# The Aboriginal Cultural Safety Initiative: An Innovative Health Sciences Curriculum in Ontario Colleges and Universities

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## Abstract

***Objectives:*** The Aboriginal Cultural Safety Initiative (ACSI) created at Anishnawbe Health Toronto offers an innovative curriculum to address gaps in postsecondary health sciences curricula in this area for future healthcare providers. ***Participants:*** Evaluations were collected from 1,275 students in health sciences programs in colleges and universities in Ontario. ***Setting:*** Trained volunteer Aboriginal instructors were invited as guest speakers to college and university classes in various health science disciplines. ***Intervention:*** Our instructors offered a 2- to 3-hour teaching session to health sciences students that included 3 modules on the health of Aboriginal peoples: (a) The impact of colonial and postcolonial policies on social determinants of health, (b) Contemporary health determinants and health outcomes, and (c) Aboriginal concepts of health and healing practices. ***Outcomes:*** The ACSI was able to impart the intended learning objectives to a wide array of students across health sciences disciplines, as demonstrated in the student evaluations. A significant number of students reported that their knowledge of, and interest in, Aboriginal health increased substantially when compared to their prior knowledge and interest. ***Conclusion:*** The success of this program suggests that, in the absence of Aboriginal faculty members in postsecondary health sciences departments, a committed cadre of volunteer Aboriginal instructors can improve student knowledge around issues related to Aboriginal health and can influence student attitudes through the inclusion of personal experiences in the teaching session. A lack of availability in curriculum time continues to be the largest obstacle to including content on Aboriginal cultural safety in health sciences programs.



## Keywords

Cultural safety, cultural competency, postsecondary education, health education, medical education, Indigenous health services



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## Introduction

In the fall of 2008, Brian Sinclair was found dead in a hospital emergency room in Winnipeg, Manitoba, after waiting over 30 hours for care. An inquest began in early 2014 to examine how the healthcare system can prevent similar deaths in the future. Aboriginal groups noted that systemic racism likely played a role in this type of hospital neglect, as Sinclair was both homeless and Aboriginal (CBC News, 2014). Stories like these, as well as many similar observations in our own clinical practice, prompted the creation of the Aboriginal Cultural Safety Initiative (ACSI) at Anishnawbe Health Toronto.

The province of Ontario has the highest number of Aboriginal people (including First Nations, Métis, and Inuit) in Canada (Statistics Canada, 2010). The health status of Aboriginal Peoples, whether they reside in First Nations communities (reserves) or off reserve, is significantly lower than that of the non-Aboriginal population in Ontario and in Canada (Gracey & King, 2009; King, Smith, & Gracey, 2009). Improving the health status of Aboriginal Peoples requires a multipronged approach that addresses issues related to the determinants of health, the provision of culturally sensitive healthcare, and advocacy around self-determination. While efforts have been made in Canada to address cultural insensitivities generally in the healthcare field, the provision of culturally appropriate healthcare to the Aboriginal population has been largely neglected, and Aboriginal Peoples continue to meet with subtle and overt racism in the healthcare system (Health Council of Canada, 2012). One proposed solution is to train all frontline healthcare professionals in the area of Aboriginal cultural safety.

A recent environmental scan completed by Anishnawbe Health Toronto (Shah & Reeves, 2012) explored the extent to which health sciences programs in Ontario universities and colleges include Aboriginal cultural safety in their curricula, as well as barriers and challenges they face in incorporating this type of content. Findings indicated that, other than in nursing and a few personal care support worker programs, Aboriginal content in college curricula is quite sparse. Although two thirds of the university programs that responded noted that they include some aspects of Aboriginal history, content related to colonization and resultant health impacts are limited. The health sciences program directors who responded to this survey indicated that there were few Aboriginal faculty members available to teach this curriculum; however, they noted that if an Aboriginal instructor were available, they would consider further inclusion of this curriculum. In response, we developed a curriculum in Aboriginal cultural safety and offered this training seminar to all students enrolled in undergraduate health sciences programs in colleges and universities in Ontario.

