programs are educated in the provision of culturally safe care to the Aboriginal peoples of Canada.

The purpose of this document is to address these nursing education challenges by integrating the literature and consequently developing a best practice framework. This framework will assist educators to foster cultural competence and safety among students and particularly in relation to First Nations, Inuit and Métis contexts.

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### Background

In 1996, the Report of the Royal Commission on Aboriginal Peoples proposed that postsecondary educational institutions, including nursing education programs, collaborate with Aboriginal organizations ( i.e. , A.N.A.C.) to examine how they could (i) increase the number of Aboriginal students participating in and graduating from their programs; and (ii) modify program curricula leading to registration so as to increase the cultural appropriateness and effectiveness of training to Aboriginal and non-Aboriginal students who will be providing services to Aboriginal people.

The Aboriginal Nurses Association of Canada (Chabot, 2006) articulated a number of recommendations regarding the development of cultural competency in Aboriginal nursing education. Also A.N.A.C. developed a discussion paper to advance the development of an Aboriginal Health Nursing project with the guidance of the Aboriginal Health Nursing Steering Committee (Stout, 2006). In order to advance Aboriginal Health Nursing as a specialty, this document recommenced that cultural competency, cultural safety, and traditional knowledge be incorporated into nursing curricula. Nursing graduates would then be prepared to provide culturally safe care to Aboriginal peoples and other ethno-cultural groups.

## EVIDENCE OF THE NEED FOR CULTURAL COMPETENCE FRAMEWORK IN NURSING EDUCATION

The evidence of the need for cultural competence in nursing education--as it relates to First Nation, Inuit and Métis students--provides context in which to situate the cultural competency framework. In this section, colonization; health disparities; health inequities; diversity of First Nations, Inuit and Métis people; historic trauma transmission; nursing education and potential First Nation, Inuit and Métis student candidates; number of Aboriginal nursing students in Canada; and, nursing education and First Nation, Inuit and Métis students will be presented.

### Colonization

Colonization did not begin at the point of original contact between the Europeans and First Peoples. The newcomers came to a continent that was already inhabited by diverse nations of First Peoples who formed alliances with one another to access and distribute their tribal resources. The First Peoples had their own economic, health, political, and social systems that were developed within their communities according to their traditions and the need imposed by their environments. The initial relationship between the First Peoples and the French and English in Canada, was one of mutual tolerance and respect: The social, cultural, and political differences between these societies were maintained (Dickason, 1994).

The Royal Proclamation of 1763 demonstrates the partnership between First Nations and the British Crown as one of cooperation and protection. In exchange for cooperation in the partnership that characterized the relationship between them at the time, the King of England extended royal protection to the First Peoples' lands and political autonomy. This legislation formed the basis for dealing with First Peoples as nations when Canada was formed in 1867. Additional alliances with the newcomers were created in the form of Treaties which were mutually binding obligations between two or more nations of people. The Treaties demonstrate the unique relationship between the First Nations in Canada and the Crown (the government of

Canada representing Queen of England); no other population in Canada has this status—historical or contemporary.

Colonization became another phase of a relationship between the First Nations and the Government of Canada. Driven by a worldview that embraces dominion, self-righteousness, and greed, colonization affects all aspects of Aboriginal peoples' lives at the nation, community, family and individual levels (Hart, 2005). Colonization was formidable to the Indigenous way of life: First Nations economic and political systems were destroyed; worldviews were trivialized; overt expressions of cultures, such as spiritual ceremonies were desecrated, degraded and labelled as devil worshipping; and, feasts, give-aways, singing and dancing were deemed sinful. The First Peoples' connection to the land was considered an expression of their primitiveness.

Cultural oppression coupled with colonial action destroyed long-standing indigenous education, health and judicial systems. According to Tobias (1991), the Indian Act was the legislative vehicle for implementing policies to civilize, protect, and assimilate First Nations people. Cooperative learning, now acknowledged as being important to education, was ignored or seen as inferior and were replaced by industrial and residential schools.

Approximately one hundred residential schools operated in Canada from 1849 to 1983 (Smylie, 2000). Indian Act legislation in 1920 made school attendance compulsory for all First Nation children where children were removed, sometimes forcefully, from their homes, families, culture, and language between the ages of seven and 15. Inuit and Métis children were not exempt from attending residential schools in Canada.[2] Smylie also reminds us that accelerated removal of Aboriginal children into the twentieth century occurred with the "Sixties Scoop."

The *Sixties Scoop* was precipitated as result of amendments to the Indian Act in the 1950s which guaranteed federal funding for each Aboriginal child apprehended by child protection agencies. These amendments resulted in a ballooning in the number of First Nation children who were taken into care and made legal wards of the state. In a presentation, Wieman related (as cited in Smylie, 2000) the percentage of apprehended Aboriginal children dramatically increased from one per cent in 1959 to between 30 and 40 per cent in the 1960s. Aboriginal children continue to make up a disproportionate percentage of the apprehended children by social service agencies. Many of the parents of these children are themselves survivors of residential schools.

With colonization, Canada's First Peoples were exposed to new diseases and forced to live less healthy lifestyles (Clarke, 2007). These negative results continue to be played out in many ways in First Nations, Inuit and Métis communities. Now decolonization is occurring where First Nations, Inuit and Métis people in urban, rural and northern communities are at various degrees in the transition to decolonization (Hart, 2005).

