A REPORT ON THE IMPACT OF AN INTEGRATED CULTURAL SAFETY AND ANTIDISCRIMINATION TRAINING PROCESS ON STAFF WORKING IN TWO PRIMARY HEALTH CARE CENTRES

by

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INTRODUCTION

A large body of research continues to demonstrate the persistence of health and social inequalities influencing particular population groups (Hampton, Bourassa, & Mckay-Mcnab, 2004; Heaslip & Ryden, 2013; Hyaman, Wilkes, Halcomb, & Jackson, 2013; Karlsen & Nazroo, 2002; Pollock, Newbold, Lanfreniere, & Edge, 2012; Veenstra, 2011). Evidence suggests that these disparities are in part a result of processes stemming from structural inequities and discrimination. Discrimination is the “unfair or morally wrong social, arrangements or acts, or the perception thereof, that have the potential for disadvantage or denial…discrimination arises from social arrangements that are potentially remedial.” (Varcoe, Browne, & Ponic, 2013). Discriminatory mechanisms result in disproportionate access to the social, economic, cultural and political capital that is foundational to acquiring and maintaining health throughout life. Discrimination occurs at the institutional, structural and interpersonal levels.

Institutional discrimination is entrenched in policies and practices that govern state or non-state organizations (Krieger, 2014; Varcoe et al., 2013). Structural discrimination emerges from “those fundamental institutions and structures in society … that define, determine and reproduce unequal power relations, racialization, class and patriarchy as a basis for social relations … they exist in the institutional and social practices of our society and cannot be explained as merely situational or by the intentions of individuals …” (Varcoe et al., 2013). Therefore, the deprivation of discrimination manifests as unequal access to health-related resources resulting in poorer health outcomes in oppressed groups (Adelson, 2005; Marmot, Friel, Bell, Houweling, & Taylor, 2008; Raphael, Curry-Stevens, & Bryant, 2008). Interpersonal discrimination involves interactions between individuals that could or could not be positioned within these larger organizations or social systems (Krieger, 2014). Primary health care centres,
with their focus on preventative services and services tailored to the populations they serve, are
uniquely positioned as one key area in which equity might be promoted and discrimination
mitigated (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015; Politzer, Schempf, Stafield, & Shi,
2003).

Browne et al. (2012) describe the dimensions of what encompasses equity oriented
primary health care. These include: i) providing care that is responsive to inequity by making it a
priority to address the social determinants of health, ii) providing care that recognizes the
pervasiveness of various forms of trauma and violence resulting from the effects of systemic
inequities and structural violence, iii) providing care that delivers services that are contextually
tailored to meet the specific needs of the populations served, and iv) providing care that is
culturally safe. To implement these dimensions, they suggest ten intersecting strategies that work
to improve the provision of health services. The EQUIP (Equity Oriented Primary Health) study
incorporates these dimensions and strategies as an intervention that promotes the uptake of
equity oriented practice in primary health care centres (Browne, Varcoe, Ford-Gilboe, Wathen,
& EQUIP Research Team, 2015).

The EQUIP intervention takes the form of staff education and tailored organizational
changes with the goal of facilitating the provision of responsive equity oriented care (Browne et
al., 2015). The EQUIP study will serve as the basis for the inquiry undertaken in this report. In
particular, this report focuses on the staff education components concerned with the education
and integration of culturally safe care (Browne et al., 2015). It explores, from the perspectives of
the staff working at PHC clinics, the impact of the antidiscrimination educational training
embedded in the cultural safety training module on the staff at the PHCs. The purpose of this
report is to explore the process and impact of engaging with the training. Furthermore, the report
will provide recommendations for organizations aiming to incorporate educational interventions to mitigate various forms of discrimination experienced by their clients.

**Overview of the EQUIP Study**

The EQUIP intervention combines staff education tailored to the clinical realities of the organizations involved in the study, with strategies for enhancing the capacity of organizations to provide equity oriented care responsive to the needs of the marginalized populations they serve (Browne et al., 2015). The EQUIP intervention is designed to guide primary care practices by orienting staff to the key dimensions and strategies of equity oriented PHC. These key dimensions and practices are aimed at alleviating the effects of structural violence with the ultimate goal of improving patients’ health and wellness. This intervention aims to increase responsiveness of PHCs to the particular needs of populations that are marginalized and is tailored to suit the contexts in which the PHC sites operate.

As described by Browne et al., (2015), the EQUIP intervention is founded on a framework that identifies: a) four key dimensions of equity oriented services: Trauma and Violence Informed Care (TVIC), culturally safe care, contextually tailored care, with inequity responsive care incorporated throughout, and b) ten guiding strategies for enhancing the capacity to providing equity oriented health services. The EQUIP research is entirely focused on studying the impact of the integrated intervention on staff, the organization and on patient outcomes. In this report, the focus is specifically on the impact of the cultural safety component of the EQUIP intervention. The San’yas Indigenous Cultural Safety (ICS) online training aims to enhance health care providers’ capacities to counter various discriminations in the context of delivering health services by providing education on cultural safety. All 80 staff members took the ICS core
training while in two of the four PHC clinics, staff elected to take an additional “bystander”
training module that was tailored to their specific organizational context.

The Cultural Safety Training Component

Cultural safety training was provided by inviting staff to complete the Provincial Health
Services Authority of B.C. (PHSA) San’yas Indigenous Cultural Safety Training online module.
As discussed below, a series of integration and tailoring discussions followed to help staff at the
clinics integrate content from the training into their practice and organizational contexts. The ICS
San’yas program is founded on critical race theories, transformative learning and anti racist
pedagogy. It is designed to improve the cultural safety competency of individuals working with
Indigenous\(^1\) people as well as people from other visible and ethnic minorities (Browne et al.
2015; PHSA, 2015). The term \textit{Cultural Safety} arose from Maori nurse leaders in New Zealand
and looks to target health care as a focus of addressing the harms to health and wellness due to
historical, institutionalized and individual injustices, namely racism and other forms of
discrimination. It moves beyond the issue of cultural differences and instead places the onus on
the site and the culture of health care delivery to address the prevalent health and health care
inequalities. Action is taken to reduce the differentials in power and access resulting from
inequity (Browne et al., 2009, 2015; Kirkham, 2003; Papps & Ramsden, 1996). The ICS
especially focuses on health care and Indigenous people and how to integrate the concept of
cultural safety to provide care that acknowledges and addresses the health needs resulting from
inequity experiences by marginalized peoples (PHSA, 2015). This ICS component consisted of
an eight-hour-long online training comprised of self-directed modules with discussions

\(^1\) This report uses the terms Indigenous and Aboriginal peoples to refer to the original Inhabitants of
Canada including First Nations, Metis and Inuit people (Browne et al., 2016)
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administered over eight weeks. As noted above, all staff members were invited to complete the training. Staff were compensated for their time and had their tuition paid for.

In addition to the online training, integration discussion sessions that involved interactive learning and drew on staff’s knowledge and experience were provided at all sites. A practice consultant facilitated integration sessions to guide the integration of concepts from the training into the particular contexts of the organizations. Consultants were available throughout the intervention to revisit the content of education sessions and assist with their integration into clinical sites. Rather than traditional didactic teaching strategies, sessions integrated the consideration of local contexts and the tailoring of educational content and strategies as this was more likely to create catalysts for change in the sites (Browne et al., 2015).

The other components of the EQUIP intervention are described elsewhere (Browne et al., 2015). To summarize, these included:

- **An Orientation to Key Dimensions of Equity Oriented PHC Services**: This was a two-hour workshop on the key dimensions of equity PHC and strategies for enhancing equity (Browne et al., 2015). A consultant facilitated the workshop and was available thereafter to reinforce concepts from the course and help integrate them into everyday practice.

- **Trauma and Violence Informed Care (TVIC)**: This was offered as two, four-hour long workshop sessions that focused on educating staff on how to integrate elements of TVIC into their clinical practice. TVIC incorporated the awareness of structural, historical and interpersonal violence and trauma and their effect on health and wellness. The need for action at the individual practice, organizational level and further was stressed as the focus of action to counter the effects of trauma and violence (Browne et al., 2015).
• Organizational Integration and Tailoring (OIT): The EQUIP intervention is undertaken with the assumption that long-lasting changes cannot happen unless staff members are supported to integrate what they learned into the organizational context (integration), and local structures and processes are created to support changes (tailoring) (Browne et al., 2015). The OIT processes were determined in collaboration with clinical practitioners who were responsible for evaluating the organizational context, selecting priorities for change, and planning, implementing and evaluating the effect of the changes during the study duration and beyond. A catalyst grant and practice consultant was made available for each of the sites in order to facilitate the OIT processes (Browne et al., 2015).