### Defining Cultural Safety

Developing a curriculum for postsecondary students in Aboriginal cultural safety led us to review the literature on cultural safety, a concept that has received various definitions since Irihapeti Ramsden, a Maori nurse in Aotearoa (New Zealand), wrote extensively on the topic of cultural safety in nursing education (Ramsden & Spoonley, 1994). Our review included key documents in the area of Aboriginal cultural safety in Canada, including publications by the National Aboriginal Health Organization (NAHO, 2006, 2008), the Indigenous Physicians Association of Canada (IPAC, 2008), and the Aboriginal Nurses Association of Canada (ANAC, 2009), as well as an often-cited publication on cultural safety by Brascoupé and Waters (2009)

published in the *Journal of Aboriginal Health*. A few central tenets of cultural safety emerged from this review. First, cultural safety is inclusive of cultural competency (which includes having an understanding of colonial history, having an awareness of cultural differences, being culturally sensitive, and refining one's skills, knowledge, and attitudes), but it extends further to include a focus on clinician self-awareness of his or her own historical and social location. Second, cultural safety emphasizes relationship building between client and practitioner by creating an environment of respect, acceptance, trust, caring, and empathy, and it encourages mutual goal setting for shared responsibility of care. Third, cultural safety employs a social justice lens to considering power imbalances in society and seeks to empower Aboriginal clients and communities in terms of advocacy and political power sharing. Fourth, it is the client herself/himself who determines whether the care she or he has received has indeed been culturally safe (ANAC, 2009; Brascoupé & Waters, 2009; IPAC, 2008; NAHO, 2006, 2008). This assessment of whether care has been culturally safe should be revisited over time and across multiple visits; therefore, cultural safety is an *active* and *ongoing* process.

Although many of these tenets are universal principles of client-centred care, concepts of cultural safety are unique for Aboriginal Peoples when compared to other disadvantaged or oppressed groups in Canada. Brascoupé and Waters (2009) argue that while Canada is well known for having an ethic of cultural tolerance and for celebrating ethnic diversity, this reputation overlooks the long-standing assimilationist policies of the federal government toward Aboriginal Peoples that has historically denied them many of their human rights (Reading & Wien, 2009). Specifically, failure to distinguish between the colonized histories of Aboriginal Peoples and issues of other immigrant groups in Canada risks invalidating the centuries-long struggles of Aboriginal Peoples and their unique marginalization status at government hands. Aboriginal Peoples deserve recognition as an equal founding nation and thus have an inherent right to self-determination; therefore, cultural safety explicitly requires recognition of the cultural identity of Aboriginal Peoples and an understanding of the history of colonial repression (Brascoupé & Waters, 2009).

## Participants, Setting, and Intervention

There are approximately 57,000 students enrolled in postsecondary health sciences programs across Ontario. At present, the majority of the health sciences programs in colleges and universities that are training frontline healthcare workers across Ontario have little to no curriculum content on Aboriginal cultural safety (Shah & Reeves, 2012). This is in part due to the lack of available Aboriginal faculty members in these institutions. The ACSI sought to train students to better prepare them to serve Aboriginal clients and work with these clients in a culturally safe manner. A 3-hour cultural safety training seminar for students was developed, drawing heavily from the work of the Indigenous Physicians Association of Canada (IPAC, 2008). The ACSI was created to address the lack of curriculum content on the impacts of colonization on Aboriginal health outcomes and culturally safe care for Aboriginal clients. Further, we sought to transmit this relevant knowledge through trained volunteer Aboriginal instructors who could also share lived experiences on these topics.