[2] In all about 150,000 First Nations, Inuit and Métis children were removed from their communities and forced to attend the schools. Retrieved January 19, 2009 from http://www.cbc.ca/canada/story/2008/05/16/f-faqs-residential-schools.html

The focus has been on Indigenous people and how they have been affected by colonization and what they need to do in the decolonization process. However, according to Hart, since colonization and decolonization are about relationships between Indigenous and non-Indigenous people, non-Indigenous people also need to be included in the dialogue and subsequent actions.

The Aboriginal Nurses Association of Canada (2001) relates the following Cree concept to describe the effects of colonization on First Nation, Inuit and Métis peoples: *kitimakisowin* or poverty "of all kinds and to the pathologies they bring about if unresolved." Five areas of *kitimakisowin* include:

i. The poverty of participation because of marginalization.

ii. The poverty of understanding arising from poor education.

iii. The poverty of affection resulting from lack of support and recognition.

iv. The poverty of subsistence in light of inadequate resources.

v. The poverty of identity given the imposition of alien values, beliefs and systems on local and regional cultures.

First Nation, Inuit and Métis nursing students bring their living contexts and histories of colonization to the educational setting. The student is vulnerable to *kitimakisowin* as she or he enters into power imbalance relationships within the nursing educational system. The challenge for nursing education is to provide learning situations that create power and relationship balance between the student and individual teacher, curricula, and nursing faculty.

- Nursing students, both Aboriginal and non-Aboriginal, must understand:

  i. The historical impact of colonialism on the First Nation, Inuit, and Métis peoples;

  ii. How the contemporary lives of the First Nation, Inuit and Métis peoples have been duly affected by colonialism;

  iii. The suffering inflicted on First Nations, Inuit, and Métis as a consequence of Canadian laws; and,

  iv. That the signing of the treaties and land claims established a unique "place" for First Nation, Inuit and Métis peoples within the ethno-cultural and political landscapes within Canada.

**Health Disparities**

The consequences of health disparities are most pronounced for First Nations, Inuit and Métis in Canada according to the Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security (2004). Adelson (2005) describes health disparities as those indicators of a relative disproportionate burden of disease on a particular population. The Health Disparities Task Group explains health disparities as not simply a *have-have not* issue: A gradient exists where there are differences in risk factors and risk conditions, health status, incidence of disease and mortality across a wide range of physical and mental disorders. The most important consequences of health disparities are avoidable death, disease, disability, distress and discomfort.

The Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security identified the following health disparities as they affect First Nations, Inuit and Métis populations in Canada:

i. All men in Canada (as a whole) live 7 years longer than First Nation men; all women in Canada (as a whole) live 5 years longer than First Nation women.

ii. The death rate from injury among Aboriginal infants is 4 times the rate for Canada as a whole. Among Aboriginal preschoolers and among Aboriginal teenagers, the death rate is 5 times and 3 times the national rate respectively.

iii. Of Canadians in the lowest income quintile,[3] 47 per cent report their health as excellent or very good compared with 73 per cent in the top quintile. People in the lowest quintile are five times more likely to rate their health as fair or poor than people in the highest quintile. Aboriginal peoples are twice more likely to report fair or poor health status than non-Aboriginal peoples with the same income levels.

iv. Middle and low-income Aboriginal peoples have more chronic conditions than non-Aboriginal peoples with the same income levels. Higher education, and what it affords people, is protective against chronic conditions.

v. People living in Canada's northern remote communities have the lowest disability-free life expectancy and lowest life expectancy in the country. Their rates of smoking, obesity and heavy drinking are above Canadian averages.

[3] In statistics, quintile is defined as one of the values that divide a frequency distribution into five parts, each containing a fifth of the sample population. Retrieved January 19, 2008, from http://encarta.msn.com/dictionary_1861698410/qunitle.html?partner=orp

vi. Some 10 per cent of Canadian households (3 million people) experience food insecurity each year. Prevalence is greatest among those who rely on social assistance, lone mothers with children, Aboriginal people and Canadians who live in remote communities. Food insecurity is associated with increased odds of poor or fair self-rated health, multiple chronic conditions, distress and depression.

In addition to socio-economic status, gender, Aboriginal status, and geographic location, other factors contribute to health disparities and these include distribution, accessibility and quality of health care services, and community characteristics. Consider, for example, suicide rates in Aboriginal communities are lower where important governance and cultural continuity factors are present. Youth suicide rates are lower where the following six attributes are present: land claims, self-government, educational services, health services, police and fire services, and cultural facilities (Chandler and Lalonde, 1998). It is noteworthy that youth suicide rates are high where only one or two of these attributes are present.

While the Canadian suicide rate is dropping, the Inuit rates are rising (Ajunnginiq Centre, 2006). The Canadian rate had fallen from 16.5 suicides for every 100,000 people in 1980, to 14.0 for each 100,000 in 1998. In what is now Nunavut, the 1989 to1993 rate was 79 cases in 100,000, but had risen to 119.7 cases for the years 1999-2003. According to a Health Canada document on suicide prevention, suicide rates among Inuit youth are among the highest in the world.