The Significance of Culturally Safe Care

In Canada, as in other nations, there exists a system of privilege and disadvantage associated with social categories such as gender, class and race. Individuals can experience these social locations simultaneously which when interacting with existing systems of power, give rise to forms of privilege and disadvantage. It is the interplay or intersection of these social locations and structural processes that result in systems of inequities and discrimination as one’s social location within a given context determines access to social and political benefit (Crenshaw, 1991).

Distribution of social, political and economic benefits shapes the social determinants of health and access to health care services, both of which operate to influence better or worse health outcomes (Browne et al., 2015; Kirkham & Browne, 2006; Pollock et al., 2012; Richmond & Ross, 2009). Experiences of discrimination work against and compounds these effects. At the individual level for example, this can manifest as unsatisfactory encounters with the health care
system and inadequate or inappropriate delivery of care that can be discriminatory or marginalising in nature.

Health care delivery policies and practices operating within the community or in institutions can act as barriers to health access for people who are marginalized\(^2\). Primary health care centres (PHC) are ideally suited for the delivery of comprehensive health services, especially to meet the needs of people who are marginalized by various forms of disadvantage and discrimination (Baum et al., 2013; Gottlieb, 2013; Parchman et al., 2013; Politzer et al., 2003). Comprehensive PHC services attend not only to an individual’s presenting health issue but ought to also cater to the greater situational or structural influences on the wellbeing of patients (Hogg, Rowan, Russell, Geneau, & Muldoon, 2008; Marmot et al., 2008). In spite of this, PHCs are not necessarily optimally prepared to adequately meet the needs of populations that are vulnerable (Browne et al., 2015; Canada, 2013).

Despite the growing body of research that shows the persistence of discrimination, not much has been done in health care to actively counteract discrimination. The problem of discrimination can be countered by considering the underlying systemic causes of inequity and providing care that seeks to address the effects of structural discrimination with the goal of closing the health equity gap. The key dimensions and strategies for the integration of equity oriented care described by Browne et al. (2012) are an illustration of how health care organizations can integrate equity into their specific contexts. These strategies specifically consider the effects of structural violence, individual discrimination, systemic discrimination

\(^2\) In this report ‘people who are marginalized’ refers to people who are disadvantaged through their location in intersecting social categories (race, class, gender) that do not afford them access to the same benefits accessible to those who are more privileged.
and, historical and interpersonal trauma in order to make the delivery of health services more responsive to the needs of populations that have been marginalized. Although these strategies have been identified, there is a need to develop a greater understanding of how they can be integrated into practice. Moreover, there is need to understand the processes that reinforce the integration of these strategies within the workings of an organization.

This report provides the opportunity to examine the impact of ICS, and specifically focuses on how ICS may be supporting staff to counter various forms of discrimination within the PHC organizations. Though the ten strategies identified by Browne et al. (2015) intersect and are interrelated in their implementation, this report will focus on strategies that “work to counter the impact of intersecting oppressions on health, access to care, and quality of life” (Browne et al., 2012). ICS training was provided through the PHSA’s online San’yas Indigenous Cultural Safety Health course. Subsequent integration sessions, based on concepts of transformative learning, were designed to guide staff members to incorporate cultural safety into their practice.

**Purpose of Report**

This report explores staff members’ perspectives on the impact of the intervention implemented to address the issues of structural inequities, in particular ways of countering the ongoing discrimination that patients experience. Specific impacts of the ICS Online training program will be the entry point for this analysis. Major outcomes of this analysis are to examine how staff members describe the impact of ICS on their own awareness and practices, and on organizational and interpersonal practices within their clinics with the goal of mitigating various forms of discrimination their patients experienced. The questions that guide this report are:
• How did staff members describe their experience of engaging with the ICS online training program, and the integration discussions that followed?

• How did staff members describe the impacts of ICS on their individual practices, and on the organizations in which they work?

• What recommendations can be put forward for organizations aiming to enhance their capacity to address issues of discrimination in health care?

**SYNTHESIS OF LITERATURE**

**Theoretical Background**

**Health Equity**

Despite Canada’s reputation for being an inclusive society, some people residing in the country do not experience this as a reality. For example, visible minorities, those who do not speak English or French fluently in areas where either is the primary language of communication, and those from non-dominant religions report alienation despite multiculturalism being touted as part of Canadian national identity. This can be seen, for example, in policies relating to First Nations people’s self-determination, health and land claims. These policies are particularly limiting to the socioeconomic wellbeing of Aboriginal people (Varcoe, Browne & Ponic, 2013).

Research has documented significant disparities in health outcomes at a population level. In Canada, populations that are marginalized have been shown to have poorer health outcomes and less access to health-determining resources (Gershon et al., 2014; Gozdzik, Salehi, O’Campo, Stergiopoulos, & Hwang, 2015; Torchalla et al., 2014; Trachtenberg, Dik, Chateu, & Katz,). These inequalities arise as manifestation of structural violence that works to cause harm
to people. A responsibility of health care personnel is the reduction or eradication of these inequalities. This is the goal of achieving health equity. Health equity is defined as the “...absence of systemic and potentially remediable differences in one or more characteristics of health across populations or population groups defined socially, economically, demographically, or geographically.” (Institute for Population and Public Health, 2009; World Health Organization, 2008; Varcoe et al., 2013, p.13).

**Racism and Other Forms of Discrimination**

**Discrimination**

Discrimination is the “…unfair, or morally wrong, social arrangements or acts, or the perception thereof, that have the potential for disadvantage or denial…discrimination arises from social arrangements that are potentially remedial” (Varcoe et al., 2013. Pg. 14). Discrimination is pervasive, manifesting at the structural as well as the individual levels (Burgess, Ding, Hargreaves, Van Ryn & Phelan, 2008; Karlsen & Nazroo, 2002). At the structural level, the existence of institutional mechanisms and practices privilege some groups while creating vulnerability in others (Krieger, 2014). These mechanisms exist as belief systems and, values, and in patterns of economic, political and social power and resource distribution. Oppressive forces such as historical realities, political disadvantage, and economic and social stressors operate outside of the health care environment and have an impact on the lives of people (Krieger, 2012; Krieger, 2014).

At the individual level it is the influence of attitudes, values and beliefs that shape the perception and interaction of people between social groups and therefore give form to the manner in which people within the health care experience engage with each other (Browne & Fiske, 2001; Browne et al., 2015; Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008). The
nature of discrimination is intersectional. Individual and structural effects cannot be parsed out separately. Rather, the different axes of oppression and privilege at different levels relate and compound to create the lived reality of those experiencing discrimination (Crenshaw, 1991; Varcoe et al., 2013). Health equity in part can be attained by addressing the unfair structures that are inherent to sustaining discrimination.

**Racism**

Racism is a form of discrimination that is based on the concept of there being a hierarchy of value within the construct of race (Varcoe et al., 2013, p.14). Like other forms of discrimination, it is systemic in that it is informed and propagated by socially constructed structures and institutions which then influence individual behaviour. Though the effects of racism are detrimental to the wellness of individuals, this form of discrimination is often not experienced alone. Rather racism is experienced in conjunction with other forms of structural marginalisation and inequity (Varcoe et al., 2013).

**Structural Violence**

Structural violence is defined as “…a host of offences against human dignity, including extreme and relative poverty, social inequalities ranging from racism to gender inequality, and the more spectacular forms of violence” (Farmer, 2003, p.8). Discrimination works to sustain structural violence in the lives of people who are marginalized. By focusing on relieving discriminations experienced by people, the effect of structural violence can be lessened. ICS focuses on changing negative attitudes against Indigenous people and increasing awareness of racism and negative stereotypes (Browne et al., 2015). Through integrating cultural safety, health care practitioners can learn to be cognizant of the effects of structural violence and work towards mitigating them.
Discrimination and Primary Health care

Ecosocial Theory

Krieger (2014) describes the impact of discrimination on health through ecosocial theory. According to this theory, health results from the embodied effects of a combination of societal and ecological factors. These factors arise from exposures to socially constructed influences and are mediated by individual physiology, behaviour and genetics (Krieger, 2012). According to Krieger, these influences could include: economic and social deprivation, exposure to toxins, hazards and pathogens, social trauma, health harming responses to discrimination, targeted marketing of harmful commodities, inadequate health care, ecosystem degradation and alienation from the land (pg. 14).