Based on a literature review of cultural safety in healthcare, a curriculum design workshop with Aboriginal experts from academia, and ongoing revisions with these professors, our curriculum incorporated the tenets of cultural awareness, cultural sensitivity, cultural competence, and cultural safety. Within the framework of cultural safety, we hoped that students would first engage in a process of *self-reflection*, in order to understand that cultural values and

norms of the practitioner and client may be different due to unique sociopolitical histories. In turn, we hoped that this process of self-reflection would lead to *empathy* for the client, which we conceptualized as the ability to understand and share another person's mental, social, and emotional experience, or to "walk in their shoes" in a sense. Our goal was to improve each therapeutic encounter with clients and their communities, ultimately leading to *improved health outcomes*. Practicing cultural safety could also involve *advocacy* and social justice work on behalf of clients and their communities. Thus, the overarching goal of the ACSI was to improve health outcomes of Aboriginal peoples, either by improving encounters between clients and healthcare providers or by encouraging providers to become health advocates for Aboriginal communities. Figure 1 reflects a holistic image of cultural safety and was developed for this intervention by the ACSI team.


**Figure 1.**
***Conceptual model developed for the Aboriginal Cultural Safety Initiative***

The curriculum content for the ACSI was organized around three modules: (a) The impact of colonial and postcolonial policies on social determinants of health of Aboriginal Peoples, (b) Contemporary health determinants and health status of Aboriginal Peoples, and (c) Aboriginal concepts of health and healing practices. The curriculum also included content on the organization of health services for Aboriginal peoples, as well as gaps in services and barriers to receiving services for Aboriginal peoples.

The success of the initiative rested on the ability of volunteer instructors to transfer knowledge and inspire change. These instructors were willing to share personal, family, and community examples to supplement the course materials and to engage students on a more intimate level. They also incorporated personal and local community traditions into the training sessions, including talking circles, drumming and singing, and smudging. A group of 32

Aboriginal instructors made up our teaching cadre and represented lay volunteers who were located across Ontario and in proximity to colleges and universities. We organized the first training workshop in Toronto in June of 2011 for the volunteers prior to their receiving invitations to deliver the seminar in classrooms. The Aboriginal volunteers were invited to return to Toronto for a second gathering with us the following year, in order to debrief about their experiences and offer suggestions for improvement.

This intervention involved delivering the curriculum content to students and asking students to voluntarily complete a cultural safety course evaluation. Ethics approval for this intervention was not sought from an academic institution, but Aboriginal community ethics approval was obtained through consultation with the Anishnawbe Health Toronto ethics team. Our volunteer Aboriginal instructors were asked to inform students about local Aboriginal community resources should students wish to obtain further information on these topics, as well as local counselling resources at the college or university should the students feel the need to seek out these services after exposure to stories about colonization and associated traumas.

A multifaceted awareness campaign for the initiative was undertaken to promote uptake of the seminar, including efforts to make direct contact with health sciences deans of colleges and universities as well as course instructors via letters, emails, telephone contact, and distribution of promotional materials; through the development of a dedicated website, promotional materials, and videos; and through newspaper coverage and participation in radio and television talk shows. This initiative also gained public awareness when it was awarded a Canadian Race Relations Foundation's Honourable Mention in the category of Best Practices in their 2012 Awards of Excellence; when it was included as an innovative practice in the Health Council of Canada's 2012 report; and most recently when it received the 2014 Health Equity Award through the Association of Ontario Health Centres.

## Evaluation Methods

Students participating in the seminars were invited to complete a two-page evaluation tool (see Appendix) which looked at (a) whether the Aboriginal Cultural Safety Initiative of Anishnawbe Health Toronto made a difference in terms of increasing student knowledge of Aboriginal health and history, and increasing personal interest in Aboriginal cultural safety; and (b) the effectiveness of trained volunteer Aboriginal instructors in teaching the subject matter. Specifically, the tool measured students' (a) knowledge of content on Aboriginal health (the Indian Act and government policies, residential schools, determinants of health, health outcomes, Aboriginal cultures generally, and understanding of cultural safety), and (b) personal interest in the seminar topics (Aboriginal Peoples' cultures and well-being, cultural competence and cultural safety for Aboriginal Peoples in Canada, and advocacy and/or empowerment work). We also asked students to rate the instructor's clarity, enthusiasm, interest, and teaching ability. To assess these items, we employed quantitative measures in the form of Likert scales ranging from 1 to 5, with descriptions of *Very poor* to *Excellent*; these scales were collapsed into three ratings (*Excellent/Good, Fair* and *Poor/Very poor*) for the analysis. Additionally, we invited qualitative responses regarding students' enjoyment of the sessions, suggested areas for improvement, and opinions as to whether and how the knowledge will impact their future work.

