Conceptualizing Cultural Safety:
Definitions and Applications of Safety in Health Care for Indigenous Mothers in Canada

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Abstract

The importance of delivering culturally-appropriate health care to meet the unique health needs of Indigenous peoples in Canada has resulted in the emergence of various concepts to describe how care should be provided. However, there is lack of clarity regarding how these terms differ from one another and what they look like in practice. An extended literature search was performed to conceptualize terminology used to describe culturally-appropriate care, emphasizing the concepts of 'cultural safety' and 'cultural competence'. Maternal and child health programs that utilize these concepts were then surveyed to explore how they are being applied in practice. Relevant literature was identified through major databases (Ovid Medline, CIANHL, and the CHR Collection) with key terms "cultural competency", "cultural safety", and "Indigenous health care", along with forward citation and grey literature searches. This literature review demonstrates that the theoretical definitions of cultural safety and cultural competence are distinct, but lack strict delineations, much like the variable and dynamic nature of their application. By comparing the conceptual bases of culturally-appropriate care with their actual application, gaps in current provision of culturally-appropriate health care for Indigenous peoples are identified and recommendations generated for enhanced development of care.

KEYWORDS: Indigenous; Mothers; Health care; Cultural competence; Cultural safety

Introduction

The Indigenous-Canadian population experiences significant health resource disparities in comparison to non-Indigenous Canadians, which result in generally inferior health outcomes. These disparities are perpetuated by reduced access to health care services and are rooted in inequities in the determinants of health, which include social, economic, cultural, and political factors (Baba, 2013). The severity of these inequalities are reflected in comparative rankings on the World Health Organization Human Development Index, which is a composite measure of every country's life expectancy, education, and income, or standard of living. As a whole, Canada ranks 6th on this scale, while First Nations communities rank 68th (Canadian UNICEF Committee, 2009). Current data show that Indigenous peoples face urgent health issues, including disproportionate burdens of communicable diseases such as HIV and tuberculosis, as well as epidemic rates of non-communicable conditions, such as obesity and diabetes (Monette, 2011; Public Health Agency of Canada, 2007; Public Health Agency of Canada, 2000).

Many barriers reduce the access of health care by Indigenous peoples, including those related to geography and financial expenses. Additionally, negative experiences with the mainstream health care system have become prominent reasons for the delay or omission of seeking timely care (McCormick, 1996; Smye & Browne, 2002). Health care institutions that do not practice culturally safe care ultimately alienate Indigenous peoples from seeking needed health services, thus perpetuating poorer health outcomes (DiLallo, 2014). The impact of this factor is pressing; in an urban sample of Indigenous people, 23.9% of participants identified lack of trust in their health care provider as a barrier to receiving care (Smylie et al., 2011). Furthermore, 20.9% of the sample reported that they felt the service was not culturally appropriate, 19.9% reported difficulty obtaining a variety of services they felt were necessary,

and 13% indicated that they experienced unfair treatment because of their Indigenous identities (Smylie et al., 2011). Racialization, stereotyping, and lack of professionalism continue to compromise quality of care for Indigenous patients, and failure to recognize patients' cultural backgrounds may lead to high health program drop-out rates and less effective healing (Sue & Sue, 1981; McCormick, 1996).

In recent years, the recognition that the health care system is not systemically suited to meeting the unique health priorities of Indigenous clients has driven the development of cultural competence and cultural safety as ways of providing services that acknowledge cultural difference. The purpose of culturally safe and competent services is to consider the cultural identities, histories, and sociopolitical contexts of Indigenous people within their care, in order to maximize quality, outcome, and seeking of care (Narayan, 2002; Smye & Browne, 2002). While these concepts are still in development and have not yet been universally adopted, they are key indications of progress towards creating more positive relationships with Indigenous peoples within health care services and beyond. The aim of this paper is to consolidate an understanding of the theoretical bases behind culturally safe and competent care, and to explore examples of their implementation in the context of maternal and child health services.

Literature Review

Terminology for Culturally-Appropriate Care

Cultural competence and cultural safety are the predominant models of care described in the literature and are the broadest, most often-used terms by universities, organizations, and governments when discussing culturally-appropriate care for Indigenous patients (Baba, 2013). However, a variety of other terms exist to describe the elements that constitute cultural safety and cultural competence, and it is still widely debated which terms are most accurate or most suited to the clinical context. Terms such as cultural humility, cultural awareness, cultural sensitivity, cultural knowledge, and cultural proficiency all partake in the discussion of what true culturally-appropriate care resembles. This diversity of terminology also exemplifies the complexity of determining whether these characteristics are sequentially or simultaneously developed. The major concepts of cultural competence and cultural safety encompass and share many of these ideas and themes and are summarized in Figure 1. Whether proficiency

is more achievable than safety, or whether safety plays a role in acquiring proficiency, or whether competence is essential for safety are all questions that demonstrate the lack of perfect clarity and distinction of these concepts. Regardless of semantics, their mutual goal is to make health services more accessible and relevant for Indigenous patients for the ultimate improvement of health outcomes.