In health care, discrimination operates in practices and policies that marginalise some patient populations and not others. Examples of these alienating policies are those that result in cuts to health benefits to refugees, the underfunding of health services in rural and remote communities, or in institutional practices such as exclusion of health practices that are not considered traditionally biomedical but that might align with patients’ preferred traditions and beliefs (Adelson, 2005; Barnes, 2012). The pervasiveness of these inequities can create a system of inverse care. That is, health systems that are unsuited for caring for populations that have a greater need for health services (Browne et al., 2012).

Additionally, experiences of discrimination have been shown to have a direct effect on health. Individuals that have been subject to the effects of structural violence demonstrate physiological effects such as increased cortisol levels, blood pressure, and heart rate, and show atherosclerotic changes to the vascular system (Adelson, 2005; Burgess et al., 2008; Fang & Myers, 2001; Krieger, 1990; Krieger & Sidney, 1996). Furthermore, factors such as dismissive
or prejudicial attitudes by health care providers can negatively affect the experience of seeking care leading to mistrust in providers, the undermining of relationships between patients and providers, delays in seeking care, poor communication, low utilization of preventive care services and lower adherence to treatment regimen (Browne & Fiske, 2001; A. Browne et al., 2015; Krieger & Sidney, 1996; Wyatt et al., 2003).

Given the large amount of evidence to support the effects of discrimination on health, it falls within the responsibilities of nurses and other health care professionals to work to counter such practices and their consequences. Previous studies have identified potential strategies that can be incorporated into the workings of a health care organization in an effort to subvert inequities that are present in the populations they serve (Beach et al., 2005; Browne et al., 2012). Such interventions include staff education on the integration of cultural safety, cultural competence and trauma and violence informed care in daily practice. Other strategies that have been identified include organization-wide changes that attempt to address the specific needs of patients that have been marginalized and to lower power differentials to promote environments that are safe spaces for patients in order to foster positive health care experiences and improve health outcomes (Beach et al., 2005; Browne et al., 2012). The EQUIP intervention aims to enhance the capacity for organizations to respond the needs of populations that experience inverse care. This document presents a report of how practitioners describe integrating the concepts of cultural safety and antidiscrimination in their practice.
SOURCE OF REPORT DATA: AN OVERVIEW OF THE EQUIP STUDY

Setting and Population

During the development of this report, the EQUIP study was being implemented in four PHC sites in Canada with two sites in British Columbia and two in Ontario. The PHCs provide low barrier access health care to people facing social disadvantages such as those with no housing or unstable housing, low income, complex medical needs, trauma histories, substance use and addictions. One of the PHC clinics serves a population that is predominantly Aboriginal and integrates elements of traditional healing practices in the provision of health care practices. Collectively, the sites have commitments to address the needs of people that are marginalized and thus are primed and receptive to the intervention provided by the EQUIP study. Staff interviews from the B.C. sites were used in the development of this report. Staff members interviewed worked in a variety of clinical and administrative roles (such as nurses and physicians, administrative leaders and office staff) and have been employed at the clinics for a period between two months and 14 years.

Theoretical Perspectives Underpinning the EQUIP Study

This inquiry was guided by critical theoretical and transformative learning frameworks that are integrated into the EQUIP intervention (Browne et al., 2015). Critical theories such as intersectionality, critical social theories, Indigenous perspectives, postcolonial theories, critical political economy and Black feminist theories were used to inform the study (Browne et al., 2015). These theories share common assumptions about the existence of differential power relations in society. These differential power relations then create inequities that are institutional and individual. Collectively these theories contribute to an analysis of how inequities are created and sustained; their effects on health and the strategies that act as tools to bring about health
equity (Browne et al., 2012, 2015). Critical social theories draw attention to the effects of systemic inequities and discrimination on health status (Browne et al., 2011). Intersectionality theory suggests that people are situated at the intersection of multiple social and systemic locations subject to oppression and domination (Crenshaw, 1991; Hampton et al., 2004; Van Herk, Smith, & Andrew, 2011; Varcoe et al., 2013). Together these theories explain the marginalising realities within which patients presenting to the PHC clinics exist. Additionally, complexity theory guided the implementation of the intervention. Following this understanding, the intervention used a standardized approach but allowed for it to be adapted to meet the local contexts of the PHC clinics. These theoretical perspectives are further explained in the Browne et al. 2015 report.

Transformative learning requires that learners reflect on their inherent values, beliefs, attitudes and practices in order to achieve a shift in perspective that results in changes in behaviour (Matthew-Maich, Ploeg, Jack, & Dobbins, 2010). Frameworks based on transformative learning guide the integration of the equity oriented intervention to the staff members working within the PHC site-specific contexts and underpin the ICS online program. Similarly, transformative learning perspectives will inform the analysis in this inquiry.

**DESIGN AND METHODS**

This report was generated using principles of qualitative methodology to explore staff’s perspectives of the impact of an intervention aimed at integrating cultural safety into PHC organizations and staff practice. In-depth interviews with staff about the impact of integrating ICS concepts were used in the analysis. Use of qualitative interviews allowed for analysis of the contextual factors that are important to understand when examining the impact of an equity oriented intervention. This was especially relevant when trying to develop a clear picture of how
the abstract concepts were adapted to everyday clinical practice. Additionally, open ended questions allowed staff members to exhaustively describe the impact on their individual clinical practice. Interviews were conducted as part of the EQUIP study. Purposive sampling was utilized to obtain qualitative staff interviews from a variety of different roles within the organizations. (Polit & Beck, 2012). Staff members in different roles were selected as participants to obtain a broader understanding of the organizational context. Ten interviews were selected to be analyzed in this report. Staff members selected were chosen to represent a diversity in terms of length of employment, the exposure to the intervention and to be representative of different clinical and administrative roles within the clinics. As described below, this served to develop credibility of data since a variety of voices are represented in the analysis.

The analysis of staff members’ interviews was guided by interpretive description. Interpretive description allows for the exploration of the practice context within the PHCs of interest in this report (Thorne, 2008). Through cleaning the transcripts and creating summaries of a majority of the interviews I was able to be immersed in the data. I read and reread the transcripts to determine common elements and to create codes. I analyzed codes for emerging themes which were interpreted to determine study findings (Polit & Beck, 2012; Thorne, 2000). Interview transcripts were entered into NVivo qualitative analysis software and themes were developed through constant comparative analysis. With constant comparative analysis, data is broken down and coded into categories to be further analyzed. Relationships between categories are then further developed and refined to formulate concepts. In this process coding and analysis occur simultaneously (Thorne, 2000; Thorne, 2008). Themes were developed and continually revised in collaboration with the thesis supervisor to ensure validity. To ensure integrity I kept a
record of my notes, memos as well as an audit trail to demonstrate my journey from developing codes to the final themes identified in the analysis.

Data Collection

This report drew on and analyzed data from semi-structured in-depth interviews with staff working at the PHC clinics. Interviews were conducted with nurses, nurse practitioners, physicians, medical office assistants, counsellors, social workers and other staff members at the four sites. The staff from the different roles within the B.C. sites made up the sample of interviewees. A variety of roles was important for capturing the realities experienced by the clinic staff operating in different scopes of practice and responsibilities. The majority of interviews selected for this report were those that I had conducted personally. Additional interviews were selected from staff members holding different roles from those selected previously. Ethics approval was in place for the original EQUIP study through the University of British Columbia Behavioral Research Ethics Board.

DATA ANALYSIS

I used thematic analysis using procedures for Interpretive Description as outlined by Thorne (2008) to analyze interview data used in this report. Initially I summarized and presented five out of ten interviews to the primary supervisor of the project. Afterwards I read, analyzed and marked up all ten interviews. I identified the preliminary patterns from the interviews with common and seemingly contradictory patterns and ideas presented by participants. Initial coding categories were developed and then discussed with the primary supervisor. These codes were included: validation, discussion sparked, frustration over slow change, shared values, hallway conversations, improved practice, awareness, advanced knowledge and support. As I read and analyzed more interviews and these broad codes were revised and refined, narrow codes were
identified through an iterative process (Thorne, 2008). I narrowed them down to awareness, enhanced practice, opening discussions and organizational change. I identified themes from the process of analysis as outlined in the findings section of this document. Throughout this process, the primary supervisor was involved in the development and refining of themes.

**LIMITATIONS**

This report has some limitations that need to be considered when taking the findings into account. Sites involved in this report included a large number of staff in both administrative and clinical roles. This report selected interviews with ten staff members as representatives of the entire staff. Though this small sample represented only a portion of the staff, the qualitative interviews provided rich data which allowed for a greater evaluation of context and perspective. Additionally, the variability of the sample chosen allowed for a depiction of different perspectives across the staff cross section.