Furthermore, despite higher overall use of health services, availability of fully insured Medicare services, large increases in health care spending, health disparities among Aboriginal populations exist. As such, it is important to evaluate accessibility and effectiveness of health care to those in poorest health.

- Nursing students, both Aboriginal and non-Aboriginal, must understand:
  i. The health determinants affecting First Nation, Inuit, and Métis peoples;
  ii. Socio-cultural and political factors that are health-protective and those factors that undermine the health of Aboriginal peoples and place them a risk for morbidity and mortality, and;
  iii. The “place” of traditional teachings and the role of Elders, the grandmothers and grandfathers, in promoting the health of Aboriginal peoples.

**Health Inequities**

Health inequities point to the underlying causes of the disparities where many, if not most, are situated primarily outside the arena of health (Adelson, 2005).[4] For example, inadequate, and overcrowded housing has led to high rates of respiratory illnesses and violence in Inuit communities. Canadian Institute for Health Information state that tuberculosis rates in Inuit communities are 70 times the Canadian average.[5]

Among Métis women, access to health care is a challenge (Women of Métis Nation, 2007). About 11per cent of Métis women indicated that when they needed some form of healthcare, they did not receive the care required. Lack of income has a role in accessing this care. In addition, when health services are utilized, they are considered to be pan-Aboriginal in nature and are not designed to meet the unique needs and realities of Métis women.

Additional determinants of health Métis women identified as affecting their health included: social environments; social programming and supports; education; culture; employment and working conditions; physical environmental health; the protection of traditional practices, including intellectual property rights; health research and the lack of a Métis identifier; healthy child development; health services; and Métis women's health and identifying specifics in relation to Métis women. The health system is another key determinant of population health. If health care, and public health programs and services do not include a focus on the needs of disadvantaged individuals, populations and communities, there is a risk of increasing rather than reducing health disparities.

- Nursing students, both Aboriginal and non-Aboriginal, must understand:
    i. The barriers faced by First Nations, Inuit, and Métis that contribute to health inequities;
    ii. How post-colonial theory accounts for health disparities and health inequities among Aboriginal peoples;
    iii. How contemporary health inequities for Aboriginal peoples have been precipitated by colonialism, and;
    iv. How basic human rights (adequate housing, employment) are "out of reach" for many, if not most Aboriginal peoples.

[4] The term, 'health inequities' is used internationally to refer to differences in health status. However, Kawachie, Subramanian and Aleda-Filho (as cited in Health Disparities Task Group of the Federal/Provincial/Territorial Advisory Committee on Population Health and Health Security, 2004) state that health inequity refers to those inequalities in health that are deemed to be unfair or stemming from some form of injustice. Kawachie et al. also explain the distinction between equality and equity and how this is determined.
[5] This was retrieved from the Inuit Tuttarvingat website April 19, 2009 from http://www.naho.ca/inuit/e/overview

## Diversity of First Nation, Inuit and Métis Peoples

Statistical data about Aboriginal populations provides insightful information to reducing both the inequities and the disparities of health; however, the interpretation of this information requires a cautionary note (Adelson, 2005). Cultural, historical, linguistic and social contexts among and between First Nations, Inuit and Métis are unique. Additional factors, and according to population health these are key determinants of health, can serve as guides to develop understandings about the diversity of Aboriginal people and their health.

In other words, statistical interpretation needs to examine differences within and between age groups, genders, levels of socio-economic status, education and other significant markers of both identity and inequity. Adelson suggests that these interpretations need to be broad enough "to navigate the terrain between individuals and communities and include studies of housing, water, education, development and resource extraction, different social and cultural valuations of health and empowerment (p. 45)." The ability to effectively reduce both the inequities and the disparities of health requires being cognizant of the "very real" cultural and social barriers which may exist between First Nations, Inuit and Métis individuals and health service providers in communities and urban centres.

- Nursing students, both Aboriginal and non-Aboriginal, must understand:

    i. That unique histories, cultures, languages, and social circumstances are manifested in the diversity of First Nation, Inuit and Métis peoples, and;

    ii. That Aboriginal peoples will not access a health care system (and its practitioners) when they do not feel safe doing so—and where encountering the health care system places them at risk for cultural harm.

## Historic Trauma Transmission

The effect of trauma passed from one generation to the next is now understood as one of the causes of social problems among First Nations, Inuit and Métis (Clarke, 2007). People who have been traumatized pass the effect of trauma on through their parenting. Trauma victims do not have the skills to parent; it is not because they lack the desire or interest in doing so. Wesley-Esquimaux and Smolewski (2004), explain the etiology of historic trauma transmission (HTT) in a new model they developed to better understand the social and cultural diffusion that has devastated Aboriginal communities for many years. In this model, they describe historic trauma as a cluster of traumatic events and as a causal factor operating in many different points of impact; it is not a disease itself.