Defining Cultural Competence

Cultural competence is not a term uniquely applicable to servicing Indigenous populations, nor is it only applied within health care. Since its conception in the 1980s, it has been described as "a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or amongst professionals and enables that system, agency, or those professionals to work effectively in a cross-cultural situation" (Cross, Bazron, Dennis, & Isaacs, 1989, p. 28). Its emphasis is on acknowledging the importance of culture and the presence of cultural differences and culturally-unique needs. Within health care, cultural competence suggests that these considerations must be integrated in how patients are cared for (Betancourt, Green, Carrillo, & Ananeh-Firempong, 2003; Davis, 1997). Tangibly, this involves the recognition of different health beliefs, disease prevalence and incidence, and treatment outcomes for different demographics. Cultural competence has also been applied beyond the cultural context to include race, language, age, gender, lifestyle, ethnicity, faith, location, and socioeconomic status, thus shifting the focus towards reduction of ineffective health care through respect and acceptance for all. It must be recognized, however, that cultural competence for one population does not necessarily translate into competence for another (Kim, Kim, & Kelly, 2006), identifying the need for competence to be developed in specific intercultural contexts.

Cultural competence is most often used to describe the health care provider; it focuses on the knowledge, awareness, and skills of the practitioner that "promote and advance cultural diversity and recognizes the uniqueness of self and others in communities" (Betancourt et al., 2003; Walker & Sonn, 2010, p. 62). Wells (2000) describes the development of this knowledge, awareness, and skills as a continuum that begins with learning the elements of culture and their role in shaping and defining health behavior (knowledge). This knowledge is then followed by the recognition of the cultural implications of behavior (awareness) and the integration of cultural knowledge and awareness into

individual and institutional behavior (sensitivity). Subsequently, routine application of culturally appropriate health care interventions and practices (competence) is developed, culminating in its integration into the culture of the organization (proficiency) (Wells, 2000; Cross et al., 1989). Understanding cultural competence in this way conceptualizes it as the "process of becoming, not a state of being" (Campinha-Bacote, 2008, p. 149), beginning with the appreciation that we are all raised and live within social cultures that shape how we perceive and interact with the world around us (Kruske, Kildea, & Barclay, 2006). It is necessary that this continuum of development be present at all levels of the health care system, as solely shifting a practitioner's perspective is inadequate; the practitioner's knowledge, awareness, and skills need to be endorsed by the profession, hiring institution, and the health care system on municipal, provincial, and federal levels (Nguyen, 2008). Recognizing the scope of cultural competence demonstrates how vast a concept and distant a reality true competence is in practice today.

Over the years, certain theorists have also noted that cultural competence should require that the practitioner identify and challenge his or her *own* cultural assumptions, values, and beliefs that extends beyond simply being culturally aware but strives to see the world through others' cultural lens (Tervalon & Murray-Garcia, 1998). Tervalon and Murray-Garcia (1998) further note that cultural competence necessitates simultaneous knowledge acquisition (life-long learning) and self-reflection (realistic and ongoing self-appraisal) that shifts the power balance so that the practitioner does not assume capability of knowing everything about others' cultures (Brown as cited in Tervalon & Murray-Garcia, 1998). This definition emphasizes the change in attitude and behavior above knowledge acquisition and is the characteristic that forms the focus of cultural safety. For the most part, however, cultural competence prizes knowledge attainable by the practitioner which leads some to claim the impossibility of its realization, calling it a "myth that is typically American and located in the metaphor of American 'know-how'". (Dean, 2001, p. 624). This argument asserts that because modern culture is individually constructed and dynamic in nature, competence is not a generalizable skill set. Instead, Dean and Tervalon and Murray-Garcia suggest that a power shift occur, lest competency reinforce the passive receiver role that Indigenous peoples have been historically subjected to (Brascoupé & Waters, 2009; Dean, 2001; Tervalon & Murray-Garcia, 1998). The patient-practitioner relationship requires complete

transformation and redefinition, which is the notion emphasized in cultural safety.

Defining Cultural Safety

The concept of cultural safety emerged in the 1980s from the work of Maori nurse Irihapeti Ramsden in the context of disadvantaged nursing care provided to Indigenous peoples in New Zealand (Ramsden, 2003). Since then, the concept has been extended and applied to Indigenous peoples in other countries where service inequalities persist. This theory has been applied to social policy areas outside of health, including education, economic opportunity, and criminal justice, although its primary application remains within health policy (Brascoupé & Waters, 2009). Because this concept did not originate in Canada, its definition in the Canadian Indigenous context continues to be refined and its transportability examined, but similarities in the way colonization has affected the Indigenous populations of Canada and New Zealand make the concept largely applicable (Smye & Browne, 2002; Kirkham et al., 2002).

Cultural safety extends beyond cultural understanding and knowledge of the health care worker by emphasizing the power imbalance inherent in the patient-practitioner relationship. This concept shifts power and authority to the Indigenous patient receiving care, who is given the ultimate say in whether care provided was culturally safe or not (Ramsden, 2002). As Ramsden (2002) acknowledges, this definition is more complex than it appears. On the one hand, it may be conceptualized as an extension of cultural competence; however, it is simultaneously a radical and explicit departure from it (Ramsden, 2002). Cultural safety lies on the continuum of cultural competence in that it will not be realized in practice all at once, but will likely be built out of cultural competency practices, as stronger and more trusting mutual relationships develop between the patient and the provider (Brascoupé & Waters, 2009). While conceptualizing cultural safety in this way makes the goal more achievable and relevant in practice-based settings, there is danger that broadening the definition too much may dilute its significance and strength because it is, by nature, a paradigm shift; it rejects the limited cultural competency approach, which is based on knowledge, and refocuses instead on power transfer (Jackson as cited in Ramsden, 2002). In this sense, cultural safety is radically different; it redefines the patient-practitioner relationship such that responsibility and power lie with the patient, who is not a passive receiver, but a powerful player in the relation-

ship (Brascoupé & Waters, 2009). Its success therefore cannot be evaluated as a function of knowledge of the practitioner, but is an outcome in and of itself that the practitioner can only help facilitate.

