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ABSTRACT

This thesis examines the operationalization of culture in cultural competency and cultural safety strategies at AIDS Saskatoon, a local HIV/AIDS non-profit organization. This community-based ethnographic research was conducted using the methods of participant observation in the agency’s drop-in centre and semi-structured interviews with PWAS and staff. Situated within a critical-interpretive theoretical foundation, this project seeks to explore a) how staff and people who access services (PWAS) at AIDS Saskatoon frame their understandings of culture; and b) how these understandings have contributed to the creation of cultural competency and cultural safety strategies within the agency. Conceptualizing culture as patterns of shared behaviour, beliefs, values, and ideas that are dynamic and evolving to current political and social contexts, I argue that staff at the agency understand and operationalize culture on both an individual and collective level. On an individual level, PWAS negotiate dynamic and overlapping cultural models. Using Delvecchio Good and Hannah’s (2015) concept of “shattering culture”, I explore how staff take into account individual perspectives and experiences to build relationships and “meet people where they are at”. In addition to this, staff recognize the unique culture that has emerged in the 601 Drop-In Centre and use this knowledge to develop cultural competency and cultural safety strategies in the agency. By operationalizing culture in both ways, an effective framework for cultural safety has been developed over time in the organization. This research contributes to literature on the use of cultural competency and cultural safety frameworks in NGO settings and the unique ways individuals understand their own culture and the implications of these understandings on health and well being. Finally, this research contributes to ongoing efforts in Saskatchewan to address health disparities in urban Indigenous populations, particularly disproportionate rates of HIV/AIDS and HCV. Further research into these areas and the role of additional intersecting identity markers needs to be conducted.
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DEDICATION

For my parents. Thank you for always encouraging me and supporting me to forge my own path.
And for Mike. Thank you for your unwavering support and patience.
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LIST OF ABBREVIATIONS

- Human immunodeficiency virus (HIV)
- Acquired immunodeficiency syndrome (AIDS)
- Hepatitis C virus (HCV)
CHAPTER 1: INTRODUCTION

Canada has long been known as a country of multiculturalism, filled with the vibrancy that arises when individuals of many backgrounds come together. However, it would be careless to idealize all the experiences of minority populations. With a multitude of cultural contexts comes a multitude of experiences. Over time, the necessity of service providers to take cultural differences into account in respectful and inclusive ways has been recognized as increasingly important, given that racialized and minority populations continue to face disproportionate burdens of disease, addiction, and poverty in Canada.

Since the 1980s, culture competence, cultural competency, and cultural safety have gained widespread popularity in multiple domains. The concept of cultural competence first appeared in social work and psychology literature in the 1980s, and later expanded to include areas such as nursing, health care, and education. According to Cross et al. (1989), the term refers to a “set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations”. Frameworks and strategies are operationalized in a multitude of ways in order to prevent, address, and mitigate existing health disparities among disadvantaged and often racialized populations. The term ‘cultural competency’ later emerged and moves beyond this earlier definition to address the cultural fluidity and the never-ending process of learning that must occur in cross-cultural situations. Hammer (2007, 2) defines cultural competency as “self-reflective awareness and intentional processes focused on understanding patterns of difference and commonality between yourself (and your cultural group) and other cultural group’s attitudes, knowledge, perceptions, values and practices”. The term cultural safety was developed by Irihapeti Ramsden, a Maori nurse in New Zealand. Cultural safety focuses on the health care provider’s understandings of power dynamics and cultural difference. However, it is not the provider who determines whether they feel safe, but rather those who are accessing services (Papps and Ramsden, 1996).

Since these terms first emerged, there has been considerable research on the implementation of interventions in health care settings in a number of disciplines, including anthropology, sociology, psychology, and public health (Benson and Thomas 2010, Monaghan et
al. 2008, DelVecchio Good and Hannah 2015). Furthermore, there has been increased recognition of the importance of interventions and frameworks to improve quality of life for Indigenous Peoples in Canada, the United States, Australia, and New Zealand (Clifford et al. 2015, Herring et al. 2013, Brascoupé and Waters 2010, St. Onge 2009, Hart-Wasekeesikaw 2009, Caron 2006). Health and social disparities between Indigenous and non-Indigenous populations in Canada are well researched and documented. Indigenous Peoples are disproportionately burdened with poverty, homelessness, unemployment, addictions and ill-health across the country (NCCAH 2013). The importance of implementing cultural competency frameworks in services provided to Indigenous adults and children has become increasingly recognized in light of these existing disparities in socio-economic and health status. Kirmayer (2013:366) writes that “recent recognition of the historical injustices of the state-supported oppression and forced assimilation of Aboriginal peoples have led to a new level of attention to culture as a human right”. The National Collaborating Centre for Aboriginal Health (NCCAH) (2013) notes a number of reasons why cultural competency and cultural safety are areas of concern in health care provided to Indigenous peoples in Canada. NCCAH (2013) sees culturally competent and safe care as beneficial to both the service provider and the individual accessing services; it can increase visitation and care and benefit the provider by increasing job satisfaction and confidence.

However, the research on cultural competency in services provided to Indigenous Peoples in Canada has been sparse compared to that of other cultural groups, and while interventions are taking place, it remains unclear whether the intended results are being produced. Brascoupé and Waters (2010) point to the fact that the proliferation of terms related to cultural competency has largely been confined to academia and government reports. There is little evidence of how they translate into measurable outcomes. This appears to be the most prevalent gap found in research surrounding cultural competency; there is little research that determines the outcomes of cultural competency in clinical settings. Kleinman and Benson (2006, 1673) write: “This lack of evidence is a failure of outcome research to take culture seriously enough to routinely assess the cost-effectiveness of culturally informed therapeutic practices, not a lack of effort to introduce culturally informed strategies into clinical settings”. Brascoupé and Waters (2010) identify the same gap, pointing to the lack of extensive fieldwork in the area.
Anthropologists are both proponents and critics of cultural competency. While proponents of cultural competency point to its importance in clinical encounters, critics have argued that not only has the term not been defined precisely enough, but that many existing cultural competency frameworks reduce culture to a learnt skill and use harmful generalizations (Kleinman and Benson 2006, Malat 2013). It is clear, however, that culture does matter in service provision. What is often unclear is how the term “culture” is operationalized within cultural competency frameworks and understood by service providers and those accessing services, and whether mutual understandings of the term culture between the two groups can result in better relationships and increased satisfaction and access to services. Furthermore, although non-governmental organizations (NGOs) play a vital role in health and social service provision to people from a variety of cultures, the operationalization of cultural competency frameworks within NGOs has been largely neglected in academic studies.

To address these shortcomings, I began a project in September of 2016 that focused on the use of cultural competency frameworks within an NGO setting. Fieldwork began in 2017 when I spent three months at AIDS Saskatoon, the primary AIDS service organization in northern and central Saskatchewan. Dr. Pamela Downe’s positive relationship with the agency helped to facilitate the research project. Dr. Downe’s ongoing research relations with AIDS Saskatoon led the previous Executive Director to approach Dr. Downe with the idea to study cultural competency within the agency. Prior to beginning, I met with leadership at the agency, who provided feedback for the interview guide and encouragement for this research. The value of this research was recognized by staff as they continuously seek ways to engage with new and returning people who access services (PWAS) and provide services that are barrier-free and culturally relevant.

The Rates of Human Immunodeficiency Virus (HIV) in the province have drawn attention on both a national and international level, and nearly half of HIV diagnoses in the province have been in Saskatoon (Hatala et al. 2018). In addition to high rates of HIV, Saskatchewan’s rates of Hepatitis C (HCV), a virus with similar modes of transmission to HIV, are the highest in Canada and it is estimated that 70 percent of those diagnosed with HCV may

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1 In August of 2020, AIDS Saskatoon went through a rebranding process and changed their name to Prairie Harm Reduction.
also be co-infected with HIV (Skinner et al. 2018). While Indigenous Peoples make up only 15 percent of the population in the province, 79 percent of newly diagnosed HIV cases self-reported Indigenous ethnicity (Government of Saskatchewan 2017). These numbers are rooted in Canada’s colonial legacy, in which discriminatory practices have resulted in trauma and intergenerational trauma today. Indigenous Peoples have been dispossessed from their land, subjected to the residential school system and the forced apprehension of children, and continuously marginalized in mainstream society.

During my time at the organization, I relied on ethnographic methodologies and the theoretical framework of critical-interpretive medical anthropology to explore: a) how staff and PWAS at AIDS Saskatoon frame their understandings of culture; and b) how these understandings have contributed to the creation of cultural competency strategies within the agency. Throughout this thesis, the term culture is used to describe patterns of shared behaviour, beliefs, values, and ideas that are dynamic and evolving. Additionally, Warrier (2008, 540) suggests that a more critical understanding of culture must recognize that shared experiences within groups “have developed in relation to changing political and social contexts”. The concept of intersectionality, which refers to the various ways identity markers such as race, class, gender, and sexuality intersect to further marginalize groups and uphold systems of power, plays a central role in this thesis (Crenshaw 1991). While there are plenty of shared experiences among PWAS and staff, recognizing differences is critical to understanding how culture manifests in the lives of staff and PWAS at the agency. An analysis of power structures and historical contexts of oppression and how they intersect with categories of identification must take place (Warrier 2008).

While the terms cultural competency and cultural safety were rarely used by staff to describe their interactions when working with PWAS, the ongoing process of learning and adjustments that are brought up in interviews by staff, and the clear link made between culture and health by many staff and PWAS, indicate that the principles of cultural competency and safety hold high priority for staff at AIDS Saskatoon. It quickly became evident that for staff and PWAS at AIDS Saskatoon, the concept of culture was lived in a multitude of ways. Personal connections with one’s own culture were described with varying levels of importance when it came to maintaining health and well being in both everyday life and in living with HIV or HCV.
This led to a diverse set of interviews with 29 individuals who are employed by or access the services at AIDS Saskatoon.

1.1 Research Questions

Throughout my research, I explored the following question: how is “culture” operationalized in the cultural competency frameworks and strategies developed at AIDS Saskatoon? Five objectives were met to address this question:

(i) To examine the main components of the cultural competency framework and strategies developed at AIDS Saskatoon;

(ii) To explore what the staff perceive to be the benefits and drawbacks of the cultural competency framework and strategies;

(iii) To explore what the PWAS perceive to be the benefits and drawbacks of the cultural competency framework and strategies;

(iv) To determine how the concept of “culture” is understood by staff and PWAS as the cultural competency framework and strategies are operationalized at AIDS Saskatoon;

(v) To identify the implications of cultural competency frameworks and strategies for future cultural competency capacity building at AIDS Saskatoon.

To help address this question, I draw on William Dressler’s concept of cultural consonance, as the “degree to which individuals approximate, in their own beliefs and behaviors the prototypes for belief and behavior encoded in shared cultural models” (2012, 390). I explore how individual understandings of culture between PWAS and staff are both shared and distinct. While the connection between culture and health has been a hallmark of medical anthropology, the concept of cultural consonance allows for a more precise way to examine this relationship (Dressler 2012). Identifying whether a sense of cultural consonance in the relationships among service providers and recipients exists proves important in determining how cultural competency is understood and further operationalized by staff at AIDS Saskatoon. Whether or not service providers and recipients share congruent understandings of culture and health can determine whether an interaction between the two is positive or negative.
1.2 Ethnographic Context

1.2.1 HIV and Hepatitis C in Saskatchewan

In an article in Maclean’s Magazine published in 2015, Ken MacQueen (2015) draws attention to Saskatchewan’s HIV epidemic by writing “Third World levels of HIV infection rates in one of the world’s wealthiest countries are ‘a national disgrace’”. Although the phrase is problematic in many respects, the article increased public attention to the epidemic at hand. At its peak in 2009, Saskatchewan’s HIV rates were more than twice the national average, at 19.2 cases per 100,000 population compared to Canada’s 7.1 cases per 100,000 population (Government of Saskatchewan 2014). By 2014, the province had dropped to a low of 9.8 cases per 100,000 population, with Canada at 5.8 (Government of Saskatchewan 2015). In 2016, rates had risen once again, with Saskatchewan sitting at 14.5 cases per 100,000 population and Canada at 6.4 (Government of Saskatchewan 2017). Rates on reserves in the province are thought to be even higher, with some doctors citing them as high as 64 cases per 100,000 population in 2014 (CMAJ 2015). Despite making up approximately 4.3 percent of Canada’s total population, Indigenous peoples make up 9 percent of people living with HIV in Canada (CATIE 2016). In Saskatchewan, where Indigenous Peoples make up approximately 15 percent of the population, 79 percent of newly diagnosed HIV cases self-reported Indigenous ethnicity (Government of Saskatchewan 2017).

The vast majority of new cases in the province are attributed to injection drug use (IDU). Of 112 new cases, 55 (or 49 percent) reported IDU as the main exposure to the virus in 2014 (Government of Saskatchewan 2015). This is unique when compared to the rest of the country, where reported risks are concentrated mainly in men who have sex with men and heterosexual sex (CATIE 2016). Saskatchewan’s unique HIV epidemiology has had further implications in the province. In the summer of 2018, a new report was presented by the B.C. Centre for Excellence in HIV/AIDS and Simon Fraser University that found that “the strains of HIV in Saskatchewan have high levels of immune-resistant mutations compared to ones in other areas of Canada and the United States” (The Canadian Press 2018). This strain can lead to faster progression of the virus if untreated (The Canadian Press 2018). Despite this, Saskatchewan has not had an HIV strategy in place since the most recent one ended in 2014.
In response to the increase in new cases, a group of doctors in Saskatchewan called for the provincial government to declare a state of emergency in September of 2016, two years after the provincial strategy on HIV had ended (Markewich 2016). While the government declined this request, an additional $600,000 was allocated in the 2018-2019 budget to help cover universal HIV medication (MacVicar 2018). However, experts and front-line workers continue to advocate for preventive measures to be taken throughout the province.

In addition to high rates of HIV, Hepatitis C (HCV) rates in Saskatchewan are the highest of any province in Canada (Skinner et al. 2018). With similar modes of transmission as HIV, injection drug use is the most common risk factor in Saskatchewan to contract HCV (Skinner et al. 2018). Indigenous populations, particularly on reserves, face the greatest burden of HCV infection in the province and are seven times more likely to be infected with HCV than non-Indigenous populations (Skinner et al. 2018). Skinner et al. (2018) also note that 21 to 44 percent of those infected are unaware of their status. Access to treatment, doctors, and testing on reserves contribute to this high burden (Skinner et al. 2018). Unlike HIV, HCV can be treated and cured. However, many individuals are asymptomatic for long periods of time, which prevents the identification of infected individuals (Skinner et al. 2018). As well, for individuals who have identified the virus, treatments can last from eight to twelve weeks, a timeline that is not realistic for many of those in need.

1.2.2 Saskatoon’s Core Neighbourhoods

The city of Saskatoon is the largest city in the province of Saskatchewan, with a population just under 250,000 (Statistics Canada 2017). City officials have projected that by 2030, Saskatoon may double its population to 500,000 (City of Saskatoon 2014). The city has also seen a major increase in its Indigenous population over the last 60 years. In the 2016 Census, 27,310 residents declared Indigenous identity, just over 10 percent of the city’s population (Statistics Canada 2016). Compare this to the 1951 census, where 48 individuals identified as Indigenous (Norris et al. 2013). Norris et al. (2013, 36) find that this change in population is the result of three factors: a natural increase in births, “net migration”, which refers
to more Indigenous people moving to the city than moving away, and an increase of individuals claiming their Indigeneity.

While the demographic diversity in Saskatoon is increasing, the city remains a space that is often regarded as unsafe and exclusive towards its Indigenous population. Despite being ten percent of the city’s population, Indigenous Peoples make up 33 percent of Saskatoon’s core neighbourhoods (Lemstra and Neudorf 2008). Peters and Lafond (2013) find that Indigenous residents in Saskatoon often recount experiences of racism, police abuses, and feelings of insecurity. However, “Against these spaces of vulnerability and stigmatization, First Nations participants created some inclusive spaces in Aboriginal organizations, in Aboriginal cultural events, and in Native studies at university” (Peters and Lafond 2013, 99). There are a number of organizations throughout Saskatoon’s core neighbourhoods that offer this inclusivity and feelings of safety, including AIDS Saskatoon.

The AIDS Saskatoon building is located on 33rd Street², straddling the neighbourhoods of Caswell Hill and Mayfair. Mayfair is one of Saskatoon’s oldest neighbourhoods and could be found on a map of Saskatoon in 1907, one year after the city was incorporated. Today, the neighbourhood has a population of over 3,000 people and a median personal income of $32,490 (City of Saskatoon, 2017). Over 20% of Mayfair’s residents have a personal income of under $14,999, above Saskatoon’s average of 17.7 percent (City of Saskatoon, 2017). Caswell Hill is considered one of Saskatoon’s five core neighbourhoods, with a population of 3,732 and a median personal income of $34,980 (City of Saskatoon, 2017). Almost 18% of Caswell Hill’s residents have a median income of less than $14,999 (City of Saskatoon, 2017). These numbers are interesting to note, as Lemstra, Neudorf, and Opondo (2006, 438) speculate that neighbourhoods in Canada are becoming “increasingly polarized along income lines”. Their study in 2006 investigates health care utilization between Saskatoon’s five core neighbourhoods and other neighbourhoods in the city, including the five most affluent (Lemstra et al. 2006). Using a cross-sectional study design, the researchers find that greater health disparities exist between low income residents in the city and other residents, particularly for mental disorders,

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² In 2019, the agency moved to 20th Street in Saskatoon’s Pleasant Hill neighbourhood.
diabetes, chronic obstructive pulmonary disease, and coronary heart disease (Lemstra et al. 2006).

Despite adverse statistics, and assuming that health disparity would play a dominant role in the local, every-day rhetoric, I experienced a joyful and vibrant community. What was once an area of the city in which I had spent little time, soon became familiar as I rode my bike to AIDS Saskatoon. I enjoyed local businesses, took part in community BBQs, and developed relationships with a number of individuals who lived in the area. I saw firsthand the importance of community in these neighbourhoods, and I was lucky enough to be welcomed. Everyday life has many ups and downs for PWAS, but that did not deter individuals from enjoying their time in their community. It is clear that more research that explores the strengths and vibrancy of Saskatoon’s core neighbourhoods is needed to tell the full story.

