A CONCEPTUAL FRAMEWORK FOR INDIGENOUS CULTURAL SAFETY MEASUREMENT

Harmony Johnson (sɛ̓ƛakəs) and Julie Sutherland

National Collaborating Centre for Indigenous Health
Centre de collaboration nationale de la santé autochtone

CULTURAL SAFETY AND RESPECTFUL RELATIONSHIPS

Front and Back Cover Photo © Credit: iStockPhoto.com, ID 1180434600
Inner Cover Photo © Credit: iStockPhoto.com, ID 522711459

 This publication was funded by the NCCIH and made possible through a financial contribution from the Public Health Agency of Canada (PHAC). The views expressed herein do not necessarily represent the views of PHAC.

Acknowledgements

The NCCIH uses an external blind review process for documents that are research based, involve literature reviews or knowledge synthesis, or undertake an assessment of knowledge gaps. We would like to acknowledge our reviewers for their generous contributions of time and expertise to this manuscript.

This publication is available for download at: nccih.ca.

Citation: Johnson, H., & Sutherland, J. (2022). *A conceptual framework for Indigenous cultural safety measurement*. National Collaborating Centre for Indigenous Health.

La version française est également disponible au ccnsa.ca sous le titre : *Un cadre conceptuel pour la mesure de la sécurité culturelle des Autochtones.*

For further information or to obtain additional copies, please contact:

National Collaborating Centre for Indigenous Health (NCCIH)
3333 University Way
Prince George, British Columbia
V2N 4Z9 Canada
Tel: (250) 960-5250
Fax: (250) 960-5644
Email: nccih@unbc.ca

ISBN (print): 978-1-77368-325-6
ISBN (online): 978-1-77368-324-9

Download publications at
nccih.ca/34/Publication_Search.nccih

Télécharger des publications à
ccnsa.ca/524/Recherche_de_publication.nccih

issuu.com/nccah-ccnsa/stacks

CONTENTS

INTRODUCTION ---- 4

METHODOLOGY ---- 7

INDIGENOUS PEOPLES' EXPERIENCES WITH HEALTH CARE: RACISM, BIAS, ASSIMILATION, ERASURE, AND THE CONTEXT OF CARE ---- 9

CORE CONCEPTS IN CULTURAL SAFETY ---- 12

CULTURAL SAFETY INITIATIVES IN HEALTH CARE: A BRIEF OVERVIEW ---- 14

CULTURAL SAFETY INITIATIVES: FROM EVALUATION TO SYSTEM-WIDE MEASUREMENT ---- 15

CULTURAL SAFETY MEASUREMENT: A CONCEPTUAL FRAMEWORK ---- 19

- Health System Actions and Interventions ---- 20
- Experience of Health System ---- 24
- Health System Performance ---- 25
- Health and Wellness Outcomes ---- 25

CONCLUSION ---- 27

REFERENCES ---- 29

APPENDIX A: CONCEPTS ACROSS CULTURAL SAFETY FRAMEWORKS ---- 39

APPENDIX B: THEMES OF CULTURALLY SAFE EXPERIENCE ---- 42

INTRODUCTION

Recent years have seen a growing social awareness about the history of Canada's relationship with Indigenous[1] Nations and Peoples, and the legacy of colonialism and racism that continues to shape Canadian society and its institutions. This consciousness, which has deepened into an imperative to catalyze reconciliation, is partially a consequence of the efforts and outcomes of studies such as the Truth and Reconciliation Commission (TRC, 2015) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG, 2019). Reports resulting from both these inquires have called on all governments to comply with rights instruments outlined in, among other human rights documents, the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP).

The UNDRIP sets "minimum standards for the survival, dignity and well-being of Indigenous Peoples worldwide" (Johnson & METL, 2021, p. 1). These standards, or rights, can be grouped into four categories: the right to practise Indigenous medicine, the right to access services without discrimination, the right to the highest possible health outcomes, and the right to self-determination. Colonial practices, systems, and structures have compromised these rights and require urgent redress. Responding to Call #43 of the TRC, the Government of Canada and some provinces and territories are advancing measures, including laws, to apply UNDRIP as the "framework for reconciliation" (TRC, 2015, p. 5).

Indigenous cultural safety is a key concept in health care that reflects the Indigenous rights to health as articulated in the UNDRIP, including the rights to be self-determining, practise traditional and cultural healing and medicine, and access services without discrimination (Johnson & METL, 2021). Originating in Aotearoa[2], cultural safety describes an outcome whereby Indigenous patients and staff can access health services and environments that validate their humanity and cultural identity, are free from racism, and support their right to self-determination. The importance of cultural safety as a means to address inequities in health care and health care outcomes between Indigenous and non-Indigenous populations has been internationally recognized (Curtis et al., 2019). This recognition has led to the development and implementation of frameworks, actions, and interventions (e.g., cultural safety training, cultural safety policies) in health care settings across the world. It has stimulated a call for:

> strategies, accountability mechanisms, and interventions … [to disrupt] deep-seated patterns of power and paternalism operating in health care; the racist and stigmatizing discourses about Indigenous peoples that remain pervasive; and the dismissive, unwelcoming and often demeaning practices and policies that so profoundly impact peoples' experiences. (Browne, 2017, p. 25)

[1] Throughout this paper, the term "Indigenous" is considered synonymous with the term 'Aboriginal' and used to refer to First Nations, Inuit, and Métis peoples in what is now Canada, as well as original inhabitants and owners of lands in other countries.
[2] The term 'Aotearoa' is the Māori term for New Zealand.

© Credit: iStockphoto.com, ID 1131495021

Health system performance and health outcomes measurement are well-established disciplines; however, a conceptual framework that measures cultural safety actions and interventions has seen minimal development to date.

However, conclusively demonstrating results of these interventions has proven elusive, and there have been frequent calls to grapple with and work through the complexities inherent in measuring cultural safety (e.g., Baba, 2013; Curtis et al., 2019; Turpel-Lafond, 2020a).

This paper aims to respond to this challenge by offering a starting point for cultural safety measurement through a review and thematic analysis of available literature. It builds on this literature review to provide a system-level conceptual framework for understanding the relationship between cultural safety interventions, experience, and outcomes.

Health system performance and health outcomes measurement are well-established disciplines; however, a conceptual framework that measures *cultural safety* actions and interventions has seen minimal development to date. Given this gap, this paper highlights the attributes of a culturally safe health care experience. It also focuses on identifying the domains (e.g., governance, human resources, physical spaces) and sample health system performance indicators (e.g., access, effectiveness, efficiency) in the proposed conceptual framework that require more attention. Drawing on available literature, this paper also proposes concepts to inform discussion among and with Indigenous Peoples and organizations about measuring cultural safety in health care. It serves, therefore, as a launching pad to help the evolution, adaption, and improvement of cultural safety measurement take flight through dialogue and relationship.

A key understanding of this paper is that the concepts of cultural safety and relationality are deeply intertwined. It takes its definition of relationality from Elliot-Groves et al. (2020): the awareness that "human lives are interdependent with and contingent on living in ethical

relations with other people, with our ancestors, with plants and animals, and with the natural world" (abstract, p. 158). It also upholds Elliot-Groves et al.'s view that "Indigenous systems of relationality are the heartbeat of Indigenous existence" (ibid.). With respect to cultural safety, the relationship between patient and provider—as shaped by the past, policy, and the care environment—determines the extent to which the patient deems their care as culturally safe. Mirroring the relationality inherent in cultural safety, the domains and indicators presented in this paper are also relational. Any single indicator cannot, on its own, measure the concept of cultural safety; instead, each indicator is influenced by, and in relationship with, many other indicators.

Following a brief description of our methodology, this paper turns to an account of colonialism and Indigenous-specific racism in health care, followed by a description of the concepts, actions, and interventions that have emerged to address these issues. The evaluation and measurement of the effectiveness of those actions and interventions are summarized, as are the various calls for enhanced measurement efforts within these categories. This paper then presents a high-level visual depiction of a Cultural Safety Measurement Conceptual Framework (Figure 1) that is drawn from prevailing logic in the literature. The subsequent four subsections build on this figure, expanding the categories depicted in ovals therein.

The first subsection summarizes and examines 10 domains in which process measures can be designed to monitor the effectiveness of common and established interventions and actions for increasing cultural safety. It also delineates implementation considerations. Of course, these implementation considerations are not exclusively connected with these domains; rather, they should be considered throughout the process of collecting and governing relevant data. The second subsection summarizes six themes arising from a review of the literature focusing on desired Indigenous experiences of cultural safety in health care. In the third subsection, we consider how efforts in cultural safety in health care may be less about designing entirely new indicators and more about supporting the visibility of Indigenous Peoples in these data. The fourth subsection considers how equitable health and wellness outcomes for Indigenous Peoples and the upholding of Indigenous human rights are the result of health system interventions and actions that have led to an experience of the health system which Indigenous Peoples deem as culturally safe. We conclude with a brief invitation to Indigenous Peoples and health systems in Canada to continue discussing and identifying relevant domains, as well as to design actions and interventions that promote Indigenous cultural safety in the health care system from coast to coast to coast.

METHODOLOGY

An initial draft of this paper was prepared in mid-2018, based on online and academic library searches for articles, frameworks, plans, and strategies related to Indigenous cultural safety. This was supplemented by a 2019 academic literature review conducted for a related project, using the following search terms:

Table 1: Search Terms for an Academic Literature Review in a Related Project, 2019

Concept 1	Concept 2
Canada [Mesh] OR Americas [Mesh] OR New Zealand [Mesh] OR Australia [Mesh] OR American Native Continental Ancestry Group [Mesh] OR Oceanic Ancestry Group [Mesh] OR Aboriginal OR "First Nations" OR Māori OR Indigenous OR Metis OR Inuit	"Cultural Competency"[Majr] OR "Culturally Competent Care"[Majr] OR "Transcultural Nursing"[Majr] OR "Health inequality"[Majr] OR "Organizational culture"[Majr] OR "Organizational innovation" [Majr] OR "Health services, Indigenous" [Majr] OR Cultural adj1 safety OR cultural adj1 humility OR cultural adj1 sensitivity OR cultural adj1 awareness OR Culturally adj1 appropriate OR cultural adj1 responsiveness OR Stereotype adj1 harm OR "Critical race theory" OR Settler adj1 identity adj1 development OR "Prejudice reduction theory" OR "Contact theory" OR "Scaffolding learning" OR Institutional adj1 racism OR Confirmat ion adj1 bias OR oppression

This search resulted in the identification of 1,665 articles which were screened against the criteria in Table 2, resulting in 203 articles from PubMed included as part of the literature review.

Table 2: Screening Criteria for the Inclusion of Literature in this Report

Inclusion criteria	Exclusion criteria
• Published in the last 5 years • English • Related to Indigenous Peoples/cultures • Indicators and/or measurement • Touches on structural, system, provider levels of health system • References to Traditional healing/medicines • Social care	• Non-English • Non-Indigenous references (i.e., African-Caribbean, Asian, etc.) • Articles that did not include abstracts • Articles discussing specific medical approaches to treat conditions based on genetic pre-disposition • Protocols for reviews and clinical trials

Further searches were conducted in 2021, in which we used university library and Internet searches to identify recent academic and grey literature, with snowball searching based on references. Finally, outreach was undertaken to the equivalent Ministry of Health in each province and territory to identify any cultural

safety plans, frameworks, measures, or strategies relevant to this effort. The majority of papers we selected for our review are newer than five years, though the snowball searching and examination of the articles' references also turned up a number of studies that are older than five years and which we felt were pertinent to the present paper. The decision to primarily focus on more recent material was based, in part, on advice from an Indigenous advisory group to the literature review, who informed the search terms and the inclusion/exclusion criteria. They felt this criterion would keep the scope of the review manageable. Additionally, the group's intent was for the literature review to assist in the measurement and development of an associated standard and as such, using the most recent publications would result in a more relevant product.

Selection of the frameworks described in Appendix A conformed to the following criteria: related specifically to Indigenous Peoples; was specific to cultural safety; and articulated various organizational domains. Selection of the articles described in Appendix B adhered to the following criteria: related specifically to Indigenous Peoples; was specific to cultural safety; and articulated desired Indigenous experiences of cultural safety in health care.

Addressing disparities in health care and outcomes is impossible without one key aspect of cultural safety: the eradication of anti-Indigenous racism (Kétéskwēw Dion Stout et al., 2021; Turpel-Lafond, 2020a). For the purposes of this paper, we deliberately kept our focus trained on the term "cultural safety" in order to contribute to the analysis of less-developed aspects of cultural safety. Naturally, these aspects need to be paired with the more developed work that focuses more broadly on racism and discrimination, and indeed some of these studies—especially those addressing measurement of racial discrimination—informed the current paper. Many studies that assessed approaches to measuring racial discrimination or provided systematic reviews of such assessment studies found a shortage of adequate tools and studies for measuring health care provider racism and called for more interdisciplinary, comprehensive, and/or sophisticated research and measurement approaches (Adkins-Jackson et al., 2021; Bourke et al., 2020; Boynton-Jarrett et al., 2021; Kressin et al., 2008; National Research Council, 2004; Paradies et al., 2014).