Cultural safety centres upon sharing: shared respect, shared meaning, and shared knowledge and experience, of learning together with dignity and attention (Williams, 1999). This calls practitioners to understand the bicultural nature of the patient-practitioner relationship, beginning with themselves, their own race, culture, and imprinted stereotypes, and seeking to understand the social determinants of health, as they have evolved in post-colonial times, to influence Indigenous populations today. Redefining the relationship, as cultural safety calls, questions how the practitioner is positioned relative to the patient and to the system of health care delivery, and endorses a shared power paradigm, in which each patient is perceived as a "person of value" (J. Anderson et al., 2003, p. 208). This element of care can only be achieved through systemic alteration of institutional standards of practice (J. Anderson et al., 2003). Cultural safety therefore extends beyond clinical practice to become a moral discourse for informing policy analysis. It is necessarily coupled with application at systemic levels, including consideration of whether mainstream health policies put Indigenous peoples' health at risk, or whether they fail to address gaps in health in Indigenous populations, thereby also producing a lack of safety (Smye & Browne, 2002).

Regardless of how we perceive the development of cultural safety—as an extension on the cultural competency continuum or as a distinct concept—its premise highlights the issue of power, making it highly political, and therefore controversial, in nature. It is embedded in overarching notions of Indigenous sovereignty and it challenges the hierarchies in society and the position that Indigenous peoples have been relegated to (Ellison-Loschmann as cited in Brascoupé & Waters, 2009). In fact, Ramsden presents cultural safety as 'critical social theory', claiming it to be "no different from teaching people to be aware of the sociopolitical, economic issues in society and to recognize the impact that these issues have on people" (Papps as cited in Ramsden, 2002, pp. 132-133). Ultimately, cultural safety demands an examination of Indigenous peoples' power in society as a whole, beyond the confines of health care. It upholds the political ideas of self-determination and decolonization (National Aboriginal Health Organization, 2006), while also taking into account the post-colonial theories that demonstrate how colonization has brutalized and

dehumanized the colonizer as much as the colonized (Gandhi as cited in Anderson et al., 2003). This encourages respectful consideration of both the patient and the health professional as individuals with unique experiences, histories, and positions in relation to the health care system (Anderson, 2003). Because this is as much a political position as it is clinical, however, the concept has been criticized for its integration into education, being deemed as "force feeding culture" and "indoctrinating nursing students" with specific political views (National Aboriginal Health Organization, 2006, p. 1).

While cultural competence exhibits adaptability to different ethno-cultural group interactions, cultural safety was birthed with a strictly Indigenous purpose and context. Cultural safety therefore requires explicit, detailed recognition of the cultural identity of Indigenous people and is dissimilar to universalism and multiculturalism, where all cultures are assumed to possess equal and undifferentiated claims on rights and resources in Canada (Brascoupé & Waters, 2009). Instead, cultural safety asserts the primary position of original people of the land, the historic legacy of power relations and repression (National Aboriginal Health Organization, 2006), and acknowledges the identity of a disadvantaged Indigenous minority to a colonizing majority (Polaschek, 1998). These reflections give way to questioning whether current health policies, research, and practice have been shaped by political, social, cultural, and economic structures that could be systemically recreating historical trauma (Smye & Browne, 2002).

Finally, it must also be noted that cultural safety is still in development. Currently, little evidence of its application in professional practice exists beyond academic studies and government reports and critics have questioned how readily it can truly be implemented, because it seeks to redesign social structure and draw attention to individuals' personal attitudes of social influence (Polaschek, 1998). Nevertheless, it serves as an important interpretive lens to view the current state of health policies, research, and practice to examine how they may be inadvertently perpetuating neocolonial approaches for Indigenous people (Smye & Browne, 2002). This understanding will ultimately enable the creation of "an environment which is safe for [Indigenous] people: where there is no assault, challenge or denial of their identity, of who they are and what they need" (Williams, 1999, p. 213) and subsequently improve health outcomes.

