Barriers to Culturally Safe Care for Indigenous Peoples: A Key Informant Perspective

by

Ashley Victoria Mary Wilkinson

A thesis

presented to Lakehead University

in fulfillment of the

thesis requirement for the degree of

Master of Health Sciences

With Specialization in Indigenous & Northern Health

Thunder Bay, Ontario, Canada

September 2021

Author's Declaration

I hereby declare that I am the sole author of this thesis.

This is a true copy of the thesis, including any required final revisions, as accepted by my examiners.

I understand that my thesis may be made electronically available to the public.

Abstract

Health inequity for Indigenous Peoples persists on a global scale, due to the ongoing impacts of colonization. Racism, power dynamics, and health professionals with limited understanding of the historical context and lived realities of Indigenous Peoples are among the many factors which create unsafe spaces in health care environments (Turpel et al., 2020; Browne, 2017; Jacklin et al., 2017; Goodman et al., 2017). These unsafe spaces foster unsafe care which undermines the quality of care that Indigenous Peoples receive, with detrimental outcomes. Cultural safety is a health concept originating in New Zealand (and adopted in many other countries such as Australia and Canada) that emphasizes provider reflexivity, facilitates care that is free from discrimination, racism and prejudice, and empowers Indigenous patients to define the quality of the care they receive. There is a growing body of research which suggests that culturally safe care could have a meaningful impact on health experiences of Indigenous Peoples when embedded into practice (Churchill et al., 2020), and supports the idea of cultural safety being incorporated into healthcare environments (Goodman et al., 2017; Wesche, 2013; Schill & Caxaj, 2019). However, cultural safety has not been widely implemented at an organizational or systemic level within the health sector, and remains absent from health policy, despite calls for its implementation (Truth and Reconciliation Commission, 2015).

This research seeks to understand barriers and facilitators to the implementation of culturally safe care in Canada and Aotearoa/New Zealand and provide recommendations. It asks: What are the barriers and facilitators to providing culturally safe care for Indigenous peoples? To answer this question, purposeful and snowball sampling (Creswell & Poth, 2017) were used to conduct in-depth, semi-structured interviews (n = 14), with key informants in both countries. The main inclusion criterion was experience in cultural safety, and as such, Indigenous and non-

Indigenous participants from a range of backgrounds were included. Findings from thematic analysis included barriers, facilitators, and recommendations & strategies for change. Barriers centered around three themes: 1) organizational barriers, 2) systemic barriers and 3) implementation of cultural safety. Key issues within these themes identified by key informants included systemic racism, lack of organizational accountability and/or buy-in, ineffective health provider education, funding, health system structure, undervaluing Indigenous knowledges, negative framing, lack of understanding of the historical/social/political context experienced by Indigenous Peoples, power, terminology, and changes to the concept of cultural safety over time. The main facilitators identified by key informants also centered around three themes including: 1) working in relationship, 2) organizational commitment, and 3) valuing Indigenous Peoples. Recommendations centered around service delivery, changes to health care provider education, and health frameworks that align with Indigenous worldviews. Findings from this study point to the fact that barriers to culturally safe care exist at every level and require a whole-of-systems approach which prioritize equity and incorporate Indigenous knowledges, to provide culturally safe care for Indigenous Peoples, and advance Indigenous health equity.

Acknowledgements

This research project represents an incredible achievement, the culmination of many new learning experiences, and a piece of work that I am immensely proud of. However, it isn’t something that I could have accomplished without a tremendous amount of support. Therefore, I would like to recognize some of the many people who helped make this project a reality.

First and foremost, I would like to thank my supervisor, Dr. Rebecca Schiff. From the moment I approached you to be my supervisor, I knew you were the right choice for me. You’ve believed in me, encouraged me (even as my project pushed the boundaries of feasibility), and always been there when I needed you most. Without your support I wouldn’t be where I am today, and I’m very grateful.

To my committee members Dr. Lana Ray and Dr. Helle Møller, I would like to extend my sincere appreciation for your guidance, time, and commitment. Your contributions have helped shape this project into a piece of work that I hope will be meaningful to many.

To my committee member Dr. Jacquie Kidd, I would like to say thank you for taking a chance on me and accepting a request from a student on the other side of the world. Your continued support has been incredible, and I can’t thank you enough for the opportunity.

To my incredible colleague Crystal Hardy, I would like to thank you for everything you’ve done for me. Whether it was making time for brainstorming sessions, lending a compassionate ear, or challenging me to grow as a person, you’ve had an incredible impact and I’m so grateful. I look forward to continuing our academic journey together, and hopefully one day returning all of the support you gave to me.

To the professors throughout my journey who’ve inspired me to pursue my goals, Dr. Carolynn Pietrangeli, Sakoieta Widrick, and Lyn Trudeau, I would like to say thank you for encouraging me, broadening my perspective, and setting me on this path. I look forward to continuing this work and sharing it with all of you.

To all of the family members who’ve supported me, I can’t say enough how much I appreciate each of you. All of your love and encouragement has meant the world, and this achievement wouldn’t have been possible without you.

Lastly, thank you to all of the study participants. Without your important contributions, this work would not exist. The insights you’ve shared have expanded my perspective and will be something I carry with me throughout my journey.

Table of Contents

Chapter 1: Introduction & Overview

Introduction

Health inequity for Indigenous Peoples persists on a global scale, due to the ongoing impacts of colonization. Racism, power dynamics, and health professionals with limited understanding of the historical context and lived realities of Indigenous peoples are among the many factors that create unsafe spaces in health care environments (Turpel et al., 2020; Browne, 2017; Jacklin et al., 2017; Goodman et al., 2017). These unsafe spaces foster unsafe care which undermines the quality of care that Indigenous peoples receive, with detrimental outcomes. This is especially important considering that several health professional organizations have position statements about cultural safety and encourage its implementation. According to data from the Canadian Census Mortality and Cancer Follow-up Study, the number of deaths which could have potentially been averted through effective prevention practices, public health policies, and/or provision of timely and adequate health care from 1991-2006 was twice as high for Indigenous men, and two and a half times for Indigenous women in Canada when compared to non-Indigenous people (Park et al., 2015). Similarly, in New Zealand the number of deaths that could be avoided through “access to high-quality and timely medical interventions”, (Walsh & Grey, 2019, p. 47) and deaths which could have been avoided through addressing social determinants of health represented 53% of all deaths among Māori based on 2013-15 death registration and population data (Walsh & Grey, 2019). This data demonstrates that these continued health inequities, unsafe practices and inadequate care have a devastating impact on the health of Indigenous Peoples in Canada and New Zealand.

Originating in New Zealand, the concept of cultural safety was developed by Irihapeti Ramsden, a Māori nurse and academic. Building on her early work that focused on enabling a "considered analysis of the historical, political, social and economic situations that were continuing to impact on the health of Maori people" (Ramsden, 2002, p.98), Ramsden further developed the concept with a dream of helping health professionals to "become aware of their social conditioning and how it has affected them and therefore their practice" (Ramsden, 2002, p.2). The initial focus of Ramsden's work was individuals in nursing education, with the help of nurses and midwives as key enablers (Ramsden, 200, p.98) however, the concept has been broadened hereafter, and has been applied to additional groups of health professionals.

A key component of cultural safety is the focus on the power differentials within health care provider and patient relationships, that lead to health inequities (Ramsden, 2002; Kurtz et al., 2018; Josewski, 2012; Dell et al., 2016). Cultural safety emphasizes the need for reflexivity on the part of the health care provider, in order to understand the power inherent in relationships within the health care field and the impact of their own biases (Ramsden, 2002; Auger et al., 2019; Cameron et al., 2014; Oda & Rameka, 2012). As Curtis et al. (2019) write, "This requires health providers to question their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients" (p.13).

By acknowledging the power imbalances in these relationships, cultural safety recognizes the influence of continued colonization, the structures that continue to undermine Indigenous peoples, and their contribution to health inequity (Kurtz et al., 2018; Berg et al., 2019; Andermann, 2016). In culturally safe care, the power imbalance is rectified as far as possible, with the care recipient having the power to determine whether the care is appropriate and meets their needs (Brooks-Cleator et al., 2018; Brascoupé & Waters, 2009; Ramsden, 2002). The goals of culturally safe care are for Indigenous peoples to feel safe and respected in their interactions with the health care system (Benoit et al., 2019), to be equal partners in their care (Bracoupé &

Waters, 2009) and have their health providers “recognize, respect, and nurture the unique cultural identities...and safely meet their needs, expectations, and rights” (Auger et al., 2019, p.189).

Research has suggested that culturally safe care could have a meaningful impact on health experiences of Indigenous peoples when embedded into practice (Churchill et al., 2020), and supports the idea of cultural safety being incorporated into healthcare environments (Goodman et al., 2017; Wesche, 2013). While components of cultural safety have been integrated into nursing education in New Zealand (Penn, 2014), and are recommended in the Calls to Action from the Truth and Reconciliation Commission of Canada (Truth and Reconciliation Commission of Canada, 2015) cultural safety has not been fully implemented, and health inequities for Indigenous Peoples in both countries persist. Understanding the barriers to implementing cultural safety could be crucial to successfully implementing cultural safety into practice.

The overarching goal of my research is to better understand how cultural safety as a concept is/can advance health equity and improve health outcomes for Indigenous peoples. In seeking to understand this, I proposed the following objectives:

1. Identify barriers/facilitators to the provision of culturally safe care to Indigenous peoples
2. Develop a contextual understanding of the issue through identifying other factors (social, political, economic, cultural etc.) that may shape the discourse and practice of cultural safety
3. Identify strategies to address the barriers

4. Provide useful information for key informants to impact health policy, professional competency requirements, and development of wise practices

My research uses a grounded theory methodology informed by a social constructivist framework. A research partnership was formed with academics at Auckland University of Technology in New Zealand, based on a mutual interest in Indigenous health research. Purposeful and snowball sampling was used to conduct in-depth, semi-structured interviews with 14 participants between Canada and New Zealand. These participants represented a variety of professions including health system administrators, academics, and health service providers such as physicians, and nurses, but all shared cultural safety expertise as the main inclusion criterion. The inclusion of sites with a similar history of colonization creates an opportunity for shared learning.

Literature Review

Introduction

This literature review provided the foundation for conducting this qualitative study. It presents a comprehensive overview of the discourse surrounding cultural safety in Canada and New Zealand. The literature highlights examples of structural racism, and emphasizes the need for further education on cultural safety for health professionals, a shift towards recognizing and actively working to change the power dynamics that exist, and a change in the lens through which Indigenous peoples are viewed.

Literature Review Strategy

The literature review strategy began with the consultation of a qualified librarian to develop a search strategy. Consultation with the librarian identified four key databases for searching and search terms (See Appendix A for detailed search strategy). ProQuest Nursing & Allied Health Database, PubMed, CINAHL and Sociology Database (formerly Proquest Sociology). A total of 828 unique articles were identified and after both title and abstract screening, a total of 95 articles remained for full-text review. Inclusion criteria were the presence of keywords or themes related to the search criteria and primary location of Canada or New Zealand. Exclusion criteria included: lack of keywords, length (1 page or less), or formats other than research articles (ie. Commentary, book reviews, abstract only). Following full-text review, 55 articles remained. In addition to the systemic search of peer-reviewed literature, the references of articles were examined in order to identify relevant articles, and grey literature was identified through searching health organization and government websites.

Articles were then read and uploaded to Google Drive. This was an iterative process, as I continued to reread articles and identify relevant points. Highlighting within articles was done on the basis of pieces relevant to the key issues relating to Indigenous cultural safety. Comments were added to the articles as part of the process, in order to pinpoint key pieces of information for easier follow-up later on

Overview of Findings

Discrimination, bias and racism from health care providers.

Research studies frequently acknowledge racism, discrimination and bias against Indigenous peoples when accessing the health care system, which contribute to health inequities and barriers to access and use for Indigenous peoples (Nelson & Wilson, 2018). This racism against Indigenous peoples is systemic, perpetuating disadvantages against Indigenous peoples and is embedded in the social structure of several colonialist countries (Benoit et al., 2019; Browne et al., 2016). A qualitative study by Jacklin et al. (2017) described the experiences of Indigenous peoples in Canada seeking treatment for type II diabetes, and recounted numerous instances of racism and invalidating encounters within mainstream health services. Participants described having their concerns dismissed, being sent home without any care after travelling long distances, and assumptions made about intoxication, which the participants believed to all be racially motivated (Jacklin et al., 2017). Stereotyping relating to intoxication was also mentioned by Cavin (2015) in their review of health care provider attitudes. Similar issues were discussed in the study of Indigenous women in Canada, by Benoit et al. (2019). The authors identified stereotypes about misuse of pain medication, which continue to be perpetuated by health providers, leading to dismissal of chronic pain conditions. Jacklin et al. (2017) also found that other participants had experienced racist language and comments from health care staff including, “skip through these so we can get to the real patients”, using ‘these’ in reference to the Indigenous patients waiting for appointments (Jacklin et al., 2017, p. E108). Other racist comments included, “tell your community that we’re not running a lodging service here,” (Jacklin et al., 2017, p. E109) in response to a large number of family members visiting a patient. As reported, this led the patient to stop accessing health service due to the discrimination they experienced

An Australian qualitative study, focusing on what health providers need to work more effectively with Indigenous patients, found similar results. Participants described feeling that their concerns were not heard, and instances where health providers had shown disrespectful behaviour such as sitting with their back turned to the patient (Abbot et al., 2014). They also found that participants experienced demeaning behaviours from health providers, including providers “dumbing down” their language when speaking to Indigenous patients, as well as openly calling them incompetent during appointments (Abbot et al., 2014). Dismissive attitudes, assuming lower levels of understanding from patients and openly making negative remarks to Indigenous peoples all demonstrate bias from health professionals which are similar to the experiences found by Jacklin et al. (2017) and Jennings et al. (2018), which contribute to health inequities. In accessing care, Māori face similar experiences with health providers. As DeSouza (2008) noted, Māori are “seen for a shorter time, offered less treatment and prescribed fewer secondary services, such as physiotherapy” (p.127).

In their qualitative study about Indigenous women in Canada and their experience with health care services, Browne and Fiske (2001) found similar experiences of discrimination. Several participants mentioned that their concerns were ignored by health professionals and dismissed by professionals who felt that their concerns were not serious enough, hypothesizing that the reason for this mistreatment was their Indigeneity (Browne & Fiske, 2001). In addition, the women described the effects of racism from health professionals. One participant shared,

> This woman went to the hospital and was very sick and was turned away because they thought maybe she was drinking or something. And I think that the woman went home and died. And that was quite horrible, and that’s kind of always kind of haunted me. (Browne & Fiske, 2001, p. 134)

The above example highlights the tragic extent of the detrimental effects that structural violence and structural racism can have. Structural violence can be defined, most simply, as “a power system wherein social structures or institutions cause harm to people" (Lee, 2019, p.134). Building on this definition, as Galtung (1969) writes, "that the general formula behind structural violence is inequality, above all in the distribution of power" (p. 175). Structural violence is often embedded and normalized within social structures, which may make it subtle, and more difficult to eliminate (Galtung, 1969; Lee, 2019). However, when examined closely, its pervasiveness because clear within many systems, particularly the health system. Along similar lines, structural racism may be defined as macrolevel systems, social forces, institutions, ideologies, and processes that interact to disadvantage racial groups (Powell, 2008). As with structural violence, structural racism is harder to eliminate because it is rooted in structural inequalities (Gee & Ford, 2011).

By denying care to an Indigenous patient, the actions of the health care provider caused harm to that individual, in this case leading to their death. By doing so on the basis of a racial stereotype, they also perpetuated the racist ideology that continues to disadvantage Indigenous Peoples within the health system. This racism is also visible in the Joyce Echaquan case, as nurses subjected her to racial slurs while she lay dying in hospital. The coroner's report concluded that racism played a significant role in her death, and her death was ruled accidental due to inadequate care (Nerestant, 2021). In her acknowledgement of racism within the case, the coroner even stated that she felt Joyce would still be alive if she were white, and acknowledged the systemic prejudice and bias within healthcare (Nerestant, 2021). Ensuring that Indigenous peoples are visible, heard and respected as Indigenous peoples within the health system is critical to ensuring culturally safe care (Hole et al., 2015), and can mediate these culturally unsafe practices which produce health inequalities on a global scale.

Similar to Indigenous peoples in Canada, studies have found that the Māori of Aotearoa/New Zealand also experience racism within the health system. In their analysis of the 2006/2007 New Zealand health survey, Harris et al. (2013) found that Māori "being socially assigned as European-only tended to be associated with lower reporting of experience of racial discrimination and better self-rated health than being socially-assigned to any non-European group, including Māori" (p.5). In a qualitative study focusing on health inequities among Māori, Manhire-Heath et al. (2019) explored the discourses of health inequities with a focus on general practice receptionists. These receptionists, as one of the first points of contact which individuals interact with in their health care journey, play a pivotal role in influencing an individual's health care experience. It was found that receptionists were, in many cases, aware of the social determinants of health and their impacts on Māori health, however many of those interviewed still shared negative remarks (Manhire-Heath et al., 2019). Most frequent were comments based on victim-blaming, placing most of the blame onto Māori for their ill-health, citing lifestyle factors. Discriminatory comments were also given by participants as reasons for health inequities among Māori. One such comment highlights this discrimination,

> ...they'll come in and, I dunno, it seems a lot, like not sounding awful, but it seems a lot less controlled. So the [Maori or Pasifika] kid will be like running outside and stuff and they're sick and they don't have many clothes on whereas when you get like, a white mum and a baby and it's warm and like a very different relationship whereas the families are bigger and there's less control on what they do (Manhire-Heath et al., 2019, p. 432).

Describing Māori as less controlled, and wearing less clothing reflect a bias, and connecting white New Zealanders with a more positive light are both undeniably racist. By making broad generalizations, these receptionists are practicing essentialism. Downing and Kowal explain essentialism as ascribing specific characteristics to a particular group of people, and developing a specific understanding of that group of people's or, in the context of their research, Indigenous culture (Downing & Kowal, 2011). This, in turn, creates a "stereotypical understanding of what 'Indigenous culture' is, what it means for Indigenous peoples and how it will be an 'issue' in the health care setting" leading to further inequity (Downing & Kowal, 2011, p.9).

Discrimination against Māori can influence more than just perceptions of health providers. In their qualitative study focusing on Māori women's experiences with gynaecology, Cook et al. (2014) found that the participants internalized the attitudes of their health providers. The women described the health provider attitudes as impacting their feelings about themselves. One participant said:

> There is one [examination] where it was uncomfortable - the whole vibe of it wasn't comfortable. She wasn't comfortable to be down there. It's kind of like you felt ashamed and I don't usually feel ashamed when I go to places like that. (Cook et al., 2014, p.26)

As stated by Browne et al. (2016), these experiences of racism and discrimination in health care are extensions of the ongoing inequities in social determinants of health that Indigenous peoples experience. Distal determinants such as colonialism, racism and social exclusion negatively contribute to intermediate determinants (Reading & Wien, 2009). Of note is the impact on the intermediate determinant of cultural continuity, which has led to intergenerational trauma through colonialist policy. Browne et al. (2016) continue, explaining racial discrimination is "amplified in the contexts of poverty, substance use, or stigmatizing conditions such as chronic pain, mental health issues, and HIV" (Browne et al., 2016, p.3). These experiences are demonstrations of structural violence, steeped in colonialism, which contributes to the health inequities Indigenous peoples face.

Care Providers lacking familiarity with social, political and historical factors influencing health.

Several studies included in the literature review identified historical trauma, social structures, and governmental policy as factors influencing the health of Indigenous peoples. In their study Jacklin et al. (2017) identified that residential school experiences contributed significantly to perceptions and practices of Indigenous peoples accessing health care. Participants described being apprehensive and resistant to health care providers during interactions that evoked memories of their residential school experiences, especially when the physicians were prescriptive or authoritarian in their actions (Jacklin et al., 2017). Through these statements it is clear that residential schools play a large role in shaping how Indigenous peoples approach health care as a result of previous experiences, and also that physicians may not realize how their approaches can affect people who have experienced trauma through the residential school system. This was also reinforced by the Indigenous women in Canada interviewed by Browne and Fiske (2001) who stated:

> I didn’t want anybody to look at my body. Because we were told not to show our bodies. Maybe it has to do with our upbringing and by the way we were taken out of our homes and told to be ashamed of our bodies. Like in [residential school], they used to tell us we’re just Indians. They call us worse names, but I don’t want to repeat what they call us ... So you had a dislike for your body and your person, as a Native person. And I was scared. I was embarrassed. (p. 138)

The authors elaborate on these experiences and highlight that some of the women chose to avoid health care procedures that involved exposing their bodies, based on the past trauma experienced in residential schools (Browne & Fiske, 2001).

Victim-blaming towards Indigenous peoples for their mental health issues was also noted, with emphasis placed on individual lifestyle and dysfunction, similar to the findings of Manhire-Heath et al. (2019) and also noted by Wilson (2008).

The idea that physicians were lacking familiarity with the social, political and historical factors influencing Indigenous health was emphasized by participants in Jacklin et al. (2017) who felt that “the doctors do have to be educated on what happened, and also to realize that it’s intergenerational” (Jacklin et al., 2017, pg. E108). Participants in that study also shared experiences in accessing health care that reinforced historical colonialist relationship, such as being denied care, negative perceptions, experiences of inferior care, and policies that do not support cultural practices (Jacklin et al., 2017). These experiences highlight that physicians may be wholly ignorant of how their actions contribute to a colonialist relationship, perpetuating historical inequities, and emphasizes a need for further education. All of these actions by health providers lacking familiarity with factors that influence health affect the way that Indigenous peoples perceive health care, leading to resistance, mistrust and avoidance which further contribute to health inequities.

In an article on cultural safety and care of Indigenous peoples in Canadian emergency departments, Dell et al. (2016) explored the connection to historical factors that influence the health of Indigenous peoples. They explained that Indigenous peoples accessing health care may display behaviours that health providers may view as challenging, however, they explain, these behaviours “might be ways of coping that have developed in response to complex psychological trauma" not unlike the trauma resulting from experiences with the residential school system (Dell et al., 2016, p.303). The authors go on to say that "the legacy of residential schools and colonial policies created deep intergenerational traumas and suspicion, the consequences of which remain visible today." (Dell et al., 2016. p. 301). This underscores the need for health providers to be better educated on historical trauma and its intergenerational effects, mentioned by participants in the study by Jacklin et al. (2017). This article also highlighted the need again, saying "a culturally safe provider practices critical thinking and self-reflection... and understands the unique historical legacies and intergenerational traumas affecting [their] health and fosters an understanding of [their] health values" (Dell et al., 2016, p. 302). The comment "tell your community that we're not running a lodging service here," (Jacklin et al., 2017, p. E109) mentioned previously also fits into the discourse on culturally safe providers as the provider who made this comment was not practicing the critical thinking and reflection which are integral to cultural safety. In addition to being discriminatory and a comment reflective of culturally unsafe practice, it also shows that the physician is ignorant of Indigenous cultural practices in which several family members may wish to be with a loved one who is ill, as discussed further in the section on health systems which are not in line with Indigenous health systems.

Benoit et al. (2019) also addressed the idea of health providers lacking familiarity with underlying factors which affect the health of Indigenous peoples. In their article they noted that health providers had a limited understanding of social determinants of health, barriers that Indigenous women experience, and specific examples of how historical, colonial relationships have impacted the health of Indigenous peoples. With respect to historical and ongoing colonial practices, the authors noted several impacts among those who experienced the residential school system (Benoit et al., 2019). These individuals were taught not to question authority and had lost knowledge of traditional birthing practices as a result of the cultural destruction of residential schools. Additionally, many of these women were distrustful of children's aid societies out of fear of racially motivated rules and discrimination (Benoit et al., 2019). Similar mistrust was reported by Gerlach et al. (2017) in their exploration of how a Canadian Indigenous early intervention programme influenced families involved. Specifically, they pointed to mistrust based on negative generational experiences with child service agencies, and suspicions of service workers' motives (Gerlach et al., 2017). All of these outcomes are directly related to societal and historical factors and influence how Indigenous peoples approach and perceive the health care system.

Overall, these studies highlighted the fact that historical trauma plays a role in Indigenous health. Along with historical trauma, ongoing colonial attitudes, social factors and cultural practices are key areas that influence Indigenous health, and providers should be well educated on how these factors tie into the larger picture of Indigenous health.

Western, Biomedical health systems which are not in line with Indigenous health systems.

In their analysis of key knowledge for nurses working in Indigenous communities, Foster (2006) addresses several components the Western medical model is lacking, in comparison to Indigenous health systems. For example, she describes how healing in Indigenous cultures is more holistic, encompassing physical, spiritual, emotional and mental aspects (Foster 2006). She highlights the results of previous research (Silverman et al., 2001) which indicate that nursing staff were more focused on physical aspects of health, rather than the emotional and spiritual, which are key in Indigenous health systems (Foster, 2006).

In their exploration of cultural safety in Canadian mental health care, Josewski (2012) points to the fact that health systems have a Western, biomedical focus which is incongruous with Indigenous belief systems. Participants in the study mentioned that the health system is flawed from the ground up. In describing these flaws, study participants cited the top-down decision-making model in the community health organizations and health authority (Josewski, 2012). This system of decision making which excludes community members and primarily consists of individuals with a business background and no connection to Indigenous culture (Josewski, 2012). The author noted that this leads to policies which continue legacies of colonialism by neglecting to give Indigenous peoples a voice in how their care is shaped at a structural level. As a result of these factors and a lack of culturally appropriate care due to the Western model, Josewski (2012) noted that mental health services are underused by Indigenous people. Viewed in another light, the comment made in response to a large group of family members visiting a loved one (Jacklin et al., 2017) shows how the system is not designed to accommodate Indigenous cultural practices, and this is reflected in similar regulations in New Zealand. In these cases, the strict rules on the number of visitors clash with Indigenous practices, and this can have profound impacts on family members.