1.2.3 AIDS Saskatoon and the 601 Drop-In Centre

First established in 1986, AIDS Saskatoon is the primary AIDS service organization in central and Northern Saskatchewan. AIDS Saskatoon provides support and advocacy for individuals living with and affected by HIV, AIDS, and HCV. AIDS Saskatoon is discretely located within what was once a small store attached to a house. With very little visible signage, individuals are able to enter and exit the building without feeling the shame or embarrassment often associated with HIV service provision.

In reality, AIDS Saskatoon and the 601 Drop-In Centre provide much more for the community than support and advocacy for those living with and affected by HIV and HCV. Working within a harm reduction approach, defined by the Canadian Nurses Association (2018) as a “public health approach aimed at reducing the adverse health, social and economic consequences of at-risk activities”, the agency provides a space where PWAS feel a sense of safety and belonging. From Monday to Friday, 10:30 A.M. to 2:00 P.M., members of the community drop in to the 601 to drink coffee, eat lunch, do laundry, exchange needles, use a computer, spend time with friends, and access support for a variety of reasons. Support workers provide a number of services. They make hospital visits, drive individuals to and from appointments, and provide advocacy in housing court to name a few. The “601”, as it is fondly
called by those accessing services, is a large room attached to the AIDS Saskatoon offices. It has two computers, a clothing depot, comfortable, well-worn couches, and a television set that is most often turned to a local news station or Dragon’s Den. The shaking of heads and utterances of “I could have thought of that” are daily occurrences during the half hour television show.

People of all ages spend time at the 601. Each morning people trickle in to drink their morning coffee, read, and complete the daily crossword puzzle that is photocopied from the local newspaper. Around 11:45 A.M. the place fills up in anticipation for lunch. Lunch is served promptly at noon and often runs out by the hour. I learned quickly what times of the month to expect more people and when to expect less, based on Saskatchewan’s Social Assistance Program (SAP) payments. Because my research took place over the summer months, when children are not in school, there were often youngsters running around, accompanied by their parents and caregivers. Faces soon became familiar, as the same individuals stopped by daily, offering a sense of community and friendship to all those who walked in the door. While many individuals were there to access support services, others just needed a cup of coffee and a space to relax for a few hours.

1.3 Methodology

1.3.1 Participant Observation

H. Russell Bernard (2011, 256) writes “Participant observation is the foundation of cultural anthropology”. After receiving approval from the University of Saskatchewan’s Behavioural Research Ethics Board (REB), I conducted participant observation at the 601 Drop-In Centre, located within AIDS Saskatoon, from May to August of 2017. Every Monday, Tuesday, and Wednesday from 10:30 a.m. to 2:00 p.m., I observed daily pleasantries, the sharing of meals, and the odd conflict in the space. This offered me deeper engagement with PWAS and understanding of the research setting within AIDS Saskatoon. I spent my time drinking coffee, chatting with staff and PWAS, and helping out when needed. Spending time in the drop-in centre

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3 Dragon’s Den is a popular Canadian television show in which entrepreneurs pitch their products to a panel of venture capitalists.
allowed me to build rapport with participants and experience the sense of community the space offers more fully.

Helping out often meant serving lunch and helping to keep the space clean. My time at the 601 was marked not only by my observation of the community, but by my participation in the day-to-day happenings within the space. Along with my time in the Drop-In Centre, I participated in and attended a number of events hosted in the summer by the AIDS Saskatoon staff. I sat at the AIDS Saskatoon table during Pride Week; I walked with staff in the “Rock Your Roots” walk on National Aboriginal Day; I attended the Annual General Meeting, and I helped to serve hamburgers at their Hepatitis-C Awareness Day barbeque. This allowed me to form relationships with staff outside of daily pleasantries in the 601 Drop-In.

I was eager to lend a hand in whatever capacity I could at the 601. However, this quickly marked my positionality to PWAS in the drop-in centre. From early on, I was seen as a sort of pseudo-staff member, or I was referred to often as a “practicum student” in reference to the social work students who often complete their work placements at AIDS Saskatoon during the school year. This meant that I was often asked to do staff-related tasks, and to address questions that would otherwise be posed to staff members. My perceived position to PWAS undoubtedly shaped my day-to-day interactions in the 601 and formulated my observations. While many PWAS were eager to ask me questions and share their unique stories, others were reluctant to interact with me. My positionality as a middle-class graduate student from the university had the potential to make people uncomfortable with my presence in the space. I found, however, that being a young woman-of-colour settled some of that unease. Almost daily I was asked about my own ethnic background. My response, that I am a mix of Indian, English, and Irish, was often met with curiosity rather than any sort of contempt. I was aware that while the class privileges I held within the space marked me as an outsider in the community, my presence was rarely seen as threatening due to the colour of my skin. As well, many of my daily conversations with PWAS included the topic of housing and issues that arise when renting and living with roommates, a topic I could relate to personally at the time. These small interactions shaped many of the relationships I made in the 601 Drop-In and informed my own positionality within the research. Despite the many serious, often heartbreaking, topics that arose during my field work, my time at AIDS Saskatoon and the 601 Drop-In was full of laughter and light-hearted banter. It
was quite common for individuals to use humour to discuss illness and all aspects of their unique and dynamic lives.

Each day I would discretely make field jottings (Bernard 2011) in my phone. At the end of the day, I would go home and write descriptive field notes that thoroughly summarized my daily interactions and observations. Field notes are essential to the ethnographic process, enabling researchers to better remember events as they happen. My own field notes allowed me to take the time to reflect each day on the happenings in the 601 Drop-In and in my interviews.

1.3.2 Semi-Structured Interviews

During my time at AIDS Saskatoon, I conducted 29 individual semi-structured interviews with both staff and PWAS (See Appendix for interview guide). Interviews varied in length, from twenty minutes to two hours. Interview questions addressed individual understandings of culture, as both a concept and a personal identifier, how culture influenced their health, and of their experiences at AIDS Saskatoon. Staff were recruited through conversation and word of mouth in the AIDS Saskatoon building, and PWAS were recruited through a poster in the drop-in centre and word of mouth around the agency. I approached some PWAS personally, after interactions over a number of weeks in the 601. All interviews took place in the 601 or the upstairs offices in the AIDS Saskatoon building. While the confidentiality of participants was of importance to me, it quickly became clear that the layout of the building would not allow for the level of privacy I anticipated. However, staff and PWAS were comfortable in the setting.

Of my 29 interviews, 13 were with staff members and 16 were with PWAS. Of the 13 staff members, two were men and 11 were women. Experience, position, and time spent at the agency varied. Of the 16 PWAS, 11 were men and six were women. Age, ethnicity, and time spent at the agency varied. However, the majority of participants identified as First Nations or Métis. PWAS were offered a twenty-dollar gift card for a nearby grocery store to compensate for their time. To protect participant identities, pseudonyms are used throughout.

The flexibility of semi-structured interviews allowed me to explore topics that were important to participants. The ability to share their own story and experience was significant to
participants, and I probed areas of interest to the participant while still maintaining the topic of the interview. In asking participants to describe their own culture, discussions went in a variety of directions, from cultures based on ethnicity, the cultures of addiction, and “street culture”. I further addressed the importance of culture for individuals when managing their health. I explored experiences within the 601 Drop-In, relationships between staff and PWAS, and feelings of safety and belonging at AIDS Saskatoon. When interviewing staff, I also explored the role cultural competency in their job.

1.3.3 Analysis

I spent the fall and winter months of 2017 and 2018 transcribing and coding interviews. Throughout the long and often daunting process of transcribing, I was able to become increasingly familiar with the details of each interview. This aided in the coding (using NVivo) and organization of the data.

To code interviews, I used a simultaneous descriptive coding method and thematic analysis. Using simultaneous coding allowed me to draw on the multiple meanings within interviews (Saldana 2016). Participants’ answers were often complex, necessitating the use of multiple codes. I then began to consider how these categories formed overarching themes: individual connections to culture and its impact on health and well being, the collective culture that has formed in the 601 Drop-In Centre, and the benefits and challenges of using cultural competency.

1.4 Theoretical Framework

1.4.1 Critical-Interpretive Medical Anthropology

assumptions surrounding health and the human body, often rooted in Western epistemological thought, had been commonplace in past medical anthropological works. Rather than viewing disease as solely a biological construct, CMA’s theoretical framework recognized that disease is also a social construct interacting with political economy to produce health outcomes in individuals and populations. This approach was in contrast to the widely accepted research agenda that used biological indicators to determine the effects of a number of constraints on health. Critical-interpretive medical anthropology went one-step further, to incorporate a culture-based interpretive approach to individual knowledge relating to health, illness, and bodies (Lock and Scheper-Hughes 1996). The human body and the notion of ‘embodied personhood’ are central to critical-interpretive medical anthropology. Embodied personhood refers to “the relationship of cultural beliefs and practices in connection with health and illness to the sentient human body” (Lock and Scheper-Hughes 1996, 44). Particularly, critical-interpretive medical anthropologists are faced with “rebellious and “anarchic” bodies – bodies that refuse to conform (or submit) to presumably universal categories and concepts of disease, distress, and medical efficacy” (Lock and Scheper-Hughes 1996, 43).

Lock and Scheper-Hughes (1996, 44) write “The task of a critical-interpretive medical anthropology is, first, to describe the culturally constructed variety of metaphorical conceptions (conscious and unconscious) about the body and associated narratives and then to show the social, political, and individual uses to which these conceptions are applied in practice”. In the context of my own research, these interpretations enabled me to identify degrees of cultural consonance among service providers and recipients, specifically, the extent to which culturally constructed knowledge of health, illness, and the body was shared among participants and how this knowledge shaped cultural competency strategies within the agency. Using this theoretical framework allowed me to question both the political-economic forces that demand and shape cultural competency programs and the interpretive and NGO-specific contexts in which these programs are based.

1.5 Significance and Thesis Outline
This thesis contributes to the growing body of work that addresses existing health disparities among urban Indigenous Peoples, specifically drawing attention to Saskatchewan’s high rates of HIV, in which Indigenous populations in Canada have been disproportionately affected. Angela Jenks (2011, 230) writes that “[m]edical anthropology can play an important role in the further development of a more culturally competent health system” by providing essential critiques of the way culture is defined. There has been considerable research on cultural competency within health care settings, however, there is little research that explores the role of NGOs. NGOs, such as AIDS Saskatoon, provide crucial services in addressing the HIV epidemic within the province and should not be overlooked. In exploring this role through an anthropological lens, this research may inform the further development of cultural competency frameworks and strategies to be utilized by NGOs providing health-related services. This thesis explores how AIDS Saskatoon operationalizes culture in cultural competency strategies in two ways: (1) through individual understandings of culture that shape relationships between staff and PWAS, and (2) through the shared 601 culture that has come to define the drop-in space. In doing so, I argue that the agency has developed an effective and dynamic framework for cultural safety.

Chapter Two surveys relevant literature on the topics of cultural competency, cultural consonance, Indigenous health, HIV/AIDS, and HCV. In Chapter Three, I explore how PWAS and staff engaged personally with the concept of culture and particularly how it connected to their own health and well being. What is often missing from studies of cultural competency is how individuals understand their own cultural models, whether these understandings are shared between service providers and those accessing services, and the role that shared understandings play in providing culturally competent and safe services. To address this shortcoming, I explore how staff at AIDS Saskatoon seek to better understand the multiplicity of cultures of PWAS and draw on these understandings to further develop cultural competency and cultural safety strategies in the agency. In Chapter Four, I shift from the personal to the collective. I explore the culture of the 601 Drop-In, both how it is represented by staff and PWAS, and through my own observations made throughout the summer. Further, I focus on the ways in which a holistic understanding of health and well being, an emphasis on safe space, understandings of historical injustices, and a harm reduction approach shape cultural competency strategies in the agency. In Chapter Five, I conclude by demonstrating how AIDS Saskatoon has created a unique and
effective framework for cultural competency. Finally, I discuss the implications of this research and suggest areas of further inquiry.
CHAPTER 2: LITERATURE REVIEW

As my research focuses on the cultural competency frameworks and strategies operationalized at AIDS Saskatoon, it is important for me to ground my understandings and writing in relevant literature on the concepts of cultural competence and cultural competency, cultural consonance, as well as the socio-cultural context. The latter includes Indigenous health, HIV/AIDS, and HCV in Canada and specifically Saskatchewan, and how these topics have intersected. This will be done from both an anthropological and interdisciplinary perspective.

While the majority of PWAS at AIDS Saskatoon identified as Indigenous, the degree to which individuals connected with their Indigenous backgrounds varied, as did how individuals defined and described their own cultures. This led me to consider just what is meant by “culture” in cultural competency frameworks. I begin this literature review with a brief historical overview of the concept of culture in anthropological literature.

2.1 Central Concepts

2.1.1 The Culture Concept

Culture and its fluidity have been the hallmark of anthropological study, and anthropologists have long linked culture to health, well being, disease, and illness in their work. There are a number of ways in which anthropologists have theorized and engaged with the concept. In 1871, Edward Tylor provided the first formal definition of culture in his work *Primitive Culture*, as “that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of society” (White 1959, 227). Since that time, the concept expanded to offer a variety of definitions. In the 1930s, Franz Boas argued that culture emerged from historical processes rather than universal coherence of humans. In the 1950s, Leslie White and Julian Steward examined how culture fulfilled the needs of a society (Vandenbroek 2014). This was in contrast to anthropologist Bronislaw Malinowski, who believed that culture fulfilled the needs of the individual (Vandenbroek 2014). In the 1960s and 1970s, theories of symbolism developed in the works of Claude Levi-Strauss.
and Victor Turner (Vandenbroek 2014). To Levi-Strauss, the mind organized knowledge in a universal manner, while for Turner, culture was multivocal symbols, mediated through social action (Vandenbroek 2014).

In contemporary anthropology, these past frameworks, which often described culture as a “trait of humanness that follows universal laws” (Vandenbroek 2014), have been reworked or replaced. Poststructural critique suggests that even the theory of culture is flawed and unnecessary to current work because of its static and bound nature (Vandenbroek 2014). However, still today culture remains central to anthropological studies, including medical anthropology. The fluidity of culture and its evolution with current social, political, and cultural landscapes has been integral to my own education and understanding of the concept. Culture continues to be defined as a set of shared beliefs, values, and ideas. Moreover, Hudelson (2004, 345) writes “[r]ather than simply the presence or absence of a particular attribute, culture is understood as the dynamic and evolving socially constructed reality that exists in the minds of social group members”. There has been a recent call to expand how culture is thought of in academic work. Warrier (2008, 540) writes:

Critical thinking requires that culture not only has to include the human constructs of race, ethnicity, gender, class, age, sexual orientation, immigration, disability, and all other axes of identification, but also has an analysis of power structures and the historical context of oppression. These categories however, cannot be understood as isolated and discrete from each other but must be examined as they intersect, interlock, and interconnect to produce differences within and between groups. The intersections and interconnections change as the social and political landscape changes.

Here, Warrier (2008) develops anthropological understandings of culture to further incorporate how power structures and oppression play a role. I found this development particularly pertinent to my own research, as participants’ understanding of their own culture was often framed within Canada’s colonial history that has oppressed and neglected Indigenous Peoples.

2.1.2 Cultural Competence and Cultural Competency
In response to increased cultural diversity in health settings and a growing body of research examining health inequities in minority populations, cultural competence and later cultural competency frameworks and strategies were developed. The terms cultural competence and cultural competency have been defined by a number of scholars, social workers, and health-care professionals. Often, the two terms are conflated. For the purpose of this thesis, I differentiate between the terms as follows: cultural competence refers to a “set of congruent behaviors, attitudes and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations” (Cross et al. 1989). Cultural competency refers to “self-reflective awareness and intentional processes focused on understanding patterns of difference and commonality between yourself (and your cultural group) and other cultural group’s attitudes, knowledge, perceptions, values and practices” (Hammer 2007, 2).

Cultural competence and cultural competency have been operationalized in a multitude of ways, and there is no singular way to train health care professionals, social workers, or individuals working in non-profit organizations to apply cultural competency strategies in their day-to-day work. Instead, many different theories and practices have developed over time and across disciplines. Rose (2013) developed a cultural competency continuum for health professionals to engage with the concept and to explore their own positionality. The continuum goes as follows: cultural destructiveness, cultural incapacity, cultural blindness, cultural pre-competency, cultural competency, and lastly, cultural proficiency (Rose 2013). St. Onge (2008, 82) encourages non-profit capacity builders to “examine nine ways to discover key contexts in the ecology of cultural competency”: (1) To see differences as always present; (2) To locate one’s own culture; (3) To develop intimacy with the “Other”; (4) To see the dominant culture as one of many; (5) To examine the influence of geography; (6) To look for conflicting cultural norms; (7) To look for intersecting identities; (8) To see race as a major fault line in the context of the U.S.A.; and (9) To observe the historical roots of institutions. While St. Onge (2008) speaks directly to cultural context in the U.S.A., her work is also particularly relevant in the Canadian context, where health disparities and inequities between Indigenous and non-Indigenous Peoples are stark.
A growing number of health-related studies have recognized the importance of cultural competency interventions to improve quality of life for Indigenous Peoples in Canada, the United States, Australia, and New Zealand (Clifford et al. 2015, Herring et al. 2013, Brascoupé and Waters 2010, St. Onge 2009, Caron 2006). In 2009, the Aboriginal Nurses Association of Canada identified six core competencies for nursing education in the country: post-colonial understanding, communication, inclusivity, respect, Indigenous knowledge, and mentoring and supporting students (Hart-Wasekeesikaw 2009). In 2012, the Health Council of Canada conducted meetings across the country in an effort to learn about the use of culturally competent care for Indigenous Peoples in urban settings. The final report, “Empathy, Dignity, and Respect”, summarizes interventions across the country that focus on culturally competent health care practices and services. The report emphasizes practices that have included system-wide transformation, promote collaboration and partnership, and increase cultural awareness and competency among health professionals.