By drawing attention to deficits in studies and measurements, the literature on measurement of racial discrimination indicated that effective measures would include: those based in theory and assessing specific dimensions of racism (Adkins-Jackson et al.; Kressin et al., 2008); those involving empirical analyses (Tan et al., 2021); those extending beyond self-reported/self-perceived experiences of discrimination, as these do not facilitate understanding of racism at a systemic level (Boynton-Jarrett et al., 2021; Irani et al., 2020); those capturing the multidimensional nature of structural racism (Chantarat et al., 2021; Shelton et al., 2021); and those focusing on specific populations (Marrie & Marrie, 2014). Studies also called for the development of strengths-based, culturally relevant, experience measures (Churchill, 2015; Green et al., 2021).

INDIGENOUS PEOPLES' EXPERIENCES WITH HEALTH CARE: RACISM, BIAS, ASSIMILATION, ERASURE, AND THE CONTEXT OF CARE

Indigenous Peoples in what is now Canada have a long and rich history of health and wellness, characterized by a wholistic definition of health that emphasizes the interconnectedness of physical, emotional, spiritual, and mental dimensions of well-being. Indigenous Peoples' health and wellness is intertwined with their relationship with the environment, community, ancestors, and future generations. Through processes of colonialism, Indigenous Peoples' wholistic, relational, approach to health and wellness was intentionally disrupted and replaced by a Western system of health and wellness that inflicted trauma upon families and societies, undermined the self-determination and decision making of individuals and Nations, and systematically devalued their practices, beliefs, and traditions (Public Health Agency of Canada [PHAC], 2015; Turpel-Lafond, 2020a).

Whether consciously or unconsciously, racial stereotypes continue to shape healthcare providers' beliefs, decisions, and actions. These lead to poorer quality care for Indigenous Peoples, who face longer wait times and delays in service, less medication, fewer referrals, disrespectful treatment, and even misdiagnosis and preventable death.

This Western system tends to focus exclusively on the treatment of physical disease and fails to recognize or implement the values and practices upheld by Indigenous populations in the country. It is also operating at overcapacity—now more than ever because of strains related to the COVID-19 pandemic. This latter point is sometimes used to justify the system's failure to address Indigenous-specific racism ("how can an overtaxed system take on another issue?"). What is more, the overtaxed and understaffed system is sorely underrepresented by Indigenous staff. Additionally, jurisdictional wrangling between federal and provincial governments systematically embeds health care inequity for Indigenous populations in comparison to non-Indigenous populations (Allan & Smylie, 2015; Baker & Giles, 2012; Reading, 2013; Reading & Wien, 2009). Thus, the mainstream system in almost every respect fails to equitably serve and support Indigenous Peoples.

In short, the philosophical gap in the definition of health care between Indigenous (wholistic) and mainstream (biomedical) medicine, and a prevailing organizational culture that systematically and interpersonally reinforces racism, have resulted in a health care system which largely rejects Indigenous views of health and wellness. The mainstream system's failure to offer Indigenous Peoples culturally relevant or acceptable care (Health Council of Canada [HCC], 2012; Turpel-Lafond, 2020a) is only the beginning. Indeed, Indigenous health care practices and cultural protocols may even be prohibited by organizational policy and regulatory barriers, and physical spaces reinforce and resemble processes of colonialism that harken back to treatment in such colonial systems as residential schools (Goodman et al., 2017; Hole et al., 2015; Loppie et al., 2014).

While many of the more visible segregationist and assimilationist policies of colonialism (e.g., residential schools, Indian hospitals) have ended, their impacts continue to shape the experiences of Indigenous clients accessing the health system in many ways. Whether consciously or unconsciously, racial stereotypes continue to shape healthcare providers' beliefs, decisions, and actions. These lead to poorer quality care for Indigenous Peoples, who face longer wait times and delays in service, less medication, fewer referrals, disrespectful treatment, and even misdiagnosis and preventable death (Allan & Smylie, 2015; Dehaas, 2014; HCC, 2012; Harding, 2018; Johnston, 2017; Loppie et al., 2014; Turpel-Lafond, 2020a; Vukic et al., 2012). The very experience of racism is also associated with lower health and well-being, including suicidal ideation and stress (Turpel-Lafond, 2020a).

Moreover, individuals living in rural and remote geographies of Canada, which are largely populated by Indigenous

people (Statistics Canada, 2020; Organisation for Economic Co-operation and Development [OECD], n.d.), experience additional inequities in the form of limited access to health services, which is more frequently cited as a barrier to health and wellness among Indigenous populations than among non-Indigenous populations (National Collaborating Centre for Indigenous Health [NCCIH], 2019; Wilson et al., 2020). This, too, is related to historical and ongoing colonial practices. For example, First Nations communities were relocated to reserves on the fringes of their territories, areas that are now underserved by health care services (Turpel-Lafond, 2020a). Indeed, racism and bias are continuously reinforced through the ways in which they are structurally embedded in the institutions and processes of health care.

Many Indigenous people also carry memories associated with the injustice and trauma inflicted by Western institutions—including medical institutions—and have passed this trauma and memory through successive generations (Aguiar & Halseth, 2015). Trauma and violence (including structural violence) have led to a mistrust of non-Indigenous institutions (HCC, 2012) and serve as "the backdrop to all potential health interactions" (Kétéskwēw Dion Stout et al., 2021, p. 15). Trauma and violence are compounded by present-day racism. Over time, individuals and entire populations internalize oppression, resulting in depression, substance use, and other factors, such as interpersonal violence (Aguiar & Halseth, 2015). Interpersonal and structural violence disproportionately affect Indigenous women specifically (Cullen et al., 2021; Gerlach et al., 2017; Heidinger, 2021). The institutions of Western medicine that may be able to assist with these symptoms of trauma are the same institutions that trigger its root cause.

Indigenous people working within the health care system also witness how racism and bias impact the care their peers provide to Indigenous clients. In addition, they themselves directly experience racism from their colleagues and employers (Kétéskwēw Dion Stout et al., 2021; Turpel-Lafond, 2020a; Vukic et al., 2012). Racism and bias have also been noted as barriers to the recruitment of more Indigenous health care professionals within the system. Additionally, they have been cited as a key reason for many Indigenous health care professionals leaving mainstream health care even though the employment of more Indigenous people is vital to making the system more welcoming for Indigenous clients (Turpel-Lafond, 2020a; Vukic et al., 2012).

In summary, Indigenous Peoples, coming from a place of intergenerational trauma related to institutional "care," are driven further from health services because of racism and stereotyping (Allan & Smylie, 2015; HCC, 2012; Reading & Wien, 2009; Turpel-Lafond, 2020a; United Nations [UN] Human Rights Council, 2016). Systemic racism, as well as attitudinal and systemic stereotyping in the client–provider relationship, has deep cumulative impacts on the health and well-being of Indigenous populations. A recent comprehensive report on Indigenous-specific racism in British Columbia's (BC) health care system described the connection between racism and significant disparities between First Nations and Métis Peoples and other residents in BC in such areas as life expectancy, infant mortality, and chronic disease (Turpel-Lafond, 2020a). This report also found that "events happened which illustrated the enduring reality of racism in health care in other parts of the country" (p. 7). It specifically noted that "the racist taunting and subsequent death of Joyce Echaquan took place in Quebec, demonstrating that the problem is likely not unique to B.C." (p. 7). The interpersonal and structural bias which pervades all social, political, and economic contexts makes racism one of the most profound determinants of ill health for Indigenous Peoples (Reading & Wien, 2009).

CORE CONCEPTS IN CULTURAL SAFETY

A range of interrelated concepts, including cultural awareness, cultural sensitivity, cultural competency, cultural safety, and cultural humility, have developed and evolved to address racism, eliminate the disparities in health outcomes between Indigenous and non-Indigenous Peoples, and support Indigenous health and wellness (Allan & Smylie, 2015; Baker & Giles, 2012; Brascoupé & Waters, 2009). Cultural awareness refers to a health care provider's recognition and acknowledgement of cultural difference (e.g., beliefs, languages, teachings) as a factor influencing and shaping the client's experience (Baba, 2013; HCC, 2012; Society of Obstetricians and Gynaecologists of Canada [SOGC], 2013). Cultural sensitivity is a recognition on the part of health care providers of the need to respect that cultural difference (Baba, 2013). Learning about cultural differences, with the goal of enabling the health care provider to adapt their care to suit the client's cultural context, is the focus of cultural competency (Baba, 2013; HCC, 2012; SOGC, 2013). Common to these interrelated concepts is the notion that cultural difference is the primary issue to be addressed in the context of health care delivery, and that the health care provider can mitigate this issue by enhancing their knowledge of another's culture(s) (Baba, 2013; Curtis et al., 2019).

While the abovementioned concepts focus on provider knowledge about other culture(s), cultural humility shifts the emphasis to acquiring knowledge about colonialism and building provider skills in self-reflection (Indigenous Physicians Association of Canada [IPAC] & Royal College of Physicians & Surgeons of Canada [RCPSC], 2009; Walker et al., 2010; Yeung, 2016). Unlike "competency," which, from the perspective of Western education, connotes "demonstrable mastery of a finite body of knowledge" (Tervalon & Murray-Garcia, 1998, p. 118), cultural humility focuses on lifelong learning (Hook et al., 2013). It is an ongoing process of self-reflection the provider or decision maker embraces to examine how their own culture, bias, and society shape and influence their practice and decision making (Baba, 2013; Brascoupé & Waters, 2009; HCC, 2012; IPAC & RCPSC, 2009; National Aboriginal Health Organization [NAHO], 2008; Yeung, 2016). Cultural humility analyzes power imbalances, discrimination, and colonial relationships as they apply to health care (NAHO, 2008; Papps & Ramsden, 1996). By these means, practitioners strive to find a way to self-regulate the sense of superiority that may be rooted in the dominant (white Western) worldview to which they have been exposed and which also has a natural tendency to accompany higher education (Hook et al., 2013). Cultural humility is not only limited to health care providers but also to administrators and decision makers who are responsible for institutions, policies, legislation, and other systemic factors that shape professional practice and the health care environment (Brascoupé & Waters, 2009; Yeung, 2016).

Cultural humility is a behavioural practice that contributes to the main concept in this paper: cultural safety. Cultural safety was championed by Irihapeti Ramsden, a Māori nurse in Aotearoa in response to observing a lack of safety in the system for Māori patients (McEldowney & Connor, 2011).

By placing the definition of success in the client's hands, cultural safety challenges existing dynamics by shifting power from provider to client, acknowledges the validity of cultural values (including the importance of relationships and trust), and restores the self-determination that processes of colonialism undermined.

This lack of safety arises from colonial and historical factors shaping modern-day systemic bias and perpetuating power imbalances between health care providers and Indigenous clients (Hole et al., 2015). By contrast, a culturally safe environment is physically, socially, emotionally, and spiritually safe. It does not challenge, ignore, or deny an individual's identity and it is free from racism (Turpel-Lafond, 2020a). Importantly, cultural safety is an outcome defined by the client receiving care (HCC, 2012; IPAC & RCPSC, 2009; SOGC, 2013; Yeung, 2016). This approach reflects the fact that racism is best defined by the client as it often occurs without intention on the part of the provider, whose values and norms both shape and are shaped by the mainstream (Goodman et al., 2017; SOGC, 2013). By placing the definition of success in the client's hands, cultural safety challenges existing dynamics by shifting power from provider to client, acknowledges the validity of cultural values (including the importance of relationships and trust), and restores the self-determination that processes of colonialism undermined (Brascoupé & Waters, 2009; Yeung, 2016).

CULTURAL SAFETY INITIATIVES IN HEALTH CARE: A BRIEF OVERVIEW

Many efforts are underway to embed cultural safety in health care delivery across Canada, Australia, Aotearoa, and the United States. In some cases, the focus has been on exploring how culturally safe practices can be embedded in specific health disciplines, such as arthritis, cancer, diabetes, oral health, palliative care, or substance use (Crowshoe et al., 2018; Forsyth et al., 2017; Goodman et al., 2017; Shahid et al., 2018; Taylor et al., 2018; Thurston et al., 2014). Although less frequent, there have also been efforts to implement cultural safety at organizational, regional, or national levels, taking into account practices across the health care system (Anderson & Hansson, 2016; Australian Health Ministers' Advisory Council, n.d.; Greenwood, 2019; Muise, 2019). The most common approach appears to be the design and implementation of a specific type of cultural safety intervention, particularly education and training for health care professionals (Coombe et al., 2019; Hojjati et al., 2018; Kerrigan et al., 2020; Vogel, 2018).


© Credit: iStockPhoto.com, ID 1309150846

Efforts are also frequently focused on the recruitment and retention of Indigenous health care workers and liaisons (Gwynne & Lincoln, 2017; Huria et al., 2014; Lai et al., 2018; McKenna et al., 2015). Other initiatives include building relationships with Indigenous Peoples and facilitating Indigenous involvement in the design and delivery of health services, as well as developing communications and resources that are culturally appropriate for Indigenous clients (Anderson & Hansson, 2016; Banna & Bersamin, 2018; Mitchell et al., 2019; Williams et al., 2018).

CULTURAL SAFETY INITIATIVES: FROM EVALUATION TO SYSTEM-WIDE MEASUREMENT

There has been a recognized need to evaluate the abovementioned and other cultural safety initiatives, which has led to a variety of approaches, indicators, and methods across a range of health disciplines. This has included efforts conducted within maternity care, palliative care, and mental health (Auger et al., 2019; Fleming et al., 2019; Nadin et al., 2018; Thackrah et al., 2020). Other evaluations have focused on specific health professions (e.g., nursing) or health care settings (e.g., hospitals) (Elvidge et al., 2020; Hunter & Cook, 2020). Some efforts have focused on specific interventions, such as integrating cultural practices in health care, increasing and supporting the Indigenous health care workforce, or creating culturally appropriate tools and resources (Li et al., 2017; Lowell et al., 2015; Percival et al., 2018). A frequent focus of evaluations has been on various education and training initiatives intended to increase the cultural awareness and humility of health care providers (Alexander-Ruff & Kinion, 2018; Jongen et al., 2018; Kurtz et al., 2018; McDonald et al., 2018; Rand et al., 2019).