When her grandfather was very ill, Dr. Annelind Wakegijg of Baawaating Family Health Team described the experience her family had in interacting with the health care system. She explained that her family had only been allowed in one at a time to visit him, which was hard for her family (Cancer Care Ontario, 2016). One morning she received a page that her grandfather was not doing well and that she needed to get over to the hospital, only to receive a page a few moments later that he had passed away. The experience is one that she carries with her, steeped in guilt over the fact that, “He died alone, and that is what I want *not* to happen” (Cancer Care Ontario, 2016). If the rule on visitors had been different and health professionals had more understanding of

Indigenous culture, this experience could have been different. To further contextualize the harm that these actions perpetuate, during the residential school system, Indigenous peoples often were not informed that their loved ones were ill, if they died, or where they were buried (Truth and Reconciliation Commission of Canada, 2015b). This example moves beyond the rules into the humanistic aspects of culture and loss, showcasing the impact of a medical system that fails to acknowledge and create space for Indigenous cultural practice and belief systems.

It has been reported that Māori experience lack of cultural understanding in a predominantly biomedical healthcare system which does not incorporate Māori worldview and culture. Josewski (2012) notes that frequently the health system fails to adequately address health problems experienced by Māori, medicalizing social problems and conflating “health inequities experienced with people’s culture, when in fact, they are part of colonial history and ongoing inequitable social relations” (Josewski, 2012, p. 224). This inability to address unique cultural differences is also described by Halseth (2018) as a key barrier to culturally safe and appropriate care for Indigenous peoples. Similarly, Heke et al (2018) point out that “The socio-cultural constructions of health means that equitable healthcare is contingent on health practitioners identifying and responding to the unique cultural needs of both Māori and their whānau [family]” (p.2). This kind of care that is both holistic and deeply personal is not part of a biomedical system, a system which Heke et al (2018) further describe as “a healthcare system that delivers universal services and lacks culturally responsive approaches” (p. 2).

As a potential solution to some of the problems created by the Western biomedical model, Josewski points to cultural safety within mental health care. The author explains:

> Culturally safe mental health and addiction approaches draw attention to other dimensions of experience that include historical trauma transmission, poverty and racism.

> [Participants] argued that given the experience of often multiple trauma histories, effective services need to include opportunities for establishing long-term and trusting relationships between service provider and client (Josewski, 2012, p. 228-229).

Similar to Dell et al. (2016), Jacklin et al. (2017) and Benoit et al. (2019), this article is emphasizing the importance of understanding other factors that influence health. However, here it is also a means to make mental health care more accessible and more culturally safe for Indigenous people.

Overall, these articles highlight how the Western health system is not aligned with Indigenous cultural practices or belief systems. The biomedical model fails to recognize unique cultural backgrounds and is not holistic in its approach. In situations where health providers are not practicing culturally safe care, Indigenous peoples may feel apprehensive about seeking care due to negative experiences in the past which complicate their relationship to health care. Cultural safety could be used to mediate some of these challenges and positively impact how Indigenous peoples are treated within the health system.

Inadequate cultural safety curriculum and experiences in health education.

Within the literature, cultural safety is mentioned as a strategy to provide better care for Indigenous peoples, however limited literature exists that assesses the level of cultural safety in practice or whether it is an effective strategy. Within their literature review, Kurtz et al. (2018)

examine cultural safety education among health providers in Australia, Canada, New Zealand, and the United States and its impact on practice. Among the articles reviewed in the study, educational methods varied, evaluation was not present and several challenges were found within the cultural safety education protocols (Kurtz et al., 2018). In one case, the authors discuss a web-based cultural safety immersion experience, which experienced challenges with student engagement and interest, and limitations in the amount of discussion due to the format of the course (Kurtz et al., 2018). In spite of these challenges, the authors note that students felt that they had gained valuable insight. Referring to the articles as a whole, they found that engagement with Indigenous community members and community practitioners was essential and fostered meaningful experiences that were lacking with other methods of instruction including the online courses (Kurtz et al., 2018). The experiences students had with the cultural safety training depended on a variety of factors including involvement of Indigenous community members, the format of the cultural safety education (i.e. online or experiential), maturity of healthcare students, students' previous personal and professional experiences, and levels of unconscious racist attitudes (Kurtz et al., 2018). These factors speak to the complexity of engaging health care students in cultural safety education and can pose challenges to engaging effectively with health care students in order to ensure they receive adequate cultural safety education. Overall, this article highlighted challenges associated with providing cultural safety education. This education is critical for health professionals working with Indigenous people, and as this article pointed out, some methods used may not be adequate in preparing students to provide culturally safe care to this population.

Working with occupational therapy students, Jamieson et al. (2017) examined the effectiveness of a cultural safety intervention. Students rated their knowledge and responses to cultural safety, and then were exposed to three modules developed by Anishnawbe Health Toronto related to cultural safety (Jamieson et al., 2017). After completing the modules, the students rated their knowledge and responses again, in order for the researchers to measure improvement. Results showed that the majority of participants showed perceived improvements in knowledge, and perceived increase in cultural and emotional responses (Jamieson et al., 2017). From a qualitative standpoint, the participants found that the educator in the modules was pleasant, the information was easy to understand, and the interactive components were engaging (Jamieson et al., 2017). Overall, the results of the study seem positive, however there are limitations in the applications. While the participants responded positively to the modules, the responses captured perceptions about growth, which can be subjective, the response rate was low, and the study did not capture the effects of the intervention in the long-term. The participants sought more group discussion and speaker-student interactions suggesting, similar to Kurtz et al. (2018), that a more immersive experience could be more beneficial. Overall, while received positively, this study begs the question of whether an online module is enough to adequately prepare health students to provide culturally safe care.

In their study on cultural safety in occupational therapy in New Zealand, Gray and McPherson (2005) examined health professionals' attitudes towards cultural safety in their practice. In their analysis, the authors separated their participants into two categories based on when they received their health education; pre-1993 training in settings without cultural safety training, and post-1993 with cultural safety embedded in courses (Gray & McPherson, 2005). In sharing their views, some participants spoke negatively about the emphasis on Māori through cultural safety training saying things like, "'... I think the profession is too focused on Maori and white man... I mean, biculturalism is just about two cultures trying to meet anyway, so I kind of wonder why it's always focused on Maori and not any culture ...'" (Gray & McPherson, 2005, p.

39). A point that the authors highlight in reference to comments of this nature is the fact that these comments were made by occupational therapists in the second grouping, who had completed their education with cultural safety training. In terms of education, participants highlighted the benefit of experiential learning related to cultural safety saying

> ... A lot of stuff you can't learn academically, though. Like living with them, being round another culture a lot; that is where you pick up the most, I think. Yeah, I don't know that academic learning in itself is enough ... people can just put it into a little corner of their mind. (Gray & McPherson, 2005, p.39).

In addition to learning from experience, older occupational therapists cited maturity, becoming parents, development of critical thinking skills and coping with change as key reasons for changes in attitude. Insight from these health professionals was interesting because it showed that negative attitudes towards Māori and against cultural safety can exist irrespective of whether individuals have experienced cultural safety education as part of their health education. The potential ineffectiveness of that training is also emphasised by the fact that older health professionals (who had not experienced cultural safety education as part of their health curriculum) in some cases had more positive attitudes toward cultural safety.

Viewed through a different lens, the negative attitudes shown by some younger health professionals could be seen partially as a failure of the cultural safety education to adequately prepare health students for their work. This concept is mentioned by Pavagada and DeSouza (2012) in their discussion of cultural safety and mental health care in New Zealand. They noted that "whilst 70 per cent of psychiatrists responding to their survey believed there was a need to consult with Māori when working with Māori... only 40 per cent felt that their training had prepared them to work effectively with Māori" (Pavagada & DeSouza, 2012, p. 245). This was echoed by

Richardson et al (2009) who found that some nurses in their study had never received formal education on cultural safety. Additionally, Gibbs (2005) cites challenges of time constraints of educators, as a key contributor to limited competency among students. She asserts that with the demands of teaching there may not be enough time to include cultural safety, but that it should be made more of a priority (Gibbs, 2005). Both the points raised by Pavagada and DeSouza (2012) and Gibbs (2005) point to a need for additional cultural safety education among health professionals. The importance of health provider reflexivity as a component of cultural safety training is highlighted within the elements of culturally safe health initiatives by Gibbs (2005) and Brooks-Cleator et al. (2018). Gibbs (2005) asserts that in addition to a lack of training, another barrier is that many students lack understanding of the central concepts. This is also suggested by Spence (2005). However, Gibbs (2005) also asserts that the key to cultural safety is in a student's attitude; something that can't be learned because it relies on an assessment of one's own beliefs and values.

This is consistent with the assessment by Brooks-Cleator et al. (2018) that self-reflection on attitudes towards Indigenous peoples are critical to culturally safe practice and that an individual can expand their worldview through self-reflection, as stated by Spence (2005). Perhaps another barrier to developing competency is that self-reflection can be uncomfortable, as students and educators alike are made to explore the implications of privilege on health inequities (Browne et al., 2009). Therefore, the attitudes of some health professionals and their limited capacity to deliver culturally safe care may be due to insufficient education, possibly resulting from time constraints, or other barriers such as lack of understanding or an unwillingness to practice the necessary self-reflection.

In their study of health care providers and consumers, Johnstone and Kanitsaki (2007) examined understandings of cultural safety and competence in health care. Through interviews, health care providers shared that across the board, health professionals lacked knowledge and understanding of cultural safety and competence in health care. This is similar to the findings of Pavagada and DeSouza (2012), Gibbs (2005) and Richardson et al. (2009). To remedy this, providers in their study suggested education and training as critical to improving individual and organizational capacity (Johnstone & Kanitsaki, 2007). As conversations continued, some providers were able to see connections between lack of culturally informed care and poor quality of care, but further education to deepen this understanding was recommended. In a similar study in the United States by Hart and Mareno (2014), the challenges and barriers around culturally safe nursing were examined. Nurses interviewed cited several challenges including; language barriers, difficulty obtaining education and remembering beliefs and practices of different cultures, and a lack of individual and colleague knowledge about diverse cultures (Hart & Mareno, 2014). One participant went so far as to say, “Is it realistic to expect a single provider to know the ins/outs of multiple cultures?” (Hart & Mareno, 2014, p.2226). Along these lines, some nurses expressed significant biases towards individuals of other cultures and felt that individuals should adapt to an American culture. Key barriers to culturally safe care were time, money and a lack of training, which is consistent with findings from other studies. Finally, while many challenges and barriers were reported by the nurses in the study, some spoke about the importance of reflecting on individual prejudices and biases as a means to provide culturally safe care (Hart & Mareno, 2014).

As Browne and Fiske (2001) explain, “health care encounters and the dynamics that constitute and shape these encounters are significant...because they reflect, involve, and construct social, political, economic, and ideological relations” (p.126). Health care for Indigenous peoples has been shaped by colonialism, leading to a system rife with inequity, discrimination and structural violence. The acknowledgement of these factors and the power dynamics in health care are possible through the application of cultural safety. In many ways, cultural safety empowers the patient in a way that the current health system does not allow. Broadly, cultural safety is a framework that has the potential to improve the health system for Indigenous peoples worldwide, providing culturally safe care to all Indigenous peoples.

Conclusions

In general, the literature recognized that health inequities are experienced disproportionately by Indigenous peoples and are exacerbated by a lack of culturally safe care. The results of the literature review speak to structural racism through four broad categories of barriers:

1. Discrimination, bias and racist attitudes from health care providers
2. Physicians lacking familiarity with social, political and historical factors which influence Indigenous health outcomes, including power differentials
3. Western, biomedical health systems which are not in line with Indigenous belief systems
4. Inadequate cultural safety curriculum and experiences in health education

All of these categories represent examples of structural racism occurring at different levels within the health system, and throughout the health care pathway for Indigenous peoples. The aim of this research project is to develop a deeper understanding of barriers and facilitators to culturally safe care, and identify the broader social, cultural and historical structures that contribute to these barriers and inform the perspectives of the health providers.

Gaps in the Literature

Within the body of literature on Indigenous cultural safety, there are some gaps. Many of the articles included in the literature review highlight barriers to accessing care that Indigenous peoples experience, including underlying causes of distrust towards the health system, experiences with racism, bias and discrimination, and an overall health system that is not in line with Indigenous cultural practices and knowledge systems. Understanding these barriers is crucial for developing ways to make the health system less prohibitive and addressing the disparities in health care access that Indigenous peoples experience. However, only a few articles identified in this literature search examined cultural safety from a health provider's perspective. Within the original scope of this project which sought to interview health professionals, this gap would have been addressed. However, due to challenges created by the onset of the COVID – 19 pandemic during the developmental stages of this research, there was a move to interviewing key informants rather than healthcare professionals, and as such, this research no longer addresses this. Instead, by speaking to key informants from a variety of backgrounds, this research project adds diversity to the discourse on cultural safety. Additionally, some key informants may have experience with health through academic or other work and could therefore shed some light on the health provider perspective.

In addition to limited information from the provider's perspective, few studies addressed barriers such as geographic isolation, provider education, jurisdictional challenges, and additional difficulties faced by Indigenous peoples accessing services, such as those mentioned by Halseth (2018). Much of the literature focused on barriers related to structural racism. The current study aimed to address this gap by considering these barriers during data analysis and interviews.

Overall, the proposed research project aimed to address gaps in the literature on cultural safety by focusing on key informants to understand the barriers and facilitators to providing culturally safe care from their perspectives. Contextualizing these barriers will be key in order to identify the broader social, cultural and historical structures which contribute to these barriers and inform the perspectives of the health providers. Using key informants will be especially useful for contextualizing, since they will provide a variety of perspectives based on a diverse set of unique backgrounds and experiences.

Research Questions

My primary research question for this study is: What are the barriers and facilitators to providing culturally safe care for Indigenous peoples? To meet the objectives outlined above and answer this primary question, I will aim to answer the following sub questions:

1. What are the educational/cultural/social/political barriers to providing culturally safe care as identified by key informants in Canada and Aotearoa/New Zealand?
2. How could cultural safety be implemented in order to be most effective?
3. What are the next steps for cultural safety in a health context?

Contribution to Public Health & the Community

Examining the barriers to culturally safe care for Indigenous Peoples has the potential to contribute valuable knowledge to the field of health science research. Understanding the barriers and facilitators to culturally safe care represents a first step in addressing the larger issues related to Indigenous health equity. Having a solid understanding of these aspects, as they currently exist is key to developing effective solutions. Additionally, including key informants from a variety of backgrounds (i.e. academics, health providers, administrators etc.) broadens the diversity of perspectives included, allowing for a collaborative, intersectoral discussion, which is key to addressing systemic health disparities and underlying determinants (Danaher, 2011). These diverse perspectives also increase the likelihood that the proposed solutions will be more broadly relevant across disciplines. Therefore, this project has the potential to contribute significantly to disciplines across the health sciences and others.

In addition to its relevance to health science research, this work has also facilitated the development of international research relationships and has additional implications. Bringing together academics from institutions in Canada and New Zealand creates opportunities for future partnerships, and continued research prospects, creating a space for continued conversation on this subject. Furthermore, by sharing the findings of this project with diverse stakeholders, the findings of this project have the potential to be put into practice within healthcare organizations, educational institutions and beyond.

Importantly, this project also contributes to a body of knowledge on cultural safety that has been built by Indigenous peoples. For years, Indigenous peoples have been calling for culturally safe care that addresses the ongoing health inequities which Indigenous peoples continue to face, however it has largely been ignored due to the epistemological racism inherent in a positivist paradigm, and academia more broadly, which "privileges the assumptions of white Euro-American civilization and positions them as superior to the knowledges embraced by other civilizations, cultures, or peoples" (Kubota, 2020). In this space, positivism, which largely dominates the health system and associated discourse, "has historically undermined and/or dismissed Indigenous ways of knowing" (Martin, 2012) in favour of Western approaches. This work represents an additional contribution to the cultural safety discourse and would not be possible without the contributions made by Indigenous peoples that have come before. It is my hope that this research will be beneficial to health organizations in Canada and Aotearoa/New Zealand and will be a catalyst in facilitating meaningful change.

Chapter 2: Methodology

Description of the Setting

The two locations in this study, Canada and Aotearoa/New Zealand, are both rich with history and have unique cultural identities. However, in both locations, a history of colonization has impacted the health and wellbeing of Indigenous people, leading to health inequities.

At the time of this study, the population of Canada was 35,151,728, per the 2016 census (Statistics Canada, 2017). Within Canada, 1,673,785 people identify themselves as Indigenous according to the 2016 census (Statistics Canada, 2017), representing approximately 4.76% of the population. The Canadian constitution recognizes three groups of Indigenous Peoples, First Nations, Inuit and Métis (CIRNAC, 2021), but this restrictive definition is a by-product of historical and ongoing colonialism. In 1867, the Canadian government only recognized First Nations Peoples with status, which was later amended in 1939 to include Inuit (Bonesteel & Anderson, 2008). At this time, both groups were recognized as having rights under Canadian law, provided certain conditions were met, however Métis were not recognized as Indigenous Peoples. In 1982, the repatriation of the *Constitution Act* recognized First Nations, Inuit *and* Métis as Indigenous peoples with rights under the law (Chartrand, 1991). In contrast to the narrow definition maintained by the government, there are many more Indigenous Peoples in Canada with unique histories and traditions.

A world away from Canada, lies New Zealand. With a population of over 4.5 million, New Zealand has about a third of the population of Ontario (Statistics New Zealand, n.d.). Nationally, about 16.5% of the population are Māori, the Indigenous peoples of New Zealand. Approximately 8% of the population are Pacific Peoples, Indigenous to the Pacific Islands including Samoa, Tonga, and the Cook Islands to name a few (Statistics New Zealand, n.d.).

Methodology

Situating the Researcher

When I set out to undertake this research project, my understanding of my role in this work was limited. I considered my family background and my previous experiences, but it was really only the tip of the iceberg. I focused so narrowly on the concept of in/out group as a way to understand positionality, that there were aspects that I didn't even realize I had missed.

As I wrote originally, I navigate a unique cultural space, but I've come to understand that in a different way. I'm fortunate to come from a blended family, with both settler (Caribbean and European) and Indigenous members, all of whom have helped shape my worldview. I've also come to reflect on the significant level of privilege that has shaped my perspective. Coming from a middle-class background, having had access to and being supported in accessing education, being able-bodied and living in an urban environment all allowed me opportunities which may not have been otherwise available. In contrast however, being a black woman also impacts the lens that I bring to this work. I've had the misfortune of experiencing racism in daily life and within a healthcare setting, I've been dismissed, and my voice has been ignored because of the way people perceive me. Seeing my family members, particularly those who are Indigenous and black, experience similar things makes this work personal in a unique way.

In my pursuit of professional and educational opportunities, I've moved freely across Ontario, and into Europe without recognizing the significance of the land I was on. I was born and raised on Treaty Number 19 (Ajetance Purchase) territory, and pursued my undergraduate education on Between the Lakes Treaty Number 3 Territory, both part of the original lands of the Mississaugas of the Credit (Duric, 2017a; Duric, 2017b). I conducted this research in Anishinnabeg territory on the traditional lands of the Fort William First Nation, now known as Thunder Bay Ontario. In recognizing those whose lands I have traversed as an uninvited settler, I seek to recognize that these lands are not mine, and show appreciation for the opportunity to work and live in such beautiful places.

I came to this research hoping to expand my understanding of the realities of Indigenous health and the hope that in some small way, I could make a difference. Throughout this research process, my participants described what allyship looks like. While there are limitations to what I can appropriately do in this field, my aim is to strive to embody those qualities through additional work as I move forward.

There are many limitations to this project, due in part to the fact that this is only the beginning of my learning journey. I'm proud of this work, but I remain cognizant of how much I have left to learn. I am learning from the body of research that I have engaged with, the participants – both Indigenous and allied - in this research, and the incredible team of scholars who have supported this work from the beginning. All of the errors and limitations present in this work are my own representing areas for growth. I look forward to carrying the recommendations and findings from this project with me.

Rationale for a Qualitative Approach to Inquiry

As outlined in the research objectives, this project aimed to identify barriers/facilitators to the provision of culturally safe care and develop a contextual understanding of the issue through identifying other factors (social, political, economic, cultural etc.) that may shape the discourse and practice of cultural safety. Contextualizing the barriers, facilitators and experiences of the key informants was key in order to identify the broader social, cultural and historical structures that work broadly to influence the quality of care provided to Indigenous Peoples. A qualitative approach was chosen for this project because qualitative data collection methods allow for rich data with greater depth than quantitative methods, which was necessary in order to understand the complex relationships between the aforementioned barriers and contributing factors. Another benefit of qualitative research methods is that they facilitate more meaningful relationships between the researcher and the participant, which can provide an additional layer of context to the information participants share.

During interviews for this project, there was often a more conversational atmosphere, and participants often shared additional details about themselves. These details were valuable in understanding their perspectives, and greatly enhanced the research process in a way that quantitative methods would not have. In addition, the exploratory nature of this study aligns with a qualitative approach. As this study aimed to get a broad understanding of barriers, facilitators and contributing factors based on individual experiences, using qualitative methods worked well. Overall, the benefit of qualitative methodology for this project is captured poignantly by Hammarberg et al (2016) who write, "'qualitative' methods are used to answer questions about experience, meaning and perspective" (p.499). In utilizing qualitative approaches to explore the barriers and facilitators to culturally safe care in Canada and Aotearoa/New Zealand, this study specifically employed a grounded theory design, guided by a social constructivist framework.

Grounded theory is "a qualitative research design in which the enquirer generates a general explanation (a theory) of a process an action or an interaction shaped by the views of a large number of participants" (Creswell & Poth, 2017, p.82). The grounded theory design also uses an inductive approach that discourages the use of pre-existing theories to guide the development of research questions, and objectives (Creswell & Poth, 2017; Carter & Little, 2007).

As the above quote suggests, grounded theory studies typically have a large number of participants. While I was only able to include 14 participants for this project due to feasibility considerations, I feel that the grounded theory design was the appropriate choice because my goal was to develop a theory primarily based on participants' views. In the earlier stages of this project, I briefly considered phenomenology, however it did not align with my goals for this study. My understanding of phenomenology, was based on Creswell and Poth (2017) who describe phenomenology as "[describing] the common meaning for several individuals of their lived experiences of a concept or phenomenon…The basic purpose of phenomenology is to reduce individual experiences with a phenomenon to a description of the universal essence" (p.185). For this project, while I was interested in the barriers to culturally safe care, my goal was not to produce universal barriers. I was much more interested in exploring the barriers within their social, political, and cultural contexts, and ultimately decided that grounded theory would be a more effective framework for doing so. Because the social constructivist framework also emphasizes building understanding through multiple perspectives, it greatly complements a grounded theory approach.

Social constructivism is an interpretive framework which is guided by an ontological belief that "reality is locally and specifically constructed" (Lauckner et al., 2012, pg. 5), and focuses on using varied and subjective meanings of experiences, in order to understand a research topic (Creswell & Poth, 2017). Research using a constructivist framework aims to understand how these meanings are constructed (Lauckner et al., 2012) through an understanding of the context in which their views reside and how their views have been shaped by internal and external factors.

The social constructivist framework was chosen for this project to try and situate the perspectives of participants and understand the structural components that have contributed to their perceptions, within the unique social contexts of Aotearoa/New Zealand and Canada. In Aotearoa/New Zealand there exists a monocultural system fraught with inequities that promotes a bicultural rhetoric. It was these inequities and system racism that neglected the health needs of Māori in mainstream care, which led Ramsden to start work on cultural safety. In Canada, the situation is similar, with leadership at organizations like the Canadian Public Health Association (CPHA), and Canadian Institutes of Health Research (CIHR) claiming to support both cultural safety and reconciliation with Indigenous peoples in Canada, while significant inequities persist.

Understanding that biases and prejudices do not develop in isolation, but rather, life experiences, cultural norms, personal beliefs and others all contribute to an individual's understanding, was key to understanding the perspectives of the key informants involved in this research. Understanding the combined impact of these influences was also key in understanding the barriers, facilitators and contributing factors to providing culturally safe care because the structure that creates health inequities for Indigenous peoples is situated within these relationships as well.

Therefore, by using a social constructivist framework, individual and broader context surrounding barriers and facilitators to providing culturally safe care were developed through the subjective experiences of participants. This information, with a grounded theory approach, developed into a more in-depth understanding of the overall barriers to providing care that is culturally safe for Māori and Indigenous peoples in Canada.

Ethical Considerations & Methodological Limitations

In approaching this project, I considered that my position as a female researcher of colour could play a role in my data collection. I wondered whether my participants, who were largely white, might provide answers that weren't completely honest, were incomplete, or perhaps wholly different than their actual views, based on my position as a woman of colour and the potentially sensitive nature of the topic. In short, I was worried that my participants would be hesitant to openly share their views on sensitive or polarizing topics like Indigenous health equity or systemic racism, because I'm a person of colour. Interestingly, in one interview in particular, I felt that my positionality did play a role in how the participant spoke, the tone they used, and the way that we interacted, but looking deeper into this could be an entire study on its own.

My position did have an impact on the study in other ways. As stated previously, I am not Indigenous, though I have Indigenous family members, which makes me a step removed from the issues this project set out to examine. While these issues are important to me, they are not my lived reality, which changes the lens that I used. Additionally, though I am more familiar with Indigenous issues in Canada, particularly Ontario, I am an outsider to the New Zealand context. This limits my analysis and interpretation of the data. This project initially included 2 months of data collection in New Zealand, which could have helped to broaden my understanding of the cultural context, but this was changed due to the ongoing COVID-19 pandemic. My participants were integral to helping address this limitation, and many provided additional resources after our conversations to help me contextualize our conversations.

In working with Indigenous Peoples both in Canada and New Zealand, I sought advice from my committee. In the ethics process, I used cultural safety expertise as my main inclusion criteria for participants. For this same reason, I included Indigenous peoples as an incidental group within the ethics application, explaining to the REB that the goal was to include both Indigenous and non-Indigenous participants, which had led to the selection of the inclusion criteria. In addition, Indigenous scholars on my committee emphasized the need for member checking, particularly when working with Indigenous participants. Member checking is a strategy used to “enhance confidence in the data interpretations” (Creswell & Poth, 2017, p. 182) and can encompass a variety of techniques including member check interviews, returning transcripts to participants, or conducting focus groups, among others (Birt et al., 2016). The member checking process was then incorporated for all participants, discussed in more detail below.