As the term gained popularity in health and social service provision, cultural competency research in and frameworks for HIV specific contexts have emerged. Particularly, there has been a focus on interventions in African, Caribbean and Black communities. Este et al. (2009) conducted a study in Calgary, Alberta in 2008/2009 to better understand the unique experiences of HIV-positive African newcomers in the city and recommend enhanced HIV programming and resources for African newcomer communities. However, the Ontario HIV Treatment Network’s Rapid Response Service did a thorough search of academic literature in 2013 in search of what HIV interventions were shown to be effective in African, Carribean and Black communities in North America and found limited data available on the assessment of these interventions. They did find that successful interventions included skill-building and education delivered to small groups, faith-based interventions, interventions led by community members, and awareness initiatives that target the entire community rather than individuals (Rapid Response Service 2014). An early intervention in Florida was the Churches United to Stop HIV (CUSH) project, a collaboration between faith-based organizations and public health officials to provide HIV prevention, counseling and testing to Black communities (Agate et al. 2005). The program rapidly expanded, and by 2003 had provided HIV education to more than 32,000 people.
Several frameworks for cultural competency in healthcare and service provision have also been developed. McNeil (2003) created the BESAFE model for service providers working with African Americans infected with HIV. The model is based on six elements: Barriers to health care, Ethics in cultural competency, Sensitivity of the Provider, Assessment appropriate to a cultural determination, Facts related to ethnocentric physiologic differences, and Encounters (McNeil, 2003, 45). The objective of the model is to foster relationships between service providers and those accessing services. Williams et al. (2010) developed a framework for HIV prevention for African Americans using four C’s: crisis, condoms, culture, and community. Their approach addresses past challenges of interventions that fail to consider cultural and historical context and the essential role of community partners (Williams et al. 2010).

The importance of engaging with culture in clinical and health-related settings has received considerable attention in the field of anthropology. One of the most famous examples of the need for cultural competency in health care is Anne Fadiman’s 1997 ethnography *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*. This popular book, often used in anthropology classes, tells the story of Lia Lee, a Hmong child born to immigrant parents in California in the 1980s. Lia begins to have seizures as a baby; her parents view this as a loss of soul, to be treated with a shaman and herbal remedies, while her American doctor diagnoses Lia with epilepsy, and prescribes medications. Fadiman (1997) tells the story of the collision of two explanatory models of illness and disease, ultimately leading to a seizure in 1986 that leaves Lia comatose. This ethnography gained popularity not only among anthropologists, but also as an example of the necessity of clinical cultural competency for medical students (Taylor 2003).

There are a number of lessons to take away from Fadiman’s (1997) work, but as Taylor (2003) points out, the story is influential because of the tragic story it tells and the static understanding of culture it uses. Taylor (2003, 179) writes that ethnographies such as these and courses in cultural competence “assume their proper place when we take them not as solid lumps of congealed truth, but as goads to curiosity, invitations to make meaning, moments in the ongoing process that is culture”. Plenty of stories like Lia’s have emerged in clinical encounters, and anthropologists are answering the resulting calls for culture to be taken into account in biomedical settings. Kirmayer (2013) praises the *Working with Culture* seminar at McGill.
University in Montreal, led by Cécile Rousseau and Jaswant Guzder. In their work with psychiatry students, Rousseau and Guzder move away from the idea of cultural competency as a form of clinical expertise that relies on assumptions based on observational or demographic data, and instead encourage embracing uncertainty and the unknown and taking an ethical stance in clinical settings (Kirmayer 2013).

While there seems to be little question that culture does play a role in the delivery and quality of a number of services, anthropologists are wary of the application of cultural competence and cultural competency frameworks, and the operationalization of culture therein. Fisher-Borne, Cain and Martin (2015, 169) observe four critiques of cultural competency: (1) the focus on the comfort of the practitioner when working with different cultural groups, while failing to “encourage critical self-awareness”, (2) the conflation of culture to race and ethnicity, (3) the emphasis on mastering the Other, and (4) the absence of a recognition of social inequalities. In their critique of cultural competency, Kleinman and Benson (2006) note that there is no precise definition of the term cultural competency, and a lack of research that proves the importance of culture to improve clinical services. Muaygil (2018, 16) finds that “the promoted benefits of cultural competence, the practice, when employed hastily and without thorough understanding or nuanced attention to the intricacies of not just cultural communities but of individual persons as well, might be considered ethically problematic”.

DelVecchio Good and Hannah (2015) question whether broad cultural categories can be used to create evidence-based practices in health-care settings, particularly in mental health practices. They use the phrase shattering culture to capture the “uncertainty that arises in these cultural environments of hyperdiversity in which broad identity-based indicators of cultural difference are often too blunt to capture current social and individual identities (DelVecchio Good and Hannah 2015, 201). To combat this uncertainty, DelVecchio Good and Hannah (2015) recommend that clinicians and health care professionals work to consider local context and appreciate the diversity of lived experiences in individuals. Similarly, Jenks (2011) notes that more recent cultural competence education has rejected what she describes as a “list of traits” associated with different ethnic and racial groups and has moved towards a more nuanced approach that values open-mindedness and individualism. However, she warns that this shift can “ultimately reinforce behavioral understandings of culture and draw attention away from the
social conditions and power differentials that underlie health inequalities” (Jenks 2011, 209). Malat (2013) similarly questions the ability of cultural competence to move beyond teaching these harmful cultural generalizations. She notes that cultural competence training often neglects issues of white privilege and the effects of bias and racism on health, focusing rather on cultural differences. Baker and Beagan (2014) find that despite increasing attention to cultural competence within health professions, the LGBTQ community has remained relatively invisible. Reiterating much of the criticism of cultural competency above, Kleinman and Benson (2006) recommend an alternative approach to current cultural competency frameworks, in which the clinician takes on the role of an ethnographer, engaging with and trying to understand the patient’s understandings of illness.

2.1.3 Cultural Safety

The concept of cultural safety originated in New Zealand in nursing education. Maori nurse Irihapeti Ramsden first coined the term in the late 1980s and early 1990s, shifting nursing education in New Zealand and elsewhere around the world (Koptie 2009). Cultural safety seeks to move beyond concepts such as cultural awareness and cultural competence by acknowledging power imbalances evident within health care between service providers and those accessing services. While the term holds no single definition, Williams (1999, 213) describes it as “an environment that is spiritually, socially and emotionally safe, as well as physically safe for people; where there is no assault challenge or denial of their identity, of who they are and what they need”. Since its initial development in nursing, the concept has spread to include a wider variety of health services, programs and policies, most notably in New Zealand, Australia, and Canada.

According to Spence (2001, 105), cultural safety is “predicated upon understanding power differentials inherent in health service delivery and redressing these inequalities through processes of education that are free from threat or guilt”. Rather than a focus on knowledge, as seen in cultural competence, there is a focus on power. In the document “Cultural Competence and Cultural Safety in Nursing Education”, Hart-Wasekeesikaw (2009) notes that cultural safety urges nurses and other healthcare practitioners to move beyond cultural competence. This means
redressing issues of inequity and understanding and challenging power imbalances that may exist. Ball (2009) describes five principles necessary for cultural safety: personal reflexiveness, cultural protocols, process, partnerships, and positive purpose. However, applying cultural safety is not without its difficulties, and Stout and Downey (2006) point to the political realities evident in the research: how will applying cultural safety be beneficial for Indigenous populations within the current frameworks that produce structural inequalities?

Of particular interest to this thesis is how anthropologists have begun to engage with the concept. Brascoupé and Waters (2009) explore the implications of cultural safety for Indigenous health policies and programs in Canada. They point to one difficulty in understanding cultural safety: “as a concept, it emerges as a distinct paradigm shift from the concept of cultural competence; but as a practical tool, it appears less as a shift in direction but rather a further step on the [cultural competency] continuum” (Brascoupé and Waters 2009, 9). In their article, Brascoupé and Waters (2009) argue that individual initiatives seem to fall short, concluding that institutional applications of cultural safety must be applied for changes to occur.

In a similar vein, Browne and Fiske (2001, 139) interviewed ten Indigenous women from rural communities in northwestern Canada, seeking to gain an understanding of their experiences in health care settings, they used the construct of cultural safety to guide their work. Browne and Fiske (2001) find that being “able to speak openly and to participate in health care decisions through sharing knowledge and power” and having one’s cultural identity respected are important to participants and contribute to a sense of empowerment. Browne and Friske (2001) point out that while these actions may appear to sit at the individual level, using a critical anthropological approach reveals a deeper need for institutional change. Anderson et al. (2013, 197) used ethnographic methods to complete two studies in Canadian health care settings and propose a rewriting of cultural safety to include “critical postcolonial and postnational feminist discourse”. Taking the abstract concept of cultural safety, Anderson et al. (2003) apply it in practice with South Asian and Chinese individuals experiencing re-settlement and migration. In doing so, “hard” categories of the colonized, the colonizer, and the oppressed are no more (Anderson et al. 2013).
2.1.4 Cultural Consonance

To determine whether PWAS and staff at AIDS Saskatoon shared understandings and knowledge of health and well being, I turned to the concept of cultural consonance. In the 1990s, the concept of cultural consonance emerged in anthropological discussion surrounding the relationship between culture and health. Dressler (2012) notes that while there is little debate whether culture influences health, investigating the connection has proven more difficult. Dressler (2012, 390) coined the term to mean “the degree to which individuals approximate, in their own beliefs and behaviors, the prototypes for belief and behaviour encoded in shared cultural models”. To calculate cultural consonance, Dressler (2012) first uses cultural consensus analysis. This involves the creation of a set of questions along with their “culturally appropriate responses” using a small set of key informants (Dressler and Bindon 2000, 247). These same questions are then surveyed to a larger group. Cultural consonance is determined by comparing the larger groups answers with the culturally appropriate responses from the cultural consensus analysis. For use in this thesis, I adapt Dressler’s (2012) concept to focus on the qualitative aspects of cultural consonance using interviews and extensive fieldwork, rather than the statistical dimensions used in other studies.

In a study in urban Brazil (Dressler et al. 2000, 2005), researchers found that higher levels of cultural consonance in lifestyle and social support are strongly correlated to lower blood pressure and a lower level of depressive symptoms in individuals. In their study of leisure activities and self-rated health in six cities in China, Chick et al. (2014) determined that higher levels of cultural consonance in leisure resulted in greater leisure satisfaction, which related positively to self-reported health. Reyes-García et al. (2010) used five annual surveys of 791 adults in the Bolivian Amazon and found a positive association between cultural consonance in material lifestyle and psychological well being. Copeland’s (2017) anthropological research in sub-Saharan Africa tied together cultural competence and cultural consonance among HIV-positive women. According to Copeland (2017:15), using cultural consonance allowed the women living with HIV to “define self-management behaviors that are healthy in a particular cultural context, rather than only including those included in public health messages”. Findings
from this study indicated that cultural knowledge and cultural behaviour are predicato
d in a significant way (Copeland 2017).

2.2 Central Contexts

2.2.1 Indigenous Experiences in Canada

The experiences of Indigenous Peoples in Canada have long been a topic of interest for Canadian scholars. Of particular interest has been the health of Indigenous Peoples. Waldram, Herring and Young (2006) offer a comprehensive account of Indigenous health from historical, anthropological, and epidemiological perspectives. While there has been a heavy focus on the current state of Indigenous health services, Waldram et al. (2006, ix) point out that the current system “did not come about spontaneously, but has been shaped over the years by policies and practices reflecting the social and political realities of the time”. Canada’s history of colonialism has shaped the health of Indigenous Peoples all over Canada today. Starting with a historical-cultural overview of Indigenous health, Waldram et al. (2006) use a holistic approach to further explore topics such as past and present Indigenous medicine and healing practices and self-determination. Of particular importance to the reader, argued by Waldram et al. (2006, 258), is understanding the “rich diversity” in Indigenous communities in Canada, to avoid Pan-Indigenousism that fails to differentiate between the many experiences of Indigenous Peoples across the country.

Much of the available literature on Indigenous experiences in Canada is focused in northern communities and reserves. And while many participants in my research have ties to home reserves and small rural communities, their experiences in Saskatoon and other urban centres is distinct and directly shapes their current health status. Cooke and Wilk (2018, 69) note that the attention to rural and on-reserve Indigenous populations may be due to the tendency of academics to “construct Indigenous peoples and culture as a static, unchanging, and exotic ‘other’”. The authors argue, however, that “Understanding and reducing the health disparities faced by urban Indigenous populations should... be an important focus for policy and research” (Cooke and Wilk 2018, 69). Tomascik et al. (2018) argue these health disparities and inequities
can be adequately addressed only when the impact of racism on Indigenous Peoples is recognized. Urban Indigenous Peoples are at a higher risk of numerous health problems and have a lower life expectancy than non-Indigenous urban dwellers (Cooke and Wilk 2018). Indigenous Peoples have higher rates of chronic illness and infectious disease, poverty, infant mortality, and suicide (Frolich et al. 2006). To combat this, Cooke and Wilk (2018, 76) propose improving “the functioning of the overall urban health and social service system”, rather than focusing on individual programs and services.

Norris et al. (2013, 29) contribute to the discussion of health among urban Indigenous Peoples by focusing of the “relatively recent phenomenon” of Indigenous migration to cities. While the 1951 Census indicated very few Indigenous people lived in cities, by the 2006 census, more than half of the Indigenous population were living in urban centers (Norris et al. 2013, 29). Andersen (2013), however, argues that urban Indigenous identities are distinct from the categories of First Nations, Métis, and Inuit offered by the Canadian state in the census and should be treated as such. He writes that urban Indigenous communities are “characterized by legal and cultural heterogeneity, a lack of territoriability, variable and complex identifications, socio-economic diversity, hypermobility, and a greater range of attachment (or lack thereof) to the ‘urban community’” (Andersen 2013, 51). In their study based in Saskatoon, Peters and Lafond (2013, 99) find that Indigenous Peoples in the city “prepare themselves for discomfort and lack of safety when they participate in the ordinary institutions of the city”. To combat this, Indigenous participants often create what they feel are their own inclusive spaces at local organizations, cultural events held in the city, and at the university (Peters and Lafond 2013).

2.2.2 HIV/AIDS and Indigenous Peoples in Canada

The disproportionate rate of HIV/AIDS among Indigenous populations in Canada has resulted in a large body of literature on the topic. A review of relevant literature on the subject by Duncan et al. (2011) analyzes 39 articles that contain incidence and prevalence estimates for Indigenous Peoples in Canada, and an additional seven that correlate HIV infection with Indigenous ancestry. Three themes emerge: (1) risk and vulnerability, (2) HIV-related stigma and intersections of stigma, and (3) HIV programming and policy. Below, I draw on literature to
explore these topics further. While this review is far from comprehensive, I look to include articles I find best exemplify these three themes.

A literature review by Negin et al. (2015, 1720) assesses “the evidence on HIV-related behaviors and determinants” in Canada, Australia, New Zealand, and the United States. Findings of the review indicate that Indigenous HIV research in these countries has focused considerably on vulnerability and risk. Early in the epidemic, with little surveillance data available, Craib et al. (2003, 19) find that due to “established links between entrenched poverty and risk of HIV infection”, Indigenous peoples in Canada are at greater risk of HIV/AIDS. According to Larkin et al. (2007, 179), as Indigenous Peoples are “disproportionately affected by social, economic, and behavioural risk factors”, it is no surprise that communities are experiencing disproportionate rates of HIV. In their study with Indigenous and non-Indigenous youth in Toronto, researchers find that Indigenous youth are far more aware and worried about contracting HIV than their non-Indigenous counterparts. The Cedar Project, conducted in Vancouver and Prince George, British Columbia from 2003 to 2005, finds high levels of housing instability in young Indigenous Peoples using drugs, similarly suggesting a heightened risk of HIV risk for Indigenous Peoples in Canada (Jongbloed et al. 2015).

The intersections of stigma for Indigenous Peoples living with HIV has also received considerable attention. Mills et al. (2009), for example, argue that individuals are often burdened with multiple layers of stigma. HIV status intersected with stigma associated with race or ethnicity, gender, sexual orientation, and social class. For some individuals in the study, the fear of HIV-related stigma led to secrecy and avoidance of treatment and support services (Mills et al. 2009). Ship and Norton (2001) further explore the unique position Indigenous women living with HIV occupy. They argue that for First Nations women working on the streets of Vancouver, gender inequity and cultural disruption, largely due to the effects of colonialism, has left them in vulnerable situations away from their home communities and without adequate support (Ship and Norton 2001). Women in the study chose not to disclose their HIV status due to fear of being labeled as promiscuous or a bad mother (Ship and Norton 2001, 29). Similarly, Robertson’s (2007, 534) interviews with HIV-positive women in Vancouver’s Downtown Eastside reveals “struggles to contain otherness and resist stigmatization” through place-making. A study by Cain et al. (2013) uses 72 interviews with Indigenous Peoples living with HIV across Canada to better
understand the experience of diagnosis and the intersection of depression. The project is community-based and recruitment took place through community organizations in several Canadian cities (Cain et al. 2013). Participants recount their experiences with HIV-related stigma and feelings of rejection and discrimination. Findings of this study indicate that the broader context of an individual’s life is closely linked to the individual’s experience of receiving an HIV diagnosis and the subsequent use of services and support (Cain et al. 2013).

Policy concerned with the disproportionate rates of HIV among Indigenous Peoples in Canada is another area that has more recently received significant attention. The edited collection Seeing Red: HIV/AIDS and Public Policy in Canada was published in 2018. Many articles in this collection are relevant to discussion in this thesis, such as Prentice et al’s (2018) article “‘Good Medicine”: Decolonizing HIV Policy for Indigenous Women in Canada”. The authors begin by noting that the current HIV response in the country has emerged from a “fundamentally pathogenic orientation that responds to disease over health, illness over wellness, and HIV risk factors over HIV protective factors” (Prentice et al. 2018, 236). In doing so, the harmful realities of colonialism on the lives of Indigenous women living with HIV go unrecognized (Prentice et al. 2018). Instead, Prentice et al. (2018) advocate for a policy response that is rooted in understanding the strengths of Indigenous women living with HIV, uses a holistic understanding of health, centers the voices and perspectives of Indigenous women living with HIV, and creates safe spaces. In their article on Indigenous communities aging with HIV in the same collection, Gabel et al. (2018) find that close to 70 percent of Indigenous Peoples living with HIV are between thirty and forty-nine years old. This means that in the next two decades, there will be an increase in older Indigenous Peoples living with HIV and AIDS. Using sharing circles to collect data, Gabel et al. (2018, 261) look to “gain a better understanding of the lived experiences of this diverse population” to aid in the creation of effective and culturally competent strategies that “facilitate successful aging among older Indigenous peoples” living with HIV and AIDS. Five themes that were important to aging successfully among Indigenous peoples living with HIV were: physical, emotional, spiritual, mental, and social engagement (Gabel et al. 2018). Gabel et al. (2018) recommend that future policy should be grounded in Indigenous world views and knowledge and a holistic understanding of health, to better understand the experiences of Indigenous Peoples aging with HIV and AIDS.
2.2.3 HIV and Indigenous Peoples in Saskatchewan

Increasingly, HIV research in Canada has focused on Saskatchewan, where rates of HIV incidence and prevalence in the past have been as high as three times the national average, and Indigenous populations are overwhelmingly over-represented. Several academic studies concentrate on high HIV rates in the province through a variety of subtopics. Bird et al. (2016) examine the transmission and prevalence of HIV among sex trade workers in Saskatoon, finding that histories of physical and sexual assault, drug use, Indigenous status, and depression are linked to an increased risk of poor health outcomes, including HIV and AIDS. To counteract these results, Bird et al. (2016) recommend building capacity in local, Indigenous NGOs to create effective programming. Sami et al. (2018) seek to better understand front-line service provider’s experiences and appraisal of the province’s HIV Strategy, which was implemented from 2010-2014. Results from the study show that while service provider’s see an increase in awareness of the HIV epidemic, there is a need to further address HIV-related stigma and peer-led and mental health programming (Sami et al. 2018). As well, service provider’s note the need for an increase in specialized physicians and pharmacists (Sami et al. 2018).