Another limitation was the high turnover of staff in the clinics. This meant that not all staff were exposed to the educational intervention to the same extent. The intervention not only included an online course that could be taken at any point but also had an integration discussion that was provided at one point early in the study. Those who were unable to attend the sessions or those who were hired after the sessions were not exposed to this aspect of the training. This is especially important to consider as it was these sessions that permitted staff to discuss integration of content from the online course into their practices, allowed for discussions and provided strategies for context-specific organizational shifts. To try and mitigate the effect of newcomer staff with gaps in knowledge, the representative sample included one participant who had not been a part of the integration session. Despite this, this participant was a part of a body within the
clinic that actively worked to integrate cultural safety within the clinic and so was familiar with the content from the integration sessions through his duties.

Lastly, the EQUIP intervention involved multiple components which intersected with each other and which were delivered concurrently. Namely, this included the components that integrated Trauma and Violence Informed Care (TVIC) within the clinic and the Organizational Integration and Tailoring (OIT) processes discussed earlier in this report. Staff members expressed difficulty differentiating between the different components and therefore could not parse out the specific changes attributed to particular aspects of the intervention. Despite this, although antidiscrimination was the issue of concern in this report, the different intervention components had commonalities in terms of addressing underlying issues related to mitigating the effect of structural inequities. Thus, the different issues of concern were not meant to be addressed individually in the study but rather simultaneously.

**FINDINGS FROM STAFF INTERVIEWS**

**Awareness**

*Prompting learning and self-reflection*

Staff members reported that the San’yas Cultural training and the subsequent integration sessions provided educational content and prompted them to reflect on their biases in attitudes and practice that might have contributed to structural violence. The result was a transformation amongst the staff who were made aware of historical and ongoing injustices, structural violence and the role of cultural safety and practices in attending to health equity and alleviating the effect of these injustices and forms of violence on their patients. The training led staff to seeking out more education regarding related topics.
“.... So, you’re like, ah! [gasp] You suddenly get it? Yeah and I think that happened a long time, not a long time ago but when I first came here and because of this previous office manager like all of a sudden, I had empathy which I didn’t have before. Because it all goes back to being enlightened, it all goes back to education, it goes back to training and that’s why, you know, people discriminate because they don’t understand, you know...”

**Developing an understanding of how staff are perceived**

Because of the training, some staff members developed an understanding of their positions of privilege not in terms of being non-Indigenous people but also in terms of being in a position of power as a health care provider or administrator. They could acknowledge how this differential in power could shape how patients perceive them, and thus shape their encounters. These insights, in turn, opened their eyes to the importance of cultural safety and the need to work to mitigate the imbalances of power between the patient and provider to foster their relationship to improve health care experiences.

“That’s probably the largest impact it’s just being more aware and in one of, in the bystander to ally module, they talked about settlers and like white people being settlers and I’ve never even been familiar with that term before so that was interesting to kind of revisit that and discuss it. Because to me like that was a foreign concept like I hadn’t even heard of that ‘settlers’ before. So that was interesting as well because I then again kind of realized how I may be perceived because I’m Caucasian, you know, my grandparents are Scottish, English so I think that was the largest impact, just how I’m seen...”
Challenging the dismissal and invalidation of Aboriginal peoples’ experience

For some participants, this was their first time learning of the history of First Nations people. Others were familiar with the content as part of their formal education, through personal experience or through encounters in their normal clinical setting. Having formal education that relayed historical evidence and personal anecdotes validated what some staff members had heard outside of the training and cemented this knowledge as fact to individuals who participated in the education.

“No, I think it’s just getting to know people and, and knowing I think that people learned about residential schools that it wasn’t just say in like sometimes people would say like, you know, like get over it type of thing...it’s like they know, they know more about it, they know, know the truth about it rather than just something they might have heard.”

Understanding the historical and cultural context

The San’yas training provided a historical overview of the colonial experience of First Nations people, the ongoing structural violence that has an effect on their health and, well-being, and how this has impacted their perception of and experiences within the health care system. This was fostered by the integration sessions which allowed staff to better understand the historical and sociopolitical background that sets the climate within which they practice clinically within the community.

“Well I think, I think the biggest impact is not so much within my organization here but just the way I interact with my client and I think just a little bit about what I said about taking into consideration their roots and their experiences in the past. And sort of like recognizing, you know? I, sort of like a white person you don’t want to have that, that
very narrow white person sort of attitude about assuming how, what their experience has
been and how they’ve grown up.”

Obtaining knowledge useful in clinical practice

Some clinicians found that the training provided content that was directly useful in practice. Issues of how historical injustices and trauma, and the effect of ongoing structural violence, affect Aboriginal patients’ health and perception of health care were found to be directly applicable to individual clinical practice. Even those who had some familiarity with the content were exposed to subject matter they could use when interacting with patients.

“A lot of my clients, my patients are First Nations so I’ve been just incorporating a lot of the data, especially from the, the cultural competency workshops and readings and videos and all the rest, just becoming more and more aware of there are really some unique approaches that work very well with First Nation’s people that I don’t use at all with, with other clients. So just keeping it constantly in my head that it’s different, it’s different don’t go into it as if it were a regular run of the mill sort of, you know, maybe addictions case or whatever, yeah.”

Some staff already possessed the knowledge

To some, the information presented in the training was not unfamiliar. Some were aware of the historical content presented in the online course. Others were familiar with the concepts related to cultural safety, antidiscrimination and health equity through their own learning or practice. For others, these concepts were already being practiced but the language and terminology as presented in the ICS online training and integration session was new. For some
participants, the training was a reminder or refresher for staff members of the concepts and their importance in providing care to marginalized people.

“Well the cultural competency one was like, a lot of it was kind of a refresher like a reminder. Some of it was new information for sure ... And I think, I think for the most part around here like people in discussing it I think, and it may have been new for people, some people, I don’t know but I think that there’s this understanding that we all come with our own biases and our own ingrained, you know, that we have, we all carry racist sort of opinions and ideas about people... think we’re, I think, I think there’s kind of a basic understanding around here about that at least with the core team..”

Adding to staff members’ knowledge

Most staff members in the sites were already aware of the effect of social and historical violence and its effects on people’s health and well-being. The content from the San’yas training was also familiar to some. Nonetheless, they found that the session provided additional information and tools or the process of reflecting and discussions allowed them to shift their perspectives or renewed their awareness of their positions of privilege.

“But I think definitely, yeah, having more of an awareness would I think, I think I’m a pretty sensitive, compassionate person anyway but just having more depth of knowledge has made me probably even more sensitive...I mean I thought it was good to have more information but it was just sort of adding onto, you know, what I see every day. And again, I think that I already come from a place of non-discrimination and, yes, so. But something I think was good to learn was not so much about being non-biased but being sensitive.”
Some staff members did not perceive any impact

Though most staff members found the cultural safety training and integration to be useful in practice, there were a few who did not find that anything new came from it. For some, the content did not provide additional information. For others though the content was relevant to their practice, they could not extricate a way to directly apply the content to their clinical work.

“I wouldn’t say it was, you know, massively impactful, it was just again more information and a chance to hear other people actually responding as well. And again, it’s just incorporating more information, just increasing the awareness level, increasing the knowledge so that was probably what I got out of it...”

Enhanced Practice

Self reflection of personal biases and their effect on practice

The antidiscrimination training challenged practitioners to reflect on their personal biases as these biases could contribute to systems and settings that can be violent to marginalized peoples. The intervention created tools, an opportunity and setting where staff members could do that individually and collectively as part of their own organizations. Within the setting of the study, time and resources were set apart, separate from busy everyday tasks, where the organizations values and practices were examined to determine if they might contribute to inequity and staff could discuss how they could be addressed. Individually, staff members were presented with information that perhaps challenged their privileged point of view and made them pause and to reflect on their individual practice, including what might be helpful and harmful to their interactions with patients.
“I’ve always thought was when providers speak in a very, it’s like they’re used to talking in the medical field a certain way and they’re used to, you know, like, okay, I have so much time I have to talk to this person, see what’s wrong. And I’ve had patients in here who tell me they are so nervous to see a doctor that they agree with everything. And or they’re, they don’t have the time to say what they need to say and I think it’s those kinds of things that where they’ve been silenced, people have been silenced for long enough. And where I think one of the biggest impacts out of the residential school is you can’t talk, you can’t speak your language, you just keep quiet. And what I’ve noticed in my work with people is that people say things in the minimum amount of words. They say things in the least amount of words as they can. And I think that it’s communities are like that and it’s changing now but there’s still people who haven’t worked through stuff who are doing this. And, and just push things down, and are shut down and those are the ones who are hurt the most...I think the whole system, the structure needs to change and for that to happen and I think that what we’re doing is looking at the top and it just needs to go further down.”