Information gathering about the strength of these initiatives often reflects the value Indigenous Peoples place on qualitative evidence. Measures of the quality of relationships and the experiences of individuals, families, and communities are common in cases of Indigenous evaluations and considered equally valid to quantitative and "scientific" indicators (National Collaborating Centre for Aboriginal Health [NCCAH], 2013a). A central feature of evaluation within Indigenous communities is the importance placed on relationships between the community and evaluator throughout the process. The quality and utility of any outcome of the process will directly correlate with the quality of the relationship and engagement with the people and community (NCCAH, 2013a; PHAC, 2015).

Indigenous communities place great value on integrating their worldviews, philosophies, values, and knowledge into their information gathering, such as the "everything is connected" philosophy. Indigenous Peoples' approaches to information gathering also include a greater focus on historical and environmental factors and their impacts on people, communities, and interventions—including the past and present impacts of colonialism (Assembly of First Nations [AFN], 2006; NCCAH, 2013a; PHAC, 2015).

These approaches to evaluation can at times be challenging for Western preferences for "well-tested" measures (AFN, 2006; NCCAH, 2013a). Many qualitative studies have been conducted nevertheless but have primarily focused on the effectiveness of training curriculum on provider cultural knowledge (Aboriginal Health Research Networks Secretariat [AHRNS], 2012; Brascoupé &

Waters, 2009; Walker et al., 2010) rather than on outcomes (i.e., programs, policies, services, and practices that the patient deems culturally safe). Some studies have counterbalanced this by aiming attention at Indigenous Peoples' experiences of cultural safety in the health care system and/or attempting a broader view that encompasses health status, outcomes, determinants of health, and health system performance (Auger et al., 2019; Australian Institute of Health and Welfare, 2020; Elvidge et al., 2020; Smith et al., 2017; Turpel-Lafond, 2020a). A small number of studies have also demonstrated some promising findings on the impact of culturally safe approaches on health behaviours, such as attachment to primary care and adherence to treatment (Johanson & Hill, 2011; Taylor et al., 2009).

The efforts to evaluate cultural safety initiatives have highlighted several challenges, including: the newness of the field; the lack of integration of cultural safety into legislated standards; and the complexities of translating an inherently individual-based practice, underpinned by personal reflection and learning, into the quantitative or statistical measures valued by the West (AHRNS, 2012; Brascoupé & Waters, 2009; Walker et al., 2010; Yeung, 2016). The notion of replicability or "one size fits all" can also be a key challenge, with an inherent tension between the concept of system-wide measurement and the need for indicators to have local relevance and be rooted in local Indigenous contexts (AFN, 2006; PHAC, 2015).

Another significant and fundamental point relates to data collection and governance. A key enabler of cultural safety—and a requirement of cultural safety measurement—is identifying Indigenous clients and staff. However, given the term "Indigenous" refers to diverse cultural groups, each of which is associated with different processes for identification and registration, and some of which continue to be challenged in the courts because of their colonial legacy (NCCAH, 2013b), a single Indigenous identifier does not exist and no existing Indigenous identifiers are embedded in identification processes associated with accessing health care. Consequently, there is a significant reliance on self-identification processes for all data collection related to Indigenous Peoples. Self-identification is a necessary process if data about health system performance for Indigenous Peoples, and resulting inequities, are to be made visible (Smylie & Firestone, 2015).

An interrelated point arises here. Many Indigenous people are reluctant to self-identify because data about Indigenous Peoples have often been used against them, without benefit to them, and with no recognition of their rights to self-determination. Historically, data and research about Indigenous Peoples have been interpreted and released from non-Indigenous paradigms and without Indigenous involvement. These have been used against Indigenous rights and interests, and have stigmatized and depicted Indigenous Peoples as inferior (Canadian Institutes of Health Research [CIHR] et al., 2014). In response, Indigenous Peoples and their governing bodies have asserted their rights to data sovereignty. They have articulated standards and protocols for ownership, decision making, and participation by Indigenous Peoples in the data and research relating to their populations (CIHR et al., 2014; First Nations Information Governance Centre [FNIGC], 2014, 2020). At a systemic level, Indigenous data governance principles such as Ownership, Control, Access, and Possession (OCAP®) have been developed and adopted to articulate Indigenous data sovereignty (FNIGC, 2014). These rights are further reinforced by the UNDRIP's Indigenous human rights standards affirming self-determination and intellectual property.

The imperative to address all the abovementioned issues and requirements and move beyond evaluation to system-

wide measurement is growing. Uprooting the colonial underpinnings of the health care system and eliminating the negative influence of long-standing racial stereotypes about Indigenous Peoples on the quality of health care delivery require system-wide change. Actions and interventions must happen at multiple levels, and across dozens of organizations and hundreds of health care sites and facilities. There is an increasing, nationwide focus on the need for deep change to address Indigenous-specific racism, and for this change to be systemic, aligned, and mandated (Indigenous Services Canada, 2021; Turpel-Lafond, 2020a).

A key feature of such complex and/or system-wide change is coordinated measurement (Best et al., 2012; Canadian Health Services Research Foundation [CHSRF], 2011; Kania & Kramer, 2011, 2013; Ken Blanchard Companies, 2018). Many have noted the lack of systemic measurement related to cultural safety, and calls have been increasing for the development of standardized indicators and measures in collaboration with Indigenous Peoples (AHRNS, 2012; Allan & Smylie, 2015; Australian Government, 2017, 2019; Baba, 2013; Indigenous Primary Health Care Council, 2021; Inuit Tapiriit Kanatami, 2021; Jongen et al., 2018; Kumas-Tan et al., 2007; Paradies et al., 2014; Turpel-Lafond, 2020a; Walker et al., 2010; Yeung, 2016). Most recently, the need for improved measurement was emphasized in the report, *In Plain Sight: Addressing Indigenous-specific Racism and Discrimination in B.C. Health Care*, which calls for "systematic action" (Turpel-Lafond, 2020a, p. 2)

Improving experiences of care will encourage Indigenous Peoples' utilization of health services and thus contribute to improved health system performance.

that encompasses governance, leadership, legislation, policy, education, and practice, and which provides a set of recommendations intended to establish a "renewed foundation for Indigenous Peoples' access to, interaction with, and treatment by, the health care system" (p. 181).

To support such a renewal, the present report describes core concepts for the further development and validation of a system-wide cultural safety measurement framework that would include the development of indicators, regular reporting, and protocols for data collection and management at multiple levels of the system. A set of indicators organized into themes and/or domains within an overall measurement framework can help support a strategic view of, and consistency and comparability in, data collection and reporting (BC Association of Aboriginal Friendship Centres, 2010). In addition to a set of indicators, comparability can also be achieved through developing and utilizing shared approaches to data collection. This may also support greater cost-effectiveness through enhanced economies of scale and prevention of duplication of effort. Cost-effectiveness would also be improved through systematically including cultural safety measurement in existing processes of assessment and performance measurement. This would have the added benefit of normalizing concepts about racism and cultural safety within health system performance in Canada.

Timely and accurate feedback on the impact of change can show what is working, what is not, and what barriers to progress may exist, thereby feeding continuous quality improvement and the sharing and dissemination of knowledge (CHSRF, 2011; Ivers et al., 2012; Kania & Kramer, 2011; Ken Blanchard Companies, 2018). Successful change efforts utilize measurement for the purposes of accountability inside and outside the organization, making it clear what success looks like and supporting compliance and alignment with that vision of success (Best et al., 2012; Hogg, 2018; Kania & Kramer, 2011, 2013; Ken Blanchard Companies, 2018).

CULTURAL SAFETY INITIATIVES: A CONCEPTUAL FRAMEWORK

Figure 1 provides a high-level visual depiction of a conceptual Cultural Safety Measurement framework drawn from the prevailing logic in the literature. This framework posits that an array of interrelated *actions* and *interventions* can be implemented to enhance cultural safety of all health services and associated administration. These will improve both *health system performance* for Indigenous Peoples and Indigenous patients' *experiences* of health care. Improving experiences of care will encourage Indigenous Peoples' utilization of health services and thus contribute to improved health system performance. The Framework also reflects the evidence demonstrating that the experience of health care contributes to health outcomes (Australian Government, 2019; Betancourt et al., 2002; First Nations Health Authority [FNHA] et al., 2019; National Aboriginal and Torres Strait Islander Health Workers Association, n.d.; Paradies et al., 2015; Paradies & Cunningham, 2012; State of Victoria, 2009; Turpel-Lafond, 2020b; Vancouver Coastal Health & FNHA, 2014; Walker et al., 2010). High-quality health system performance is, in turn, one contributor to improved health outcomes (Alberta Health, 2014; Canadian Institute for Health Information [CIHI], 2013a).

It is widely known that health system performance alone does not drive health and wellness outcomes. Supporting improved health and wellness outcomes for Indigenous Peoples and communities will require efforts in the health sector to be supplemented by efforts in areas such as income, education, and housing (Chief Public Health Officer of Canada, 2019; National Collaborating Centre for Determinants of Health, 2018; Paradies et al., 2015; Reading & Halseth, 2013; Reading & Wien, 2009). With these points in mind, the framework in Figure 1 visually depicts how determinants of ill-health and health surround components that are specific to the health system (interventions, experience, performance, outcomes). Associated indicators (enhanced cultural safety, participation, relational care, equitable access, equitable health and wellness, upholding of Indigenous human rights, etc.) can be nested within each of the broadly-categorized components depicted in the multi-coloured ovals.

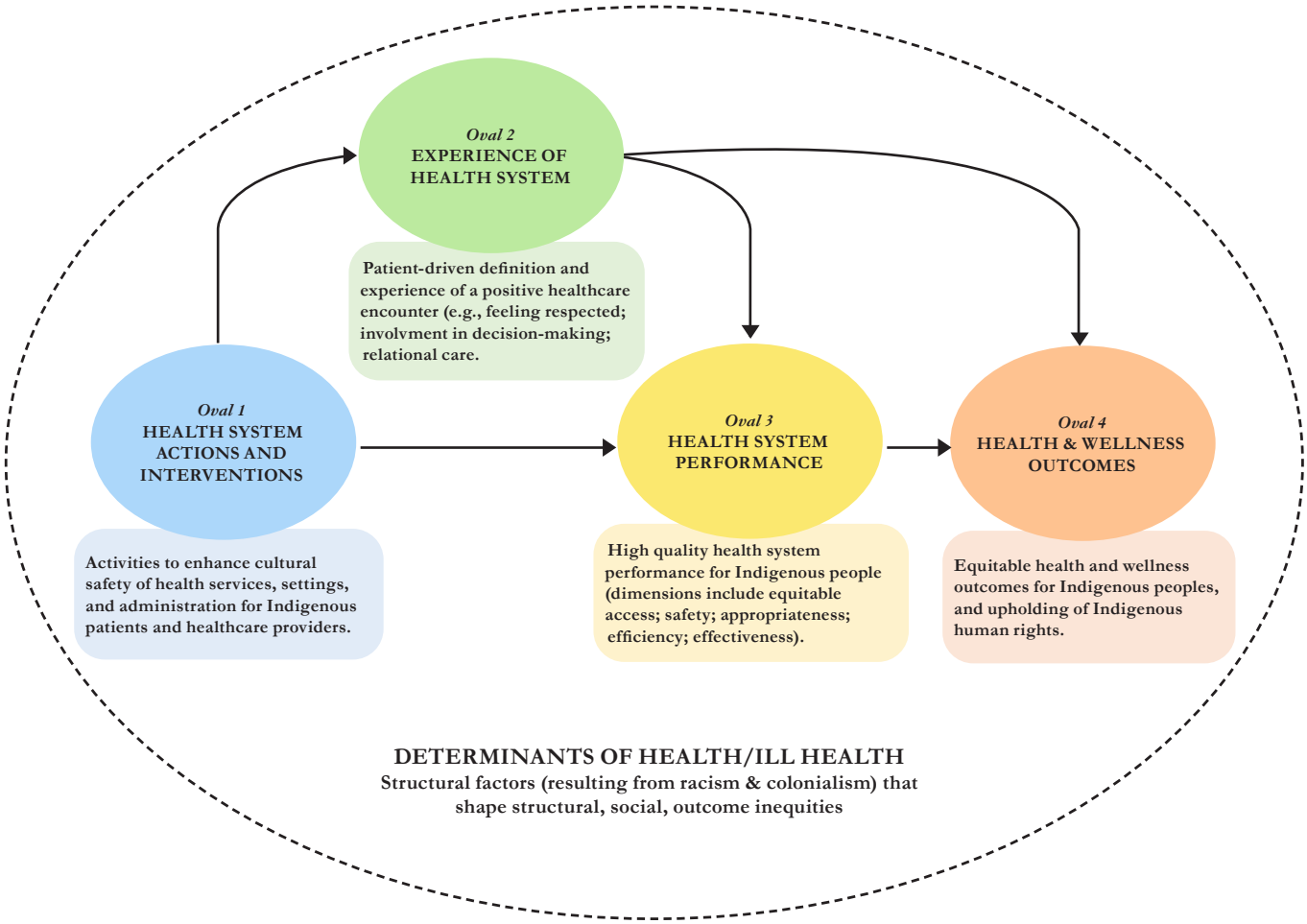


Figure 1: Cultural Safety Measurement Conceptual Framework

Health System Actions and Interventions

A review of Indigenous cultural safety frameworks reveals 10 common health system domains in which organizations or health systems can undertake actions and interventions (Fig. 1, Oval 1) to support enhanced cultural safety (see Appendix A for thematic analysis). Process measures that reflect common and established actions and interventions to increase cultural safety can be designed to monitor their effectiveness within each of the domains listed below. The following description of the domains includes implementation considerations, some of which are, of course, also applicable to other domains.[3]

1. **Data and Evidence**: entails cultural safety audits or assessments, identification and reporting of performance measures, evaluation of cultural safety initiatives, and culturally-safe methods for clients to self-identify as Indigenous. As indicated above, implementation of cultural safety measurement must proactively involve strategies (e.g., engagement with Indigenous Peoples, staff training, transparent information about how the data will be used) to ensure that the collection of self-identification information is

[3] A number of these implications shape the content of the framework proposed in this paper, particularly as related to health system actions and interventions. Navigating these implications effectively will require strong partnerships and co-development of solutions between Indigenous Peoples and leaders in health systems.

culturally safe. It will require surveying that explores, as examples, the following: personal experiences of cultural safety based on the domains described in this framework; personal experiences of cultural unsafety and racism, such as misdiagnosis and stereotyping, and experiences of discrimination; how likely Indigenous Peoples would be to make a complaint (and why); opinions on how Indigenous Peoples are treated in health care; and opinions on what makes good health care for Indigenous Peoples (e.g., the importance of cultural spaces and/or client navigators).[4] Throughout the entire cycle—from data collection, to analysis and interpretation, to release and publication—implementation of cultural safety measurement must be guided by Indigenous data governance processes.