Figure 1: *A Schematic Representation of the Terminology used in Describing Culturally-Appropriate Care and Their Generalized Relationships to One Another*
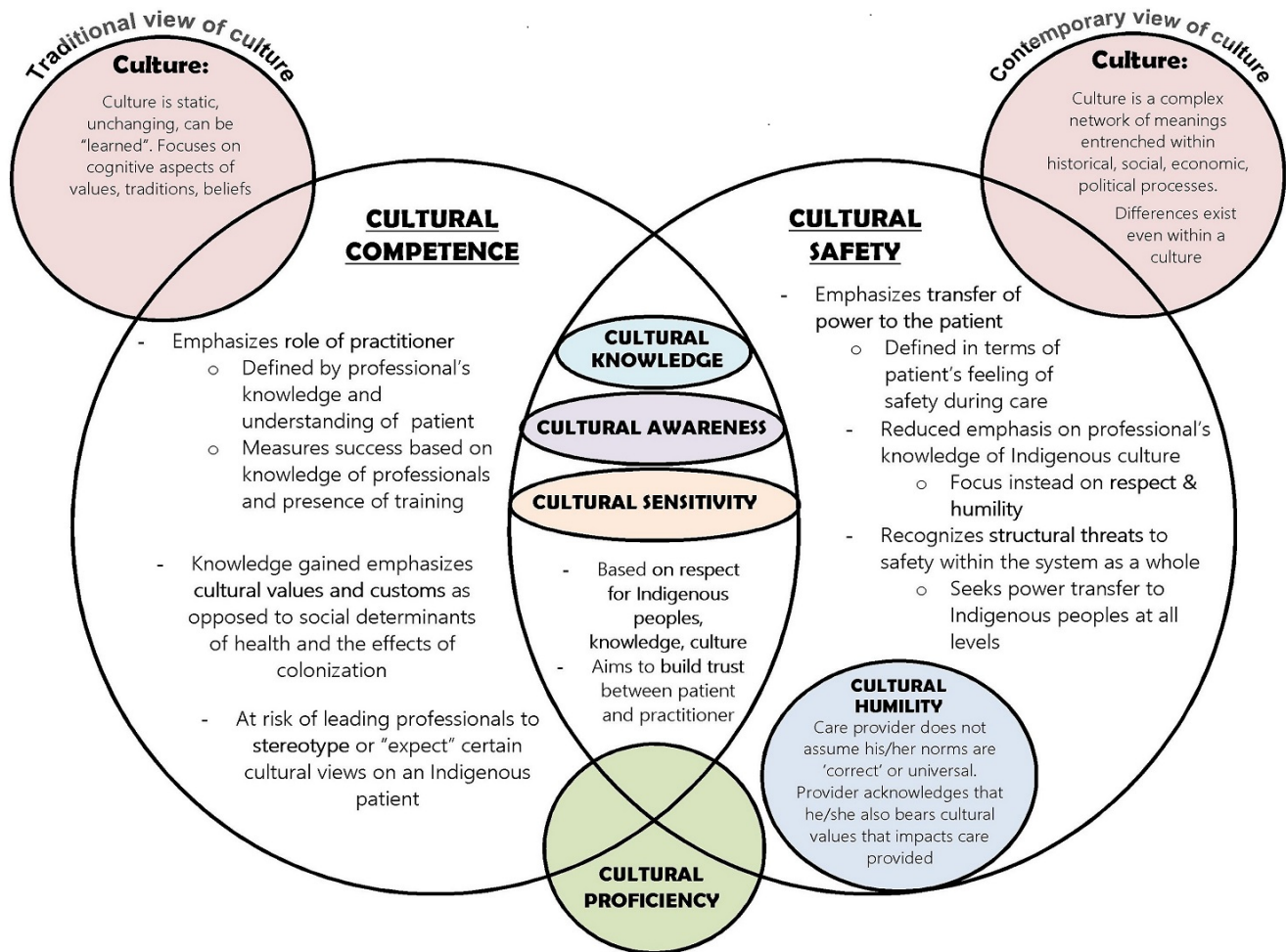
Emergent Characteristics of Applied Cultural Safety and Competence in Care

The complexity of cultural safety and competence naturally results in complex models of application, and like theoretical precedents, they too are still in development. Limited literature exists on the application of culturally appropriate models of care for Indigenous peoples and little concrete evidence proves the efficacy of one method of application over another, particularly for cultural safety.

Cultural competence, being rooted in the more traditional view that the practitioner directs and defines culturally appropriate care, unsurprisingly involves professional education centred upon developing a practitioner's knowledge, attitudes, and beliefs (Nguyen, 2008). Cultural competence teaches practitioners to understand specific historical patterns that affect the contemporary conditions of Indigenous people, including the impacts of colonization and social assimilation and specific phenomena such as the residential schools system that has led to historical trauma and lost culture. Practitioners are taught about Indigenous spirituality, religiosity, and family dynamics, as well as cultural constructs in communication, social etiquette, and social values (Nguyen, 2008). The extent and breadth of this knowledge practitioners are called to know may be dangerous, however, because it may instill a false confidence that seeks to fit all Indigenous patients into one stereotypical mold and fails to consider diversity within the Indigenous population (Williamson & Harrison, 2010). While elements of knowledge are useful in establishing rapport, asking the right questions, and identifying potentially relevant cultural variables, practitioners must be reminded that cultural competence is an ongoing process, and that cultural assessment

must be done to understand the unique needs of every individual, family, and community (Campinha-Bacote, 2008).

In contrast, cultural safety focuses less on understanding the details of cultural traditions and values and instead emphasizes knowledge of colonization, residential schools, generational trauma, and its impact on generating the current social determinants of health that breed health inequalities (Health Council of Canada, 2011; Canadian Association of Nurses in AIDS Care, n.d.). Practitioners are encouraged to evaluate current institutions and the policies that continue to implicitly marginalize and demean Indigenous people, as well as acknowledge Indigenous peoples' sentiments of being discriminated against, isolated, and judged when accessing care (Health Council of Canada, 2011). Increasing the knowledge base in this way prevents the practitioner from developing a paternalistic attitude and instead encourages sensitivity and compassion. Practitioners are also taught about the complexity of Indigenous information systems and their dynamic nature that is to each community, nation, and family, in an effort to garner deep respect for traditional healing customs.