During data collection, some Māori participants requested to open and close our interviews with prayers in te reo Māori [Māori language], which I welcomed and encouraged. At one point during my data collection, I realized that a large proportion of my participants were Indigenous. Since I had only written that Indigenous people might be an incidental group, I wrote to the Research Ethics and Administration Officer as a precaution to find out whether an amendment was required. The Research Ethics and Administration Officer concluded that there was no need for an amendment. Overall, with all of the Indigenous participants, my goal in working with Indigenous Peoples in both countries was to disseminate the knowledge they shared with me in a respectful way.

An additional limitation of this project was the lack of participant identification. The need to identify whether participants were Indigenous was not brought forth until after the final results had been written up and presented to my committee. Asking participants to self-identify was not part of the initial research protocol and would require an additional ethical considerations and approval. Additionally, retroactively assigning participants identity felt intrusive and inappropriate, and therefore was not done. However, examining the perspectives brought forth by Indigenous and non-Indigenous participants represents an important piece layer of analysis that could help to contextualize the findings of this study. Therefore, not doing so presents a methodological limitation. The use of a social constructivist framework, which centres individual perspectives, also contributes to this limitation. If most of the study participants are non-Indigenous, or were not asked to self-identify, this could contribute to centering non-Indigenous perspectives in the study conclusions and therefore subjugating Indigenous perspectives on this issue. Not identifying whether participants were Indigenous also begs the question of whose voices are being centered in this research. In the presentation of participant quotes, there was no intentional privileging of non-Indigenous voices. Though my study design intended to be as inclusive as possible, and was never my intention to subjugate Indigenous voices or knowledge, in retrospect the lack of self – identification may have limited capacity to know whether Indigenous or non-Indigenous voices were centred in this research.

Lastly, consistent with the TCPS2, the principles of Respect for Persons, Concern for Welfare and Justice (Government of Canada, 2019) were ensured in this study. Respect for persons was maintained throughout the study valuing the time and contributions of the study participants. Gratitude and respect was demonstrated by responding to emails or inquiries in a timely manner and so as not to waste participants' time, and participants were thanked sincerely at the conclusion of all interviews. Participant autonomy was also respected by ensuring that they were able to give their free, informed and ongoing consent. As described previously, participants were asked to review all study information, and provide written consent prior to interviews. Participants were also given a thorough explanation of the research questions and study aims, as well as the opportunity to ask questions prior to their participation in the study. At the beginning of each interview, participants were asked again if they had any questions or concerns about the project, and their continued consent was confirmed.

The principle of Concern for Welfare was maintained by ensuring some level of participant control over the information they contributed, and how this information was represented. This was accomplished through several aspects of the study. Firstly, interviews were transcribed and sent back to all participants to review as part of a member checking process. At this stage, transcripts were revised to reflect any corrections, or clarifications had participants, and identifying information such as place of work, names of partner organizations, or other information they were not comfortable sharing, were removed at their request. Corrections brought forth by participants were minimal, and were mostly minor details related to audio distortions. The data collected for this study will be maintained for the minimum 5 years required by Lakehead, and will then be destroyed to maintain confidentiality.

Lastly, the principle of Justice was incorporated into the study design, to ensure that this project was as inclusive, fair and equitable as possible. As mentioned elsewhere, I chose to use cultural safety expertise as the main inclusion criterion in order to include all individuals with relevant knowledge and experience. I also chose to include participants from a range of backgrounds in order to have a more diverse range of perspectives on this important issue, and to make sure the study was inclusive. The principle of justice also includes the fair distribution of the knowledge gained from the research. The knowledge generated by this study will be disseminated back to the community in several ways. Firstly, an outline of the project was presented at the 2020 University of Toronto Indigenous Health Conference. Included in this thesis are two manuscripts, written for the Journal of Racial and Ethnic Health Disparities, and The International Indigenous Policy Journal, which represent another form of knowledge dissemination. I hope to present my findings at the CEAD-Contemporary Ethnography Across the Disciplines Conference in New Zealand, scheduled for later in 2021. I also plan to share my final thesis with all of the individuals who participated in this project. It is my intention that this research will be beneficial to the health communities in New Zealand and Canada. It is important to me that the knowledge from this research is shared with the communities that could benefit the most including Māori and Indigenous research networks, and stakeholders outside of academia with the potential to put these findings into practice.

Methods

Data Collection

Data for this project was collected through semi-structured video interviews with key informants in Canada and Aotearoa/New Zealand. Purposeful sampling was employed to recruit participants, with cultural safety expertise as the key inclusion criterion for participants. When considering inclusion criteria, cultural safety expertise was broadly construed. For academics, individuals who had cultural safety as a primary research focus, and/or a significant amount of research related to cultural safety, were considered to have expertise. However, I recognize that participants outside of academia possessed expertise in a different way. In this context, individuals who engage with cultural safety on a daily basis, such as healthcare providers, activists, or other healthcare professionals were also considered to have expertise. This use of a key informant approach and broad definition of cultural safety expertise aimed to encourage diversity among participant perspectives and recognize that knowledge and expertise can take many forms beyond what is valued in academia.

Prior to data collection, lists of potential participants in both countries were developed with my committee members, based on this criterion. In New Zealand, Dr. Kidd used her familiarity with the research community to provide suggestions and contact information for several individuals who met the inclusion criteria. Additionally, during data collection, one participant provided the contact details for a few other potential participants who they thought would have valuable insight for the project. Therefore, in addition to purposeful sampling, some snowball sampling also took place. Through both of these strategies, the key informants who took part in the study encompassed a variety of backgrounds, including health system administrators, academics, and service providers, namely physicians, and nurses (See Table 1). Note, this table is a simplistic representation and is not comprehensive as several participants work in more than one context.

Table 1: ***Interview participants by organization type***

Canada	Aotearoa/New Zealand
Academic (4)	Academic (4)
Indigenous Healthcare Organization (1)	Healthcare (1)
Private (1)	Professional Organization (3)
Total: 6	Total: 8

The use of interviews allowed for an opportunity to speak to professionals one-on-one, and the semi-structured nature allowed them to share their experiences with minimal interruptions. As DeJonckheere and Vaughn (2019) write, semi structured interview “allows the researcher to collect open-ended data, to explore participant thoughts, feelings and beliefs about a particular topic and to delve deeply into personal and sometimes sensitive issues" (p. 2). Semi-structured interviews allow the participants as much space as possible to share their experiences and perspectives. In contrast to a structured interview with a more rigid interview structure and adherence to a set of questions, the questions in semi-structured interviews serve more as a guide, giving the interviewer more ability to probe and minimize missed information.

The interview guide was discussed with committee members prior to my proposal in order to assess appropriateness, and ensure the questions were targeted enough to gather the information desired. Questions in the interview guide were based on 1) general understandings of cultural safety, 2) barriers to cultural safety, 3) societal, cultural and political factors, and 4) implementation. See Appendix D for a sample of the interview guide.

During the interview scheduling, participants were provided an electronic copy of the consent and information forms. Participants were asked to return the consent form prior to their interview. All participants were offered an opportunity to ask questions about the project at the beginning of the interview.

Qualitative interviews (n = 13) were completed using Zoom software from November 2020 to March 2021. One interview included two participants, and this resulted in a total of 14 participants. Interview sessions varied based on participant feedback and were approximately 30 minutes to 1 hour and 45 minutes in duration. In addition to the video and audio recorded by Zoom, handwritten notes were taken in order to capture additional details. These included notes about body language, tone, research environment, and other thoughts which prompted later reflection. Conducting a grounded theory study is an iterative process. Therefore, during the process of interviews, data was analyzed to identify emerging themes.

Data Analysis

In analyzing the data for this project, I used a thematic approach based on the process outlined by Creswell and Poth (2017) and sought guidance from Dr. Schiff at several points throughout the process.

Firstly, all interviews were recorded using Zoom software. Interview recordings were saved locally, and transcribed by hand, without the use of transcription software. While doing this took more time, it allowed me to become intimately familiar with the details of each transcript. During transcription, I also continued memoing, making notes on important themes, questions, or ideas that came up as I worked through the transcript. As I accumulated more interviews, I found myself making connections between the conversations I was having, prompting additional memos on similarities and differences.

Once the transcripts were complete, they were sent to participants to review as a form of member-checking (Creswell & Poth, 2017). At this stage, participants were asked to ensure that their perspectives were accurately reflected, and submit any corrections that were needed. Additionally, in the case of participants in Aotearoa/New Zealand who often incorporated te reo Māori [Māori language] into the conversation, their assistance was required to ensure that the language translation was captured correctly. In some instances, participants reviewed their transcripts and clarified meanings, or submitted corrections, and so the member checking process proved to be an important step. Once interviews were approved by participants, all transcripts were uploaded to NVivo 12, and the coding process began.

In line with the grounded theory approach, analysis was an inductive process informed by connections, patterns and themes and memos that emerged from the interviews. The notes taken during interviews about tone, body language, and other thoughts formed an added layer to the research. For some interviews, I made note of controversial points raised by participants as a lens through which I viewed other interviews. I also used these as points of comparison to help me contextualize the data collected in subsequent interviews, particularly in New Zealand. For example, one participant mentioned government apologies to Indigenous peoples. I used this as a point of comparison when conducting my analysis across the other interviews to see if other participants shared similar views. This also helped me to consider the lenses my participants brought to the work and identify that particular individual as an outlier within my data. To a much lesser degree, some of the themes were informed by prior engagement with the literature.

My coding strategy was informed by that of Braun and Clarke (2006). In the initial stages of coding, potential themes were collated into a concept map (See Appendix A) in order to visualize connections between them. These themes came from the transcription process, reading and re-reading the transcripts, my handwritten interview notes, and memoing.

From this map, I merged many of the concepts to create an initial coding framework (Table 2) based on the themes that stood out the most. These steps are in-line with phases 1 and 2, as outlined by Braun and Clarke (2006), which focus on familiarizing yourself with your data and developing initial codes.

I started by testing the coding framework on a few transcripts first (#1, #2, #13) to see if it adequately fit the data in the transcripts. These interviews were chosen because they include participants from both Canada and Aotearoa/New Zealand, and represented different points in the data collection process. I coded the remainder of the transcripts using the initial coding framework, but quickly realized that additional codes were needed. I added additional codes to the coding framework, then went back to previously coded transcripts to check for these newly added codes.

When coding of all interviews was complete, I examined the framework and began to group the codes into themes and sub-themes. I submitted this adapted list to Dr. Schiff for feedback, and made changes based on our discussion of these themes and her suggestions. Once I had finalized my codes and themes, I put together a chart containing themes and accompanying rationales, which I also shared with Dr. Schiff (Appendix A - Table 2). I also put together a data dictionary, outlining the codes, a description of what was coded under each, and an example segment from the transcripts (Appendix A - Table 3). Once the final edits were made, I submitted both of these charts to my participants for feedback as a second stage of member checking. While including member checking took extra time, it allowed participants an opportunity to engage in the analysis process, and is both a validation and quality assurance strategy (Creswell & Poth, 2017; Tong et al., 2007). Additionally, member checking can help protect against bias by "ensuring that the participants' own meanings and perspectives are represented and not curtailed by the researchers' own agenda and knowledge" (Tong et al., 2007, p. 356). Participant feedback was overwhelmingly positive at this stage. Participants who provided feedback felt that the themes aligned with what they expected, and were accurate. With this final member checking, I concluded my analysis, and began writing up my results.

Thesis Format

This thesis is presented in a manuscript style format. It continues with a description of the barriers identified by participants presented in the form of a manuscript, prepared for submission to the Journal of Racial and Ethnic Health Disparities in Chapter 3. In Chapter 4, the strategies and frameworks for implementing cultural safety are presented in the form of a manuscript prepared for the International Indigenous Policy Journal. Chapter 5 presents a discussion of the study results as a whole, and finally, Chapter 6 presents the conclusion to this study including personal reflections, and implications for policy, practice and future research.

Chapter 3: Addressing Colonialism in The Room: Barriers to Culturally Safe Care for Indigenous Peoples

[corresponding author] Ashley Wilkinson, Department of Health Sciences, Lakehead University, 955 Oliver Rd., Thunder Bay, Ontario P7B 5E1, Canada, awilkin2@lakeheadu.ca, ORCID: 0000-0001-8377-4674

Rebecca Schiff, Department of Health Sciences, Lakehead University, 955 Oliver Rd., Thunder Bay, Ontario P7B 5E1, Canada, rschiff@lakeheadu.ca

Lana Ray, Department of Indigenous Learning, Lakehead University, 955 Oliver Road, Thunder Bay, Ontario P7B 5E1, Canada, lray@lakeheadu.ca

Helle Møller, Department of Health Sciences, Lakehead University, 955 Oliver Rd., Thunder Bay, Ontario P7B 5E1, Canada, hmoeller@lakeheadu.ca

Jacquie Kidd, Jacquie Kidd, Faculty of Health and Environmental Sciences, Auckland

University of Technology, Private Bag 92006, Auckland 1142, New Zealand,
Jacquie.Kidd@aut.ac.nz

Abstract

This research project examined the perspectives of key informants to better understand the existing barriers and facilitators to culturally safe care for Indigenous Peoples in Canada, and Māori of Aotearoa/New Zealand. This paper discusses the three major themes that emerged, including organizational and systemic barriers, and barriers associated with the implementation of cultural safety. Key issues identified by key informants included systemic racism, lack of organizational accountability and/or buy-in, ineffective health provider education, funding, health system structure, undervaluing Indigenous knowledge, negative framing, lack of understanding of the historical/social/political context experienced by Indigenous Peoples, power, terminology, and changes to the concept of cultural safety over time. Many of these barriers were similar between key informants in Canada and New Zealand. These findings point to the fact that barriers to culturally safe care exist at every level and require a whole-of-systems approach to provide culturally safe care for Indigenous Peoples, and advance Indigenous health equity.

Keywords: Indigenous, Indigenous health, Health equity, Health services, Cultural safety, Barriers

Introduction

Indigenous Peoples worldwide continue to experience health inequities, and negative care experiences, due in part to the ongoing impacts of colonization (Jacklin et al., 2017; Reading &

Wien, 2009). The health inequities arising from the effects of colonization include poorer health outcomes, disparities in the social determinants of health, racism and marginalization within the health care system (Nelson & Wilson, 2018; Reid et al., 2019; Adelson, 2005).

Most recently, two reports have come to light, demonstrating the pervasiveness of racism for Indigenous Peoples accessing healthcare. The Wai 2575 report presents all of the alleged breaches of Te Tiriti o Waitangi within the health sector, including institutional racism, Māori health inequities, limited funding for Māori health services and lack of support for services in line with Māori traditional values (Came et al., 2020; Waitangi Tribunal, 2019). In Canada, the In Plain Sight Report presents a thorough examination of the health system in British Columbia. The report came about after allegations of physicians in BC playing a game to guess the blood alcohol levels of Indigenous patients and aimed to examine Indigenous-specific racism within the healthcare system (Turpel et al., 2020). Both reports suggest significant barriers to quality care for Indigenous peoples and provide recommendations that involve cultural safety.

Culturally safe care is defined in the In Plain Sight report as occurring when:

> [an] environment is physically, socially, emotionally and spiritually safe. There is recognition of, and respect for, the cultural identities of others, without challenge or denial of an individual's identity, who they are, or what they need. Culturally unsafe environments diminish, demean or disempower the cultural identity and well-being of an individual (Turpel et al., 2020, p. 212).

A key component of cultural safety is the need for reflexivity on the part of the health care provider to understand the power differentials within provider-patient relationships that lead to health inequities (Kurtz et al., 2018; Josewski, 2012; Dell et al., 2016; Richardson, 2004; Auger, 2019). As Curtis et al (2019) write, “This requires health providers to question their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients” (p.13).

This was reiterated in the Wai 2575 report, which stated:

> Cultural safety intends to recognise that sociocultural difference manifests, in part, as a power imbalance…It recognises the dynamics of institutional racism: that tikanga and mātauranga Māori, while centrally important to many Māori, are not recognised as ‘ordinary’ in the nation as a whole and, as a result, are not often properly provided for by institutions. In this way, cultural safety recognises not just that services need to be culturally appropriate but that, if services are delivered inadequately, then the delivery method of those services can become a negative determinant of health outcomes. (Waitangi Tribunal, 2019, p. 156)

Cultural safety has been shown to improve patient experiences by making patients feel supported, creating safe spaces, and increasing access to Indigenous knowledge, cultural teachings and ceremony, and more (Churchill et al., 2020; Brown et al., 2016). Through creating positive experiences for patients, and mitigating barriers to effective care, cultural safety can help to address persistent health inequities. Despite this support for cultural safety, it has not been widely implemented in health care settings. This research project explored the challenges associated with providing culturally safe care for Indigenous Peoples of Canada, and Māori of Aotearoa/New Zealand through the perspectives of key informants. The study of these barriers in a cross-cultural context provides an opportunity to learn from and share information between the two study locations, as both countries have a similar colonial history. Importantly however, New Zealand has a longer history with cultural safety which could provide valuable insights that can be applied to a Canadian context, where cultural safety is a more recent addition to the Indigenous health discourse. Understanding these barriers will help to identify areas of improvement for health services, increase the quality of care for Indigenous Peoples, and improve Indigenous health equity.

Methods

This work is part of a larger study on culturally safe care for Indigenous Peoples in Canada and Māori of Aotearoa/New Zealand. This sub-research paper focuses specifically on the barriers to culturally safe care, and strategies and frameworks for enhancing cultural safety education and implementing culturally safe care are discussed elsewhere.

Ethics approval for this project was granted by the Lakehead University Research Ethics Board (approval #1468273).

Prior to the commencement of the project, lists of potential participants in Canada and Aotearoa/New Zealand were developed by the research team. Individuals with experience in cultural safety were the primary participant pool, and as such, lists of potential participants included a range of professions including health system administrators, academics, and service providers such as physicians, and nurses. Because experience in cultural safety were the primary participant pool, Indigenous and non-Indigenous participants were invited to participate.

Potential participants were contacted via email and invited to participate in the study, and interviews were carried out once written consent was obtained.

Qualitative interviews (n = 13) were completed using Zoom software from November 2020 to March 2021. One interview contained two participants, for a total of 14 research participants. Interview sessions varied based on participant feedback and were approximately 30 minutes to 1 hour and 45 minutes in duration. A qualitative approach was chosen for this project because qualitative data collection methods allow for rich data and greater depth than quantitative methods, which was necessary in order to understand the complex relationships between the aforementioned barriers and contributing factors. Qualitative research methods also facilitate more meaningful relationships between the researcher and the participant, which can provide an additional layer of context to the information participants share. The benefit of qualitative methodology for this project is captured poignantly by Hammarberg et al (2016) who write, "'qualitative' methods are used to answer questions about experience, meaning and perspective" (p.499).

Physicians, nurses, academics, and organizational directors/leaders, herein referred to as key informants, were interviewed to understand the barriers to culturally safe care for Indigenous Peoples. Semi-structured interviews included 8 in-depth questions to understand their perspectives on defining cultural safety, access barriers, contributing factors, effectiveness of cultural safety education, implementation of cultural safety, and the next steps for cultural safety in a health context. For the purpose of this study, Indigenous Peoples included First Nations, Inuit and Métis Peoples in Canada, and Māori of Aotearoa/New Zealand.

All interviews were voice and audio recorded, transcribed and coded using NVivo 12 software. In addition, handwritten notes were taken to capture additional detail about tone, body language, and other considerations which prompted later reflection (Creswell & Poth, 2017).

Themes emerged after coding (Braun & Clarke, 2006)., and included both organizational and systemic barriers, and barriers relating to the implementation of cultural safety. Codes were organized into these themes, and relevant quotes were identified across multiple codes, that also fit into these themes. This paper explores the barriers to culturally safe care for Indigenous Peoples in Canada, and Māori of Aotearoa/New Zealand as identified by key informants in each country with cultural safety expertise.

Findings

Key informants expressed that they have witnessed organizational, structural and systemic barriers to cultural safety for Indigenous peoples and patients, as well as barriers related to the implementation of cultural safety within healthcare and health education. In the literature, there is significant overlap between systemic and structural barriers, which are often defined as exclusionary policies or practices that result in unequal access, and may be the result of institutional policies and values (Canada Research Coordinating Committee, 2021). The terminology in this project takes a slight departure in the way that these terms are used. The term ‘systemic barriers’ refers to barriers which participants described as occurring at a systems level. The term ‘structural barriers’ refers to barriers which participants described as related to specific, fixed constructs within systems that hinder culturally safe care. Lastly, the term ‘organizational barriers' refers to barriers which participants described as occurring at an organizational level. The results are presented below, according to these themes.

Organizational Barriers

In describing the existing barriers to culturally safe care, participants often described challenges at an organizational level, which emerged as a theme. Several sub themes in relation to organizational barriers emerged, including: policy practice; and structure.

Policy & Practice

Participants discussed barriers related to policy and practice that prevent effective, culturally safe care within healthcare organizations and organizations that train healthcare providers. These barriers included lack of accountability, lack of organizational buy-in, and unsafe care practices.

A common theme among participants was a lack of organizational accountability, both within organizations, and at a higher level. In many instances, participants referred to a need for external accountability for organizations, through governing or regulatory bodies. Several participants suggested that regulatory bodies do not adequately hold organizations and healthcare staff accountable. This can in turn lead to lower standards across organizations, contributing to unsafe care. As one participant mentioned:

> …the regulatory body is the nursing council, ensures the curricula delivered and they hold account the education facilities for the curricula. So, if they set the standards on the curriculum, then they are supposed to monitor and hold the provider accountable…they just don’t have the balls to do that. (Participant #10 - NZ)

Additionally, some participants emphasized the need for external accountability due to bias. As one participant mentioned:

> Then you have hospitals that when they assess the competency of their staff, [it’s] self-reporting, and it’s optional as to how much of this or that you show. So you might write up a case study that bears as much resemblance to reality as a total fairytale. (Participant #6b - NZ)

Many participants also noted how a lack of accountability can contribute directly to poor practice. In some instances, failing to hold staff accountable can perpetuate stereotypes or racism and contribute to the racism that Indigenous Peoples experience when accessing care. As another participant explained:

> I don’t think we’ve adequately tackled that institutional transformation that's required to make healthcare a culturally safe place, and so we then continue to see racist practice that’s ignored, or that is not challenged, or is not held accountable, or is not corrected and so that I think is the biggest problem. (Participant #11 - CAN)

Another common theme among participants, was the emphasis on organizational buy-in. Participants felt that for many health care providers, their organizations had not bought into cultural safety, which created an unsafe space, particularly for individuals of colour. As one participant shared:

> …the main thing is that we aren't institutionalizing cultural safety in the way that we organize our healthcare system and provide care. So people who've done cultural safety training – who are well-intentioned - often find themselves within an institution that does not support them to actually practice in a culturally safe way. (Participant #11 - CAN)

Additionally, participants stressed that without organizational buy-in, particularly from leadership, change was unlikely to happen. One participant summarized,

> how I do my job is decided a lot by managers who may or may not – and largely not – buy into it as well. If we can't infiltrate them, and we're probably not gonna infiltrate their learning. If we're not gonna change how the managers are thinking and doing, then that's gonna be really hard to get any on the ground change 'cause form drives function. (Participant #7 - NZ).

Lastly, participants spoke about unsafe care practices within organizations that created a barrier to culturally safe care. Some participants identified blatant examples of unsafe care practices caused by stereotypes, discrimination, and racial biases. One participant shared,

> people are like 'oh okay I know about residential schools and I know about that intergenerational trauma and now here you are as an Indigenous parent in my hospital and I will think that you don't love your children because of that past history that you have and that you're passing trauma on to your children and that you're going to have psychological issues and trauma' and all of those things and that may or may not be true but it still is perpetuating a stereotype (Participant #11 - CAN)

Others emphasized practices such as health providers rushing through visits or not considering a holistic approach, which undermines the quality of care received. This also limits the ability for care to consider additional aspects that may be a core part of the patient journey such as including traditional medicines. As one participant shared,

> the nurses and doctors who are part of the care there are not recognizing the totality of the human being and for Māori it's not just the human being, it’s *whānau*, the collective that’s part of them. They haven’t conceptualized that as part of who the care should be for, so the care is missed and I think that’s unsafe. (Participant #2 - NZ)

These examples demonstrate some of the many ways in which policy and practice contribute to organizations providing culturally unsafe care. It was clear that participants were able to recognize the many ways that health organization policy and practices are incongruous with the tenets of cultural safety. These factors also combine with structural factors to create additional barriers for Indigenous Peoples seeking care.

Structural Barriers

Participants frequently discussed barriers related to the structure of health and educational organizations. These barriers included education models, funding arrangements, and the overall structure of the health system.

In terms of education, almost all participants identified issues with the way cultural safety is taught. Many participants mentioned that health provider education is ineffective, inadequate, or misguided, inconsistent, and not meaningful, among others.

Several participants pointed to the structure of the education programs as a barrier. As one participant shared:

> We do a paper on this, and then you do a paper on something else, then you do a paper on something else and I think we've lost some of the cohesion and integration that we might once have had. So when we bring something like cultural safety into our curriculum we then commodify it to learning outcomes or learning objectives and things that can be tested in an exam or an essay. I think that that's a flaw. (Participant #2 - NZ)

Another participant shared a similar sentiment with regard to the way cultural safety is taught:

> I think there needs to be mandatory training, not only this one class. When I taught, there was one class in nursing, usually one class in medicine and that's it, you get one class over your four years and that's not enough. It needs to be reinforced over the course of your program, and I think it's more than just a cultural safety course… (Participant #4 – CAN)

Participants also took issue with the content and organization of cultural safety training programs. Several felt that programs were not locally contextualized, applied a pan-indigenous framework, and were thus ineffective:

> communities are very different. If you develop cultural safety training and you do a pan-Indigenous approach, it is not going to work, and I think there is a lot of pan-Indigenous training going on. (Participant #4 - CAN)

Another participant expanded on these points and commented on the lack of diversity among educators:

> Thinking about who I have ever studied, who I learned from, looking at all the sources – teachers from kindergarten to professors through my B.A., M.A., doctorate degree – were predominantly white and mostly white male, so who am I taught to listen to and conditioned into listening [to]? (Participant #3 - CAN)

For many participants, funding was also a significant barrier to culturally safe care. Participants primarily discussed challenges with organizations not providing funding due to lack of support for cultural safety initiatives, or due to budgetary constraints.