**Fostering relationship-building with patients**

Clinicians recognized that establishing trust and building relationships with patients is important in their work. Concepts of cultural safety and health equity affirmed this knowledge. Consequently, the staff could utilise information from the courses to foster this process of implementing these concepts into their practice. This was done in various ways such as acknowledging and talking with patients about their Aboriginal ancestry, not prioritizing their own medical agenda, or even taking a step back and analysing what about patient encounters could be a barrier and addressing them.
“Well more an idea of a greater insight into how the impact of say residential school or the impact of just that whole inequity in the system has impacted the people so that when I’m aware of it and I start a dialogue with some of them I’m able to slip stuff in now just because I’m a little more attuned to it and I’ve noticed I’m more relaxed, better responses from, from people who generally are fairly reticent and some of the people I have noticed a change in not only are they easier to speak to, they’re not coming to a point where they, it’s hard to stop them when they get going because now they’re enthusiastic about they’re being heard. They’re being listened to. Something is changing and they’re noticing its changing... One of the points that was made is often the area that a First Nation’s person comes from is really a very significant part of any interaction, it’s a very big part of their life. And in one session there was one woman that I remember working with, it was a Saturday morning and she was really struggling with the session because there was a lot of trauma in her background and she was going through some fairly heavy emotional stuff at the time. And just as an aside from the session at one point I just so where are you from? And that moment just changed the whole session she lit up, she told me in great detail where she was, where she worked, how she integrated into that community and all the rest of it. And the whole flavor of our interaction just changed immediately after that.”

Addressing systemic needs and barriers

The training brought on an awareness that clinics and practitioners need not just focus on presenting medical needs but also the issues relating to the social determinants of health that have a greater effect on patients’ health. These issues might not only be related to patients’
environment but also whatever barriers or limitations to health equity or cultural safety that exist at clinic sites.

“Yeah so, I would go back to what I said at the beginning more about how to not just think of people as all, you know, just to like treat everyone equally is maybe not the best approach right? To be, you know, obviously you treat everyone with fairness equally but just to be sensitive to like some people may have some extenuating factors happening in their life that would mean extra care, extra attention. Yeah, so to make the sort of adjustments that, you know, that would need to happen to, yeah, make things easier for that person, yeah.”

**Increased confidence in practice**

Staff members reported having greater confidence in their clinical practice. This resulted from validation or affirmation of previously observed or learned knowledge on how to provide care for people experiencing systemic inequity. The increased confidence also comes from the shared recognition of common ideology of equity and structural violence and various forms of discrimination as leading to health inequity. This was brought up in group discussions by staff members who might have felt that way but now had a platform to express and share their perspective. The open discussion bolstered the commitment of staff members to enacting antidiscriminatory efforts in their practice and the organization as a whole.

“Well I think again just being a little more comfortable to talk to people about their particular, um, cultural beliefs and cultural identity. And that’s important for people and [pause] it’s hard. So, in the training, you know, they say, you know you should ask somebody where they’re from and, you know, take time to explore those. But a lot of
times people don’t want to talk about that stuff and they’re there because their foot hurts not because they want to connect, go with their ancestry or whatever. So but I certainly have kept that in my mind and feel like when it’s appropriate I’d like to ask people if they feel a bit more comfortable talking about those things. The tape recorder can’t tell but I’m white so [laughs] and I’m not Aboriginal so any time you’re talking to people of a different culture than yourself, you know, you’re always conscious of trying to be respectful and inquisitive about somebody who is stupid and racist.”

_Fostering a climate of collaboration_

The process of going through the training together, participating in group sessions, acknowledging the effect of structural violence in the lives of their patients and working together towards a common goal enhanced the feeling of teamwork. For some, it was the recognition of the shared awareness of the issues of discrimination that brought them together as colleagues.

“Everybody like the research team knows about it and they’re, you know, bringing in us, bringing it to us and presenting it and teaching us. And I think it, it just helped, you know, it more brought us together because when the whole team is using the skills and learning the skills and knowing what, I mean we do it, we just do a better job and we feel like we’re doing a better job and working more as a team, I guess more, from what I remember that’s. And I think it was really for me really I was very excited about it and so was the other members of the team because it’s like we know it. We know when we see it, when we’re dealing with it it’s just like being talked about and recognize that, that this is what we need to do.”
There were organizational changes that met the unique cultural, social needs of patients

Concurrent and as a result of the study’s intervention, the organization made changes to their operation in response to observed deficiencies in addressing health inequity. During discussions, staff members were able to reflect on their practice and in the workings of the organization to determine where there were shortcomings to promoting health equity.

“...I think as an organization as the staff at the clinic that we already had an awareness and a sensitivity to the experiences of our patients. But I think it’s just sort of made us more aware and so the little different changes like, you know, changing the, opening up the doors and having a meditation group and like more awareness of Indigenous people’s role and their space. Yeah, I think those things have all been sort of heightened, all those things existed before but they’ve been, yeah, just embellished or like not embellished but, you know, like, yeah, yeah just added to, yeah.”

Organizational Change

Prioritizing more than just medical needs

Because of the intervention, organizations could consider the influence of inequities on patients’ presenting health issues not just highlighting the medical problems patients present with at the clinics. An example of the manifestation of this integration was how the agendas in team meetings were not primarily dominated by biomedical concerns, but began also highlighting the issues faced by staff concerned with the psychosocial needs of clients. These changes especially eased some underlying opposition to the hegemonic practice which had caused some contention amongst staff who wanted to explicitly adhere to the clinics’ commitment to attending to the needs of people who experienced greater marginalization.
“In our meetings where it turned from and we always talked about this where because we have team meetings every week and it really centred around the, the medical stuff. And so what we’re really doing now with [primary care coordinator] and is looking at the inequities and the how those contribute to, you know, it’s like the medical is good, yes, the person needs to get fixed up and looked at and all that stuff. But all the other things is what helps to bring that person to that point. It’s like where do they live, why aren’t they accessing health, you know, all of that stuff and it’s like we in the meetings it’s starting to shift which is really big because for years we’ve been saying, okay, we need the psych-social piece to come out in the meetings and not talk three quarters of the time about the medical stuff, yeah.”

Increasing the shared ideology of cultural competence and cultural safety

Participating in the course brought up concepts that were already being executed in the practice of individual staff members as well as in the clinic processes. Additionally, staff could recognise the kinship of colleagues practicing outside of the organization who were familiar with the concepts and thus perceive the opportunity for collaboration. This not only happened outside the sites, but also within the organization; the intervention brought up the incentive and opportunity to have serious conversations about how the clinics could make significant efforts to realize concepts of antidiscrimination and cultural safety.

“But also, getting people talking about the bigger picture of things like how we can make it safer and better for our clients overall and, you know, people are kind of getting down to those tough conversations and saying we need answers instead of just kind of saying, okay, you know, we’ll talk about this some more although that happens a lot.”
Healing relationships

One participant mentioned that one of the sites had difficulty connecting with the communities they served. They suggest that this arose from the absence of representation from these communities in the past. According to the staff members, one of the clinics acknowledged this shortcoming and worked to rectify this by involving community representatives and advocating for the incorporation of local practices.

“I think it would be useful because you have to like with the, we’re [First Nation] traditional territory, we have to know about them and I think that we’re part of the, the reason that we’ve had trouble or some issues is because we haven’t knowingly acknowledged the, the [First Nation] people by hiring one of the elders. And the more I work in communities the more I find out that this is, this exact issue is in other communities. And so what people are doing is correcting that and going to their host nation and just working with them. And I think once you do that then it will acknowledge them and I, and this is, has to do with like in our situation with the elders and then ... you’re hiring people who aren’t from this territory and, and we have very capable people, smart people who can do the work that he’s doing. And so what I think we’re doing now is healing that relation, healing what we did because we unknowingly did that and, and then working with [First Nations group] and having connection with their elder and then we can kind of look at other elders once we’ve done that”

Acknowledging the need for First Nation and Aboriginal leadership and participation

Staff recognize the need for First Nations and Aboriginal representation. The importance being to attend to the mandates of the clinics as well as having the space embody a familiar environment for the people that clinics serve to create a safe space for clients. This was done by
embracing local leaders and cultural health and wellness practices that mesh with staffs’ clinical practice. In one instance an Elder from the local First Nations community was brought in as one of the staff members in one of the clinics.

“Well I think we, we as a team try and like what we’ve talked about and what we’ve discussed for a long time is having kind of like a client, some client involvement somehow. And, and part of that would be having art, their art displayed or have them involved in because there’s so many talented artists in our patient population that I think that if we kind of rotated their art or something that would be really a good thing.”

