

**Working Within a Public Health Frame:  
Toward Health Equity Through Cultural Safety**

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*This thesis is dedicated in fond memory to Dr. Dawn Smith who has inspired new ways of seeing, knowing and doing.*

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## Abstract

This study explored how public health nurses (PHNs) work to address health inequities. Cultural safety was used as a theoretical lens. Methods for interpretive description were relied on for data collection and analysis. Data sources included interviews with 14 staff from an urban public health unit and document review of three policies.

Two themes emerged: *building relationships* and *working within a frame*. Building relationships involved: delivering the message, taking the time, being present, the right nurse and learning from communities. The public health frame influenced the capacity of PHNs to address health inequities through: culture and stereotypes, public health standards, setting priorities, inclusion of priority populations, responding to change and (re)action through reorganization. Discursive formations of priority populations, and partnership and collaboration, were revealed. Findings highlighted downstream public health approaches to addressing health inequities. Importantly, embedding cultural safety as a framework for public health practice can guide upstream action.

## Table of Contents

Acknowledgements.....	iii
Abstract.....	iv
Glossary of Terms.....	x
<b>Chapter One: Introduction.....</b>	<b>1</b>
1.1 Background.....	2
1.1.1 Health Equity.....	3
1.1.2 Social Justice.....	4
1.1.3 Health Inequities in Canada.....	5
a) Health Status of Aboriginal Peoples.....	5
b) Health Status of Newcomers.....	6
1.2 Statement of the Problem.....	8
1.3 Study Purpose and Research Questions.....	9
1.4 Thesis Outline.....	9
<b>Chapter Two: Literature Review.....</b>	<b>10</b>
2.1 Colonization and Canada’s White Mainstream.....	11
2.1.1 Whiteness.....	11
2.1.2 Racialization.....	12
2.1.3 Racism.....	13
2.2 A Culture of Public Health Practice.....	15
2.2.1 The Ontario Context.....	15
2.2.2 Social Justice and Health Equity in Public Health Nursing.....	18
2.3 Approaches to Exploring Culture and Difference in Nursing.....	20
2.3.1 An Essentialist View.....	21

a) Multiculturalism and Diversity.....	21
b) Cultural Competence.....	22
2.3.2 A Constructivist View.....	24
a) Cultural Safety: Origins and Underpinnings.....	26
b) Cultural Safety Approaches in Nursing Practice.....	28
2.4 Chapter Summary.....	31
<b>Chapter Three: Research Methods.....</b>	<b>32</b>
3.1 Situating the Researcher.....	32
3.2 Research Design.....	34
3.2.1 Setting.....	34
3.2.2 Sample.....	34
3.2.3 Data Collection.....	36
3.2.4 Data Analysis.....	37
3.3 Rigour.....	39
3.3.1 Credibility.....	39
3.3.2 Transferability.....	40
3.3.3 Dependability.....	41
3.3.4 Confirmability.....	41
3.3.5 Authenticity.....	41
3.4 Ethics.....	42
<b>Chapter Four: Findings.....</b>	<b>43</b>
4.1 Thematic Summary.....	43
4.1.1 Building Relationships.....	44

a) Delivering the Message.....	44
b) Taking the Time.....	46
c) Being Present in the Community.....	47
d) The Right Nurse.....	49
e) Learning from Communities.....	51
4.1.2 Working Within a Frame.....	53
a) Culture and Stereotypes.....	54
b) Public Health Standards.....	56
c) Setting Priorities.....	58
d) Inclusion of Priority Populations.....	60
e) Responding to Change.....	64
f) Re(Action) through Reorganization.....	65
4.2 Thematic Description.....	67
4.2.1 Priority Populations.....	68
4.2.2 Partnership and Collaboration.....	69
4.3 Chapter Summary.....	69
<b>Chapter Five: Discussion and Implications.....</b>	<b>71</b>
5.1 Priority Populations: Neocolonial Notions of Culture and Difference.....	71
5.2 Partnership and Collaboration: Rhetoric or Meaningful Participation.....	72
5.3 A Cultural Safety View of Public Health Nursing Practice.....	74
5.3.1 Postcolonial Understanding.....	76
5.3.2 Communication.....	78
5.3.3 Inclusivity.....	79
5.3.4 Respect.....	80

5.3.5 Indigenous Knowledge.....	80
5.3.6 Mentoring and Supporting Students.....	81
5.4 Implications to Promote Cultural Safety in Public Health Nursing.....	82
5.4.1 Implications for Practice.....	82
a) Engage in critical reflection.....	83
b) Develop a postcolonial understanding.....	84
5.3.2 Implications for Education.....	85
5.3.3 Implications for Policy.....	87
5.3.4 Implications for Research.....	89
5.4 Study Strengths and Limitations.....	91
5.5 Conclusion.....	93
References.....	95

## List of Tables, Figures and Appendices

### Tables

Table 1: CINAHL Literature Search Strategy for Primary Research Studies of Social Justice and Health Equity in Public Health Nursing Practice.....	19
Table 2: CINAHL Literature Search Strategy for Primary Research Studies of Cultural Safety in Nursing Practice.....	29

### Figures

Figure 1: Conceptual Framework of Study Findings.....	75
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### Appendices

A: Study Schematic.....	114
B: Interview Participant Information Letter.....	115
C: Interview Guide—Public Health Nurses and Project Officers.....	116
D: Interview Guide—Public Health Managers and Supervisors.....	117
E: Interview Participant Consent Form.....	118
F: Participant Demographic Form.....	119
G: Working Through a Theme: Building Relationships.....	120
H: Rigour Criteria and Strategies.....	121
I: Certificate of Ethical Approval.....	122

## Glossary of Terms

**Cultural safety:** A formal definition has yet to be determined; a working definition is provided. Cultural safety is a historicized approach to identify and redress health inequities. The aim of cultural safety is to change power differentials inherent in relationships through educational processes (Aboriginal Nurses Association of Canada, 2009; Spence, 2001).

**Discursive formations:** The ways in which clusters of keywords, metaphors, ideas and forms of knowledge are used to commonly communicate issues across various sites (Wemyss, 2009).

**Health equity:** The absence of systematic differences in health, both between and within countries that are judged to be avoidable by reasonable action (World Health Organization, 2010).

**Health inequity:** The presence of a difference in health status either between or within countries that is unnecessary and avoidable, and thus unfair and unjust (Canadian Nurses Association, 2008; Whitehead, 1992).

**Determinants of health:** Key social, economic, environmental and individual factors that exert a major and potentially modifiable influence on the health of populations, including: income and social status, social support networks, education and literacy, employment/working conditions, social environments, physical environments, personal health practices and coping skills, healthy child development, biology and genetic endowment, health services, gender and, culture (Public Health Agency of Canada, 2011). Collectively, they represent structural determinants and conditions of daily life that are largely responsible for health inequities (World Health Organization, 2008).

**Social justice:** The fair distribution of society's benefits and responsibilities and their consequences (Canadian Nurses Association, 2008).

## Chapter One: Introduction

During my undergraduate nursing education we were taught that a client's cultural background is an important factor to consider throughout the nursing process. Checklist approaches to understanding culture were used to impart knowledge of different cultural preferences and ways of life, suggesting that individuals possess tangible, universal cultural characteristics upon which they may be categorized accordingly. This "essentialist" approach to understanding culture is deeply embedded within nursing discourse, where I, among the majority, have participated in and perpetuated cultural categorization without questioning the need or purpose for such practices. Although the concept of culture has been analyzed and utilized extensively, it is perhaps one of the most complex and difficult concepts to ascertain (Campesino, 2008).

This thesis explores the concept of culture in public health nursing practice in relation to working with populations at risk for health inequities. The introductory chapter provides a brief overview of the context within which public health operates, including some underpinning assumptions about health and its determinants. Specifically, health equity and social justice are presented as key concepts for public health nursing practice. The health status of Aboriginal<sup>1</sup> and newcomer<sup>2</sup> populations are each described in turn to illustrate how culture comes to bear on public health discourse on health inequity. The chapter concludes

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<sup>1</sup> The term "Aboriginal" collectively refers to peoples who identify as having First Nations, Inuit and Métis ancestry. Though used to represent this population, the term Aboriginal fails to reflect the immense intra-cultural diversity that exists among the peoples of this group.

<sup>2</sup> The term "newcomer" collectively refers to immigrants, refugees and asylum seekers. Immigrants (generally, those who left their country of origin by choice) and refugees (those who fled their country of origin) have legal status in Canada. Asylum seekers have uncertain immigration status and thus are at risk for being deported.

by introducing the thesis research with a statement of the problem, a description of the study purpose and research questions.

## **Background**

Within Canada, concepts of health and healthcare reflect a dominantly Western biomedical model (Robertson, 1998; VanderPlaat & Teles, 2005), which is founded on neoliberal ideology that accelerates health inequity both locally and globally (Brown, 2012; Brown, McPherson, Peterson, Newman, & Cranmer, 2012; Browne & Dion Stout, 2012; Falk-Rafael & Betker, 2012; Labonte, 2004; Mooney, 2008). Situating the healthcare system as ideological emphasizes that it is not objective or neutral, but rather contaminated by theoretical, methodological and political bias (Robertson, 1998). For example, those who value a community and societal level of responsibility for health are often marginalized and disadvantaged by mainstream systems that operate from the different and at times conflicting individualist worldview (Falk-Rafael & Betker, 2012; Richardson, 2004).

In recent decades, health discourse in Canada has shifted toward an understanding of health outcomes as being affected by factors beyond the healthcare sector, namely determinants of health (Fennelly, 2006; Reading & Wein, 2009; Lynam, Grant, & Staden, 2012; Public Health Agency of Canada, 2011; Robertson, 1998; VanderPlaat & Teles, 2005). This paradigm shift embodies a largely social as opposed to biomedical explanation of health status that has led to calls for broad health promotion strategies to create healthy public policy and support intersectoral action to improve health at community and population levels (Robertson, 1998). This shift is particularly evident in the context of public health, where addressing the unequal distribution of determinants of health represents the next frontier for action (Bryant, Raphael, Schrecker, & Labonte, 2011).

Indeed, goals of public health must be informed with an understanding of the social

nature of health and complex interactions that occur between individuals, communities and populations (Kenny, Sherwin, & Baylis, 2010). As such, public health nurses (PHNs) are called to address social, political and economic conditions that create and sustain health inequities, such as reducing poverty by ensuring quality education, employment and housing opportunities (Brown et al., 2012; Bryant et al., 2011; Drevdahl, Kneipp, Canales, & Dorcy, 2001; Pauly, MacKinnon, & Varcoe, 2009).

### **Health Equity**

Health equity is defined as the absence of systematic differences in health between and within countries that are avoidable with reasonable action (World Health Organization [WHO], 2010). Aims to achieve health equity convey principles of fairness and justice where need guides the distribution of opportunities for health and wellbeing (Community Health Nurses Association of Canada [CHNAC], 2008). Health equity may be considered both in terms of equitable access to services and achieving equity in health outcomes (Brown et al., 2012; Pauly et al., 2009). Importantly, even with equitable distribution of health services, health inequities still exist (Drevdahl et al., 2001), which reinforces that health services are not the main driver of people's health (National Association of Friendship Centres, 2010).

Health inequity, therefore, is the presence of a difference in health status that is unnecessary and avoidable, and thus unfair and unjust (Canadian Nurses Association [CNA], 2008; Whitehead, 1992). Indeed, health inequity is a moral concern (Williams, 2005). Health inequities arise from how political and economic aspects of society are organized (WHO, 2008), and are violent in that they injure quality of life and wellbeing (Browne & Dion Stout, 2012). In this way, health inequities are "structural" because they result from social injustices that are created by human action in social, economic and political spheres of society (Falk-Rafael & Betker, 2012). Therefore, when discussing health inequities the goal is to unearth

root causes of poor health and reallocate resources beyond healthcare to other sectors that target determinants of health (Green, 2010; Hankivsky & Christoffersen, 2008; Robertson, 1998).

### **Social Justice**

Public health efforts aim to improve the health and wellbeing of the overall population while attending to the needs of the most marginalized and disadvantaged (Gostin & Powers, 2006; Kenny, Sherwin, & Baylis, 2010). This aim reflects the concept of social justice, which is defined as “the fair distribution of society’s benefits and responsibilities and their consequences” (CNA, 2008, p. 28). As such, social justice is thought to be a vital feature of public health research, practice and policy development (Drevdahl et al., 2001; Edwards & Davison, 2008; Krieger & Birn, 1998; VanderPlaat & Teles, 2005).

Ultimately, health outcomes are the object and measure of social justice in action (Reimer Kirkham & Browne, 2006). Here, determinants of health represent structural determinants and conditions of daily life that are largely responsible for health inequities (WHO, 2008). Although evidence exists to link social conditions with inequitable health outcomes, there remains a limited understanding of how these conditions have been created and sustained (Brown et al., 2012), or of how health inequities can be addressed (Dion Stout, 2012; Green, 2010; Raphael, 2006; Raphael, 2011). Furthermore, a discourse of discontent surrounding social justice has emerged with a notably cultural face (Blix, Hamran, & Normann, 2012; Smelser & Alexander, 1999). For example, the social exclusion, marginalization and systemic discrimination against Canada’s Aboriginal peoples reflect structural inequities that negatively impact health at a population level (Browne & Dion Stout, 2012). This demonstrates how culture discourse comes to bear on health inequities that arise from social injustices that are deeply embedded within the fabric of society.

## **Health Inequities in Canada**

A critical component of public health in Ontario is to identify and work with population subgroups that are at risk for health inequities and stand to benefit from public health interventions (Ministry of Health Long Term Care [MOHLTC], 2008). Within Canada's population, Aboriginal peoples represent one such subgroup whose overall health status is described as "much worse" than the health of non-Aboriginal Canadians (Canadian Population Health Initiative, 2004). Similarly, newcomers to Canada are another population subgroup at disproportionate risk for health inequities compared to other Canadians due to marginalization stemming from economic disadvantage and acculturation stressors (Ali, McDermott, & Gravel, 2004). Both Aboriginal peoples and newcomers have also been displaced from traditional communities and practices, contributing to their marginalization (Lynam et al., 2012). Importantly, the historical relations of Aboriginal peoples with the nation state must be recognized as unique compared to other minority groups (Brown, 2012), as opposed to competing with others for "cultural space" (Wepa, 2003).

**Health status of Aboriginal peoples.** According to 2006 Canadian Census data 1,172, 785 respondents reported Aboriginal identity, representing 3.8% of all Canadians (Statistics Canada, 2008). This rapidly growing population increased 45% between 1996 and 2006, with nearly 60% of the Aboriginal population residing in urban areas and therefore off-reserve and within provincial jurisdiction (Statistics Canada, 2008). Ontario reported the largest number of Aboriginal people across provinces and territories, with a total of 242,495 residents identifying as Aboriginal (Statistics Canada, 2008).

The health inequities and disparities experienced by Aboriginal peoples in Canada are well documented (Adelson, 2005; Lix, Bruce, Sarkar, & Young, 2009; Shah, Gunraj, & Hux, 2003; Tjepkema, Wilkins, Senecal, Guimond, & Penney, 2009) and are entrenched in a

shared colonial history with the nation state, relating to economic, social and political disparities and not any inherent Aboriginal trait (Adelson, 2005; Blix et al., 2012; Browne & Fiske, 2001; Browne, Smye, & Varcoe, 2005; Dion Stout, 2012; Fridkin, 2012). For example, the dispossession of lands and languages have been identified as underlying causes of health inequities for Aboriginal peoples, and are key determinants for their health as a population (Brown et al., 2012; Reading & Wein, 2009; Richmond & Ross, 2009). Indeed, a shared history of colonization has led to considerable health problems among Indigenous peoples across the globe (Mooney, 2008).

A notable trend observed in Canadian epidemiological data is higher rates of hospitalization for potentially preventable conditions and lower rates of utilizing specialist services among Aboriginal peoples when compared to non-Aboriginal Canadians (Shah et al., 2003). For example, the mortality rate of cervical cancer is six times higher for Aboriginal women and is partially explained by their lower incidence of undergoing cervical cancer screening (O'Brien, Mill, & Wilson, 2009). In fact, research has shown that Aboriginal peoples often feel misunderstood and mistreated by the mainstream healthcare system and its providers (Arnold, Appleby, & Heaton, 2008; Baba & Reading, 2012). For example, one study found that Aboriginal women living with HIV and AIDs feared judgment and discrimination that made them reluctant to access "unsafe" care (McCall & Pauly, 2012).

**Health status of newcomers.** Newcomers represent another subgroup of Canada's population who may be at increased susceptibility to health issues because of economic strain, acculturation stress and lack of familiarity with Canadian healthcare institutions (Ali et al., 2004). Canada admits over 200,000 newcomers annually, accounting for 20% of the overall population and representing 60% of the country's total population growth (Statistics Canada, 2001). The profile of source regions for Canadian newcomers has shifted since 1970

when Europe and the United States represented 85% of newcomers, to less than 20% in 2002 with majority source regions from Asia and the Pacific, Africa and the Middle East, and South and Central America (Beiser, 2005). Refugees in particular have been shown to experience poorer health status compared to other newcomers (DesMueles et al., 2004). Of note, a working estimate of about half a million unauthorized immigrants are thought to live in Canada (Simich, Wu, & Nerad, 2007), and are therefore without insurance to cover costs of many healthcare services.

The *Longitudinal Survey of Immigrants to Canada* (Statistics Canada, 2005) reported that upon transitioning to a new country newcomers might postpone their use of health services, with language barriers cited as a key deterrent. Some research suggests that immigrants utilize health services less than Canadian-born residents, particularly those from non-European source regions (Beiser, 2005; Fenta, Hyman, & Noh, 2007; Maticka-Tyndale, Shirpak, & Chinichian, 2007; Reitmanova & Gustafson, 2008). Issues such as gender roles, trust in Western medicine and different health beliefs and practices may contribute to differential access to preventive health care and result in disparate health outcomes among newcomers (Woltman & Newbold, 2007). One study showed that a woman's immigrant status was associated with undergoing cervical cancer screening in an urban Canadian centre, where compared to women born in Canada, recent immigrants were significantly less likely to participate (Woltman & Newbold, 2007). This has important implications for strategies aimed at preventive health services given that non-participation in cervical cancer screening is the greatest risk factor for poor outcomes in women who develop cervical cancer (Health Canada, 2002).

Of concern is that research on the use of healthcare services among Aboriginal peoples and newcomers have reported experiences of discrimination, insensitivity, negative

stereotypes and lack of knowledge about cultural and religious practices among healthcare professionals (Arnold et al., 2008; Baba & Reading, 2012; Dean & Wilson, 2010; McCall & Pauly, 2012; Reitmanova & Gustafson, 2008; Simich et al., 2007). These findings on the health status of Canada's Aboriginal peoples and newcomers are perhaps indicative of an avoidance of a healthcare system "that is not culturally safe and that does little to acknowledge or counter patterns of individual or institutional discrimination" (Browne & Fiske, 2001, p. 129). Nurses are uniquely positioned to identify and redress sources of health inequities, but first they must create culturally safe spaces.

### **Statement of the Problem**

A commitment to health equity and social justice has been made within the nursing profession and the discipline of public health (Anderko, 2010; Brown et al., 2012; CNA, 2008; Cohen & Gregory, 2009; Krieger & Birn, 1998; Pacquiao, 2008; Schim, Benkert, Bell, Walker, & Danford, 2006; VanderPlaat & Teles, 2005; Williams, 2005). Since PHNs represent the largest proportion of the public health workforce, they are ideally situated to address health inequities (Falk-Rafael & Betker, 2012; Williamson & Drummond, 2000).

However, a framework for ensuring justice and equity has yet to emerge and public health as a discipline remains poorly equipped to address this spectrum of problems (Hanlon, Carlisle, Hannah, Lyon, & Reilly, 2012; Mansyur, Amick, Franzini, & Roberts, 2009; Mooney, 2008; VanderPlaat & Teles, 2005). Notably, public health efforts have failed to target broad societal structures where root causes of inequities are found (Fridkin, 2012). For example, despite the presence of established public health services, very few public health units (PHUs) in Ontario have been shown to meaningfully address social justice, specifically with regard to action on improving determinants of health and reducing health inequities (Raphael, 2000; Raphael, 2003). Indeed, innovative approaches that contextualize social

location, determinants of health and health inequities are pressing (Hankivsky & Christoffersen, 2008).

### **Study Purpose and Research Questions**

The purpose of this study is to explore how PHNs address health inequities by answering the research questions: 1) how do PHUs and PHNs work to address health inequities? and 2) what factors influence the capacity of PHUs and PHNs to address health inequities? The concept of cultural safety, initiated within an Indigenous context in nursing education in New Zealand, was used as a theoretical lens to inform this research with the aim to consider its potential to guide public health nursing action on addressing health inequities.