As one participant mentioned:

> …all of the management focus is on financial management and austerity. I think this austerity agenda has created a toxic environment that makes it difficult for anybody to take on that agenda of change and provide the resources, and so cultural safety is one of those things that is suffering (Participant #11 - CAN)

Another participant echoed this sentiment and shared:

> we've come to a point in New Zealand where we've implemented a wee bit of Treaty and Māori health training to be a little bit compulsory in some areas, but because there's no money in it as such, there's no funding for it, the government's not chucking out new money to do more training…it costs $1200 per doctor. Not very much in the scheme of things, but enough that the colleges or the health system isn't gonna pay for all the doctors to do it. (Participant #7 - NZ)

Finally, participants also discussed how the structure of the health system itself creates a barrier to culturally safe care. In many cases, participants referred to limited appointment times, an emphasis on budgets, and a system that is run more like a business than a service with a focus on patient-centered care, which all create barriers to culturally safe care.

Several participants shared comments to this effect:

> These systems are all so busy, overrun, under-resourced, so if it's not seen as a really important issue, nothing's gonna happen. (Participant #3 - CAN)
>
> Whether it's the system that we have as a health system, and how it is designed in a way which is transactional… that filters all the way down, I guess, to the doctor or the nurse who is told that they've got 20 appointments that need to be kept and filled and so the transactional part of care means that you can't necessarily practice culturally safe because some people need more of your time, and some people need less. (Participant #7 - NZ)

In addition to the barriers that exist at an organizational level, participants also identified barriers at a systemic level that often represent the distal cause of the organizational barriers.

Systemic Barriers

Systemic barriers emerged through two sub – themes: Implementation of cultural safety; and relations between Indigenous and non-Indigenous groups. These themes were additionally framed through discourse on eurocentrism, systemic racism, undervaluing Indigenous knowledges, inequities, negative framing, attitudes and understanding the historical/political/social context of Indigenous Peoples.

Implementation of Cultural Safety

For many participants, challenges around providing culturally safe care were rooted in challenges with the terminology. Many participants took issue with the word culture, which they felt caused HCPs, educators and the general public to shift their attention to Indigenous culture, and away from prioritizing patient safety, and care outcomes. As participants explained:

> It's bigger than culture and I always draw people's attention to the term 'safety' that's in that definition. Those two pieces together, it's important that people understand why both terms are there in the definition. (Participant #3 - CAN)
>
> In talking about that language I think we still get caught up in using terms interchangeably and I know for myself, I don't correct people. People talk about cultural appropriateness, cultural sensitivity, cultural competence, and then cultural safety, and they seem to use those terms interchangeably. It just goes to show that learning has to catch up in some of those circles. (Participant #5 - CAN)
>
> New Zealand sadly did move away from cultural safety, it now uses a language of cultural responsiveness. Personally, I think that's wussing out because for me it was around safety [keeping] people alive or dead… At the same time, the language of cultural safety is one that's so much easier for people to approach than racism, racism gets peoples' backs up so fast. (Participant #6b - NZ)

Along these lines, participants also described important differences between cultural competence and cultural safety, favouring cultural safety as a more effective tool. Many participants felt that the language of cultural competence was more limited in scope, and presented health provider understanding as something that has a measurable outcome, as opposed to a continuous learning process like cultural safety. These concerns are consistent with other literature such as Curtis et al (2019) who also suggest that cultural safety is a more effective approach.

Changes to cultural safety from its original conception also presented a barrier that participants felt inhibited the growth of the concept, did not provide sufficient credit to Indigenous Peoples, and impacted how cultural safety has been taken up. As one patient shared:

> *Kawa Whakaruruhau* which Irihapeti Ramsden promoted, got taken from being a Māori concept and inclusive and got put into a box which was packaged and delivered out educationally to the wider nursing fraternity, but it was changed. Its – we call it a *mauri*, so its life force or its essence – was changed from conception to policy writing in the way it got implemented. (Participant #10 - NZ)

These challenges around the terminology of cultural safety and the changes that have occurred within the way people conceive of it, represent fundamental barriers to implementing culturally safe care. If cultural safety for Indigenous peoples is going to be implemented effectively, these issues need to be addressed.

Relations between Indigenous and non-Indigenous peoples

Many participants specifically mentioned Eurocentrism[1] as a systemic barrier. They highlighted eurocentrism in the way that systems are designed, and the procedures within. As one participant explained:

> I think really that our institutions are still primarily the dominant culture. One of the treaty obligations was equity, well historically inequity has occurred…so the biggest barrier really is institutions which are still primarily run on a model which is the model of the oppressor (Participant #1 - NZ)

As this participant alludes to, the systemic emphasis on a Western model creates and perpetuates inequity - often in the form of hierarchies - particularly for Indigenous people. This was echoed by several participants including:

> I think our education system has conditioned us, and all people, to believe that Indigenous people are inferior by denying or elevating the settler explorer history. (Participant #3 - CAN)
>
> Our health system is set up to make *Pākehā* ordinary, not Māori being ordinary and that's the fundamental problem 'cause it just makes no sense the way the system runs, and you see it all the time when you interact with health services. (Participant #6a - NZ)
>
> societal worldviews at the moment are normalized to seeing white people at the top and brown people at the bottom. We see it in the justice system, criminal proceedings, the way that police treat people, social profiling. (Participant #8 - NZ)

---

[1] In several instances, participants used the term Eurocentric, 'Europeanised', or 'European' in their discussion of this systemic barrier. In other instances, they used terms like 'Westernized', 'White' or 'Western', but proceeded to refer to similar themes when using either terminology.

Unsurprisingly, this racial bias and the resulting inequities impact care experiences for Indigenous people. Participants described examples of how the health system is set up in a way that does not align with Indigenous cultural practices or belief systems. One participant described how this takes shape within a health care setting:

> Every sign on every wall virtually establishes the norms of *Pākehā* or euro-centric New Zealand, you know? You can have two visitors at the bedside, you can only visit between this hour and that hour, you have to sit on a chair. It's all designed for the nuclear family that wasn't the norm for other people. (Participant #6b - NZ)

Another participant expanded on this point and provided additional examples of culturally unsafe care. They stated:

> It's a whole systemic challenge, but it's the humans that get the hard edge of the craziness, of people not releasing bodies and not letting people do *karakia* [prayer], mispronouncing peoples' names and everyday violence of a health system that's fundamentally flawed. (Participant #6a -NZ)

Participants spoke at length about a systemic undervaluing of Indigenous knowledge, often rooted in this racial bias. This undervaluing of knowledge came in many forms, including Indigenous traditional healing being banned or undermined, communities not being consulted on key projects, and cultural expertise not being valued in the same way as Western education. As one participant shared:

> our *tōhunga* were seen as our healers, our experts in that space…we had a *tōhunga* suppression act come in in I think 1907 – back in the 1900s – and aligning to that, we had the quackery act that came in at the same time. The quackery act for me was kind of the

> start of not being allowed to use *rongoā* Māori or the stuff that we know that is natural medicine for us, so that prevented a lot of things happening, and then they brought in Florence Nightingale's system (Participant #9 - NZ)

Overall, these comments highlight how the Westernized health system promotes values of colonizers and is not aligned with Indigenous cultural practices or belief systems. The current model fails to recognize unique cultural backgrounds, and perpetuates inequities against Indigenous people.

For many participants, limited understanding of the historical, social, and political context Indigenous Peoples face created a significant barrier. This was often connected to racial bias in the way that historical events have been presented, often in ways that present settlers in a more positive light. As one participant shared:

> I think New Zealand hasn't told those stories, they're not part of our national consciousness. We tell stories of Captain Cook arriving…and I mean we have street names here named after the Parihaka story, street names of the politician who led the invasion. They get streets named after them and so if you don't know the story, you just think you live on Bryce Street and you think nothing of it. (Participant #2 - NZ)

Another participant expanded on this with a specific example:

> Florence Nightingale was very anti-Indigenous Peoples and actually her healthcare was about mopping their brow as they died… so effectively the model that she was operating on was around the extinction of Indigenous people…That's caused a whole lot of problems because people don't want to believe that Florence, who helped out in the Crimean war and helped many soldiers, actually was seeing the death and devastation of

> Indigenous Peoples… that re-writing of history is incredibly important, but unless we do that, we're never gonna get anywhere. (Participant #8 - NZ)

Emphasizing the important of ensuring that Indigenous Peoples have a voice and work towards changing the colonial narrative, this participant continued:

> …what we're trying to do is not agitate, but allow our people to have our story told in health, allow our history of well-being to be told and to be brave enough to try and change a system that has largely oppressed the voice of our people, but also the wellbeing of our future (Participant #8 - NZ)

In addition to the aforementioned factors, a universal theme among participants, was the presence of systemic racism as a barrier to culturally safe care. Participants often described systemic racism as a product of historical and ongoing colonization in Canada and New Zealand, which is deeply entrenched within our systems.

As several participants shared:

> Racism in this country is rampant and as Canadians we try to pretend that it's not...white supremacist ideology is embedded within the institutions of Canada. (Participant #11 - CAN)

> I don't think as a society, we have come to terms with that and I think, certainly not in medical training environments have we really come to terms with how deep those systems of racism affect us… (Participant #13 - CAN)

Participants discussed attitudes, and negative framing behaviour towards Indigenous Peoples as a result of this systemic racism. Several participants described how the attitudes of some individuals within a health organization – referred to in many cases as ‘culture-setters’ – can trickle down and affect the beliefs of others.

As one participant shared:

> …charge nurse managers I think, are culture-setters. There’s what the directors of nursing say should happen and what happens on the floor is determined, I would argue, more by the local leader than by what the head of the organization says because those things get actualized in different ways… if there happens to be some old, crusty nurses that are mean and nasty and judgemental then it doesn’t take long for some of our novice clinicians to subconsciously align themselves to that… (Participant #2 - NZ)

Many participants shared examples of stereotypes, which underpin these attitudes, and are often informed by negative beliefs about Indigenous people. Two examples of stereotyping shared by participants included:

> we see the first question in ER is ‘how much do you drink?’ and ‘are you sure you don’t drink?’ by every person that they see through that health care journey (Participant #3 - CAN)
>
> for us we’ve had a really tough last few years with the amount of social media abuse, like ‘Māori nurses sit on their fat a***s, grow weed and smoke drugs’ (Participant #9 - NZ)

While these blatant examples of racist stereotypes abound, participants also highlighted more subtle forms of racism, through negative framing. As one participant shared:

> The hard part is often the unseen stuff, or the stuff that's not as obvious. The interpersonal, the flat-out racism's really easy to spot, some of the systemic stuff is easy to spot, but not as much, it's often just those little microaggressions and the systemic stuff of negative framing, deficit-thinking and that kind of stuff which is the stuff which becomes like a hidden curriculum and is taught through not being taught, but just through the actions and the behaviours of the clinicians and of the staff…ultimately the deficit thinking, the framing of Māori as the problem rather than the historical reasons why we're where we are keep on coming through, and that ultimately leads to people not getting the culturally safe care that they need. (Participant #7 - NZ)

Importantly, as several participants pointed out, this racism can also impact health care staff both as victims of racism (Turpel et al., 2020; Mpalirwa et al., 2020; Kidd et al., 2020), and as challengers of racism. As one participant shared, it can be very difficult for staff to address racism within the health system, due to uneven power differentials:

> where a person has to work with someone, so they don't say anything when they witness racism. That [means] this person who's come to that engagement, that encounter – with the knowledge, awareness, and skill – doesn't feel that they can interrupt the racism because of the power and the dominance of some people in those systems, so the coaching has to stop. (Participant #3 - CAN)

Overall, systemic racism was described by participants in both countries as one of the most significant barriers to culturally safe care for Indigenous people. Referring specifically to New Zealand – though potentially applicable to Canada as well – one participant poignantly summarized:

> New Zealand is racist… and I don't think we can get away from it. (Participant #2 - NZ)

Discussion

The Truth and Reconciliation Commission (2015) called upon the Canadian government to reduce the inequities in health outcomes between Indigenous and non-Indigenous people, and called for the implementation of cultural safety training. The Wai 2575 report (Waitangi Tribunal, 2019) also recognized that unsafe care contributes negatively to health outcomes, and called for additional support of Māori organizations that design and deliver culturally safe services. As this research has demonstrated, the barriers to providing culturally safe care for Indigenous Peoples are numerous and extensive.

As key informants pointed out, a lack of accountability at the organizational level contributes to unsafe care environments. These comments were in line with additional literature which has also described the need for organizational accountability and mandates around cultural safety (Wylie et al., 2021; DeSouza, 2008). In order to achieve cultural safety, as Curtis et al, (2019) write, "healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity" (p. 14).

Concerns raised by participants about health care provider education, including scope, the limited effectiveness of one-off training, and the need for continuous learning were consistent with other literature (Wylie et al., 2021; Ewen et al., 2021). Educational models were also criticized by participants for being white-dominated. While this point was not specifically in reference to cultural safety education, it highlights an important gap in the education system. Research has demonstrated that in Canadian universities, racialized and Indigenous professors are under-represented, paid less than white professors and hired at lower rates (Henry et al., 2017). Similar data has been found in New Zealand universities where 56-83% of academics were European from 2012 to 2017, and the proportion of Māori academics was between just 4.2% and 5.1% during the same time period (McAllister et al., 2019). This data suggests that the structure of the education system perpetuates racial hierarchies and facilitates biases by minimizing the voices of racialized groups, which – when applied to postsecondary healthcare training - creates barriers to providing culturally safe care earlier in the process. The data also suggests that similarly to other areas like Nunavut and Greenland, the educational systems have been developed and governed by people of European descent, which privileges Eurocentric ways of knowing (Møller, 2016).

Overall, ineffective cultural safety education does not adequately prepare providers to interact with Indigenous people, which results in a failure to address the biases health care providers may have and power differentials present within a healthcare setting. This leads to an unsafe environment for Indigenous Peoples seeking care.

Several of the barriers mentioned also tie into a larger issue of power, which many participants emphasized. A key component of cultural safety is the focus on the power differentials within health care provider and patient relationships, that lead to health inequities (Kurtz et al., 2018; Josewski, 2012; Dell et al., 2016; Browne et al., 2005; Richardson, 2004). Cultural safety emphasizes the need for reflexivity on the part of the health care provider, in order to understand the power inherent in relationships within the health care field (Auger et al., 2019; Cameron et al., 2014; Oda & Rameka, 2012; Vogel, 2015). Because of the racial bias, and devaluing of

Indigenous knowledges, spaces are often unsafe. This leads to power imbalances where Indigenous Peoples and allies may be unable to speak out (Harding, 2018). Along these same lines, participants described Indigenous Peoples being disempowered by centuries of ongoing colonization, and biased practices, as well as the issues that arise because of these distorted power dynamics, related to systemic racism.

Participants highlighting systemic racism as a significant barrier to safe care is consistent with other literature (Goodman et al., 2017; Browne et al., 2011). Additional literature has demonstrated that racism within the healthcare system can create unwelcoming environments for Indigenous people, foster mistrust and impact care-seeking behaviours (Browne et al., 2011; Wylie & McConkey, 2019), all of which may exacerbate existing health inequities. In some instances, the impact of racism within the healthcare system may lead to life or death situations with devastating consequences, as seen in the Brian Sinclair case (Allan & Smylie, 2015). The examples of negative framing and stereotypes discussed by participants ties into a larger issue around societal perceptions of Indigenous people, which is ultimately built on a foundation of systemic racism. As Gilchrist (2010) describes in her analysis of press coverage on missing/murdered Indigenous women in Canada, Indigenous women are often subject to dehumanizing stereotypes such as that of a "“squaw” who is dirty, lazy, degraded and easily sexually exploited" (p. 384), in contrast to missing white women who were often described with positive adjectives such as devout, caring, and gifted. The use of these degrading stereotypes are blatant in the case of Joyce Echaquan. In September 2020, Joyce Echaquan, an Indigenous woman from Atikamekw First Nation livestreamed a video that showed her being subjected abusive remarks from nurses as she was dying in hospital. Among others, the nurses made comments that she was “stupid” and “only good for sex” (CBC, 2020). These comments demonstrate the dehumanizing, racist framing used against Indigenous Peoples, and show that these ideas are persist today.

In the In Plain Sight Report (2020), a nurse in a senior leadership position also mentioned having witnessed an Indigenous patient referred to as a “squaw” (p.103), among other awful examples of racism. Because of how deeply entrenched racism is within the structure of our healthcare system, it directly impacts health care experiences for Indigenous people, contributes to culturally unsafe care environments and undermines the quality of care for Indigenous peoples (Jacklin et al., 2017; Manhire-Heath et al., 2019; Reading & Wien, 2009).

Conclusion

This study has identified a host of barriers to culturally safe care for Indigenous people, with societal, cultural, and political factors, which are known to have major implications for Indigenous Peoples accessing and receiving care (Adelson, 2005; Reading & Wien, 2009). The barriers noted by key informants were similar between both Canada and New Zealand, suggesting that the contributing factors may be similar in both cultural contexts. This also raises the question of whether solutions may be similar in both countries as well. In order to address this health inequity, health care providers need to have a foundational understanding of cultural safety. This will require systemic and organizational change, as well as a commitment to addressing the many social, cultural and political factors that contribute to the unsafe spaces within the healthcare system. If we can work on addressing those barriers, and identifying the root causes, perhaps we can work towards turning around the 400 year-old belief system based on colonial values, that continues to marginalize Indigenous people.

References

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian journal of public health*, *96*(2), S45-S61. https://doi.org/10.1007/BF03403702

Allan, B., & Smylie, J. (2015). First peoples, second class treatment: the role of racism in the health and well-being of indigenous peoples in Canada. Toronto: Wellesley Institute.

Auger, M., Crooks, C., Lapp, A., Tsuruda, S., Caron, C., Rogers, B., & van der Woerd, K. (2019). The essential role of cultural safety in developing culturally-relevant prevention programming in First Nations communities: Lessons learned from a national evaluation of Mental Health First Aid First Nations. *Evaluation and Program Planning*, *72*, 188–196. https://doi.org/10.1016/j.evalprogplan.2018.10.016

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research, 16*(1), 544–544. https://doi.org/10.1186/s12913-016-1707-9

Browne, A., Smye, V., Rodney, P., Tang, S., Mussell, B., & O'Neil, J. (2011). access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative Health Research, 21*(3), 333–348. https://doi.org/10.1177/1049732310385824

Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2020). The Waitangi Tribunal's WAI 2575 report: Implications for decolonizing health systems. *Health and Human Rights*, *22*(1), 209.

Cameron, B. L., Plazas, M. D. P. C., Salas, A. S., Bearskin, R. L. B., & Hungler, K. (2014). Understanding inequalities in access to health care services for aboriginal people: A call for nursing action. *Advances in Nursing Science*, *37*(3), E1-E16. https://doi.org/10.1097/ANS.0000000000000039

Churchill, M. E., Smylie, J. K., Wolfe, S. H., Bourgeois, C., Moeller, H., & Firestone, M. (2020). Conceptualising cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: Qualitative interviews with Indigenous and non-Indigenous clients. *BMJ Open, 10*(9), e038168–e038168. https://doi.org/10.1136/bmjopen-2020-038168

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174–174. https://doi.org/10.1186/s12939-019-1082-3

Dell, E. M., Firestone, M., Smylie, J., & Vaillancourt, S. (2016). Cultural safety and providing care to Aboriginal patients in the emergency department. *Canadian Journal of Emergency Medicine*, *18*(4), 301-305. https://doi.org/10.1017/cem.2015.100

DeSouza, R. (2008). Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing*, *13*(2), 125–135. https://doi.org/10.1177/1744987108088637

Ewen, S. C., Paul, D. J., & Bloom, G. L. (2012). Do Indigenous health curricula in health science education reduce disparities in health care outcomes? *Medical Journal of Australia, 197*(1), 50–52. https://doi.org/10.5694/mja12.10219

Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. *Social Science & Medicine*, *178*, 87–94. https://doi.org/10.1016/j.socscimed.2017.01.053

Henry, F., Dua, E., Kobayashi, A., James, C., Li, P., Ramos, H., & Smith, M. S. (2017). Race, racialization and Indigeneity in Canadian universities. *Race, Ethnicity and Education*, *20*(3), 300–314. https://doi.org/10.1080/13613324.2016.1260226

Jacklin, K., Henderson, R., Green, M., Walker, L., Calam, B., & Crowshoe, L. (2017). Health care experiences of Indigenous people living with type 2 diabetes in Canada. *Canadian Medical Association Journal, 189*(3), E106–E112. https://doi.org/10.1503/cmaj.161098

Josewski, V. (2012). Analysing 'cultural safety' in mental health policy reform: Lessons from British Columbia, Canada. *Critical Public Health*, *22*(2), 223-234. https://doi.org/10.1080/09581596.2011.616878

Kidd, J., Came, H., Herbert, S., & McCreanor, T. (2020). Māori and Tauiwi nurses' perspectives of anti-racism praxis: Findings from a qualitative pilot study. *AlterNative: An International Journal of Indigenous Peoples, 16*(4), 387-394. https://doi.org/10.1177/1177180120974673

Kurtz, D. L. M., Janke, R., Vinek, J., Wells, T., Hutchinson, P., & Froste, A. (2018). Health sciences cultural safety education in Australia, Canada, New Zealand, and the United States: A literature review. *International Journal of Medical Education*, *9*, 271-285. https://doi.org/10.5116/ijme.5bc7.21e2

Manhire-Heath, R., Cormack, D., & Wyeth, E. (2019). "…but I just prefer to treat everyone the same…": General practice receptionists talking about health inequities. *Australian Journal of Primary Health, 25*(5), 430–. https://doi.org/10.1071/PY19026

McAllister, T. G., Kidman, J., Rowley, O., & Theodore, R. F. (2019). Why isn't my professor Māori? A snapshot of the academic workforce in New Zealand universities. *Mai Journal*, *8*, 235-249. https://doi.org/10.20507/MAIJournal.2019.8.2.10

Mpalirwa, J., Lofters, A., Nnorom, O., & Hanson, M. D. (2020). Patients, pride, and prejudice: exploring black Ontarian physicians' experiences of racism and discrimination. *Academic Medicine, 95(11S),* S51-S57. https://doi.org/10.1097/ACM.0000000000003648

Nelson, S. E., & Wilson, K. (2018). Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada. *Social Science & Medicine*, *218*, 21-27. https://doi.org/10.1016/j.socscimed.2018.09.017

Oda, K., & Rameka, M. (2012). Students' corner: Using Te Tiriti O Waitangi to identify and address racism and achieve cultural safety in nursing. *Contemporary Nurse, 43*(1), 107-112. https://doi.org/10.5172/conu.2012.43.1.107

Reading, C. L., & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health* (pp. 1-47). Prince George, BC: National Collaborating Centre for Aboriginal Health.

Reid, P., Cormack, D., & Paine, S.-J. (2019). Colonial histories, racism and health—The experience of Māori and Indigenous peoples. *Public Health*, *172*, 119–124. https://doi.org/10.1016/j.puhe.2019.03.027

Richardson, S. (2004). Aotearoa/New Zealand nursing: From eugenics to cultural safety. *Nursing Inquiry*, *11(1),* 35-42. https://doi.org/10.1111/j.1440-1800.2004.00195.x

Turpel, M. E., White-Hill, E., British Columbia Ministry of Health. (2020). In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. Health Care. https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

Vogel, L. (2015). Is your hospital culturally safe? *Canadian Medical Association Journal, 187*(1), E13. https://doi.org/10.1503/cmaj.109-4953

Waitangi Tribunal. (2019) *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Report no. Wai 2575). Retrieved from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

Wylie, L., & McConkey, S. (2019). Insiders' insight: Discrimination against Indigenous peoples through the eyes of health care professionals. *Journal of Racial and Ethnic Health Disparities, 6*(1), 37–45. https://doi.org/10.1007/s40615-018-0495-9

Wylie, L., McConkey, S., & Corrado, A. (2021). It's a journey not a check box: Indigenous cultural safety from training to transformation. *International Journal of Indigenous Health, 16*(1), 314–332. https://doi.org/10.32799/ijih.v16i1.33240

Chapter 4: Seeking a Way Forward: Strategies and Frameworks for Implementing Culturally Safe Care

[corresponding author] Ashley Wilkinson, Department of Health Sciences, Lakehead University, 955 Oliver Rd., Thunder Bay, Ontario P7B 5E1, Canada, awilkin2@lakeheadu.ca, ORCID: 0000-0001-8377-4674

Rebecca Schiff, Department of Health Sciences, Lakehead University, 955 Oliver Rd., Thunder Bay, Ontario P7B 5E1, Canada, rschiff@lakeheadu.ca

Lana Ray, Department of Indigenous Learning, Lakehead University, 955 Oliver Road, Thunder Bay, Ontario P7B 5E1, Canada, lray@lakeheadu.ca

Helle Møller, Department of Health Sciences, Lakehead University, 955 Oliver Rd., Thunder Bay, Ontario P7B 5E1, Canada, hmoeller@lakeheadu.ca

Jacquie Kidd, Jacquie Kidd, Faculty of Health and Environmental Sciences, Auckland University of Technology, Private Bag 92006, Auckland 1142, New Zealand, Jacquie.Kidd@aut.ac.nz

Abstract

Cultural safety is a health concept originating in New Zealand that emphasizes provider reflexivity, facilitates care that is free from discrimination, racism and prejudice, is supportive of Indigenous cultures, and empowers Indigenous patients to determine the quality of the care they receive. This paper explored facilitators for culturally safe care practices, strategies for improving cultural safety training and health care provider education, as well as strategies and frameworks to implement culturally safe care for Indigenous Peoples of Canada and Māori of Aotearoa/New Zealand. In order to examine these facilitators, strategies, and frameworks to implement culturally safe care, qualitative interviews were carried out with key informants with cultural safety expertise. The main facilitators identified by key informants included: working in relationship, organizational commitment, and valuing Indigenous Peoples. Recommendations centered around service delivery, changes to health care provider education, and health frameworks that align with Indigenous worldviews. These findings point to the fact that delivering culturally safe care requires organizations to prioritize equity and incorporate

Indigenous knowledges, in order to create environments where such care is possible. This article concludes with policy recommendations.