Both culturally competent and safe care extends beyond patient-practitioner relationships to acknowledge how social and cultural influences interact at organizational and structural levels of the health care delivery system (Betancourt et al., 2003). Organizational structural competence involves expanding Indigenous leadership and a workforce composition that is representative of the proportion of Indigenous patients seen, as well as developing relationships between federal and provincial authorities, and Indigenous organizations (Betancourt et al., 2003; Health Council of Canada, 2011). Additionally, regardless of ethnicity, providers should be given training about Indigenous culture and language (Anderson, Scrimshaw, Fullilove, Fielding, & Normand, 2003). Structural cultural competency requires that a system minimize barriers of access to quality health care and services, providing services like interpreters and linguistically appropriate health education materials, as well as proper signage (L.M. Anderson et al., 2003).

With regard to patient-practitioner relations, both cultural competence and safety call for respect, trustworthiness and self-awareness on the part of the care provider (National Aboriginal Health Organization, 2006). However, because cultural safety emphasizes power transfer, self-determination, and empowerment of the Indigenous patient, it promotes the collaborative

agreement on a treatment regime, using a 'strengths-based approach' in which practitioners focus on the positive underlying basis of the person's resources and resilience, drawing upon their own community supports and resources (Canadian Association of Nurses in AIDS Care, n.d.). The ultimate goal of promoting this empowerment is to return complete control of health care systems and provision of health care to Indigenous communities. As such, cultural safety also advocates for the inclusion of Indigenous peoples in the health care and education disciplines, along with return of ownership of research and health systems planning (Williams, 1999; Smylie et al., 2011). The holistic nature of culturally safe practice that respects the physical, mental, social, spiritual, and emotional domains of health, as well as the role of individuals within their respective families and communities, also shifts the focus of care to a more macroscopic scale. The application of cultural safety is therefore broad, as it is concerned with ultimately binding Indigenous and non-Indigenous society to live together collaboratively and respectfully, while still operating in self-determined, independent manners, for the purpose of building complete wellness in both health care systems and society-at-large for both Indigenous and non-Indigenous people alike (Polaschek, 1998).

CASE STUDIES: INDIGENOUS MATERNAL AND CHILD HEALTH

The largest growing demographic in Canada is that of the Indigenous population, having reached 1.17 million in 2006 and being significantly younger than the non-Indigenous population, as well as possessing significantly higher birth rates (Statistics Canada, 2008). Despite the fact that Indigenous peoples will continue to comprise a significant proportion of future generations, there exists a deficiency of Indigenous maternal and child health data (Smylie, Fell, Ohlsson, Joint Working Group on First Nations Indian Inuit, & Canadian Perinatal Surveillance System, 2010). The few reliable statistics indicate a grim reality that infant mortality rates for Status First Nations remains twice as high as Canadian rates, and the health of Indigenous children is significantly poorer, with higher risk of injury, extreme birth weights, and skyrocketing rates of obesity (Boyd, 2007; Health Canada, 2011). These health inequities are exacerbated by poor access to and quality of Indigenous maternal care; Indigenous women often have little or no prenatal or antenatal care, and the birthing experience is frequently negative, which

resonates intimately with the intergenerational trauma and historic destruction of experiences surrounding pregnancy and parenting (David Thompson Health Region as cited in DiLallo, 2014).

Increasing the self-directed seeking of health care by Indigenous mothers depends on creating positive and supportive maternal health service experiences. The Royal Commission on Aboriginal Peoples (1996) noted that Indigenous women who are pregnant "need culture-based prenatal outreach and support programs, designed to address their particular situation and vulnerabilities" (p. 122). The concepts of cultural safety and competence are therefore highly relevant in the field of Indigenous maternal and child health. There is no definite, objective standard with which we measure how 'culturally safe' a program is, resulting in a large spectrum of programs that vary in how and to what extent they integrate cultural values. The following case studies provide several instances of cultural safety in practice and are selected for their diverse but clear demonstrations of the principle's core values. A more detailed comparison of case study elements is provided in Figure 2.

Case Study 1: Aboriginal Prenatal Wellness Program (APWP)

Culturally-safe practice is characterized by holistic, continuous care, and empowerment of families and communities to become key actors in health programming. The Aboriginal Prenatal Wellness Program (APWP), which operates from Wetaskiwin Family Medical Practice, based in Wetaskiwin, Alberta, exemplifies these qualities by recognizing the pivotal role of maternal health in the wellness of children and families (DiLallo, 2014).

APWP is based on a holistic care model that aligns with Medicine Wheel teachings, encompassing mental, emotional, spiritual, and physical wellness (National Aboriginal Health Organization, 2006). Every client is cared for in all domains; the first evaluation within the program, for instance, includes assessments in each area of health (DiLallo, 2014). Services provided also involve community agencies, health professionals, social workers, life support counselors, and Indigenous community elders, acknowledging the multifaceted determinants of health (DiLallo, 2014). The respect for holistic care and health experiences is also applied in APWP's commitment to walking every client through pregnancy, from prenatal care to delivery, to postnatal care (DiLallo, 2014).