### **Thesis Outline**

This chapter has situated health inequity as a concern for public health, and has outlined the study aim to describe how PHNs address health inequities and identify factors that shape this work. Chapter two offers a review of the literature to: 1) provide an overview of Canada's neocolonial context within which PHUs and PHNs are situated; 2) locate a culture of public health nursing practice in Ontario; 3) explore how notions of culture and difference permeate nursing discourse and to introduce the concept of cultural safety. Then, chapter three provides an overview of the research methods used to collect and analyze data. Chapter four presents thematic findings along with a sample of supporting data. Lastly, chapter five discusses the findings in relation to a cultural safety framework, and concludes with implications for public health nursing practice, education, research and policy contexts.

## **Chapter Two: Literature Review**

The concept of cultural safety has the potential to guide public health nursing action on addressing health inequities. The purpose of this literature review is to synthesize the current state of nursing knowledge and practice with regard to creating culturally safe healthcare encounters. First, a cultural safety lens calls for consideration of the colonial and neocolonial contexts within which public health nursing practice and health inequities have been created and remain situated. Literature that described the goals and outcomes of European colonization provides a “white” background for this study, revealing where power and privilege form contemporary Canadian society in part through processes of whiteness, racialization and racism. Then, the culture of public health practice in Ontario is explored via an overview of the public health aim to address health inequities, and evidence on how PHNs work to achieve health equity and social justice is synthesized. Finally, theoretical literature describing essentialist and constructivist views on culture are presented to illustrate how these philosophical underpinnings ultimately shape healthcare encounters and outcomes. Studies that have explored cultural safety in nursing are reviewed. The chapter concludes by identifying the gap in knowledge with regard to cultural safety in public health nursing practice, thus supporting the need for this study.

Literature was identified through searches of two electronic databases, CINAHL and PubMed. Articles were identified according to keyword searches and limited to the English language. Keywords were entered in several combinations, and included: culture; cultural competence; cultural safety; Aboriginal; newcomer; postcolonial; public health; public health nursing; public health nurses; health equity; health inequities; social justice; social injustice; determinants of health; and, social determinants of health. Research articles, theoretical analyses, reviews and commentaries were all included for review due to the ongoing

conceptual development of cultural safety. Furthermore, reference lists of all sources were scanned for other related sources. Grey literature was also reviewed.

### **Colonization and Canada's White Mainstream**

The colonial modernity project, driven by materialism, individualism and consumerism, has provided health and social benefits to some but created considerable inequities for others (Hanlon et al., 2012). Literature on whiteness, racialization and racism are reviewed to situate PHUs and PHNs within Canada's colonial and neocolonial contexts. Whiteness literature reports on systems of power and privilege to explicate unmarked colonial forces that have shaped society so that they may be analyzed, destabilized, undermined and transformed (Anijar, 2003; Bonnett, 2000; Frankenberg, 1997; Garner, 2007; Martin-McDonald & McCarthy, 2008). Discussion of whiteness and its privilege can never ensure that it will not simultaneously support it (Anijar, 2003; Bonnett, 2000; Sullivan, 2006). To mitigate this risk, the focus of the review turns to explore processes of racialization and racism to challenge unequal and unjust power relations that permeate society (Anijar, 2003; Garner, 2007). Here, whiteness becomes the fulcrum of power relations involved in processes of racialization and racism, for without it all other constructions disappear (Garner, 2007).

#### **Whiteness**

Whether as colonizing nation or settler colony, nearly all of contemporary nations are colonialist creations derived from a long history of European colonialism and imperialism (Allen, 1999; Sullivan, 2006). The historical relationship between power and whiteness is reflected in societal forces with which all are engaged including modernization, civilization and development (Bonnett, 2000; Leonard, 2010). Through global colonialism, whiteness has come to represent humanness, normality and universality, marking the space from which

difference is measured (Garner, 2007). Indeed, due to its social and economic hegemonic power, whiteness has become widely internalized “as a symbol of freedom, of excitement, of the possibilities that life can offer” (Bonnett, 2000, p. 76).

Importantly, whiteness is not a thing or several things but rather a practice that constructs relationships of power and privilege that dictate normality, dominance and control (Allen, 2006; Frankenberg, 1997; Garner, 2007; Olsen, 2002). Whiteness represents processes of domination that works on individual, interpersonal, institutional and societal levels (Garner, 2007; Schroeder & DiAngelo, 2010), and is neither stable nor predictable (Leonard, 2010). In the context of settler states such as Canada, colonial structures have never been dismantled and therefore colonial ways of knowing are actively reproduced within neocolonial dynamics of power (Anderson, 2003). Power struggles result where the construction and use of knowledge is victorious over other forms of knowledge (Wemyss, 2009). For example, there is an underlying colonial assumption that Western health beliefs and practices are beneficial to society as a whole and lead to desired health outcomes for all (Richardson, 2004). Another example would be how organizations, such as PHUs, are extensions of the nation state that are created to embody white discourse (Wemyss, 2009).

### **Racialization**

Racialization refers to the social construction of racial and ethnic categories as a means to order groups in society and it is this structural nature that enables its persistence (Ford & Airhihenbuwa, 2010; Garner, 2007). Racialized identities in Canada arguably include Aboriginal, Black, Chinese, South Asian and White, among others, and are constructed as being distinctive based on racial, ethnic or cultural dimensions (Browne & Varcoe, 2006; Veenstra, 2009). However, racialized identities are derived from objective and objectionable features and perpetuate false perceptions of authenticity (Anijar, 2003;

Richardson, 2004; Veenstra, 2009). In fact, these identities are often sites of resistance (Allen, 2006). As such, designations based on skin colour represent categories of domination and control and contribute to an unequal distribution of power (Puzan, 2003).

The process of racializing of bodies and space is not unique to contemporary times nor does it occur in a vacuum (Allen, 2006). Rather, racialization has been a colonial process aimed to naturalize whiteness and legitimate its difference and superiority within society (Bonnett, 2000). In this way, the ideology of race has been disseminated globally, making a profound impact on sense of self and other (Bonnett, 2000). For example, it is commonly assumed that white is not a racialized category and that only non-white people have a race, ethnicity or culture (Sullivan, 2006; Williams & Christman, 1994). This illustrates how a “white collective unconscious” pursues and perpetuates white privileged goals and values (Sullivan, 2006), which is often invisible to its white benefactors (Anijar, 2003; Frankenberg, 1997; Garner, 2007). However, the sufferings produced by whiteness have long been understood, described and resisted among communities of colour (bell hooks, 1992; Schroeder & DiAngelo, 2010).

### **Racism**

Racism is another colonial process that maintains, reinforces, reproduces, normalizes and renders invisible the power and privilege of whiteness (Schroeder & DiAngelo, 2010). Indeed, it is often difficult to isolate a “bad” racist white influence (Bonnett, 2000). A common misunderstanding is that racism solely represents individual action, a way of being, thinking, feeling and acting toward the “Other” rather than processes of institutional and systemic oppression that implicate all whites in its action (Garner, 2007; Gustafson, 2007; Puzan, 2003). As such, analyses of racial difference must begin with replacing the dominant

understanding of racism as isolated acts of individuals with an understanding of it as a system within which we are all enmeshed (Schroeder & DiAngelo, 2010).

For white people, being white comes with structural advantage and numerous privileges that represent the systemic nature of racism. Indeed, even white people who do not support or wish not to be part of this system still benefit from and are privileged by it (Garner, 2007; Schroeder & DiAngelo, 2010). For example, white people are generally devoid of personal responsibility for representing white views in a given forum (Blix et al., 2012; Seiler, 2003). As Allen (2006) stated: “I am not regarded as a ‘stand-in’ for all white American men yet it is not uncommon to ask a First Nation’s student for the ‘American Indian’ perspective on an issue” (p. 70). This line of thought points to the problematic of positioning individuals as representative of others which must be remedied by emphasizing that there is no single quintessential representation of cultural, ethnic or racial groups (Allen, 2006; Katz, 2005). Other privileges associated with whiteness regardless of class or gender include higher pay and lower risk for poverty, with better access to, and outcomes of, health services, education, and the legal system (Leonard, 2010). Even not encountering as many obstacles is a significant privilege (Garner, 2007). The impact is an unequal distribution of resources and power that benefit those who are white and simultaneously disadvantage people of colour (Schroeder & DiAngelo, 2010).

As such, healthcare policies and practices must take into account how culture and health are intertwined due to historical relationships and subsequent effects on health (Brown et al., 2012). Examples include: what constitutes acceptable and unacceptable patterns of communication; appropriate and inappropriate attitudes toward authority; and among others, the geographical location and non-location of health services (Puzan, 2003). Allen (2006) argued that healthcare institutions are not culturally empty spaces but rather are penetrated

by authoritarian white perspectives. Similarly, white influences have been described as deeply embedded within nursing education and practice institutions (Puzan, 2003).

Therefore, nurses must understand how their views and everyday interactions with clients can promote or resist social injustices that create and sustain health inequities (Anderson et al., 2009; Pauly et al., 2009). Explicating whiteness, racialization and racism within public health requires nurses to consider the complicated history upon which they stand and challenge colonial forces that shape their work (Allen, 1999; Gustafson, 2007; Martin-McDonald & McCarthy, 2008; Puzan, 2003).

### **A Culture of Public Health Practice**

A wealth of literature has situated healthcare systems as having cultures of their own, including shared values and beliefs, social structures, language, and initiation practices (MacDonald, 2007; McCall & Pauly, 2012; Suominen, Kovasin, & Ketola, 1997). Likewise, nurses' thinking, decision-making and actions are guided by cultural norms and practices (Garner, 2007; Suominen et al., 1997). As such, the power of organizations must be acknowledged for the capacity to control daily routines of workers and to shape their relations and identities (Leonard, 2010). The following section reviews literature to situate PHUs and PHNs within a culture of public health. Specifically, policy documents that guide public health practice in Ontario are discussed to illustrate the aim to address health inequities. Then, studies that have explored public health nursing practice with regard to social justice and health equity issues are reviewed.

### **The Ontario Context**

In Ontario, PHUs and PHNs design and deliver programs and services aimed to promote health and prevent disease at a population level. Currently 36 PHUs across the province are each governed by a local board of health, and are individually responsible and

accountable to provide public health services to the population within their respective geographic boundaries (MOHLTC, 2008). Each board of health is mandated under the *Health Protection and Promotion Act* (Government of Ontario, 1990) to organize and deliver public health programs and services. This legislation also provides the Minister of Health the authority to establish guidelines that each board of health must comply with, namely the *Ontario Public Health Standards* (MOHLTC, 2008). Furthermore, core standards and competencies guide public health nursing practice in Ontario, and reflect the skills, knowledge and values necessary for providing effective public health programs and services (Baba & Reading, 2012). Specifically, the practice of PHNs is informed by the *Community Health Nursing Standards* (CHNAC, 2008) and by *Public Health Nursing Discipline Specific Competencies* (CHNC, 2009). These policies provide a framework for programs and services, nursing roles and responsibilities, and facilitate ongoing professional development, evaluation and feedback (Community Health Nurses of Canada [CHNC], 2009). Collectively, these documents reflect a public health culture in Ontario and offer insight into the mission, values and priorities with which PHUs and PHNs operate.

The *Ontario Public Health Standards* (MOHLTC, 2008) require PHUs to deliver health programs and services that address issues of community sanitation, provision of safe drinking water, family health, home care, health promotion and protection, and disease and injury prevention services (Government of Ontario, 2010). PHUs are also responsible for improving the health of populations through a variety of initiatives including immunization, control of infectious disease, sexual and reproductive health, and chronic disease and injury prevention (MOHLTC, 2008). To ensure that outcomes are achieved, the standards require PHUs to tailor programs and services to address local needs, and emphasize population

health assessment and surveillance to inform program planning and service delivery (MOHLTC, 2008).

In addition to required standards of practice for nurses established by the College of Nurses of Ontario (CNO, 2009b), the practice of PHNs is directed by five standards for community health nursing that define scope and expectations of acceptable practice (CHNAC, 2008), and by eight competencies specific to the discipline of public health nursing that define essential knowledge, skills and abilities required for practice (CHNC, 2009). There is clear direction within the standard of *Facilitating Access and Equity* (CHNAC, 2008) and the competency of *Diversity and Inclusiveness* (CHNC, 2009), which outline the PHN role in responding to health inequities.

The *Facilitating Access and Equity* standard for PHN practice involves consideration of financial resources, geography and culture of a client, and reflects the use of advocacy as a key strategy to influence public health programs, policies, and those of other sectors to positively impact determinants of health (CHNAC, 2008). In an advocacy role, PHNs are expected to take action with and for clients (at organizational, municipal, provincial, territorial, and federal levels) to ensure appropriate distribution of resources that influence health determinants and access to health services, in particular for marginalized populations (CHNAC, 2008). This role includes use of outreach and case finding strategies to ensure those who are ill, elderly, young, poor, immigrants, isolated or who have communication barriers receive access to health services and health-supporting conditions (CHNAC, 2008).

The competency of *Diversity and Inclusiveness* is demonstrated when a PHN, in relation to others in society, embodies actions and attitudes that result in inclusive behaviours, practices, programs and policies (CHNC, 2009). This requires PHNs to effectively meet the needs of a diverse clientele, be it individuals, families, groups or

communities (CHNC, 2009). Specifically, PHNs must be able to understand and recognize how broad determinants of health, including biological, social, cultural, economic and physical factors influence the health of a population and its unique subgroups. This competency also requires PHNs to address population diversity in public health programs and policies by applying “culturally-relevant and appropriate approaches with people from diverse cultural, socioeconomic and education backgrounds, and persons of all ages, genders, health status, sexual orientations and abilities” (CHNC, 2009, p. 7).

### **Social Justice and Healthy Equity in Public Health Nursing**

In addition to public health practice standards and competencies, a small number of studies have examined how PHNs address social injustices and health inequities (see Table 1 on p. 19 for search strategy). Interestingly, all three primary studies found in the literature were qualitative in nature and were conducted in Canada. For example, one qualitative study set in urban Alberta explored the process of designing PHN-delivered health education sessions for parents of children who were enrolled in a primary health care program designed for low-income families (Williamson & Drummond, 2000). Ten focus group interviews with a total of 65 parents were facilitated by PHNs. The purpose of these discussions was to explore parents’ issues, needs, knowledge and abilities related to promoting the health of their children (Williamson & Drummond, 2000). No specific research methods were cited; however, findings were categorized according to six main topics that were used to direct group discussion. Determinants of children’s health were identified, most notably perhaps was that parents discussed low-income status, inadequate health insurance and lack of transportation as barriers they faced in promoting their children’s health (Williamson & Drummond, 2000). Likewise, these issues reflected recommendations made by parents that

they perceived would assist them to better promote their children's health (Williamson & Drummond, 2000).

Table 1

*CINAHL Literature Search Strategy for Primary Research Studies of Social Justice and Health Equity in Public Health Nursing Practice*

Search Terms	Total # Documents Retrieved	Citations of Primary Research Studies Related to PHN Practice
Health Equity AND Public Health Nursing/Nurses	2	*Source listed more than once No primary research studies
Health Inequity/ Inequities AND Public Health Nursing/Nurses	5	*Williamson, D. L., & Drummond, J. (2000). Enhancing low-income parents' capacities to promote their children's health: Education is not enough. <i>Public Health Nursing, 17</i> (2), 121-131.
Social Justice AND Public Health Nursing/Nurses	13	Falk-Rafael, A., & Betker, C. (2012). Witnessing social injustice downstream and advocating for health equity upstream: "The trombone slide" of nursing. <i>Advances in Nursing Science, 35</i> (2), 98-112.  *Williamson, D. L., & Drummond, J. (2000). Enhancing low-income parents' capacities to promote their children's health: Education is not enough. <i>Public Health Nursing, 17</i> (2), 121-131.
Social Injustice AND Public Health Nursing/Nurses	0	No primary research studies
Social Determinants of Health AND Public Health Nursing/Nurses	4	No primary research studies
Determinants of Health AND Public Health Nursing/Nurses	12	Richard, L., Gendron, S., Beaudet, N., Boisvert, N., Sauv, M. S., & Gardeau-Grodeur, M. (2010). Health promotion and disease prevention among nurses working in local public organizations in Montreal, Quebec. <i>Public Health Nursing, 27</i> (5), 450-458.

Another qualitative study investigated how PHNs in Montréal, Québec conceptualized health promotion and disease prevention (Richard et al., 2010). The authors reported a sample of 41 PHNs who participated in semi-structured interviews (Richard et al., 2010). Methods for data analysis relied on investigator triangulation whereby data were analyzed by four investigators to enhance reliability of study findings. The authors reported

an absence of discussion among PHNs about broad determinants of health, which was also reflected by the narrow range of health promotion and disease prevention activities used by the participants (Richard et al., 2010). Findings emphasized health education and screening targeted to individuals and families, with little mention of policy-level activities or action at organizational or community levels (Richard et al., 2010).

More recently, Falk-Rafael and Betker (2012) used a comparative case study design to explore the congruence of critical caring theory with public health nursing practice. Ten “expert” nurses from three cities in Southern Ontario were interviewed and asked to discuss how ethics of caring and social justice related to their practice. Then, two focus groups with a total of 16 community health nurses from across Canada were used as a means of confirming or disconfirming preliminary findings and as an opportunity to generate more data. In contrast to Richard et al (2010), findings from this study identified political and social advocacy as an important focus in the practice of these PHNs (Falk-Rafael & Betker, 2012). Of note was the finding that participants had difficulty when asked to articulate the frameworks they used to guide practice. Instead participants discussed how their practice was based on values of respect and social justice.

### **Approaches to Exploring Culture and Difference in Nursing**

Within nursing, it is widely held that the cultural backgrounds of clients must be taken into account when planning and delivering programs and services (Bearskin, 2011; McCall & Pauly, 2012). However, there exists considerable variation in how culture is understood and applied (McCall & Pauly, 2012), including how differences are acknowledged and addressed. To date, many definitions of culture equate culture with race and ethnicity and have yet to eliminate the problem of stereotyping (Williamson & Harrison, 2010). Literature relating culture and health has traditionally reinforced an essentialist

understanding, one that categorizes all people who share certain characteristics into the same cultural group. More recently, a constructivist view has gained attention as a means to situate culture within a critical paradigm and circumvent dangers inherent in adopting “checklist” approaches to cultural difference. The philosophical underpinnings of these two approaches and their impact on nursing encounters are outlined below.

### **An Essentialist View**

An essentialist bias predominates nursing literature on culture where culture is a feature thought to be stable over time and is often used to distinguish groups of people based on race, ethnicity and religion (Gray & Thomas, 2006; Gregory & Harrowing, 2012; McCall & Pauly, 2012). The tendency is to form assumptions about groups that are subsequently applied to all individuals who are part of those groups (Gray & Thomas, 2006). This narrow understanding of culture is reinforced within nursing education and practice (Aboriginal Nurses Association of Canada [ANAC], 2009; Browne & Varcoe, 2006). In recent decades, a number of approaches to attend to matters of negotiating cultural difference in nursing have appeared, including multiculturalism, diversity and cultural competence approaches.

**Multiculturalism and diversity.** Within nursing discourse, multiculturalism and diversity approaches prevail as a means for negotiating difference (CNA, 2009; Swanson, 2004), and are primarily an approach of “add colour and stir” (Hagey & MacKay, 2000). Central to these concepts is an essentialist understanding of culture, viewing it as something to celebrate, appreciate and preserve (Browne & Varcoe, 2006). For example, nurses are required to work with diverse client populations through the development of appropriate skills to embrace diversity and work with diverse groups (Registered Nurses Association of Ontario [RNAO], 2007).

However, multiculturalism and diversity approaches have been described as providing code words for non-white people, which perpetuate systemic racism by situating white people as the neutral standard with which to measure diverse peoples (Sullivan, 2006). As Puzan (2003) identifies, “under the rubric of ‘cultural diversity’, nurses are taught that health beliefs and self care practices associated with certain non-white populations need to be identified and reconciled within the white, Eurocentric medical model” (p. 194). Moreover, these types of conscious intent to honor and appreciate diversity can simultaneously be routes for white habits of ownership (Sullivan, 2006).

**Cultural competence.** Another widely used strategy believed to build capacity for nurses to work across cultural difference has been to provide cultural competency training (Bearskin, 2011). Conceptually, cultural competence denotes the skills needed by health professionals to work with clients who come from cultures that differ from their own (Duke, Connor, & McEldowney, 2009). In fact, recommendations to improve cultural competence exist at individual, organizational and systems levels (Johnstone & Kanitsaki, 2007; RNAO, 2007). For nurses, cultural competence approaches focus on changing personal attitudes and professional behaviours by targeting self-awareness and communication strategies. Cultural competence, cultural sensitivity and cultural awareness are terms often used interchangeably (Foronda, 2008; Suh, 2004). Similar to cultural competence approaches, cultural sensitivity and awareness programs aim to guide people, willing or not, toward greater cultural awareness of themselves and others (Frankenberg, 1997). This type of anti-racism movement found within “white areas” typically encourages white people to be aware of and redress their attitudes toward non-white people, and has been “structured around the appraisal of representations of non-whites in the white imagination” (Bonnett, 2000, p. 127).