Hatala et al. (2018) explore HIV disclosure and the role of “helper” taken on by HIV-positive individuals by sharing their experiences and journey in their community in Saskatoon. The researchers involved argue that the potential benefits of disclosure, including a decrease in stigmatization, an increase in HIV-related knowledge, testing, and role models in the community, outweighed the potential harm (Hatala et al. 2018). The role of “helper”, Hatala et al. (2018) argue, is relevant to the call from Indigenous scholars to increase culturally sensitive services for individuals living with HIV. Using Indigenous sharing circles in Saskatoon and Prince Albert, the Indigenous Red Ribbon Storytelling Study by Nowgesic et al. (2015) found that participants felt that they often had to choose between living with an active substance use disorder and accessing antiretroviral therapy.

The short volume AIDS Saskatoon: A History of Service, Hope, and Engagement (Downe and Dravland, 2016) is the result of a community-to-classroom partnership with AIDS Saskatoon and a University of Saskatchewan undergraduate anthropology class in 2014. Themes of
colonization, stigma, and HIV programming in the province are common to the contributions in this volume and can be found throughout the book. Downe’s own work at AIDS Saskatoon is highlighted in her 2011 article “Feminist Anthropology Anew: Motherhood and HIV/AIDS as Sites of Action”. In her interviews with mothers living with HIV, Downe (2011) argues that feminism and the struggle of women often framed the participant’s narratives surrounding maternal care, access to services, and the fight against public stigma.

2.2.4 HCV and Indigenous Peoples in Canada

While my proposed research initially focused on individuals living with and affected by HIV, it became quickly evident that I needed to additionally focus on the Hepatitis C virus. HCV is a virus that affects the liver, and in 2011 it was estimated that 250,000 people in Canada were infected (CATIE 2019). Transmission of HCV is similar to that of HIV, through blood-to-blood contact (CATIE 2019). Due to this, over 30 percent of individuals infected with HCV worldwide are co-infected with HIV (Klein et al. 2014). In Canada, it is estimated that 13,000 to 15,000 of the 65,000 HIV-infected individuals are co-infected (Klein et al. 2014). Using a syndemic approach, in which two or more epidemics interact synergistically to contribute to increased burden of disease, Singer (2003) suggests that combined with alcohol consumption, HIV status can lead to an increase in HCV burden, higher transmission rates of HCV to sexual partners and children, and the acceleration of end-stage liver disease progression. Unlike HIV, HCV can be treated and cured; however, it is estimated that twenty percent of those infected do not know their HCV status (CATIE 2019).

Despite these staggering numbers, there is considerably less research on HCV in Canada than that of HIV, much of which has been confined to medical studies and surveillance data. Uhanova et al. (2013) note there is limited data on HCV in the country that focuses the epidemiology of the virus. Creating a research database in Manitoba using health records from a number of sources, Uhanova et al. (2013) conclude that Indigenous populations with HCV in the province are characteristically different than the non-Indigenous population. Indigenous People living with HCV in Manitoba were found to be younger, more often women, and more often living in urban centres (Uhanova et al. 2013). Klein et al. (2014, 17) conclude that while
“evidence that successful treatment for HCV infection is the most effective means of preventing liver-related outcomes in co-infection”, over 70 percent of their studies cohort were untreated.

2.3 Conclusion

There is considerable anthropological and other social science and health related research from which to draw on the topics of cultural competence, cultural competency and cultural safety. As health disparities remain prevalent in Indigenous and other minority populations, education, programming, and other interventions continue to be developed, implemented, and more recently, evaluated. Anthropologists continue to provide valuable insight into the operationalization of culture in cultural competency and cultural safety frameworks.

In Saskatchewan, high rates of HIV and HCV, and the racialization of these infections has led to a small but significant body of literature on the topic that encourages health care and service providers to build capacity for programming and interventions targeting Indigenous populations in the province. It is clear however, that there is a need for more research that takes into account Saskatchewan’s unique epidemiology and provides future direction for effective cultural competency and cultural safety in service provision.
Above the back wall of the 601 hangs a large red and white quilt. Patches adorn the quilt, names with small items or symbols next to them, representing 601 community members who have passed away. Some have lost their lives to HIV and related illness, others to overdose and suicide. I am told that every so often the quilt is taken down, and when it returns a new patch has been added. The quilt is one way the 601 community mourns and celebrates community members whose lives have been lost and serves as a reminder to not forget the individual in the midst of an epidemic in the province.

In a time when the rhetoric of Indigenization dominates discourse in Canadian institutions, particularly in education, health care, and service provision, it is imperative to further explore how the concept of culture is utilized in broad and often problematic ways that center pan-Indigenous frameworks for cultural competency with little attention paid to individual perspectives and experiences. In this chapter, I examine how culture is understood and framed on an individual level by PWAS and staff at AIDS Saskatoon as well as its perceived significance to health and well being. I further explore the operationalization of culture in cultural competency strategies utilized at AIDS Saskatoon and how these strategies are developed with an understanding of the importance of individual beliefs and values. I explore the individualized ways that PWAS create meaning and exercise agency over their cultural identity. As Lakes et al. (2006, 391) write, “[t]he understanding of individual experience of culture can inform the clinical encounter in significant and meaningful ways”.

I begin this chapter by discussing the importance of taking into consideration individual constructions of culture when developing cultural competency strategies. Drawing on DelVecchio Good and Hannah’s (2015) concept of “shattering culture”, I argue that broad cultural categories, which center markers such as race and ethnicity, are unfit to capture the complex identities present in NGOs such as AIDS Saskatoon. I go on to examine these complex
identities from the many perspectives of PWAS, in particular the two most common individual constructions of culture that were brought up in interviews, and further, the variance within each category. How these individual constructions affect perceptions of health and well-being is then explored. I conclude this chapter by exploring how staff at AIDS Saskatoon understand these individual constructions of culture and use them to develop and practice cultural competency in the agency. I contend that by taking into account how PWAS define and identify with the concept of culture, staff at AIDS Saskatoon are able to further cultivate relationships and “meet people where they are at”.

3.1 Individual Constructions of Culture

It is clear that how both PWAS and staff relate individually to the concept of culture has been integral to how AIDS Saskatoon has developed cultural competency and cultural safety strategies. As discussed previously, cultural competency and cultural safety strategies became popular tools for health care professionals, social workers, and non-profit service providers in the late twentieth century (U.S. Department of Health and Human Services 2007, Papps and Ramsden 1996). Many frameworks have been developed over time. However, many criticisms of the concepts have also emerged. One such criticism, echoed by a number of anthropologists, is the use of culture as a static and fixed entity that teaches lists of traits for different cultural groups. In response to this, Jenks (2011, 230) notes that cultural competency educators have adapted workshops that “direct attention away from a social understanding of difference and toward an individual one”. In turn, providers seek to recognize difference, gain knowledge about these differences, and maintain an open-mind in interactions with those accessing services (Jenks 2011). Jenks, however, goes on to suggest that this individualistic approach can prevent service providers from further examining larger social contexts and historical realities, and “reinforce a depoliticized understanding of cultural differences” (2011, 212).

In my interactions with staff and PWAS at AIDS Saskatoon, I did not find this to hold true. Staff are knowledgeable about the lasting effects of colonialism on Indigenous Peoples and the marginalization and stigmatization of intravenous drug users in mainstream society. Staff are also usually acutely aware of their own positionality and privilege within the agency and how it
affects their relationships with PWAS and can be the source of misunderstandings and conflict. While staff often credit their backgrounds in social work for this knowledge, most note that there has still been plenty to learn working in the field. What is learned in the classroom does not always translate to the real-life struggles and realities that PWAS face in their personal lives. In daily interactions between staff and PWAS, the political quickly became the personal.

In her examination of Fadiman’s (1997) widely read ethnography *The Spirit Catches You and You Fall Down: A Hmong Child, Her American Doctors, and the Collision of Two Cultures*, Taylor (2003, 177) questions: “However one defines ‘culture,’ does not attention to it demand, at the very least, taking an interest in what people think, and say, and what they have experienced—in short, "the story of the person"?”. Much of the research on cultural competency seems to be missing this individual understanding of culture and the implications of this in health-care settings are seldom discussed when examining existing frameworks and strategies. I look to redress this shortcoming. Schwartz’s (1978) concept of the idioverse is particularly useful here. Idioverse refers to an individual’s subjective reality and is an organizing system for an individual’s portion of culture. The concept acknowledges the unique personalities of individuals within cultural models. The overlapping of idioverses among members of a group can then be understood as the culture of said group (Linger 1994).

During interviews I asked participants to define the word culture and to go on to describe their culture in their own words. The meanings individuals attached to culture were subjective and PWAS and staff defined culture and described their own cultural models in a multitude of ways. Culture was described by PWAS as “where you come from”, “how you’re raised”, and that it “involves different people”. When asked to elaborate on their culture, many participants turned to their ethnic backgrounds as I initially expected. However, a number of participants brought up more than one culture or community to which they feel a sense of belonging, while a few did not feel they fit into any cultural group in particular. The overlapping of idioverses resulted in the emergence of two distinct categories: Indigenous cultures and street cultures. These categories are not always explicit, nor are they stand alone. They often intersected with each other within interviews and were fluid and changed over time. For participants, culture seems to be constantly evolving to their current life circumstances. Rather than a fixed entity, the culture of PWAS at the agency is defined by its hybridity. It is “the name of a land one travels
through as much as one lives in” (Mattingly 2008, 139). Below, Alicia, shares her experience as such:

Me, I grew up in a white family. So I was growing up, like, white. But then after I started meeting, I started growing up or whatever, I realized that I was Native. So I started getting to know my Native culture. So, I believe in the Creator and stuff like that. That’s my culture.

Later in the interview, Alicia tells me that her community now is the people she has met at AIDS Saskatoon. She does not feel that she fits into just one cultural category. This sentiment is common throughout a number of interviews. I use this quote to highlight the complex histories and idioverses of participants that are not encapsulated neatly by racial or ethnic markers that are often conflated with the term culture or by broad understandings of what it means to be “culturally competent”. Anthropologists DelVecchio Good and Hannah (2015) coin the term “shattering culture” in their ethnographic research of mental health services in Boston to draw attention to this very phenomenon.

3.1.2 When Culture Shatters

The term “shattering culture” refers to “the uncertainty that arises in these cultural environments of hyperdiversity in which broad identity based indicators of cultural difference are often too blunt to capture current social and individual identities” (Delvecchio Good and Hannah 2015, 201). Delvecchio Good and Hannah (2015) refer to the use of both race and ethnicity as indicators of cultural differences that lead to health disparities in health-care settings. The authors point to the issues that arise when race and ethnicity are conflated by health-care professionals, such as a lack of considerations for cultural variances within groups of people. In researching the increasing hyperdiversity in America, particularly in younger generations, the authors find that social categories of race and ethnicity as cultural identities are becoming increasingly fluid and complex. However, the term hyperdiversity is not meant to discard the concept of culture in medicine altogether, but instead problematizes the predominant use of categories of race and
ethnicity in creating cultural competency frameworks under the guise of “the greater good” or equality (Delvecchio Good and Hannah 2015, 203).

When researching in the settings they describe as hyperdiverse, Delvecchio Good and Hannah (2015, 210) identify five broad challenges to consider:

(a) multiplicity, where the number of racial and ethnic groups present are numerous, (b) ambiguity, where the racial and ethnic identity of patients is not easily recognized using physical features alone, (c) simultaneity, where patients occupy multiple racial/ethnic categories at once, (d) fluidity, where the self-asserted racial and ethnic identity of patients is flexible or changes over time, and (e) misapplication, where and individual patient’s cultural orientation is idiosyncratic and does not significantly resemble the cultural characteristics associated with their racial/ethnic group.

I found the concept of “shattering culture” to be particularly insightful during analysis of interviews as AIDS Saskatoon provides a rich ethnographic environment, and the five challenges identified by DelVecchio Good and Hannah (2015) are present throughout this thesis.

While many participants quickly identified with their racial or ethnic background when first asked to describe their culture in interviews, the variance of idioverses within these groups is apparent and salient. Indigenous PWAS and staff more often acknowledged their ethnic backgrounds, while non-Indigenous PWAS and staff frequently identified under the broader racial category of “White” or referred to their belonging to the dominant culture. Spending just a few hours in the 601 confirmed the hyperdiverse nature of the agency for me, as Indigenous and non-Indigenous PWAS from various cultural backgrounds congregate daily. Participants come from a multitude of upbringings and connect with the concept of culture in a variety of ways.

Alicia’s story above provides one example of how some participants simultaneously occupy multiple racial and ethnic categories that are fluid and evolve over time, leading to ambiguity for many PWAS and staff. And while the initial responses from several participants may have been to identify racially as Indigenous or White, as interviews went on, participants often went on to describe other, perhaps more nuanced, identities, such as their connection to street and 601 cultures. Additionally, while participants may identify with their ethnic background, their interpretation of that culture is unique and may not reflect common
characteristics associated with that group. For example, while several participants speak of their Cree background, understanding of Cree cultures is distinct based on whether the individual had grown up on a reserve, in an urban setting, or in the foster care system. These points further complicate just what is meant by the concept of culture within cultural competency strategies and frameworks.

3.2 Common Cultural Identifications

3.2.1 Indigenous Cultures

The vast majority of PWAS and about half of the staff I interviewed identified as Indigenous when asked to describe their culture. Important to note, however, is the diversity of Indigenous cultures represented in this sample. Participants come from Cree, Dene, Saulteux, Dakota and Métis backgrounds. Geography plays a large role in how individuals identify with their Indigeneity. Some individuals grew up on reserves, while others grew up in cities. Some went back frequently to visit their home reserves, while others note they are happy to have left. Many have never stepped foot on a reserve. For individuals who grew up on reserves, the city could be a foreign and sometimes overwhelming space. As one participant, Amy, observes: “It’s very depressing in the city I think”. She describes her time back home in northern Saskatchewan as peaceful and connected to nature. Another participant, Troy, describes to me the teachings from his childhood on a southern Saskatchewan reserve that he now uses with his own children, such as smudging and sharing circles. However, growing up on a reserve is not a positive experience for all. For one participant, Janine, it felt like a form of escape to leave the reserve for the city. She left at a young age and has not returned.

Knowledge of Indigenous traditions and beliefs also varied within the sample. Some participants were brought up with Indigenous values and knowledge, some connected to their Indigenous knowledge later in life, and some never connected at all. One participant, a middle-aged man named Steve, tells me how he did not connect with his Indigenous culture at all until he was incarcerated, but now it is an important part of his life. He articulates, however, that while the healing lodges and pow wows he has attended since then had been powerful and proud
experiences, they are often few and far between. “In the urban area it’s kind of hard to find any place where you can find any traditional areas, you know, like Elders or whatnot”, Steve explains. Like Steve, several Indigenous participants who grew up solely in the city or away from their home reserves feel as though they have missed out on a piece of their culture. One staff participant, Jan, describes it as such:

Well, I always joke that I’m a city Indian, but the thing is, the older I get, the more I’m aware of what I missed. I don’t want my grandchildren to miss that. I don’t want them to wait until they’re in their 30s or 40s or 50s to go into a sweat, to feel comfortable in a sweat, to feel shame at being First Nation. I want them to be proud that they’re a long line of First Nations.

In her daily interactions at the 601, Jan observes an increasing desire from PWAS to connect to their Indigenous roots. For some, this might mean a return to what they had learned as a child, while for others it means learning about their Indigenous culture for the first time. Several participants have been directly involved or impacted by the residential school system and the 60’s Scoop, both of which sought to assimilate Indigenous Peoples into mainstream society and caused the destruction of traditional knowledge and culture. She remarks:

I see more and more people here, coming here, looking, how can I put this? Looking for something to believe in. I think they’re looking for their roots, like what their parents or grandparents, or what they’ve heard. They see other people going back traditional, and they want it.

In several interviews, participants expressed a desire to connect with more traditional Indigenous practices. Connecting with Elders, attending sweats, and smudging were brought up frequently. This is confirmed one day mid-summer, when an Elder spent the day in the Drop-In Centre and a line-up of PWAS formed, waiting patiently for their turn to speak with her. Connection to one’s Indigenous culture, whether it is from a young age or for the first time at AIDS Saskatoon, is a proud and powerful experience for many PWAS, but for others, it was not something they wish to pursue, for various personal reasons. PWAS identify with their Indigeneity along a spectrum. Similarly, Indigenous staff members exist along this same spectrum. As the agency works
towards a more representative workforce, staff come from different First Nations and Métis backgrounds, and similar to PWAS, connect with their cultural heritage in diverse ways.

3.2.2 Street Culture

In Saskatchewan, high rates of HIV and HCV are predominantly associated with the use of intravenous drugs. According to The Saskatchewan Ministry of Health, the use of injection drugs often “takes root in conditions of poverty, childhood sexual abuse and neglect, lack of education and employment and racism” (2008). AIDS Saskatoon has been a leader in the province; they currently operate a needle exchange and in August of 2019 it was announced that the agency will be home to the province’s first supervised consumption site opening in 2020. It is no surprise then that a number of participants identify with, what I refer to as street culture, throughout interviews. AIDS Saskatoon prides itself in being a safe place for all and free of judgment.