**Institutionalizing antidiscrimination education**

Staff members suggested that the cultural safety course and the integration sessions helps staff members perform in their roles. They expressed that there is a perceived need especially in communities with a large population of First Nations people. Currently health care settings do not adequately meet the needs of people who are marginalized and can instead be harmful and unsafe. Education to provide staff members with the skill to challenge this environment should be mandatory according to staff at the sites.

“So, I think it should be mandatory in, in urban areas where there’s a large native population for anything, anyone in that like from dentist, doctors, nurses, social workers, everything like that. I think everyone should take that training because it really makes you aware of anything that native people might have gone through and have all the colonization and residential schools, Indian hospitals have all affected native people’s perception of the health care field. And in the past it’s always been negative and working
here I see that it, it’s becoming more about positive experience for everyone that comes and accesses the services.”

**The need for follow-through from organizational leadership**

In one of the sites, staff members felt that the organization had a climate of superficially adhering to the organizational mandates rather than actually honoring the ideologies of inclusivity, antidiscrimination and equity. It was suggested that the leadership maintaining this practice led to the existing barriers to equity and cultural safety within the site. During the study, discussions were undertaken to attempt to rectify this but according to a staff member, no one fully took advantage of the opportunity to move forward and fully address this issue.

“Well I think it’s, you know, that structural violence is everywhere and I think even in the clinic here and not in a way, you know, it’s more of having like control, you know, of where there is, it’s like there’s a certain control when people at the top control things and make it to the way that they want it even if they’re nice, it still impacts everybody in a negative way. And I think people, you don’t move forward when that happens and it’s like, it’s really hard to see, it’s like covert racism, it’s really hard to see because it’s like first it’s right up where everybody can see it and then people change and then it’s no longer acceptable so it goes underground. And I, I think that with, with this organization that it needs to be run by if we’re serving native people it needs to have native people in leadership. And, and I think, you know, the people who run it are very good now, you know, they do have, they have, they want to do well, they want to do, you know, they’re looking out for people but there’s a certain part where I think they don’t want to lose the control... and you know, that’s a hard thing to look at and a hard thing for me to say...

Structural violence that’s what it was and where we felt that the leaders or the
management of this clinic were not, we felt that there was changes that should be made within the leadership but it’s like the leadership wasn’t able to do that… And I think that, that’s probably the fear is that, okay, we, we opened this up and we, we all know that we’ve talked about it and we talk about it on our own and we feel that it’s not always, this is a very good place to work, you know, don’t get me wrong it’s a very good place but there are things that happen that are within the, the leadership and how it, it runs that we don’t feel like is always the best for everybody, yeah… Oh it’s like what we talked about was the native like this is, we feel like, yes, we have a say but only to a certain extent and, and one of the things that two people were very strong about it’s like [organization name] and they don’t feel like the native is really that it, we don’t do what it’s like are we saying native only because funding purposes are we really being, adding cultural content into the program that is, will positively effect not only the staff but the people who come here or is it just a word that, that is there to get more funding. ”

**Getting down to tough conversations**

According to the staff, their organizations are having the beginning of discussions resulting from acknowledging the deficit in meeting the needs of marginalized people. Though these discussions are preliminary, people in the clinics are open to the act of continued self-reflection and development of strategies that are applicable with the goal of moving towards lowering barriers and promoting the practice of cultural safety and antidiscrimination.

“But also getting people talking about the bigger picture of things like how we can make it safer and better for our clients overall and, you know, people are kind of getting down to those tough conversations and saying we need answers instead of just kind of saying, okay, you know, we’ll talk about this some more although that happens a lot… I think
that we are starting to change a few things the way that, you know, we’re sort of starting to realize that just because that’s how it’s been like overall I think the team is realizing that, that doesn’t mean that it can’t change and change again and be reviewed and be reviewed and, you know, try to, try to go in that direction... when the team is here the EQUIP team is here and we’re having these face-to-face interventions and we’re having these training sessions and we’re having these conversations what it does is put the focus back on the patients. And not just on some of the bad behavior from certain patients or non-patients because we’re a drop-in centre as well. And so what it does is it sort of puts the focus back on we can do better for our patients, our patients deserve better. And I do feel that by trying to keep the environment more safe for everybody that it is going to benefit our patients because obviously they’re going to feel more comfortable to come down here. Or at least feel more comfortable to stay coming down here so I do feel that that, that’s come out of that clip because people are sort of saying enough.”

Opening Discussions

Increasing discussions

The educational intervention led to an increase in a shared awareness. More staff members began discussing issues of cultural safety, structural violence and health equity in addition to what the staff and the clinic needed to move forward. One site mentioned staff members forming groups that have the goal of following up on site specific issues that have come up. At this site, there is hope that changes will continue beyond the length of time of the study.

“A lot more awareness, just a lot, lot more awareness and again because we work as an integrated team we’re able to trade that stuff back and forth in the hallways and just in
staff meetings it’s coming up now so again it’s that, that idea that I think we’re all just a little more acutely aware that there’s important stuff here that needs to be done in relation to that. And it’s going to carry over now in at the conclusion of the EQUIP study because we’re already now starting to put together our own ideas around pain management and all the rest of it. So, we’re already setting up our little sub teams and things and stuff to follow on that. So it, it becomes a topic pretty regularly in the staff meetings and again because we dialogue a lot in the hallways, it’s not again a specific, you know, example of something but I can say it’s definitely changed from where it was five, six years ago to what we’re doing now.”

Recognition of cultural safety outside the clinics

Discussions about cultural safety and antidiscrimination as an ideal way to deliver health care are reportedly moving beyond the clinic sites. Staff feel confident about opening up to share this ideal way of health care delivery and educate colleagues outside the clinic to foster the continuity of equitable care. One staff member reports the increased incidence of cultural safety and competence outside the organization has eased collaboration within the community.

“I think knowing that people were taking this training was, was really amazing to me and not only people in my team but people in the hospital and other agencies and it was every, well not everybody, it’s like you heard that, you’ve heard the word cultural competency as you went out in the community or you heard people talking about it and it’s a big thing, it it’s a big thing. And I think it just opens the doors to other stuff and, and I think that I was just amazed and really thought this like I said.”
Increasing dialogue but trouble moving on

Although there are ongoing discussions there have been few who have stood out as leaders in the endeavours to further the development of greater changes towards equity. This was presented as a challenge as any progress could be undermined without strong championing.

“The conversations go on but they go on and on and on and on and never get to, not never but sometimes they get to solutions that, you know, everyone has got a great idea but nobody wants to put them into action or follow them through. And at the end of the day what happens a lot of times is those things will just fall to the MOAs which is unfair... I do feel that when we had a facilitated discussion and what we had were, you know, people, eighty percent or eighty-five percent of some of the people that were in the room researching and said that there would be just for our patients only clinic instead of a drop-in and one of the barriers that I feel there was that we were quite divided but it, it just didn’t. There was a chance there for a really good conversation to happen but nobody stepped into the leadership role.”

Resistance to shifting practice

Most staff members have embraced the concepts from the antidiscrimination training and have readily incorporated them if they had not already been practicing them. There is sentiment that those who more directly experienced a transformative effect from the training or from past experience were likely to readily adopt the concepts personally or at an organization-wide level. It is believed that this occurred more so at the clinical level and lower in the administrative hierarchy than in the leadership. This has led to slow pace of progress and hesitance to change due to fear of “upsetting the apple cart”. 
“And when I gave the presentation they, it kind of hit them more at a personal level rather than like outside of them looking at patients and seeing how. And I think when you, when it hits you on a personal level, you know, then you, if there’s any work that needs to be done people might tend to do that. And then what it does is it changes their outlook on everything. So I think that this stuff has made a difference but the slow, I mean the change has been slow and gradual so it’s kind of hard to really see because what it also does I think it upsets the apple cart and then people kind of, you know, it, I think with this trauma stuff and the other stuff it’s like, it brings out the issues I guess, it brings out the issues where you talk about them and, and maybe deal with them but there’s, there’s other stuff it brings out and I don’t know if that makes sense.”