With its focus on the knowledge and skill development of nurses as its reference point, the concept of cultural competence has been criticized for reinforcing unequal power relations inherent in the provider-client interaction (Brascoupe & Waters, 2009). Underlying whiteness assumptions have been identified as being embedded in cultural competence skill development programs, which are often left unexamined (Carlson & Chamberlain, 2004; Frankenberg, 1997), including those of neutrality, superiority and dominance (Aanerud, 1997). Moreover, cultural competence approaches typically fail to link health inequities to the broader social and historical context of colonialism (ANAC, 2009).

Collectively, multiculturalism, diversity and cultural competence approaches tend to operate upon broad cultural categories and disregard attributes of individuals, which permits long-lasting effects of injustice and exploitation that are rendered largely invisible to the mainstream (Mosse, 2010). The essentialist view that informs these approaches tends to see culture as relevant only to those who differ from the mainstream, typically those who have less power and fewer resources (Anderson et al., 2009; Blix et al., 2012; McCall & Pauly, 2012). Indeed, essentialism causes the most harm in situations of unequal power relations where individuals are constructed as inferior, subordinate or needy (O'Mahony & Donnelly, 2010). Furthermore, the use of cultural categories to neutrally describe difference has been criticized for replacing direct discussion of racism (Allen, 1999; Browne & Varcoe, 2006; Reimer Kirkham, 2000). Apolitical and non-contentious differences between people are emphasized, doing little to implicate agents and forces of dominance and oppression that operate in, and benefit from, the construction of cultural categories (Allen, 2006; Gray & Thomas, 2006; Sullivan, 2006).

Several problems arise from essentialist approaches that have been developed without historical consideration (Allen, 1999), including stereotyping and generalization (Browne &

Varcoe, 2006; Mansyur et al., 2009). Also, a focus on culture distracts from important contextual factors such as historical, social, economic and political forces that are the main contributors to barriers clients face in achieving good health and wellbeing (Blix et al., 2012; Campesino, 2008; Duke et al., 2009; McCall & Pauly, 2012; O'Mahony & Donnelly, 2007; Polaschek, 1998). Essentialist analyses of culture illustrate how processes of culturalism, racialization and "Othering" systematically create and sustain the notion of difference, which gets measured against dominant cultural norms (Allen, 1999; Browne & Varcoe, 2006; Gray & Thomas, 2006). The notion of the Other is a colonial product, a process that marginalizes those who are identified as different from the mainstream to reinforce positions of domination and subordination (Johnson et al., 2004). Furthermore, whiteness remains unimplicated and untouched among dominant selves who engage in these processes (Bonnett, 2000; Frankenberg, 1997; Gustafson, 2007). Indeed, these culturalist discourses have been reported to signify the influence and agendas of dominant mainstream powers that aim to legitimate cultural difference against its norms, and which fuel stereotyping and racism (Allen, 2006; Browne et al., 2009; Calhoun, 1996). As bell hooks (1992) explained, "the eagerness with which contemporary society does away with racism, replacing this recognition with evocations of pluralism and diversity that further mask reality...[has] become a way to perpetuate the terror by providing a cover, a hiding place" (p. 345). As such, critical consideration of the notion of cultural difference is essential to challenge assumptions about how it is understood and taken up within nursing practice (Browne & Varcoe, 2006).

### **A Constructivist View**

Importantly, health inequity is connected to historical, social, political and economic factors, rather than issues of cultural difference (Blix et al., 2012). More recently, the

literature has presented dialogue that disrupts essentialized understandings of culture within nursing (Anderson et al., 2009). Specifically, a constructivist view of culture is thought to foster a more comprehensive understanding of shifting historical, political, social and economic influences (Browne & Varcoe, 2006; McCall & Pauly, 2012). With this view, culture is constructed rather than discovered and does not represent something in and of itself (Allen, 1999). In this context, cultural categories are created and taken up within systems of injustice (Allen, 1999). Culture becomes a reflection of values and assumptions inherent in the societal context within which the process of construction occurs (Bearskin, 2011).

Culture, then, is not reducible to specific characteristics, nor politically neutral, but rather “a relational aspect of ourselves that shifts over time depending on our history, our past experiences, our social, professional and gendered location, and our perceptions of how we are viewed by others in society” (Browne & Varcoe, 2006, p. 162). Also, a constructivist approach accounts for shared meanings held within groups while allowing for shifting individual identities based on the “intersectionality” of these features (Reimer Kirkham, 2000). Furthermore, a constructivist stance accounts for power differentials that exist at interpersonal, organizational and systemic levels, which ultimately contribute to health inequities (McCall & Pauly, 2012).

A constructivist view of culture can support nurses to work across difference without succumbing to racializing, Othering and reinforcing existing power imbalances (Reimer Kirkham, 2000). With such a view there is no list of features to be memorized but rather complex interactions that nurses must examine and engage in order to connect and communicate with clients in a meaningful way (Gray & Thomas, 2006). It is thought that a constructivist perspective in nursing “fosters awareness, sensitivity, competence, and moreover the need for *cultural safety* in the care of clients” (ANAC, 2009, p. 1).

**Cultural safety: Origins and underpinnings.** To disrupt essentialist views about culture and the nursing practices that derive from it, several scholars have purported cultural safety as a critical, historicized approach toward affecting social change and addressing health inequities (Browne & Varcoe, 2006; Brascoupe & Waters, 2009; Duke et al., 2009). A finalized definition of cultural safety has yet to be determined (National Aboriginal Health Organization [NAHO], 2006). It is described as a tool to examine the impact of colonization to account for health inequities (ANAC, 2009; Browne, Smye, & Varcoe, 2005), where a cultural safety lens exposes social, political and historical contexts of health and healthcare (Anderson et al., 2003; Bearskin, 2011). Within healthcare encounters, cultural safety approaches seek to rebalance power relations inherent between nurses and clients in ways that affirm, respect and foster cultural expression (CNO, 2009a).

The concept of cultural safety was originally developed by Maori nurses in New Zealand (Ramsden, 1992; Polaschek, 1998) out of concern for disparate health outcomes among the Maori people. Cultural safety was inspired by principles of protection, participation and partnership (Woods, 2010), and led to all New Zealand nurses being required to learn about cultural safety (Browne & Varcoe, 2006). Although initially developed to guide action on addressing inequities among colonized Indigenous peoples of New Zealand, cultural safety has also informed responses to health problems among other oppressed and marginalized groups (McCall & Pauly, 2012; Mortensen, 2010; Woods, 2010). For example, cultural safety has been discussed in relation to addressing health inequities experienced by the Aboriginal peoples of Canada (Browne & Fiske, 2001; Smye & Browne, 2002). Furthermore, cultural safety has been used to examine healthcare experiences of people of South Asian and Chinese ancestry who immigrated to Canada (Anderson et al., 2003), and to explore experiences of an immigrant Muslim community

(Baker, 2007). This broad application of cultural safety suggests that the concept is relevant to everyone (Anderson et al., 2003; Woods, 2010).

In general, cultural safety approaches are thought to promote morally and ethically responsive nursing care by calling on nurses to practice in a way that is regardful, not regardless, of difference (Bearskin, 2011; McCall & Pauly, 2012). Indeed, cultural safety embodies the need for variation rather than assimilation (Richardson, 2004). At the level of client encounters, a cultural safety approach situates nurses as bearers of their own cultures and attitudes (NAHO, 2006) where any interaction with clients is a meeting of different cultures (Richardson, 2004). Importantly, the concept of cultural safety draws attention to power relations. For example, nurses are situated in positions of power where they consciously or unconsciously exercise power over clients and actively perpetuate or confront oppressive practices (NAHO, 2006; Richardson, 2004). As such, nurses are directed to identify and change prejudicial attitudes, to address stereotypes, and to eliminate acts of discrimination by connecting the dynamics of client encounters with broader social issues (Browne & Fiske, 2001).

Cultural safety is also thought to be a political concept due to its aim to redistribute power within healthcare encounters in favour of clients (Gray & McPherson, 2005; NAHO, 2006; Nguyen, 2008; Wepa, 2003). The “safety” component of the concept suggests that if a cultural safety standard is not met then care is, by definition, unsafe (Polaschek, 1998). Nguyen (2008) describes cultural safety as comparable to clinical safety where clients are supported to feel safe in healthcare encounters and to be involved in changes to programs and services. In this way, a culturally safe approach aims to counter tendencies in healthcare relationships that create cultural risk or cause clients to feel unsafe, which may result in delay or avoidance in seeking care (ANAC, 2009; McCall & Pauly, 2012). Furthermore, a

cultural safety perspective emphasizes limitations of dominant cultural values and assumptions that underlie healthcare encounters and policies (Arnold & Bruce, 2005). As Browne and Fiske (2001) argued, the concept of cultural safety is unique in that it “extends analyses well beyond culturalist notions of cultural sensitivity to power imbalances, individual and institutional discrimination, and the nature of health care relations” (p. 127).

**Cultural safety approaches in nursing practice.** Despite an increasing number of discussion papers and commentaries on the concept of cultural safety and its applicability to nursing, very few primary research studies have been conducted (see Table 2 on p. 29 for search strategy). With regard to cultural safety and nursing practice, five studies were identified in the literature, all of which relied on qualitative methods to explore the concept in a variety of settings. Only one of these studies specifically focused on the relevance of cultural safety approaches for use in public health nursing practice. Each of these studies is described below.

Spence (2001) studied the experiences of 17 New Zealand nurses with regard to caring for an increasingly culturally diverse patient population in both acute and community healthcare settings. Data were collected through interviews using open-ended questions and two focus group sessions to clarify participant experiences (Spence, 2001). Importantly, this study revealed that for these nurses it was individual differences, rather than culture, that mattered in the care of clients (Spence, 2001). Also, trying to nurse in the face of difference and related uncertainties required greater effort for the nurses than did caring for people from one’s own culture (Spence, 2001).

Yet another study from New Zealand researched the perceptions among senior nurses about cultural safety in their work in a small, acute care setting (Richardson, Williams, Finlay, & Farrell, 2009). In this context, the authors emphasized that cultural safety was well

Table 2

*CINAHL Literature Search Strategy for Primary Research Studies of Cultural Safety in Nursing Practice*

Search Terms	Total # Documents Retrieved	Citations of Primary Research Studies Related to Nursing Practice
Cultural Safety AND Nursing/Nurses	65	Anderson, J., et al. (2003). "Rewriting" cultural safety within the postcolonial and postnational feminist project. <i>Advances in Nursing Science</i> , 26(3), 196-214.  Baker, C. (2007). Globalization and the cultural safety of an immigrant Muslim community. <i>Journal of Advanced Nursing</i> , 57(3), 296-305.  Richardson, S., Williams, T., Finlay, A., & Farrell, M. (2009). Senior nurses' perceptions of cultural safety in an acute clinical practice area. <i>Nursing Praxis in New Zealand</i> , 25(3), 27-36.  Spence, D. G. (2001). Prejudice, paradox, and possibility: Nursing people from cultures other than one's own. <i>Journal of Transcultural Nursing</i> , 12(2), 100-106.
Cultural Safety AND Public Health Nursing/Nurses	1	Smith, D., Edwards, N., Peterson, W., Jaglarz, M., Laplante, D., & Estable, A. (2010). Rethinking nursing best practices with Aboriginal communities: Informing dialogue and action. <i>Canadian Journal of Nursing Leadership</i> , 22(4), 24-39.

established within New Zealand nursing discourse, including widespread nursing policy, practice and education initiatives (Richardson et al., 2009). A convenience sample of nine nurses were interviewed to explore their perceptions, attitudes and beliefs about the concept of cultural safety in relation to their practice. A questionnaire with open-ended questions was used to collect qualitative data, which was analyzed inductively for themes. Findings illustrated how cultural safety was broadly acknowledged among senior nurses as a practice requirement for nursing as a profession. In an acute care setting, nurses reported challenges in adopting cultural safety approaches in the midst of nursing workload issues such as complex care requirements and limited time for patient interaction (Richardson et al., 2009).

In Canada, Anderson et al (2003) drew on findings from two ethnographic studies conducted in an urban centre, one of which was set in a hospital environment and the other

pertained to home-based care. Specifically, the authors examined the concept of cultural safety in relation to the healthcare experiences of South Asian and Chinese immigrants compared to those of Canadian-born citizens of European ancestry, as well as the experiences of their healthcare providers (Anderson et al., 2003). Between the two studies, a purposive sample of 56 healthcare professionals and 60 patients was reported. Methods for data collection included observation of healthcare interactions and interviews with both healthcare providers and patients about their care-giving and care-receiving perceptions and experiences (Anderson et al., 2003). Independent coding of data by three researchers allowed for the exploration of differences in interpretations of data. Findings from this study emphasized the importance of communication as a key process for culturally safe encounters between patients and healthcare providers (Anderson et al., 2003).

In another Canadian study, Baker (2007) used the concept of cultural safety to study the social health of a small immigrant Muslim community in New Brunswick. The study was in response to concern about anti-Muslim sentiments following the events of 9/11 (Baker, 2007). Using naturalistic inquiry and a purposive sampling strategy, 31 interviews with Muslims who originated from 12 different countries were conducted. Interview questions probed experiences about what life was like both pre- and post-9/11, for example if their relationships with mainstream service providers had been affected (Baker, 2007). Findings revealed a shift among participants from having a sense of cultural safety in their communities, to that of cultural risk following the events of 9/11. As Baker described, it was at this time that participants became “suddenly visible” within the community and negative stereotypes of Muslims took hold (Baker, 2007).

Only one study was found in the literature that studied the concept of cultural safety in relation to public health nursing practice (Smith et al., 2010). The authors drew on

findings from exploratory research to discuss best practices in providing public health nursing care within rural and isolated Aboriginal communities in Canada (Smith et al., 2010). Methods included literature review and interviews with 16 key informants who were leaders in Aboriginal health and best practices, including nurses, researchers, policy makers and non-regulated Aboriginal healthcare providers. Cultural safety was described as involving respect, knowledge, understanding and awareness of the historic contexts of all peoples everywhere (Smith et al., 2010). Moreover, cultural safety emerged as a central theme from key informant consultation as a means to support and strengthen PHN efforts toward reducing health inequities (Smith et al., 2010).

### **Chapter Summary**

PHNs are ideally situated to address the growing social injustices and health inequities experienced among Aboriginal peoples and newcomers in Canada. As a whole, research on public health nursing practice with regard to cultural safety or approaches used to address health inequity and social justice is limited. To date, no research has used cultural safety as a lens to explore public health nursing practice with regard to addressing health inequities in an urban context. As such, a cultural safety lens was adopted in this study to situate health inequity as a chief concern for public health nursing practice. Specifically, a cultural safety lens aims to: 1) anchor the research within a historicized (postcolonial) perspective of health inequities and of public health nursing practice; and 2) identify where power differentials may reside in relationships that exist across all levels of public health nursing practice.

### **Chapter Three: Research Methods**

In Ontario, public health policies outline the roles and responsibilities for PHUs and PHNs. Knowledge of how PHUs and PHNs address health inequities is embedded somewhere between these practice standards and competencies and the actual uptake and use of them in practice. This chapter provides an overview of methodological approaches used to explore how PHNs work to address health inequities and identify factors that influence their capacity to do so. The chapter begins by situating the researcher in the study with regard to personal and professional influences that ultimately shaped the course and outcomes of the research. Then, the chapter moves on to describe the research design including details of the study's setting and sample, as well as the methods used to collect and analyze data. The chapter concludes with a description of strategies that were implemented to enhance rigour, and a brief discussion of ethical considerations is presented.

#### **Situating the Researcher**

Knowledge is socially constructed and value laden; therefore, it must be acknowledged that the work and words of researchers are located within the unique contexts that they occupy (O'Mahony & Donnelly, 2010). As such, I offer the following discussion to help situate myself as the researcher within this study in terms of personal and professional attributes and contexts. Notably, my existence as a white, female PHN and researcher from a middleclass upbringing has influenced all aspects of the research process, from the study's earliest objectives and research questions through to its final conclusions.

During data collection I audited an online course designed to help healthcare professionals better understand how cultural competence and cultural safety relate to their work. This was an opportunity to become immersed in a forum that reflected contemporary representations of cultural safety, and allowed me to consider the essence of the concept in

relation to data, and in turn carve out findings and implications for public health nursing. In this way, cultural safety was “on my mind” during data analysis and permeated my engagement with data and themes that emerged. The course also served to guide me through reflexive writing exercises designed to encourage personal introspection. The following paragraphs draw on my responses to these exercises and are presented to explicate where and how I may have exerted my influence in this study.

As a PHN I value my role in promoting health across difference and throughout the lifespan. I have come to appreciate how broad determinants of health impact individuals, families, communities and society as a whole. I believe that the values of social justice and health equity could be strengthened in public health nursing practice to guide meaningful action on addressing health inequities. Also, I think that PHNs could develop a deeper understanding of these values and how they can be taken up in practice.

Engaging in this research from a cultural safety perspective has led me to question and challenge historical and contemporary causes of health inequities. I am particularly disturbed that postcolonial understanding and historicized perspectives have been notably absent from my training as a nurse, which perhaps reflects a general lack of knowledge or acknowledgement within mainstream society of Canada’s history and its impact on health. For example, for Aboriginal peoples, colonial acts of land possession and “cultural genocide” through reservation and residential school systems make me ashamed that this chapter in Canadian history is broadly understood as a time of modernization and growth, and worse, with the assumption it was for the greater good of all. It is a horrific history and it is clear that modernization has not served the wellbeing of Aboriginal peoples. For me, this begs the question how historical and contemporary colonial influences affect the capacity of PHNs to address health inequities. I think historicized concepts such as cultural safety have a

significant potential to critically orient public health action on addressing health inequities. This has largely influenced my thesis research, which for me was an opportunity to explore how PHNs work to address health inequities and identify factors that influence their capacity to do so.

### **Research Design**

To tap this knowledge, methods for conducting an interpretive description (Thorne, 2008) were used to explicate, articulate and disseminate knowledge that is situated between public health policy and practice. Interpretive descriptive methods are particularly useful to generate understanding of complex experiential clinical phenomena (Thorne, 2008), where the constructed and contextual nature of daily life becomes emphasized and examined (McCall & Pauly, 2012). See Appendix A for a schematic of the study design.

### **Setting**

A PHU was chosen as the setting for this research because of the potential to yield rich data to examine how health inequities are addressed within public health practice and to identify factors that affect public health capacity to address local health inequities. An urban PHU in Ontario was selected for its increasingly culturally diverse population, in particular with regard to Aboriginal peoples and newcomers. Of the city's total population, more than 20% had immigrant status and nearly 2% self-identified as having Aboriginal ancestry. According to reports from local Aboriginal health centres, this number underestimates the city's Aboriginal population by about 50% (Dawn Smith, personal communication, June 25, 2010).

### **Sample**

With regard to sample size, no firm criteria exist for an interpretive descriptive study (Thorne, 2008). A smaller sample, between five and 30 participants, is considered

appropriate when the purpose is to develop a meaningful description of a complex clinical phenomenon and a particular disciplinary lens is useful (Thorne, 2008). A sample of PHNs and other public health professionals was purposefully selected for their experiences working with clients at individual, group, and community levels, and for their organizational knowledge of the PHU. Where PHNs work to meet the health needs of clients from different social, economic, political, historical and cultural contexts, they are situated to identify personal, organizational, and systemic forces that create and sustain health inequities. Thorne (2008) identifies this purposive sampling technique as the recruitment of specific settings and individuals based on their “angle of experience”, which may lead to a better understanding of phenomena under study. As such, a purposive sampling strategy was used to recruit participants from a variety of public health programs, including: sexual health and harm reduction, chronic disease and injury prevention, family and school health, priority populations, and equal access and diversity. This sample was an appropriate data source for interpretive description, where practitioners are considered a rich source to gather informed and thoughtful insights that may not otherwise find the forum to be shared or documented (Thorne, 2008). Participants were eligible to participate if at time of data collection they: 1) were an employee of the PHU; 2) practiced in a professional capacity, either as a PHN, project officer, program manager, or supervisor; and 3) could participate in an English interview.