Prior to the seminar, course instructors distributed the survey and students were asked to complete the first page (see Appendix). Following the completion of the seminar, students were asked to turn over the paper and respond to the same items, as well as rating the instructor. Students completed this evaluation tool on a voluntary basis, and not all students chose to submit

their evaluation. An independent program evaluator was hired to analyze the results of the evaluations in order to look at change in knowledge and personal interest in these topics following the seminar.

## Results

Health sciences course instructors invited our volunteer Aboriginal instructors into the classroom to deliver the cultural safety training to students. Although attendance was not taken in classrooms, we estimate that approximately 1,500 students attended the cultural safety training each semester from the fall of 2011 to the fall of 2013. Sessions were held in a variety of colleges and universities throughout Ontario, with the majority of sessions being held in the southern Ontario region. In total, 34 sessions were delivered at eight institutions, and 18 of the 32 instructors were invited to deliver one or more sessions to students in the following health sciences streams: nursing, naturopathic medicine, chiropractic medicine, the Physician Assistant Initiative, medicine, speech language pathology, and clinical psychology residency. The remaining instructors did not have an opportunity to deliver the training, as the colleges and universities in their regions did not institute the program.

Data from 1,275 student evaluations were analyzed to consider percentage change in student ratings from prior to the seminar to after the seminar. In addition, responses from three discrete qualitative questions were collected for descriptive purposes and were grouped and arranged thematically. Of the 1,275 student evaluations, 240 were not included in the quantitative analysis due to several content changes made by a volunteer instructor on those particular evaluation forms. While the majority of students did complete the evaluation, Aboriginal instructors reported that some students declined to do so, and the specific level of participation for this evaluation was not recorded.

### Quantitative Results

Table 1 indicates results from the evaluation questions designed to measure change in students' perceptions of their knowledge of the curriculum content before and after the session. These findings suggest that students perceived their knowledge in these areas to have increased substantially as a result of the seminar. For instance, student ratings of *Excellent/Good* knowledge of residential schools increased by 49.8 percentage points (218% change) following the seminar and their ratings of *Poor/Very Poor* knowledge of residential schools decreased by 41.3 percentage points (95% change) following the seminar. "Understanding of cultural safety" showed an increase in ratings of *Excellent/Good* on this tool of 13.4 percentage points, or 179% change

**Table 1**
***Self-Assessed Knowledge Ratings by Students Before and After Aboriginal Cultural Safety Training***

| Topic | Rating | Before ($N$ = 1,035) | | After ($N$ = 1,035) | |
|---|---|---|---|---|---|
| | | % | # | % | # |
| Indian Act, government policies affecting Aboriginal Peoples | Excellent/Good | 13.5 | 140 | 59.1 | 611 |
| | Fair | 21.1 | 218 | 33.1 | 343 |
| | Poor/Very Poor | 63.2 | 654 | 4.6 | 48 |
| | No response | 2.2 | 23 | 3.2 | 33 |