Keywords: Indigenous, Indigenous health, Health equity, Health services, Cultural safety, Service delivery

Introduction

Due to the ongoing impacts of colonization, Indigenous Peoples in Canada and Māori of Aotearoa/New Zealand continue to experience health inequities and face significant barriers when accessing health services (Wylie, & McConkey, 2019; Cassim et al., 2021; Evans et al., 2014; Nelson & Wilson, 2018). Racism, which disadvantages Indigenous peoples, is embedded in the social structure within the healthcare system (Tang & Browne, 2008; Allan & Smylie, 2015) and is often coupled with health care providers lacking understanding of the social, political, and historical factors influencing the health of Indigenous Peoples (Jacklin et al., 2017; Abbott et al., 2014). These factors contribute to unsafe care environments and undermine the quality of care for Indigenous Peoples, as well as creating uneven power dynamics and undermining the role Indigenous Peoples have in their care.

Originating in New Zealand, the concept of cultural safety was developed by Irihapeti Ramsden, a Māori nurse and academic. A key component of cultural safety is the focus on the power differentials within health care provider and patient relationships, that lead to health inequities (Ramsden, 2002; Kurtz et al., 2018; Josewski, 2012; Dell et al., 2016). Cultural safety emphasizes the need for reflexivity on the part of the health care provider, to assist in understanding the power inherent in relationships within the health care field and the impact of their personal biases (Ramsden, 2002; Auger et al., 2019; Cameron et al., 2014; Oda & Rameka, 2012). As Curtis et al (2019) write, “This requires health providers to question their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients” (p.13).

In acknowledging the power imbalances in these relationships, cultural safety recognizes the influence of continued colonization, the structures that continue to undermine Indigenous peoples, and their contribution to health inequity (Kurtz et al., 2018; Berg et al., 2019; Andermann, 2016). In culturally safe care, the power imbalance is rectified as far as possible, with the care recipient having the power to determine whether the care is appropriate and meets their needs (Brooks-Cleator et al., 2018; Brascoupé & Waters, 2009). The goal of culturally safe care is for Indigenous Peoples to feel safe and respected in their interactions with the health care system (Benoit et al., 2019), to be equal partners in their care (Bracoupé & Waters, 2009) and have their health providers "recognize, respect, and nurture the unique cultural identities...and safely meet their needs, expectations, and rights" (Auger et al., 2019, p.189).

Cultural safety has been shown to improve patient experiences by making patients feel supported, creating safe spaces, and increasing access to Indigenous knowledge, cultural teachings and ceremony, and more (Churchill et al., 2020; Brown et al., 2016). Through creating positive experiences for patients, and mitigating barriers to effective care, cultural safety can help to address persistent health inequities.

Despite promising work emphasizing the benefits of cultural safety and its potential role in addressing inequities, it has not been widely implemented in health care settings. Researchers have noted challenges with cultural safety training as one reason (Wylie et al., 2021; Kurtz et al., 2018; Gray & McPherson, 2005), however, additional research on barriers to implementation is limited. In order to address these gaps in knowledge, this paper focuses on facilitators for culturally safe care practices, strategies for improving cultural safety training and health care provider education, as well as strategies and frameworks to implement culturally safe care for Indigenous Peoples of Canada, and Māori of Aotearoa/New Zealand through the perspectives of key informants. Using the information provided by key informants from a variety of backgrounds will help to identify areas of improvement, allow for strategies to be developed from an intersectoral lens, and develop policy and practice that will provide a starting point to improve Indigenous health equity.

Methods

This work is part of a larger study on culturally safe care for Indigenous Peoples in Canada and Māori of Aotearoa/New Zealand. This sub-research paper focuses specifically on strategies and frameworks for enhancing cultural safety education and implementing culturally safe care, barriers to culturally safe care are discussed elsewhere.

Ethics approval for this project was granted by the Lakehead University Research Ethics Board (approval #1468273).

Prior to the commencement of the project, lists of potential participants in Canada and Aotearoa/New Zealand were developed by the research team. Individuals with experience in cultural safety were the primary participant pool, and as such, lists of potential participants included a range of professions including health system administrators, academics, and service providers such as physicians, and nurses. Because cultural experience in cultural safety was the main inclusion criteria, Indigenous and non-Indigenous participants were welcome to participate. Potential participants were contacted via email and invited to participate in the study, and interviews were carried out once written consent was obtained.

Qualitative interviews were completed using Zoom software between November 2020 to March 2021, totaling 14 respondents. Interview sessions varied based on participant feedback and were approximately 30 minutes to 1 hour and 45 minutes in duration. A qualitative approach was chosen for this project because qualitative data collection methods allow for rich data and greater depth than quantitative methods (Hammarberg et al., 2016), allowing greater understanding of the complex relationships between the aforementioned barriers and contributing factors. Qualitative research methods also facilitate more meaningful relationships between the researcher and the participant, which can provide an additional layer of context to the information participants share. The benefit of qualitative methodology for this project is captured poignantly by Hammarberg et al. (2016) who write, "'qualitative' methods are used to answer questions about experience, meaning and perspective" (p.499).

Physicians, nurses, academics, and organizational directors/leaders, herein referred to as key informants, were interviewed to understand the barriers to culturally safe care for Indigenous Peoples. Semi-structured interviews included 8 in-depth questions to understand their perspectives on defining cultural safety, access barriers, contributing factors, effectiveness of cultural safety education, implementation of cultural safety, and the next steps for cultural safety in a health context. For the purpose of this study, Indigenous Peoples included First Nations, Inuit and Métis Peoples in Canada, and Māori of Aotearoa/New Zealand.

All interviews were recorded using Zoom, transcribed by hand, and coded using NVivo 12 software. In addition, handwritten notes were taken to capture additional detail about tone, body language, and other considerations which prompted later reflection.

Themes related to barriers and facilitators emerged after coding, and included organizational and systemic barriers, and barriers relating to the implementation of cultural safety. Codes were organized into these themes, and relevant quotes were identified across multiple codes, that also fit into these themes. This paper explores the strategies for improving cultural safety education and frameworks for implementing culturally safe care in Canada and Aotearoa/New Zealand as identified by key informants in each country with cultural safety expertise.

Findings

Three themes that emerged from the analysis were: (1) Facilitators, (2) Recommendations & (3) Strategies. Several sub-themes were identified in each area. These themes are presented below, supported by quotes from the key informants.

Facilitators

Facilitators identified by key informants were factors that positively contribute to providing or implementing cultural safety. The subthemes identified in relation to facilitators were organizational commitment, working in relationship, and valuing Indigenous Peoples.

Organizational Commitment

Participants mentioned examples of organizations using their power in ways that facilitate improved quality of care or demonstrate accountability. They provided examples of external accountability from regulatory bodies that contribute to enhanced service quality. Discussions of accountability centered on organizations being held accountable through regulatory bodies, as well as holding themselves accountable to the tenets of cultural safety.

One example mentioned by several participants, was the role of registering bodies auditing health care provider education programs to ensure they meet quality requirements:

> the health registering boards that decide whether or not to approve a program, they interview the students of the program and they target knowledge about Māori inside of those programs, and every one of those registering boards always has Māori representation and they have a strong voice. (Participant #6b - NZ)

> We're in the early days of cultural safety probably, as a profession [medicine]… We're getting there in universities, LIME and all the great people at all the undergrad and university level are doing a good job of getting it in there and doing new things there…the Australasian medical council who basically accredit the training programs of all the specialities has kind of signed up to this direction. They're doing work with LIME to basically have criteria that they will assess the colleges for and if they aren't doing those criteria, then they won't get accreditation. (Participant #7 - NZ)

By holding educational institutions accountable, these regulatory bodies help to ensure that future health professionals receive adequate training and will be prepared to provide quality care.

Participants also emphasized the need for organizations to hold themselves accountable through organizational standards, and internal processes:

> we need to make sure that we're equitable and we have some really clear standards of expectation, and we do something if they're not competent or they're not safe, we do something and we either exit them or put them on some monitoring programs. We need to be serious about making change and accountability. (Participant #8 – NZ)

Both internal and external accountability, as described by participants, represent opportunities for organizations to demonstrate a commitment to cultural safety.

Valuing Indigenous Peoples & Knowledges

Another important facilitator noted by participants was valuing Indigenous Peoples. Participants discussed incorporating and elevating Indigenous perspectives, which are frequently overlooked or ignored due to systemic racism, and/or power differentials, as crucial to facilitating cultural safe care.

When discussing the elevation of Indigenous voices, participants specifically emphasized the importance of Indigenous voices being prominent, valued and given the autonomy they deserve. In regard to health policy, participants noted that Indigenous voices need to be integrated into the conversation at all stages, and that if Indigenous voices are *not* included, the work is incomplete:

> Indigenous voices need to be at the table for what content is taught, the processes, and how we actually evaluate whether we've done it. (Participant #11 - CAN)

> they need to make sure that every time they write a policy document, they include the bibliography and they need to make sure that they're citing a significant number of Māori academics that are speaking to the area they're talking about, and if they haven't, they need to go back and keep writing because they haven't finished the job yet. (Participant #6a - NZ)

Some participants expanded this, and described the need for Indigenous Peoples, particularly Māori, to have a unique role in cultural safety:

> I think there's a lot of things that could shift, but you still have to give the local *Iwi* their own autonomy to be able to do that as well, and what that looks like for them. (Participant #9 - NZ)

> If there was any way that it [cultural safety] could be rebooted so that it went back to the philosophies of the concepts, wellbeing and beliefs that it started with… kept in it's initial context and promoted out through Māori nurses so that they became *kaitiakitanga*, they become the guardians for that knowledge and it's shared with everyone else, but it's

> taught in the way that it was supposed to have been taught. I suppose it's about creating space to allow that to happen so that the Māori worldview becomes part, natural course of the nursing delivery for cultural safety… (Participant #10 - NZ)

As an extension of elevating Indigenous voices, representation was also mentioned as a key facilitator to culturally safe care. In many cases, participants representation as a need to have Indigenous Peoples included in various settings. In some instances, participants described Indigenous representation as a crucial component to culturally safe environments within healthcare:

> what I think is most useful around cultural safety is to have people that look like you serving you. To me that's way more important, that should be the focus. Whoever is being served in a hospital or at a clinic looks at the people who are being served, right?... think that goes a long way (Participant #13 - CAN)

Others described a need for representation at other levels, including the committees and policy tables within healthcare organizations, in order to ensure decisions are made with Indigenous Peoples and reflect the needs of the community:

> when you have committees, you have to ensure that the make-up of your committee reflects your community because if you don't have the right people at the table then you're just not going to address those gaps. (Participant #12 - CAN)

> it's really making sure that that Indigenous lens, or that voice is integrated right across and actually dictating what that looks like. (Participant #9 - NZ)

In both of these examples, participants described increased representation as a step towards culturally safe environments. Another key step towards culturally safe environments, is working in relationship.

Working in Relationship

For most participants, working *with* Indigenous Peoples was integral to providing culturally safe care, with developing meaningful relationships as a crucial first step. Many participants recognized the importance of working in relationship, and the way this was usurped by the processes of colonization:

> Our Elders years ago signed a treaty [with] the Crown that recognized the *mana* or strength of the Indigenous people, the rights of the Indigenous people, and then the rights of the Crown. The expectation was that both those groups would collaborate and work together, and learn how to work in Aotearoa, but the Crown was never to usurp the *mana Motuhake* or the self-determination of Indigenous people. We were to determine for ourselves how that works. (Participant #8 – NZ)

Additionally, some participants described working in relationship as an opportunity for allies to contribute to the work of cultural safety, in order to enable Indigenous scholars and health professionals to pursue their work and achieve the best outcomes:

> it's really valuable when you have Indigenous People that can mentor younger people and be a role model. What I find is if we want to make space so that Indigenous health professionals have the time for that, then we need to make sure that allies are taking up

> some of the work that needs to happen to transform our institutions. (Participant #11 - CAN)

> In working with allies, they could bring that lens to the table, you don't need to be Indigenous to say, 'what cultural safety principles are you bringing into your teaching?'. It doesn't have to be an Indigenous person that asks that question, right? (Participant #5 - CAN)

Along similar lines, one participant emphasized recognising the complementarity of western and indigenous models:

> I remember an Elder telling me once, 'our systems aren't adversarial, they're in fact complementary' so an Indigenous way of looking at wellness isn't adversarial to a Western model or medical care model, they're actually quite complementary. (Participant #5 – CAN)

In recognizing the ways that Indigenous and Western systems can complement each other, new opportunities are created to develop relationships, and gain a deeper appreciation for each way of doing things.

Another common theme among participants was the need to address power imbalance in service delivery, ensuring that Indigenous peoples are empowered as health consumers:

> …cultural safety really is about organizations acknowledging the power differentials that they are perpetuating and then doing what they can to address those, right? It means not just making sure that we're providing care that's culturally appropriate to meet the needs

> of Indigenous patients, but that we're doing everything we can to address those power imbalances and to correct that in that relationship so that the Indigenous client is respected and are equal partners in the healthcare plan (Participant #11 – CAN)

> it's only culturally safe if they themselves define it as being safe care… it's not safe until the client or the patient can say 'I really felt like that care provider thought about the way I live my life. I believe that they considered my ways of knowing, being and doing.'…having Indigenous Peoples feel empowered to take that interview or their interaction with the physician as 'this is mine!' (Participant #5 - CAN)

In this regard, participants across the board also emphasized the need for community engagement, and ensuring that Indigenous worldviews are central to any collaboration:

> I do think that means that we have to go to the communities and if we're gonna walk the talk, if we're gonna be in alignment with the TRC [Truth and Reconciliation Commission], that means that we ask the communities what they want and what they need. We might have some ideas about what it could look like, but ultimately it's not really our decision, it is their decision. (Participant #4 - CAN)

> unquestionably Māori should lead and around the world Indigenous people should be central to that work and not in a advisory group, but at the final decision-making state (Participant #2 - NZ)

In regard to working in relationship, participants also made important comments about the nature of the relationship itself. They recognized the need for Indigenous Peoples to be a part of cultural safety work, but emphasized that they should not have to carry the responsibility for doing all of it:

> I said that it shouldn't just fall on the backs of Indigenous Peoples, it shouldn't be done without Indigenous Peoples. It should never be done without Indigenous Peoples, but I do feel like the responsibility for broad things like reconciliation, [and] teaching in a culturally safe way, that people have they can contribute whether they're Indigenous or not and I think that that's important to say. (Participant #5 - CAN)

Additionally, participants recognized the expertise of Indigenous Peoples as crucial to cultural safety work, but also the fact that Indigenous Peoples are not provided the resources necessary to do the work, and implement the required changes:

> there needs to be some co-design because so often we see that the government wants to give the responsibility over to Māori, but then they don't give the resources or the funding or the control or power…it's about having the right people at the table to make the changes and to promote some solutions that ensure that Indigenous outcomes or solutions are put forward as well (Participant #10 - NZ)

In a way, both of these points speak to the challenge of unequal power differentials, and the need for meaningful Indigenous representation. Representation at all levels is important, to ensure that Indigenous Peoples have control over allocation of tasks and resources and are treated equitably.

Working in relationship through partnership and collaboration were emphasized by participants as key facilitators that can occur at any level, and these examples demonstrate the many ways that working in relationship can be achieved.

Recommendations & Strategies

In addition to facilitators, participants provided several recommendations and strategies. The subthemes identified in relation recommendations and strategies were service delivery, and educational changes.

Service Delivery

In providing recommendations and strategies for implementing culturally safe care, participants described examples of what organizations could do to create safe spaces and provide culturally safe services, taking into consideration the need for these services to be locally contextualized to ensure that the unique cultural traditions of Indigenous Peoples are recognized.

When describing services, participants described practices within a care setting that are wholistic, and culturally safe:

> I might be the patient, but please don't shut the door on just me and the doctor 'cause I might like my sister or my brother or my *whānau* to come with me to be there when I'm hearing the information (Participant #10 - NZ)

> culturally safe care to me, looks more holistically at wellness, it's defined from an Indigenous person's perspective as to what that care might look like and what it might include…it might be something like in cancer care if someone would extend a question as to whether someone was interested in receiving traditional medicine to assist them in their cancer journey. (Participant #5 - CAN)

In order to facilitate these case practices, participants described strategies and frameworks to implement cultural safety into organizations. In particular, participants highlighted Indigenous frameworks and approaches as especially important.

One specific health frameworks highlighted was *Te Whare Tapa Whā* (Durie, 1985)*:*

> …they talk about *Te Whare Tapa Whā* which is a Māori health model from Mason Durie and it's around the 4 pillars of the house. You get your *taha tinana*, the physical realm or the physical dimension, the spiritual dimension, the psychological dimension and the cultural or social wellbeing which includes the *whānau*. (Participant #10 - NZ)

Participants also provided examples of these health frameworks in their approaches to service delivery:

> …we've got services which are *Kaupapa Māori*, so they are services which in the daily operation although they use aspects of western medicine, they use aspects of traditional medicine…they have a cultural feel to them, they start the day in a culturally specific way, they have ceremony in culturally specific way, the languages are mixed, all of those sorts of things (Participant #1 - NZ)

Participants also described ways that some of the tenets of cultural safety have been implemented, or are being developed for implementation in healthcare settings:

> …as of last year we have a clinical nurse educator Māori that works in there. We're also lucky enough to have three *tikanga* cultural facilitators that work alongside us, so we have embedded those practice changes, not only as an organization within our orientation packages, but we've also embedded it like through HR strategies and we've put it

> through our nursing and midwifery plans. We've got bicultural job descriptions for all of nursing, so it's gone through that (Participant #9 - NZ)
>
> …with the medical council in New Zealand, they're doing a lot of work around cultural safety and so there's Indigenous Māori doctors who've got a group and they're starting to look at culturally appropriate service delivery and vision statements, looking at ways you can improve your practice through language, through pronunciation of Māori people's names when you greet them, inclusiveness of having *whānau* come in with you or introducing *whakawhanaungatanga* is what we call it. (Participant #10 – NZ)

Lastly, participants discussed how there is a need for the provision of culturally safe care, but also for safe spaces. Participants described the need for health care organizations to be safe, and equitable, with protection for staff, to facilitate an environment where culturally safe care is possible:

> One of the things that was highlighted in the BC report In Plain Sight and I see this here too, is that part of the requirement of making our institutions more culturally safe is that we need to make these safe places for Indigenous people to work…if we want to see more Indigenous people working in our healthcare system, we need culturally safe hospitals for people to be safe in there, we need to protect whistleblowers, we need to protect the people who are gonna call out racism, and right now those people don't feel safe in those institutions. (Participant #11 - CAN)
>
> we must build in systems that allow people to feel safe, that allow Indigenous people to feel safe and flourish. We have to monitor their wellbeing within that space, and allow

> them to teach in a way that is appropriate for Indigenous people to learn in (Participant #8 - NZ)

One participant provided a specific strategy for creating safe spaces. They suggested a collective of people who monitor for the safety of one another, as a key way to support one another:

> It has to be safe enough to move it forward as well. It's very easy for a monocultural institution to marginalize anyone that they see on the fringes and they have so many ways of doing that. My recommendation would be that it always needs to start with a collective of people who look out for each other and can look after each other because it's not a safe place to be if you're in a culturally unsafe institution. You've got to have the support of colleagues, friends, you've got to have support of experts that you can draw on (Participant #6b - NZ)

Creating these culturally safe services and organizations begins with well-trained, culturally safe health care professionals. In line with this, participants had several recommendations and strategies for improving provider education.

Educational Changes

All participants provided strategies to improve health care provider education, as a key step towards implementing culturally safe care.

Referring to education strategies broadly, many participants felt that cultural safety should be integrated throughout the curriculum, rather than being a one-off as it often is:

> I definitely think we need mandatory training. I mean, we need to embed it within the education system so that we don't have health professionals out there who've never taken it, and we need to think carefully about how it's integrated into the curriculum so it's not this side, add-on thing that people can miss that day and still get through medical school. We need to think of how we integrate it into all of the education around practice. (Participant #11 – CAN)

> I can say that it's been limited and although some people are trying to include it, it's been a one-off in order for it to be implemented, it needs to be more than – like I said – a workshop, or a one-off experience (Participant #5 – CAN)

In addition to being integrated throughout the curriculum participants suggested that the cultural safety pedagogy should be examined, to identify effective training that allows students to engage with the concept of cultural safety in ways that expand their perspective.

Some participants emphasized the benefits of experiential learning with elements of Indigenous knowledge, as a strategy to improve provider education:

> Pedagogies that include being on the land, pedagogies that include things outside, bringing in experiences into the classroom from others who maybe wouldn't be in that traditional academic setting, so inviting Elders and knowledge-keepers. Community members who've been through certain experiences and having health education students, whether that be medical students or nurses, have them hear firsthand from the perspective of Indigenous Peoples who are walking that way of life or who've had experience with some of these things. I think that's the best kind of cultural safety education is experiential, right? (Participant #5 – CAN)

Other participants shared ideas for coursework to help students engage with cultural safety in different ways. One participant in particular, shared an idea for work that would effectively make students cultural safety stewards, allowing them to share the concept with other students:

> The idea I'm playing with at the moment is what if students designed a teaching package around notions of cultural safety and Māori health for more junior students, what would that look like? So that they become the salesperson of this notion and again all I'm trying to do is how do I shift your relationship with this topic, which is more than a topic, so that you have no choice but to engage in it at a different kind of level? (Participant #2 – NZ)

Lastly, one participant recommended having health professionals and students continue their cultural safety education by getting to know their local Indigenous communities in greater depth, through personal experience:

> the advisory committee – Indigenous advisory committee – recommended was that people not only take the online training, but also get to know the communities that they serve. For example, taking part in cultural events, spending some time in Indigenous communities to really take a look at some of those gaps, challenges and barriers that they face, and look at some of the good things that are happening in the community (Participant #12 – CAN)

Participants also suggested that training should include additional components to help HCPs identify ways to practically apply their knowledge:

> the next step that they should take is to really evaluate the training that they received and how some of the things they're learning [are] implemented in the organization. How did

> the things that they learn in training really improve healthcare? What's the outcome of the training? One of the things that we would like to see happen is having debriefing sessions after the training, so giving staff the opportunity to discuss the training to see what's good, and how things could be implemented to improve health outcomes for Indigenous people. (Participant #12 – CAN)

Continuous learning was also mentioned by many as a key component that needs to be part of the foundation of cultural safety education. Many participants felt that cultural safety should not be a single, measurable endpoint, but rather an ongoing process:

> that's a gift of cultural safety…there's no point in time where you can say 'because I'm competent now, I will be competent forever'. It's an invitation to work, a life of continuing to work at it. the question of whether you have arrived or not is immaterial 'cause you'll never arrive, the point is to come on this journey of just discovering' (Participant #2 – NZ)

Finally, reflexivity was highlighted as a key component to health care providers:

> as soon as you start to think that you've got it right, that's probably when you start to need to reflect a little bit on how right you've actually got it. (Participant #1 – NZ)

> It requires - to me - a whole set of competencies from care providers beyond just the cultural safety training that they've done. I think it involves them being reflective of their own biases and how they bring that to the healthcare system, and addressing those very deliberately. (Participant #11 – CAN)

Through understanding the conscious and unconscious biases they carry and how those biases impact their care, providers work to addressing power imbalances within their patient relationships and provide improved quality care.

Discussion

The results of this study demonstrate that there is significant room to improve the provision and implementation of culturally safe care for Indigenous Peoples. This was recognized by all of the key informants, including Indigenous and allied scholars, and those working directly in the healthcare system. This study has demonstrated numerous ways in which cultural safety can be implemented and cultural safety education improved, to address the health inequities that Indigenous Peoples face when accessing care.

The education that health care providers receive sets the stage for their future interactions with patients and the ensuing relationships (Møller, 2016). Participants in this study described strategies to improve health care provider education to enable cultural care, such as embedding cultural safety throughout the curriculum, expanding educational pedagogies to include experiential learning and opportunities for providers to engage with the concept of cultural safety in a different way, and additional components to cultural safety education that shows future providers how to apply the concepts of cultural safety into their area of practice. These recommendations are especially relevant when considered with the literature, which has highlighted its importance (O'Neil et al., 2016), identified a lack of cultural safety education, and called for more attention to it (Wylie et al., 2021; Gibbs, 2005; Brooks-Cleator et al., 2018). In their review of undergraduate medical education and Bachelor of Nursing Education program curricula, Baba (2013) found that very few institutions had cultural safety integrated into the curriculum. Many of the institutions had optional courses related to Indigenous social issues, fewer had mandatory courses on similar topics, and only a couple had courses with a focus on cultural safety (Baba, 2013). Suggestions for provider education are also consistent with other literature that has identified many of these aspects as important components of pedagogy in this area (Ryder & Edmondson, 2015; Vass, 2015).