Summary of Findings

In general, changes arising from staff members’ engagement with the ICS online training modules, and the subsequent integration discussions were observed within clinicians’ individual practice rather than within the greater organization. Staff in the clinics already possessed a high level of knowledge in regards to caring for vulnerable people, many of whom they realized experience racial and other forms of discrimination. Existing knowledge was gained from the process of developing their professional education as well as informally through personal experience and ongoing clinical practice. Training introduced or cemented this knowledge by providing terminology and strategies that enhanced their capacity to deliver equitable care. Consequently, the staff often described feeling more confident in their practice, and their existing practices were validated. Additionally, the ICS training process provided an arena where staff members could voice their need to further advance and make more explicit efforts to integrate cultural safety and antidiscrimination in the organizations.
Adoption of the concepts and strategies from the training was described as having greater impact when staff members had experienced a transformative effect from the ICS training and integration. Many described developing an awareness of and acknowledgement of historical injustices and ongoing structural inequities, gaining an awareness of existing personal and organizational biases and alienating structures and recognizing the structures within the clinics as possibly promoting structural violence. Thus, the online training provided staff with a sense that they could initiate and enrich relationships with patients and the local communities which they serve.

At the organizational level, the training triggered discussions, ongoing evaluation and strategy building with the goal of eliminating any processes or practices that might contribute to patients’ marginalisation. Additionally, it contributed to the adoption of practices that enable cultural safety and build the capacity to access the social determinants of health. Finally, staff members saw increased informal collaborative efforts to continue having these dialogues beyond the presence of the study. Despite the ongoing efforts towards health equity, there were challenges to moving forward. The obstacles to integration arose when clinical staff perceived that leaders were not fully supporting the implementation of antidiscriminatory efforts at the same level as clinical staff and when there was a perceived absence of champions to foster integration.

**DISCUSSION**

**Amplifying unheard voices**

Many of the staff members interviewed were already knowledgeable about providing culturally safe and antidiscriminatory care. If anything, the education and integration discussions served to reignite the enthusiasm they had to provide care to the communities. This could suggest
that although there was willingness to integrate antidiscrimination efforts, there might be challenges to fully implementing and sustaining these practices due to institutional barriers.

Important in culturally safe care is the acknowledgement of privilege and evaluation of shortcomings or deficiencies in areas that contribute to the promotion of institutional discrimination (Brascoupe & Waters, 2009; Browne et al., 2009). The EQUIP intervention and especially the components of the intervention that centred on antidiscrimination, provided a forum where staff members could do so. Per one staff member:

“...and it’s like we in the meetings, it’s starting to shift which is really big because for years we’ve been saying, okay, we need the psycho-social piece to come out in the meetings and not talk three quarters of the time about the medical stuff.”

Through these discussions staff voices on these issues, previously unheard, were amplified and realized. They identified the need to reinforce processes at the interpersonal and clinic levels that challenge varying forms of institutional discrimination as potentiators of poor health and wellness in clients. In addition to this they saw the need for fostering the client-provider relationship and relationships with communities they serve.

Despite this, a majority of the participants’ reports demonstrate that an integration of antidiscrimination is challenging to fully embrace at the clinic level. Through self reflection, staff described how they recognized that they had fallen into the pattern of prioritizing the need to “fix” the patients. The delivery of care became task driven. Structural limitations such as competing demands (limited resources, limited time, not enough staff, high staff turnover and patients perceived as challenging) meant that clinicians began to slide into patterns that were easy and familiar. As this staff member described:
“It’s challenging when there’s just like so many demands placed on your daybook so, for instance, I mean like when there are so many patients to be seen it’s hard to, you know, always practice in a way that’s, you know, holistic, and considerate of everyone’s circumstances. For instance, like I notice like a lot of patients here if we’re just a little bit late like they really don’t tolerate it and they’ll get angry and they’ll leave. So that’s probably the hardest part is just, is just the demand sometimes.”

Traditionally, biomedical principles dominate the delivery of health care. Within this paradigm, health is narrowly defined as an absence of illness. Health services delivery is primarily individualistic in scope. Providers are tasked with assessing the individual or family, diagnosing or finding a cause of illness and providing interventions that target the specific agent that brought about ill health (Browne et al., 2009; Gladman, Ryder, & Walters, 2015). The biomedical model of health care delivery has been criticized for having a limited definition of health and wellness, reinforcing hierarchies between health disciplines, failing to consider the socially located influencers of health and consequently having restricted systems for addressing these influencers to the benefit of health (Gladman et al., 2015). In the clinics involved in the study, staff members are familiar with more critically informed health care practices, especially those that operate with a goal of social justice. They are generally aware that, especially in highly marginalized populations, the need to address larger structural injustices such as poor housing, inadequate nutrition or increased vulnerability to interpersonal violence better serves to establish long term wellness (Browne et al., 2011; Browne & Fiske, 2001; Gershon et al., 2014; Varcoe, Browne, & Ponic, 2013). This perspective is especially relevant to Aboriginal people (who are largely represented in the patient population seen in the clinics) whose perspective on health and wellness is holistic, incorporating aspects related to mental, physical, spiritual, emotional and
social wellbeing (Browne et al., 2009). Attending to these needs can be time consuming and require greater effort and more resources than are usually allocated in more mainstream health care organizations. Unfortunately, by not providing care that reflects the holistic needs of marginalized people, each encounter only provides a superficial fix to greater underlying social, historical and structural factors.

Antidiscrimination training acted as a catalyst to interrupt the pattern of prioritising biomedically-influenced health care delivery for the sake of compensating for the constraining practicing environments. This ongoing pattern of practice had led to tensions within the organization as different parties hold different opinions on what to prioritize. Both clinic sites had mandates to provide care that meets the unique needs of vulnerable people. Some staff strongly felt that these mandates were not being adhered to but they could not voice their opinion or their concerns were being dismissed for the sake of maintaining the reliance on heavily biomedical standards of practice. The study presented opportunities for these previously suppressed voices to confidently articulate their perspectives and reinforce non-discriminatory and cultural safe practice. After all, the content presented in the courses and the integration sessions reflected what they felt should be practiced and thus validated their belief.

Creating and healing relationships

Unfortunately for people who are marginalized, the health care environment is one where they have been subjected to violence that is both structural and interpersonal in nature. The disconnect between institutions that deliver health care and marginalized communities has been well documented (Blanchard & Lurie, 2004; Brondolo et al., 2008; Browne et al., 2009, 2011; Browne & Fiske, 2001; Burgess, Ding, Hargreaves, van Ryn, & Phelan, 2008). Dismissive attitudes from health care providers, institutions that were unable or unwilling to devote
resources to people’s needs, or hostility in responding to people expressing their needs are common occurrences that have led to mistrust between health care workers and vulnerable patients (Browne & Fiske, 2001). One goal of the study was to foster the capacity of clinics to create safe spaces where the health care encounter can occur in a way that is beneficial to the patient without contributing to the structural violence they often experience. By incorporating a practice of cultural safety, staff members can achieve this and move towards building trusting and respectful relationships with patients.

A crucial component of the EQUIP process of fostering integration of cultural safety was the encouragement of participants to take part in critical self reflection of internal biases, attitudes as well as an examination of social positioning and privilege and its effect on their interactions with patients (Browne, Varcoe, Ford-Gilboe, & Wathen, 2015). From the interviews, it was evident that staff members could step back and evaluate the manner in which they presented themselves, how they were perceived and how this could be a barrier to establishing healing relationships with their patients. It is through this process that they could critically reflect on their own care and bring to consciousness any discriminatory or alienating practices to shift towards more respectful and trusting interactions.

A major impact of the antidiscrimination educational intervention is the recognition of the importance of relationship building between patients and health care providers. Clinic staff report that the integration of antidiscrimination and cultural safety precepts into their clinical practice led to positive interactions with clients. For example, providers acknowledged the importance of patients’ Aboriginal ancestry or demonstrated an awareness and understanding of the history of First Nations people and the injustices inflicted upon them. Scenarios such as these indicated to the patient that the provider was open to understanding the reality of structural
violence and oppression experienced by the patient, which then presented a stepping-off point for building rapport that could then develop into a meaningful and hopefully trusting relationship. Consequently, patients were much more free in their interactions, and those who were reserved in their communication with providers became animated and more engaged in the health care encounter. By staff report, patients felt respected, validated and safe in the interaction while practitioners could more confidently identify pressing needs and thus provide care that is more appropriate.

In addition to individual relationships with patients, the staff recognised the importance of building relationships with the local communities and especially the local Aboriginal communities. The literature discusses the importance of building collaborative relationships in efforts to achieve cultural safety (Brascoupe & Waters, 2009). Forming partnerships with leaders or representatives from the local communities serves to build trusting and open relationships. Through being integrated as part of the organizations that have previously been sites of mistrust and injustice, the local communities can start feeling a sense of ownership. They can introduce and help institutionalize the delivery of health and wellness practices that are more familiar and relevant to the needs of local communities (Manitowabi & Shawande, 2013). Additionally, they can be mentors to staff in clinics, triggering the sustained advancement of critical reflection and evaluation towards the goal of cultural safety and antidiscrimination (Manitowabi & Shawande, 2013).