2. **Policy and Protocol**: involves establishing organizational policy on cultural safety, applying cultural safety or equity as a "lens" to all organizational policy, and following Indigenous policy/protocols. Cultural safety and equity must be "hardwired" into all policies in health systems, and First Nations, Métis, and Inuit protocols (e.g., cultural protocols regarding interactions between individuals or groups) must be followed. Implementing these policies will require education and training for staff, as well as mechanisms to assure compliance.

Throughout the entire cycle—from data collection, to analysis and interpretation, to release and publication—implementation of cultural safety measurement must be guided by Indigenous data governance processes.

3. **Incidents, Complaints, and Whistleblowing**: refers to processes for both employees and clients to provide feedback and report incidents of cultural unsafety or racism. Incidents, complaints, and whistleblower processes must be developed and implemented in ways that ensure individuals' safety from judgement or penalty, and without concern that their issues will be discredited.[5] With respect to Indigenous Peoples, the processes should involve culturally appropriate practices, for example, "options for mediation through traditional ways such as circles and inclusion of Elders" (FNHA, 2016, p. 16). They should also be linguistically sensitive, "providing notice in other languages about the right of each patient/consumer to file a complaint or grievance" (Weech-Maldonaldo et al., 2012, p. 59).

4. **Indigenous Perspectives and Practices**: refers to an acknowledgement of a different definition of "health" on the part of Indigenous Peoples, and/or the integration or design of Indigenous-specific services within the mainstream health system. As noted above, Indigenous Peoples

[4] Several instruments exist, particularly with respect to racism and discrimination, that could serve as a starting point for the design of these questions (Williams, 2016). For example, at least two survey instruments were deployed as part of the In Plain Sight inquiry, which were based on instruments designed by the Provincial Health Services Authority (PHSA) of BC and the Fraser Health Authority (Turpel-Lafond, 2020a, 2020b). The PHSA developed Checkbox, a survey tool that sits on its Information Management, Information Technology Services-controlled server and is made available to PHSA researchers and several organizations and institutions in BC (PHSA, n.d.). Additionally, Patient Reported Experience Measures and Patient Reported Outcome Measures provide reflections on patient experiences with health care processes and the impact of a condition on their quality of life, respectively (CIHI, 2014, 2015; Cuthbertson, 2014), with some of these continuing to evolve to capture cultural safety data and an Indigenous identifier.

[5] Lautensach and Lautensach (2011) refer to a history of discrediting Indigenous whistleblowers. With respect to the atrocities of residential schools, the authors note that there were "coordinated efforts to cover up the events and to discredit whistleblowers" (p. 186, 2n.)

have a wholistic definition of health. They emphasize the interconnectedness of physical, emotional, spiritual, and mental dimensions of well-being. Incorporating Indigenous perspectives and practices means critically examining and dismantling aspects of a colonized system founded on European supremacy that present barriers to culturally safe care. It means identifying conventional services or practices that are in conflict with "traditional practices specific to the culture(s) in question" (Cromarty & Walker, n.d., p. 2). It also means that in order to extend health care practices to include Indigenous perspectives on health and wellness and incorporate traditional practices into health care professions, barriers to recruiting and retaining Indigenous health care professionals need to be identified and overcome (Turpel-Lafond, 2020a; Vukic et al., 2012). Additionally, "specific social and cultural factors that form the basis for individual health beliefs, behaviors, values, and preferences and how they potentially mitigate a patient's ability to obtain quality care" (Betancourt et al., 2003, p. 295) must also be identified and addressed. For example, offering services in traditional languages would help to deconstruct one major barrier to culturally safe care (Betancourt et al., 2003).

5. **Leadership, Governance, and Administration**: means involving Indigenous Peoples (including specifically the Nations on whose territories operations are delivered) in decision making, utilizing cultural safety as a "lens" for governance decisions, and ensuring visible leadership support for cultural safety. Without considering ways in which Indigenous self-determination and governance principles are disrespected or ignored in health care policies, practices, and programming, and without ensuring that traditional healing practices and medicines are acknowledged and advanced (Indigenous Primary Health Care Centre, 2021), a cultural safety framework will be impossible to establish. First Nations, Inuit, and Métis Peoples must be involved in governance, leadership, prioritization, and decision making, including reciprocal accountability, budgeting, and research (Simmonds et al., 2020; Brascoupé & Waters, 2009; Browne et al., 2016; FNHA et al., 2019).
6. **Planning**: refers to the involvement of Indigenous Peoples in strategic and operational planning, as well as in cultural safety strategic

The most valuable human resources for ensuring culturally safe health care programs, planning, and initiatives are Indigenous Peoples.

priorities and workplans. Strategic plans drive prioritization, investment, and accountability within health sector organizations, including shaping what gets measured and how it is measured. Indigenous involvement and visibility of cultural safety and Indigenous human rights across organizational strategic and operational plans are core indicators of the depth of an organization's commitment.

7. **Human Resources**: refers to cultural safety training and the recruitment and retention of Indigenous employees, as well as the integration of cultural safety expectations in job profiles, recruitment processes, and all performance appraisals. The most valuable human resources for ensuring culturally safe health care programs, planning, and initiatives are Indigenous Peoples. The recruitment and retention of Indigenous employees within health care is dependent on initiatives that seize the opportunity to "educate First Nations, Inuit, and Métis students at the baccalaureate, master's and doctoral levels [… and ensure their] safe passage through these programs" (Hart-Wasekeesikaw, 2009, abstract). To achieve this means identifying and redressing where Indigenous worldviews have been disrespected, eradicated, or ignored in the academic community and creating curricula that "foster competence among Aboriginal and non-Aboriginal graduates in the provision of care to Aboriginal peoples" (Hart-Wasekeesikaw, 2009, abstract). Here, too, "the First Nations, Inuit and Métis youth population is a significant and potential human resource" (Hart-Wasekeesikaw, 2009, abstract).
8. **Partnership and Engagement**: means formalized partnerships with Indigenous Peoples and engagement and communications strategies that raise staff and public awareness about Indigenous Peoples, priorities, racism, and/or cultural safety. Developing partnerships with individuals, communities, and organizations with the specific objective of collaborating to implement measures in health care that will ensure cultural safety is crucial in the development of cultural safety frameworks (Australian Indigenous Doctors' Association, n.d.). While culturally relevant print and communications materials are key, frameworks must go beyond recognizing a need for greater communication to include meaningful relationships and measures that "activate and breathe life" into these frameworks (Federation of Saskatchewan Indian Nations, n.d., p. 27).
9. **Health Services**: includes Indigenous cultural care providers, liaisons, and navigators integrated with community services, as well as tools, standards, and guidelines to reinforce cultural safety in all health service delivery. Indicators assess the provision of Indigenous cultural, social, and spiritual care services for Indigenous clients—affirming their identity and wholistic definitions of health and well-being and making these Indigenous cultural health and wellness services a seamless part of care teams and models. Indicators also align with guidelines and service models that enable health care professionals to uphold cultural safety in their practice.
10. **Physical Spaces:** involves Indigenous artwork and language/signage throughout facilities, and built environments (e.g., cultural and healing rooms) that accommodate Indigenous practices. Implementing frameworks to ensure culturally safe physical spaces requires an understanding that a physically safe space is also an emotionally safe

one. An indicator of a high-performing health system that Indigenous health care providers and patients may deem culturally safe is if that environment has spaces that support diverse Indigenous cultures (Brooks-Cleator et al., 2018); for example, there may be spaces in which Indigenous health care providers and staff have access to resources that are not only culturally relevant, but are also available in Indigenous languages. These physical spaces may include a welcoming and culturally safe birthing room, where women have access to traditional practices and birthing methods (Western Health, 2019). Culturally safe built environments can extend beyond interior areas to outdoor spaces that include Indigenous flags, feature plants that are important to Indigenous Peoples, showcase Indigenous sculptures and other artwork, and make room for ceremony (Western Health, 2019).

Experience of Health System

As explained above, cultural safety is achieved when clients say that it is (Baba, 2013; Brascoupé & Waters, 2009; HCC, 2012; IPAC & RCPSC, 2009; SOGC, 2013; Walker et al., 2010; Yeung, 2016). Therefore, a significant

component of the Cultural Safety Measurement Framework (see Fig. 1, Oval 2) entails drawing on client perceptions and experiences, which are intended to be improved through the actions and interventions described above. Although Indigenous clients enter health care with different histories, cultural backgrounds, and health care needs and priorities, six key themes arise from a review of studies focusing on desired Indigenous experiences of cultural safety in health care (see Appendix B for thematic analysis):

1. **Respect**: involves the feeling of being valued and one's dignity being upheld by a health care provider and health care environment.
2. **Identity**: refers to positive acknowledgement or affirmation as an Indigenous person or part of an Indigenous culture.
3. **Empowerment and Equity**: encompasses an equal partnership that supports the self-determination of the client and enables the client to feel heard, and in which the provider and patient are in a cooperative and reciprocal relationship.
4. **Safety**: refers to a sense of protection from harm or risk, and an experience free of racism.
5. **Relationality**: includes a sense of dignity, an experience of connection with a health care provider, and observations of health care providers demonstrating care, compassion, and empathy.
6. **Reciprocity**: involves two-way or shared learning, curiosity, interest, and effective communication, facilitated by an understanding of the impacts of colonialism on Indigenous Peoples.

Within these six common themes delineating a culturally safe health system, experience-based cultural safety measures can be designed and tracked over time. Survey instruments and other modalities such as focus groups and journey mapping, amongst others, could be designed to collect data on these indicators. These outcomes can and must supplement existing surveys and validated indicators related to the experience of racism and common forms of anti-Indigenous stereotyping and discrimination (see Turpel-Lafond, 2020b).

Health System Performance

This portion of the Framework (see Fig. 1, Oval 3) points to an awareness that undertaking cultural safety actions and interventions across all health systems and organizational domains will improve the health care experience of Indigenous Peoples. These actions and interventions will also enhance the overall performance of the health care system for this population. Health system performance is a well-established field, particularly in Canada, with many frameworks describing core domains and key indicators of high-performing health systems (Braithwaite et al., 2017; Fekri et al., 2017; Müller et al., 2021; Young et al., 2019). Common domains cover matters such as: the health system's ability to deliver services that patients and populations need; the ease of access of health services; the safety of services; the degree to which health services are appropriate and effective, based on available evidence; and the efficiency of those services, meaning maximizing the output of those services within available resources (Alberta Health, 2014; BC Patient Safety & Quality Council, 2020; CIHI, 2013a; Health Quality Ontario, 2018). Within these domains, many validated indicators exist (e.g., wait times, readmission rates) that are routinely measured and reported at national, regional, and local levels.

Given that health system performance in Canada is comprehensively examined through an established set of validated indicators, some of which are noted in the previous paragraph, efforts in cultural safety measurement in this area may, at least initially, be less about designing new indicators than it is about supporting the visibility of Indigenous Peoples in these data. Doing so illuminates the inequitable and poor way in which the health system performs for this population. For example, the recent data report of the *In Plain Sight* review of Indigenous-specific racism in BC's health care system identified major problems in this province's ability to deliver primary and preventative care and maternal and child health services for Indigenous Peoples living in this province in comparison to its non-Indigenous residents. As a result of these failures, a disproportionate number of Indigenous people use emergency services when compared with non-Indigenous populations (Turpel-Lafond, 2020b). This report, among others,[6] importantly attributes this poor system performance to Indigenous-specific racism in health care and the lack of cultural safety in health care services and settings—a critical understanding also embedded in the framework proposed herein (Allan & Smylie, 2015; Australian Government, 2019; Boyer, 2017; College of Family Physicians of Canada Indigenous Health Working Group, 2016; Turpel-Lafond, 2020b).