Moreover, to capture the complexity of the phenomena under study, Thorne (2008) also suggests that textual sources can be valuable data for interpretive description to limit the extent of researcher subjectivity on how phenomena are constructed during analysis. For this study, inclusion criteria used to sample documents for review were: 1) the document was designed to guide public health practice in Ontario; 2) the document was mentioned during

interviews when participants were asked to identify policies that supported their public health practice; 3) the document was publicly available, that is, internal organizational documents were excluded; and 4) that the citation of the document, in the context of presenting raw data to support findings, would maintain the anonymity of the PHU.

### **Data Collection**

Data collection occurred over a four-month period in 2011, between the months of March and June. The researcher supplied PHU program managers with a recruitment letter outlining the study (Appendix B), which was distributed to potential participants via internal E-mail and at staff meetings. Some participants requested copies of the recruitment letter at the time of their interview so that they could distribute it to colleagues who they recommended as potential participants. Those interested in participating in the study contacted the researcher directly to arrange an interview at a time and place of their convenience. Participants were offered a copy of the interview guide to review prior to their interview if they so desired (Appendices C and D). Interview questions were designed to explore the meaning of culture among participants and to identify concepts, organizational approaches and personal attributes that shape their work with clients from different cultural backgrounds.

Interviews were semi-structured, and were conducted in-person in meeting rooms and offices of the PHU. One interview was conducted in the participant's home at her request. Interview questions were designed with a cultural safety lens in that the concept of culture was selected to focus the discussion. As in other studies (Spence, 2001), the term *culture* was not defined for interview participants. Rather, the meaning of culture in the context of this study emerged and unfolded throughout the research process.

Prior to commencing interviews, consent was discussed in detail and participants were invited to have any questions or concerns regarding the research addressed by the researcher. Participants were made aware that their decision to participate or not was voluntary and that they could withdraw from the study at any time without explanation. Written consent was obtained (Appendix E), and participants completed a demographic form (Appendix F). Interviews lasted between 20 and 45 minutes, and were audio-recorded and transcribed verbatim. Seven of the interviews were transcribed by the researcher, described by Thorne (2008) as an opportunity to attend to the “nuances, words, phrases, and pauses, and to hear more deeply what the language contains” (p. 143). The remaining seven were professionally transcribed.

Prior to, during, and after data collection an effort was made to create a thick description of experiences and settings encountered in the field. Thorne (2008) suggests that researchers should maintain a field notebook to track reflections and analytical thoughts that arise. Ultimately, these records were not included as data per se, but contribute to a researcher’s understanding of their own role in constructing data collection and analysis (Thorne, 2008). For this study, handwritten notes were taken at the time of interviews to record details of the encounters, and an electronic record was maintained throughout the research process to capture researcher reflections. Also, an audit trail was kept to document what was collected as data, how it was analyzed, and what interpretations evolved throughout the research process.

### **Data Analysis**

Cultural safety served as a theoretical lens that guided an interpretive analysis in order to describe how a PHU and PHNs address health inequities. For example, a cultural safety lens aimed to identify evidence of postcolonial understanding among PHNs and where

power differentials may reside in relationships that exist across all levels of practice. To begin, the researcher became immersed in data by listening to audio-recordings and conducting multiple readings of transcripts and policy documents, which occurred throughout and beyond data collection. Thorne (2008) suggests that themes identified early on in data collection be broadly coded so that bits of data that might be thematically related are brought together.

Initially, a broad coding scheme was developed according to themes that emerged from across data sources. Specifically, an inductive content analysis of interview transcripts and public health policy documents yielded broad codes and categories that were pertinent to the research questions. Inductive content analysis is appropriate when no previous research has explored the phenomenon under study (Elo & Kyngäs, 2008). Thorne describes this level of analysis as a *topical survey*, which represents an inventory of topics that were covered by participants. This coding scheme then served as a template for coding of transcripts, where initial codes and categories were then considered in light of subsequently collected data. The flexible nature of the coding process allowed for the exploration of emergent issues and inclusion of both convergent and divergent data. Also, the ongoing engagement with data helped to confirm, test and expand on conceptualizations that arose early on in the data collection process (Thorne, 2008).

Coded data were then considered in relation to each other to create a *thematic summary*, which was an ordered representation of initial thematic groups and patterns (Thorne, 2008). That is, relationships were identified among coded data to comprise thematic findings. Finally, findings were moved to a higher level of abstraction toward what Thorne (2008) calls a *thematic description*. At this level of analysis, themes are considered in relation to concepts exported from other sources or derived from study data to reveal latent

patterns within the data (Thorne, 2008). To achieve this, concepts derived from document review were considered in relation to findings from the thematic summary. Specifically, “discursive formations” within public health nursing practice were identified. Discursive formations are the ways in which clusters of keywords, mobilizing metaphors, ideas and forms of knowledge are used to commonly communicate issues across various sites (Wemyss, 2009). With regard to this study, the ways in which the aim to address health inequities was communicated within and between public health practitioners, organizations and disciplinary bodies were sought. See Appendix G for an example of how findings moved from topical survey to thematic summary, and finally to thematic description.

### **Rigour**

Lincoln and Guba’s (1985; 1994) trustworthiness framework is a widely used tool to assess the degree of confidence researchers have in their data in terms of five criteria: credibility, transferability, dependability, confirmability and authenticity. Each criterion is described in relation to how it was utilized to establish rigour in this study (also see Appendix H).

#### **Credibility**

Credibility addresses the confidence in truth and subsequent interpretations of data (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Polit & Beck, 2012). This criterion is two-fold. First, the study must be carried out in such a way that enhances the believability of findings. Strategies included reflexivity, data and method triangulation, and member checking. Reflexivity was used throughout the research process to identify how and when researcher perspectives influenced study findings. This was accomplished through the construction of a primary record that included field notes, an electronic record of analytic

thoughts and reflections of the researcher, an audit trail of data analysis, and responses to guided reflexive writing exercises.

Triangulation enhances credibility of research findings with its goal being “to explore levels of convergence, complementarity, and dissonance” of data (Farmer, Robinson, Elliott, & Eyles, 2006, p. 380). For this study, multiple methods for data collection (interviews, document review) and a variety of data sources (public health leaders and frontline practitioners serving a range of clients) were used to converge multiple perspectives and inform the findings. Also, investigator triangulation was achieved where four transcripts were selected for independent coding by the researcher and another committee member.

Member checking was another essential component to help validate findings. The researcher shared preliminary findings from data analysis with study participants and invited their comments to confirm, challenge, and refute the researcher’s interpretations. Of the 14 participants, two requested to speak with the researcher to clarify and expand on the findings. Both member check interviews occurred via telephone conversations that lasted between 20 and 30 minutes, during which the researcher took handwritten notes. Member check participants were in general agreement with preliminary findings and their insights were incorporated into the analysis and presented as part of the findings.

### **Transferability**

Transferability is the extent to which study findings can be used or applied to other groups or settings (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Polit & Beck, 2012). It is therefore important for the researcher to sufficiently describe the study context and findings so that an external reader can assess applicability of findings to other contexts. As such, thick descriptions of the study setting and sample were developed to enhance transferability so that

readers may determine the extent to which findings from this study could be relevant to other settings or groups.

### **Dependability**

Dependability addresses the stability or reliability of data over time and conditions (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Polit & Beck, 2012). Credibility and dependability are inextricably linked (Polit & Beck, 2012); therefore, similar strategies were used to enhance these criteria including triangulation of data collection and analytic methods, as well as investigator triangulation where four transcripts were independently coded by the researcher and another committee member. Furthermore, member checking was performed and a detailed record of decision-making during the research process was kept in the form of an audit trail.

### **Confirmability**

Confirmability is concerned with ensuring data is representative of information provided by participants, where findings reflect participants' voice and not researcher interpretation that is influenced by their own motivations, biases and perspectives (Guba & Lincoln, 1994; Lincoln & Guba, 1985; Polit & Beck, 2012). Strategies to meet this criterion included three debriefing sessions where the thesis committee, composed of the researcher and three faculty members, reviewed data and discussed thematic findings. Four transcripts were selected for independent coding by the researcher and another committee member, and an audit trail was maintained to document decision-making throughout the research process.

### **Authenticity**

Authenticity is achieved when external readers get a keen sense of the lives of participants and an increased sensitivity to issues being described, including the experience, mood, feeling, language and context of the lives of participants (Guba & Lincoln, 1994;

Lincoln & Guba, 1985; Polit & Beck, 2012). Strategies to enhance authenticity included reflexivity and thick description of the study setting and sample.

### **Ethics**

This study received ethical approval from two research ethics boards, one was at the University of Ottawa and the other was internal to the PHU. The University of Ottawa required ethical approval from the PHU to grant final approval for this study. As such, ethical approval from the PHU is implicit in the certificate of ethical approval from the University of Ottawa (see Appendix I). A certificate of approval from the PHU is not presented to preserve its anonymity.

Prior to an interview, the researcher described the study and outlined how confidentiality and data would be protected. All electronic data, including digital audio-recordings of interviews, were stored in password-protected files. Only the researcher and members of the thesis committee had access to electronic data. To maintain participant anonymity, each participant was assigned a numeric identifier that was used to identify data. A list of names with corresponding numeric identifiers was stored in a locked cabinet available only to the principal researcher and thesis supervisor, and is to be destroyed upon publication of study findings. All identifying information was removed from transcripts of audio-recordings. Hard copy data, including consent forms signed by participants, were stored in locked cabinets at the School of Nursing, University of Ottawa. There was no financial incentive to participate in this study.

## **Chapter Four: Findings**

This chapter presents the findings of the interpretive descriptive research process to describe how a PHU and PHNs work to address health inequities. A total of 14 participants were recruited, including nine PHNs, one project officer (PO), two program managers (PM), and two supervisors (SUP). Participants ranged in age from 29 to over 60 years old, and had less than one year to over 30 years of experience working in public health. Twelve participants were female and two were male. Participants self-identified with eight ethno-cultural backgrounds and collectively spoke ten different languages. With regard to document review, a total of three policy documents were sampled to illustrate how and why health inequities are addressed within public health practice. They included the: *Canadian Community Health Nursing Standards of Practice* (CHNAC, 2008); *Public Health Nursing Discipline Specific Competencies* (CHNC, 2009); and the *Ontario Public Health Standards* (MOHLTC, 2008).

### **Thematic Summary**

Two major themes emerged that described how the PHU and PHNs addressed health inequities: *building relationships* and *working within a frame*. Building relationships was central in the work of PHNs, which involved: delivering the message, taking the time, being present, the right nurse and learning from communities. The “frame” of public health practice comprised factors within and outside of the PHU that influenced the capacity of PHNs to address health inequities, including: culture and stereotypes, public health standards, setting priorities, inclusion of priority populations, responding to change and (re)action through reorganization.

## **Building Relationships**

The theme of building relationships describes how PHNs worked with local population subgroups that were identified as being at risk for health inequities. This aspect of their practice was strongly reinforced in all three public health policy documents, where building relationships with communities aimed to promote partnership and collaboration on the design and delivery of public health programs and services. The following data illustrates how public health policy has shaped the practice of building relationships with regard to addressing health inequities:

Public health has a leading role in fostering relationships to support broader health goals to achieve the best possible outcomes for all Ontarians [MOHLTC, 2008, p. 13]

A PHN is able to involve individuals, families, groups and communities as active partners to identify assets, strengths and available resources and to take action to address health inequities, needs, deficits and gaps [CHNC, 2009, p. 7]

This theme of building relationships in public health practice comprised five subthemes that illustrated various influences on this process: *delivering the message, taking the time, being present in the community, the right nurse and learning from communities.*

**Delivering the message.** This subtheme revealed how public health practitioners relay public health information, situating themselves as messengers in relation to their clients. Many participants identified barriers to delivering public health messages, including language and literacy issues:

Not being able to access a certain population because we can't speak the language...or they can't read, so that's the other barrier. So sending a flyer won't work, knocking on their door I'll need an interpreter, those are barriers [SUP\_1]

Utilizing translation and interpretation services, and simplifying content, were used to facilitate communication and address various language abilities and literacy levels. These

strategies are noted in the following exemplars from interviews with a project officer and supervisor:

The tactics are ...to outreach them through community leaders who promote culture actually, not health. And then we try to blend with their cultural events and then send out messages.... we really focus on the messaging and we really, really simplify them [PO\_9]

Many participants identified that hiring frontline staff that speak different languages facilitated client access to public health programs and services, while also minimizing cost to the PHU:

More and more [we] actually have hired people with language capabilities to serve the population, so we decrease the interpretation service [PM\_11]

However, one participant explained that having employees with multiple language abilities was desirable for the PHU, but PHNs were not remunerated or given support for this additional skill:

The [PHU] did like to have nurses who spoke different languages, but not necessarily gave extra support or...pay them for language.... It was good that you spoke another language but (laughs) that's all that it is really [PHN\_8]

In addition to language and literacy issues, a variety of media strategies were found to play an instrumental role in communicating public health messages to the public. This was evident in both interviews with public health practitioners and document review:

They use different means of communicating with the communities, whether it's [radio station], community newspapers...they're using social media more and more. And I think it all ties in to the service excellence plan, the outreach to the cultural communities. I think [PHU] is very good at that [PHN\_5]

[A PHN] understands and uses social marketing, media and advocacy strategies to raise awareness of health issues, place issues on the public agenda, shift social norms and change behaviours if other enabling factors are present [CHNAC, 2008, p. 11]

Collectively, these communication strategies aimed to raise community awareness of public health and ultimately to encourage behavior change.

**Taking the time.** Investing time for relationship building was described as vital to developing meaningful relationships at individual and community levels. Having continuity of frontline staff over time was essential to identify community leaders and establish trust:

Having continuity of care...to give the time for that public health nurse to ingrain herself in that community so she gets to know who's who and who can help her get in...it takes at least one year to wet your feet in a community. And what happens because of staffing issues or reorganizations we move people around, so in terms of [higher risk populations]...they need more intensive effort on our part to get to know them, build trust, because trust is often an issue, so that we can start that relationship and eventually get to the health promotion [SUP\_1]

In the following quote one frontline PHN shares her experiences of attending community events to build relationships with communities over time, which then led to opportunities for delivering public health programs:

And it's not forcing any programs or any services on them. And now it's taken three years and now I get requests all the time from the community, not necessarily interested in sustained programming for the Aboriginal and Inuit communities, it's more one-offs [PHN\_5]

Given the "long time" it takes to build relationships, some participants identified that time constraints set by the PHU and provincial government were often a barrier that they encountered in their work with communities:

I think nurses have the skills to do it. It's just on paper it's difficult to report the work that we do to get us to point B. And it's a long time relationship building. What do you report on to the province? 'I'm doing relationship building', 'well you've been doing that for three months', 'well I need another eight thank you very much' kind of thing [SUP\_1]

The biggest challenge often is the timeline. Oftentimes our timeline is very short, so the community isn't really responding to the short timeline that we have [PM\_11]

These findings emphasized a temporal nature of relationship building, where continuity of frontline staff over time and the amount of time spent with communities were important factors that influenced the work of PHNs.

**Being present in the community.** Maintaining a physical presence was found to be paramount for PHNs in building relationships with communities. This subtheme showed how participants reached out to communities where essentially, relationships were built by being present. Being present was supported by standards that guided PHN practice:

Caring is expressed through competent practice and development of relationships that value the individual and community as unique and worthy of a nurse's "presence" and attention [CHNAC, 2008, p. 6]

Similarly, many participants explained that their physical presence in community settings was necessary to build relationships. This required practitioners to be flexible in the time and place of their work, for example attending events during evenings and weekends. This flexibility was not universal across the PHU, but rather unique to specific programs and teams. One key example of how this was achieved by the PHU was a "multicultural health team" composed of public health practitioners who specifically reached out to newcomers, typically those in their first year of arrival:

The multicultural team members here...they're the ones out there in the evenings and on the weekends having their face in the community and being recognized. And that's how you outreach these communities, it's hard work [PHN\_5]

Being present also involved reaching out to community agencies to establish partnerships and opportunities for collaboration. Additionally, public health practitioners maintained a presence by attending and presenting at a variety of community-held events. These approaches to building relationships were articulated by a frontline PHN who explained:

We also reach out to libraries because a lot of newcomer [are] using the library quite a lot. So we work with those settlement agencies and now [they] have partnership with those libraries... So we collaborate with them and deliver those presentations, workshops in the libraries.... different community like, Arabic, they have a Muslim festival in the summer... those kind of events. We also have a display, we use different strategies, we...do the presentation and go to the community events [PHN\_2]

In fact, during member checks, one participant emphasized that linking with community partners was an essential aspect of their work to target determinants of health, such as housing and employment issues. For example, health promotion strategies aimed to prevent chronic disease and mental health issues were often implemented in conjunction with partnering agencies that worked specifically in these areas.

Maintaining a physical presence in the community was also described as helping to establish trust in PHN relationships with clients, in particular when historical influences persist. The following quote demonstrated evidence of some understanding among PHNs of the importance of relational processes within colonial and neocolonial contexts:

And I think that that's key with Aboriginal community is that because of the residential school experience and because of the 60's scoop, they have a lot of mistrust towards organizations such as public health going into their communities and saying, "This is what you need and this is what I'm going to tell you you need to do." And so I've never approached it from that angle, it's always being present in the community first [PHN\_5]

This understanding of power relations that exist within healthcare encounters was also echoed within public health policy, as illustrated by the following:

[PHNs] build caring relationships based on mutual respect and understanding of the power inherent in their position and its potential impact on relationships and practice [CHNAC, 2008, p. 13]

A number of participants identified that the time and place of their work were potential barriers to maintaining a presence in communities, with daytime working hours on weekdays and being in an office building as key examples. A few participants felt they could "go farther" in their work with communities if they were able to be more present:

We're in schools a lot...but that's just one place of many that people gather and I think we're in the office a lot, we're not out and I think sometimes it takes having someone out in a community to sort of gain that trust and build that trust. That would really help to build some capacity in working with groups [PHN\_4]

I don't think we would be encouraged to have our desk there and work right with that community... I think that those kinds of things probably could go farther.... Sometimes if you're part of a community then it makes a big difference.... the only [barrier] I see is that we're not really like centred in the community, we're kind of here in an office building.... we get comfortable here in our office and with our hours.... I think that we could be out more in the community kind of walking in their shoes with them [PHN\_6]

Interestingly, through member checking, it was discovered that the PHU had recently launched a pilot project of mobile roles for PHNs working in certain programs. This pilot had been introduced more than one year after data had been collected for this study. The mobile aspect means that PHNs no longer hold a dedicated office space, but rather they travel with a laptop and other resources and work from community centres, libraries, schools and other community settings.

**The right nurse.** Findings suggested that not all PHNs are created equal in their capacity to build relationships with communities. A number of participants described certain qualities that were perceived to influence their ability to engage in respectful relations with communities. Specifically, being non-judgmental, respectful and open-minded, and having good communication skills were thought to be essential for building relationships.

Importantly, some participants felt that not all nurses are equally skilled in reaching out to communities:

I find that a lot of the time the nurses view the different cultures, people differently....you classify them, whereas if you really look that they are just like you. Just the matter of the appearance or maybe their belief and so on, but deep down there is more similarities than differences. So I think when you actually approach them and somehow you can convince them that you are interested in them, they will listen to you.... you've got to have a right nurse to do that [PHN\_7]

I think it takes a special personality and somebody with really good people skills to work with clients from different cultural backgrounds... all public health nurses are not, is not necessarily their strength to have people skills in working with clients from different cultural backgrounds [PHN\_5]

Furthermore, when PHNs shared ethno-cultural backgrounds or languages with clients, some participants felt it can facilitate reaching out and building relationships. This was expressed by a PHN who described how public health capacity for building relationships might be enhanced by a more diverse workforce:

Like they really respect me in whatsoever because they knew that I have knowledge... but as soon as you bring someone of their colour, of their language, the bond is like incredible, it's amazing to see that. So that's why we're trying to sort of prove or demonstrate to our administration team that the importance actually of having at least that one person that would be able to actually to link and do the networking within those communities.... it's lacking quite a lot [PHN\_10]

A supervisor shared the view that one's skin colour or ability to speak other languages does not necessarily translate to "doing a great job":

One thing that we take for granted is, if you're not a mainstream culture... it's easy to put you in a multicultural health role and assume that you'll be doing a great job and it's not the case. So it's not because I have white skin or I speak French that I'm not capable of doing multicultural work. So there's that little tendency that I find that's odd to me. You know it's not because a person has dark skin or has curly hair or whatever that they can be better at working with other cultures. And sometimes if you're bringing a person from that culture and you're trying to get to that group that person can actually be a barrier because the values and the rituals of that particular person is blocking, especially if she's an elder and that group is youth. Because they don't see the world the same way as she did. So that's very interesting, I've seen that [SUP\_1]

One frontline PHN described how being a visible minority, not necessarily sharing an ethno-cultural background but simply not being from the mainstream culture was a common ground from which relationships could be built:

The program I was previously in there was a project that was falling down and I guess they just put me in partly because of the colour, working with Inuit... at first there was a bit of testing ground for me... And I knew I had to get a trust from them and I was interested to learn from them as much as they wanted to find out about me... And they come out right away and said, "Well you know you probably know where we are, our situation because you understand. Because we had a blonde and a brunette come from your health unit before and they're going nowhere" (laughs). So right away I knew where I am and sometime that helps.... And I think partly because I am in the different culture, I am living with it [PHN\_7]

This participant described their skin colour and language abilities as useful to the PHU, and perceived their role as “politically correct” at times:

I think I was hired in partly because I was colour, and I speak another language....  
 And I would say whenever there is an urgent need of having maybe colour, a nurse in a certain situation politically correct they probably would ask me. And I’ve been in many situations like that... I would be able to tell what my role would be in certain...  
 I know my place of what I’m supposed to do [PHN\_7]

The same participant also shared how being a visible minority led to personal experiences with prejudice in the workplace:

And you’d be surprised at this day and age that some of the teachers actually have a bit of a prejudice and weren’t happy that I’m actually colour and I represent the health unit.... I was being questioned in my education and my background.... certainly I wouldn’t say the school, but in certain individual teachers... So you have to overcome that and certainly that hinder, that is a barrier for what I was doing. So I actually asked at the end of that school year for a non-colour nurse to go into that school just for a change, because I think it was not helping. Not that I couldn’t handle it but I think it just benefit us better. So I did and they took it well. You just have to deal with it [PHN\_7]

Ultimately, PHN capacity to build relationships was influenced by a myriad of factors including a variety of personal qualities and communication skills. With regard to building relationships with professional associates and communities, PHNs encountered both positive and negative experiences that were in some ways shaped by the colour of their skin.