In addition to education, participants mentioned several frameworks for health services or service delivery that would promote cultural safety. One health framework mentioned by participants was *Te Whare Tapa Wha*. This Māori health model was created by Mason Durie and describes Māori health in terms of the four pillars of the house, *taha tinana* (physical health), *taha wairua* (spiritual health), *taha whānau* (family health) and *taha hinengaro* (mental and emotional health) (Durie, 1985; Rolleston et al., 2020; Taurerewa, 2014). Another framework mentioned by participants was *Kaupapa Māori*. This model embodies a 'by Māori, for Māori, with Maori' approach that allows healthcare to be provided in a way that centres Māori knowledge and values, empowering Māori to practice self-determination in their care, in contrast to a Western health system which often disempowers and marginalizes (Rolleston et al., 2020; Wilson et al., 2021). As with many Indigenous health models, *Te Whare Tapa Wha* encompasses additional aspects of health that are often neglected in a Western biomedical health model. These types of models were suggested by participants as examples to ensure that services align with Indigenous worldviews and promote culturally safe care environments. Interestingly, participants in Canada did not mention any comparable frameworks in detail, however, one participant made reference to the medicine wheel. The medicine wheel provides a visual representation of complex and fulsome teachings, demonstrating the interconnectedness of all things, and is intimately tied to health and wellbeing within many First Nations' worldviews (Roberts, 2006; Graham & Stamler, 2013). The literature shows that First Nations conceptions of health are nuanced and complex, vary between groups, and feature the medicine wheel as only one component (Bearskin et al., 2016; Sasakamoose et al., 2016; Graham & Martin, 2016). As Absolon (201) describes, “Indigenous wholistic theory is whole, ecological, cyclical and relational” (p.76).

In addition to these frameworks, participants also described the creation of safe spaces within health organizations, reflexivity on the part of organizations and individual health providers, a need to work in relationship with Indigenous Peoples, and valuing Indigenous Peoples and knowledge as facilitators to culturally safe care. These suggestions are in line with additional literature on culturally safe health initiatives, which identified these as important components (Brooks-Cleator et al., 2018; Browne et al., 2016). All of these facilitators require organizations to focus on health equity, in order to create an environment where culturally safe care is possible. In considering the strategies and recommendations brought forth by participants, important policy implications become apparent.

Policy Recommendations

Implementing additional health policy is crucial to facilitating equity within a health setting. In this section, we provide policy recommendations for governments, health care organizations and communities, to implement and enhance cultural safety within healthcare. Several policy calls and recommendations for Indigenous health already exist, and building off of the recommendations from participants, we connect some of our policy recommendations to the work of the Truth and Reconciliation Commission (TRC), and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).

Work in partnership with Indigenous Peoples

In keeping with UNDRIP articles 18 (Right to Self-Representation), 19 (Consent, Consultation, and Cooperation), and 23 (Right to Development), Indigenous Peoples are to be consulted, and actively involved in the development, and implementation of administrative measures, and/or programming that may affect them. In their suggestions, participants outlined strategies including greater representation on the committees and policy tables within healthcare organizations, as well as more meaningful consultation with Indigenous communities. The following policy recommendations would demonstrate health organizations' commitment to working in equal partnership with Indigenous Peoples:

- Ensure committees have Indigenous representation, including members of local First Nations or *Iwi*, and these members are given equal decision-making power

- Consult members of First Nations or *Iwi* during the development of new programming or internal policies to ensure that outcomes will meet community needs

- Implement a review process whereby new programming, policies or administrative decisions are reviewed by Indigenous committee or board members

Enhance Indigenous Curriculum

In keeping with the TRC's Calls to Action 23, 24, 57, 62i, and 63i, education on the history of Indigenous Peoples in Canada, including historical and contemporary contributions, are to be provided to students from kindergarten to grade 12, public servants, and nursing and medical students. While the TRC is specific to a Canadian context, participants in Canada and New Zealand both emphasized the need for additional education on Indigenous Peoples and improved cultural safety training. Therefore, the following policy recommendations would be beneficial for federal and provincial governments in both countries:

- In partnership with local Indigenous Peoples, develop curriculums on the history of Indigenous peoples, the United Nations Declaration on the Rights of Indigenous Peoples, Treaties and Indigenous rights, Indigenous law, and Indigenous–Crown relations for use in K-12 institutions, university and college settings, and public servants

- In partnership with local Indigenous Peoples, provide cultural safety training for all health professionals as a stand-alone component of post-secondary education

Address Systemic Racism within Healthcare

In keeping with UNDRIP articles 2 (No Discrimination) and 15 (Dignity and Diversity of Cultures), Indigenous Peoples have the right to be free and equal to all other people and be free from any kind of discrimination based on their Indigeneity. Cultural safety training can help care providers develop an understanding of their own biases and how they may impact the care they provide, which can help address some of the underlying contributors to racism within a healthcare setting. In line with the many participants who highlighted racism as one of the most significant contributors to culturally safe care, the following recommendations would assist health organizations and regulatory bodies in addressing systemic racism within healthcare settings, and facilitate more culturally safe care:

- Provide funding and support for cultural safety training for all staff and health care providers

- Ensure that staff and health care providers who perpetuate culturally unsafe care practices or behaviour are held accountable to the same extent as those who perpetuate clinically unsafe practices

- Ensure cultural safety training is repeated by staff and health care providers on a regular basis

- Implement evaluation mechanisms to examine the outcomes of cultural safety training to determine the impact on care and ensure its efficacy

- Provide meaningful support and protection for Indigenous health professionals within the workplace

Honour Indigenous Knowledge, Practices and Traditions

In keeping with UNDRIP articles 11 (Right to Cultural Practices), 12 (Spiritual and Religious Freedom), and 24 (Right to Traditional Medicines), Indigenous Peoples have the right to their cultural, spiritual and religious traditions including traditional medicines. In line with the recommendations from several participants relating to the importance of Indigenous perspectives, honouring Indigenous knowledge, practices and traditions are crucial to providing culturally safe care. Therefore, the following policy recommendations would be beneficial to health organizations in order to provide more culturally safe services:

- Ensure person-centered care is a core component of organizational mandates

- Create space for traditional medicine in the healthcare system, including the development of a compensation model for traditional healers that is on par with western health professional compensation

- Evaluate current organizational policies for sections that may interfere with Indigenous cultural, or spiritual practices

- Incorporate practices such as land acknowledgments and ceremonies involving Elders and knowledge-keepers to pay respect to the Indigenous Peoples whose land organizations are on, and the communities they serve

Conclusion

This study has identified numerous ways to improve cultural safety education, facilitators to culturally safe care, and health frameworks that could enable holistic, culturally safe care consistent with an Indigenous worldview. While the facilitators and frameworks identified were specific to participants in each of the study locations, aspects of these findings may be more widely applicable. Successfully implementing culturally safe care requires a commitment to health equity, and a shift in the way that Indigenous Peoples are viewed within the health system. Understanding the facilitators to culturally safe care and developing strategies for implementation is just the beginning of this work. Many of the recommendations and strategies put forth by participants have policy relevance, as they align with both the Calls to Action from the Truth and Reconciliation Commission of Canada (TRC), and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Only through a commitment to working in relationship with Indigenous Peoples, and shifting to a system that values Indigenous knowledge, can health systems begin to transform into culturally safe spaces.

References

Abbott, P., Dave, D., Gordon, E., & Reath, J. (2014). What do GPs need to work more effectively with Aboriginal patients? Views of Aboriginal cultural mentors and health workers. *Australian Family Physician*, *43*, 58–63.

Absolon, K. (2010). Indigenous wholistic theory: A knowledge set for practice. *First Peoples Child & Family Review, 5*(2), 74-87.

Allan, B. & Smylie, J. (2015). First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada. Toronto, ON: the Wellesley Institute

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: A framework for health professionals. *Canadian Medical Association Journal, 188*(17-18), E474–E483. https://doi.org/10.1503/cmaj.160177

Auger, M., Crooks, C., Lapp, A., Tsuruda, S., Caron, C., Rogers, B., & van der Woerd, K. (2019). The essential role of cultural safety in developing culturally-relevant prevention programming in First Nations communities: Lessons learned from a national evaluation of Mental Health First Aid First Nations. *Evaluation and Program Planning*, *72*, 188–196. https://doi.org/10.1016/j.evalprogplan.2018.10.016

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services.* Prince George, BC: National Collaborating Centre for Aboriginal Health.

Bearskin, R. L., Cameron, Brenda L,R.N., PhD., Weber-Pillwax, C., Stout, M. K. D., PhD., Voyageur, E., PhD., Reid, A., . . . Martial, R. (2016). Mâmawoh kamâtowin, "coming together to help each other in wellness": Honouring Indigenous nursing knowledge. *International Journal of Indigenous Health, 11*(1), 18-33. https://doi.org/10.18357/ijih111201615024

Benoit, A., Cotnam, J., O'Brien-Teengs, D., Greene, S., Beaver, K., Zoccole, A., & Loutfy, M. (2019). Racism experiences of urban Indigenous women in Ontario, Canada: "We All Have That Story That Will Break Your Heart." *International Indigenous Policy Journal*, *10*(2), 1–27. https://doi.org/10.18584/iipj.2019.10.2.1

Berg, K., McLane, P., Eshkakogan, N., Mantha, J., Lee, T., Crowshoe, C., & Phillips, A. (2019). Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review. *International Emergency Nursing*, *43*, 133–140. https://doi.org/10.1016/j.ienj.2019.01.004

Brascoupé, S., & Waters, C. (2009). Cultural safety exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *International Journal of Indigenous Health*, *5*(2), 6-41. https://doi.org/10.3138/ijih.v5i2.28981

Brooks-Cleator, L., Phillipps, B., & Giles, A. (2018). Culturally safe health initiatives for Indigenous Peoples in Canada: A scoping review. *Canadian Journal of Nursing Research*, *50*(4), 202-213. https://doi.org/10.1177/0844562118770334

Brown, A. E., Middleton, P. F., Fereday, J. A., & Pincombe, J. I. (2016). Cultural safety and midwifery care for Aboriginal women – A phenomenological study. *Women and Birth, 29*(2), 196–202. https://doi.org/10.1016/j.wombi.2015.10.013

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research, 16*(1), 544–544. https://doi.org/10.1186/s12913-016-1707-9

Cameron, B. L., Plazas, M. D. P. C., Salas, A. S., Bearskin, R. L. B., & Hungler, K. (2014). Understanding inequalities in access to health care services for Aboriginal people: A call for nursing action. *Advances in Nursing Science*, *37*(3), E1-E16. https://doi.org/10.1097/ANS.0000000000000039

Cassim, S., Kidd, J., Rolleston, A., Keenan, R., Aitken, D., Firth, M., Middleton, K., Chepulis, L., Wong, J., Hokowhitu, B., & Lawrenson, R. (2021). Hā Ora: Barriers and enablers to early diagnosis of lung cancer in primary healthcare for Māori communities. *European Journal of Cancer Care, 30*(2), e13380–n/a. https://doi.org/10.1111/ecc.13380

Churchill, M. E., Smylie, J. K., Wolfe, S. H., Bourgeois, C., Moeller, H., & Firestone, M. (2020). Conceptualising cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada: Qualitative interviews with Indigenous and non-Indigenous clients. *BMJ Open, 10*(9), e038168–e038168. https://doi.org/10.1136/bmjopen-2020-038168

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174–17. https://doi.org/10.1186/s12939-019-1082-3

Durie, M. (1985). Te Whare Tapa Whā: A Māori perspective of health. *Journal of Social Sciences and Medicine, 20*(5), 483-486.

Evans, M., White, K., & Berg, L. (2014). “They think you’re lying about your need”: The impact of appearances on health and social service access for aboriginal people in Canada. *Canadian Journal of Native Studies*, *34*(1), 55–71.

Gibbs, K. A. (2005). Teaching student nurses to be culturally safe: Can It Be Done? *Journal of Transcultural Nursing*, *16*(4), 356–360. https://doi.org/10.1177/1043659605278944

Graham, H., & Martin, S. (2016). Narrative descriptions of miyo-mahcihoyān (physical, emotional, mental, and spiritual well-being) from a contemporary néhiyawak (Plains Cree) perspective. *International Journal of Mental Health Systems*, *10*(1), 1-12. https://doi.org/10.1186/s13033-016-0086-2

Graham, H., & Stamler, L. L. (2010). Contemporary perceptions of health from an Indigenous (Plains Cree) perspective. *International Journal of Indigenous Health*, *6*(1), 6-17. https://doi.org/10.18357/ijih61201012341

Josewski, V. (2012). Analysing ‘cultural safety’ in mental health policy reform: Lessons from British Columbia, Canada. *Critical Public Health*, *22*(2), 223-234. https://doi.org/10.1080/09581596.2011.616878

Kurtz, D. L. M., Janke, R., Vinek, J., Wells, T., Hutchinson, P., & Froste, A. (2018). Health sciences cultural safety education in Australia, Canada, New Zealand, and the United States: A literature review. *International Journal of Medical Education*, *9*, 271-285. https://doi.org/10.5116/ijme.5bc7.21e2

Møller, H. (2016). Culturally safe communication and the power of language in Arctic nursing. *Etudes Inuit, 40*(1), 85–104. https://doi.org/10.7202/1040146ar

Nelson, S. E., & Wilson, K. (2018). Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada. *Social Science & Medicine*, *218*, 21-27. https://doi.org/10.1016/j.socscimed.2018.09.017

O'Neil, J., Gallagher, J., Wylie, L., Bingham, B., Lavoie, J., Alcock, D., & Johnson, H. (2016). Transforming First Nations' health governance in British Columbia. *International Journal of Health Governance, 21*(4), 229–244. https://doi.org/10.1108/IJHG-08-2016-0042

Oda, K., & Rameka, M. (2012). Students' corner: Using Te Tiriti O Waitangi to identify and address racism and achieve cultural safety in nursing. *Contemporary nurse, 43*(1), 107-112. https://doi.org/10.5172/conu.2012.43.1.107

Ramsden, I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu [Doctoral dissertation]. *Wellington, New Zealand: University of Wellington*.

Richardson, S. (2004). Aotearoa/New Zealand nursing: from eugenics to cultural safety. *Nursing Inquiry*, *11(1),* 35-42. https://doi.org/10.1111/j.1440-1800.2004.00195.x

Richardson, S., Williams, T., Finlay, A., & Farrell, M. (2009). Senior nurses' perceptions of cultural safety in an acute clinical practice area. *Nursing Praxis in New Zealand*, *25*(3), 27–36. https://doi.org/10.1002/ps.1925

Roberts, R. A. (2006). *Stories about cancer from the Woodland Cree of northern Saskatchewan.* (Doctoral Dissertation, University of Saskatchewan).

Rolleston, A. K., Cassim, S., Kidd, J., Lawrenson, R., Keenan, R., & Hokowhitu, B. (2020). Seeing the unseen: Evidence of kaupapa Maori health interventions. *AlterNative: an International Journal of Indigenous Peoples, 16*(2), 129–136. https://doi.org/10.1177/1177180120919166

Ryder, C., & Edmondson, W. (2015). Developing an enhanced Aboriginal health curricula for medical student engagement. *LIME Good Practice Case Studies Volume 3*, 52. https://www.limenetwork.net.au/wp-content/uploads/2018/12/RYDER-GPCS-3-1.pdf

Sasakamoose, J., Scerbe, A., Wenaus, I., & Scandrett, A. (2016). First Nation and Métis youth perspectives of health: An Indigenous qualitative inquiry. *Qualitative Inquiry*, *22*(8), 636-650. https://doi.org/10.1177/1077800416629695

Tang, S. Y., & Browne, A. J. (2008). "Race" matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity & Health, 13*(2), 109–127. https://doi.org/10.1080/13557850701830307

Taurerewa, R. (2014). Te Ao Maori, Te Ao Hauora: A student nurse's reflection. *Whitireia Nursing & Health Journal*, *21*(21), 43–47.

Vass, A. (2015). Training emergency medicine specialists in Indigenous health and cultural competency. *LIME Good Practice Case Studies Volume 3*, 69. http://www.limenetwork.net.au/wp-content/uploads/2018/12/VASS-GPCS-3.pdf

Wilson, D., Mikahere-Hall, A., & Sherwood, J. (2021). Using indigenous kaupapa Māori research methodology with constructivist grounded theory: Generating a theoretical explanation of indigenous womens realities. *International Journal of Social Research Methodology,* 1–16. https://doi.org/10.1080/13645579.2021.1897756

Wylie, L., & McConkey, S. (2019). Insiders' insight: Discrimination against Indigenous Peoples through the eyes of health care professionals. *Journal of Racial and Ethnic Health Disparities, 6*(1), 37–45. https://doi.org/10.1007/s40615-018-0495-9

Wylie, L., McConkey, S., & Corrado, A. M. (2021). It's a journey not a check box: Indigenous cultural safety from training to transformation. *International Journal of Indigenous Health, 16*(1), 314–332. https://doi.org/10.32799/ijih.v16i1.33240

Chapter 5: Discussion

This research project was undertaken to answer the following research question: What are the barriers and facilitators to providing culturally safe care for Indigenous peoples? To answer that question, the following sub-questions also guided this work 1) What are the educational/cultural/social/political barriers to providing culturally safe care as identified by key informants in Canada and Aotearoa/New Zealand? 2) How could cultural safety be implemented in order to be most effective? And 3) What are the next steps for cultural safety in a health context?

As mentioned elsewhere, the interview guide was designed with these questions in mind. Some questions, including those about barriers to culturally safe care, implementation and contributing factors were more pointed, aiming to gather specific information to inform the research questions. However, other questions were more open, allowing participants to provide additional detail, or share their own experiences, which informs the research questions while providing important context. Through the semi-structured interviews, I was able to address each of the research questions that I started this project with and gather important data, while also generating new questions.

As highlighted in Chapter 3, participants brought forth a significant number of barriers to culturally safe care that exist at multiple levels within the health system. Key barriers included lack of accountability, limited and/or inadequate health care provider education, ineffective cultural safety training, power differentials, and systemic racism. Issues around health care provider education, ineffective cultural safety training and systemic racism were consistent with the literature examined prior to the beginning of the study (see Chapter 1), providing further evidence that these issues persist. All of the barriers identified helped to answer the main research question guiding this work. In their discussion, several participants also highlighted social, cultural and political factors that contribute to these barriers, which also provided key context for understanding these barriers.

As highlighted previously, participants shared valuable information about how to improve health care provider education and cultural safety training, how cultural safety can be implemented, and recommendations and strategies to facilitate more culturally safe care environments. In order to improve health provider education, participants suggested strategies like embedding cultural safety throughout the curriculum, expanding educational pedagogies to include experiential learning and opportunities for providers to engage with the concept of cultural safety in alternatve ways. In describing ways to create safer environments, participants highlighted Indigenous frameworks like *Te Whare Tapa Wha* and *Kaupapa Māori* approaches. Participants also noted a need to create safe spaces within health organizations, promote reflexivity on the part of organizations and individual health providers, work in relationship with Indigenous Peoples, and value Indigenous Peoples and knowledge as facilitators to culturally safe care. All of these strategies and recommendations provided helped to answer the second sub-question related to implementation and effectiveness that guided this work. Building on this feedback, I examined the Calls to Action from the Truth and Reconciliation (TRC) and UNDRIP articles to see how the strategies and recommendations provided could be incorporated into policy recommendations. These policy recommendations were developed based on key themes highlighted by participants and included working in partnership with Indigenous Peoples, enhancing Indigenous curriculum, addressing systemic racism within healthcare, and honouring Indigenous knowledge, practices and traditions. Under each of these sections, specific recommendations are provided that connect to information shared by participants, UNDRIP articles, and the TRC Calls to Action. These policy recommendations are for government and health organizations and are largely applicable to both Canada and New Zealand.

The third sub-question about the next steps for cultural safety in a health context, was included in the interview guide. In answering this question, participants had a range of responses. Most were in favour of the concept and called for a reset of the educational system, additional collaboration with Indigenous Peoples, better cultural safety evaluation mechanisms within healthcare organizations, or greater support from regulatory bodies. Others felt that the terminology around cultural safety needs to change in order to shift the focus away from culture, and a very small group felt that a move away from cultural safety entirely was the next step. One in fact went as far as questioning whether cultural safety has failed entirely within a health context. This interview question elicited a range of responses and provided data to answer the sub-question on next steps that guided this work, however, the discussion and an analysis of the existing discourse on cultural safety could be an entirely separate thesis in and of itself. Therefore, while the information uncovered in this study informed the research question, the larger conversation on the next steps for cultural safety is an ongoing one.

While cultural safety has been the focus of this research, it is worth reiterating that cultural safety is not the only framework that seeks to improve Indigenous health equity. Other related concepts include cultural competence, cultural humility, cultural awareness, and anti-racism. While all of these can be viewed as inter-related concepts on a continuum, each one has its own merits and disadvantages. Cultural competence and anti-racism were mentioned by participants in this study and will therefore be the focus of this section, which will discuss their respective merits and how these concepts interact.

Cultural Competence

Definitions of cultural competence vary slightly between sources, as Truong et al., (2014) note, “there is no one widely accepted and definitive conceptual cultural competency framework. The literature contains many analogous terms/concepts” (p.2). Broadly, cultural competence is a set of behaviours and attitudes that allow health providers to interact effectively with patients from a different cultural background than their own (Cross et al., 1989). Other definitions of cultural competency define the concept as very individualistic. For example, Cooper and Roter (2003) write, “Cultural competence may be defined as the ability of individuals to establish effective interpersonal and working relationships that supersede cultural differences” (p.554). Additionally, the language around cultural competence presents the concept as something that can be mastered by health professionals, as if it is an ability that has a finite end-point at which the health professional will have achieved all that they need to provide care to patients from a different cultural background than their own. All of these points represent limitations of the concept, which is where cultural safety comes in.

Cultural Safety

Originating in New Zealand, the concept of cultural safety was developed by Irihapeti Ramsden, a Māori nurse and academic. Ramsden developed the concept with a dream of helping health professionals to “become aware of their social conditioning and how it has affected them and therefore their practice” (Ramsden, 2002, p.2) and “to enable a considered analysis of the historical, political, social and economic situations that were continuing to impact on the health of Maori people" (Ramsden, 2002, p.98). With a focus on understanding the patient experience rather than the health professional themselves, cultural safety is a markedly different approach to cultural competence.

As Curtis et al., (2019) write,

> Cultural safety requires health practitioners to examine themselves and the potential impact of their own culture on clinical interactions. This requires health providers to question their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients. (p.13)

By examining their own biases, health professionals are better able to address the power imbalance within health care settings, which often disempowers Indigenous Peoples and other racialized groups. This concept expands on cultural competence to include recognition of power and individual biases, however, anti-racism takes things another step further.

Anti-Racism

Anti-racism, in the simplest terms, is "forms of thought and/or practice that seek to confront, eradicate and/or ameliorate racism" (Bonnett, 2000, p. 3). Expanding on this, Came and Griffith (2018) write,

> Often, anti-racism seeks to heal, organize and empower the oppressed, not those who are advantaged by racism and privilege. An anti-racism approach often includes a structural analysis that recognises that the world is controlled by systems, with traceable historical roots, that batter some and benefit others. Anti-racism praxis seeks to enable equity,

> social justice and peace and move toward a world where racism is non-existent or its health effects are negligible (p.182).

In the context of this project, some scholars highlight the importance of language. Harding (2018) clarifies between Indigenous-specific racism and anti-Indigenous racism. As she explains, Indigenous-specific racism is the racism, stereotyping and discrimination experienced by Indigenous Peoples in Canada, and anti-Indigenous racism are actions aimed at addressing that Indigenous-specific racism (Harding, 2018). Anti-racism therefore represents an extension of the key tenets of cultural safety. It acknowledges the social and systemic aspects that lead to health inequity, while also moving beyond recognition by promoting meaningful action. Some participants in each country discussed an anti-racism approach as beneficial in addressing the persistent health inequities experienced by Indigenous Peoples, however, an in-depth examination of anti-racism strategies is beyond the scope of this project.

As mentioned, each one of these concepts has their own merits and disadvantages. As part of the interview guide, participants in this study were asked what they thought was the next step for cultural safety in a health context, and their opinions were often split between one or more of the above approaches.

What’s next for cultural safety in a health context?

For many participants, cultural safety represented an important step towards improving Indigenous health equity. However, as discussed in detail elsewhere, there was an overall desire for better cultural safety education, additional supports for health professionals, and changes within healthcare settings to enable an environment where delivering culturally safe care is possible.

Based on the responses from participants, it seems cultural competence has been the primary strategy for addressing health inequities. This is reflected in the literature with work by Curtis et al., (2019) that seeks to shift the conversation away from cultural competence. Organizations like the Health Quality and Safety Commission of New Zealand also describe a shift in focus from cultural competence to cultural safety as part of a renewed strategy for Māori health equity (Health Quality and Safety Commission New Zealand, 2021). In contrast, one participant felt that cultural safety was restrictive, and lacking in depth. However, they did feel that some of the tenets of cultural safety, like reflexivity on the part of health professionals would be greatly beneficial.

Overall, what’s next for cultural safety in a health context remains to be seen. There was some variation in opinion among the participants in this study, with some outliers on each end of the continuum, however most seemed to be in favour of cultural safety. As mentioned elsewhere, there is literature to support the effectiveness and importance of cultural safety (Churchill et al., 2020; Goodman et al., 2017; Wesche, 2013). If the health system as a whole were to fully embrace the concept of cultural safety through policy and meaningful implementation, it would be possible to create effective change. Until then, research like this study will have to continue, to amass more evidence in favour of cultural safety as an effective health framework.

Chapter 6: Conclusion

Summary of Findings

Overall, this research project uncovered several barriers and facilitators to culturally safe care for Indigenous Peoples. Barriers centered around three themes: 1) organizational barriers, 2) systemic barriers and 3) implementation of cultural safety. Key issues within these themes identified by key informants included systemic racism, lack of organizational accountability and/or buy-in, ineffective health provider education, funding, health system structure, undervaluing Indigenous knowledge, negative framing, lack of understanding of the historical/social/political context experienced by Indigenous Peoples, power, terminology, and changes to the concept of cultural safety over time. The main facilitators identified by key informants also centered around three themes included: 1) working in relationship, 2) organizational commitment, and 3) valuing Indigenous Peoples. Recommendations centered around service delivery, changes to health care provider education, and health frameworks that align with Indigenous worldviews. Findings from this study point to the fact that barriers to culturally safe care exist at every level and require a whole-of-systems approach which prioritize equity and incorporate Indigenous knowledge, in order to provide culturally safe care for Indigenous Peoples, and advance Indigenous health equity.