> Hidden collective memories, or a collective non-remembering, of this trauma are passed from generation to generation. There is no single historical trauma response; rather, there are different social disorders with respective clusters of symptoms. *Social disorders* are repetitive maladaptive social patterns, such as post-traumatic stress disorder that occur in a group of people and are associated with a significantly increased risk of suffering. A *symptom* is a manifestation of maladaptive social patterns such as suicide, domestic violence, sexual abuse, and interpersonal maladjustment. Symptoms are not caused by the trauma itself. Rather, historic trauma disrupts adaptive social and cultural patterns changing them into maladaptive ones that manifest themselves in symptoms. In short, historic trauma causes deep breakdown in social functioning that may last for many years, decades or even generations. Symptoms that parents exhibit (family violence, sexual abuse) act as a trauma and disrupt adaptive social adjustments in their children. In turn, these children internalize the symptoms and, much like catching a 'trauma virus,' fall ill to one of the social disorders. In the next generation, the process perpetuates itself and the trauma, a relentless causal agent continues.

Historic trauma transmission can be compared to a widespread and complex form of post-traumatic stress disorder. The results of HTT are also expressed in addictions, disease and illnesses, violence, and other aspects of un-wellness that are physical, social, spiritual, and mental in nature (Clarke, 2007). According to the Aboriginal Healing Foundation (1999), intergenerational or multigenerational trauma happens when the effects of trauma are not resolved in one generation. When trauma is ignored and there is no support for dealing with it, the trauma will be passed from one generation to the next. Children learn what they see as "normal" behaviour and pass this on to their children. Children who learn that physical and sexual abuse is "normal", and who have never dealt with the feelings that come from this, may inflict physical and sexual abuse on their children. The unhealthy ways of behaving that people use to protect themselves can be passed on to children, without them even knowing they are doing so.

- Nursing students, both Aboriginal and non-Aboriginal, must understand:
    i. The effect of historic trauma transmission (HTT) on the health and well-being of First Nations, Inuit, and Métispeople, and;
    ii. That Aboriginal peoples have, individual and collective, historical and contemporary, strengths to counter the impact of HTT.

**Nursing Education and Potential First Nation, Inuit and Métis Nursing Student Candidates**

A vital part of Canada's future lies in maximizing the lives and opportunities of the First Nations, Inuit and Métis people. *Toward 2020: Visions for Nursing* describes the future demographics for Canada as having a youthful Aboriginal population and a growing, racially diverse population. It is forecasted that by 2017, one in 25 Canadians will be Aboriginal. Furthermore, in 2020, the Aboriginal population in Canada will be larger and more influential than at any point in history.

Provinces like Manitoba and Saskatchewan are predicted to have ever-increasing numbers of First Nations and Métis people.[6] For example, in 1996, 11 per cent of Saskatchewan's population was Aboriginal and it is expected that by 2020 the First Nation population will increase to 20 per cent. Approximately 25 per cent of youth (ages 15 to 24 years) in Saskatchewan are Aboriginal with a forecasted increase to one in three by 2010. Aboriginal communities are forming their own health, education, and social service systems.[7] Another trend is apparent: Increasing numbers of Aboriginal people are living in urban areas.

Providing culturally safe care to these growing numbers of Aboriginal people demands that nurses, whatever their ethnic-cultural background, develop competencies that equip them to be not only culturally sensitive, but to have a deeper and more sophisticated understanding about the health and wellbeing of First Nation, Inuit and Métis peoples. Thus, it is incumbent upon nursing programs to facilitate students' development of the knowledge and understanding that permits them to be culturally safe—for all patients, and for Aboriginal peoples in particular. Since human beings tend to identify with care providers who look and speak like themselves, it would be beneficial to employ more Aboriginal nurses across all sectors of the health system—including rural, northern, and urban contexts. The call for more First Nation, Inuit and Métis nurses to work within Aboriginal communities is clear; however, shortages across the country have made plain the need to attract nurses from all backgrounds and both genders to deliver services in all domains of nursing practice.

In addition, we must consider that nursing education in Canada continues to face significant challenges in *recruiting and retaining* First Nation, Inuit and Métis students. Professional image, gender, race, and power in nursing are variables that all impact recruitment of non-traditional candidates into Canadian nursing and merit our attention. Pringle, Green and Johnson (2007) noted that a career in nursing may present opportunities 'to help other people,' but at the same time may not be appealing to those who do not view it as a profession that is respectful of Aboriginal people. According to participants in focus groups they held, Pringle et al. stated Aboriginal people may experience conflict between Western worldviews and Aboriginal healing

[6] Villeneuve and MacDonald cite these demographics from Kouri, D. (2000). *Saskatchewan 2020 technical report*. Regina, SK: Saskatchewan School Boards Association. Retrieved September 7, 2005 from http://www.ssta.sk.ca/research.social_trends/2020.pdf

[7] Villeneuve and MacDonald related this information from the Government of Saskatchewan, Regional Colleges Review Committee. (1999). Background information strategic planning workshops, Regional Colleges Review. Retrieved September 7, 2005 from http://www.sasked.gov.sk.ca/branches/institutions/re_review/strategicplanningphases.htm

ways and medicine. In addition, Aboriginal youth notice that it is difficult for Aboriginal nurses in their communities to make changes within nursing. Knowing all these hurdles can make nursing a difficult career choice for potential candidates.