Cultural safety also requires that the value of Indigenous knowledge be accepted as an equal partner in health. APWP possesses a traditional healing component led by Elders and community members that is not additional or superficial, but a core element within the program. For instance, when a client confirms a pregnancy, she is offered an appointment with an Elder for personalized discussion and education that explains the prenatal care to be received (DiLallo, 2014). Experiences are placed in the context of teachings of the Creator's role in conception and blessings and ceremonies are performed (DiLallo, 2014). The presence of Elders and community member workers serving alongside nurses, physicians, laboratory specialists, counsellors and doulas establishes a power balance that prizes Indigenous health values and practices as equals to biomedical care (DiLallo, 2014). The culturally safe mandate of equality and collaborative community partnership is also evident in program governance, as program representatives meet regularly with community members, health unit and clinic representatives, as well as practitioners (DiLallo, 2014). Beyond equalizing power, the tenets of cultural safety also resonate in how the role of the biomedical practitioner is defined: they are not expected to be 'experts' in Indigenous culture whatsoever. Instead, the traditional Healers and Elders assume authority over the traditions and ceremonies, leaving the non-Indigenous practitioners to focus on provision of biomedical care that assumes no authority over traditional healing.

Case Study 2: Inuulitsivik Health Centre Midwifery Initiative

Cultural safety is ultimately concerned with restoring power, autonomy, self-government, and revival of Indigenous peoples' culture in all domains of society. The reclamation of authority over health services is exemplified in the establishment of the midwifery ward at the Hudson Hospital (Inuulitsivik), located within the village of Puvirnituq in Nunavik, Québec. This initiative is a result of efforts between the Inuulitsivik Health Centre and local activists who advocated for return of birth to Inuit communities as a part of reviving Inuit culture and self-governance (Centre de santé Inuulitsivik, n.d.). Being a community-led initiative, its very creation thus represents the empowering outcome cultural safety is designed to promote (Epoo, Stonier, Van Wagner, & Harney, 2012). The mission of the centre is to reintegrate traditional knowledge about birth into the modern approaches to care, and its inception has encouraged the opening of local birth programs within

the network of Inuulitsivik Health Centres in Inukjuak and Salluit (Van Wagner, Epoo, Nastapoka & Harney, 2007). These centres were opened in response to the lack of local birthing services in many Inuit communities in Northern Canada, which made it necessary for pregnant mothers to fly into urban centres weeks before their due date to give birth (Chamberlain & Barclay, 2000). Over time, evacuation of women from their communities has led to a loss of birth as a celebrated component of the community culture, thereby weakening the health, strength, and spirit of the communities (Lalonde, Butt, & Bucio, 2009; Crosbie as cited in Van Wagner et al., 2007). The removal of birth from the community has been seen as an "act of disrespect, neglect, and a colonialist approach to health care and to indigenous communities" (Van Wagner et al., 2007, p. 387), and the placement of women in foreign and lonely biomedical institutional environments produces psychological fright and perpetuates the dread of seeking of medical care, which is particularly unhealthy during birth (Smith, 2002).

Cultural safety, which requires an equal valuing of Indigenous knowledge, is epitomized and even expanded by the Inuulitsivik centres in that all care provided is midwifery-led, in accordance with the traditional ways of birth (Van Wagner et al., 2007). Power over the birthing services is therefore not simply equalized, but completely owned by the Inuit peoples and their unique expertise and ways of knowing. The midwives are the lead caregivers and are supplemented by a multidisciplinary team of nurses, physicians, social workers, and Southern midwives, who act primarily as back-up support and trainers (Benoit, Carroll, & Eni, 2006; Stout & Harp, 2009). The Inuit midwives provide care in Inuktitut, the Inuit language, and encourage practice of cultural tradition such as that of having multiple friends and family attend and witness the birth (Epoo et al., 2012). The power redistribution in this model also extends into the government of the hospital in Puvirnituq by an interdisciplinary council that receives feedback from the Perinatal Committee, which is led by a team of midwives (Van Wagner et al., 2007).

As a value of cultural safety, the ownership and transfer of responsibility and power over health to the community is also embedded within the Inuulitsivik's education model that ensures its sustainability and continuation as being locally-led in the future. Within the program, Inuit women are provided with academic and clinical education in their own communities, with a curriculum framework that is consistent with clinical content of southern Canadian programs, but adapted

for northern realities and inclusive of Inuit culture (Van Wagner et al., 2007). Transferring education of health care to the communities is in itself a statement of recovery and healing from the effects of colonization on health system. The training program focuses on observational learning from midwives who act as 'mentors', through storytelling, and other oral methods of teaching of Inuit pedagogy (Epoo et al., 2012). In this way, the traditional methods of knowledge transfer are preserved, while also meeting the standards for midwifery practice in Québec. The program also has a heavy emphasis on experiential learning; mentors guide and teach new students along with Elders, who pass on traditional knowledge of how to benefit from healthy diets of natural foods, and Inuit approaches to labor, birth, and baby care (Van Wagner et al., 2007). Southern midwives are involved to teach skills on emergency situation care, but the practices of using pharmaceuticals and acute interventions are always coupled with traditional beliefs, such as avoiding knots during pregnancy or folding a finger to control post-partum hemorrhage (Van Wagner et al., 2007). Ultimately, each student is assessed on the development of key competencies in Inuit midwifery that have been established; these competencies also cover the requirements for standard midwifery education in Quebec. This provides a systematic way to utilize traditional learning methods while blending Inuit and non-Inuit knowledge and approaches (Van Wagner et al., 2007).