Health and Wellness Outcomes

The Canadian Institute for Health Information (CIHI, 2013a) states that health and wellness outcomes "are a fundamental goal of health systems and include the health and well-being of both individuals and population" (p. 11).

[6] Examples of other reports include the final report of the National Inquiry into Missing and Murdered Indigenous Women and Girls (2019) and Ignored to Death: System Racism in the Canadian Healthcare System, a submission to the UN Human Rights Council (Expert Mechanism on the Rights of Indigenous Peoples [EMRIP]) (Gunn, n.d.).

In addition to established population health and well-being indicators, what are increasingly and importantly emerging are Indigenous-driven and strengths-based indicators of health and well-being that describe what Indigenous Peoples conceptualize as good health outcomes and that balance Western perspectives with measures that Indigenous Peoples value.

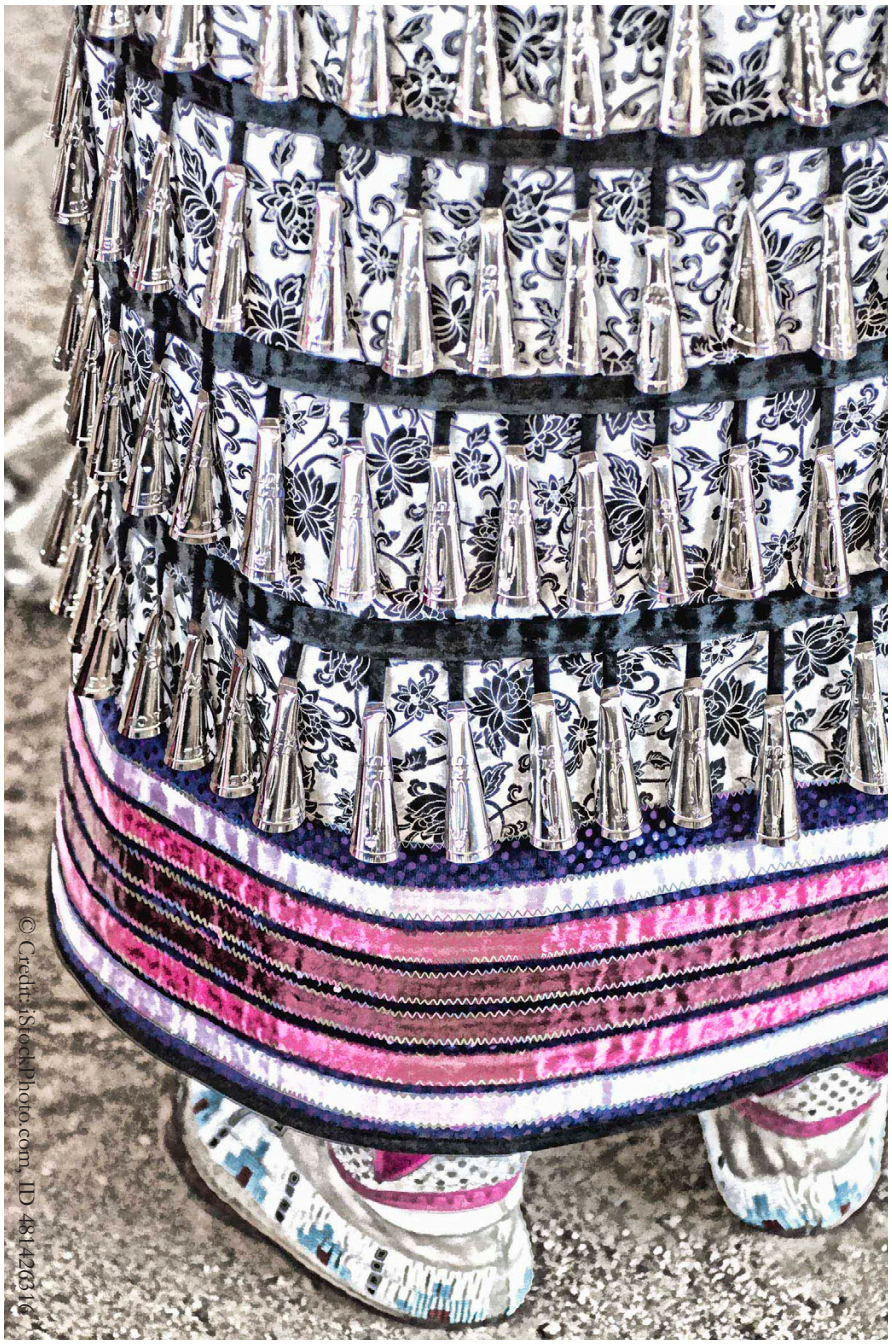
Improved health system performance will contribute to the achievement of enhanced population health and wellness outcomes (Fig. 1, Oval 4), particularly when performance advancement within health systems is developed and achieved in concert with additional initiatives designed to address inequities in sectors outside of health.

As with health system performance, there are many validated population health indicators, such as life expectancy, infant mortality, injuries, and chronic disease burden. Culturally safe health outcome themes for Indigenous populations have been framed by the Canadian Institute for Health Information in accordance with four themes: 1) life expectancy and well-being (e.g., life expectancy at birth and at 65 years); 2) death (e.g., infant and child mortality, suicide); 3) health conditions (e.g., pervasiveness of disease [e.g., STIs], injury, and trauma [e.g., residential school attendance] at various life stages); and 4) human function and behaviour (e.g., limitation due to injury; alcohol/illicit drug consumption) (CIHI, 2013a, 2013b). These and other Indigenous health outcome measures are routinely reported at national, provincial, and territorial levels, including for Indigenous populations (Government of Canada, 2018; Provincial Health Officer [PHO] & FNHA, 2018). As with health system performance, the framework presented in this paper proposes continuing to make Indigenous Peoples and their health outcomes visible in a way that attributes resulting disparities to systemic racism and the legacy of colonialism. This is critical for ensuring that racist beliefs of Indigenous Peoples as responsible for their own poor health status are not reinforced.

In addition to established population health and well-being indicators, what are increasingly and importantly emerging are Indigenous-driven and strengths-based indicators of health and well-being that describe what Indigenous Peoples conceptualize as good health outcomes and that balance Western perspectives with measures that Indigenous Peoples value (Allen et al., 2020; FNHA & PHO, 2020; Heggie, 2018; Smylie & Firestone, 2015; Thiessen et al., 2020). This is especially important given both Indigenous Peoples' wholistic approach to health and wellness (Akbar et al., 2020) and the diversity within and between Indigenous Peoples and Nations. Indigenous-led indicators tend to emphasize traditional practices, healing methods, and culturally relevant programming (Akbar et al., 2020; Auger et al., 2016; CIHI, 2013a). For example, multiple studies measuring health and well-being among diverse Indigenous populations highlight the importance of land to wholistic healing (Ahmed et al., 2021; FHNA & PHO, 2021; Redvers, 2020). Continuing to support the development and monitoring of measures that reflect Indigenous philosophies of health and well-being is an important mechanism for advancing cultural safety and Indigenous human rights standards described in the UNDRIP.

CONCLUSION

This paper has sought to propose an Indigenous Cultural Safety Measurement Framework as a critical tool for revealing the impacts of colonialism and racism, past and present, on health system performance and Indigenous Peoples' health and wellness. The Framework can also be used to monitor progress on achieving cultural safety in health care. Given that data and measurement have historically been used against Indigenous Peoples to justify continued oppression and colonialism, this paper urges some caution for those interested in using such a framework for measuring cultural safety. At the same time, if health systems and Indigenous Peoples do not collaborate to advance systemic measurement of cultural safety, the historic and ongoing invisibility of Indigenous Peoples and health inequities, and the masking of the very real problem of anti-Indigenous racism in health care, will persist.



The implementation of cultural safety measurement is inherently an effort that must be done together, between Indigenous and non-Indigenous Peoples and health systems. While the

problem of Indigenous-specific racism and the required changes to enhance cultural safety lies with non-Indigenous individuals, communities, organizations and governments, those who experience racism in the health care system – Indigenous Peoples and, in particular, Indigenous women (Fridkin et al., 2019) – must be intimately involved in developing solutions and making decisions about health policy (Fridkin et al., 2019) as, ultimately, success in achieving cultural safety can only be determined by Indigenous Peoples themselves.

This will require working together, and not unilaterally, to agree upon a measurement framework. It will demand identifying and validating a set of priority or mandatory indicators. It will also necessitate supporting local settings to develop indicators that reflect their cultures, priorities, and practices, while maintaining the ability to aggregate across settings, regions, and geographies for system-wide monitoring and knowledge development.

We are at a unique and important time in the history of Indigenous–settler relations in Canada. This involves truth-telling about the past and recognizing how the colonial lineage of that past is deeply embedded in our society, laws, systems, and institutions. It involves systematically eliminating the racist beliefs that allowed colonialism to occur and decolonizing today's policies and practices in order to enable expression of Indigenous human rights. This framework is an invitation to Indigenous Peoples and health system partners in various jurisdictions and geographies to engage in discussion and dialogue in order to identify measures and domains of relevance to them, to design data governance processes that contribute to repair, restoration, and reconciliation, and most importantly, to issue concrete, recurring, and normalized reporting of Indigenous cultural safety in Canada's health care system.

REFERENCES

Aboriginal Health Research Networks Secretariat (AHRNS). (2012). National colloquium on racism, cultural safety and Aboriginal peoples' health. https://dspace.library.uvic.ca/bitstream/handle/1828/5381/National-Colloquium-2012.pdf?sequence=1&isAllowed=y

Adkins-Jackson, P. B., Chantarat, T., Bailey, Z. D., & Ponce, N. A. (2021). Measuring structural racism: A guide for epidemiologists and other health researchers. *American Journal of Epidemiology*. https://doi.org/10.1093/aje/kwab239

Aguiar, W., & Halseth, R. (2015). *Aboriginal peoples and historic trauma: The processes of intergenerational transmission*. National Collaborating Centre for Aboriginal Health. https://www.ccnsa-nccah.ca/docs/context/RPT-HistoricTrauma-IntergenTransmission-Aguiar-Halseth-EN.pdf

Ahmed, F., Zuk, A. M., & Tsuji, L. J. S. (2021). The impact of land-based physical activity interventions on self-reported health and well-being of Indigenous adults: A systematic review. *International Journal of Environmental Research and Public Health*, *18*(13), 7099. doi:10.3390/ijerph18137099

Akbar, L., Zuk, A. M., & Tsuji, L. J. S. (2020). Health and wellness impacts of traditional physical activity experiences on Indigenous youth: A systematic review. *International Journal of Environmental Research and Public Health*, *17*(21), 8275. https://doi.org/10.3390/ijerph17218275

Alberta Health. (2014). *Alberta's health system outcomes and measurement framework*. https://open.alberta.ca/dataset/da2ccb08-3d8d-4b4f-8b66-293fb55338d7/resource/806cb451-6a89-4bec-976a-86cb7ba5eef5/download/pmis-outcomes-measurement-framework-2014.pdf

Alexander-Ruff, J. H., & Kinion, E. (2018). Engaging nursing students in a rural Native American community to facilitate cultural consciousness. *Journal of Community Health Nursing, 35*(4), 196–206. https://doi.org/10.1080/07370016.2018.1516423

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*. The Wellesley Institute.

Allen, L., Hatala, A., Ijaz, S., Courchene, E. D., & Bushie, E. B. (2020). Indigenous-led health care partnerships in canada. *Canadian Medical Association Journal (CMAJ), 192*(9), E208-E216. https://doi.org/10.1503/cmaj.190728

Anderson, B. & Hansson, W. K. (2016). Engagement in system redesign: A wellness example to enable a cultural transformation. *Healthcare Management Forum, 29*(5), 205–210. https://doi.org/10.1177/0840470416649732

Assembly of First Nations (AFN). (2006). *First Nations' wholistic approach to indicators. Meeting on Indigenous Peoples and indicators of well-being, Ottawa, March 2006*. United Nations Department of Economic and Social Affairs. http://caid.ca/AFNUNIndWelBei2006.pdf

Auger, M., Crooks, C. V., Lapp, A., Tsuruda, S., Caron, C., Rogers, B. J., & 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

Auger, M., Howell, T., & Gomes, T. (2016). Moving toward holistic wellness, empowerment and self-determination for Indigenous peoples in Canada: Can traditional indigenous health care practices increase ownership over health and health care decisions? *Canadian Journal of Public Health, 107*(4-5), e393-e398. https://doi.org/10.17269/CJPH.107.5366

Australian Government. (2017). *Aboriginal and Torres Strait Islander health performance framework 2017 report*. https://www.niaa.gov.au/sites/default/files/publications/2017-health-performance-framework-report_1.pdf

Australian Government. (2019). *Cultural safety in health care for Indigenous Australians: monitoring framework*. Retrieved March 15, 2021, from https://www.aihw.gov.au/getmedia/153ec5b7-35fd-4348-9166-b13d458befa0/Cultural-safety-in-health-care-for-Indigenous-Australians-monitoring-framework.pdf.aspx?inline=true

Australian Health Ministers' Advisory Council. (n.d.). *Cultural Respect Framework 2016–2026 for Aboriginal and Torres Strait Islander Health: A national approach to building a culturally respectful health system*. https://nacchocommunique.files.wordpress.com/2016/12/cultural_respect_framework_1december2016_1.pdf

Australian Human Rights Commission. (2011). Chapter 4: Cultural safety and security: Tools to address lateral violence. *Social Justice Report 2011*. https://www.humanrights.gov.au/publications/chapter-4-cultural-safety-and-security-tools-address-lateral-violence-social-justice#Heading41

Australian Indigenous Doctors' Association. (n.d.). *Cultural safety factsheet*. https://nacchocommunique.com/wp-content/uploads/2017/02/cultural-safety-factsheet1.pdf

Australian Institute of Health and Welfare. (2020). *Aboriginal and Torres Strait Islander Health Performance Framework 2020 summary report*. Cat. no. IHPF 2. Australian Institute of Health and Welfare.