When participants first referred to street culture, my mind initially turned to gang involvement, but this is not often what PWAS meant. I learned that street culture looks different for different people. For many PWAS at AIDS Saskatoon, addiction to crystal methamphetamine or heroin dictates daily interactions and choices. Others rely on alcohol or prescribed painkillers, some no longer use at all but still understand the culture all too well. When asked about his own culture, one participant, Jeff, explains that he is Métis, but that is not the culture he identifies with most strongly. Jeff’s observation below is particularly insightful:

I don’t think I really see it as race, I see it as addiction I think because I’m an addict, I see them as an addict. Everybody I know is some kind of addict, like honest to God. It’s a pill or booze, you know what I mean? That’s just the culture that I’m in, right?

As an individual, Jeff identifies first and foremost as an addict. He tells me that he had driven a truck for well over twenty years and had been well paid. When he was forced to stop working due to health issues, he turned to drinking to cope. Similarly, several PWAS explain
that they have stopped using drugs, but beliefs in line with the doctrine of Alcoholics Anonymous or Narcotics Anonymous and the disease model of addiction (Wagener 2020) are commonplace; individuals remind me more than once, “once an addict, always an addict”. Some PWAS currently live in stable housing situations with partners or family members, while several are homeless and sleeping on the couches of friends or in shelters. One PWAS, a middle-aged Indigenous woman named Penny, speaks of her and her partner’s recent experience of homelessness: “I haven’t had that up until just recently here. Oh my God that’s horrible. That is so horrible. It’s so horrible.”

Research in more formal health care settings finds that individuals who use illicit drugs characterize health care settings as “unsafe due to stigmatizing constructions that individualize, criminalize, and medicalize illicit substance use” (Pauly et al. 2015, 131). This is confirmed by several PWAS who speak about their bad experiences in hospitals and clinics as street-involved individuals. PWAS recount stories of judgment and mistreatment, of not being listened to or believed, and of neglect. I heard stories that made me both sad and angry, but that are all too common for Indigenous Peoples and intravenous drug users. In contrast, the warmth and informality of the 601 nurtures feelings of belonging and safety, drawing individuals in to a community that respects and sees PWAS as more than clients. In the 601, I found that street culture refers to shared experiences among PWAS, which include illicit drug use, precarious housing situations, food insecurity, and the practices and informal rules of a “street economy”, where “fragile income-generating strategies and tenuous social networks of street addicts mandate risky practices” (Bourgois 1998, 2330). These rules of the street economy are tangled with the moral economy of PWAS, where informal economic practices are guided by principles of reciprocity (Bourgois 1998).

These moral economic practices are commonplace in street cultures and might include sharing cigarettes, drugs, or other resources among friends and peers. In their interviews, two PWAS, Jeff and Alicia, speak to the use of moral economic practices. While he does not drink anymore, Jeff tells me he sometimes helps support his friends who still drink with any extra money he may have. When I ask about her community, Alicia explains that her community is “street people” or people who had grown up in the system, like she had. Similarly, she tells me that she likes to help her friends out when they are struggling
and often, this means aiding them by sharing clean needles or a dollar or two if she has it to spare. These practices are carried out with both care for one’s friends and peers, and with the expectation that the favour may be returned one day. One staff member, Nikki, puts it as such:

People kind of think about drug use or drug culture as this really competitive, dog-eat-dog world and there is a component of that, but there’s also this very strong sense of community and brotherhood, sisterhood, where people share and have each other’s backs.

Of course, as Nikki and Bourgois (1998) allude, street culture on the individual level is not always centred around a moral economy but also includes practices of daily survival. In interviews, PWAS also speak of theft, violence, and feeling unsafe in their communities. The street economy that PWAS enter into also involves income generating activities, like panhandling, bottle collection, sex work, theft, and the selling of drugs, that have little to do with reciprocity and can have adverse effects (Gwadz et al. 2008). In more public conversations within the 601 Drop-In Centre space, PWAS usually refrain from speaking about drug use, income generating, or street involvement.

Staff in the agency are not only aware and knowledgeable about street culture, but a few of them explain to me that they also understand it from an inside perspective. One staff member, Adam, describes it as such: “I know what it’s like to be reliant on a substance. I’ve dealt with some stuff growing up that sucked. And so I know, I’ve shared a lot of experiences with the people that we work with. And so that way I relate to them. It’s more on a street cultural level”. Adam is not the only staff member who could relate to PWAS on this level and more than once staff tell me that for this reason, representation matters. “I came from them. I was one of them. And I know where their headspace [is], I can always put myself back in that headspace”, Jan discloses in her interview.
3.3 Connecting Culture to Individual Health and Well Being

During interviews, I invited PWAS to share their understanding of the relationship between their culture and the management of their health and well being. I did not provide formal definitions but instead left PWAS to interpret the terms as they saw fit. This question yielded a variety of responses. PWAS identify culturally in numerous ways, as I discuss above. As this research took place within an HIV/AIDS service organization with over 80 percent of PWAS identifying as Indigenous, I initially expected participants to speak to their experiences with HIV and AIDS and to healing in the context of their Indigenous cultures.

Several participants were at ease discussing their HIV, AIDS, or HCV diagnoses. Some shared uplifting stories. Jack tells me with pride that he has been following his medications closely and currently has an undetectable viral load, while others had less positive news to share. Amy discloses that her HIV had recently advanced to AIDS. Despite the openness of some participants, also evident in interviews is the stigma that exists surrounding HIV, AIDS and HCV. While several individuals feel comfortable sharing their diagnoses with me, equally interesting was the speed at which other participants share that they themselves are not living with HIV or HCV. Whether they are affected or not, PWAS are aware of the biases and judgments that are associated with these afflictions.

When asked to describe the relationship between their culture and illness or health status, PWAS found creating connections more difficult, and frankly, less applicable to their lived experiences. However, when I asked PWAS to tell me the things they did to stay healthy in their day-to-day lives, the role of culture appeared clearer, but was often viewed with little importance. While each individual experience is vastly different, there appears to be a common understanding among PWAS that one’s well being is directly tied to a current level of stability. This aligns with Mathews and Izquierdo’s (2011) use of well being as a subjective state that is determined by one’s cultural context. PWAS were more interested in discussing substance use, violence, housing, and community when asked about their health and did not often connect these topics with their Indigenous background. For example, when I ask Janine if she is interested in learning more about her Cree culture she responds:
Well right now in my life I’m not kind of situated and settled. Probably not right now, I’d want to learn, participate and stuff like that, ‘cause I’m not feeling settled right now. Maybe if I had my own place and all that I would.

These everyday modes of survival hold clear importance in the lives of PWAS. Where one’s next meal or fix is coming from and both individual and familial safety often occupy thought and action more than long-term medical treatment plans. Singer (1996, 99) developed the term SAVA (substance abuse, violence, AIDS) to emphasize the interconnectedness between these threats to health and well being. In the example of PWAS at AIDS Saskatoon, an HIV diagnosis may be further exacerbated by injection drug use and instances of physical, emotional, and structural violence. Rather than understand substance abuse, violence, and AIDS as stand-alone issues, Singer (1996) encourages service providers to use a holistic approach when providing support.

A few Indigenous participants do recount the natural remedies passed down to them from family members, such as the use of rat root or time spent in sweat lodges. Upon receiving her HIV diagnosis, Amy explains she had wanted to treat her health in a holistic sense, like she had been taught growing up on her home reserve. Others see little to no connection between their Indigenous culture and their health. When asked if his culture had played a role in his pain management, Jeff responds:

I don’t think my culture has anything to do with it… I don’t go to sweats, I don’t smudge, you know what I mean? I don’t have nothing to do with my culture, I just, I got a treaty card to pay for my meds. Pays for my ambulance rides, that’s good enough.

Whether participants find the concept of culture important in the management of individual health and well being or not, what is clear is the significance placed on individual agency. Each day, PWAS make decisions regarding their health and well being that are directly tied to cultural knowledge, but it might not be knowledge from the culture they identify most strongly with in interviews. While some PWAS describe sweats they have attended, time spent with Elders, and teachings from their childhoods, for the majority of PWAS I interview, decisions regarding health and well being are more directly linked to physical aspects of survival.
3.3.1 Survival Mode

Several staff members brought up the idea of survival mode throughout interviews. They use this term to refer to the daily hardships faced by PWAS that cause them to focus only on the present with little room for long term plans, and as staff explain to me, for connecting with their cultural heritage. This includes issues of housing and food security, community safety, and making sure children have a safe place to stay. Daily life for many PWAS often includes elements of trauma and emotional and mental instability that is exacerbated by substance dependence and withdrawal or illness. For staff, these realities reinforce the need to allow PWAS to determine their own needs when accessing services.

This sentiment can be applied to the application of cultural competency in NGO settings. In their exploration of anthropology in the clinic, Kleinman and Benson encourage clinicians to evaluate “what is at stake” for patients when facing illness (2006, 1674). For staff at AIDS Saskatoon, evaluating “what is at stake” includes taking into account the circumstances that may prevent individuals from adhering to medications, attending appointments, or connecting with public health messages deemed surrounding safe drug use. These daily tactics are necessitated by broader cultural and social forces. Structural violence, violence that is exerted indirectly and systematically, is pervasive in the lives of those accessing services in the agency due to the intersections of race and class in which they live (Farmer 2004). PWAS do actively resist their subjugation while in survival mode. They exert agency over their lives as they plan and prioritize their days around the pressing issue of survival, including a safe place to sleep, food to eat, and obtaining the substances they need to avoid withdrawal symptoms.

To better understand the needs and choices that PWAS make, several staff members referred to Maslow’s Hierarchy of Needs. The hierarchy, created by psychologist Abraham Maslow in 1943, seeks to understand human behavioural motivation (McLeod 2018). At the base of the pyramid used to conceptualize the hierarchy is physiological needs, such as food, water, and rest. Moving up the pyramid are safety and security, belonging and love, esteem and finally, at the top, self-actualization. In order to reach the needs at the top of the hierarchy, the needs
below must be met. Staff use their understanding of the hierarchy to better support PWAS. One staff member, Kate, describes it as such:

    If you look at Maslow’s Hierarchy of Needs, I think the cultural and the sense of connection and the love is step three, right? We’re usually working with people in step one and two. They might not have a place to sleep that night, they might not have food. They’re in a domestic violence relationship, and they’re dealing with mental health and addiction.

Maslow’s model, however, is not without its criticisms, including that it is a culturally constructed model based predominantly on Western individualistic values (Blackstock 2011). The pyramid fails to account for the variance in cultures and context in spaces such as AIDS Saskatoon, where the collective values that emphasize community and family are evident in both Indigenous and street cultures. While the hierarchy assumes the most basic needs at the base of the pyramid must be met to move up, my research indicates that for Indigenous and street-involved PWAS, well being is far more “interdependent in nature with cultural values” (Blackstock 2011, 3). Feelings of belonging held clear importance for PWAS and were often connected to whether or not one accessed services. Cultural competency strategies urge service providers to take into account the multitude of cultures present and their dynamic nature, however, Maslow’s hierarchy remains fixed in its interpretation of behavioural motivation. For example, while cultural safety refers to the various social and historical contexts that shape safe environments, Maslow’s use of the word safety refers to only the physical aspects of individual safety.

Nonetheless, for many PWAS, the daily effort to meet basic physiological needs does mean that some levels of Maslow’s pyramid go unattended. PWAS speak freely of housing issues, lack of food security, and issues surrounding safety in their homes and neighbourhood. It is further confirmed when in the first few minutes of the interview, one participant burst into tears. How could she answer questions about her culture when she is currently homeless and experiencing domestic violence from her partner? Unfortunately, this is commonplace; my daily interactions with PWAS in the 601 Drop-In Centre yielded stories I often did not want to believe. It was during these less formal interactions that I felt I was truly getting a glimpse into the day-to-day lives and struggles of PWAS. To meet the most basic needs, the majority PWAS I
interviewed rely on monthly cheques from social services, participation in the street economy described above, and support from staff at the agency. However, PWAS often speak of their troubles with a dry and dark sense of humour and of connecting with their Indigenous cultures in the future with a sense of longing. Alice, a staff member, explains:

> A lot of people want to be able to live peacefully and care for themselves and be cared for by their community...They have no way to attain that peace and comfort and community, because either they’re just too far removed, maybe they grew up in foster care and were adopted out and don’t even know who the hell their family is, maybe they’re rejected by their family. Maybe their family is, all of them, too unwell and scattered to help them or give them that community or whatever.

Here, Alice pin-points why DelVecchio Good and Hannah’s (2015) concept of shattering culture is particularly salient. The lived experiences of PWAS are vast and complex and must be understood by staff as such. As PWAS operate in survival mode, the use of broad identity markers, such as race and ethnicity, to determine the support provided to an individual is problematic. Instead, I argue below that culture must be operationalized on an individual level that prioritizes the agency and empowerment of PWAS.

3.4 Operationalizing the “Culture” in Cultural Competency

The central question I aim to address in this thesis is how culture is operationalized in cultural competency strategies at AIDS Saskatoon. Este et al. (2009) position culture as a central consideration for individuals working in HIV/AIDS organizations working with minority populations. This includes the recognition of power differentials between the dominant culture and newcomers, the balancing of beliefs and values from newcomers’ country of origin with those of the dominant culture, and the potential tensions that arise in the process of acculturation. However, despite its perceived importance in health care and social work settings, pin-pointing just what is meant by the word culture within these frameworks and strategies proves to be more difficult. Throughout this chapter, I aim to address just why this is: because individuals understand and connect with their cultures on many different levels.
In the policy manual at AIDS Saskatoon, the term cultural competency is used throughout, yet there is never a clear definition of what is meant by the term or just how it is operationalized within the agency. This is not to say that specific strategies do not exist, only to point to the lack of formality in its use and definition. As culture is defined by both staff and PWAS in a variety of ways, it is difficult to determine a common understanding of the term. Often, staff members referred to individual beliefs and values when I asked them to define the word culture, as well as feelings of belonging and connection. When I probed further about the cultures of PWAS, more often than not, staff turned to either broad racial or more specific ethnic markers. This surprised me, because although staff seemed to demonstrate a good understanding of culture as a broad concept, they often narrowly focused on race and ethnicity when using it in a real-life situation.

However, as staff members tell me about their interactions with PWAS, it becomes clear that there is indeed a much deeper understanding of the various cultures of PWAS, and particularly the intersections between Indigenous cultures and street culture. Staff understand that many PWAS have not been raised with a strong connection to their Indigenous backgrounds and refrain from pushing PWAS to connect further unless asked. For many PWAS, AIDS Saskatoon is the first point of contact to learn about their Indigenous background, both through formal supports provided in the agency and informal relationships among PWAS in the 601. When I inquire about providing cultural supports, staff member Ashley responds:

I think that that’s a huge piece that a lot of professionals could remember, is that you cannot assume a person’s culture and you can also not assume that they want to be a part of any culture, until they identify that as a need to you.

Staff members, like Ashley, did not usually use the terms cultural competency or cultural safety in interviews unless asked about it specifically. Instead, they described the ways they practice non-judgement, listen, and accept PWAS every day, no matter their circumstances. To
better understand just how culture is operationalized at AIDS Saskatoon on an individual level, it is imperative to further explore the relationships between staff and PWAS in the agency.

3.4.1 Individual Staff-PWAS Relationships

Existing research on cultural competency is largely focused on the interactions between the service provider and the individual accessing services. However, the relationships addressed in the literature are most often between patient and doctor, or client and social worker. They tend to be shorter-term interactions. The relationships between staff and PWAS at AIDS Saskatoon differs from this. Relationships are often longer-term and often more casual. One staff member, Amber, describes it as being the “good guys”, as staff are not there to apprehend children, to act as law enforcement, or to judge individuals on their lifestyles. The agency prides itself on being low-barrier. Individuals are able to access services no matter their current situation.

Examining relationships between staff and PWAS at AIDS Saskatoon is essential to understanding the success of cultural competency and cultural safety strategies within the agency. I asked PWAS to describe their relationship with staff and asked staff to describe their relationship with PWAS. This question elicited a variety of responses, most of which were positive. The themes of belonging, trust, and non-judgment come up frequently throughout interviews from the perspective of both staff and PWAS. Communication is centered on respect and dignity. As Adam explains, “we take them to that next step, but then we never judge them for taking three steps back or going right back to the beginning”. Several PWAS confirm this; explaining that they continue to return to AIDS Saskatoon for support, rather than other local NGOs that offer similar services, because they do not feel judged or “preached to” by staff members. One staff member, Allison, sums up why an individual approach to cultural competency has been essential to relationship building in the agency:

You know, everybody has got a story and everyone here has done some really neat things so, a lot of what I’ve learned is just really listening to everybody’s story and treating everybody like the individual that they
are... And really taking it down to just an individual idea of care versus we treat groups of people a certain way.

In the above passage, Allison’s words reflect back to Taylor’s (2003) pertinent question: no matter how one defines culture, should importance not be placed on how the individual understands and thinks about their own culture? Of course, a focus solely on how an individual is able to articulate their culture is problematic. As participants speak to the cultural contexts they navigate daily, they are also describing political processes and claims to identity. And while claims to identity may seem fixed, they rarely are.

Mattingly (2008, 138) suggests an emphasis on narrative mind reading, in which the motives that underlie the actions of another are inferred, as a strategy that takes into account cultural sense making that places action within an unfolding story and helps to construct shared narratives. Staff are aware that different individuals both require and desire different styles and levels of support and by listening to the narrative of the individual, and “shattering” the static race and ethnicity-based notions of culture that dominate cultural competency frameworks, they are able to avoid making identity-based assumptions about certain groups and focus on the agency of PWAS to ask for the support they need.

Mattingly (2008) contends narrative mind reading becomes possible when the actors involved draw on shared cultural scripts. Having knowledge, and for some, first-hand experience of Indigenous cultures and street culture enables staff to provide PWAS with these supports or refer them to someone who can. This includes things like access to Elders, rides to sweats, pow wows, and daily smudging practices in the 601, but it also includes advocacy with landlords and doctors, support to begin the methadone program, the provision of clean needles, and education on HIV and HCV treatment options. The “individual idea of care” Allison speaks to not only ultimately empowers PWAS to make the best decisions regarding their own health and well being, but also to regain a sense of dignity and control over their lives.
I argue that staff at AIDS Saskatoon practice cultural competency through the lens of harm reduction, on both an individual and collective level. Harm reduction, which refers to policies, programs, and philosophies that aim to reduce the negative impacts associated with drug use and drug policy in the agency takes on multiple forms. It includes initiatives like the agency’s needle exchange program but also the overarching philosophy that guides the relationships between staff and PWAS (Canadian Nurses Association 2018). The phrase “meeting people where they are at” was used often by staff when describing interactions with PWAS. This mandate is popular in harm reduction philosophy and denotes a commitment to the avoidance of stigmatizing language and judgment when working with people who use drugs or are HIV positive (Harm Reduction International 2020).