Historically, the cost of obtaining a degree in nursing has made it accessible primarily to middle and upper-class women with the implication that they were Caucasian. Villeneuve and MacDonald (2006) cited Curran who said that American nursing had become the de facto territory of "nice white women from the suburbs." They went on to argue that "nursing, like society, is still playing catch-up to correct inequities that underpin the profession as it exists today.. Aboriginal people and other visible minorities are nearly absent from the power structures and decision-making structures of Canadian nursing (Villeneuve and MacDonald, p. 30)." A new vision for the nursing profession calls for diversification along cultural, racial and gender lines. Specifically, this vision calls for increased numbers of Aboriginal nurses so they are more in proportion with that of the Aboriginal population in Canada.

- Nursing and faculty (Hart-Wasekeesikaw, 2006) must understand that:

    i. Potential candidates learn from nurses telling their stories about nursing education and practice experiences;

    ii. It is important to provide information about First Nation, Inuit and Métis nurses who have changed the nursing profession in the areas of practice, education, and administration in relation to the health of Aboriginal people;

    iii. The provision of upfront information on how the nursing program will support Aboriginal students in their journies toward degree completion and their "place" as registered nurses within the profession; and,

    iv. Potential candidates are offered answers to the question: What does the nursing education program have to offer First Nation, Inuit and Métis candidates regarding the development of cultural competence and cultural safety?

**Number of Aboriginal Nursing Students in Canada**

The actual number of First Nation, Inuit and Métis students in Canada is not known as obtaining statistics is largely dependent upon students making the choice to declare their ancestry. Based on statistics where students have declared their Aboriginal status, the overall number of Aboriginal nursing students is estimated to have increased from 237 in 2002 to 737 in 2007 (Gregory and Barsky, 2007).

The provinces with significant increases in the real number of Aboriginal students are Manitoba, Saskatchewan, and British Columbia where they have a total of 510 Aboriginal nursing students. In Nunavut, there were 27 Aboriginal students. These numbers are likely the consequence of nursing-specific access, bridging, and transition programs for First Nation, Inuit, and Métis students. Some of these education programs include the following:

- In British Columbia, the Thompson Rivers University School of Nursing and Pre-Health Program.
- In Saskatchewan, the College of Nursing, University of Saskatchewan; Nursing Division, Saskatchewan Institute of Applied Science and Technology; and, Native Access Program to Nursing and Medicine.
- In Manitoba - the Nursing Department and the ACCESS southern Nursing Program at Red River College.

Gregory and Barsky also noted that the majority of schools of nursing are not keeping statistics to monitor the progress of self-declared Aboriginal students. However, reported attrition rates for schools that responded to a survey ranged from 10% to 50%. According to the National Task Force on Recruitment and Retention Strategies, attrition rates are affected by many factors and some of these include culture shock and cultural differences; racism, discrimination, and prejudice; lack of culturally relevant curricula; lack of roles models; and lack of academic, personal and financial support. Some programs and services exist to address these factors affecting First Nation, Inuit and Métis nursing student enrolment.

Gregory and Barsky identified that of the ninety one nursing schools surveyed in Canada, the following types programs and services were available to First Nations, Inuit and Métis individuals who are preparing to gain entry or who are already in a nursing education program.

- Nineteen Canadian general bridging or transition programs, and eight nursing-specific programs which is an increase of five since 2002. These programs assist students to meet the admission requirements for nursing and offer personal and scholastic supports to nursing students once admitted into a program.

- Twenty-one schools of nursing reported general support programs that included First Nations Centre (or its equivalent); tutoring services; information related to scholarships and bursaries; housing assistance; access to an Elder(s); academic and personal advisement; participation in cultural traditions such as pow-wows, feasts, and sweat lodges; access to computers; and student lounges.

In addition to these programs and services, the majority of nursing schools are engaged in curriculum initiatives regarding Aboriginal people, health, and students.

The estimated increase in the number of Aboriginal nursing students over a five year period can be attributed to these various programs and the development of curriculum relative to Aboriginal people and health. However, despite these efforts the absolute low numbers of First Nation, Inuit and Métis nursing students require further attention. Moreover, the cross-sectional surveys regarding the numbers of Aboriginal nursing students is really only half the story. A more complete account entails the number of Aboriginal nursing students who are admitted to programs—and then who leave these programs before completing their nursing degree.

- Nursing education recruiters, both Aboriginal and Non-Aboriginal (Gregory, Piji-Zieber, Barsky, and Daniels, 2008) must understand:

    i. Aboriginal youth need early encouragement and advice from guidance counsellors to pursue the courses required for nursing programs;

    ii. Collaborative endeavours between schools and communities (urban, rural, or northern) provide a foundation for successful recruitment efforts;

    iii. Educating elementary, middle and secondary students about nursing as a profession is an important strategy;

    iv. Parents and relatives can also play a key role in promoting nursing as a career option (Hart-Wasekeesikaw, 2006);

    v. Developing promotional materials such as pamphlets, DVDs, and websites that focus on First Nation, Inuit and Métis students is helpful;

    vi. Aboriginal nurse role models who can identify the challenges and promote the rewards of pursuing a nursing career are fundamental to recruiting future nurses;

    vii. Bridging, transition, and access programs are contributing to student success;

viii. Dedicated seats for First Nation, Inuit and Métis students, reflecting regional demographics, would make nursing more accessible;

ix. Ensuring the availability of supports such as academic, housing, child care, funding, access to computers and Internet, cultural safety contributes to decreased attrition;

x. The development of relevant curricula that support Aboriginal learners needs to continue as progress is being made; and,

xi. Graduates from nursing programs need encouragement to pursue further studies and they require mentorship in graduate school.