Baba, L. (2013). *Cultural safety in First Nations, Inuit and Metis public health: Environmental scan of cultural competency and safety in education, training and health services*. National Collaborating Centre for Aboriginal Health. https://www.nccih.ca/docs/emerging/RPT-CulturalSafetyPublicHealth-Baba-EN.pdf

Baker, A., & Giles, A. (2012). Cultural Safety: A Framework for interactions between Aboriginal patients and Canadian family medicine practitioners. *International Journal of Indigenous Health, 9*(1), 15–22. https://doi.org/10.18357/ijih91201212390

Banna, J., & Bersamin, A. (2018). Community involvement in design, implementation and evaluation of nutrition interventions to reduce chronic diseases in indigenous populations in the U.S.: A systematic review. *International Journal for Equity in Health, 17,* 116. https://doi.org/10.1186/s12939-018-0829-6

BC Association of Aboriginal Friendship Centres. (2010). *Indigenizing outcomes measurement: A review of the literature and methodological considerations*. BC Association of Aboriginal Friendship Centres. https://thesummerinstitute.ca/wp-content/uploads/indigenous_measurement_lit_review.pdf

BC Patient Safety & Quality Council. (2020). *BC health quality matrix*. https://bcpsqc.ca/wp-content/uploads/2020/02/BC-Health-Quality-Matrix-March-2020.pdf

Best, A., Greenhalgh, T., Lewis, S., Saul, J., Carroll, S. & Bitz, J. (2012). Large-system transformation in health care: A realist review. *Milbank Q, 3*, 421-56. https://doi.org/10.1111/j.1468-0009.2012.00670.x

Betancourt, J. R., Green, A. R., & Carrillo, E. (2002). *Cultural competence in health care: Emerging frameworks and practical approaches*. The Commonwealth Fund.

Betancourt, J. R., Green, A. R., Carrillo, J. E., & Ananeh-Firempong, O. I. (2003). Defining cultural competence: A practical framework for addressing racial/ethnic disparities in health and health care. *Public Health Reports, 118*(4), 293–302. https://doi.org/10.1016/S0033-3549(04)50253-4

Boyer, Y. (2017). Healing racism in Canadian health care. *Canadian Medical Association Journal, 189*(46), E1408–E1409. https://doi.org/10.1503/cmaj.171234

Bourke, C., Truong, M., Jones, Y., Hunyor, J., & Lawton, P. (2020). Addressing racism to improve healthcare outcomes for Aboriginal and Torres Strait Islander people: A case study in kidney care. Deeble Institute for Health Policy Research. *Perspectives Brief, 9*. https://apo.org.au/sites/default/files/resource-files/2020-05/apo-nid303540.pdf

Boynton-Jarrett, R., Raj, A., & Inwards-Breland, D. J. (2021). Structural integrity: Recognizing, measuring, and addressing systemic racism and its health impacts. *Eclinicalmedicine, 36*, 100921-100921. https://doi.org/10.1016/j.eclinm.2021.100921

Braithwaite, J., Hibbert, P., Blakely, B., Plumb, J., Hannaford, N., Long, J. C., & Marks, D. (2017). Health system frameworks and performance indicators in eight countries: A comparative international analysis. *SAGE Open Medicine*. https://doi.org/10.1177/2050312116686516

Brascoupé, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health, 5*(2), 6–41.

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

Browne, A. J. (2017). Moving beyond description: Closing the health equity gap by redressing racism impacting Indigenous populations. *Social Science and Medicine*, *184*, 23-26. https://doi.org/https://doi.org/10.1080/02722011.2019.1653694

Browne, A., & Fiske, J. (2001). First Nations women's encounters with mainstream health services. *Western Journal of Nursing Research, 23*(2), 126–147.

Browne, A., 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. https://doi.org/10.1186/s12913-016-1707-9

Canadian Foundation for Healthcare Improvement, First Nations Health Managers Association, & Keith, L. (n.d.). *A journey we walk together: Strengthening Indigenous cultural competency in health organizations*. https://www.cfhi-fcass.ca/sf-docs/default-source/documents/Indigenous-cultural-competency-primer-e.pdf?sfvrsn=be0ad444_2n

Canadian Health Services Research Foundation (CHSRF). (2011). *Understanding whole systems change in healthcare: The case of emerging evidence-informed nursing service delivery models*. https://www.cfhi-fcass.ca/sf-docs/default-source/ogc-reports/Edwards-Grinspun-EN.pdf?sfvrsn=0

Canadian Institute for Health Information (CIHI). (2013a). *A performance measurement framework for the Canadian health system*. https://secure.cihi.ca/free_products/HSP_Framework_Technical_Report_EN.pdf?_ga=2.72044693.761583149.1615076923-336550796.1584984414

Canadian Institute for Health Information (CIHI). (2013b). *A performance measurement framework for the Canadian health system: Addendum*.

Canadian Institute for Health Information. (2014). *PROMs and PREMs at CIHI: Measuring patient-centered care*. https://obrieniph.ucalgary.ca/sites/default/files/Nav%20Bar/Groups/The%20Methods%20Hub/1-chow_wc21_cihi_final.pdf

Canadian Institute for Health Information. (2015). *PROMs background document*. https://www.cihi.ca/sites/default/files/proms_background_may21_en-web_0.pdf

Canadian Institutes of Health Research (CIHR), Natural Sciences and Engineering Research Council of Canada, & Social Sciences & Humanities Research Council of Canada. (2014). *Tri-Council policy statement: Ethical conduct for research involving humans*. https://www.cmcc.ca/Tri-Council%20Policy%20Statement.pdf

Chantarat, T., Van Riper, D. C., & Hardeman, R. R. (2021). The intricacy of structural racism measurement: A pilot development of a latent-class multidimensional measure. *Eclinicalmedicine, 40*, 101092-101092. https://doi.org/10.1016/j.eclinm.2021.101092

Chief Public Health Officer of Canada. (2019). *Addressing stigma: Towards a more inclusive health system – The Chief Public Health Officer's report on the state of public health in Canada 2019*. Public Health Agency of Canada. https://www.canada.ca/content/dam/phac-aspc/documents/corporate/publications/chief-public-health-officer-reports-state-public-health-canada/addressing-stigma-what-we-heard/stigma-eng.pdf

Chin, J. (2000). Culturally competent health care. *Public Heath Reports, 115*, 25–33. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1308553/pdf/pubhealthrep00023-0027.pdf

Churchill, M. E. (2015). *Defining and evaluating cultural safety at seventh generation midwives Toronto: Exploring urban Indigenous women's perspectives on culturally safe maternity care* [Unpublished master's thesis]. Lakehead University. https://knowledgecommons.lakeheadu.ca/bitstream/handle/2453/738/ChurchillM2015m-1b.pdf?sequence=4&isAllowed=y

College of Family Physicians of Canada Indigenous Health Working Group, The. (2016). *Health and health care implications of systemic racism on Indigenous Peoples in Canada*. https://portal.cfpc.ca/ResourcesDocs/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf

Coombe, L., Lee, V. & Robinson, P. (2019). Educating for Indigenous public health competence – how do we stack up in Australia? *Australian and New Zealand Journal of Public Health, 43*(2). https://doi.org/10.1111/1753-6405.12872

Cromarty, H., & Walker, R. (n.d.). *Cross-cultural client safety. Achieving cultural safety in health service: Understanding & responding to the underlying cultural factors*. Sioux Lookout Meno Ya Win Health Centre. http://www.slmhc.on.ca/assets/files/traditional-healing/cross-cultural_client_safety_factor.pdf

Crowshoe, L., Henderson, R. I., Green, M. E., Jacklin, K. M., Walker, L. M., & Calam, B. (2018). Exploring Canadian physicians' experiences with Type 2 Diabetes care for adult Indigenous patients. *Canadian Journal of Diabetes, 42*, 281–288. https://doi.org/10.1016/j.jcjd.2017.06.012

Cullen, P., Mackean, T., Walker, N., Coombes, J., Bennett-Brook, K., Clapham, K., Ivers, R., Hackett, M., Worner, F., & Longbottom, M. (2021). Integrating Trauma and Violence Informed Care in Primary Health Care Settings for First Nations Women Experiencing Violence: A Systematic Review. *Trauma, Violence & Abuse*, 1524838020985571-1524838020985571. https://doi.org/10.1177/1524838020985571

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*, 174. https://doi.org/10.1186/s12939-019-1082-3

Cuthbertson, L. (2014). *Measuring patient reported experience of care in British Columbia*. http://chspr.sites.olt.ubc.ca/files/2015/06/Lena-Cuthbertson-Slides-CHSPR2014.pdf

Dehaas, J. (2014, December 12). Death after 34-hour ER wait was preventable: Judge. *CTV News*. Retrieved August 26, 2021, from https://www.ctvnews.ca/health/death-after-34-hour-er-wait-was-preventable-judge-1.2144671

Elliot-Groves, E., Hardison-Stevens, D., & Ullrich, J. (2020). Indigenous relationality is the heartbeat of Indigenous existence during COVID-19. *Journal of Indigenous Social Development, 9*(3), 158-169. https://journalhosting.ucalgary.ca/index.php/jisd/article/view/70761/54424

Elvidge, E., Paradies, Y., Aldrich, R., & Holder, C. (2020). Cultural safety in hospitals: Validating an empirical measurement tool to capture the Aboriginal patient experience. *Australian Health Review, 44*, 205–211. https://doi.org/10.1071/AH19227

FASD Evaluation. (2012). Culturally safe. *Mapping evaluation of community-based FASD prevention and FASD support programs*. http://www.fasd-evaluation.ca/wp-content/uploads/2012/10/Culturally-Safe.pdf

Federation of Saskatchewan Indian Nations. (n.d.). *Cultural responsiveness framework*. https://allnationshope.ca/userdata/files/187/CRF%20-%20Final%20Copy.pdf

Fekri, O., Leeb, K., & Gurevich, Y. (2017). Systematic approach to evaluating and confirming the utility of a suite of national health system performance (HSP) indicators in Canada: A modified Delphi study. *BMJ Open, 7,* e014772. http://dx.doi.org/10.1136/bmjopen-2016-014772

First Nations Health Authority (FNHA). (2016). *FNHA's policy statement on cultural safety and humility*. http://www.fnha.ca/Documents/FNHA-Policy-Statement-Cultural-Safety-and-Humility.pdf

First Nations Health Authority (FNHA), Government of Canada, & Province of British Columbia. (2019). *Evaluation of the British Columbia tripartite framework agreement on First Nation health governance appendices*. https://www.fnha.ca/Documents/Evaluation-of-the-BC-Tripartite-Framework-Agreement-on-First-Nations-Health-Governance-Appendices.pdf

First Nations Health Authority (FNHA), & Office of the Provincial Health Officer (PHO). (2020). *First Nations Population Health & Wellness Agenda: Summary of findings*. https://www.fnha.ca/Documents/FNHA-PHO-First-Nations-Population-Health-and-Wellness-Agenda-Summary-of-Findings.pdf

First Nations Health Authority (FNHA), & Office of the Provincial Health Officer (PHO). (2021). *First Nations population health & wellness agenda*. https://www2.gov.bc.ca/assets/gov/health/about-bc-s-health-care-system/office-of-the-provincial-health-officer/reports-publications/annual-reports/first-nations-population-health-wellness-agenda.pdf

First Nations Information Governance Centre (FNIGC), The. (2014). *Ownership, Control, Access and Possession (OCAPTM): The path to First Nations information governance*. https://achh.ca/wp-content/uploads/2018/07/OCAP_FNIGC.pdf

First Nations Information Governance Centre (FNIGC), The. (2020). *A First Nations data governance strategy*. https://fnigc.ca/wp-content/uploads/2020/09/FNIGC_FNDGS_report_EN_FINAL.pdf

Fleming, T., Creedy, D. K., & West, R. (2019). Evaluating awareness of Cultural Safety in the Australian midwifery workforce: A snapshot. *Women and Birth, 32*, 549–557. https://doi.org/10.1016/j.wombi.2018.11.001

Forsyth, C. J., Irving, M. J., Tennant, M., Short, S. D., & Gilroy, J. A. (2017). Teaching cultural competence in dental education: A systematic review and exploration of implications for Indigenous populations in Australia. *Journal of Dental Education, 81*(8), 956–968. https://doi.org/10.21815/JDE.017.049

Fridkin, A., Browne, A. J., & Dion Stout, M. (2019). The RIPPLES of meaningful involvement: A framework for meaningfully involving Indigenous peoples in health policy decision-making. *The International Indigenous Policy Journal*, *10*(3), 8309. https://doi.org/https://doi.org/10.18584/iipj.2019.10.3.8309

Gerlach, A. J., Browne, A. J., Sinha, V., Elliott, D. (2017). Navigating structural violence with Indigenous families: The contested terrain of early childhood intervention and the child welfare system in Canada. *The International Indigenous Policy Journal, 8*(3). https://doi.org/10.18584/iipj.2017.8.3.6

Gomersall, J. S., Gibson, O., Dwyer, J., O'Donnell, K., Stephenson, M., Carter, D., Canuto, K., Munn, Z., Aromataris, E., & Brown, A. (2017). What Indigenous Australian clients value about primary health care: A systematic review of qualitative evidence. *Australian and New Zealand Journal of Public Health 41*(4), 417-423. https://doi.org/10.1111/1753-6405.12687

Goodman, A., Fleming, K., Markwick, N., Morrison, T., Lagimodiere, L., Kerr, T., & Western Aboriginal Harm Reduction Society. (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.