This phrase fits into the agency’s approach to care and further, into their individualistic approach to cultural competency. For Adam, harm reduction philosophy goes hand-in-hand when working with Indigenous and street-involved people, as autonomy is a central component to this approach. When asked what AIDS Saskatoon does best when it comes to working with these populations, Adam responds:

We listen to people, so when they come in and they say they need support on one thing, that tends to be what we try to find them support in. Now if someone comes in and they clearly need to go to emerg(ency), we’re going to try to get them to emerg(ency). But, we try to support people with what they identify as being the need. And we are fairly successful at that.

Above, Adam expresses what it means to him to “meet people where they are at”. Allowing individuals to identify their own needs is important practice for staff. This can mean helping to fulfil basic needs like food and housing, connecting individuals to cultural practices like sweats and smudges, creating safety plans for families, or when they are not able to meet the specific needs of the individual, referring them to an agency who can. For PWAS living with HIV, AIDS, or HCV, it means allowing the individual to decide when they are ready to enter into treatment.
By creating space for individuals to forge their own path, the notions of vulnerability and “at-risk” populations, which often serve to further stigmatize, marginalize, and criminalize groups of people, can be challenged. This is not to say that vulnerability does not exist for PWAS, as the marginalization of Indigenous and street-involved people is both real and pervasive in the lives of participants. However, the terms can serve to erase the stories and experiences of resilience I heard and witnessed almost daily. In their ethnographic study in a needle-exchange and drop-in centre in a Midwestern city, Gowan et al. (2012, 1258) conclude that promoting individual autonomy can help to “create the preconditions for claims to social citizenship”, which includes the right to economic welfare, security, and social heritage, without instilling discourses of “responsibization”. The authors (2012, 1257) contend that by extending opportunities for individuals to make their own decisions regarding appropriate care, harm reduction “lends users the legitimacy to demand fair treatment, resources, information, and access to treatment alternatives, pushing back against decisions usually controlled by medical professionals or legal authorities”.

3.5 Conclusion

In this chapter, I explore how PWAS and staff identify individually with the concept of culture and further, how staff at AIDS Saskatoon use these understandings to operationalize cultural competency in the agency through the lens of harm reduction strategies that center individual experience and perspective. For staff, learning about different Indigenous histories, ceremonies, and traditions, along with the ins and outs of street culture is important, but even more important than that is connecting to individual stories and “meeting people where they are at”. Staff are acutely aware that individuals identify with culture on a multitude of levels and that to fully understand the support that an individual may need, you sometimes just have to ask.

While there is little research that prioritizes individual constructions of culture in cultural competency strategies, it is clear from the stories and perspectives told by PWAS why it needs to be taken into consideration. Staff and PWAS at AIDS Saskatoon are probably not aware that they are “shattering culture”, but in their day-to-day actions at the agency, they re-imagine the operationalization of culture in cultural competency and cultural safety frameworks. By seeking
out individual stories and perspectives, the concept of culture takes on new meaning and significance in the lives of PWAS.
I quickly fall into routine during my mornings at AIDS Saskatoon: brew coffee, photocopy the daily crossword puzzle from the local paper, discuss current events and the weather with regulars as they trickle in. Around lunch time, the space tends to fill up with more unfamiliar faces, children running around, and often a chaotic energy. But mornings are consistent and offer me deeper insight into the tight-knit community and culture that has emerged in the space.

The 601 Drop-In Centre located in AIDS Saskatoon is a safe and welcoming space that has over time become a popular and essential community gathering spot in the Mayfair area of Saskatoon. Over the years, a distinct culture has emerged in the centre. In the early days of my fieldwork, I began to notice shared values, beliefs, and experiences among PWAS. It is not merely the geographic location that regularly brings people to the 601, it is the warm atmosphere, familiar faces, unwavering support from staff and peers, and this shared culture. Delvecchio Good and Hannah (2015, 212) remind us that culture manifests on multiple levels – “in the unique lived experience of individuals, in the historical legacies of particular ethnic and racial groups, and in the emergent cultures that develop within institutional settings.” In this chapter, I shift away from individual understandings of culture and towards the collective culture that has established within the 601 and informs cultural competency and cultural safety strategies in the agency.

To further explore the importance of taking into account this collective culture, I begin with an examination of Dressler’s (2012) concept of cultural consonance and its relevance in this particular context. I argue that PWAS negotiate multiple cultural models and in turn, cultural behaviour often aligns with a shared 601 cultural model. I explore these distinct shared cultures that have developed at AIDS Saskatoon over time, particularly in the 601 Drop-In Centre and among staff in the agency. Next, using the concept of cultural consonance to guide the discussion and providing specific examples from the agency, I examine how staff at AIDS Saskatoon have
applied these understandings to operationalize culture as a dynamic and fluid concept that positions cultural competency and cultural safety as process models of learning, rather than fixed sets of skills. I conclude the chapter by arguing that the success of AIDS Saskatoon’s approach to cultural competency and cultural safety is predicated on the agency’s ability to integrate more nuanced cultural knowledge into innovative and effective policies, programming, and practices that increase cultural consonance and result in better health outcomes.

4.1 Applying Cultural Consonance

While semi-structured interviews with PWAS and staff at AIDS Saskatoon provided me with valuable insight into how individuals conceptualize their own cultural models and further connect them to their health and well being, my time spent conducting participant observation in the 601 Drop-In Centre often told alternate sides to their stories. My observations highlight the need to further understand how culture manifests on a collective level within the agency. Dressler (2015) draws on Bourdieu (1984) to argue that people do not only think things, they also do things. For PWAS, the relationship between cultural knowledge and cultural behaviour often includes an array of inconsistencies and conflicts as they negotiate multiple cultural domains in their lives. To better understand how staff make sense of this, particularly in regard to making health related decisions, I turn to the concept of cultural consonance.

Cultural consonance refers to “the degree to which individuals, in their own beliefs and behaviors, approximate prototypes for belief and behaviour encoded in shared cultural models” (Dressler 2015:1). Dressler develops the concept to encourage researchers to consider culture and its impact on health behaviours throughout the illness experience. The concept offers anthropologists and health researchers a means to connect knowledge and behaviour, identifying conflicts between cultural models and how individuals attempt to perform these models in their day-to-day lives. An individual’s “degree of consonance, or social conformity, serves to locate that individual within the multidimensional space of their community” (Degnah et al. 2019, 444).

To determine cultural consonance, Dressler uses cultural domain analysis, in which individuals use pile sorting methods to determine important cultural categories. In his research in urban Brazil in the early 2000s, Dressler (2012) and his colleagues determine that low cultural
consonance, in which individual cultural knowledge and individual behaviour contradict one another, results in poorer health outcomes. Similarly, Copeland’s (2017) use of Dressler’s methodologies with HIV positive women in Kenya finds that high cultural consonance, where shared cultural knowledge is aligned with behaviour regarding the self-management of HIV/AIDS, produces the best health outcomes. Copeland (2017) suggests anthropological research has repeatedly shown that health interventions fail when cultural context is not taken into consideration. Gauging the degree of cultural consonance in the delivery and access of HIV-specific services is important to ensuring safe and effective response to the HIV epidemic in Saskatchewan. I depart methodologically from Dressler’s approach to cultural consonance, but I rely on the concept to explore how AIDS Saskatoon staff and PWAS navigate the cultural terrains of Indigeneity and the 601. While my use of consonance relies on notions of cultural consensus, in which the precise contents of a cultural model are shared, it further examines the extent to which participants align themselves in consonance with a shared understanding of culture.

Cultural consonance converged in several cultural domains for PWAS regarding what is necessary to attaining individual health and well being, including social supports, culturally appropriate services and treatments, access to basic needs (housing, employment, food), and respect from the larger community. PWAS shared knowledge of behaviours understood to be “healthy” and contribute to overall well being. On several occasions in the 601, however, I observed a noticeable disconnect between what PWAS shared with me in private interviews and in their observable action. While PWAS shared anecdotal stories about the use of traditional Indigenous medicines and ways of knowing, proper HIV or HCV management, and the safe use of illicit drugs, their behaviour did not always reflect this knowledge and could point to a low level of cultural consonance. However, interpreting an abstract understanding of culture in interviews to observed behaviour is problematic.

There is, of course, much that anthropologists can contribute to understanding the complexity of how people position themselves in their local worlds. Behaviours are not always consistent with principles and values of health and well being. Identities shift. Personal and community priorities are re-ordered almost every day. Daily activities of survival and subsistence are prioritized by PWAS, while long term health goals tend to fall short. Dressler et
al.’s (2017) findings indicate that greater economic resources contribute to higher cultural consonance. Dressler et al. (2017, 59) suggest “realizing consonance in all these domains truly is a goal, but one that can only be achieved with difficulty, and hence only partially, by most people”.

Through all this complexity is the stability that AIDS Saskatoon, as a place and service, offers. Staff are acutely aware of the shifting identities and priorities of PWAS and actively work to provide education and support that takes into account the unique cultural context of the space and the barriers PWAS face that prevent them from achieving their goals. Education developed in the 601 includes sharing knowledge regarding the prevention and management of HIV, AIDS, HCV and addiction, safe sex practices, and the safe use and consumption of illicit drugs. It also includes providing Indigenous cultural supports when requested. When speaking to how the agency implements programming, staff member Adam tells me that “it’s not based off judgment, it’s based off trying to support people and realizing people know when they made a mistake, people know the decisions they’re making which are unhealthy. They’re making them for reasons beyond our control”. Therefore, developing cultural competency and cultural safety strategies at AIDS Saskatoon requires staff to understand and prioritize the 601 culture that has emerged in the drop-in space that often transcends individualized understandings of culture to determine everyday action. In doing so, staff are able to create the conditions necessary for PWAS to align cultural knowledge and behaviour.

One particular story illustrates how staff navigate the unique challenges of providing culturally competent and safe support especially well. Early in the summer, I was invited to attend the peer support group that met weekly in the space on Tuesday nights. The group was small, comprised of a few familiar faces I had met in the drop-in centre already and was led by a peer support worker. As the group settled in, a hot meal was served, and a few informational handouts were distributed. I was surprised to find myself reading an academic journal article about new HCV research, filled with medical terminology and jargon. Without a medical background, I could not make sense of much of the information presented, so I waited to see how the rest of the group would respond. The peer support worker began reading directly from the article, but interest from the group quickly waned and the conversation shifted directions. Soon, members of the group were discussing their daily struggles with HIV and HCV, drug use,
unreliable landlords, and the challenges of parenting and acting as caregivers. Members of the group offered some advice, but mostly just an ear to listen and an understanding nod. During this time, Adam’s words rang particularly true; PWAS were aware of the implications of drug use and not adhering to HIV and HCV medication on their health and well being.

I was struck by the events of the meeting. What began as a formal space to discuss new illness-specific information quickly shifted to a more informal gathering where PWAS shared their personal experiences, illness-related or not, and a hot meal. The conversations were personal and raw, illustrating the clear sense of acceptance and safety felt by those in attendance. I initially wondered if there was a disconnect between the peer support worker who began the meeting with the biomedical, jargon-filled article and those attending the meeting regarding cultural and health-related knowledge and decision-making, but quickly determined this was not the case. Rather, this was a way for individuals in the group to settle in, get comfortable, and the starting point for many personal and educational conversations. While the peer support worker first framed health through a biomedical lens of HCV treatment and management, the conversation soon shifted to encompass a holistic understanding of health that focused on the social aspects that determine day-to-day health choices and barriers to care. Opening up these broader conversations allowed PWAS to determine relevant topics to discuss, to define their needs, and for staff to discover cultural similarities and differences among an array of cultural domains.

I use the above story to illustrate how staff navigate what might be considered conflicting cultural models. Further examination shows PWAS negotiate multiple cultural models simultaneously, including Indigenous, street, and dominant Western norms and beliefs. The question of cultural consonance remains, however, “how effectively can people act on these shared understandings?” (Dressler et al. 2015, 223). Dressler et al. (2015) note two reasons why individuals may have low cultural consonance: (1) they choose to be different, or (2) the odds are stacked against them, usually economically. In their study with Utah women, Dengah et al. (2019) find that women who try to live up to two competing cultural models, religious and secular expectations of womanhood, have lower levels of cultural consonance resulting in higher levels of stress and poorer mental well being. Similarly, while PWAS are knowledgeable about both Indigenous and Western cultural values and norms regarding health and well being, their
ability to align their individual behaviour within these models is often constrained by macro social and historical processes that have left them disassociated from their Indigenous backgrounds and marginalized from mainstream society. From my observations, however, I argue while behaviour in the drop-in centre and in the everyday lives of PWAS may sometimes be inconsistent with the individual cultural knowledge shared with me in interviews, it is often in line with the shared cultural knowledge found in the 601 that comes to shape health patterns. The ability of staff to not only understand how health is embedded within the 601 culture but provide support, programming, and practices based on this knowledge is essential to raising levels of cultural consonance and improving the health and well being of PWAS.

4.2 Exploring Emerging Cultures

Insight into the emergent cultures within AIDS Saskatoon offers a more nuanced understanding of how culture comes to inform knowledge of and behaviour regarding health and well being and how the concept of culture can effectively be operationalized in cultural competency and cultural safety strategies within the agency. While Chapter Three offered meaningful discussion in regard to the importance of taking into account the complex and diverse individual understandings of culture to develop support strategies, it is necessary to further understand the emergence of shared cultures in spaces like AIDS Saskatoon in order to inform new skills, processes, and resources that benefit the community as a whole. To do so, I explore the 601 culture and staff culture of the agency.

4.2.1 The 601 Culture

The 601 is located in an old and creaky building, but there is a sense of warmth upon entering the space. The couches are well worn, the vaulted ceiling tiles have been colourfully painted by PWAS, and no matter the time of day, there is always a fresh pot of coffee brewing. It is clear why community members congregate here. I soon recognize the regulars; some quietly drink coffee and do the daily crossword puzzle, some bring in big bags of laundry to wash in the communal washer and dryer, and others meet up with friends for a cup of coffee and lunch. Here,
Wilson’s (2003) concept of therapeutic landscapes is particularly useful, as it is not only in extraordinary spaces that identity and health is shaped, but also in spaces like the 601, where the everyday lives of PWAS play out.

In his interview, Jeff notes that the 601 itself “is like a little culture”. I agree. Warrier (2008, 540) suggests the use of a more critical definition of culture: “shared experiences or commonalities that groups and individuals within groups have developed in relation to changing political and social contexts”. The 601 is a culture embedded within specific political and social contexts and it sets the stage for the interactions and relationships I observed daily in the space. As was discussed in the previous chapter, hybridity is a defining feature of the culture of PWAS at AIDS Saskatoon. Previously, I explored the variance within two broad cultural categories that came up most frequently in interviews: Indigenous cultures and street culture. Regardless, however, of this variance within each category and in the continuum in which individuals understand and connect to their cultures, I observed in the 601 the many ways PWAS share complex cultural model that intertwines the various elements from these two categories and from the dominant Western culture prevalent in the larger Canadian context. While it is necessary to take into account cultural differences among people of the same group, Warrier (2008) also advises that it is equally important to understand the strong affinities among people of different groups.

Shared experiences, values, and beliefs in the space are evident and it was the daily informal conversations in the 601 that shed the most light on the pressing issues PWAS think about: housing instability, food insecurity, daily consumption, run-ins with law enforcement, and instances of marginalization and discrimination. As indicated above, there are undoubtedly some inconsistencies between what PWAS tell me in interviews in reference to cultural knowledge regarding health and well being and in observable daily action and behaviour in the 601 and the outside community. I argue, however, that PWAS negotiate and draw from multiple cultural models that shape their day-to-day lives to best achieve their short-term health and well being needs and goals. In turn, a hybrid cultural model in the 601 has emerged. While several PWAS shared stories about their Indigenous cultures in interviews - including experiences of attending pow wows, beliefs surrounding the Creator, and the use of traditional medicines – the behaviour I observed daily in the drop-in space also overlaps with knowledge from street culture and the values of the larger Canadian society. For PWAS, culture is multidimensional and is enacted in
complementary ways. These cultural models converge in the 601 and shape health patterns. PWAS draw on their Indigeneity, street smarts, and knowledge of dominant Western cultural norms and ideals to inform decisions and behaviour regarding health and well being, often centering around survival and subsistence.

With more than 80 percent of PWAS identifying as Indigenous, it would be remiss to not consider that much of the culture in the 601 can be attributed to a shared urban Indigenous identity. Andersen (2013) suggests urban Indigenous identities are distinct and should be understood as such. While there is plenty of cultural diversity within urban Indigenous communities, Andersen (2013) indicates that urban Indigenous Peoples find attachment to other urban Indigenous Peoples in their city, no matter their individual cultural backgrounds. This is consistent with my findings in the 601, where a community of urban Indigenous PWAS hold space for one another daily. In the previous chapter, I explored the diverse spectrum of how PWAS connect with their Indigeneity individually but also evident in the 601 is that Indigenous PWAS connect on many levels despite any individual cultural differences, particularly as their Indigeneity intersects with other cultural markers, such as class and the shared trauma of colonization.