| | | | | | |
|---|---|---|---|---|---|
| Residential schools | Excellent/Good | 22.8 | 236 | 72.6 | 751 |
| | Fair | 31.2 | 323 | 21.7 | 225 |
| | Poor/Very Poor | 43.6 | 451 | 2.3 | 24 |
| | No response | 2.4 | 25 | 3.4 | 35 |
| Determinants of health for Aboriginal Peoples | Excellent/Good | 28.8 | 298 | 74.3 | 769 |
| | Fair | 34.6 | 358 | 19.8 | 205 |
| | Poor/Very Poor | 34.0 | 352 | 2.3 | 24 |
| | No response | 2.6 | 27 | 3.6 | 37 |
| Health outcomes for Aboriginal Peoples | Excellent/Good | 25.9 | 268 | 69.7 | 721 |
| | Fair | 33.6 | 348 | 23.0 | 238 |
| | Poor/Very Poor | 37.9 | 392 | 3.6 | 37 |
| | No response | 2.6 | 27 | 3.8 | 39 |
| Aboriginal cultures generally | Excellent/Good | 19.0 | 197 | 64.4 | 667 |
| | Fair | 31.9 | 330 | 28.1 | 291 |
| | Poor/Very Poor | 46.6 | 482 | 3.8 | 39 |
| | No response | 2.5 | 26 | 3.7 | 38 |
| Understanding of cultural safety | Excellent/Good | 7.4 | 77 | 20.8 | 215 |
| | Fair | 9.6 | 99 | 8.3 | 86 |
| | Poor/Very Poor | 14.9 | 154 | 2.1 | 22 |
| | No response | 68.1 | 705 | 68.8 | 712 |

Table 2 indicates results from the evaluation questions designed to measure students' personal interest in these topic areas before and after the session. As with knowledge of content, personal interest in these topics increased, according to student ratings. In terms of *Excellent/Good* ratings, student interest in Aboriginal Peoples' culture increased by 29.1 percentage points (56%), student interest in cultural safety increased by 27.9 percentage points (54%), and student interest in advocacy work in this area increased by 31.8 percentage points (75%).

**Table 2**
***Self-Assessed Ratings of Personal Interest by Students Before and After Aboriginal Cultural Safety Training***

| **Personal interest** | **Rating** | **Before (*N* = 1,035)** | | **After (*N* = 1,035)** | |
|---|---|---|---|---|---|
| | | **%** | **#** | **%** | **#** |
| Interest in Aboriginal Peoples' culture and well-being | Excellent/Good | 51.8 | 536 | 80.9 | 837 |
| | Fair | 33.9 | 351 | 13.7 | 142 |
| | Poor/Very Poor | 11.6 | 120 | 1.9 | 20 |
| | No response | 2.7 | 28 | 3.5 | 36 |
| Interest in cultural competence/cultural safety for Aboriginal Peoples in Canada | Excellent/Good | 51.6 | 534 | 79.5 | 823 |
| | Fair | 32.5 | 336 | 14.7 | 152 |
| | Poor/Very Poor | 12.9 | 134 | 2.0 | 21 |
| | No response | 3.0 | 31 | 3.8 | 39 |

| | | | | | |
|---|---|---|---|---|---|
| Interest in advocacy and/or empowerment work in this area | Excellent/Good | 42.5 | 440 | 74.3 | 769 |
| | Fair | 36.8 | 381 | 18.1 | 187 |
| | Poor/Very Poor | 17.2 | 178 | 3.9 | 41 |
| | No response | 3.5 | 36 | 3.7 | 38 |

We also asked students to rate the effectiveness of the seminar in terms of instructors' teaching abilities. Table 3 indicates student ratings of instructors. These results indicate that the majority of students found their instructor's clarity, enthusiasm, and teaching ability to be in the *Excellent/Good* ranges.

**Table 3**
***Student Ratings of Aboriginal Instructors***

| **Teaching Qualities** | **Rating** | ***N* = 1,035 (%)** |
|---|---|---|
| Clarity | Excellent/Good | 87.6 |
| | Fair | 10.5 |
| | Poor/Very Poor | 0.6 |
| | Invalid/No response | 1.3 |
| Enthusiasm/Interest | Excellent/Good | 89.7 |
| | Fair | 8.1 |
| | Poor/Very Poor | 0.7 |
| | Invalid/No response | 1.5 |
| Teaching Ability | Excellent/Good | 85.8 |
| | Fair | 11.4 |
| | Poor/Very Poor | 0.9 |
| | Invalid/No response | 1.9 |