Government of Canada. (2018). *First Nations and Inuit health and wellness indicators*. https://health-infobase.canada.ca/fnih/

Green, M., Anderson, K., Griffiths, K., Garvey, G., & Cunningham, J. (2018). Understanding Indigenous Australians' experiences of cancer care: Stakeholders' views on what to measure and how to measure it. *BMC Health Services Research 18,* 982. https://doi.org/10.1186/s12913-018-3780-8

Green, M., Cunningham, J., Anderson, K., Griffiths, K., & Garvey, G. (2021). Measuring health care experiences that matter to indigenous people in australia with cancer: Identifying critical gaps in existing tools. *International Journal for Equity in Health, 20*(1), 100-100. https://doi.org/10.1186/s12939-021-01433-2

Greenwood, M. (2019). Modelling change and cultural safety: A case study in northern British Columbia health system transformation. *Healthcare Management Forum, 32*(1), 11–14. https://doi.org/10.1177/0840470418807948

Gunn, B. (n.d.). *Ignored to death: Systemic racism in the Canadian Healthcare System*. Expert Mechanism on the Rights of Indigenous Peoples - The Study on Health. https://www.ohchr.org/Documents/Issues/IPeoples/EMRIP/Health/UniversityManitoba.pdf

Gwynne, K., & Lincoln, M. (2017). Developing the rural health workforce to improve Australian Aboriginal and Torres Strait Islander health outcomes: A systematic review. *Australian Health Review, 41*, 234–238. http://dx.doi.org/10.1071/AH15241

Harding, L. (2018). *What's the harm? Examining the stereotyping of Indigenous Peoples in health systems* [Unpublished doctoral dissertation]. Simon Fraser University.

Hart-Wasekeesikaw, F. (2009). *Cultural competence and cultural safety in First Nations, Inuit and Métis nursing education: An integrated review of the literature*. Aboriginal Nurses Association of Canada. https://opus.uleth.ca/handle/10133/720

Health Council of Canada (HCC). (2012). *Empathy, dignity and respect: Creating cultural safety for Aboriginal people in urban health care*. Health Council of Canada. https://learningcircle.ubc.ca/files/2014/05/Empathy-dignity-and-respect-Creating-cultural-safety-for-Aboriginal-people-in-urban-health-care.pdf

Health Quality Ontario. (2018). *Health system performance in Ontario – 2018 highlights*. https://www.hqontario.ca/Portals/0/documents/pr/cqa-measuring-up-2018-en.pdf

Heggie, K. (2018). *Indigenous wellness indicators: Including urban Indigenous wellness Indicators in the healthy city strategy*. City of Vancouver. https://sustain.ubc.ca/sites/default/files/2018-62%20Indigenous%20Wellness%20Indicators_Heggie.pdf

Heidinger, L. (2021, May 19). Intimate partner violence: Experiences of First Nations, Métis and Inuit women in Canada, 2018. *Juristat,* Catalogue no. 85-002-X. Statistics Canada. https://www150.statcan.gc.ca/n1/en/pub/85-002-x/2021001/article/00007-eng.pdf?st=ZHaklcoo

Hogg, B. (2018). *8 change leadership strategies for sustainable results*. Retrieved August 27, 2021, from https://www.billhogg.ca/8-change-leadership-strategies-for-sustainable-results/

Hojjati, A., Beavis, A. S. W., Kassam, A., Choudhury, D., Fraser, M., Masching, R., & Nixon, S. A. (2018). Educational content related to postcolonialism and indigenous health inequities recommended for all rehabilitation students in Canada: A qualitative study. *Disability and Rehabilitation, 40*(26), 3206–3216. https://doi.org/10.1080/09638288.2017.1381185

Hole, R. D., Evans, M., Berg, L. D., Bottorff, J. L., Dingwall, C., Alexis, C., Nyberg, J., & Smith, M. L. (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

Hook, J., Davis, D., Owen, J., Worthington, E., & Utsey, S. (2013). Cultural humility: Measuring Openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3), 353–366.

Hunter, K., & Cook, C. (2020). Indigenous nurses' practice realities of cultural safety and socioethical nursing. *Nursing Ethics, 27*(6), 1472–1483. https://doi.org/10.1177/0969733020940376

Huria, T., Cuddy, J., Lacey, C., & Pitama, S. (2014). Working with racism: A qualitative study of the perspectives of Māori (Indigenous Peoples of Aotearoa New Zealand) registered nurses on a global phenomenon. *Journal of Transcultural Nursing, 25*(4), 364–372. https://doi.org/10.1177/1043659614523991

Indigenous Physicians Association of Canada, The (IPAC), & the Royal College of Physicians and Surgeons of Canada (RCPSC). (2009). First Nations, Inuit and Métis health: Core competencies for continuing medical education. http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=10851&cf_id=68&lang=en

Indigenous Primary Health Care Council. (2021). *Ne' iikaanigaana toolkit: Creating safer environments for Indigenous Peoples*. https://www.iphcc.ca/publications/toolkits/Ne-iikaanigaana/

Indigenous Services Canada. (2021, Jan. 28). *Statement by the Minister of Indigenous Services, the Minister of Crown-Indigenous Relations, the Minister of Health and the Minister of Northern Affairs on the work to eliminate racism against Indigenous Peoples in the healthcare systems*. https://www.canada.ca/en/indigenous-services-canada/news/2021/01/statement-by-the-minister-of-indigenous-services-the-minister-of-crown-indigenous-relations-the-minister-of-health-and-the-minister-of-northern-aff0.html

Inuit Tapiriit Kanatami. (2021). *Systemic discrimination in the provision of healthcare in Inuit Nunangat: A brief discussion paper*. https://www.itk.ca/wp-content/uploads/2021/02/20210122-ITK-Systemic-Discrimination-in-the-Provision-of-Healthcare-in-Inuit-Nunangat.pdf

Irani, K., Serwin, A., & Hudson, D. (2020). Investigating vigilance: A new way to account for the effects of racism on health inequities. *Journal on Race, Inequality, and Social Mobility in America, 2*(1), 4. https://openscholarship.wustl.edu/cgi/viewcontent.cgi?article=1011&context=jrisma

Ivers, N., Jamtvedt, G., Flottorp, S., Young, J. M., Odgaard-Jensen, J., French, S. D., O'Brien, M. A., Johansen, M., Grimshaw, J., & Oxman, A. D. (2012). Audit and feedback: Effects on professional practice and healthcare outcomes. *Cochrane Database of Systematic Reviews, 6*. https://doi.org/10.1002/14651858

Johanson, R., & Hill, P. (2011). Indigenous health: A role for private general practice. *Australian Family Physician, 40*(1), 16–19.

Johnson, H., & METL. (2021). United Nations Declaration on the Rights of Indigenous Peoples and *In Plain Sight*: Addressing Indigenous-Specific Racism and Discrimination in B.C. Health Care. Engage BC. https://engage.gov.bc.ca/app/uploads/sites/121/2021/03/UNDRIP-and-IPS-FINAL.pdf

Johnston, J. (2017). Woman with broken femur ordered to leave Chilliwack hospital. *CBC News,* September 28. Retrieved Aug. 27, 2021, from https://www.cbc.ca/news/canada/british-columbia/mary-stewart-chilliwack-general-hospital-1.4312521

Jongen, C., McCalman, J., & Bainbridge, R. (2018). Health workforce cultural competency interventions: A systematic scoping review. *BMC Health Services Research, 18,* 232. https://doi.org/10.1186/s12913-018-3001-5

Kania, J., & Kramer, M. (2011). Collective impact. *Stanford Social Innovation Review*. Retrieved March 15, 2021, from https://ssir.org/articles/entry/collective_impact

Kania, J., & Kramer, M. (2013). Embracing emergence: How collective impact addresses complexity. https://ssir.org/articles/entry/social_progress_through_collective_impact

Ken Blanchard Companies, The. (2018). *Leadership strategies for making change stick*. http://www.blanchard.com.tr/Uploads/files/Arastirma/leadership-strategies-for-making-change-stick.pdf

Kerrigan, V., Lewis, N., Cass, A., Hefler, M., & Ralph, A.P. (2020). "How can I do more?": Cultural awareness training for hospital-based healthcare providers working with high Aboriginal caseload. *BMC Medical Education, 20*(173). https://doi.org/10.1186/s12909-020-02086-5

Kétéskwēw Dion Stout, M., Wieman, C., Bourque Bearskin, L., Palmer, B. C., Brown, L., Brown, M., & Marsden, N. (2021). Gum yan asing Kaangas giidaay han hll guudang gas ga. I Will Never Again Feel That I Am Less Than: Indigenous Health Care Providers' Perspectives on Ending Racism in Health Care. *International Journal of Indigenous Health*, *16*(1), 13-20. https://doi.org/10.32799/ijih.v16i1.36021

Kressin, N. R., Raymond, K. L., & Manze, M. (2008). Perceptions of Race/Ethnicity-Based Discrimination: A Review of Measures and Evaluation of Their Usefulness for the Health Care Setting. *Journal of Health Care for the Poor and Underserved 19*(3), 697–730. doi:10.1353/hpu.0.0041.

Kumas-Tan, Z., Beagan, B., Loppie, C., MacLeod, A., & Frank, B. (2007). Measures of cultural competence: Examining hidden assumptions. *Academic Medicine 82*(6), 548–557.

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

Lai, G. C., Taylor, E. V., Haigh, M. M., & Thompson, S. C. (2018). Factors affecting the retention of Indigenous Australians in the health workforce: A systematic review. *International Journal of Environmental Research and Public Health, 15*, 914. https://doi.org/10.3390/ijerph15050914

Lautensach, A., & Lautensach, S. (2011). Prepare to be offended: cultural safety inside and outside the classroom. *International Journal of Arts and Sciences, 4*(25), 183-194.

Lawrence, B. (2017). *An organizational self-assessment tool for Aboriginal cultural competency* [Draft version 10.3]. Interior Health.

Li, B., Cashmore, A., Arneman, D., Bryan-Clothier, W., McCallum, L. K., & Milat, A. (2017). The Aboriginal Population Health Training Initiative: A NSW Health program established to strengthen the Aboriginal public health workforce. *Public Health Research and Practice, 27*(4). https://doi.org/10.17061/phrp2741739

Loppie, S., Reading, C., & de Leeuw, S. (2014). *Aboriginal experiences with racism and its impacts*. National Collaborating Centre for Aboriginal Health. https://www.nccih.ca/495/Indigenous_experiences_with_racism_and_its_impacts.nccih?id=131

Lowell, A., Kildea, S., Liddle, M., Cox, B., & Paterson, B. (2015). Supporting aboriginal knowledge and practice in health care: Lessons from a qualitative evaluation of the strong women, strong babies, strong culture program. *BMC Pregnancy and Childbirth, 15*(19). https://doi.org/10.1186/s12884-015-0433-3

Mander, S., & Miller, Y. D. (2016). Perceived safety, quality and cultural competency of maternity care for culturally and linguistically diverse women in Queensland. *Journal of Racial and Ethnic Health Disparities*, *3*(1), 83–98. https://doi.org/10.1007/s40615-015-0118-7

Marrie, A., & Marrie, H. (2014). *A matrix for identifying, measuring and monitoring institutional racism within public hospitals and health services*. Bukal Consultancy Services P/L.