**Nursing Education and First Nation, Inuit, and Métis Students**

Aboriginal students experience many barriers to obtaining their baccalaureate degree in nursing. Some of these include a perceived discouraging institutional climate, and problems adjusting emotionally and socially to the university culture and system (Curran, Solberg, LeFort, and Hollet, 2008).

a. Culture Shock and Cultural Differences

In the report, *Against the Odds: Aboriginal Nursing* many students experience culture shock upon arriving at university or college. The following are examples of specific barriers that affect Aboriginal students in their studies:

- Faculty members' lack of awareness about Aboriginal cultures may cause them to misunderstand a student's needs. For example, often Aboriginal students come from different socioeconomic backgrounds and social contexts that the mainstream student body and so when Aboriginal students talk about their experiences on the reserve or about their culture, other students may treat them with fascination and curiosity—and not as peers.

- The culture of nursing expects assertive participation and this may interfere with the success of Aboriginal students who are often quiet and uncomfortable in a more aggressive learning environment. When Aboriginal students are interrupted or cut off, they are less likely to speak out again.

b. Inequity and Power Differential

In a report by Malatest (2004), educators perceive that the university often represents an impersonal and hostile environment in which Aboriginal students' culture, traditions, and values are not recognized. Furthermore, postsecondary institutions define problems Aboriginal students face while taking courses as "low achievement, high attrition, poor retention" and place the responsibility on the student to adjust to the demands of higher education.

## GUIDING PRINCIPLES

Guiding principles described by Kirkness and Barnhardt (1991) are meant to enhance nursing curricula as they originate from the perspective of the First Nation, Inuit and Métis communities. Emphasis is placed on: the need for respecting Aboriginal students for who they are; programming and curriculum content that is *relevant* to their view of the world; *reciprocity* in their relationship with others, and; assisting students to exercise *responsibility* over their own lives.

1. Respect of First Nations, Inuit and Métis Cultural Integrity

Respect for the cultural integrity of First Nation, Inuit and Métis peoples can be fostered by:

- Increasing the nursing education domain of human knowledge to include First Nations, Inuit and Métis cultural values and traditions.

Kirkness and Barnhardt relate the existence of other forms of knowledge in addition to that commonly associated with higher learning: the perpetuation of literate knowledge. Traditional knowledge, oral knowledge, and indigenous knowledge are some of these. The expression can vary considerably from one group of people to another. However, the meaning, value, and use of the knowledge are bound to the cultural context in which it is situated. Kirkness and Barnhardt continue, "It is thoroughly integrated into everyday life, and it is generally acquired through direct experience and participation in real-world activities (p.7)." In its totality, such knowledge constitutes a particular world view, a form of consciousness, or a reality paradigm.

2. Relevance to First Nations, Inuit and Métis Perspectives and Experience

Relevance can be fostered by:

- Including the presence and use of Aboriginal epistemology and ontology in nursing theory, clinical practice, and research.

- Adopting standards that can be used to examine how respectful and relevant program policies and practices are toward First Nation, Inuit and Métis students in the nursing education process. See Standards for Construction of Indian Theory of Education at the back of this document for a list of 12 standards that were developed to construct a Native American theory of education.[8]

3. Reciprocal Relationships

Reciprocal relationships can be fostered by:

- Understanding teaching and learning as two-way processes, in which the give-and-take between faculty and students opens up new levels of understanding for everyone.

Reciprocity in nursing education can be achieved when faculty members make the effort to understand and build upon the cultural lifescapes of the students, and the students are able to gain access to the inner-workings of the culture and the institution to which they are being introduced.

In a reciprocal relationship, faculty members and students are in a position to create a new kind of education, to formulate new paradigms or explanatory frameworks that help to establish a greater equilibrium and congruence between the literate view of the world and the reality encountered outside the walls of nursing schools and programs.

4. Responsibility through Participation

Responsibility through participation can be fostered by:

- Finding ways to create a more hospitable climate for First Nation, Inuit and Métis students; and by providing First Nations, Inuit and Métis people with access to a system of the highest quality postsecondary, academic, and career/technical education in a culturally reinforced environment.

[8] These standards are from Eber Hampton's doctoral thesis (Harvard University), *Toward a redefinition of American Indian/Alaska Native education*. They would need to be revised to reflect First Nations, Inuit and Métis and Canadian nursing perspectives, if they are to be used for nursing education.

A hospitable climate in nursing education can be achieved by:

- Providing adequate academic and personal student supports such as housing, child care, and funding. These supports may not be required by all Aboriginal students; however, many do need them.

- Providing theoretical and clinical foundation that fosters culturally safe care among nursing students and particularly with respect to the First Nation, Inuit, and Métis students.

- Assisting students to understand the limitations of an essentialist notion of culture and what a constructivist notion of culture privileges.

## CONCEPTS

The concepts of culture, cultural awareness, cultural sensitivity, cultural competence, and cultural safety are presented in this section.