The Inuulitsivik Midwifery Education Program and its return of birth to Nunavik has become an example of a "community-led initiative capable of working creatively within the sphere of local conditions and resources to restore quality midwifery and perinatal services" (Epoo et al., 2012, p. 291). It exemplifies the reliance on the Inuit cultural perspective to not only inform, but completely guide services and education programs, representing the return of birth to remote communities for healing and capacity building. This phenomenon is not universal for all Indigenous peoples; however, there are great deficiencies in information on First Nations and Métis birthing practices, signifying the importance of moving towards application of these cultural safety principles in birth universally (National Aboriginal Health Organization, 2008).

Case Study 3: Strengthening Families Maternal and Child Health Program

Beyond power transfer in clinical settings, cultural safety prioritizes and ultimately endeavours to restore complete community wellness. The Strengthening Fam-

ilies Maternal and Child Health Program exemplifies this tenet of safety by providing family-focused, in-home visiting programs by nurses and trained home visitors for pregnant women, fathers, and families of infants and young children aged 0 to 6 years, reaching directly into the daily lives of mothers and children and caring for them within the context of the rest of the family (Eni, 2010; Eni & Rowe, 2011). The program emphasis of restoring family structure and relationships recognizes the intergenerational effects on Indigenous families that persist from historic assimilationist and colonialist endeavors, like the residential schools policy. The program is based in 14 First Nations communities in Manitoba, and fosters strong attachments between parents and children, improves parental capacities in parenting and child development, and increases access in supports and health services to decrease isolation (Eni & Rowe, 2011). This is particularly important for the coordination of services for children with complex needs.

Cultural safety includes the element of a strengths-based approach that acknowledges the diversity in culture between Indigenous communities. The Strengthening Families program is operated in part by the Assembly of Manitoba Chiefs, which provides regional support to tailor a standardized program model to individual community cultures, thus mitigating assumptions regarding communities' needs and priorities (Health Council of Canada, 2011). Existing services (taking into account characteristics like opportunities for employment, education, extra-curricular activity, social services, etc.) are used in each context to increase the program's sustainability and relevance (Eni, 2010; Eni & Rowe, 2011).

Figure 2: *Summary Chart of Case Studies and Their Unique Applications of Cultural Safety*

CULTURAL SAFETY ELEMENTS IN:	Aboriginal Prenatal Wellness Program (APWP)	Inuulitsivik Midwifery Initiative	Strengthening Families Maternal and Child Health Program
Governance	Operates out of Wetaskiwan Family Medical Practice – no information on independent governance (DiLallo, 2014).	Founded by a community organization of Inuit women. Governed by interdisciplinary council that receives feedback from teams of midwives (Van Wagner et al., 2007).	Co-managed by Assembly of Manitoba Chiefs and First Nations Inuit Health. Three regional leadership positions on the Assembly of Manitoba Chiefs Secretariat (Eni & Rowe, 2011).
Philosophy of Care	Holistic: based on Medicine Wheel teachings and provides services for physical, mental, emotional, and spiritual health (DiLallo, 2014).	Holistic and based on revival of Inuit culture, autonomy, and self-government – reclamation over direction of birthing practices (Epoo et al., 2012).	Holistic and acknowledges relationships of mothers and children with the rest of the family. Emphasis is to restore family structure in all domains of health (Eni, 2010).
Biomedical Care	Biomedical care team includes physicians, nurses, lab specialists, counselors, doulas. Elders work alongside these professionals and take equal responsibility for care of clients (DiLallo, 2014).	Biomedical care supplements traditional midwifery. Midwives are the core caregivers, taking primary responsibility for clients. They are *supplemented* by Southern midwives, nurses, physicians, social workers (Benoit, Carroll, & Eni, 2006; Stout & Harp, 2009).	Biomedical care includes reproductive health, screening, and assessment of pregnancy. Program redirects participants to other biomedical services as needed (Eni, 2010).
Traditional Care and Teachings	Elders and community members run traditional healing programs which is part of core programming and program experience (DiLallo, 2014).	Traditional care is the primary modality – it is all midwifery-led. Care is provided in Inuktitut, the Inuit language (Epoo et al., 2012).	Incorporation of traditional knowledge and culture in progress, as per recommendations of participants (Eni & Rowe, 2011). Community-based nature enables participation of Elders.
Program Development	Program representatives meet with community members regularly to receive feedback and future direction (DiLallo, 2014).	Program transfers education of midwives to communities themselves – communities therefore directly drive program forward (Epoo et al., 2012).	Steering committee reports maternal and child health priorities and interests to advise on programs. Committee represents all 64 Manitoba First Nations communities (Eni & Rowe 2011).
Community Integration	Intricately community-based: Networked with community agencies, social workers, life support counselors. Model has been expanded to Wetaskiwin Primary Care Network to be implemented elsewhere in community (DiLallo, 2014).	Midwifery initiative is part of larger Inuulitsivik Health Centre which has a social services branch. Community Liaison Wellness Workers within this branch increase collaboration among establishments and organizations ("Health Care and Services", Inuulitsivik Website, n.d.).	Identity as a community-based program builds on local capacities and existing infrastructure and depends on local partnerships. One of primary objectives is to assist families in accessing health and related services in community over time to promote sustainability (birth to six years) (Eni, 2010).