Personal Reflections

Looking back on this project, there are so many things to reflect on. Firstly, this project took place during COVID-19, which had a significant impact on the study’s design and methods, and presented limitations. Because of the pandemic, the decision was made to shift the study's focus away from mental health professionals who were inundated, owing to the mental health impacts of the pandemic. This led to the decision to move to a focus on key informants, which ended up being excellent in its own way. Additionally, with the travel restrictions put in place as a result of the pandemic, interviews were conducted via Zoom. While these limitations have been discussed in previous sections, I think they bear repeating because of the unique situation created by COVID-19. In contrast to the ways that COVID negatively impacted the project, the pandemic created a unique research opportunity. During the pandemic, changes to health policy and practice occurred on a global scale. Some of these changes may have exacerbated existing health inequities for Indigenous peoples, and others created new sources of inequity (Mashford-Pringle et al., 2021). As well, the COVID situation evolved against a backdrop of heightened action against racial (in)equality, following the death of George Floyd, Chantel Moore and other Indigenous peoples and people of colour. While the impact of COVID-19 was not a focus of this project, exploring culturally safe care during COVID-19 created a unique opportunity, and may have impacted the perspectives that participants shared. In addition to the ways COVID may have impacted this project, I think it's worthwhile to reflect on how *I* have changed throughout the course of this research project.

Starting this project, I thought I had a reasonable understanding of cultural safety. In a way, I did. I understood cultural safety in a certain way, based on the articles I had read and the lens through which I viewed the world. Having spoken to so many incredible people with a variety of perspectives, I can see now that I was, and still am, only *just* scratching the surface of understanding cultural safety.

To borrow the words of a colleague, "We do the best with what we know, and when we know more, we do better." Coming into this project, I designed a methodology based on what I understood about cultural safety, and the gaps that I saw. With the knowledge I've gained, I have a deeper understanding of what it means to be culturally safe, but also about the broader implications of the term. Even the language and terminology used can be problematized in ways that I hadn't considered in my naivety.

I started this project to answer the research question: what are the barriers to culturally safe care for Indigenous Peoples? Yet, over the course of the project, I've developed more questions than answers. Some of the many questions I now have because of this project include:

- Why is education on cultural safety so limited?
- Why is there no accountability for universities to ensure cultural safety is a mandatory part of health education?
- Is cultural safety training effective?
- Are charge nurses key culture setters within health organizations, who can therefore influence the level of culturally safe care provided?
- What does cultural safety look like for Indigenous patients travelling to access care?
- Is anti-racism the next step in the evolution of culturally safe healthcare for Indigenous Peoples?

Each one of these questions represent important aspects of the discourse around culturally safe care, and Indigenous health equity more broadly, and could be the basis of several theses. However, these are just some of the questions that this research has made me consider. This project has taught me so much challenging me to reconsider the knowledge and perspective that I started with. Now that I know more, I realize how much more I have yet to learn. My work in this field is only just beginning. I look forward to examining these issues and contribute to improving Indigenous health equity as I continue my learning journey.

References

Abbott, P., Dave, D., Gordon, E., & Reath, J. (2014). What do GPs need to work more effectively with Aboriginal patients?: Views of Aboriginal cultural mentors and health workers. *Australian Family Physician*, *43*(1-2), 58-63.

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, *96*(2), S45-S61. https://doi.org/10.1007/BF03403702

Allan, B. & Smylie, J. (2015). *First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada.* Toronto, ON: the Wellesley Institute

Andermann, A. (2016). Taking action on the social determinants of health in clinical practice: A framework for health professionals. *Canadian Medical Association Journal*, *188*(17-18), E474–E483. https://doi.org/10.1503/cmaj.160177

Auger, M., Crooks, C., Lapp, A., Tsuruda, S., Caron, C., Rogers, B., & van der Woerd, K. (2019). The essential role of cultural safety in developing culturally-relevant prevention programming in First Nations communities: Lessons learned from a national evaluation of Mental Health First Aid First Nations. *Evaluation and Program Planning*, *72*, 188–196. https://doi.org/10.1016/j.evalprogplan.2018.10.016

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Métis public health: Environmental scan of cultural competency and safety in education, training and health services.* Prince George, BC: National Collaborating Centre for Aboriginal Health.

Bearskin, R. L., Cameron, Brenda L,R.N., PhD., Weber-Pillwax, C., Stout, M. K. D., PhD., Voyageur, E., PhD., Reid, A., . . . Martial, R. (2016). Mâmawoh kamâtowin, "coming together to help each other in wellness": Honouring indigenous nursing knowledge. *International Journal of Indigenous Health*, *11*(1), 18-33. https://doi.org/10.18357/ijih111201615024

Benoit, A., Cotnam, J., O'Brien-Teengs, D., Greene, S., Beaver, K., Zoccole, A., & Loutfy, M. (2019). Racism Experiences of Urban Indigenous Women in Ontario, Canada: “We All Have That Story That Will Break Your Heart.” *International Indigenous Policy Journal*, *10*(2), 1–27. https://doi.org/10.18584/iipj.2019.10.2.1

Berg, K., McLane, P., Eshkakogan, N., Mantha, J., Lee, T., Crowshoe, C., & Phillips, A. (2019). Perspectives on Indigenous cultural competency and safety in Canadian hospital emergency departments: A scoping review. *International Emergency Nursing, 43*, 133–140. https://doi.org/10.1016/j.ienj.2019.01.004

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member checking: A tool to enhance trustworthiness or merely a nod to validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bonesteel, S., & Anderson, E. (2008). *Canada's relationship with Inuit: A history of policy and program development*. Ottawa: Indian and Northern Affairs Canada.

Bonnett, A. (2000). *Anti-racism.* Routledge.

Brascoupé, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to aboriginal health and community wellness. *International Journal of Indigenous Health, 5*(2), 6-41. https://doi.org/10.3138/ijih.v5i2.28981

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Brooks-Cleator, L., Phillipps, B., & Giles, A. (2018). Culturally safe health initiatives for indigenous peoples in Canada: A scoping review. *Canadian Journal of Nursing Research, 50*(4), 202–213. https://doi.org/10.1177/0844562118770334

Brown, A. E., Middleton, P. F., Fereday, J. A., & Pincombe, J. I. (2016). Cultural safety and midwifery care for Aboriginal women – A phenomenological study. *Women and Birth: Journal of the Australian College of Midwives, 29*(2), 196–202. https://doi.org/10.1016/j.wombi.2015.10.013

Browne, A. (2017). Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations. *Social Science & Medicine*, *184*, 23–26. https://doi.org/10.1016/j.socscimed.2017.04.045

Browne, A. J., Varcoe, C., Lavoie, J., Smye, V., Wong, S. T., Krause, M., Tu, D., Godwin, O., Khan, K., & Fridkin, A. (2016). Enhancing health care equity with Indigenous populations: Evidence-based strategies from an ethnographic study. *BMC Health Services Research*, *16*(1), 544–544. https://doi.org/10.1186/s12913-016-1707-9

Browne, A., & Fiske, J. (2001). First nations women's encounters with mainstream health care services. *Western Journal of Nursing Research, 23*(2), 126–147. https://doi.org/10.1177/019394590102300203

Browne, A., Smye, V., Rodney, P., Tang, S., Mussell, B., & O'Neil, J. (2011). Access to primary care from the perspective of Aboriginal patients at an urban emergency department. *Qualitative Health Research, 21*(3), 333–348. https://doi.org/10.1177/1049732310385824

Came, H., & Griffith, D. (2018). Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis. *Social Science & Medicine*, *199*, 181–188. https://doi.org/10.1016/j.socscimed.2017.03.028

Came, H., O'Sullivan, D., Kidd, J., & McCreanor, T. (2020). The Waitangi Tribunal's WAI 2575 report: Implications for decolonizing health systems. *Health and Human Rights*, *22*(1), 209.

Cameron, B. L., Plazas, M. D. P. C., Salas, A. S., Bearskin, R. L. B., & Hungler, K. (2014). Understanding inequalities in access to health care services for Aboriginal people: A call for nursing action. *Advances in Nursing Science, 37*(3), E1-E16. https://doi.org/10.1097/ANS.0000000000000039

Canada Research Coordinating Committee. (2021). *Best Practices in Equity, Diversity and Inclusion in Research.* https://www.sshrc-crsh.gc.ca/funding-financement/nfrf-fnfr/edi-eng.aspx?wbdisable=true#1

Cancer Care Ontario. (2016). *Chapter 4 - Cultural Competence from the Patient's Perspective*. https://elearning.cancercare.on.ca/mod/scorm/player.php?scoid=1264&cm=847

Carter, S. M., & Little, M. (2007). Justifying knowledge, justifying method, taking action: Epistemologies, methodologies, and methods in qualitative research. *Qualitative Health Research, 17*(10), 1316–1328. https://doi.org/10.1177/1049732307306927

Cassim, S., Kidd, J., Rolleston, A., Keenan, R., Aitken, D., Firth, M., Middleton, K., Chepulis, L., Wong, J., Hokowhitu, B., & Lawrenson, R. (2021). Hā Ora: Barriers and enablers to early diagnosis of lung cancer in primary healthcare for Māori communities. *European Journal of Cancer Care, 30*(2), e13380–n/a. https://doi.org/10.1111/ecc.13380

Cavin, E. L. (2015). Culturally safe oral health care for Aboriginal peoples of Canada. *Canadian Journal of Dental Hygiene*, *49*(1), 21-28.

Chartrand, P. L. A. (1991). Aboriginal rights: the dispossession of the Métis. *Osgoode Hall Law Journal*, *29*(3), 457–482.

Churchill, M. E., Smylie, J. K., Wolfe, S. H., Bourgeois, C., Moeller, H., & Firestone, M. (2020). Conceptualising cultural safety at an Indigenous-focused midwifery practice in Toronto, Canada:

Qualitative interviews with Indigenous and non-Indigenous clients. *BMJ Open, 10*(9), e038168–e038168. https://doi.org/10.1136/bmjopen-2020-038168

Cook, C., Clark, T., & Brunton, M. (2014). Optimising cultural safety and comfort during gynaecological examinations: Accounts of indigenous Māori women. *Nursing Praxis in New Zealand*, *30*(3), 19-34.

Cooper, L. A., & Roter, D. L. (2003). Patient-provider communication: the effect of race and ethnicity on process and outcomes of healthcare. In Smedley, B.D., Stith, A.Y., & Nelson, A.R. (Eds.), *Unequal treatment: Confronting racial and ethnic disparities in health care* (pp. 552-593). The National Academies Press.

Creswell, J. W. (2017). *Qualitative inquiry & research design: Choosing among five approaches* (Fourth edition.). SAGE.

Cross, T. L., Bazron, B.J., Dennis, K.W., & Isaacs, M.R. (1989). *Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed*. Georgetown University Child Development Center. https://spu.edu/~/media/academics/school-of-education/Cultural%20Diversity/Towards%20a%20Culturally%20Competent%20System%20of%20Care%20Abridged.ashx

Crown-Indigenous Relations and Northern Affairs Canada (CIRNAC). (2021, June 11). *Indigenous peoples and communities.* https://www.rcaanc-cirnac.gc.ca/eng/1100100013785/1529102490303

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*(1), 174–17. https://doi.org/10.1186/s12939-019-1082-3

Danaher, A. (2011). *Reducing Health Inequities: Enablers and Barriers to Inter-sectoral Collaboration*. Wellesley Institute. http://www.wellesleyinstitute.com/wp-content/uploads/2012/09/Reducing-Health-Inequities-Enablers-and-Barriers-to-Intersectoral-Collaboration.pdf

Darroch, F., Giles, A., Sanderson, P., Brooks-Cleator, L., Schwartz, A., Joseph, D., & Nosker, R. (2017). The united states does CAIR about cultural safety: Examining cultural safety within Indigenous health contexts in Canada and the United States. *Journal of Transcultural Nursing, 28*(3), 269–277. https://doi.org/10.1177/1043659616634170

DeJonckheere, M., & Vaughn, L. M. (2019). Semistructured interviewing in primary care research: A balance of relationship and rigour. *Family Medicine and Community Health, 7*(2), e000057. https://doi.org/10.1136/fmch-2018-000057

Dell, E. M., Firestone, M., Smylie, J., & Vaillancourt, S. (2016). Cultural safety and providing care to Aboriginal patients in the emergency department. *Canadian Journal of Emergency Medicine, 18*(4), 301-305. https://doi.org/10.1017/cem.2015.100

DeSouza, R. (2008). Wellness for all: The possibilities of cultural safety and cultural competence in New Zealand. *Journal of Research in Nursing, 13*(2), 125–135. https://doi.org/10.1177/1744987108088637

Downing, R., & Kowal, E. (2011). A postcolonial analysis of Indigenous cultural awareness training for health workers. *Health Sociology Review, 20*(1), 5–15. https://doi.org/10.5172/hesr.2011.20.1.5

Duric, D. (2017a, May 28). Between the Lakes Treaty No. 3 (1792). Mississaugas of The Credit First Nation. http://mncfn.ca/treaty3/

Duric, D. (2017b, May 28). Ajetance Treaty, No. 19 (1818). Mississaugas of The Credit First Nation. http://mncfn.ca/treaty19/

Evans, M., White, K., & Berg, L. (2014). "They think you're lying about your need": The impact of appearances on health and social service access for Aboriginal people in Canada. *Canadian Journal of Native Studies*, *34*(1), 55–71.

Ewen, S. C., Paul, D. J., & Bloom, G. L. (2012). Do indigenous health curricula in health science education reduce disparities in health care outcomes? *Medical Journal of Australia, 197*(1), 50–52. https://doi.org/10.5694/mja12.10219

Foster, C. H. (2006). What nurses should know when working in Aboriginal communities. *Canadian Nurse, 102*(4), 28–31.

Gerlach, A., Browne, A., & Greenwood, M. (2017). Engaging Indigenous families in a community-based Indigenous early childhood programme in British Columbia, Canada: A cultural safety perspective. *Health & Social Care in the Community, 25*(6), 1763–1773. https://doi.org/10.1111/hsc.12450

Gibbs, K. (2005). Teaching Student Nurses to be Culturally Safe: Can It Be Done? *Journal of Transcultural Nursing, 16*(4), 356–360. https://doi.org/10.1177/1043659605278944

Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., & Kerr, T. (2017). "They treated me like crap and I know it was because I was Native": The healthcare experiences of Aboriginal peoples living in Vancouver's inner city. *Social Science & Medicine*, *178*, 87–94. https://doi.org/10.1016/j.socscimed.2017.01.053

Government of Canada. (2019, September 23). TCPS 2 (2018) – Chapter 1: Ethics Framework. Retrieved from: https://ethics.gc.ca/eng/tcps2-eptc2_2018_chapter1-chapitre1.html

Graham, H., & Martin, S. (2016). Narrative descriptions of miyo-mahcihoyān (physical, emotional, mental, and spiritual well-being) from a contemporary néhiyawak (Plains Cree) perspective. *International Journal of Mental Health Systems, 10*(1), 1-12. https://doi.org/10.1186/s13033-016-0086-2

Graham, H., & Stamler, L. L. (2010). Contemporary perceptions of health from an Indigenous (Plains Cree) perspective. *International Journal of Indigenous Health, 6*(1), 6-17. https://doi.org/10.18357/ijih61201012341

Gray, M., & McPherson, K. (2005). Cultural safety and professional practice in occupational therapy: A New Zealand perspective. *Australian Occupational Therapy Journal, 52*(1), 34-42. https://doi.org/10.1111/j.1440-1630.2004.00433.x

Halseth, R. (2018). *Overcoming barriers to culturally safe and appropriate dementia care services and supports for Indigenous peoples in Canada*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Hammarberg, K., Kirkman, M., & de Lacey, S. (2016). Qualitative research methods: When to use them and how to judge them. *Human Reproduction, 31*(3), 498–501. https://doi.org/10.1093/humrep/dev334

Harris, R., Cormack, D., & Stanley, J. (2013). The relationship between socially-assigned ethnicity, health and experience of racial discrimination for Māori: Analysis of the 2006/07 New Zealand Health Survey. *BMC Public Health, 13*(1), 844. https://doi.org/10.1186/1471-2458-13-844

Hart, P., & Mareno, N. (2014). Cultural challenges and barriers through the voices of nurses. *Journal of Clinical Nursing, 23*(15-16), 2223–2233. https://doi.org/10.1111/jocn.12500

Health Quality and Safety Commission New Zealand. (2021, August 24). *Cultural Safety and Cultural Competence*. https://www.hqsc.govt.nz/our-programmes/patient-safety-day/previous-psw-campaigns/psw-2019/cultural-safety-and-cultural-competence/

Heke, D., Wilson, D., & Came, H. (2018). Shades of competence? A critical analysis of the cultural competencies of the regulated-health workforce in Aotearoa New Zealand. *International Journal for Quality in Health Care, 31*(8), 606–. https://doi.org/10.1093/intqhc/mzy227

Henry, F., Dua, E., Kobayashi, A., James, C., Li, P., Ramos, H., & Smith, M. S. (2017). Race, racialization and Indigeneity in Canadian universities. *Race, Ethnicity and Education, 20*(3), 300–314. https://doi.org/10.1080/13613324.2016.1260226

Hole, R., Evans, M., Berg, L., Bottorff, J., Dingwall, C., Alexis, C., … Smith, M. (2015). Visibility and voice: Aboriginal people experience culturally safe and unsafe health care. *Qualitative Health Research, 25*(12), 1662–1674. https://doi.org/10.1177/1049732314566325

Jacklin, K. M., Henderson, R. I., Green, M. E., Walker, L. M., Calam, B., & Crowshoe, L. J. (2017). Health care experiences of Indigenous people living with type 2 diabetes in Canada. *Canadian Medical Association Journal*, *189*(3), E106-E112. https://doi.org/10.1503/cmaj.161098

Jamieson, M., Chen, S., Murphy, S., Maracle, L., Mofina, A., & Hill, J. (2017). pilot testing an intervention on cultural safety and Indigenous health in a Canadian occupational therapy curriculum. *Journal of Allied Health*, *46*(1), e1–e7.

Jennings, W., Bond, C., & Hill, P. (2018). The power of talk and power in talk: A systematic review of Indigenous narratives of culturally safe healthcare communication. *Australian Journal of Primary Health, 24*(2), 109–115. https://doi.org/10.1071/PY17082

Johnstone, M., & Kanitsaki, O. (2007). Health care provider and consumer understandings of cultural safety and cultural competency in health care: An Australian Study. *Journal Of Cultural Diversity, 14*(2), 96-105.

Josewski, V. (2012). Analysing 'cultural safety' in mental health policy reform: Lessons from British Columbia, Canada. *Critical Public Health, 22*(2), 223-234. https://doi.org/10.1080/09581596.2011.616878

Kidd, J., Came, H., Herbert, S., & McCreanor, T. (2020). Māori and Tauiwi nurses' perspectives of anti-racism praxis: Findings from a qualitative pilot study. *AlterNative: An International Journal of Indigenous Peoples, 16*(4), 387-394. https://doi.org/10.1177/1177180120974673

Kurtz, D. L. M., Janke, R., Vinek, J., Wells, T., Hutchinson, P., & Froste, A. (2018). Health sciences cultural safety education in Australia, Canada, New Zealand, and the United States: A literature review. *International Journal of Medical Education, 9*, 271-285. https://doi.org/10.5116/ijme.5bc7.21e2

Lauckner, H., Paterson, M., & Krupa, T. (2012). Using constructivist case study methodology to understand community development processes: Proposed methodological questions to guide the research process. *Qualitative Report*, *17*(25), 1–22.

Manhire-Heath, R., Cormack, D., & Wyeth, E. (2019). '… but I just prefer to treat everyone the same…': General practice receptionists talking about health inequities. *Australian Journal of Primary Health, 25*(5), 430-434. https://doi.org/10.1071/py19026

Martin, D. H. (2012). Two-eyed seeing: a framework for understanding indigenous and non-indigenous approaches to indigenous health research. Canadian Journal of Nursing Research, 44(2), 20–42.

Mashford-Pringle, A., Skura, C., Stutz, S., & Yohathasan, T. (2021). *What we heard: Indigenous Peoples and COVID-19* [Supplementary Report for the Chief Public Health Officer of Canada's Report on the State of Public Health in Canada]. University of Toronto: Waakebiness-Bryce Institute for Indigenous Health, Dalla Lana School of Public Health. https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/from-risk-resilience-equity-approach-covid-19/indigenous-peoples-covid-19-report/cpho-wwh-report-en.pdf

McAllister, T. G., Kidman, J., Rowley, O., & Theodore, R. F. (2019). Why isn't my professor Māori? A snapshot of the academic workforce in New Zealand universities. *Mai Journal, 8*, 235-249. https://doi.org/10.20507/MAIJournal.2019.8.2.10

Mpalirwa, J., Lofters, A., Nnorom, O., & Hanson, M. D. (2020). Patients, pride, and prejudice: Exploring black Ontarian physicians' experiences of racism and discrimination. *Academic Medicine, 95*(11S), S51-S57. https://doi.org/10.1097/ACM.0000000000003648

Nelson, S. E., & Wilson, K. (2018). Understanding barriers to health care access through cultural safety and ethical space: Indigenous people's experiences in Prince George, Canada. *Social Science & Medicine, 218*, 21-27. https://doi.org/10.1016/j.socscimed.2018.09.017

Nerestant, A. (2021, October 5). *If Joyce Echaquan were white, she would still be alive, Quebec coroner says.* CBC News. https://www.cbc.ca/news/canada/montreal/echaquan-coroner-report-health-care-system-racism-1.6199964

Oda, K., & Rameka, M. (2012). Students' corner: Using Te Tiriti O Waitangi to identify and address racism and achieve cultural safety in nursing. *Contemporary Nurse, 43*(1), 107-112. https://doi.org/10.5172/conu.2012.43.1.107

Park, J., Tjepkema, M., Goedhuis, N., & Pennock, J. (2015). Avoidable mortality among First Nations adults in Canada: A cohort analysis. *Health Reports*, *26*(8), 10–16.

Pavagada, R., & DeSouza, R. (2012). Culture and mental health care in New Zealand: indigenous and non-indigenous people. In K. Bhui & D. Bhugra (Eds.), *Culture and Mental Health: A comprehensive textbook* (pp. 245-259). Hodder Arnold.

Penn, H. (2014). Recognising cultural safety issues for indigenous students in a baccalaureate nursing programme: Two unique programmes. *Whitireia Nursing & Health Journal, 21*(21), 29–33.

Ramsden, I. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu [Doctoral dissertation]. *Wellington, New Zealand: University of Wellington*.

Reading, C. L., & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal peoples' health* (pp. 1-47). Prince George, BC: National Collaborating Centre for Aboriginal Health.

Reid, P., Cormack, D., & Paine, S.-J. (2019). Colonial histories, racism and health—The experience of Māori and Indigenous peoples. *Public Health*, *172*, 119–124. https://doi.org/10.1016/j.puhe.2019.03.027

Richardson, F., & Carryer, J. (2005). Teaching cultural safety in a New Zealand nursing education program. *Journal of Nursing Education*, *44*(5), 201-208. https://doi.org/10.3928/01484834-20050501-02

Richardson, S. (2004). Aotearoa/New Zealand nursing: from eugenics to cultural safety. *Nursing Inquiry, 11*(1), 35-42. https://doi.org/10.1111/j.1440-1800.2004.00195.x

Richardson, S., Williams, T., Finlay, A., & Farrell, M. (2009). Senior nurses' perceptions of cultural safety in an acute clinical practice area. *Nursing Praxis in New Zealand*, *25*(3), 27–36. https://doi.org/10.1002/ps.1925

Roberts, R. A. (2006). *Stories about cancer from the Woodland Cree of northern Saskatchewan.* (Doctoral Dissertation, University of Saskatchewan).

Rolleston, A. K., Cassim, S., Kidd, J., Lawrenson, R., Keenan, R., & Hokowhitu, B. (2020). Seeing the unseen: Evidence of kaupapa Maori health interventions. *AlterNative: an International Journal of Indigenous Peoples*, *16*(2), 129–136. https://doi.org/10.1177/1177180120919166

Ryder, C., & Edmondson, W. (2015). Developing an enhanced Aboriginal health curricula for medical student engagement. LIME Good Practice Case Studies Volume 3, 52. https://www.limenetwork.net.au/wp-content/uploads/2018/12/RYDER-GPCS-3-1.pdf

Sasakamoose, J., Scerbe, A., Wenaus, I., & Scandrett, A. (2016). First Nation and Métis youth perspectives of health: An Indigenous qualitative inquiry. *Qualitative Inquiry, 22*(8), 636-650. https://doi.org/10.1177/1077800416629695

Schill, K., & Caxaj, S. (2019). Cultural safety strategies for rural Indigenous palliative care: A scoping review. *BMC Palliative Care, 18*(1), 21–21. https://doi.org/10.1186/s12904-019-0404-y

Spence, D. (2005). Hermeneutic notions augment cultural safety education. *The Journal of Nursing Education, 44*(9), 409–414. https://doi.org/10.3928/01484834-20050901-05

Statistics Canada. (2017) Table 98-316-X2016001 *Canada [Country] and Canada [Country]* (table). *Census Profile*. 2016 Census. [Data Table]. https://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

Statistics New Zealand. (n.d.). 2018 Census ethnic group summaries. https://www.stats.govt.nz/tools/2018-census-ethnic-group-summaries

Tang, S. Y., & Browne, A. J. (2008). “Race” matters: Racialization and egalitarian discourses involving Aboriginal people in the Canadian health care context. *Ethnicity & Health, 13*(2), 109–127. https://doi.org/10.1080/13557850701830307

Taurerewa, R. (2014). Te Ao Maori, Te Ao Hauora: A student nurse’s reflection. *Whitireia Nursing & Health Journal*, *21*(21), 43–47.