Non-Indigenous PWAS also strongly connect with Indigenous PWAS when it comes to class markers and the many everyday experiences that shape their lives. The community of PWAS in the drop-in centre live in similar socio-economic situations, experience similar instances of judgement in their day-to-day lives, and despite these hardships, share a sense of dry humour that lifts spirits throughout the space and brings people together. PWAS connect deeply through experiences of disenfranchisement within the city. These experiences further illuminate cultural similarities among a seemingly diverse group of PWAS and enforce a sense of community and solidarity. For example, during the time of this research, the cancellation of the Saskatchewan Transit Corporation (STC) by the provincial government left many PWAS further marginalized. They were unable to travel back to their home communities or in a few cases, to scheduled court dates or appointments in nearby cities. This remained a popular topic of conversation in the 601 throughout the summer, as PWAS lamented and connected over shared frustrations and offered advice to one another when available.
Increasingly evident in my time in the agency is the shared resilience among PWAS in the 601. Outside of the drop-in centre, PWAS are subjected to harassment and institutional discrimination and racism in their daily lives, often intersecting with historical and intergenerational trauma, which remain particularly pertinent in the lives of Indigenous PWAS. However, focusing solely on these barriers that PWAS face, which can result in experiences such as illness and disease, substance use, violence, and housing insecurity, and often lead individuals to utilize spaces like AIDS Saskatoon, can overshadow the resilience and resourcefulness within the community. Critical to this community resilience is the social capital that comes from built relationships within the 601 that benefit the community as a whole. Interactions among PWAS hold great importance. As Jeff tells me: “A guy doesn’t really just have to talk with counselors, sure they’ve got the schooling and stuff but to actually sit down and talk to somebody else that’s been through it all too, it’s nice.” This sentiment is shared by several PWAS throughout interviews and in my daily observations; relationships among peers provide invaluable sources of knowledge and support regarding health, illness, and the body. Jane describes further why it is important for her to have the drop-in centre and the relationships within the space:

The coffee, just to get together and talk with people is big and I had, because I was so sick I wasn’t doing that. I hadn’t done it in years, I had lost touch with a lot of people. And a lot of them, I’ve lost a lot of friends.

This is not to say that the relationships among staff and PWAS are not valued, as the safe space that exists within the walls of the 601 is predicated on relationships of respect and understanding between the two groups.

Drug use in the drop-in centre provides an example of shared cultural knowledge within the 601. While there is little privacy for those accessing the needle exchange, PWAS do not seem to mind. Drug use is not often openly talked about by PWAS in the space, but it is also not judged. There is never a commotion when someone slips away from the common area to use the exchange, but PWAS still choose to keep their visits as discrete as possible. When drug use is
discussed openly, it is often framed in two ways: (1) past use of drugs, or (2) reference to a family member, friend, or acquaintance using drugs.

Early in the summer, I scheduled my first interview with a PWAS, Earl, who I had gotten to know my first few weeks in the drop-in centre. He did not show up at our scheduled time, but I noticed him biking around the neighbourhood. The following day I asked him what had happened. He told me he forgot about the interview, but also that he did not want me to see him “like that”. I came to understand that the “like that” he was referring to is a crystal-meth induced state. This example speaks to knowledge common in the 601 cultural model: individual drug-use is not judged or stigmatized in the centre, but it remains hidden from casual conversations. PWAS are aware not only of the health implications of drug use, but also of the social implications.

More often, discussions around drug use occurred in interviews or more private one-on-one conversations, where PWAS felt more comfortable discussing their habits, struggles with addiction, and other related topics. Several PWAS spoke about the use of crystal methamphetamine in interviews and the destruction it is causing in their community. Only on two occasions did I see an individual nodding in and out of sleep from drug use, as regular PWAS often choose to not enter the drop-in centre high or drunk. Several PWAS pride themselves on this fact and speak poorly of those who do, often describing it as disrespectful. Here, PWAS connect knowledge of an important cultural category to their behaviour. This speaks to an example of a high level of cultural consonance in this particular cultural domain, as PWAS understand the importance of this belief within the 601 and match their actions accordingly.

4.2.2 Staff Culture

The staff at AIDS Saskatoon is made up of individuals from diverse backgrounds. This includes individuals of various cultural backgrounds, ages, and sexual orientations. Their professional and experiential backgrounds are also diverse: social workers, educators, and people with lived experiences of addiction, HIV and HCV, and marginalization. In recent years, there
has been an internal push from management for an increasingly representative workforce to include more staff who are Indigenous, who live with HIV and HCV, and who use drugs. Building a more representative staff over time has been paramount to a shift of culture within the agency and to the continued success of programming. In interviews, several PWAS disclose that they are more comfortable seeking support from Indigenous and HIV or HCV-positive staff members because there is a sense of deeper understanding. For non-Indigenous or HIV and HCV-positive staff, reflecting on their positionality helps to address unequal power structures in personal relationships, policy creation, and program delivery. When I ask staff in interviews what makes them different from PWAS in the agency, several staff directly reference or allude to the privileges they hold.

Regardless of these diverse backgrounds, there undoubtedly is a shared staff culture at AIDS Saskatoon and central to this shared culture is the embodiment of harm reduction philosophies that guide the values of the agency. I will discuss the broader strategies the agency has developed below, but it is important to note that several staff members also refer to an attitude and frame of mind that one must possess to succeed in their respective roles. In several interviews, long-time staff allude to a shift in the staff culture in the agency in more recent years. One staff member, Avery, put it as such: “we went from really crazy co-worker stuff to kind of mellowing out and getting more of an appropriate workplace culture and being more accountable”. Adam mentions his tokenism as one of the only Indigenous staff members when he began in the agency years ago and is happy to have seen a shift over time.

During my time in the agency, I come to recognize the various shared values and beliefs among staff. As staff member, Allison, describes:

[It] comes down to being aware of people, being mindful of people, and their stories, and where they come from. Not assuming that I know more or have the right to make decisions on behalf of another person.

For staff, a high level of cultural consonance is essential to the success of cultural competency and cultural safety strategies. If shared cultural knowledge for staff includes values and beliefs
surrounding non-judgment and open-mindedness, behaviour that aligns with this knowledge must follow. It is critical for staff to build relationships of trust with PWAS and to break down barriers to care. As Adam suggests: “Wherever they’re from, you have to be willing to accept their cultural views and try and support them in whatever decision they’re making.” Further, aligning shared cultural knowledge of the collective 601 culture with programming, policies, and practices at AIDS Saskatoon offers a more nuanced and effective way of operationalizing culture, ultimately leading to higher cultural consonance and better health outcomes.

4.3 Operationalizing “Culture” in Collective Strategies

Just as there is no singular cultural identity that captures PWAS and staff at AIDS Saskatoon, there is no one-size-fits-all cultural competency or cultural safety framework for non-governmental organizations to follow. Instead, staff at AIDS Saskatoon figure out what works for them, often through trial and error and considerable capacity building. Existing frameworks for organizations and institutions working with majority Indigenous populations have often emphasized an essentialist view of culture or as Narayan (2000, 1083) puts it, a “packaged picture of culture”. This essentialist view uses the categories of race and ethnicity to explain differences among groups, leading to the development of lists of group characteristics for service providers to refer to when working with specific populations and interventions and programs that focus solely on these limited interpretations of culture (Warrier 2008). While it may seem as though the obvious departure from these lists is to individualize care and celebrate the open-minded service provider, this can “ultimately reinforce behavioral understandings of culture and draw attention away from social conditions and power differentials that underlie health inequalities” (Jenks 2011, 209).

Instead, challenging these prevailing lists and pictures of culture must involve complex understandings of the historical, political, cultural, and social contexts that blur cultural boundaries within specific communities. Warrier (2008, 541) suggests that “competency has to be developed at both the individual and the institutional level – balancing standardization with flexibility”. This includes continuously building capacity for cultural competency and further developing practices, programming, and policies in the agency that integrate a deeper, more
nuanced understanding of culture. Gilley (2006, 567) asserts that traditional HIV/AIDS prevention strategies fail because they lack “nuanced cultural relevance” and to be effective, cultural knowledge must be integrated into policy, programming, and practice. One staff member, Joanna, put it as such:

Cultural competency doesn’t mean we need to speak Cree, you know, that’s not what that means. It means that we need to make things available and change the way that we do things and change our own behaviours. So cultural competency needs to be active, not passive.

At AIDS Saskatoon, staff operationalize their understandings of the various individualized approaches to culture and the collective 601 culture in cultural competency and cultural safety strategies that seek to best address the needs and values of PWAS in regards to health and well being. I have further broken down these strategies in five categories: (a) examining inequalities and historical injustices, (b) encouraging social citizenship, (c) supporting a holistic model of health and well being, (d) emphasizing safe space, and (e) Indigenizing harm reduction. While I distinguish between these categories for ease of readership, ultimately the intersections among them are strong and should be understood as such.

4.3.1 Examining Inequality and Historical Injustices

Throughout interviews, staff members often spoke at length about Canada’s long history of colonialism that continues to shape Indigenous-settler relationships and perpetuate ongoing structural violence in the lives of Indigenous peoples. Due to the commonness of social work and social science backgrounds, staff are well versed in the Canadian government’s past discriminatory and damaging policies and practices and their effects that remain in the form of trauma and intergenerational trauma, loss of language and connectedness to Indigenous culture, and disproportionate rates of poverty, violence, disease and social ills. Similarly, in their research on decolonizing HIV/AIDS policy for Indigenous women in Canada, Prentice et al. (2018, 238)
emphasize that the impact of HIV/AIDS on Indigenous populations is “fundamentally linked to the cumulative and ongoing impacts of colonialism as a social determinant of health”.

Statistics in Saskatchewan confirm this statement as Indigenous Peoples in Canada are not only disproportionately affected by HIV/AIDS and HCV, but they are also framed as “at risk” or vulnerable to HIV/AIDS and HCV by large governing bodies because of their Indigeneity (Orsini et al. 2018). Individuals are often further placed in these categories due to intravenous drug-use and the uptake of behaviours deemed “risky”. But the use of vulnerable and at risk as identifiers for Indigenous people who use drugs can be a double-edged sword in HIV/AIDS service provision: On one hand, the terms can help NGOs legitimize increased funding and access to resources and act as a societal call-to-action grounded in moral obligations, while on the other hand it can serve to control, further stigmatize, and oppress groups of people deemed vulnerable and at-risk.

In the context of AIDS Saskatoon, staff learn to shape the notion of vulnerability in ways that best fit the needs of PWAS and the agency as a whole, while appreciating the resilience and autonomy of the unique community in the 601. To do this, staff approach care through a trauma-informed lens, which includes recognizing the signs and impact of trauma, integrating knowledge of trauma into policies and practice, and actively working to avoid re-traumatization (Interagency Coalition on AIDS and Development 2019). This can be as simple as maintaining a casual dress code. Staff encourage PWAS to be autonomous in their decision-making, and aid in cultural reclamation when requested, while also educating the larger public on the realities of HIV/AIDS through numerous outreach projects and collaborations in the city and province. This approach illustrates a commitment by staff to move further along the continuum of cultural competency into the realm of cultural safety work that recognizes unequal power structures and the barriers to care arising from them. By working to actively dismantle these structures, staff build relationships of trust and safety with PWAS in the agency.

4.3.2 Encouraging Social Citizenship

The concept of social citizenship, as referenced in the writing of T.H. Marshall (1964), “expanded the meaning of citizenship rights beyond formal legal and political equality to encompass social equality rights” (Matthews and Erickson 2005, 375). While “conventional”
social citizenship rights refer to the entitlement to social welfare services, “new” social citizenship rights guarantee equal opportunity for disadvantaged groups to participate fully in public economic life and to expect respect from others (Matthews and Erickson 2005). As Dressler et al. (2017) suggest, less one is able to present one’s self as having achieved a level of cultural consonance, the less likely one is to be respected and recognized by the larger society. At AIDS Saskatoon, PWAS face multiple intersections of marginalization and discrimination because of Indigeneity, class, and illicit-drug use, that often prevent social citizenship rights from being realized. Jeff told me the story of his friend receiving a ticket for having his dog tied up outside of the agency, while there were two other dogs tied up at what he described as the “yuppie coffee shop” up the street. As Jeff further explains, “if you’re looking poor, like I’ve got dirty clothes on, I get hassled all the time. You’ll get hassled for doing this or doing that, hey?”

However, knowledge of social citizenship rights and their perceived importance in the larger Canadian context is evident in the 601 and PWAS negotiate this cultural domain in various ways. For example, on several occasions, PWAS celebrate 601 community members who have quit using drugs, gained employment, or moved into stable living conditions. One PWAS, Jane, applauds a young mother in the community who only accesses lunch in the 601 at the end of the month when her pay cheque runs out. However, meeting these cultural standards is often unattainable for many PWAS and can result in low cultural consonance and poor health outcomes. Staff at the agency effectively use their knowledge of the 601 culture to provide relevant opportunities, resources, and support for PWAS to imagine what social inclusion could look like in their future.

While PWAS may enter the 601 for the first time to use the needle exchange, access HIV-related support and education, or eat a hot meal, they often return because the support offered extends to encompass a more holistic understanding of health and well being. In their ethnographic study in a needle exchange in a large Midwestern city in the U.S., Gowan et al. (2012, 1254) find that members of the agency’s community develop or renew their sense of social citizenship through a combination of recognition of “systemic sources of harm” and reclamation of self. Gowan et al (2012, 1258) contend for many of the drug users in their study, “coming into contact with the needle exchange marked the first time that they were able to see themselves as having a valid entitlement to social resources”.

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Similarly, at AIDS Saskatoon, PWAS find themselves in the position to reclaim or envision new citizenship rights. This goes beyond the needle exchange to include things such as access to housing, job opportunities, and applying for treaty cards or social assistance programs. Above the coffee station in the 601, several large envelopes are pinned to a cork board on the wall, clearly labeled and filled with government forms for PWAS to easily access. One PWAS, Jeff, tells me that it had been particularly helpful to him and other 601 members when signs had gone up around the drop-in centre educating individuals on the class action lawsuit claims for residential school survivors. Staff recognize and address the many constraints that prevent PWAS from accessing and receiving support, and actively work to provide opportunity for increased social citizenship. In doing so, they encourage PWAS to increase their cultural consonance in this domain, which can ultimately lead to less stress and better health outcomes.

A major consideration for management at AIDS Saskatoon has been employing a representative workforce and offering employment opportunities. This includes hiring staff who are Indigenous, who use drugs, and who live with HIV and Hepatitis C. Part of this commitment includes the Employment Readiness Team, which offers PWAS part time employment in the drop-in centre with the overarching goal of preparing individuals to eventually enter the larger job market. Tasks include helping keep the space clean, serving lunch, and taking daily drop-in statistics. The agency uses a guidebook titled “Harm Reduction at Work: A Guide for Organizations Employing People Who Use Drugs” (Balian and White 2010). The guide explores the benefits of employing people who use drugs and offers a variety of harm reduction policies and strategies for workplaces to adopt. These sorts of opportunities can be few and far between for individuals from disenfranchised communities, and members from the Employment Readiness Team often speak about their jobs with gratefulness and pride.

4.3.3 Supporting a Holistic Model of Health and Well Being

I was struck throughout my fieldwork that in an HIV/AIDS service agency, I spent very little time discussing or even hearing about HIV, AIDS, or HCV. Other than informational posters and pamphlets about HIV and HCV, which can be found around the drop-in space along with many other educational materials, little else marks the space as an AIDS service
organization. In individual interviews, several PWAS spoke freely about their diagnoses, treatments, and experience, but in daily interactions in the 601, these topics were rarely spoken about. Undoubtedly, this is largely in part due to the stigma that surrounds an HIV diagnosis or the perceived temporality of an HCV diagnosis as PWAS await curative treatments. However, it also reflects the needs of PWAS as identified by PWAS themselves. In Chapter Three, I discussed the notion of survival mode, in which individuals find themselves consumed by daily issues of survival with little room to make or act on long term plans regarding their health and well being. Supporting a more holistic model of health and well being in the agency enables staff to integrate this understanding of survival mode and 601 cultural knowledge into daily programming and practices and to provide support that best serves the collective community.

Staff at AIDS Saskatoon support PWAS throughout their HIV and HCV diagnoses, recognizing that there are barriers which prevent PWAS from seeking medical care or adhering to daily medications. One example of this came into fruition one month prior to the start of my fieldwork. A partnership with a local HIV/AIDS hospice resulted in the opening of a transitional apartment complex in the city for individuals living with HIV/AIDS. The Beehive includes eleven units, offering housing and additional support services. This unique collaboration ensures that individuals with HIV are able to live in a stable environment with access to supports that extend beyond HIV medications and physical supports to include mental, emotional, and spiritual components of care.

Within the 601, PWAS are able to not only receive support for HIV, AIDS, and HCV-related questions and issues, but also access housing support, daily meals, cultural programming and support, peer-led groups, the needle-exchange, family support services, and more. Providing a variety of supports that are low-barrier for the community supports a model of care that is holistic in nature and recognizes the distinct needs of people as a whole. With these supports in place, PWAS are able to further focus on long-term health and well being goals and effectively manage their illness.
4.3.4 Emphasizing Safe Spaces

In interviews with both staff and PWAS, the concept of safety and safe space emerged as a central theme. Safety and safe space were described as both the physical space of the 601 and in the relationships among PWAS and staff. Physically, the space is vastly different than the institutionalized appearance of police stations, doctor’s offices, and social service offices in which many PWAS described being in the past. There are no bars on the windows. PWAS are not required to sign in upon entering, and there is little formal surveillance that occurs. The staff member that oversees the drop-in space is a former PWAS and is a respected community member. Several PWAS indicate that they appreciate that there are rarely police officers who enter the space. PWAS are encouraged to get comfortable and interact with one another. One participant, Jeff, describes the 601 as a “sanctuary for people… where they can come and feel safe”. This is in contrast to the general perceptions of the core neighbourhood in which AIDS Saskatoon is located, described often as dangerous and unsafe.

Having a perceived safe space and informal community with which to spend time is important to PWAS as safe spaces are sometimes few and far between, particularly as many PWAS face unstable housing situations and discrimination outside of the 601 based on their race, ethnicity, and class status. Staff member Erin, describes it as such:

I think with everything that’s been going on in the city, people need a safe place to come. Somewhere that’s going to be consistent. Even though this place is constantly changing, I guess it has been consistently safe.

Clearly, maintaining a safe space for all those who enter is important to regular PWAS who have come to rely on the agency to be just that. PWAS trust that the 601 is not only a safe space physically, but that their relationships within the space are safe as well. For staff, this means practicing non-judgement and discretion with PWAS. Staff member Joanna elaborated:
The culture around the 601 is a culture of trust… because people here trust this agency. They trust divulging a lot of personal and sensitive information to our workers, they trust that this is a safe place to come. They trust that… they’re not going to experience any of the kind of the bullshit they experience outside of these doors inside the 601 itself. And I think that that’s something that’s been built over a long, long period of time, and it isn’t something that happened overnight.

This is not to say that the occasional conflict did not occur. Mid-summer, a loud argument erupted in the 601 between two middle-aged male PWAS with whom I had built relationships over the prior month. One man complained that the other had borrowed a trailer from him to move and had not returned it when expected. After a few tense minutes, both the drop-in coordinator and several other PWAS told the men to take the argument outside and the men obliged. While outbursts like this were not common, what was evident in this interaction is the regulation of the space by both staff other PWAS. Staff and PWAS are committed to maintaining a space that is safe to all those who enter. This reveals an alignment of shared cultural knowledge and behaviour among staff and PWAS in the 601 that emphasizes and values safety. High cultural consonance in this domain is reflected in the high return rates of PWAS to the agency to access support and programming.