Discussion and Recommendations

The preceding case studies demonstrate that promising practices integrate cultural safety within a consistent set of domains (governance, biomedical care, traditional care, program development, and community integration). However, these domains are not universally or officially recognized as elements necessary for a culturally safe practice, and as a result, the application of cultural safety is not universally standardized. This allows adaptation of services to the unique priorities of every Indigenous community, departing from a 'one size fits all' model. Simultaneously, the lack of official guideline for implementation of cultural safety also results in a large spectrum of initiatives being put forth as 'culturally safe' —some of which may, in actuality, simply consist of layering a semblance of traditional knowledge over mainstream Western biomedicine. True cultural safety in health services requires that respect for Indigenous knowledge and systems of healing underlies the foundation of all programming and the philosophy of the entire organization itself, with particular regard for Indigenous concepts of holistic health, relationship-building between patient and practitioner, and reciprocity and power balance within those relationships for mutual teaching and learning. The presence of a guiding baseline application framework for cultural safety would therefore be beneficial as a starting point for health care systems seeking to serve Indigenous populations. Similar to the necessity of a baseline application framework, cultural competency and safety training for health professionals should also have some degree of standardized curricula, for the creation of a recognized, mutual understanding of concepts and their importance.

While many different conceptualizations of cultural safety have appeared in health care practice, established efficacy evaluation of these strategies is particularly lacking in Canada, where cultural competency and safety standards are not embedded in federal and state policy and reporting requirements, like they are in the United States, or within national legislation or policy, as in New Zealand and Australia (O'Brien, Boddy, & Hardy as cited in Clifford, McCalman, Bainbridge, & Tsey, 2015; Office of Minority Health, 2001). Evaluation schemes and indicators are necessary to compare and contrast programs and objectively determine which applications of cultural safety are meeting their goals, and which are not. These evaluation criteria must be produced in a manner that, in itself, is culturally safe, through consultative processes that heavily depend on the Indigenous world view, systems of knowing, and voices of the Indigenous peoples being serviced. Producing a set of standardized evaluation criteria must not, however, prevent these tools from being dynamic enough to accurately reflect the potentially unanticipated effects of the program, nor must they neglect to consider a community's specific strengths and weaknesses.

The centralization of information on culturally safe practices exists as a gap in the literature. While it is evident that many different health services have sought to apply principles of cultural safety and introduce collaborative biomedical and traditional Indigenous practices in their own way, little work has been done to compile the impacts and lessons learned from these efforts into a single, widely-distributed document. The Health Council of Canada's report entitled *Empathy, dignity, and respect: Creating cultural safety for Indigenous people in urban health care* (2011) summarizes, to an extent, the scope of programs available by province, but a full compendium dissecting all programs would be beneficial. This type of review would enable more directed, systems-level intervention. While it is beneficial that many different programs providing culturally safe primary health care are appearing in pockets across the country, work must be done to channel efforts into a cohesive revolution of care, so that programs do not overlap and so that specific gaps are identified and filled. This lack of information sharing consequently prevents cohesive advocacy for regional, provincial, and national level policy changes to support universalized implementation of culturally safe practice for Indigenous peoples in Canada, which is necessary for sustainable impacts to be made in the most direct, efficient, and effective way possible.

Conclusion

Developing culturally appropriate care has gained attention in recent years and a multitude of concepts to describe the elements of this care have subsequently appeared. These concepts are particularly important with regards to health care for Indigenous peoples of Canada, who are often underserviced and do not receive adequate medical attention. The two most notable and applied of these concepts are those of cultural competence and cultural safety. While cultural competence emphasizes the more traditional perspective of gathering information of Indigenous culture, cultural safety is an outcome, defined and experienced by patients receiving health care service. Cultural safety is based on

respectful engagement with patients and on the understanding of the power differentials inherent in health service delivery, encouraging a return of power to the patient and a questioning of institutional and systemic discrimination by providers. Finally, cultural safety enforces the need for providers to acknowledge that they too are bearers of culture, prompting need for self-reflection. While these concepts have been developed in theory over time, little research has focused specifically on the experiences of Indigenous mothers accessing different forms of culturally appropriate care and their priorities regarding how and what type of health care is delivered. It is therefore important from an academic perspective that research efforts be made towards recognizing the unique needs of Indigenous mothers and children, which should in turn form the foundation of any program development, in order to circumvent paternalistic impositions of what is assumed to be appropriate. From an applied perspective, there is still a need to define how the concepts of cultural safety and competency may translate into practice and policy, prompting the following recommendations:

1. Guidelines for the application of cultural safety across health care services need to be developed based on key themes that have been consistently identified as important by Indigenous patients, disseminated, and universalized as a framework for application.
2. By extension, a framework detailing how cultural competency and safety training can be adapted and taught within professional health education is necessary. While many cultural safety curricula exist, an official guideline is lacking, creating a lack of universal understanding of the concepts and of their importance.
3. There is a need for a key evaluation framework that can be adapted to determine the efficacy of "culturally-safe" interventions in order to determine the best practice for care. This framework must align with Indigenous values and ways of knowing.
4. Centralization of information detailing the ways in which different health care programs are conceptualizing and applying cultural safety in their practices will be useful for understanding how much progress has been made and the gaps that have yet to be filled in the grand scheme.
5. Initiatives designed to produce systems-level changes must be put forth in order to bridge the efforts of all organizations that have interpreted provision of culturally-safe care. In order for change to

be directed and sustainable, efforts must be made to channel individual organization and program efforts into one movement towards a safer overarching landscape.

In summary, the development of cultural safety as a concept represents progress towards more respectful and appropriate engagement with Indigenous patients in health care contexts, but its application continues to remain a challenge. Future work must therefore focus on developing culturally safe care in practice, in a way that prioritizes Indigenous leadership and patient feedback throughout.

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