**Learning from communities.** Participants suggested that public health programs and services are largely developed with the mainstream population in mind. Those working with newcomers, for example, valued community participation as a means to modify existing programs and services, and tailor them to local contexts. This was believed to promote access to and utilization of what public health has to offer:

For our immigrant population...it’s not really writing a new program, it’s the same program, making sure that it is applicable [and] targeted to your population.... So the whole idea of...access and equity is targeted, well-developed, in partnership with the community, in true collaboration with the community, then you can be successful [SUP\_14]

When you're developing a program you hope that it's designed to ensure that a full diversity of people can participate and benefit.... I come with biases, it's almost like it's easy to develop a program that suits your own needs because we all come from experiences and it's only natural.... you have to I think get others involved so that there's more input so that it meets the needs of others.... [that] doesn't always happen [PHN\_4]

One participant provided the following example to illustrate their role in modifying mainstream public health messages to meet the specific needs of local communities:

Some projects... they are just developing for mainstream Canadians and then we adapt that to multicultural groups. For an example, tobacco prevention has hookah promotion... So now that is mostly with Arabic and Lebanese communities, so when they developed their promotions for smoking we developed this piece with them because that's a need for that community [PO\_9]

Another participant, a program manager, gave an example of one way the PHU supports this practice of learning from communities. Specifically, the formation of advisory committees composed of public health staff and community members promote the development of programs and services that are in line with the needs of specific populations, in this case injection drug users:

So it's really getting the population or the people that we're trying to reach out to involved in the services that we're providing.... for the harm reduction team we have what's called a consultative group where we have different organizations on this advisory board but we also have former users who sit on that committee who provide advice and direction on how we should providing services.... I think there's gonna be more of that [PM\_12]

Findings from interviews emphasized the importance of tailoring programs and services, which was reflected in public health policy documents. For example, the following statement from the *Ontario Public Health Standards* identified that:

Boards of health shall foster the creation of a supportive environment for health through community and citizen engagement in the assessment, planning, delivery, management, and evaluation of programs and services. This will support improved local capacity to meet the public health needs of the community [MOHLTC, 2008, p. 14]

Here, community engagement through relationship building emerged as a process for the PHU and PHNs to create and modify public health programs and services to meet the needs of a variety of local contexts.

Overall, the theme of building relationships emphasized its fundamental role in public health nursing practice with regard to working with communities at risk for health inequities. Subthemes revealed how relationship building was influenced by a range of factors within and outside of the PHU, such as the personal qualities and characteristics of frontline PHNs, PHU hiring and operational practices, and by the expectations of the provincial government.

### **Working Within a Frame**

This theme refers to factors that provided a “frame” for public health nursing practice. The frame represents the context within which PHNs work to address health inequities and reveals aspects of the PHU organizational culture. For example, some participants described how they actively represented the PHU when working in their professional roles. At times, their individual agency was in tension with, and in fact secondary to, representing the PHU and its mandate. This is evident in the following expressions from a PHN and project officer, respectively:

Not until you get out of a big organization like this will you be able to say freely of what you believe in and if you wanted to develop on it. I think, because you are working within a frame [PHN\_7]

It's basically be out there for the community but you're not even, you know, talk to media or nothing. We don't try to reflect ourselves a lot but it's public health, always represent public health, within our limits of our mandate and all that [PO\_9]

This influence of the PHU culture on public health practice was also acknowledged within standards of practice for PHNs as having both positive and negative effects:

[PHNs] influence practice through organizational structures, processes, values and

principles, policies, goals, objectives, standards and outcomes. These diverse influences can be enabling factors, or they may constrain how community health nursing is practiced [CHNAC, 2008, p. 9]

The public health frame within which PHNs worked is further illustrated by the following six subthemes factors that influenced public health nursing capacity to address health inequities: *culture and stereotypes, public health standards, setting priorities, inclusion of priority populations, responding to change and (re)action through reorganization*. These factors were not mutually exclusive, but rather intersected and reinforced one another to shape public health nursing practice.

**Culture and stereotypes.** Many participants shared an understanding of culture where it generally referred to values and practices shared among a group of people. At the level of individual identity, culture was described by a few participants as a dynamic rather than static concept, and was “not all defining”. This understanding of culture was believed to help prevent stereotyping:

From a sociological perspective, culture means really, acquired knowledge, acquired behaviour, acquired skill, acquired tradition that is transferable from one generation to another. This being the general understanding on concept of culture, there is one very important component of culture and culture is very dynamic. So it's, it's not stagnant, it's changing and that's why it becomes very important of understanding...culture, what it really means.... One of the things I always tell [medical students] is that they have to always keep culture as a changing dynamics. That would keep them to be free from stereotyping [SUP\_14]

Culture was also thought to exist at organizational, group and population levels, as was expressed in these statements from a PHN and program manager, respectively:

Even the workplace they have a different culture... government they are more planning...and some place they are more action based [PHN\_2]

I think [culture is] kind of a group of things...so it can be values, beliefs, principles, all those types of things grouped together can kind of create a culture... so you can have like an organizational culture... and then you can have culture in terms of populations or groups of people...it has different meanings or different settings for different people [PM\_12]

Similarly, another participant described culture as having a shifting meaning depending on whether it is applied at individual, family and population levels. At the population level, this participant went on to comment that cultural stereotypes helped frame public health engagement with populations:

Culture is one part of your identity, you identify with a particular culture but it doesn't, its not an all defining thing, right, and sometimes we put maybe too much emphasis on culture and not enough emphasis on that particular person. Depending on what the angle of your service is, if you're working with an individual, then it's that individual. If you're working with a family, then the culture is pretty much that family culture. You get into that values and rituals and stuff but when you're working with a huge population then of course you need some basic stereotype because it does help you frame it. We need stereotypes. It can work to our disadvantage but, you know, you need some stereotypes to be able to, to work [SUP\_1]

When asked about how the PHU did and could support them in their work with clients from different cultural backgrounds, participants described a variety of resources that were made available. One program manager provided the following example:

Actually we did have a lot of binders with different cultures and give a brief synopsis of what some of the practices are.... although they need updating [PM\_11]

Other participants responded in favour of receiving training on how to work with different cultural groups. However, there was an awareness that an "endless" amount of information would be required:

Basic training on cultures, the most prominent cultures I guess, like FYI this is their history, this is like where they're coming from, things like that. Or literature that would make you gain better perspective in order to provide better services.... There's a lot you could need to know [laughs]. It might be endless [PHN\_13]

Another participant cautioned that multicultural approaches could lead to stereotyping:

Maybe multicultural training, although I don't know if that is necessary really.... if you get information about a culture, it's very difficult to understand that this is the general information and your client may be different.... Not a bad idea to have some general information, you know, country of origin, are you a Muslim, are you a Christian? Yeah that may help you with certain things.... but I don't think it's

necessary... Let's not put people in, let's not define people as their cultural background only. So that's why I'm hesitant [PHN\_8]

A few participants suggested there was a need for a standardized orientation process for all new hires to learn about the PHU and its mandate, and to develop cultural sensitivity and competence. This is evident in the following exemplars from a supervisor and program manager:

What we would need, I think...refreshers on how to work with different cultures, cultural sensitivity.... I think it should also be part of orientation for all new staff... actually that's a really good one [SUP\_1]

What I would like to see is every single nurse that comes into the organization goes through a standard orientation process where it's kind of like a four to six week process where you learn more about [organization], you learn more about all the different services that we provide... that there would be some type of component within that orientation process about culture and cultural competencies.... at least it would be kind of a mandatory process for every single staff to go through [PM\_12]

The representations of culture that emerged from participant interviews reflected the construction of categories based on notions of difference that might contribute to stereotyping in public health practices. Drawing on a dynamic understanding of culture was thought to help counteract these essentialist tendencies to stereotype cultural differences. Organizational approaches to working with a culturally diverse client population emphasized training sessions for frontline staff, including PHU orientation and professional development activities for PHNs.

**Public health standards.** Standards and competencies that outlined public health practice in Ontario were another key example of how factors outside of the PHU shaped the organizational culture and work of PHNs. One public health policy document identified that practice standards were based on professional values and were designed to direct a broad range of PHN activities:

Practice standards describe the knowledge, skills, judgment and attitudes needed to

practice nursing safely.... Nurses in clinical practice will use the standards to guide and evaluate their own practice. Nursing educators will include the standards in course curricula to prepare new graduates for practice in community settings. Nurse administrators will use them to direct policy and guide performance expectations. Nurse researchers will use these standards to guide the development of knowledge specific to community health nursing [CHNAC, 2008, p. 5]

One participant, a supervisor in the PHU, illustrated how standards for public health practice were the result of provincial legislation, which strengthened the aim of PHUs to reduce health inequities:

In public health...one of the mandatory program[s] that's mentioned within that legislation is access and equity... What it says that every public health program has to be access and equitable as far as it is practicable.... especially after 2008 when the Ontario Public Health Standard[s] came to in place it become more stronger... health inequity becomes a standard in public health terminology. And then priority population based on risk factors [SUP\_14]

This participant also described how these standards were used to measure PHU performance in relation to its aim to address health inequities. In the following statement the supervisor explains that the PHU has more work to do in achieving this aim:

One of the statement[s] is that public health works to increase its access to people who are at high risk because of language, culture, sexual orientation, income and so on. This would include immigrants, Aboriginal population, gays and lesbians and every person who has some kind of problems of accessing. And at the same time addressing the health inequity. That's really clearly stated within public health.... Uh, have we done all? No. Can we do better? Of course [SUP\_14]

Furthermore, “access and equity” and “priority populations” were prominent language used within public health policy documents, which directly reflected the names assigned to specific programs and teams that operated within the PHU. One team developed and implemented crosscutting initiatives including staff training in access and equity issues. Other teams reached out specifically to priority populations, including multicultural and Aboriginal communities. Of note, these specialized teams were situated within the PHU

organizational structure under an overarching program that aimed to address determinants of health.

**Setting priorities.** The process of setting PHU priorities occurred amid shifting agendas of governments and local communities, as well as changes in epidemiological trends. The following policy statements illustrated the role of the PHU and PHNs within this environment:

The board of health identifies public health priorities, including identification of emerging public health issues. The board of health allocates resources to reflect public health priorities and reallocates resources, as feasible, to reflect emergent public health priorities [MOHLTC, 2008, p. 15]

A PHN is able to mediate between differing interests in the pursuit of health and well-being, and advocate for appropriate resource allocation and equitable access to resources [CHNC, 2009, p. 7]

Reducing health inequities and determinants of health presented a challenge for the PHU in the context of competing priorities and limited resources. Despite these challenges, the following statement from a supervisor emphasized how the PHU must demonstrate its commitment to reducing health inequities through its actions and not only its policies:

From [the public health] perspective the challenge is really competing priorities... [I] have to continuously remind people that health inequity is very important. Reading it is easy [holds up a piece of paper]. Implementing it is difficult, because competing priorities... If you are committed that this is important, then that importance have to be reflected by the share of resources that you put into that program.... my task is to make sure that this commitment is there. Not only in words but also in action.... So the challenge is resource from our perspective [SUP\_14]

Public health policy documents acknowledged that broad determinants of health influence the needs of communities. The *Ontario Public Health Standards* emphasized the importance of PHU collaboration with a variety of stakeholders to prioritize these needs:

Effective public health programs and services take into account communities' needs, which are influenced by the determinants of health.... Collaboration among boards of health, their local community partners, academic institutions, and government is integral to the interpretation and prioritization of needs. Shared knowledge can assist

in leveraging resources and aligning community goals and objectives [MOHLTC, 2008, p. 12]

A few participants suggested that a “new wave” was happening in public health, with a move away from sole reliance on epidemiological data to inform priorities toward incorporating community-identified priorities. As one PHN commented:

So based on [epidemiology], so that’s how they develop their mandates and take a direction. Now I think there is actually a new wave in public health, I think they’re looking at more the diversity of the population.... I think what we need to sort of look at through epidemiology is the population that we’re targeting.... A lot of multicultural is really hit by [hypertension or diabetes], Asian, African, and Aboriginals... I think this is where we need to sort of put more of our effort towards – that’s the way to change [PHN\_10]

Another frontline PHN described how the traditional approach of providing programs and services based on specific public health issues was seeing a shift toward topics that reflected client-identified priorities:

There’s our injury prevention program, there’s our physical activity team, we have a sexual health team, and I think we tend to deliver coming from those topics, and I’m seeing a shift, I’m seeing a more openness to having the client drive the health topic.... it’s kind of working from the ground up, with the population and they drive the focus. So I’m seeing changes there... I think people are really looking at evidence and we’re discovering that our way of maybe doing things in the past is not necessarily working [PHN\_4]

However, participants also identified examples of how community priorities were not being addressed, for example when a health issue fell outside of the public health standards:

And there’s really no emphasis on public health on mental health.... And I know that it’s not a priority with the province and it’s not coming down the public health standards... so therefore it’s not a priority, but it should be. So and if you’re out in the community mental health is mentioned all the time, especially immigrant populations [PHN\_5]

Similarly, participants identified that some public health programs and services may be irrelevant in relation to the priorities of some clients, especially among those who struggle to meet basic needs:

Some of them their needs are so great that the helmet campaign is totally irrelevant to them. They're just trying to get food on the table, and we're making sure that we want to push the, I dunno, brain injury campaign which is totally irrelevant to them. So there's that give and take about what we should be working with, with those populations [SUP\_1]

It's their first year and [refugees have] just come from... some pretty horrific places and I think they're trying to meet sort of basic necessities of life... not necessarily public health per se... sexual health programs, our injury prevention programs or healthy eating or whatever. Well you know what, when someone's trying to just find a place to live and... a job and they're trying to make money so they can eat, the last thing I think they have the time or energy for is to learn about wearing a helmet to go biking because they don't even have bikes... they can barely afford to eat let alone bike... that's a population that may not reach out to us a lot because they just have other things going on [PHN\_4]

These findings identified that PHU priorities direct the activities of PHNs, which may fall short of meeting the needs of clients whose priorities reflect determinants of health. In the context of limited resources, PHUs and PHNs appeared to rely on partnership and collaboration with communities, governments and other stakeholders to target these broad and complex issues.

**Inclusion of priority populations.** Findings revealed that a key component in the work of PHUs and PHNs was to reduce health inequities that existed among local priority populations. The *Ontario Public Health Standards* defined priority populations as incarcerated persons, Aboriginal peoples and First Nation communities, refugees, recent newcomers to Canada, and homeless persons, although other groups might also be “at risk”. In the setting of this study, Aboriginal and newcomer groups were identified as two local priority populations. As for how they were identified, the standards that guide the work of PHUs state:

Priority populations are identified by surveillance, epidemiological, or other research studies and are those populations that are at risk and for whom public health interventions may be reasonably considered to have a substantial impact at the population level [MOHLTC, 2008, p. 2]

As such, PHUs were required to engage with priority populations, as is seen in the following example that illustrates how public health standards structured PHU harm reduction strategies:

Collaborating with and engaging community partners and priority populations.... The board of health shall engage community partners and priority populations in the planning, development, and implementation of harm reduction programming [MOHLTC, 2008, pp. 35-36]

Similarly, several participants described “inclusion” of priority populations as an important element in addressing health inequities, as was illustrated in this statement from a frontline PHN:

We’re looking at equality, we’re looking at promoting the health of everyone, we’re looking at a population based approach and that what we do is evidence based. That we’re using what we have at our disposal now and we’re trying to improve that, that we’re inclusive [PHN\_6]

Another PHN described how inclusion of priority populations was a means to improve access to public health information and services:

I’m part of priority populations so... inclusion of clients, and that’s outreaching and improving access to health information and services to all priority populations.... I think that [PHU] is very inclusive of different cultures and very aware that we have to be culturally appropriate and sensitive. So I think it really promotes inclusion of different cultures [PHN\_5]

According to one supervisor, “knowing your population” was the first step to including priority populations. In line with public health policy, the participant emphasized the importance of surveillance and epidemiologic approaches to monitor characteristics of local populations:

You have to know the characteristics of the population in terms of demographic, culture and so on and so forth [to develop a program]. If you are lucky you have...epidemiologic statistics like surveillance data or morbidity data, mortality data, based on ethnicity... But it’s sad to get this data. But at least we know that generally, inferring with whatever research that we have for immigrant population, for women, for socioeconomic groups and so on, at least we know of our population groups. So knowing your population is number one [SUP\_14]

Inclusion of priority populations also appeared to occur through PHU hiring practices, where over time staff had become more representative of the general population. Furthermore, this process occurred in the context of shifting population demographics through immigration:

I remember 1991 a wave of immigration... one day we had in a kindergarten class that was full of little Somali kids who spoke neither French or English, that was from one day to the next they were all, they had arrived. And I remember that and that's when we got all this training.... And that was twenty years ago, so now it's they're all grown up and now they're public health nurses... they grew up and now they're on staff with us. So it's a fait accompli for me now [SUP\_1]

Other participants felt that the hiring of more staff from different cultural backgrounds was needed to build PHU capacity for working with communities. This, along with strengthening how priority populations were identified by the PHU, were approaches that one supervisor thought were of concern with regard to addressing health inequities:

I think we need to hire more people from different cultural background, we need to go out and look for them, we need to provide them the resources that they need for reaching out to the community. We need to increase our capacity of surveillance and data gathering system, that's very important. That's the weakest part that we are having specifically to high risk population.... We need to increase our research capacity in order to learn more from the community and make use of it... So those are areas which is really a concern for me and it should be a concern for everybody who cares for health equity [SUP\_14]

When asked about barriers to the inclusion of priority populations in public health practice, many participants described a lack of community awareness of, or interest in, what public health offered:

From my experience I really don't think the public is aware of public health services... nobody in the community knows what public health does.... I didn't before I worked at public health [PHN\_5]

[Sometimes people are] not very well informed about the role of a public health nurse ... If we deal with a multicultural population who is not used to health promotion but is used to health intervention, then they will use the hospital but they wouldn't see the value of using a drop in clinic for their baby and things like that.... they just don't

think it exist or they don't think that public health is the place to go for it. I am sure that there is a lot of population that we don't see [PHN\_8]

A couple of participants suggested that to improve inclusion of priority populations in the work of public health might be accomplished with “train the trainer” approaches. This was perceived as a means to improve community access to, control over and appropriateness of local public health programs and services:

I always believe that recruiting people from the community and then...we can use them as an outreach workers.... those individuals can be very effective.... And they also be an excellent network for us, reaching out to the communities [SUP\_14]

Public health could probably do train the trainer... a resource person that would be able to sort of be trained, and then bring that information within their population or communities. This way it would certainly...help us, they would be doing the link, we would just do the train the trainer.... And I wonder whether or not this is something that could not be a way of working with those communities and being more efficient.... So as a health promotion strategy, to me it really falls within and answers actually that strategy because you're providing them tools to look after themselves [PHN\_10]

One participant, a supervisor, offered the following example of how the PHU involved a local Hispanic community in public health interventions aimed to improve access to and participation in preventive health screening programs for women:

In collaboration with the [community agency for Hispanic women], we identified women, community women, laywomen, trained in health promotion particularly directed to breast cancer and cervical cancer screening. And we used those trained women, lay outreach workers and evaluated the intervention program. Within two years the number of women going for screening has jumped from thirty or forty to eighty percent. So those kind of intervention is using the community itself with the minimal resource and inputs, you can reach them [SUP\_14]

Drawing on personal experience, a frontline PHN elaborated on some benefits and drawbacks of train the trainer approaches:

I couldn't participate into their community event and they provided me with a nurse. And I gave her actually all the material and we went through... she was a nurse, she understood.... she's adapted everything to that community; see, see how efficient? And she even spoke the language.... So train the trainer is always a good thing to do... The drawback of this approach is that you never know whether or not the

information is given properly. If you can train a nurse this is good because she's a nurse, she does understand and she makes the connections science wise and she can relate. But if you give it to someone who is capable but does not necessarily have the medical background and the nursing background to do this, may have some difficulty... It may short fuse at some point... it could be a potential problem.... If you can find the proper resource person I think it could work quite well [PHN\_10]

**Responding to change.** The participants identified broad forces that influenced the practices of the PHU and PHNs, such as changes in politics, population demographics and public health trends, which illustrated a responsive aspect of public health practice. Often, these changes led the PHU to make changes to programs and services that reflected the political goals or population demographic profiles of the time. A number of participants alluded to forces that operated outside of the PHU that led to organizational change, including those identified by a program manager and supervisor:

For program service change usually it is...by internal or external pressure, whether it's efficiency or effectiveness, or ministry change of direction. Or due to demographic changes, for example seniors right now.... We're doing a program review in order to reflect changes in the program to meet the needs of the demographic change [PM\_11]

Our populations have changed so, so much in the past say fifteen, twenty years, when I started practicing in public health, that we've had to adjust and adopt new practices to make sure that we're in line with our populations [SUP\_1]

Keeping up with change amid shifting landscapes of politics and population demographics was identified as an ongoing and challenging process that impacted the work of frontline PHNs:

Oh that has been many, many changes because I've been here more than 20 years. I mean depending on the lead, depending on what's out there, it's politics, it gear your program to it.... Program are not staying the same all the time, the needs are different all the time [PHN\_7]

One of the big challenges is that the multicultural population, the one who need the service now and today changes. So five years ago you were talking Arabic, everybody is Arabic, now you're talking something else, you know, Pashtu or Farsi. So it's evolving [PHN\_8]

Notably, review of policy documents identified that the ability to be responsive to change was an expectation for competent public health nursing practice:

A PHN is able to adapt practice in response to the changing health needs of the individual, family, group and community and in response to the unique characteristics of the setting [CHNC, 2009, p. 6]

**(Re)action through reorganization.** Many participants described how organizational structures, for example PHU programs, teams and staff assignments, were often “reorganized” in response to shifting public health aims and priorities. A key example of this reorganization process was described by a number of participants, when teams were created to reach out to priority populations in response to changing population demographics and political contexts:

We have a multicultural team, that we didn’t have before, we have a focus now also on Aboriginal health... and multicultural health team... But it is in response to the change in demographics [SUP\_1]

In the early nineties where we had started to develop a program reaching out to the diverse population. So at that time we had a number of immigrants coming from all over the world and frankly nobody knows what to do with them in terms of public health .... we thought of having and creating a specific teams that would work with the different ethnic communities....we thought of having a specific multicultural health team, which was developed particularly for a high demographic population like Chinese, Arabic speaking, the Black population of the Caribbean origins and Vietnamese, Spanish and so on [SUP\_14]

A couple of participants questioned the use of specific teams to work with priority populations, and suggested that integrating these roles into existing teams might be more appropriate:

I think an issue with [the multicultural health team] is that I think they kinda run their own show... I do think they try to support others in different programs with supporting different multicultural groups but I kinda think they’ve got their own work...it would be ideal or better if we had a staff person kind of within the teams, like bringing multicultural to the table so that everything we do in the day to day someone is right there within our team saying, have you thought about this population or this... like sometimes that’s what it takes for change is to have someone in your face everyday reminding you like, how are we going to meet the

needs of this group and have you thought about translating for this...is it really gonna cut it because you've missed this. And we don't have that, you really have to go out of your way to put a request in for support for that piece [PHN\_4]

And I'm not sure that's the best way to do it, honestly...I've been really thinking about why do we have a separate team when in fact... we do Aboriginal, and we do multicultural in our high school program.... So I don't know why they just...hang there when they can be incorporated or integrated more in our teams [SUP\_1]

One PHN suggested that, in general, organizational change in the PHU was largely a reactive rather than proactive process, often with "no plan." This participant also shared their experience with previous reorganizations of the PHU where attempts at participation were not taken into account, which created an environment where "you don't rock the boat":

But I don't think it's as an organization taking well with change, I think it's politically driven so sometime there is no plan to it. And as the nurses working under it... not that we haven't tried, we've tried to comment and so on and so forth for the changes. But all the comments and all the recommendations are not being implemented or being accounted... it's not being taken in, so over the years you just don't comment anymore. I can only say I think partly for myself, I know quite a few nurses in my era would do the same as well as that, they're not going to do anything. So we showed up, we'll just say a few things and we wouldn't rock the boat. And of course we're being told as well you don't rock the boat (laughs) [PHN\_7]

Other participants also shared their experiences with reorganization and the challenges associated with these changes in terms of time investment, frequency of change, and how this impacted their work. Two participants suggested that changes within the PHU were ongoing and indeed were imminent:

When other teams change it's really hard, it takes a little time to again go and explain.... But it's always changing in public health, I think it's going to be a change soon too, so we are used to change [PO\_9]

I think we've had a total reorg three times in three years since I've been at public health. So, and that changes teams and different things. I think change is hard for people, absolutely, and I think with each medical officer health he wants to have his own stamp and there's constant... There's lots of change now in terms of management and things going on in public health [PHN\_5]

Participants revealed that reorganizations of the PHU typically occurred as a result of recommendations from external consultants. A few felt that reorganization could be improved with more engagement of frontline staff to involve them throughout all stages of change within the PHU. Others felt that the PHU made strong efforts to include staff in these changes. These perceptions are illustrated in the following comments from a frontline PHN and supervisor, respectively:

We re-structured the teams because the management mentioned they hire a kind of consultation team and review...and they say okay, maybe we need [to] group those two team[s] together and dismiss that team.... I don't know the top level how to doing that... also have to consult us the frontline worker and not just that person from third party.... as frontline worker we used to the changes, we have to adapt our self to the changes [PHN\_2]

Change is happening in this organization very frequently... and sometimes some of us do not even catch up with the change.... A lot of effort has been made to make some change based on some changing environment, changing policies, changing leadership. But to tell you frankly, a lot has not been taught in terms of training capacity once a change takes place or before a change takes place .... participation in terms of [staff] inputs, valuing their inputs, those are key elements.... But there is a strong effort to involve the staff. But I don't know really...how each individual, how really put their mind and souls into this change [SUP\_14]

The theme of working within a frame illustrates the organizational cultural context of the PHU within which PHNs work to address health inequities. Subthemes reflect factors that operate within and outside of the PHU to shape public health nursing practice including standards and competencies, shifting community and political priorities, as well as changes to organizational structures.

### **Thematic Description**

This thematic description provides an overview of findings that were derived from analysis of the thematic summary to uncover latent patterns within the data. To achieve this, discursive formations were sought through document review of public health policies to identify how public health discourse shaped the practice of PHNs and how they addressed

health inequities. Specifically, *priority populations* and *partnership and collaboration* were fundamental clusters of keywords found embedded within both PHU and PHN practice standards and competencies, which permeated the narratives of public health practitioners. The legitimacy of these discursive formations was especially evident in the “trickle down” of keywords from public health policy, to how the PHU organized and framed its priorities and actions, and onto the frontlines of public health nursing practice.

### **Priority Populations**

The term *priority population* was one way that the aim to address health inequities was communicated and enacted within public health policy and practice contexts. Specifically, the *Ontario Public Health Standards* (MOHLTC, 2008) established that PHUs must identify and work with priority populations, and tailor programs and services according to local contexts. This was perhaps most evident in how the PHU organized its structure to directly reflect public health policy on priority populations.

For the PHU, the notion of priority populations was used to create specialized teams of PHNs and other public health practitioners to work with specific local communities, which had a seemingly cultural orientation. For example, teams had been created to work with local Aboriginal and newcomer communities, and the names of these teams mirrored this intention (i.e. Aboriginal and multicultural health teams). This type of PHU action reflected the public health challenge of keeping up with, and responding to, the shifting needs and priorities of an ever-changing population. Some PHNs questioned the creation of specific teams to reach out to priority populations and thought it might be more helpful if these specialized roles were incorporated into existing teams. These findings suggest that addressing health inequities tends to be separated out from the work of PHNs in other programs and assigned to specific teams rather than integrated into all PHN roles.

## **Partnership and Collaboration**

A key factor that framed the work of PHUs and PHNs were standards and competencies for public health practice, within which *partnership and collaboration* were prominent keywords. For example, the *Ontario Public Health Standards* (MOHLTC, 2008) required PHUs to address determinants of health and reduce inequities by collaborating with community partners. Partnership and collaboration approaches were also found within public health nursing discourse, where building relationships and partnership and collaboration were established to be essential aspects of PHN practice (CHNAC, 2008; CHNC, 2009).

Similarly, findings from interviews with public health practitioners identified that building relationships was central in their work. With regard to reducing health inequities, partnerships with community agencies and leaders were thought to support collective action on addressing determinants of health. Building relationships through partnership and collaboration approaches also enabled PHNs to create avenues for the inclusion of priority populations in the design and delivery of PHU programs and services. Moreover, through community partnership and collaboration, PHNs learned from communities to tailor public health messages and priorities to meet the needs of local priority populations.

## **Chapter Summary**

This chapter presented two major themes that described how an urban PHU and PHNs worked to reduce health inequities that existed among local priority populations. The concept of cultural safety was used as an interpretive lens to explicate factors that operated within the PHU to ultimately shape public health nursing practice.

The first theme, building relationships, was found to be an essential part of public health nursing practice and is strongly encouraged within public health policy. Collaborating with community partners and utilizing a variety of communication tools were essential

strategies that PHNs used to deliver public health messages to communities. The findings also emphasized that continuity of staff and being present in the community helped establish trust in PHN relationships with clients. Notably, findings suggested that some PHNs possessed qualities thought to be necessary when engaging in respectful relations with communities.

The second theme described how public health nursing practice was framed by a PHU culture composed of factors that influenced the capacity of PHNs to reduce health inequities. Standards and competencies that outlined public health practice were a key example of how forces beyond the PHU shaped the organizational culture and the work of PHNs. PHUs and PHNs responded to shifting demographics and changing needs of local populations. When establishing priorities, PHUs and PHNs worked to identify and include local priority populations in the planning and delivery of public health programs and services. Keeping up with the changing landscapes of local politics and population demographics was identified as an ongoing and challenging process for the PHU and PHNs. Structural changes in the form of PHU reorganization were often made in response to shifting public health aims and priorities, which impacted the work of PHNs.

Finally, discursive formations were found embedded within public health policy that became enacted in the ways in which PHNs worked to address health inequities. Namely, priority populations and partnership and collaboration were identified as keywords in public health discourse that illustrate how PHUs and PHNs were mobilized to act and reduce health inequities at a local level. Community partnership and collaboration emerged as a vital aspect of the public health nursing practice of working with local priority populations that are at risk for health inequities.

## **Chapter Five: Discussion and Implications**

This chapter offers an integrated discussion of study findings to further illustrate how PHNs address health inequities and factors that shape this work. The first two sections of the chapter discuss the discursive formations that were identified in this study in relation to existing literature. Then, utilizing the lens of cultural safety, the discussion focuses the gaze not only on what was found in this study, but perhaps more importantly on what was not found. Specifically, findings are considered in relation to concepts derived from a cultural safety framework for nursing education (ANAC, 2009). Finally, the chapter closes with implications for how findings from this study might be used to inform public health nursing practice, education, research and policy.

### **Priority Populations: Neocolonial Notions of Culture and Difference**

With regard to reducing health inequities among Aboriginal populations, Hankivsky and Christoffersen (2008) argue that public health efforts “would be challenged to reject the often used practice of homogenizing the Aboriginal community by drawing on static conceptualizations of culture” (pp. 276-277). This study revealed practices such as the use of binders to help PHNs understand clients according to different cultural characteristics, and the creation of specific teams to work with different cultural groups, where essentialist tendencies of the PHU culture reside and inform practice. Here, the concept of culture can be a barrier rather than a bridge to understanding (Turner, 2005).

Findings from this study identify some awareness among PHNs of the impact that colonialism continues to have on the health and lives of Aboriginal peoples, including a lack of trust in mainstream health services. This is in contrast to other literature that suggests public health practitioners are typically uninvolved in post- and neocolonial analyses (Kowal & Paradies, 2005). Notably, however, the historical forces of colonialism and the

contemporary effects on health and social status remain largely unrecognized within public health policy.

In line with current public health policy, this study detected a trend toward dialogue and action on determinants of health in relation to reducing health inequities among priority populations. Although not explicitly sought, findings from this study did not identify public health practices that target upstream, societal forces that create and sustain social injustice and health inequity.

### **Partnership and Collaboration: Rhetoric or Meaningful Participation**

An emphasis on partnership and collaboration supports other literature that has identified that public health often works with and through community partners to reach target populations (Smith, 2010). In fact, local partnership and community engagement discourse are enshrined in public health policy and practice, and are increasingly viewed as the way to improving the health of populations (Anderko, 2010; Carlisle, 2010; Pacquiao, 2008). This move toward partnership signals an ideological shift from taking for granted nurses' superiority and the assumption that it was their right to shape and control healthcare encounters (Richardson, 2004). Underpinning this movement is the assumption that this approach will improve health outcomes and the sustainability of interventions (Carlisle, 2010).

Indeed, public health has been described as a fertile ground from which community participation has emerged as a central component of practice (Chiu, 2008). With regard to the findings of this study, establishing partnerships with community agencies was a means to participate in a collective action on addressing determinants of health and health inequities. Other research has found similar trends in PHN practice, where forming partnerships with communities can increase power for effecting change with regard to determinants of health,

such as establishing shared goals for policy changes on housing and transportation issues (Falk-Rafael & Betker, 2012).

However, findings from this study identify difficulties that may arise when PHN relationships are shaped by historical, political, social and economic influences. For example, PHNs were found to function as PHU representatives at times when organizational priorities conflicted or competed with those of local priority populations. This is similar to other research that has found nurses often work in between the competing values and priorities of themselves, their clients, and the organizations they work for (Rodney et al., 2002).

This finding contributes to other literature calling for effective approaches to partnership and collaboration when initiatives that target social exclusion and health inequity result in conflict if public health priorities do not align with those of communities (Carlisle, 2010). Smith et al (2010) argue that partnership approaches in public health can lead to improved responsiveness and relevance of programs and services when communities are involved in setting mutual priorities. Indeed, a key challenge for working in partnership is accounting for power differentials that exist in encounters between individuals, community groups and organizations, including the resources and networks they each have to draw upon (Carlisle, 2010). Any attempt to tackle health inequities through rhetoric of community partnership and collaboration are unlikely to make a dramatic impact on redressing unequal societal structures that create and sustain inequities in the first place (Carlisle, 2010).

Ultimately, addressing health inequities will require a transformation of relationships where public health discourses become informed by multiple worldviews (Lynam et al., 2012; Martin-McDonald, 2008). PHNs are well situated to create these new avenues of community engagement; however, establishing trust in these relationships can only be built by demonstrating public health commitments with observable action (Lynam et al., 2012;

Woods, 2010). Importantly, inequities themselves locate sites of community resistance and action where innovative approaches to working in partnership are found (Browne & Dion Stout, 2012).

### **A Cultural Safety View of Public Health Nursing Practice**

There is a call for PHNs to work with local priority populations and address health inequities. Findings from this study support other literature that recognizes the lack of a framework to critically orient and guide this action (Hanlon et al., 2012; Mansyur et al., 2009; Mooney, 2008; VanderPlaat & Teles, 2005). Likewise, there is a dearth of literature that explores to what extent and in what ways tenets of cultural safety can be applied within nursing practice. In the following section the concept of cultural safety is discussed in relation to study findings to consider its potential to guide public health nursing action at systemic levels toward achieving social justice and health equity.

A conceptual framework is presented to illustrate how the study findings relate to public health nursing practice when viewed through a cultural safety lens (Figure 1 on p. 75). It shows how priority populations, PHNs, PHUs and broad systems and society are situated in relation to one another. PHNs are positioned centrally to reflect the disciplinary focus of the study, and are a tri-coloured circle to account for how PHNs represent priority and mainstream populations, as well as PHUs. The two arrows represent where building relationships and working within a frame each symbolize routes for cultural safety to conceptually orient public health action on reducing health inequities.

*The Cultural Competence and Cultural Safety in Nursing Education: A Framework for First Nations, Inuit and Métis Nursing* (ANAC, 2009) aims to strengthen recruitment and

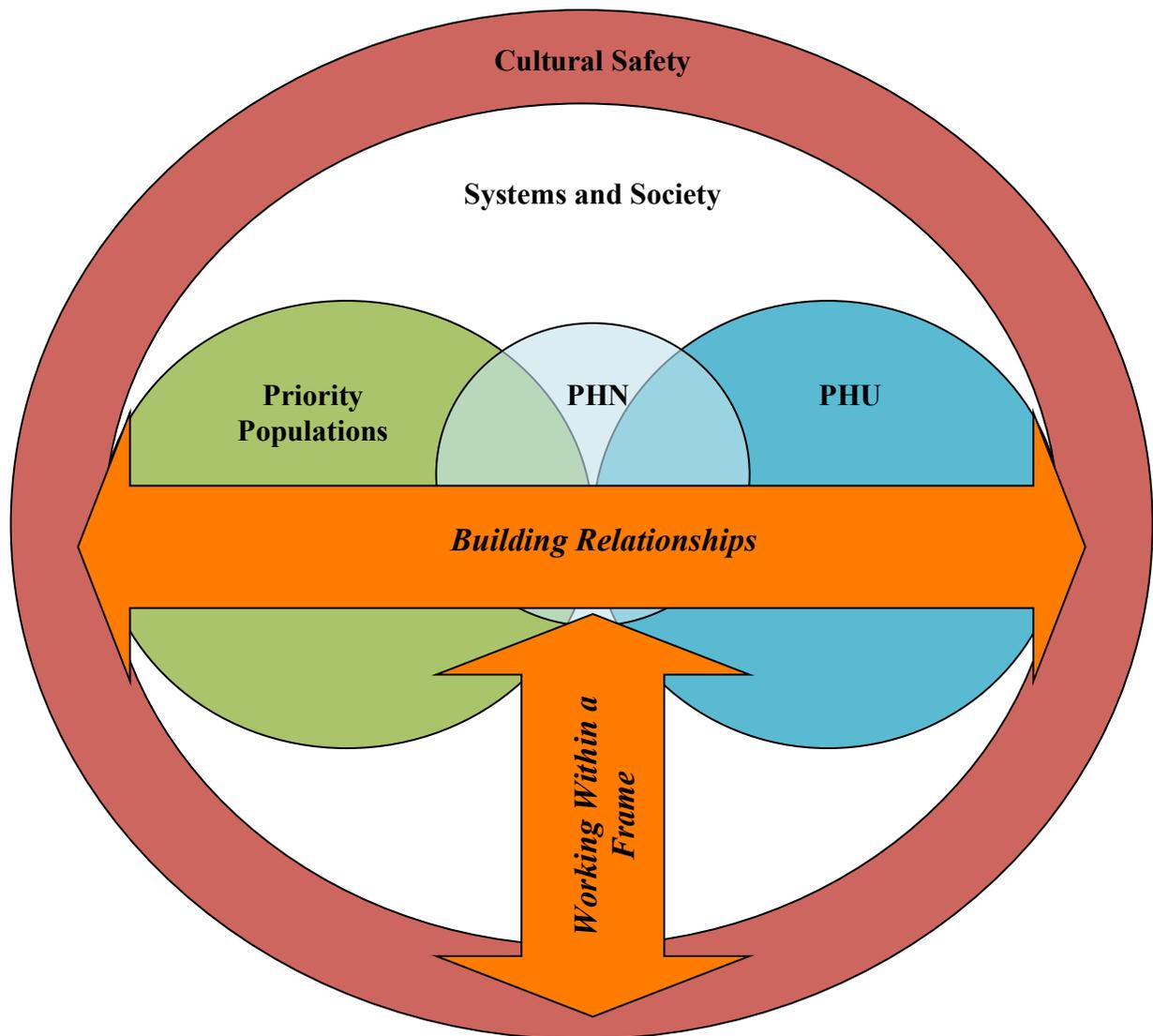


Figure 1. Conceptual framework of study findings.

retention of Aboriginal nursing students in Canada by creating culturally safe academic learning environments. This framework also serves as a tool for developing nursing curricula that prepares Aboriginal and non-Aboriginal students to recognize and address injustices and inequities at individual, group and societal levels (ANAC, 2009). Although developed primarily for use in schools of nursing, this framework has the potential to also be enacted in workplace settings (ANAC, 2009). In fact, this framework was adopted by the Canadian Healthcare Association (2013) to guide an online cultural competence and cultural safety education program for health professionals who work with Aboriginal peoples and communities. The framework operates from a constructivist understanding of culture and outlines six core competencies:

- postcolonial understanding,
- communication,
- inclusivity,
- respect,
- Indigenous knowledge,
- and, mentoring and supporting students (ANAC, 2009).