Tong, A., Sainsbury, P., & Craig, J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care, 19*(6), 349–357. https://doi.org/10.1093/intqhc/mzm042

Truong, M., Paradies, Y., & Priest, N. (2014). Interventions to improve cultural competency in healthcare: A systematic review of reviews. *BMC Health Services Research, 14*(1), 99–99. https://doi.org/10.1186/1472-6963-14-99

Truth and Reconciliation Commission of Canada. (2015a). Truth and reconciliation commission of Canada: Calls to action. http://trc.ca/assets/pdf/Calls_to_Action_English2.pdf

Truth and Reconciliation Commission of Canada. (2015b). *Canada's Residential Schools: Missing Children and Unmarked Burials.* https://publications.gc.ca/collections/collection_2015/trc/IR4-9-4-2015-eng.pdf

Turpel, M. E., White-Hill, E., British Columbia Ministry of Health. (2020). In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. Health Care. https://engage.gov.bc.ca/app/uploads/sites/613/2020/11/In-Plain-Sight-Full-Report.pdf

Vass, A. (2015). Training emergency medicine specialists in Indigenous health and cultural competency. LIME Good Practice Case Studies Volume 3, 69. http://www.limenetwork.net.au/wp-content/uploads/2018/12/VASS-GPCS-3.pdf

Vogel, L. (2015). Is your hospital culturally safe? *Canadian Medical Association Journal, 187*(1), E13. https://doi.org/10.1503/cmaj.109-4953

Waitangi Tribunal. (2019) Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry (Report no. Wai 2575). Retrieved from https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf

Walsh, M., & Grey, C. (2019). The contribution of avoidable mortality to the life expectancy gap in Māori and Pacific populations in New Zealand— A decomposition analysis. *New Zealand Medical Journal, 132*(1492), 46-60.

Wesche, S. D. (2013). Métis women at risk: Health and service provision in urban British Columbia. *Pimatisiwin: A Journal of Aboriginal & Indigenous Community Health*, *11*(2).

Wilson, D. (2008). The significance of a culturally appropriate health service for Indigenous Māori women. *Contemporary Nurse*, *28*(1-2), 173–188. https://doi.org/10.5172/conu.673.28.1-2.173

Wilson, D., Mikahere-Hall, A., & Sherwood, J. (2021). Using indigenous kaupapa Māori research methodology with constructivist grounded theory: Generating a theoretical explanation of indigenous womens realities. *International Journal of Social Research Methodology*, 1–16. https://doi.org/10.1080/13645579.2021.1897756

Wylie, L., & McConkey, S. (2019). Insiders' insight: Discrimination against Indigenous Peoples through the eyes of health care professionals. *Journal of Racial and Ethnic Health Disparities, 6*(1), 37–45. https://doi.org/10.1007/s40615-018-0495-9

Wylie, L., McConkey, S., & Corrado, A. (2021). It's a journey not a check box: Indigenous cultural safety from training to transformation. *International Journal of Indigenous Health, 16*(1), 314–332. https://doi.org/10.32799/ijih.v16i1.33240

Appendices

Appendix A: Search Strategy

Search Terms	Database	Results
(aotearoa OR "New Zealand" OR Maori) AND ("cultural safety") (indigenous OR aboriginal OR native OR first nations or metis or inuit) AND "cultural safety" AND canad*	ProQuest Nursing & Allied Health Database	388 273
(aotearoa OR "New Zealand" OR Maori) AND ("cultural safety") (indigenous OR aboriginal OR native OR first nations or metis or inuit) AND "cultural safety" AND canad*	PubMed	45 62
(aotearoa OR "New Zealand" OR Maori) AND "cultural safety" (indigenous OR aboriginal OR native OR first nations or metis or inuit) AND "cultural safety" AND canad*	CINAHL	210 63
(aotearoa OR "New Zealand" OR Maori) AND "cultural safety" (indigenous OR aboriginal OR native OR first nations or metis or inuit) AND "cultural safety" AND canad*	Sociology Database	254
Total:		1,295
Unique (non-duplicates)		828

Appendix B: Recruitment Email

Lakehead
UNIVERSITY

Dear ______ (Prospective Participant),

My name is Ashley Wilkinson and I am a student at Lakehead University in Thunder Bay, Ontario. I am in the second year Master's student in Health Sciences, specializing in Indigenous & Northern Health, under the supervision of Dr. Rebecca Schiff.

I am kindly requesting your participation in my thesis research study titled: *Barriers to Culturally Safe Care for Indigenous People: A Key Informant Perspective*. The intention is to understand the barriers, facilitators and contributing factors to culturally safe care for Indigenous Peoples in Canada and Māori of Aotearoa/New Zealand.

You are invited to be a part of this project because you have experience that relates to the research objectives. Your experience in (health/social justice/academia) has given you a uniquely valuable perspective. As a result, you have the best understanding about what barriers and facilitators exist in providing culturally safe care, and the discourse around cultural safety.

The study involves a semi-structured interview by Zoom or telephone, based on your needs and preferences. In this interview, I would like you to share your perspective on this issue facing Indigenous communities. This interview will take approximately 60 minutes, depending on how much you are willing to share.

Participation is completely voluntary, and you may withdraw from the study at any time. In all cases, nothing you say will be attributed to you individually unless explicitly agreed to in the consent process. Some characteristics (ex. occupation) may be described generally, but they will not be tied to you individually unless you have given your permission. If you wish for me to keep your identity confidential, I will ensure that any identifying characteristics in the thesis and any other related documents are removed.

If you are interested in participating, please respond to me via email or phone and we can schedule a date and time for an interview.

Thank you again for your time and interest in this project! I look forward to learning from you.

Sincerely,

AWilkinson

Ashley Wilkinson

Ashley Wilkinson
Department of Health Sciences
Lakehead University
e. awilkin2@lakeheadu.ca

Rebecca Schiff, Ph.D.
Department of Health Sciences
Lakehead University
t. 807-766-7199
e. rschiff@lakeheadu.ca

Appendix C: Information Letter

Lakehead UNIVERSITY

Barriers to Culturally Safe Care for Indigenous People: A Key Informant Perspective

Hello, Potential Research Participant!

Thank you for your interest in this research project. Your time and assistance are truly appreciated. This sheet gives some basic information on the research, what you can expect, how the data will be handled and used in the future. If anything is unclear or you would like more information, please feel free to ask any question you wish, using the contact details are at the end of this document.

Who am I and what is this research for?

My name is Ashley Wilkinson and I am a student at Lakehead University in Thunder Bay, Ontario. I am doing this research as part of my Master's degree in Health Sciences, with a specialization in Indigenous & Northern Health under the guidance of my supervisor Dr. Rebecca Schiff.

In combination with my coursework, which has focused significantly on health inequities, my goal of studying medicine and firsthand experience in the hospital has fostered a deeper interest in the health system. In an effort to understand the health inequities faced by Indigenous Peoples, I want to know what barriers may exist to providing culturally safe care. I also want to know what other factors, structural, cultural, social or otherwise, may contribute to these barriers. For this project, I have chosen to speak with people who approach health equity from many different perspectives in order to explore these questions.

I will be using this information for my Master's thesis, however I believe that this work has broader impacts. I hope this information will be useful for many institutions where Indigenous peoples face these challenges and can influence policy to foster system change.

What is this research about?

Indigenous Peoples worldwide continue to experience health inequities, due in part to the ongoing impacts of colonization. This research is about barriers and facilitators to culturally safe care for Indigenous Peoples, in an attempt to understand these health inequities and their potential resolution. I want to understand these barriers from a diverse range of perspectives, and the having conversations with key informants is the best way to accomplish that. I am interested in your perspective based on your invaluable experience!

What is being requested of me?

You are invited to be interviewed because you have experience that relates to the research objectives. Your experience in health, social justice, and/or academia has given you a uniquely valuable perspective. As a result, you have the best idea about what barriers and facilitators exist in providing culturally safe care, and the discourse around cultural safety. In this interview, I would like you to share your perspective on this issue facing Indigenous communities. This interview will take approximately 60 minutes, depending on how much you are willing to share, and with your consent, interview will be recorded. I will be patient and listen to as much as you wish to share. Your participation is completely voluntary; you may refuse to answer any questions or withdraw from the study up to the end of data collection.

Are there any benefits or risks I should be aware of?

Conducting this interview will help advance understanding of these barriers and facilitators, and supplement knowledge gaps that may lead to improved healthcare equity and appropriateness. There is limited exploration of this topic from key informants, and even less that examines this issue in a multi-national context. Therefore, this information will be a valuable contribution to the literature. I also hope that this information will be used to address health policy and foster change.

While there are very few risks from participating in this research, I recognize that some questions may be perceived as sensitive, and you wish to keep information confidential. All identifiable information will be confidential, and identifiers will be removed so that all data will be anonymous in the final research outputs. Your participation is voluntary, and you are only being asked to offer information you feel comfortable sharing.

How should I expect to be treated?

This research aims to maintain the highest standards of ethical conduct and integrity. Centrally, this means that in participating in this research you should feel that you, and your contribution to this research, have been treated with respect. Participation is entirely voluntary, and all information offered will be treated in good faith. You are welcome to refuse to participate, withdraw from the research at any time and refuse to answer any of the questions asked without any negative consequences for yourself or your organization. Your participation will not affect your employment status, nor will your employer know if you decide to participate or decline to participate. If you choose to withdraw from the research, your interview information can be removed from the study up until the point that analysis has been completed. All questions about the research, its aims and outcomes will be answered openly and honestly. You will also be given the opportunity to review a transcript of your interview and a summary of the findings to ensure your perspectives are accurately reflected. While I retain final editorial control over what we choose to write, you are free to withdraw any information you have contributed at any stage by contacting us and indicating your wish to do so. You are more than welcome to read my final thesis, and a summary of my findings so that you may be aware of what came out of your contribution!

This study has been approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

What will be done with your information?

In all cases, nothing you say will be attributed to you. Some characteristics (ex. occupation) may be described generally, but they will not be tied to you individually. All information will be anonymous in the final research outputs.

Review of Data and Findings

To ensure that your perspectives are captured accurately, member checking will be employed as part of this study. When your interview transcript is ready, you will be contacted, and the transcript will be sent to you for review. When the findings are ready, you will receive a summary of findings and asked to review it to ensure that your perspectives are accurately reflected. If there are any inaccuracies in the transcript or summary of findings, they will be corrected, and revisions will be sent to you for confirmation.

What will happen to the data after it is collected?
I will have access to the interview transcripts and other materials (including audio recordings, handwritten notes and your consent form). While I will be the primary investigator my supervisor, Dr. Rebecca Schiff, may need access to the data. Therefore, the data may be shared with her if the need arises. All raw data, audio recordings and typing up of interviews will be encrypted and stored on my personal password protected computer for up to five years and then destroyed. All data will also be stored on campus in the Health Sciences Department following completion of the project, and will be stored for a minimum of 5 years prior to being destroyed. The final research results might be written in reports, articles, or at conferences and meetings relating to Indigenous Health. A final report will also be written, and a copy will be sent to you via email.

If you have further questions about this project, or feel uncomfortable with any aspect, please let us know as soon as possible.

Thank you again for your time and interest in this project! I look forward to learning from you.

Sincerely,

A Wilkinson
Ashley Wilkinson

Ashley Wilkinson Department of Health Sciences
Lakehead University

e. awilkin2@lakeheadu.ca

Rebecca Schiff, Ph.D.
Department of Health Sciences
Lakehead University
t. 807-766-7199
e. rschiff@lakeheadu.ca

Appendix D: Consent Form

Lakehead
UNIVERSITY

Consent Form for Potential Participants

Name of Participant ___________________________

(please print)

MY CONSENT:

I agree to the following:

- ✓ I have read and understand the information contained in the Information Letter
- ✓ I agree to participate
- ✓ I understand the risks and benefits to the study
- ✓ That I am a volunteer and can withdraw from the study at any time, and may choose not to answer any question
- ✓ That the data will be securely stored at Lakehead University for a minimum period of 5 years following completion of the research project
- ✓ I understand that the research findings will be made available to me upon request
- ✓ My information will remain confidential
- ✓ All of my questions have been answered
- ✓ Audio/video recording of this interview YES/NO

By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.

_______________________ ________________________

Participant's Signature Date

If you have any questions or concerns about this study, please contact Ashley Wilkinson at awilkin2@lakeheadu.ca. If you have questions about your rights as a research participant in general, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

Appendix E: Interview Guide

Lakehead
UNIVERSITY

Barriers to Culturally Safe Care for Indigenous People: A Key Informant Perspective

1. How would you define cultural safety?
    a. What does cultural safety mean to you?
    b. How would you describe your experience with cultural safety in your field/community?

2. What do you think is the largest barrier to culturally safe care for Indigenous people?

3. How do you think cultural safety education could be implemented in order to be most effective?
    a. What strategies for implementation, pedagogy, educational experiences, would be most effective?

4. In what ways do you think societal, cultural or political norms could contribute to a lack of culturally safe care?
    a. New Zealand → Do you think discussion of Te Tiriti and measures taken to honour it, have had an impact on attitudes toward Māori? How do you think this affected the discourse around and practice of cultural safety?
    b. Canada → Do you think the calls to action from the Truth and Reconciliation Commission and resistance movements (ie. Idle no More, Unist'ot'en Camp) have had an impact on attitudes towards Indigenous people? How do you think this affected the discourse around and practice of cultural safety?

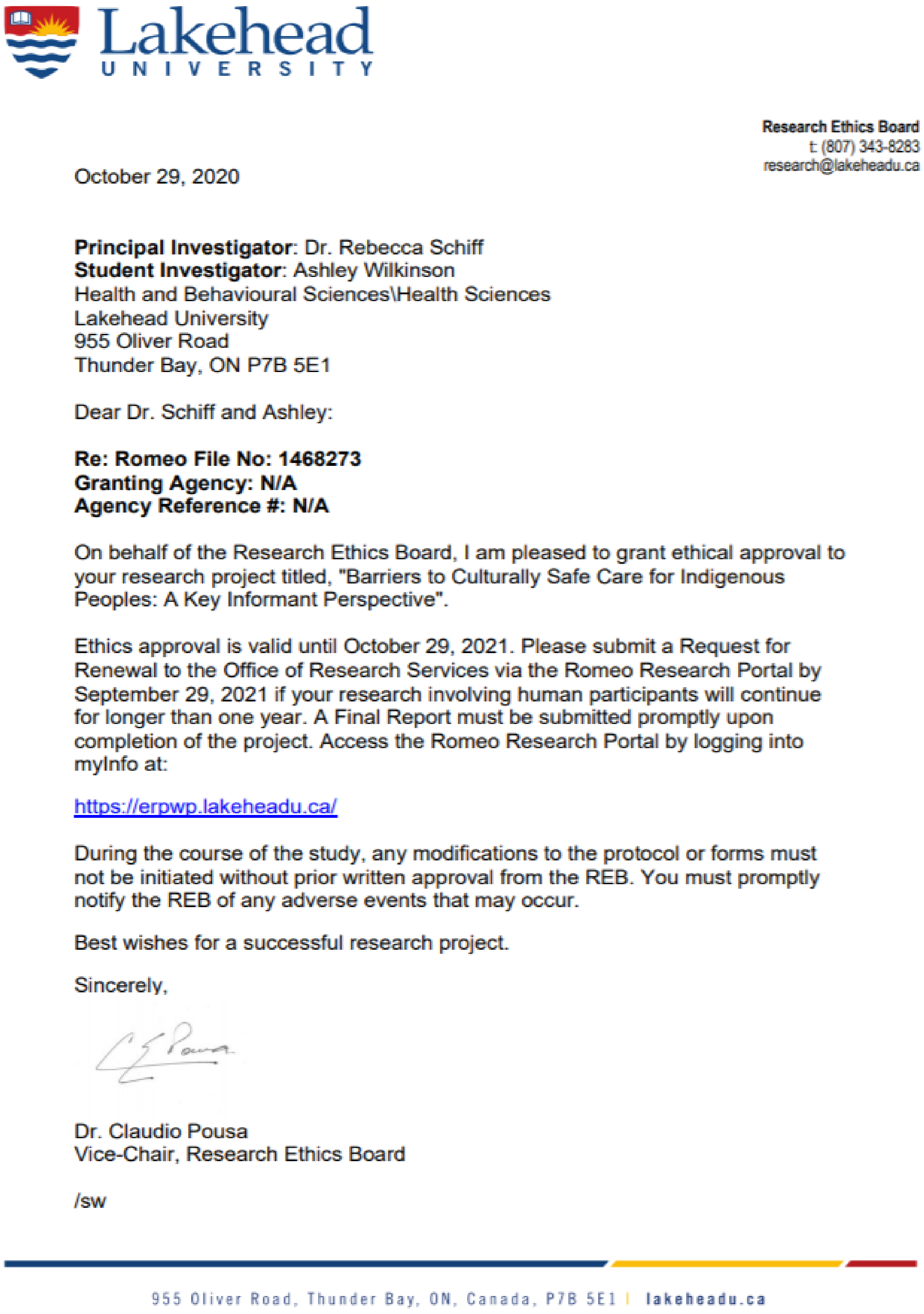
5. Who do you think should be responsible for developing cultural safety training tools?
    a. Should the responsibility lie with any particular group (ie. Indigenous peoples or allies), or should it be a collaborative effort?

6. Do you think that the concept of cultural safety has been fully implemented? If not, why?

7. How do you think cultural safety has been impacted by the colonialist ideology present in Canada/New Zealand?

8. What do you think are the next steps for cultural safety in a health context? (ex. Different implementation strategies, move on from cultural safety (ex. anti-racism space) etc.)?

Appendix F: Ethical Approval



Lakehead
UNIVERSITY

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

October 29, 2020

Principal Investigator: Dr. Rebecca Schiff
Student Investigator: Ashley Wilkinson
Health and Behavioural Sciences\Health Sciences
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Schiff and Ashley:

Re: Romeo File No: 1468273
Granting Agency: N/A
Agency Reference #: N/A

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Barriers to Culturally Safe Care for Indigenous Peoples: A Key Informant Perspective".

Ethics approval is valid until October 29, 2021. Please submit a Request for Renewal to the Office of Research Services via the Romeo Research Portal by September 29, 2021 if your research involving human participants will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Access the Romeo Research Portal by logging into myInfo at:

https://erpwp.lakeheadu.ca/

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Claudio Pousa
Vice-Chair, Research Ethics Board

/sw

955 Oliver Road, Thunder Bay, ON, Canada, P7B 5E1 | lakeheadu.ca

Appendix G: Coding Process

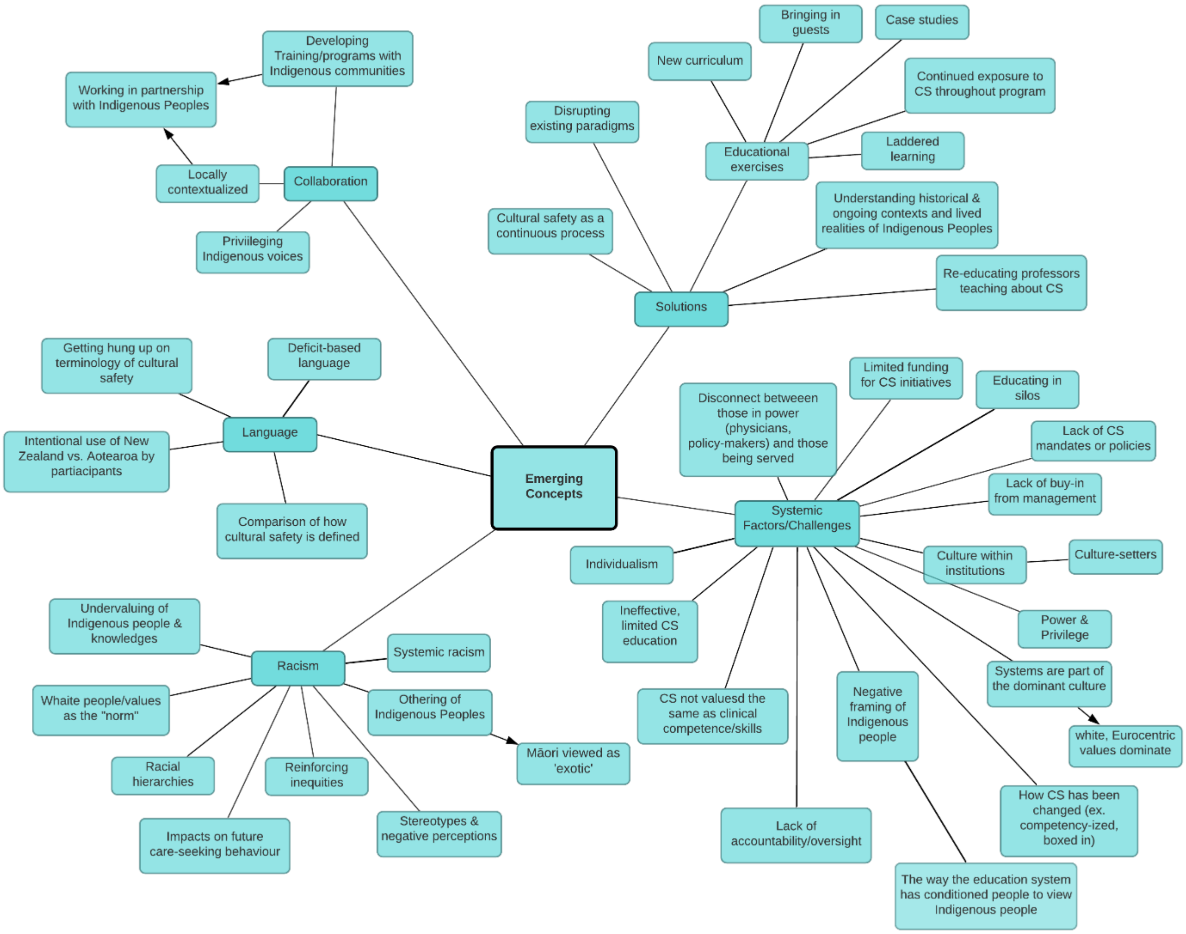


Figure 1: Emerging theme concept map

Table 2: Initial Coding Framework

Theme	Code(s)
Education	• Continuous learning • Ineffective education • Reflexivity • Understanding historical/political/social context
Systemic Challenges	• Accountability • Funding • Power • Privilege • Attitudes • Negative Framing • Systemic racism

	• Inequities
Racism	• Eurocentrism • Undervaluing Indigenous knowledge
Strategies	• Collaboration • Partnership • Privileging Indigenous voices

Table 2: Summary of themes

Barriers (directly leads to unsafe care)	Facilitators	Recommendations & Strategies
Organizational *Policy & Practice* • Accountability (negative) • Organizational buy-in • Unsafe care practices *Structure* • Ineffective education • Funding • Health system structure Participants discussed barriers that prevent effective, culturally safe care, including lack of accountability and buy-in, ineffective health care provider (HCP) education, funding issues, and the very structure of the health system. Additionally, some participants described experiences, both personal and professional, with unsafe care practices. These barriers were often discussed at an	**Working in Relationship** • Collaboration • Partnership For most participants, working with Indigenous Peoples was integral to providing culturally safe care. Many described the need to work in partnership or collaborate on projects like developing cultural safety training. Most of the information coded under collaboration and partnership emphasized the relationship between Indigenous and non-Indigenous people, and therefore these were grouped together under the theme of working in relationship. **Organizational Commitment** • Accountability (positive) • Power (positive) Some participants mentioned examples of organizations using their power in positive ways that facilitate improved quality of care, or organizations demonstrating accountability. Positive examples of power within organizations centered on empowering patients to determine if their	**Service Delivery** • Culturally-relevant services • Safe spaces In providing recommendations and strategies for implementing culturally safe care, participants described examples of what organizations could do to provide services that were culturally-relevant, taking into consideration the need for these services to be locally contextualized to ensure that the unique cultural traditions of Indigenous Peoples are recognized. Additionally, participants described the need for safe spaces in order to enable culturally safe

organizational level, such as a university, or hospital, so these codes were grouped together under the theme of organizational barriers. **Systemic** *Relations* • Eurocentrism • Systemic racism • Undervaluing Indigenous knowledge • Inequities • Negative Framing • Attitudes • Understanding historical/political/social context *Status* • Power (negative) • Privilege In addition to organizational barriers, participants also discussed barriers that extended beyond the walls of organizations. These barriers had wide-reaching impacts, and included systemic racism, eurocentrism, and undervaluing Indigenous knowledge. These all seemed to reflect societal factors, so they were grouped under the theme of systemic barriers. **Implementation of Cultural Safety** • Terminology • Changes to cultural safety	care was culturally safe, and giving power back through working groups. Positive discussions of accountability centered on organizations being held accountable, and holding themselves accountable to the tenets of cultural safety. Both of these seemed to represent examples of organizations committing to cultural safety as a concept, and therefore were grouped together under the theme of organizational commitment. **Valuing Indigenous Peoples** • Elevating Indigenous voices • Representation Participants discussed incorporating and elevating Indigenous perspectives, which are frequently overlooked or ignored due to power systemic racism, and/or power differentials, as crucial to facilitating cultural safe care. Additionally, representation was seen as a key contributor to ensuring care was culturally safe for Indigenous people. Both of these spoke to a need to value Indigenous knowledge and perspectives, and therefore were grouped under the theme of valuing Indigenous Peoples.	care, and allow honest learning. Both of these aspects were related to service delivery, and therefore were grouped under this theme. **Educational Changes** • Continuous learning • Education strategies • Reflexivity All participants provided strategies to improve HCP education, as a key step towards providing quality care. As part of that, many participants recommended continuous learning. Continuous learning was also mentioned by many as a key component of cultural safety in the sense that being culturally safe isn't a single, measurable endpoint. Finally, reflexivity was highlighted as a key component to HCPs understanding their biases and contributing to improved power dynamics. All of these related to learning in some way, and so they were

For many participants, challenges around providing culturally care were rooted in challenges with the terminology. Many participants took issue with the word culture, which they felt caused HCPs, educators and the general public to shift their attention to Indigenous culture, and away from prioritizing patient safety, and care outcomes. Additionally, the changes to cultural safety from its original conception presented a barrier that participants felt inhibited the growth of cultural safety, did not provide sufficient credit to Indigenous Peoples, and impacted how cultural safety has been taken up. Both of these codes speak to how cultural safety has or has not been implemented, and therefore they were grouped together under the theme of implementation.		grouped under the theme of educational changes.

Theme = Green
Sub-theme = *Italicized*