### Culture

Culture is a dynamic lived process that is inclusive of beliefs, practices, and values. Culture, however, is more than beliefs, practices and values that can be reduced to a list of personal characteristics (Kleinman and Benson, 2006). Culture is not homogenous or static and is not a single variable. Rather, culture comprises multiple variables and affects all aspects of experience; it is inseparable from historical, economic, political, gender, religious, psychological, and biological conditions. People also resist and/or redefine their culture during the course of their life journeys. Culture from a critical perspective is a complex shifting relational process (Browne and Varcoe, 2006). Culture is best understood as being enacted relationally; culture can also be understood as a sociopolitical construct with underlying power relationships (Gray and Thomas, 2006).

Culture is a process through which ordinary activities and conditions take on an emotional tone and a moral meaning for participants. These processes include the embodiment of meaning in psychological and social interactions; the development of interpersonal attachments; the performance of religious practices; common sense interpretations; and the cultivation of collective and individual identities. Frequently, cultural characteristics differ within the same ethnic or social group because of differences in age, gender, sexuality, life history, political association, class, religion, ethnicity, and even personality.

## Cultural Awareness

The development of cultural awareness is the beginning step toward understanding that there is difference (Gregory, 2005). It involves observing people's different activities and how they go about doing them. However, it does not usually involve looking at the political, social, and economic characteristics of difference and it does not typically involve examining one's experiences or relationships to these differences.

A strong point about cultural awareness is that it could be a starting point in the development of cultural safety. Limitations about this concept include:

- "Others" are seen as bearers of culture;
- "Others" are culturally exotic: the standpoint is the dominant culture and members of it;
- Does not challenge the health care system;
- No social action;
- Does not involve practitioners reflecting on their own perspectives regarding their actions.

## Cultural Sensitivity

Cultural sensitivity is expressed through behaviours that are considered polite and respectful by the other (Giger et al, 2007). Such behaviours, for example, may be expressed in the choice of words, use of distance, negotiating with established cultural norms of others. Some limitations of this concept include:

- "Others" are seen as bearers of culture;
- "Others" are culturally exotic; the standpoint remains the dominant culture and members of it;
- Does not challenge the health care system;
- Typically, no social action;
- Does not involve practitioners reflecting on their own perspectives regarding their actions.

**Cultural Competence**

There are a number of definitions for cultural competence. In a toolkit of resources for cultural competent baccalaureate nursing education in the United States, the following are presented:

- The California Endowment (2003) defines cultural competence as the attitudes, knowledge, and skills necessary for providing quality care to diverse populations.
- Giger, Davidhizar, Purnell, Harden, Phillips and Strickland (2007) relate competence as an ongoing process that involves accepting and respecting differences and not letting one's personal beliefs have an undue influence on those with a differing worldview from one's own. Cultural competence includes having general cultural and cultural-specific information so the health care provider knows what questions to ask.
- McNaughton-Dunn (2002) describes the development of cultural competence as focusing on the skills, knowledge, and attitudes of practitioners.

A key strength about cultural competence is that it suggests action. Achieving cultural competence means: learning about the culture of the other; being able to assess from the culture of the other; sharing in the culture of the other; the ability to communicate between and among cultures; and the ability to demonstrate skill outside one's culture of origin (McNaughton, 2002).

However, there are limitations to cultural competence and these include:

- Culture is reduced to *technical skills* for which clinicians can develop expertise;[9]
- It is reductionistic with respect to people and their cultural lifescapes;
- It tends to homogenize cultural lifescapes as a way to simplify the learning of "cultural others."
- That individuals resist and counter their "culture" is not addressed, i.e., Jewish families who do not practice circumcision.
- It is not clear who evaluates and/or confirms that cultural competence has been more or less achieved.

There exist a number of models for providing culturally competent nursing care.

[9] For example, see *Enhancing cultural competency. A resource kit for health care professionals* that was developed by the Calgary Health Region in February 2005.

## A. Models of Culturally Competent Nursing Care

There are a number of frameworks that can be used to develop cultural competency in providing nursing care. Four will be presented here: Leininger's Transcultural Model, Giger and Davidhizar Transcultural Assessment Model, Campinha-Bacote Model of Cultural Competence, and Narayanasamy ACCESS Model.

### i. Leininger's Cultural Care Diversity and Universality Theory/Model

The Transcultural Model was the first to be developed in the early 1970s. Transcultural nursing is a humanistic and scientific area of formal study and practice in nursing (Leininger, 1988). This study and practice focuses on differences and similarities among cultures with respect to human care, health, and illness which are based upon people's cultural values, beliefs, and practices. This knowledge is used to provide cultural specific or culturally congruent care. This theory/model must be viewed as a cultural artefact in and of itself, i.e., based on American values and a more essentialist understanding of culture.

### ii. Giger and Davidhizar Transcultural Model

The Giger and Davidhizar Transcultural Assessment Model (Davidhizar and Giger, 1999, 2001) present a systematic approach that can be helpful in developing skills for providing culturally competent nursing care. The model postulates that each individual is a culturally unique person and should be assessed according to six cultural phenomena: communication, space, social organization, time, environmental control, and biological variation. These phenomena are explained, first, as separate phenomena that are found in all cultural groups and then, in relation to selected cultural groups the nurse is likely to encounter in the United States.[10] Again, in order to simplify the learning of culture, a more essentialist "take" on culture is afforded.