## Qualitative Comments

The qualitative comments from students were overwhelmingly positive. Figure 2 graphically illustrates the frequency of words found in the student evaluation responses when asked, "What did you enjoy about the seminar?" Responses to this question touched on themes related to knowledge building and to personal understandings through family stories. One student noted, "I enjoyed learning more in-depth information about Aboriginal people," while another student stated, "This has made me more aware of what actually occurred in the lives of these individuals." One student felt the seminar was "very applicable" to his or her nursing practice and that this experience was "very eye opening." Some students felt the inclusion of an Aboriginal instructor to teach the seminar was especially memorable. One student wrote, "Her personal stories about her family's experiences with residential schools and reserves helped to bring meaning to the content."

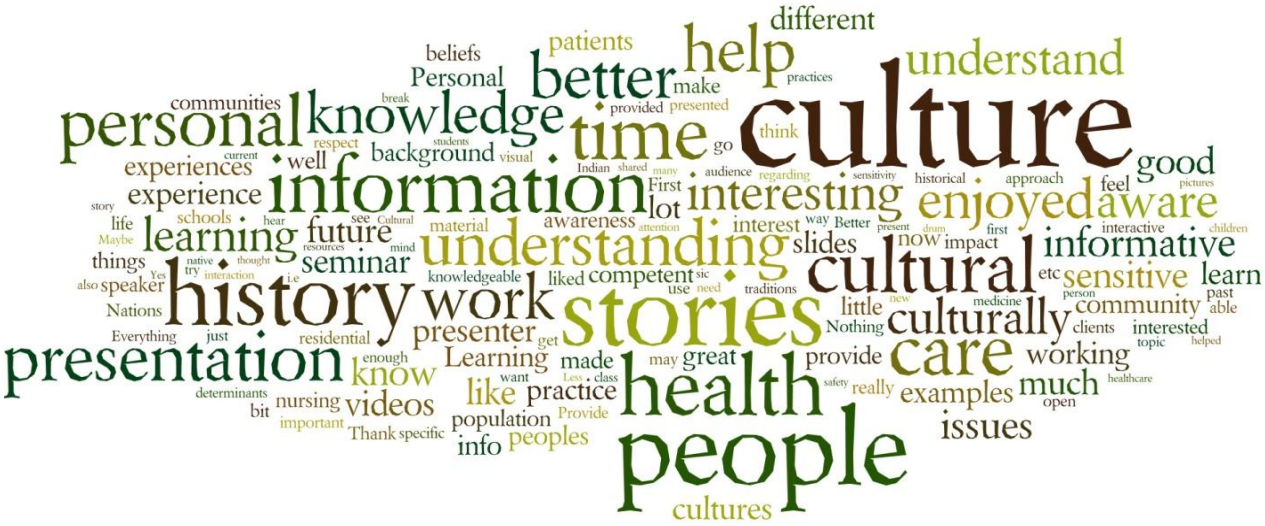


**Figure 2.**
***Words most commonly used to describe what students enjoyed about the Aboriginal Cultural Safety Training***

Students were also asked, "How will this impact your future work, if at all?" Hundreds of positive comments were returned from students, relating to the themes of cultural safety introduced earlier in this paper. For instance, many students described engaging in a process of self-reflection. One student wrote that she or he will be "aware of [her or his] misconceptions regarding Aboriginal people" and will be "culturally sensitive in [her or his] work." Another student offered the following: "I now know to reflect on my own beliefs and values and be more open to others who have different cultures." Students also included comments related to the practice of empathy. One student wrote, "I will apply the culture-sensitive approach to Aboriginal community in order to build trust and provide proper health care." Another student described the importance of acknowledging that "people have had a traumatizing past that affects them today" and that we need to "keep in mind their history and be culturally sensitive when providing care." Finally, many students stated that they wished to engage in advocacy work moving forward. One student described this seminar as a "catalyst" to want to learn more about the "Canadian political climate and how it affects Aboriginal health." Another student described an interest in "advocating for means of support toward cultural safety for Aboriginal peoples."