The following discussion draws on these concepts and applies them to study findings to illustrate how tenets of cultural safety can inform public health nursing practice with regard to reducing health inequities. Here, a cultural safety lens focuses the gaze not only on what was found in this study but also on what was not found.

### **Postcolonial Understanding**

This study adds to a growing body of public health literature on social justice and health inequity by situating PHUs as neocolonial institutions that ultimately frame public

health nursing practice. Given the historical and contemporary influences of colonialism on health, PHNs would be better equipped to address health inequities if they operated with a postcolonial understanding. Findings from this study demonstrate evidence of some knowledge of how colonial practices have negatively impacted the health of many Aboriginal peoples. However, acknowledgment within public health policy to link colonization and health inequity is lacking, as is recognition of the neocolonial context within which public health programs and services are developed and delivered for all.

There is, however, considerable mention in public health discourse of sociopolitical factors that are health protective and those that create and sustain health inequities. For example, the PHN practice standard of promoting health acknowledges that social, economic and political environments impact on the health of individuals and communities, and on PHN practice (CHNAC, 2008). Indeed, PHN practice standards and competencies guide nurses to consider the influence of these issues on health, including political climate and will, societal values and systemic structures (CHNAC, 2008; CHNC, 2009). The *Ontario Public Health Standards* (MOHLTC, 2008) fail to suggest there is any effect of political or historical influences on health or how they may affect public health capacity to address health inequities.

Findings from this study support other literature that identifies broad factors that influence public health nursing practice, such as government legislation and practice standards. In a study by Falk-Rafael and Betker (2012), PHNs encountered barriers in the form of organizational policies, structures and priorities, as well as government legislation that impacted their capacity to address health inequities upstream where root causes lie. Similar to other studies (Falk-Rafael & Betker, 2012; Richard et al., 2010), this study has added to literature that identifies an emphasis on downstream approaches in public health

nursing practice, such as reorganization and connecting with existing community resources. Of note, similar to findings from this study, Falk-Rafael and Betker found that the restructuring of public health organizations and PHN reassignments were “relentless” and were barriers to public health action on addressing health inequities. The authors also identified that these approaches, such as isolating individual and family health promotion activities to specific roles, systematically isolated PHNs from directing their work upstream toward political advocacy (Falk-Rafael & Betker, 2012).

### **Communication**

Findings from this study emphasize communication as an essential component of public health nursing practice. Language and literacy were considerable challenges for reaching out and delivering public health messages to priority populations. To address these barriers, several strategies were used to including use of professional interpreters and translators, multilingual staff, as well as informal interpreters such as community volunteers. Furthermore, a variety of strategies such as print, radio and social media were used to enhance public health capacity to communicate its messages to a wide audience. These findings reflected public health policy documents, within which PHUs and PHNs are directed to engage in communication strategies at local, provincial and national levels as part of comprehensive health promotion efforts (MOHLTC, 2008). Furthermore, communication is listed as a core competency for PHN practice (CHNC, 2009). Of note, PHN practice standards and competencies (CHNAC, 2008; CHNC, 2009) identify “culturally relevant” communication as a part of successful relationship building.

These findings are in support of other literature that describes the importance of communication in nursing. Indeed, language is described as the medium through which personal needs and identity may be understood, which must be attended to in the interest of

providing ethical nursing care (Carnevale, Vissandjée, Nyland, & Vinet-Bonin, 2010). Significant barriers at interpersonal and organizational levels have been found to influence use of interpreters by nurses, which can compromise care and perpetuate discrimination (Carnevale et al., 2010). Furthermore, literature on public health nursing practice has raised concern over how public health information can perpetuate hegemonic and oppressive messages that are influenced by dominant discourses and stereotypes (Aston, 2008).

### **Inclusivity**

Inclusion emerged from this study as a way of providing public health programs and services to priority populations. Findings revealed processes whereby priority populations were included in the work of the PHU and PHNs, namely through outreach strategies aimed to improve access to public health information, programs and services. Also, inclusivity in the PHU occurred through hiring practices that appeared to desire a workforce that is increasingly reflective of the local population in terms of ethnic, cultural and language backgrounds. Of note, none of the public health policy documents reviewed in this study made reference to concepts of inclusion or exclusion.

Similarly, other literature has argued that inclusivity makes visible the ways in which the excluded participate in a system that excluded them in the first place (Fridkin, 2012; Hankivsky & Christoffersen, 2008; Lynam et al., 2012; Mosse, 2010). For example, colonial and neocolonial processes have severely hampered the political engagement of Aboriginal peoples, who are paradoxically excluded by processes purported to be inclusive (Fridkin, 2012). Labonte (2004) points out the contradiction in including those who have historically been politically excluded as a means to effect change, and asks: “How does one go about including individuals and groups into a set of structured social relationships that were responsible for excluding them in the first place?” (p. 256). With regard to public health,

inclusion discourse has been criticized for maintaining power relations of domination and oppression and failing to disrupt structural barriers that create and sustain health inequities (Hankivsky & Christoffersen, 2008).

### **Respect**

Findings from this study indicate factors that influence public health capacity to build meaningful and effective relationships with priority populations. For example, having the right nurse who is able to engage in respectful relations is essential. This is evident in the qualities that PHNs are thought to need in order to have the capacity for building relationships with communities. Furthermore, taking the time and being present in communities were ways in which PHNs demonstrated respect in these relationships. Of note, document review showed that only PHN practice standards make reference to respect and acknowledge its importance in building relationships (CHNAC, 2008).

### **Indigenous Knowledge**

An explicit awareness of Indigenous knowledge within public health discourse or its role in public health nursing practice was absent from the findings of this study. However, with regard to providing public health programs and services to priority populations, limitations of mainstream knowledge and ways of knowing were acknowledged. In fact, learning from communities to modify mainstream public health messages to fit local contexts was essential in the work of PHNs. Within public health policy documents, shared knowledge among PHUs, community partners, academia and governments is described a means to leverage resources and align goals and priorities (MOHLTC, 2008). Furthermore, all documents reviewed in this study refer to the importance of incorporating new knowledge into practice yet there is no mention of Indigenous knowledge. Similarly, Dion Stout (2012) identifies that “scant acknowledgement is given to whether and how the responses and the

human reserves of Indigenous people with lived experience might inform new thinking about ancient ideas while drawing on new interventions from old actions” (p. 11). Hanlon et al (2012) argue that it is time for other voices from other places to be heard.

Other literature has suggested that drawing on new traditions to identify and address root causes of health inequities are underway in nursing discourse (Lynam et al., 2012). For example, Indigenous knowledge and ways of knowing are increasingly recognized as having a place in practice, education, research and policy contexts within nursing and public health (ANAC, 2009; Baba & Reading, 2012; Bearskin, 2011; Flicker & Worthington, 2012; Vukic, Gregory, & Martin-Misener, 2012). Smith et al (2010) found that public health nursing practice with Aboriginal communities must be grounded in Indigenous knowledge, values and culture to promote responsive and culturally safe care. For example, this would involve an understanding and acknowledgement among PHNs of the impact that colonization has had on the health status of Aboriginal peoples. This also calls for PHNs to cultivate innovative approaches to improving health by incorporating new ways of seeing and understanding health and health practices (ANAC, 2009).

### **Mentoring and Supporting Students**

This study has revealed processes whereby PHNs receive ongoing education within a PHU on a variety of public health issues. For example, workshops and training sessions related to culture, such as multicultural health, are prominent in professional development activities for PHNs. Furthermore, suggestions to revise standard PHU orientation processes for new hires to integrate cultural sensitivity and cultural competence education emerged as another possible avenue for essentialist discourse on culture to shape the work of PHNs.

Alternatively, literature suggests that nursing education in cultural safety can help disrupt these tendencies and their effects on nursing practice (Browne & Varcoe, 2006;

Brascoupe & Waters, 2009; Duke et al., 2009). Furthermore, cultural safety approaches to nursing education seek to cultivate mentorship opportunities and supportive learning environments for nurses to build capacity to address health inequities (ANAC, 2009). Some literature has suggested that PHNs obtain a considerable amount of practice knowledge from mentors and role models rather than policies and procedures (Smith et al., 2010).

### **Implications to Promote Cultural Safety in Public Health Nursing**

Cultural safety offers a lens to anchor health inequities within a historicized perspective, and aims to identify and redress power differentials that shape client encounters with public health organizations and professionals. As such, implications for adopting cultural safety as concept to guide public health nursing action on addressing health inequities are presented in terms of practice, education, research and policy considerations.

#### **Implications for Practice**

The importance of building relationships and working in partnership as key actions and outcomes of public health nursing practice cannot be underemphasized. In line with aims of cultural safety, shifting power from nurses to clients requires nurses to critically examine the knowledge used to inform their practice and the inherent assumptions within it, and how this knowledge is constructed and reproduced in their interactions with others (Anderson et al., 2009). Moreover, nurses are called to question how they are positioned in relation to clients and to understand the context in which nursing care is delivered (O'Mahony & Donnelly, 2010). Thus, there is a need for opportunities and tools to support critically oriented public health nursing practice with regard to addressing health inequities. Drawing on the findings of this study, cultural safety implications for the practice of PHNs include engaging in critical reflection and developing a postcolonial understanding.

**Engage in critical reflection.** It is recommended that PHNs engage in regular activities that promote reflective practice, opportunities that could be provided by PHUs during working hours. Indeed, public health practice standards and competencies require PHNs to participate in reflective practice to assess and improve their practice on an ongoing basis (CHNAC, 2008; CHNC, 2009). Engaging in reflective practice is paramount for nurses to become aware of their personal values, attitudes, beliefs, biases and worldviews, and to understand how this impacts on interactions with individuals and communities (CHNAC, 2008; RNAO, 2007). In fact, all nurses in Ontario are legislated to engage in reflective practice (CNO, 2008), which is thought to contribute to nurses' capacity to provide culturally safe care (CNO, 2009a).

Traditionally, reflective practice approaches suggest that reality is constructed and that awareness of these implicit processes allows practitioners to become aware of alternative ways of framing reality (Kinsella, 2010; Schon, 1983), and in turn improve performance (Beam, O'Brien, & Neal, 2010; CHNAC, 2008; McDonald & Glover, 2000; Nelson & Purkis, 2004). Critical self-reflection, for example, can produce an awareness of one's historical positioning, one that situates healthcare providers as holding power and privilege in relation to their clients (Anderson et al., 2009). Pauly et al (2009) echo the importance of critical reflection for nurses, in particular regarding the assumptions they make about clients, and to consider how their own actions contribute to inequities by sustaining marginalizing discourses and practices.

Furthermore, PHNs are called to critically examine disciplinary, organizational, and societal levels to illuminate factors that perpetuate harm for clients at risk for marginalization by dominant norms (Ford & Airhihenbuwa, 2010; McCall & Pauly, 2012; O'Mahony & Donnelly, 2010). Notably lacking are approaches for nurses to acknowledge institutional

contexts and guide frank and critical reflection about power and difference at systemic levels (Swendson & Windsor, 1996). Importantly, public health mentors need to create an environment that promotes open dialogue about issues of culture and difference in relation to health inequities (Spence, 2001). Cultural safety offers PHN mentors and leaders a useful concept to guide these critically reflective practices and provides a tool to understand broad factors that influence health by drawing attention to historical and political forces that shape healthcare encounters and health inequities (Woods, 2010). For example, encouraging nurses to acknowledge and analyze their emotional responses to Canada's colonial history and neocolonial context, and the impact on the health and wellbeing of Aboriginal peoples, can promote reflection on how their personal and professional relationships are shaped by prejudice, discrimination and racism (ANAC, 2009).

**Develop a postcolonial understanding.** Within public health nursing practice there is a need for historicized and politicized understandings of health inequities so that PHNs are equipped to identify and redress systems of privilege and oppression that create and sustain them. As Gustafson (2007) argues, it is ultimately at organizational and systems levels where neocolonial artifacts of whiteness can be named and the hegemonic white discourse that informs nursing practice challenged. For example, missing from public health nursing discourse are strategies that aim to alter the whiteness of clinical institutions and their processes (Hagey & MacKay, 2000).

A cultural safety lens brings this understanding to the forefront to recognize how and why health inequities exist, and aims to prepare nurses to work within (and against) dominant systems that create and sustain health inequities. McCall and Pauly (2012) argue that cultural safety is a strategy for nurses to enact social justice in their practice. The goal is to push PHNs to think beyond cultural characteristics toward a critique of institutional racism

and discrimination in the healthcare system. With regard to building relationships with priority populations, cultural safety aims to provide PHNs with a postcolonial understanding of health inequities and in turn call on them to help dismantle inherent power relations at interpersonal, organizational, and societal levels.

Ultimately, opportunities for PHNs to engage in critical reflection and to develop a postcolonial understanding might include participating in cultural safety workshops during PHU corporate orientation programs and ongoing professional development activities. Also, PHNs could be encouraged to attend to these types of activities if cultural safety principles were integrated into PHN job descriptions and performance evaluations.

### **Implications for Education**

Cultural safety was recently adopted as an entry-to-practice requirement for all Ontario nurses (CNO, 2009a) and is being incorporated into the curricula of nursing programs across the country. This stems from an understanding that achieving cultural safety requires nurses to understand power differentials inherent in healthcare encounters, which can be addressed through educational processes (ANAC, 2009; Mahara, Duncan, Whyte, & Brown, 2011; Spence, 2001). Educational approaches to preparing nurses to work safely and effectively with clients from different cultural backgrounds have found support in healthcare literature. For example, Macaulay (2009) argues that all health professionals should receive training in Aboriginal health to better equip them to work with this population. Similarly, one study reports that its sample of Aboriginal participants also suggested “cultural education” for healthcare providers as one strategy to improve health services for Aboriginal peoples (Kurtz, Nyberg, Van Den Tillaart, & Mills, 2008).

Importantly, cultural safety education goes beyond traditional ways of negotiating culture, such as concepts of multiculturalism and diversity, and approaches of cultural

awareness, cultural sensitivity and cultural competence, which tend to reinforce stereotypical representations of cultural difference. In Canada, professional nursing associations have responded to the demand for cultural safety training through recent development of frameworks and standards for nursing education and practice (ANAC, 2009; CNO, 2009a; RNAO, 2007). Similarly, cultural safety continuing education programs for health professionals are being developed and implemented across the country (ANAC, 2010; British Columbia Provincial Health Services Authority, 2010).

The relevance of cultural safety to the education of PHNs can be considered in terms of pre- and post-licensure activities. With regard to pre-licensure nursing education, a recent meeting of nurse leaders was held to discuss strategies to trouble the notion of culture, to help negotiate difference and to critically frame health inequity (Gregory & Harrowing, 2012). To date, nursing curricula has approached culture in ways that reinforce imperialist, essentialist practices (Gregory, Harrowing, Lee, Doolittle, & O'Sullivan, 2010; Gregory & Harrowing, 2012). Indeed, culture is often taught in isolation from concepts of social justice and health equity (Gregory & Harrowing, 2012). Therefore, cultural safety offers nurse educators and academics a critical approach to exploring culture in relation to nursing practice by imparting a constructivist view of culture and emphasizing power differentials at interpersonal, organizational and societal levels. For example, undergraduate curricula can help nursing students to identify limitations of essentialist approaches to understanding culture, which in turn can help them to avoid attributing client behaviours to cultural considerations alone (ANAC, 2009).

For post-licensure PHNs, cultural safety education might involve professional development activities such as new-hire orientation and ongoing training sessions to frame social justices and health inequities from a postcolonial perspective. Indeed, for PHUs, it is

an expectation that they ensure a competent workforce by providing ongoing opportunities for staff to engage in professional development and skill building related to public health competencies (MOHLTC, 2008). With regard to new-hire orientation, cultural safety education would align the PHU culture with concepts of social justice and health equity and situate it within a neocolonial context. Furthermore, orientation sessions offer the PHU an opportunity to reinforce a constructivist understanding within public health nursing practice. Moreover, cultural safety education for PHNs would satisfy disciplinary competencies with regard to participating in professional and practice development activities (CHNC, 2009). Importantly, however, “regardless of the education provided, a nurse cannot claim to be ‘culturally safe’ unless this is endorsed by the patient” (Richardson, 2004, p. 41). That is, cultural safety is ultimately achieved only if this is determined by the recipients of nursing care to be so (ANAC, 2009).

### **Implications for Policy**

Dominant institutions and members have typically made decisions that preserve their own interests (Ford & Airhihenbuwa, 2010). Indeed, those most affected by health inequities are most often the least represented in policy decisions that affect their health (Whitehead & Dahlgren, 2007). For example, Indigenous peoples whose health inequities are shaped by policies stemming from a history of colonialism have been excluded and marginalized by health policies and processes of policy-making (Fiske & Browne, 2006). Here, health policy acts as a “technology of power” to construct what is normal, who is credible, and who is deserving (Fiske & Browne, 2008). For PHNs, taking action upstream through political advocacy is paramount in their work to reduce health inequities (Falk-Rafael & Betker, 2012). For example, literature has shown that PHNs engage in political advocacy to promote health equity by organizing protests, writing letters and sitting on committees to influence

policy, and arranging meetings with politicians (Falk-Rafael & Betker, 2012). These strategies could be adopted widely by PHNs to demonstrate action on reducing health inequities; however, as PHNs are employed by municipal government structures, Falk-Rafael and Betker (2012) question whether they are situated to challenge governments to create policy that promotes social justice and health equity. Despite this position, if nurses fail to participate in the development of healthy public policy it should come as no surprise when those who are less informed on the causes of health inequities are left to make these decisions (Ervin & Bell, 2004).

For PHUs, organizational policy development can promote cultural safety in its programs and services and support frontline nurses to address health inequities (Brascoupe & Waters, 2009; Browne, 2009; Browne & Fiske, 2001; Gray & McPherson, 2005). In line with aims of cultural safety, strategies for Aboriginal involvement in health policy and decision-making would be necessary to address health inequities in ways that are meaningful for Aboriginal peoples (Baba & Reading, 2012; Fridkin, 2012). As Woods (2010) describes, a cultural safety approach can be considered a social treaty or contract, one that is inclusive of Indigenous values as well as those of all groups in a given society. Anderko (2010) identifies that participatory approaches where marginalized communities work in relationship with policy makers can encourage dialogue and problem-solving for issues at local levels, and “could in turn inform the larger, global decision-making process for achieving health equity” (p. 487). In fact, calls have been made for public policy to be “opened up” to allow new forms of information to influence governance and decision-making (Smith, 2010).

However, very little policy literature reports on how people have worked together when the knowledge and ways of knowing of one group negate those of other groups

(Carlisle, 2010; Fridkin, 2012). Furthermore, harmful implications can result when marginalized populations are misrepresented or included in superficial or tokenistic ways (Fridkin, 2012; Whitehead & Dahlgren, 2007). Cultural safety as a framework for public health discourse on health inequity would serve to acknowledge “colonizing and marginalizing effects of state-sponsored policy processes and their potential for inhibiting the development of policy agendas that promote equity” (Fridkin, 2012, p. 118).

### **Implications for Research**

It is recommended that research be conducted to study cultural safety approaches that are being implemented within public health practice contexts, and more broadly within other healthcare settings. The challenge for PHNs to utilize cultural safety approaches in their efforts to address health inequities will be studies that identify means to evaluate the concept in practice (Richardson, 2004). Indeed, firm evidence to demonstrate its application to, or effect on, practice is absent (Richardson, 2004). Thus, there is a need for research to develop, implement and evaluate tools and techniques that aim to promote cultural safety in public health nursing practice.

Some research has identified an increased perception among nurses that they provide “safe” care, yet corresponding accounts from recipients of care is lacking (Richardson, 2004). Similarly, Hankivsky and Christoffersen (2008) argue that disrupting established norms and “expertise” requires getting the perspectives of populations at risk for health inequities. Others have also identified a need for research to elicit and integrate Indigenous perspectives, ideas, and interests (Browne & Dion Stout, 2012), where “for far too long, those with much to teach us about respectful, holistic, resource-conserving approaches to the enhancement of well-being and quality of life were silenced” (Gregory & Harrowing, 2012, p. 17). As such, research into the experiences of those who access public health and engage

in encounters with PHUs and PHNs could inform cultural safety strategies and build public health capacity to address health inequities.