### iii. Campinha-Bacote's Model and Application of Cultural Competence

The central concepts in this model are cultural awareness, cultural knowledge, cultural skill, cultural encounter, and cultural desire.[11] Cultural assessment is not limited to specific ethnic groups; they need to done with each patient as each has values, beliefs, and practices that must be considered in the provision of care. Individuals, organizations, and institutions can develop cultural competence. Two strengths of this model include: according responsibility and accountability for culturally appropriate care to organizations and institutions—and not holding individuals solely responsible for this concept; and, the notion that every patient encounter is a cross-cultural encounter, i.e., person-centered care.

[10] The Transcultural nursing: Assessment and intervention (4th Ed.) has a companion book that addresses Canadian ethnic groups.
[11] The American Association of Colleges of Nursing Toolkit of Resources for Cultural Competent Education for Baccalaureate Nurses can be retrieved from http://www.aacn.nche.edu/education/pdf./toolkit.pdf

iv. Narayanasamy – The ACCESS Model

The ACCESS Model was developed to offer nurses a framework to deliver transcultural nursing care within a British context (Narayanasamy and White, 2005).

B. Strengths and limitation of cultural competence

The strengths of cultural competence are:

- Can be developed at the individual and organizational levels; and,
- Builds upon self-awareness at the individual level.

The limitations of cultural competence are:

- Focuses on the skills, knowledge, and attitudes of practitioners and reduction of culture to technical skills for which clinicians can develop expertise (Gregory, 2005); and,
- Overemphasis on cultural difference can lead to the mistaken idea that if we can only identify the cultural root of the problem, it can be resolved (Kleinman and Benson, 2006).

**Cultural Safety**

Cultural safety takes us beyond the following: cultural awareness, the acknowledgement of difference; cultural sensitivity, the recognition of the importance of respecting difference; and cultural competence, the focus on skills, knowledge, and attitudes of practitioners.

Cultural safety is predicted on understanding the power differentials inherent in health service delivery and redressing these inequities through educational processes (Spence, 2001). Addressing inequities (Varcoe, 2004), through the lens of cultural safety, enables care providers to:

- Improve health care access for patients, aggregates, and populations;
- Acknowledge that we are all bearers of culture;
- Expose the social, political, and historical contexts of health care;
- Enable practitioners to consider difficult concepts such as racism, discrimination, and prejudice;
- Understand that cultural safety is determined by those to whom nurses provide care;
- Understand the limitations of "culture" in terms of having people access and safely move through health care systems and encounters with care providers; and,
- Challenge unequal power relations.

Culture is more than beliefs, practices, and values and nursing curricula need to assist nursing students to understand the limitations of essentialist view of culture. Students require assistance to develop a constructivist understanding of culture. Awareness, sensitivity, and competence provide students and faculty with a beginning place in which to develop an appreciation of the complexity of “culture.” Cultural safety presents opportunities in which unequal power relations are exposed and managed. Cultural safety is action orientated and is in alignment with the advocacy role of nurses and the nursing profession.

According to the National Aboriginal Health Organization (2008), the need for culturally safe care for First Nations, Inuit and Métis people is matched by the need for *culturally safe learning* to improve educational outcomes for Aboriginal students.

> Developing culturally safe learning environments benefit students, educators, educational institutions, and education systems. Students are more likely to respond positively to the learning encounter when they feel safe, respected and able to voice their perspective. An educator is more likely to experience more job satisfaction when attendance is better, when the quality of scholarship is good, and when the classroom is an environment of equal engagement between different ways of knowing. This comes from an educator creating a culturally safe learning environment and delivering culturally safe curriculum. High retention rates of an Aboriginal population can be interpreted as a reflection of an educational institute’s commitment to such an environment, as well as their commitment to human rights and race relations. Such institutions produce more graduates, which attracts more students and thereby increases enrolment.

The Indigenous Physicians Association of Canada and the Association of Faculties of Medicine of Canada Cultural have endorsed cultural safety in the document, *First Nations, Inuit, Métis Health Core Competencies. A Curriculum Framework for Undergraduate Medical Education.*

## CONCLUSION

Nursing has the opportunity to actively educate First Nation, Inuit and Métis students at the baccalaureate, master’s and doctoral levels. This document presents best practices regarding the education of First Nation, Inuit and Métis nursing students. Programs adopting these best practices foster success among Aboriginal students, and create safe learning environments for all nursing students. In addition, graduates of these programs are educated in the provision of culturally safe care to the Aboriginal people of Canada.

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**Standards for Construction of American Indian/Alaska Native Theory of Education**

Spirituality – an appreciation for spiritual relationships

Service – the purpose of education is to contribute to the people.

Diversity –American Indian/Alaska Native education must meet the standards of its diverse communities and territories.

Culture – the importance of culturally determined ways of thinking, communicating, and living.

Tradition - continuity with tradition.

Respect – the relationship between the individual and the group recognized as mutually empowering.

History – appreciation of the facts of history, including the loss of the continent and continuing racial and political oppression.

Relentlessness – commitment to the struggle for good schools for American Indian/Alaska Native children.

Vitality – recognition of the strength of American Indian/Alaska Native people and culture.

Conflict – understanding the dynamics and consequences of oppression.

Place – the importance of sense of place, land and territory.

Transformation – commitment to personal and societal change.