It should also be noted, however, that a few students indicated that the information shared during the seminar would not help them in their future practice. These students represented a small minority, as reflected by the responses indicating *Poor/Very Poor* personal interest in these topics listed in Table 2. The following quote captures the perspective of one of these students:

> Overall I thought it was a good presentation; however I feel very strongly [against] discrimination. I accept—would treat an Aboriginal as I would any other person (obviously, taking into consideration cultural differences). However, I felt that this presentation in a way was putting down "non-Aboriginal" persons, which made to seem that Aboriginal people should be granted "special rights."

Overall, however, the results from this evaluation indicate that the vast majority of students learned the key concepts of Aboriginal cultural safety and reported that this seminar will impact their future clinical work with Aboriginal clients.

## Discussion

The Aboriginal Cultural Safety Initiative constitutes the only Aboriginal-specific and province-wide cultural safety initiative offered in Ontario colleges and universities. The willingness of the Aboriginal instructors to augment the seminar with their own cultural and personal knowledge was strongly linked to the initiative's success, according to student feedback. Overall, the ACSI was able to impart the intended learning objectives to a wide array of students across health sciences disciplines in Ontario, and knowledge of Aboriginal health and well-being significantly improved among student learners. In addition, student evaluations indicated in increase in interest in Aboriginal well-being, Aboriginal cultural safety, and advocacy work in this area. These results also demonstrate that while a major reason this content is not already being delivered across more college and university health sciences programs is a lack of appropriately trained staff, trained Aboriginal instructors can fill this role and deliver the content in a manner that students find clear, enthusiastic, and interesting.

This study was limited by its relatively small scope. It was a demonstration project that sought to ascertain whether recruiting trained volunteer Aboriginal instructors to teach a seminar on Aboriginal cultural safety could increase student knowledge and student interest in this area. We were not able to engage in a longitudinal study to follow this cohort of future health professionals out of postsecondary studies and into the healthcare field in order to determine whether this seminar impacted student attitudes and health practices in their work with Aboriginal clients. Future studies in this area could follow this cohort and observe interactions between health practitioners and their Aboriginal clients in order to determine whether care is seen as culturally safe by clients. This kind of outcome research could consider whether care has improved and whether this results in better health outcomes for Aboriginal clients.

In terms of lessons learned from this project, it bears repeating that the major success of this program lay in the willingness of the Aboriginal instructors to share personal stories with the students. Students used positive descriptions in their evaluations when acknowledging their increased empathy for the instructor after hearing family stories or engaging in cultural traditions such as smudging or the passing of an eagle feather. A significant number of students indicated that they enjoyed learning about the history and stories they were not taught in mainstream public schools.

The most substantial challenge faced by this initiative was to secure time in the already cramped curricula of health sciences programs across colleges and universities. There is an ongoing need for internal and external champions to promote this type of initiative within institutions. At the end of this pilot intervention project, we were fortunate to enter into a partnership with the Indigenous Peoples Education Circle, a group of committed Aboriginal professionals in Ontario's colleges. This group will be taking over administration of the program as it moves forward, and they will act as catalysts and conduct the seminars in their respective colleges. Similarly, the program staff is working toward securing a permanent home within a university structure.

The Aboriginal instructors for the pilot intervention recommended that more time be made available to teach this module, as they felt 3 hours was insufficient to sensitize students to this material. Also, it may be helpful for faculty to attend these training sessions, so that they

may consider how themes related to colonization and cognitive imperialism are present in the education system, and to incorporate aspects of cultural safety into their teaching pedagogies, where appropriate. Other feedback suggested that this training become a mandatory prerequisite for students in certain classes that relate to social determinants of health for Canadians or cultural health education. It is hoped that this initiative will continue for students through Anishnawbe Health Toronto, the Indigenous Peoples Education Circle, and other community champions.