4.3.5 Indigenizing Harm Reduction

While it is necessary to challenge antiquated definitions of culture and cultural competency that equate the terms with race and ethnicity, Brascoupé and Waters (2009, 9) suggest “cultural safety and cultural competence are key concepts that have practical meaning for Indigenous people”. This appears true at AIDS Saskatoon, where understanding aspects of Indigenous cultures was identified as significant by several staff members in interviews. Many staff members have attended sweats, regularly smudged, and look to continuously educate themselves on cultural practices and meanings. Some have been given the opportunity to learn
and participate in these practices for the first time upon being employed at the agency. Taking part in these experiences allows staff to further strengthen relationships with Indigenous PWAS. During interviews with staff, I asked participants why it might be important to know about different Indigenous cultures. One young staff member, Jackson, describes it as such: “If I educate myself on somebody else’s culture and their history then it will help me make those connections a little bit better.” But attending ceremony and smudging is not the only way staff integrate Indigenous cultures into cultural competency strategies in the agency. Staff integrate Indigenous knowledge and ways of knowing, which often go hand-in-hand with the philosophy of harm reduction, to provide support that is safe, accepting, and includes a holistic understanding of health.

To combine the harm reduction philosophy used in the agency and the commitment to the integration of Indigenous cultures in programming and practice, staff at AIDS Saskatoon have adopted the four-fire model. The model was developed by the Native Youth Sexual Health Network (NYSHN) to move beyond the four pillars model of harm reduction and better serve Indigenous Peoples affected by HIV and AIDS (NYSHN 2016). The four pillars model, which focuses on prevention, treatment, harm reduction, and enforcement, “can sometimes work to uphold colonial ideas of health, power and oppression” (NYSHN 2016, 36). Problematically, interpretations of the four pillars have focused on individual assumptions of risk, rather than systemic realities (NYSHN 2016). In contrast, the four-fire model redefines harm reduction through an Indigenous lens and takes into account ongoing colonial systems and power structures that have left Indigenous peoples at a disadvantage. The four quadrants (pictured below) include: cultural safety, reclamation, self-determination, and sovereignty.
On the ground, staff in the agency seek to implement the four-fire model into their development and delivery of services and in their relationships with PWAS. On the individual level, this includes meeting people where they are at, allowing individuals to make their own decisions based on what is important to them, and creating space for PWAS to reclaim culture. It also includes practices in line with other harm reduction strategies, like providing clean needles, condoms, and access to HIV/AIDS and HCV prevention and treatment information.

During my four months at AIDS Saskatoon, new HIV and HCV resources in Indigenous languages were being developed. This included resources in Cree, Dene and Michif. Several staff discussed the importance of this project for communities in northern Saskatchewan. There was also excitement from senior staff regarding a new condom campaign that would launch in the fall of 2017 in partnership with the Saskatoon Sexual Health Centre. After surveying 86 individuals from four northern communities, six designs with Indigenous languages and jokes were created. These can currently be found distributed not only in the agency, but across the city as well as in 47 northern communities (Monkman 2017). The six designs featured include: “Shacking Up”, “Tipi Creeper”, “Snagging Season”, as well as condoms in Cree, Dene, and Michif languages (Monkman 2017). This ongoing campaign provides a great example of how the agency intertwines harm reduction practices with Indigenous language and humour.

However, Indigenizing harm reduction is more than providing individual and physical supports. The philosophy of harm reduction itself must go much deeper. Adam, explains:
You really gotta be able to dive down into the weeds to truly understand that philosophy, to truly implement that philosophy. Otherwise, it just keeps sneaking back and you start to get judgmental, you start to get burnt out, you know?

Here, Adam establishes why a second level of analysis, one that goes beyond individual relationships, practices, and understandings of culture, must take place. The four-fire model urges service providers to guide and practice harm reduction in a way that recognizes the often overlapping needs and knowledge of Indigenous Peoples and injection drug users, the effects of colonialism on a systemic level, and power relations that dictate every day interactions. This deeper level of understanding encourages service providers to interrogate larger structural issues that shape the lives of 601 community members and impede access to basic needs, medications, and support.

Utilizing the model in the agency involves integrating the physical, mental, emotional and spiritual pieces of the medicine wheel and creating the conditions necessary for communities to be well. It includes creating inclusive spaces that recognize both the similarities and differences within the community and offering practices and programming grounded in both western and Indigenous cultures, recognizing that one or the other is not always sufficient. For example, many PWAS were raised with traditional Christian teachings and continue to seek supports that are faith-based, while others seek traditional Indigenous cultural teachings and practices, and some seek no cultural teachings at all. Further, meeting the needs of this diverse community involves building a representative staff and developing programs that are community, Indigenous, and peer-led.

4.4 Conclusion

In this chapter, I examined the collective cultures that have emerged at AIDS Saskatoon and have come to inform cultural competency strategies in the agency. Using the concept of cultural consonance while examining both the 601 and staff cultures provided insight into the beliefs and values of both PWAS and staff and further, how staff understand these beliefs and
values when creating and adapting policies and programming in the agency. While there is no one-size-fits-all framework for cultural competency or cultural safety to follow, staff at AIDS Saskatoon have operationalized a fluid and dynamic understanding of the distinct 601 culture to develop a number of useful strategies that ultimately allow PWAS to achieve a higher level of cultural consonance and better health outcomes.

Inserting culture, particularly pan-Indigenous notions of culture, into programming and strategies does little to support the complex and diverse cultural identities apparent in spaces like AIDS Saskatoon. Instead, a more nuanced understanding of culture, one in which the cultural, historical, political, and social landscapes that influence day-to-day life for PWAS in Saskatoon’s inner city, must be operationalized. By recognizing the unique traits of the culture that has emerged in the 601, AIDS Saskatoon is able to develop cultural competency and cultural safety strategies that benefit the community as a whole.
CHAPTER FIVE: CONCLUSION

In this thesis, I examine the two distinct ways in which staff at AIDS Saskatoon operationalize culture in cultural competency and cultural safety strategies used in the agency: (1) through the individual constructions of culture that inform relationships between staff and PWAS, and (2) through the shared 601 culture that has emerged over time in the space. By operationalizing culture in both ways, an effective framework for cultural competency and cultural safety has been developed over time in the organization. Using the strategies discussed in Chapter Three and Four, staff effectively build relationships with PWAS that are grounded in feelings of trust and belonging and help to establish higher levels of cultural consonance through strategies that enable PWAS to act on the vast cultural knowledge within the 601 in regards to their health and well being.

Situating this thesis within the framework of critical-interpretive medical anthropology, I argue that to practice cultural competency and cultural safety in ways that benefit PWAS most, a broader understanding of the macro political-economic forces that necessitate the use of and shape frameworks in NGOs such as AIDS Saskatoon must exist. Situating individual experiences within macro-social processes is imperative as the lives of PWAS whom I interviewed at the 601 are heavily shaped by social and historical conditions that have left many of them at a disadvantage. Furthermore, Lock and Scheper-Hughes (1996) concept of ‘embodied personhood’ allowed me to explore “rebellious and ‘anarchic’ bodies (41) and how this non-conformity shapes knowledge of health, illness, and the body that can be at odds with the broader values of society. My findings indicate that PWAS negotiate multiple cultural models within the 601 and developing a cultural safety framework that recognizes this is essential to break down barriers to care and ensure better health outcomes.

While previous anthropological research on cultural competency has criticized the use of generalizations and the reduction of culture to a learnt skill, the importance of considering culture in service provision is evident throughout this project. While anthropologists must continue to provide much needed critiques of cultural competency and the misuse of the concept of culture in health systems, ignoring the value of operationalizing culture to create more equitable health practices would be careless. Both staff and PWAS see benefit in programming
and practices that recognize the cultures that exist within the 601. Indigenous PWAS, in particular, expressed interest in increased programming that underscores Indigenous values and practices. Also evident, however, is that there is no one-size-fits-all approach to cultural competency and cultural safety in service provision. Existing frameworks and strategies are taken into consideration but are modified by staff to better reflect the lived realities of PWAS. Over time, AIDS Saskatoon has crafted an approach that is unique and effective. It includes incorporating lessons from harm reduction and Indigenous-led approaches to care and “meeting people where they are at”. While the term cultural competency is used by management and found throughout the AIDS Saskatoon handbook, I argue that strategies in the agency fall more under the category of cultural safety, as staff recognize and actively work to challenge existent unequal power structures.

Undoubtedly, there are challenges to practicing cultural safety that staff in the agency face. In interviews with staff, it was apparent that the concept of culture can be difficult to both define and navigate when working with PWAS and developing new policies and programming. The role of culture in HIV/AIDS and HCV service provision is not always explicit, particularly as synergistic interactions with addiction, homelessness, and food insecurity come to define the daily experiences of PWAS. In Chapter Three I examine why that is. Several staff repeatedly told me that what they had learned in the classroom about culture did not always translate to the various situations in which they found themselves with PWAS. Throughout the many hours I spent interviewing and observing PWAS in the 601, what became abundantly clear is the fluidity and hybridity of culture for PWAS. PWAS often occupy multiple cultural identities, do not fit into common characteristics associated with particular cultural groups, and have fluid understandings and practices of culture that change over time. For these reasons, Delvecchio Good and Hannah’s (2015) concept of shattering culture was particularly useful. Staff at AIDS Saskatoon recognize that static and simplified understandings of culture are unable to capture the diverse cultural identities they encounter daily. Instead, they seek to “meet people where they are at” and approach each situation with an open and non-judgmental mind, particularly as PWAS navigate their decisions in survival mode.

It would be careless, however, to solely take an individualistic approach in the agency and to ignore the distinct culture that has emerged in both the drop-in centre and with staff. Jenks
(2011, 212) warns that doing so can “ultimately reinforce a depoliticized understanding of cultural differences”. PWAS negotiate overlapping cultural domains that are informed by knowledge of Indigenous, street, and dominant Western cultures and navigate shared experiences of marginalization that result from oppressive power systems. The diverse ways these cultural domains and experiences overlap has resulted in what I refer to as the 601 culture. The 601 is a safe space for PWAS to learn from and share with one another over coffee and a hot lunch. Several PWAS expressed the value they placed on learning from other PWAS personal experiences with illness, addiction, safe drug use, and homelessness and in their relationships with staff.

On several occasions, behaviour I observed in the 601 was inconsistent with how PWAS described their cultural heritage and its relation to their health and well being in interviews. While many PWAS spoke to their Indigenous cultural knowledge in interviews, my daily observations were more consistent with street cultural knowledge that prioritizes strategies of survival and subsistence. To further explore this, in Chapter Four I drew on Dressler’s (2012) concept of cultural consonance to discuss how staff understand and develop strategies that prioritize shared cultural knowledge and behaviour. It is worth noting that while the inconsistencies I observed may initially point to low cultural consonance, I came to understand that the actions of PWAS were very much in line with the fluidity and uniqueness of the 601 culture. As PWAS begin to frequent the space regularly, shared knowledge and behaviour becomes increasingly evident. Shared 601 cultural domains inform the beliefs, values, and decisions made by PWAS every day regarding health and well being. Staff are well aware of this and have developed numerous strategies and practices with this mind, enabling PWAS to raise their level of cultural consonance and achieve both short and long-term health goals.

This project contributes to academic literature in the following ways. First, it explores the use of cultural competency and cultural safety in an NGO-specific setting. While NGOs provide vital services for people living with HIV/AIDS and HCV, their role has been overlooked in cultural competency research. The relationship between service provider and PWAS in NGO settings is often instrumental as people living with HIV/AIDS and HCV navigate medical decision-making and the use of healthcare and social services. Second, while there is plenty of research on cultural competency and cultural safety, few studies have explored the unique ways
that individuals understand their own culture and the implications of these understandings on health and well being. This research illustrates the importance of taking into account the diverse and individualized ways PWAS connect with their cultures in service provision. Third, this research also focuses on the significance of the emergent cultures found within AIDS Saskatoon and the roles they play in developing culturally safe policy, programming and practices. Finally, this research contributes to ongoing efforts in Saskatchewan to address health disparities in urban Indigenous populations, particularly disproportionate rates of HIV/AIDS and HCV.

Outside of academia, this research can be used by AIDS Saskatoon in several ways. Prior to beginning this project, the Executive Director of AIDS Saskatoon requested that findings from this research be outlined in a document for the agency to utilize in the future. Results can be used in grant proposals to highlight to funders the need for increased cultural programming and harm reduction services in the organization that are tailored specifically to the needs of PWAS, as identified by PWAS themselves. Additionally, while my research indicated that staff have a fairly high level of understanding of the various cultures present in the agency, it can further inform staff in the agency of the cultural beliefs, values, and viewpoints of PWAS and lead to the development of subsequent policies, programming, and practices. The AIDS Saskatoon manual uses the term cultural competency several times, however both cultural competency and culture are not clearly defined. This research can aid in developing a more comprehensive definition of these terms and how they are operationalized in the organization. Lastly, this research highlights the intersections of cultures within the agency, including Indigenous cultures, street culture, and the emergent 601 culture, and this knowledge can further inform staff interaction and relationship-building with PWAS.

Moving forward, there remains space for further research in this area to occur. The interview process was framed around individual understandings of culture, which resulted in the majority of PWAS describing their Indigenous backgrounds or their connection to street cultures. Further examination of the role gender and sexuality play in these constructions of culture would be beneficial. Additionally, while the majority of PWAS who participated in interviews appeared to be between the ages of 35 and 50, the 601 was also a popular gathering spot for young people under the age of 30. To fully grasp how culture is first understood and then operationalized, additional research with this age group needs to be conducted. Finally, as argued by Jenks
(2011), an area that requires attention in anthropological research on cultural competency is how health care professionals and service providers learn and negotiate culturally competency. While the initial conception of this project was to follow staff as they attended cultural competency workshops, budgetary restrictions and management turnover altered this plan. My interviews with staff at the agency indicated that while the majority of staff had clear understandings of Indigenous cultures, street culture, and the intersections between the two, there remains room for further reflection on the part of staff on their own culture, positionality, and power in order to fully embrace cultural safety.

Much has changed in the few short years since I conducted field work in the 601 Drop-In Centre. In 2019, AIDS Saskatoon moved approximately fifteen blocks south, from Mayfair to Pleasant Hill. Along with this change in location, the agency was approved to house the province’s first supervised injection site, set to open in late 2020. While many of the services provided in the agency have remained the same, there have been changes. For example, while the new space still hosts a daily drop-in centre, the food programming has been discontinued, as several other non-profits in the area fill this need. Many of the staff with whom I worked with during this research have moved on from the agency and with the change in location, I imagine there are many new PWAS who now frequent the space. However, Saskatchewan’s HIV rates remain the highest in Canada, injection drug use is still the primary sources of transmission, and Indigenous peoples remain disproportionately affected. AIDS Saskatoon continues to be at the forefront of the epidemic in the province and remains committed to providing services that are rooted in harm reduction principles.

As I note earlier in this thesis, according to Jenks (2011), medical anthropologists can play a vital role in developing a health system that is increasingly culturally competent and I further argue, culturally safe. For meaningful change to occur, the voices of marginalized communities must be at the forefront of research, and anthropologists are uniquely situated to make this happen. Anthropologists are able to build strong rapport with the communities in which we work and amplify voices that are often left out of the conversation. In the introduction to this thesis, I note that there is a pertinent gap in cultural competency research in regard to how culture is defined. Partnering with NGOs like AIDS Saskatoon opens up broader conversations
regarding the meaning and role of culture and expands understanding of how practicing cultural competency and cultural safety can look.
REFERENCE LIST


Ball, Jessica. 2009. Cultural safety in health care for Aboriginal Peoples. Presentations to the British Columbia Public Health Services Authority and Vancouver Coastal Health Authority. Fall, Vancouver.


DelVecchio Good, Mary-Jo and Seth Donal Hannah. 2015. “‘Shattering culture’: Perspectives on cultural competence and evidence-based practice in mental health services”. Transcultural Psychiatry 52, no. 2: 198-221.


Hatala, Andrew R., Kelley Bird-Naytowhow, Tamara Pearl, Jen Peterson, Sugandhi del Canto, Eddie Rooke, Stryker Calvez, Ryan Meili, Michael Schwandt, Jason Mercredi and Patti.
208. “Being and Becoming a Helper: Illness Disclosure and Identity Transformations among Indigenous People Living With HIV or AIDS in Saskatoon, Saskatchewan”. Qualitative Health Research 28, no. 7: 1099-1111.


Monaghan, Paul F., Carol A. Bryant and Julie A. Baldwin. 2008. “Using Community-Based Prevention Marketing to Improve Farm Worker Safety”. Social Marketing Quarterly 14, no. 4: 71-87.


Waldram, James, D. Ann Herring, T. Kue Young. 2006. Aboriginal Health in Canada: Historical, Cultural, and Epidemiological Perspectives. Toronto: University of Toronto Press.


APPENDIX: INTERVIEW GUIDE

For Staff:
How would you define culture?
- How do you identify with your own culture?
- How would you identify with the culture of those who access AIDS Saskatoon’s services?

What have you learned about Aboriginal cultures working at AIDS Saskatoon?
- How does this knowledge change the way you do your job?
- To what extent is an understanding of culture important to your work?

Currently, how often do you accommodate the cultural influences of the PWAS when developing and providing services?
- How do you accommodate these culture influences? Can you provide examples?

What was the most beneficial thing you have learned about cultural competency?
- How have you translate this into your everyday practices?
- Have individuals accessing services responded to changes?

In the future, how often do you foresee a need to accommodate the culture influences on the PWAS when developing and providing services?

For PWAS:
How long have you been coming to the 601?
- How many times a week do you drop in?
- What services have you used at the 601?
- Do you feel both comfortable and safe at the 601?

How would you define culture?
- How do you identify with your own culture?
- Do you think the 601 is a culturally diverse space?

How important is your culture when managing your health?
- Can you provide any examples?
Can you describe your relationship with the staff at the 601?

- Do you feel like they take into account your culture?
- How often do you feel the staff is/is not taking into account your culture?
- How do you react when this happens?

How important is it at AIDS Saskatoon for the staff to understand and take into account different cultures, including your own?