The importance of leadership

Largely speaking, staff members reported greater changes to individual practice compared to the degree of transformation occurring at the organizational level. Most of the reports are of how individual changes to clinical practice have been made rather than how new or
sustained efforts are being undertaken separate from those performed as part of the EQUIP intervention. Individual transformation is but a first step to creating culturally safe and antidiscriminatory environments.

Cultural safety can require the upsetting of power structures and thus discussions that relate to positions of privilege or disadvantage can lead to discomfort and tensions (Browne et al., 2009; Browne & Fiske, 2001). Transformation for the sake of social and health equity needs to engage the entire the health care organization and the staff operating within them. Organizations often have had longstanding social, professional and political structures with defined hierarchies, epistemologies and ways of practice that are challenging to disrupt (Anderson et al., 2010; Browne et al., 2009). Therefore, the process of derailing the dominating power structures can be met with resistance due to potential political ramifications not only within health care organizations but in society at large. And so, it comes with many challenges and can it be extremely difficult in achieving and sustaining transformative change (Baum et al., 2013; Baum, Houweling, & Taylor, 2009; Brascoupe & Waters, 2009). One major obstacle can be a refusal to embrace the fundamental tenet of cultural safety which demands a shift in existing power relations. Rather, organizations can choose to focus on the aspects related to cultural understanding and awareness without moving forward to sustain changes to institutions of discrimination (Brascoupe, 2009; Browne et al., 2009). Therefore, the importance of a shared understanding of ideology throughout all levels of the organization can go a long way towards successful uptake and institutionalization of new concepts and practices. This is especially relevant given the necessity of ongoing reflection and continually adjusting individual and clinic practices and policies to the benefit of antidiscrimination.
RECOMMENDATIONS

An analysis of conversations with staff members who engaged in the ICS online training and integration sessions shows that the process of learning about and in many cases, incorporating antidiscrimination was generally well accepted within the clinic staff despite some barriers. Based on this analysis the following recommendations can be made for organizations that plan to have their staff undertake ICS training or any such training on strategies to mitigate patients’ experience of discrimination.

Target organizational leaders for transformation

Analysis from this report demonstrates the importance of considering individuals in the higher organizational hierarchy in efforts to integrate equity oriented practices and policies. According to a majority of staff reports, the insufficient commitment by organizational leaders to following through with an equity lens greatly contributed to the limited organization-level changes. Though the clinics involved in these sites had a mandate to provide care for people experiencing marginalisation, some staff identify that there might be deficiencies in achieving this ideal. Staff members were invited to take part in the training and discussion but it would be important to including organizational decision makers in these discussions that allow for reflexivity. In this manner, commitments to changing to equity could come not just from the individual practices that spread organizationally but also from leadership in the form of explicit support and commitment in the shape of resource distribution, policies and practices. By considering them as a separate demographic to target for intervention, organizational leaders can be considered partners in efforts to institutionalize concepts and strategies from the training.
Identify champions and strategies that allow for sustainability of changes

The EQUIP study included a plan for sustained attention to steering the organization to more equitable practices by using facilitators during the length of the study but not for the term thereafter. The presence of the researchers served as a trigger for continued reflexivity and a source of evaluation of advancements toward more equitable health care delivery. Some staff reports identify the potential of observed changes stalling beyond what was observed during the duration of the study which could be a potential shortcoming for continual antidiscriminatory efforts at the clinic level. It would be beneficial to consider integrating champions or strategies that continue to prompt clinics’ development towards antidiscriminatory ways of operating.

One potential strategy could be the recruitment of champions who would serve a role similar to the one that the EQUIP facilitators served. These could be individuals within clinic staff or alternatively could be representatives from communities served by the clinics. These parties would be responsible for identifying areas of improvement, initiating discussions that lead to potential strategies for improvements and evaluating any ongoing efforts. Additionally, clinics could engage long standing relationships with external consultants who would be accountable for quality improvement with the intention of maintaining antidiscrimination.

Allow time and space for reflexivity and discussion

As it has been previously identified, reflexivity is a major component to the understanding and integration of cultural safety and antidiscrimination. Through discussions participants can examine the biases and attitudes within themselves and the organizations they work in that can contribute to structural barriers and discriminations experienced by their clients. These discussion spaces allow for dialogue where other staff members could bring up organizational shortcomings and come up with potential solutions to issues of discrimination.
Similar interventions should highlight the need for a safe and non-judgemental space for free discussion amongst participants. Important to consider is the creation of discussion spaces where unrestricted dialogue can occur between all staff in the organization. This open communication fosters greater reflection and allows for more honest exploration of organizational structures that can influence potential institutionalization efforts.

Consider the organizational influencers for integration

From staff reports, a majority of the staff observed changes at the individual level compared to those seen clinic wide. Staff were willing to personally integrate antidiscrimination and cultural safety in practice as they already had a familiarity with the concepts through the education efforts of the study. A greater challenge was moving forward with changes beyond individual practice. Future attempts should consider the contextual factors that play a hand in furthering the institutionalization of equity oriented practice. This could be done prior to the integration where sites are assessed for potential barriers and facilitators. Alternatively, this evaluation could occur during the discussion phase of the integration where educators and participants could collaborate in identifying context-specific challenges and possible strategies to counter these challenges.

There is always room for improvement

The clinic sites involved in this study had explicit mandates to care for populations that faced structural and social barriers that led to intersecting vulnerabilities. As such it could be assumed that they were well versed in caring for these populations and any education targeted to staff members would be redundant. This report demonstrated that there were areas of staff knowledge that needed improvement. Consequently, education validated the knowledge that staff already had and increased their confidence to serve their clients. This suggests that the education
provided by the study could be useful in all health care delivery centres despite their level of familiarity with the concepts of antidiscrimination.

CONCLUSION

This report provides a review of the process of engaging with the cultural safety and antidiscrimination components of the EQUIP study, the efforts of incorporating this training into individual and organizational practice, and the impact of all these efforts. From interviews with staff members who engaged with the training, it was evident that a large majority of them were familiar with the concepts. For those who were not aware of the content, the training provided an eye opening and transformative experience. These staff members could benefit from continuing to develop an understanding of historical and ongoing injustices against Aboriginal people in Canada as well as intersecting structural inequities and the effects on health marginalized people experienced.

For those already familiar with the content, the training served as a reminder and rekindled a desire to orient their clinical and organizational practice to mitigating the effects of systemic injustices rather than on the task-oriented biomedical approach that is typically the norm. This was attributed to the time and space allocated during the integration sessions for staff to reflect critically and discuss the implications for their practice and the organization. Therein the participants could examine where their individual and organization-wide attitudes, values, biases and practices might reinforce structural barriers or injustices that contribute to the suffering of their patient base. Consequently, they could then move forward with addressing these issues within their own practice and in the organizational milieu.
Analysis conducted for this report highlights leadership as an area of importance to consider. Implementing concepts such as cultural safety and addressing discrimination involve examining and disrupting existing power structures towards the goal of achieving environments that combat structural barriers. Commitment to reshaping existing structures within the organization could greatly influence the degree of institutionalisation more than superficial educational interventions.

Through adopting the central tenets of antidiscrimination and cultural safety, staff members reported greater confidence in engaging with patients experiencing marginalisation. One implication was that they could build better relationships with their patients, and staff described how their interactions became more engaging and fulfilling as they established and addressed the priority needs of the patients. Likewise, they determined the need for enhancing partnerships with the communities they serve. These partnerships could potentially establish feelings of shared ownership within the communities they serve as they can promote the integration of familiar and relevant practices. Additionally, partners can champion sustained efforts towards institutionalizing cultural safety and antidiscrimination.

Next, educators should not make assumptions about the knowledge levels of participants. Teaching should be administered as if all knowledge users have no prior knowledge of course content to dispel knowledge gaps they might possess. Additionally, mentors within or outside the organization should be selected and plans should be devised to allow for sustainability of the changes beyond the initial integration period. Moreover, time and space should be allocated for open and equitable discussion for the reflexivity necessary for integration. Last, structural influencers occurring within the organization should be considered when tailoring integration efforts.
This report explores staff perspectives of the process of integrating an intervention aimed at antidiscriminatory and equity oriented health care delivery. It also explores the impact of this intervention. Integrating antidiscrimination and cultural safety is necessary for the delivery of comprehensive health care to populations experiencing compounding and intersecting socially located vulnerability. It is therefore essential to develop a better understanding of the process of institutionalizing efforts to incorporate policies and practices that address the structural inequities that affect patients.
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