Including content on cultural safety in the training of future healthcare practitioners in Canada is a timely and relevant issue, especially in light of events such as the experience of Brian Sinclair touched on in this paper's introduction. We believe that interventions like the Aboriginal Cultural Safety Initiative can begin to address some of the systemic barriers, such as discrimination, that exist for Aboriginal healthcare consumers, in order to work toward preventing such tragedies.

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## Appendix: Seminar Evaluation

Please take a few moments to complete this evaluation form. It has **two** parts. The first page rates your knowledge and interest **before** the seminar. The second page rates your knowledge and interest **after** the seminar (including your comments). Your experience and perspective are important to us and will help us to improve our work. Your comments will be treated confidentially and anonymously. For each of the items below, circle the number on the 5-point scale that best describes your evaluation of the Cultural Safety seminar.

**PART 1- BEFORE THE SEMINAR**

1. Please rate your knowledge of these concepts:

| Knowledge of Content | Very Poor | Poor | Fair | Good | Excellent |
|---|---|---|---|---|---|
| a. Indian Act, government policies affecting Aboriginal peoples | 1 | 2 | 3 | 4 | 5 |
| b. Residential Schools | 1 | 2 | 3 | 4 | 5 |
| c. Determinants of Health for Aboriginal Peoples | 1 | 2 | 3 | 4 | 5 |
| d. Health Outcomes for Aboriginal Peoples | 1 | 2 | 3 | 4 | 5 |
| e. Aboriginal Cultures generally | 1 | 2 | 3 | 4 | 5 |
| f. Understanding of Cultural Safety | 1 | 2 | 3 | 4 | 5 |

2. What is your interest in the following:

| Personal Interest | Very Poor | Poor | Fair | Good | Excellent |
|---|---|---|---|---|---|
| a. Interest in Aboriginal peoples' culture and well-being | 1 | 2 | 3 | 4 | 5 |
| b. Interest in cultural competence/ cultural safety for Aboriginal peoples in Canada (or *diversity generally*?) | 1 | 2 | 3 | 4 | 5 |
| c. Interest in advocacy and/or empowerment work in this area | 1 | 2 | 3 | 4 | 5 |

**PART 2- AFTER THE SEMINAR**

3. Please rate your knowledge of these concepts:

| Knowledge of Content | Very Poor | Poor | Fair | Good | Excellent |
|---|---|---|---|---|---|
| a. Indian Act, government policies affecting Aboriginal peoples | 1 | 2 | 3 | 4 | 5 |
| b. Residential Schools | 1 | 2 | 3 | 4 | 5 |
| c. Determinants of Health for Aboriginal Peoples | 1 | 2 | 3 | 4 | 5 |
| d. Health Outcomes for Aboriginal Peoples | 1 | 2 | 3 | 4 | 5 |
| e. Aboriginal Cultures generally | 1 | 2 | 3 | 4 | 5 |
| f. Understanding of Cultural Safety | 1 | 2 | 3 | 4 | 5 |

4. What is your interest in the following:

| Personal Interest | Very Poor | Poor | Fair | Good | Excellent |
|---|---|---|---|---|---|
| a. Interest in Aboriginal peoples' culture and well-being | 1 | 2 | 3 | 4 | 5 |
| b. Interest in cultural competence/ cultural safety for Aboriginal peoples in Canada (or *diversity generally*?) | 1 | 2 | 3 | 4 | 5 |
| c. Interest in advocacy and/or empowerment work in this area | 1 | 2 | 3 | 4 | 5 |

5. Please rate the presentation provided by the Preceptor

| | **Very Poor** | **Poor** | **Fair** | **Good** | **Excellent** |
|---|---|---|---|---|---|
| 1. Clarity | 1 | 2 | 3 | 4 | 5 |
| 2. Enthusiasm/Interest | 1 | 2 | 3 | 4 | 5 |
| 3. Teaching Ability | 1 | 2 | 3 | 4 | 5 |

**What did you enjoy about the seminar?**

**What can be improved about the seminar?**

**How will this impact your future work, if at all?**