However, Richardson (2004) cautions that there are ethical concerns when researchers attempt to gather information from communities, including: the undue influence of the researcher, a desire to please among clients, as well as the likelihood of creating safe environments for clients to share their concerns. Another important consideration when undertaking research with marginalized communities is that “voice is always in tension with tokenism” (Ford & Airhihenbuwa, 2010, p. 1396). Tokenism is inclusion to give an illusion of promoting equity rather than as a challenge to the status quo; whereas voice situates marginalized perspectives as holding a privileged position that can expose power imbalances (Ford & Airhihenbuwa, 2010).

For PHUs, internal research activities would offer a tool to facilitate employee and community engagement. Findings from PHU-led research could be used to identify gaps in program and service design and delivery, and to inform strategies for improving the health of priority populations in ways that are meaningful and effective in local contexts. For example, findings from this study would suggest that research into mobile PHN roles should be conducted that explores how this trend might influence public health nursing capacity to address health inequities.

Kernaghan (2009) argues that as a service improvement strategy, employee engagement holds the opinions of employees as important because they provide “factual information, objective analysis and wise counsel concerning the public service” (p. 505). Although it is generally recommended for management to provide regular opportunities to participate in program planning and service improvement (Institute for Citizen-Centred Service, 2007), one Canadian study found that more than 40 percent of nurses working in

community settings lacked opportunities to discuss clinical or program issues with management (Underwood et al., 2009).

At the level of policy, research is a powerful tool to challenge the status quo by holding governments accountable for failed policies as evidenced by findings from studies on health inequity, and by “exposing the veritable underbelly for all to see” (Gregory & Harrowing, 2012, p. 16). As an example, Hankivsky and Christoffersen (2008) suggest it is critical for research to examine the health outcomes of policy decisions on disadvantaged citizens.

### **Study Strengths and Limitations**

Strengths and limitations for this study are described to illustrate how unique aspects of the study design and theoretical underpinnings framed the research process and its outcomes. In turn, these considerations can be drawn on to emphasize the context within which findings and implications were elicited, and to inform future research activities of a similar nature.

A key strength of this study was its purposive sample and multiple data sources. With regard to participant interviews, sampling yielded representation from a broad range of public health programs and services, which elicited diverse perspectives within an organizational culture. Triangulation of data from interviews and document review strengthened the study in that it anchored findings and implications within a public health context; however, this in turn offered support of these structures. In this way, review of public health policy documents was both a strength and limitation of this study.

Another strength of the research was prolonged engagement in the field, which allowed the researcher to observe changes within public health practice over time. Specifically, interviews and member checks occurred nearly 18 months apart. Within this

time, changes in how and where public health practice occurred in some programs were shifting from being centrally located in an office building to being mobile and working in community settings. A key strength of this research was prolonged engagement in the field, both as a researcher during data collection and as the result of maintaining employment as a PHN within the PHU. As a researcher, fieldwork occurred sporadically over a 20-month period. Importantly, findings from this study thus reflect a point in time and correspond with factors that influenced public health nursing practice at the time of data collection.

Finally, my position as both PHN and researcher within the study setting was both a strength and limitation for this research. As a strength, my employee status as a PHN meant that I had insider knowledge of the organizational culture including the PHU mandate and strategic direction, PHN orientation and training, and professional roles and responsibilities. I was also able to participate in various organizational events, including a new employee orientation session and a workshop on access and equity issues. Importantly, I advised all potential participants that I was also a PHN within the same organization. As a limitation, this could have influenced interview data where participants may not have felt comfortable discussing negative experiences or perceptions of the organizational culture and their role within it. To address this issue, I emphasized my role as a researcher during the interview process and that part of this was to maintain confidentiality and their anonymity. Being a PHN within the same organization as research participants influenced this study in other ways too. For example, I worked directly with two of the participants, which may have affected rapport during interviews or led to self-censorship given the nature of our working relationship. Though this was seemingly not an issue for my colleagues, another participant whom I had not known prior to our interview commented that knowing I worked for the

same organization affected her willingness to share candidly about the culture of the workplace.

This insider position created opportunities to attend PHU orientation and training sessions as a PHN, including a workshop on promoting equity and inclusion in municipal government programs and services. Though not included as data per se, these experiences shaped my thinking as a researcher and, I believe, deepened my interpretive capacity.

### **Conclusion**

This study has emphasized building relationships with priority populations as paramount in the practice of PHNs, a process that occurs within a public health frame. Public health nursing represented the disciplinary perspective from which to view the practice of, and possibilities for, addressing health inequities that exist among priority populations. Indeed, PHNs are well situated to operationalize tenets of cultural safety in practice, education, research and policy to build public health capacity for addressing health inequities.

Cultural safety implications for PHNs emphasize mobilizing upstream action toward identifying and redressing power differentials inherent across all levels of public health. To achieve this aim, the integration of Indigenous knowledge and ways of knowing into public health discourse is essential. Routes for cultural safety approaches to permeate public health practice would be through PHU corporate orientation programs and professional development activities, as well as integration of cultural safety principles into PHN job descriptions and performance evaluations. Through these initiatives, PHNs would become well versed on tenets of cultural safety and how they can be taken up and achieved in practice.

In closing, cultural safety offers a lens for PHNs to view the future in light of the past and to critically orient their discussion and action on addressing health inequities. It is through cultural safety that PHNs can build their capacity to contribute a socially just and equitable future by envisioning and creating new ways of being.

We are advocating peaceful, intelligent, and courageous challenges to the existing institutions of colonialism as well as questioning our own complicity in those institutions. But make no mistake: Decolonization ultimately requires the overturning of the colonial structure. It is not about tweaking the existing colonial system to make it more Indigenous-friendly or a little less oppressive. The existing system is irreparably flawed.

(Wilson & Yellow Bird, 2005, p. 4)

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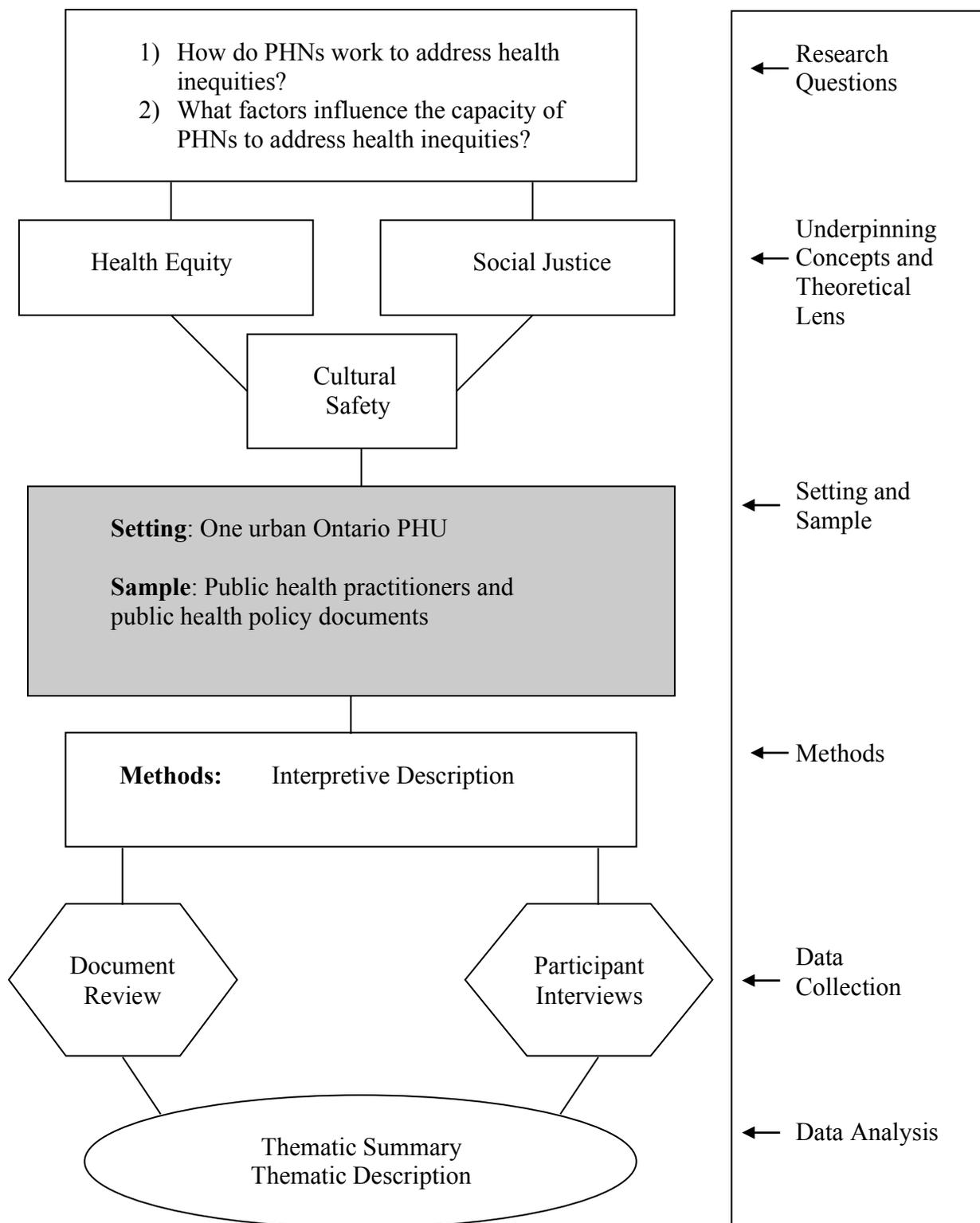
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Appendix A  
Study Schematic



## Appendix B

## Interview Participant Information Letter

March 1, 2011

This letter briefly outlines the goal and purpose of my Master's thesis research project entitled *Exploring Cultural Competence and Cultural Safety: Current Understanding and Practice in an Urban Public Health Unit*.

The goal of this project is to understand how a Public Health Unit and Public Health Nurses are responding to ethno-cultural differences within the local population you serve. The nature of this qualitative exploratory descriptive study is to tap into your experiences as a Public Health Nurse and identify supports and barriers that you encounter in your work with clients who are ethno-culturally different than yourself. Also of interest is to gather your perspectives and suggestions on how Public Health Units and Public Health Nurses can improve services for a diverse client population. Findings from this research may be used to inform public health service improvement initiatives, particularly those that involve staff orientation, training and ongoing education. Findings may also be published in a peer-reviewed scientific journal as a means to disseminate this knowledge.

As a researcher it is an ethical responsibility to guarantee that your identity and contributions to this project will be kept in confidence and will not be shared outside of our meeting. In written works, code names will be assigned to any of your quotes that may be included as evidence to support findings. I also welcome you to review my preliminary analyses and interpretations of data, and to provide comments to confirm or refute my findings.

If you agree to participate, I will arrange a time and place for an interview at your convenience. Interviews will last approximately one hour. To facilitate your participation in this study, and with your permission, I will send you a follow-up email within two weeks of your expressed interest in participating in this study if we have not otherwise been in contact.

I look forward to meeting with you in the near future, please feel free to contact me with any questions you may have.

Kind regards,

Seraphina McAlister  
Master's Student  
School of Nursing, University of Ottawa

## Appendix C

**Interview Guide—Public Health Nurses and Project Officers**

- 1) Briefly describe your education and career path that has led you to work in public health. What is your current role within the organization, and how long have you worked in this role?
- 2) What does the term ‘culture’ mean to you?
- 3) What terms, if any, have you encountered in nursing/your profession that might describe your work with clients from different cultural backgrounds?
- 4) What terms, if any, does the organization use to describe inclusion of clients from different cultural backgrounds?
- 5) What are important considerations when developing and delivering public health programs and services to clients from different cultural backgrounds?
- 6) What knowledge, attitudes and/or skills do public health nurses and other professionals need to work effectively with clients from different cultural backgrounds?
- 7) What do you do when a client’s cultural beliefs, values or practices conflict with your nursing/professional practice?
- 8) What, if any, organizational policies, resources or activities support your work with clients from different cultural backgrounds? And within the nursing/your profession?
- 9) With regard to public health, what are challenges or barriers you see that might impede the organization or public health nurses/other professionals from meeting the needs of clients from different cultural backgrounds?
- 10) From your experience, who does not access and/or utilize public health programs and services? Why do you think this is?
- 11) What would help build your capacity to work with clients from different cultural backgrounds?
- 12) Engaging in self-reflection is one strategy thought to build capacity for nurses/other professionals to work with clients from different cultural backgrounds. Do you engage in this practice? How?
- 13) Does the organization promote self-reflection? How?
- 14) In general, how does change occur in the organization (e.g. program or service changes)? Can you think of an example?

## Appendix D

### **Interview Guide—Public Health Managers and Supervisors**

- 1) Briefly describe your education and career path that has led you to work in public health. What is your current role within the organization, and how long have you worked in this role?
- 2) What does the term ‘culture’ mean to you?
- 3) What terms, if any, does the organization use to describe inclusion of clients from different cultural backgrounds?
- 4) What are important considerations when developing and delivering public health programs and services to clients from different cultural backgrounds?
- 5) What knowledge, attitudes and/or skills do public health nurses need to work effectively with clients from different cultural backgrounds? How does the organization support and ensure that nurses possess these attributes and competencies?
- 6) What organizational policies, resources or activities support public health nurses to work with clients from different cultural backgrounds?
- 7) With regard to public health, what are challenges or barriers you see that might impede the organization and/or public health nurses from meeting the needs of clients from different cultural backgrounds?
- 8) From your experience, who does not access and/or utilize public health programs and services? Why do you think this is?
- 9) With regard to public health, what would help build organizational capacity to meet the needs of clients from different cultural backgrounds?
- 10) Engaging in self-reflection is one strategy thought to build capacity for nurses to work with clients from different cultural backgrounds. Does the organization promote this practice? How?
- 11) In general, can you give an example of program and/or service changes that have been introduced within the organization? How was this accomplished?

## Appendix E

## Interview Participant Consent Form

Research Project Title: Exploring Cultural Safety in an Urban Public Health Unit

Researcher: Seraphina McAlister, Master's Student, School of Nursing, University of Ottawa

This consent form, a copy of which will be left with you for your records and reference, is only part of the process of informed consent. It should give you the basic idea of what the research is about and what your participation will involve. If you would like more detail about something

mentioned here, or information not included here, you should feel free to ask. Please take the time to read this carefully and to understand any accompanying information.

I, \_\_\_\_\_, understand that the above researcher is carrying out research as outlined in the enclosed information letter.

I understand that I will participate in an interview that will last approximately 60 minutes. I understand that this will be audio-recorded and later transcribed by the researcher. I do not have to answer any questions that I do not want to, and at anytime I may choose to discontinue the interview. I am aware that only the researcher and thesis committee will use the audiotapes and transcripts and that no other person will have access to them. My name and any other identifying information will be removed from transcripts and a research code number will be used instead. All electronic data will be stored on the researcher's computer in password-protected files so that access to electronic files will be secured by passwords known only by the researcher. All hard copy data (including participant consent forms) will be stored in a locked file cabinet at the School of Nursing, University of Ottawa. No information will be released or printed that would disclose any personal identity. All research data will be destroyed after five years.

Any questions I have asked about the study have been answered to my satisfaction. I have been assured that no information will be released or printed that would disclose my personal identity and that my responses will be completely confidential. Any risks or benefits that might arise out of my participation have also been explained to my satisfaction. In particular, I am aware that my decision to participate or not is voluntary and will not affect my work within the organization. I further understand that I can withdraw from the study at any time without explanation.

I hereby consent to participate in this study.

Date: \_\_\_\_\_

Participant: \_\_\_\_\_

Researcher: \_\_\_\_\_

Appendix F  
Participant Demographic Form

Participant ID Code: \_\_\_\_\_

1. Gender:

\_\_\_\_\_

2. In what year were you born?

\_\_\_\_\_

3. What country were you born in?

\_\_\_\_\_

4. How long have you lived in Canada?

\_\_\_\_\_

5. Do you self-identify with any cultural groups? If yes, please list all that apply:

\_\_\_\_\_

Prefer not to say.

6. How many languages do you speak? Please select all that apply.

English

French

Other \_\_\_\_\_

7. What is your highest level of education?

College degree

Undergraduate degree

Graduate degree (Master's, PhD)

Other \_\_\_\_\_

8. If applicable, how long have you worked as a registered nurse?

\_\_\_\_\_

9. How long have you worked for the PHU?

\_\_\_\_\_

## Appendix G

## Working Through a Theme: Building Relationships

Phase of Data Analysis	Thematic Categories and Codes for “Building Relationships”	
Topical Survey	<p><b>Reaching Out/Community Outreach</b></p> <ul style="list-style-type: none"> <li>Trust/mistrust</li> <li>Time</li> <li>Respect</li> <li>Inclusion, community participation</li> <li>Checking in with communities</li> <li>Being out and about in the community</li> <li>Learn from them, ask questions</li> <li>See it from client perspective</li> <li>Tailor services</li> <li>Someone that knows the ins and outs</li> <li>Train the trainer</li> <li>PHN from same culture as client</li> </ul>	<p><b>Language and Communication</b></p> <ul style="list-style-type: none"> <li>PHN communication styles and skills</li> <li>Media</li> <li>High tech</li> <li>Literacy</li> <li>Public health messages</li> <li>Language barriers</li> </ul>
Thematic Summary	<p><b>Reaching Out</b></p> <p><b>Who</b></p> <ul style="list-style-type: none"> <li>The right nurse for the job</li> <li>PHN characteristics</li> </ul> <p><b>What</b></p> <ul style="list-style-type: none"> <li>PHNs deliver public health messages</li> <li>Communication barriers</li> <li>Media strategies</li> </ul> <p><b>When</b></p> <ul style="list-style-type: none"> <li>Timing of programs/services</li> </ul> <p><b>Where</b></p> <ul style="list-style-type: none"> <li>Location of programs/services</li> <li>Being out and about in the community</li> <li>Centralized PHU offices as a barrier</li> </ul> <p><b>Why</b></p> <ul style="list-style-type: none"> <li>Tailor services</li> <li>Learn from each other</li> </ul> <p><b>How</b></p> <ul style="list-style-type: none"> <li>Building relationships</li> <li>Takes time</li> <li>Continuity of staff</li> </ul> <div style="text-align: right; margin-right: 20px;"> <p><b>Building Relationships</b></p> <ul style="list-style-type: none"> <li>Delivering the message</li> <li>Taking the time</li> <li>Being present</li> <li>The right nurse</li> <li>Learning from communities</li> </ul> </div>	
Thematic Description	<p><b>Priority Populations</b></p> <p><b>Partnership and Collaboration</b></p>	

## Appendix H

## Rigour Criteria and Strategies \*

Strategy	Trustworthiness Criteria				
	Credibility	Transferability	Dependability	Confirmability	Authenticity
<b>Research Process</b>					
Reflexivity	X				X
Decision Trail			X	X	
<b>Data Collection</b>					
Field Notes	X	X			
Audiotaping and Verbatim Transcription	X				X
Triangulation (data, method, investigator)	X		X	X	
Member Checking	X		X		
<b>Data Analysis</b>					
Search for Disconfirming Evidence	X				
Peer Review/debrief	X			X	
<b>Presentation of Findings</b>					
Documentation of Efforts to Enhance Quality	X	X			
Thick Description		X			X
Documentation of Researcher Credentials and Background	X				
Documentation of Reflexivity	X				

\*Table adapted from Polit and Beck (2012)

## Appendix I

## Certificate of Ethical Approval

File Number: h10-10-01

Date (mm/dd/yyyy): 02/15/2011



**Université d'Ottawa** **University of Ottawa**  
 Bureau d'éthique et d'intégrité de la recherche Office of Research Ethics and Integrity

**Ethics Approval Notice****Health Sciences and Science REB****Principal Investigator / Supervisor / Co-investigator(s) / Student(s)**

<u>First Name</u>	<u>Last Name</u>	<u>Affiliation</u>	<u>Role</u>
Wendy	Peterson	Health Sciences / Nursingy	Supervisor
Seraphina	McAlister	Health Sciences / Nursingy	Student Researcher

**File Number:** H 10-10-01**Type of Project:** Master's Thesis**Title:** Exploring Cultural Competence and Cultural Safety in an Urban Public Health Unit

<b>Approval Date (mm/dd/yyyy)</b>	<b>Expiry Date (mm/dd/yyyy)</b>	<b>Approval Type</b>
02/15/2011	02/14/2012	Ia

**(Ia: Approval, Ib: Approval for initial stage only)****Special Conditions / Comments:**

N/A