McDonald, H., Browne, J., Perruzza, J., Svarc, R., Davis, C., & Palermo, C. (2018). Transformative effects of Aboriginal health placements for medical, nursing, and allied health students: A systematic review. *Nursing & Health Sciences, 20*, 154–164. https://doi.org/10.1111/nhs.12410

McEldowney, R., & Connor, M. J. (2011). Cultural safety as an ethic of care: A praxiological process. *Journal of transcultural nursing: Official journal of the Transcultural Nursing Society*, *22*(4), 342–349. https://doi.org/10.1177/1043659611414139

McKenna, B., Fernbacher, S., Furness, T., & Hannon, M. (2015). "Cultural brokerage" and beyond: Piloting the role of an urban Aboriginal Mental Health Liaison Officer. *BMC Public Health, 15,* 88. https://doi.org/10.1186/s12889-015-2221-4

Mitchell, A. G., Belton, S., Johnston, V., Gondarra, W., & Ralph, A.P. (2019). "That heart sickness": Young Aboriginal People's understanding of rheumatic fever. *Medical Anthropology, 38(1)*, 1–14. https://doi.org/10.1080/01459740.2018.1482549

Muise, G. M. (2019). Enabling cultural safety in Indigenous primary healthcare. *Healthcare Management Forum, 32*(1), 25–31. https://doi.org/10.1177/0840470418794204

Müller, L., El Oakley, R., Saad, M., Mokdad, A. H., Etolhi, G. A., & Flahault, A. (2021). A multidimensional framework for rating health system performance and sustainability: A nine plus one ranking system. *Journal of global health*, *11*, 04025. https://doi.org/10.7189/jogh.11.04025

Nadin, S., Crow, M., Prince, H., & Kelley, M. L. (2018). Wiisokotaatiwin: Development and evaluation of a community-based palliative care program in Naotkamegwanning First Nation. *Rural and Remote Health, 18*(2). https://doi.org/10.22605/RRH4317

National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA). (n.d.). *Cultural safety framework*. https://www.natsihwa.org.au/sites/default/files/natsihwa-cultural_safety-framework_summary.pdf

National Aboriginal Health Organization (NAHO). (2008). *Cultural competency and safety: A guide for health care administrators, providers and educators.*

National Collaborating Centre for Aboriginal Health (NCCAH). (2013a). *Indigenous approaches to program evaluation*. https://www.ccnsa-nccah.ca/docs/context/FS-IndigenousApproachesProgramEvaluation-EN.pdf

National Collaborating Centre for Aboriginal Health (NCCAH). (2013b). *An overview of Aboriginal health in Canada*. Retrieved from https://www.ccnsa-nccah.ca/docs/context/FS-OverviewAbororiginalHealth-EN.pdf

National Collaborating Centre for Determinants of Health. (2018). Let's Talk: Racism and Health Equity (Rev. ed.). National Collaborating Centre for Determinants of Health, St. Francis Xavier University. https://nccdh.ca/images/uploads/comments/Lets-Talk-Racism-and-Health-Equity-EN.pdf

National Collaborating Centre for Indigenous Health (NCCIH). (2019). *Access to health services as a social determinant of First Nations, Inuit and Métis health*. https://www.nccih.ca/docs/determinants/FS-AccessHealthServicesSDOH-2019-EN.pdf

National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG). (2019). *Executive Summary*. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Executive_Summary.pdf

National Research Council. (2004). *Measuring racial discrimination*. The National Academies Press. https://doi.org/10.17226/10887

Northwest Territories Health and Social Services. (2019). *Caring for our people: Cultural safety action plan 2018-2020*. https://www.hss.gov.nt.ca/sites/hss/files/resources/cultural-safety-action-plan.pdf

Nursing Council of New Zealand. (2011). *Guidelines for cultural safety: The treaty of Waitangi and Māori health in nursing education and practice*. Nursing Council of New Zealand. https://ngamanukura.nz/sites/default/files/basic_page_pdfs/Guidelines%20for%20cultural%20safety%2C%20the%20Treaty%20of%20Waitangi%2C%20and%20Maori%20health%20in%20nursing%20education%20and%20practice%282%29_0.pdf

Organisation for Economic Co-operation and Development (OECD). (n.d.). *Chapter 2. Profile of Indigenous Canada: Trends and data needs*. Retrieved October 1, 2021, from https://www.oecd-ilibrary.org/sites/e6cc8722-en/index.html?itemId=/content/component/e6cc8722-en

Papps, E., & Ramsden I. (1996). *Cultural safety in nursing: the New Zealand experience. International Journal for Quality in Health Care 8*(5), 491–497.

Paradies, Y., Ben, J., Denson, N., Elias, A., Priest, N., Pieterse, A., Gupta, A., Kelaher, M., & Gee, G. (2015). Racism as a determinant of health: A systematic review and meta-analysis. *PloS one, 10*(9), e0138511. https://doi.org/10.1371/journal.pone.0138511

Paradies, Y., & Cunningham, J. (2012). The DRUID study: racism and self-assessed health status in an Indigenous population. *BMC Public Health, 12,* 131. https://doi.org/10.1186/1471-2458-12-131

Paradies, Y., Truong, M., & Priest, N. (2014). A systematic review of the extent and measurement of healthcare provider racism. *Journal of General Internal Medicine, 29*(2), 364–387.

Percival, N. A., McCalman, J., Armit, C., O'Donoghue, L., Bainbridge, R., Rowley, K., Doyle, J., & Tsey, K. (2018). Implementing health promotion tools in Australian Indigenous primary health care. *Health Promotion International, 33*, 92–106. https://doi.org/10.1093/heapro/daw049

Provincial Health Services Authority (PHSA). (2016). *PHSA Indigenous cultural safety framework: An organizational assessment tool.* PHSA.

Provincial Health Services Authority (PHSA). (n.d.). *Conducting research at PHSA.* Retrieved Sept. 9, 2021, from http://www.phsa.ca/researcher/data-access-privacy/research-privacy/conducting-surveys

Provincial Health Officer (PHO), & First Nations Health Authority (FNHA). (2018). *Indigenous health and well-being.* https://www.fnha.ca/Documents/FNHA-PHO-Indigenous-Health-and-Well-Being-Report.pdf

Public Health Agency of Canada (PHAC). (2015). *Ways tried and true: Aboriginal methodological framework for the Canadian best practices initiative.* Her Majesty the Queen in Right of Canada, as represented by the Minister of Health. Retrieved Aug. 27, 2021, from https://cbpp-pcpe.phac-aspc.gc.ca/aboriginalwtt/

Rand, M., Sheppard, A., Jamal, S., Kewayosh, A., & Mashford-Pringle, A. (2019). Evaluation of the Indigenous Relationship and Cultural Safety Courses among a sample of Indigenous Services Canada nurses. *International Journal of Indigenous Health, 14*(1), 29–41. https://doi.org/10.32799/ijih.v14i1.31967

Reading, C. (2013). *Understanding racism.* National Collaborating Centre for Aboriginal Health. https://www.nccih.ca/docs/determinants/FS-Racism1-Understanding-Racism-EN.pdf

Reading, C., & Wien, F. (2009). *Health inequalities and social determinants of Aboriginal Peoples' health.* National Collaborating Centre for Aboriginal Health. https://www.ccnsa-nccah.ca/docs/determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf

Reading, J., & Halseth, R. (2013). *Pathways to improving well-being for Indigenous Peoples: How living conditions decide health.* National Collaborating Centre for Aboriginal Health. https://www.nccih.ca/docs/determinants/RPT-PathwaysWellBeing-Reading-Halseth-EN.pdf

Redvers, J. (2020). "The land is a healer": Perspectives on land-based healing from Indigenous practitioners in northern Canada. *International Journal of Indigenous Health, 15*(1), 90–107. https://doi.org/10.32799/ijih.v15i1.34046

Shah, C., & Reeves, A. (2015). The Aboriginal Cultural Safety Initiative: An innovative health sciences curriculum in Ontario colleges and universities. *International Journal of Indigenous Health 10*(2), 117–131.

Shahid, S., Taylor, E. V., Cheetham, S., Woods, J. A., Aoun, S. M., & Thompson, S. C. (2018). Key features of palliative care service delivery to Indigenous peoples in Australia, New Zealand, Canada and the United States: a comprehensive review. *BMC Palliative Care, 17*, 72. https://doi.org/10.1186/s12904-018-0325-1

Shelton, R. C., Adsul, P., & Oh, A. (2021). Recommendations for addressing structural racism in implementation science: A call to the field. *Ethnicity & Disease, 31(Suppl)*, 357–364. https://doi.org/10.18865/ed.31.S1.357

Simmonds, S., Carter, M., Preval, N., & Wilson, R. (2020). *Baseline Data Capture: Cultural Safety, Partnership and Health Equity Initiatives.* Medical Council of New Zealand and Te Ohu Rata o Aotearoa, Wellington. https://www.mcnz.org.nz/assets/Publications/Reports/f5c692d6b0/Cultural-Safety-Baseline-Data-Report-FINAL-September-2020.pdf

Smith, K., Fatima, Y., & Knight, S. (2017). Are primary healthcare services culturally appropriate for Aboriginal people? Findings from a remote community. *Australian Journal of Primary Health, 23,* 236–242. https://doi.org/10.1071/PY16110

Smylie, J., & Firestone, M. (2015). Back to the basics: Identifying and addressing underlying challenges in achieving high quality and relevant health statistics for indigenous populations in Canada. *Statistical Journal of the IAOS, 31*, 67–87. http://dx.doi.org/10.3233/SJI-150864

Society of Obstetricians and Gynaecologists of Canada (SOGC). (2013). Health professionals working with First Nations, Inuit and Metis consensus guideline. *Journal of Obstetrics and Gynaecology Canada, 35*(6), 550–553.

State of Victoria, Department of Health. (2009). Cultural responsiveness framework: Guidelines for Victorian health services. https://www2.health.vic.gov.au/about/publications/policiesandguidelines/Cultural-responsiveness-framework---Guidelines-for-Victorian-health-services

Statistics Canada. (2020). *First Nations people, Métis and Inuit and COVID-19: Health and social characteristics.* Government of Canada. Retrieved October 1, 2021, from https://www150.statcan.gc.ca/n1/daily-quotidien/200417/dq200417b-eng.htm

Tan, S. B., deSouza, P., & Raifman, M. (2021). Structural racism and COVID-19 in the USA: A county-level empirical analysis. *Journal of Racial and Ethnic Health Disparities.* https://doi.org/10.1007/s40615-020-00948-8

Taylor, E. V., Haigh, M. M., Shahid, S., Garvey, G., Cunningham, J., & Thompson, S. C. (2018). Cancer services and their initiatives to improve the care of Indigenous Australians. *International Journal of Environmental Research and Public Health, 15*, 717. https://doi.org/10.3390/ijerph15040717

Taylor, K., Thompson, S., Wood, M., Ali, M., & Dimer, L. (2009). Exploring the impact of an Aboriginal Health Worker on hospitalised Aboriginal experiences: Lessons from cardiology. *Australian Health Review 33*(4), 549–557.

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Underserved 9*(*2*), 117–125. https://doi.org/10.1353/hpu.2010.0233

Thackrah, R. D., Wood, J., & Thompson, S. C. (2020). Cultural respect in midwifery service provision for Aboriginal women: Longitudinal follow-up reveals the enduring legacy of targeted program initiatives. *International Journal for Equity in Health, 19,* 210. https://doi.org/10.1186/s12939-020-01325-x

Thiessen, K., Haworth-Brockman, M., Stout, R. Moffitt, P., Gelowitz, J., Schneider, J., & Demczuk, L. (2020). Indigenous perspectives on wellness and health in Canada: Study protocol for a scoping review. *Systematic Reviews, 9*, 177. https://doi.org/10.1186/s13643-020-01428-0

Thurston, W. E., Coupal, S., Jones, C. A., Crowshoe, L. F. J., Marshall, D. A., Homik, J., & Barnabe, C. (2014). Discordant indigenous and provider frames explain challenges in improving access to arthritis care: a qualitative study using constructivist grounded theory. *International Journal for Equity in Health*, *13,* 46. http://www.equityhealthj.com/content/13/1/46

Tripartite Committee on First Nations Health Executive Working Group on Cultural Safety and Humility. (2016). *Cultural safety and humility in health services for First Nations and Aboriginal people in British Columbia: A guiding framework for action.* Tripartite Committee on First Nations Health.

Truth and Reconciliation Commission (TRC) of Canada. (2015). *Truth & Reconciliation Commission of Canada: Calls to action*. https://www2.gov.bc.ca/assets/gov/british-columbians-our-governments/indigenous-people/aboriginal-peoples-documents/calls_to_action_english2.pdf

Turpel-Lafond, M. E. (2020a). *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

Turpel-Lafond, M. E. (2020b). *In plain sight: Addressing Indigenous-specific racism and discrimination in B.C. health care data report*. https://engage.gov.bc.ca/app/uploads/sites/613/2021/02/In-Plain-Sight-Data-Report_Dec2020.pdf1_.pdf

United Nations (UN) Human Rights Council. (2016). *The right to health and indigenous peoples, with a focus on children and youth: Draft study of the Expert Mechanism on the Rights of Indigenous Peoples*. United Nations. https://www.ohchr.org/EN/Issues/IPeoples/EMRIP/Pages/HealthStudy.aspx

Vancouver Coastal Health, & First Nations Health Authority. (2014). *VCH First Nations and Aboriginal culturally competent and responsive strategic framework: Implementation plan: Phase one: Indicators*. Vancouver Coastal Health.

Vogel, L. (2018). Residency programs grapple with new Indigenous cultural safety training requirement. *Canadian Medical Association Journal, 190*(25), E778–E779. https://doi.org/10.1503/cmaj.109-5616

Vukic, A., Jesty, C., Mathews, S. V., & Etowa, J. (2012). Understanding race and racism in nursing: Insights from Aboriginal nurses. *ISRN Nursing, 2012*. https://doi.org/10.5402/2012/196437

Walker, R., St. Pierre-Hansen, N., Cormarty, H., Kelly, L., & Minty, B. (2010). Measuring cross-cultural patient safety: Identifying barriers and developing performance indicators. *Healthcare Quarterly 13*(1), 64–71.

Weech-Maldonado, R., Dreachslin, J., Brown, J., Pradhan, R., Rubin, K., Schiller, C., & Hays, R. (2012). Cultural competency assessment tool for hospitals: Evaluating hospitals' adherence to the culturally and linguistically appropriate services standards. *Health Care Management Review, 37*(1), 54–66. http://doi.org/10.1097/HMR.0b013e31822e2a4f

Western Health. (2019). *Aboriginal health cultural safety plan: January 2019-December 2021*. https://www.westernhealth.org.au/AboutUs/CorporatePublications/Documents/AboriginalHealthCulturalSafetyPlan/WH_Aboriginal%20Health%20Cultural%20Safety%20Plan_2019-2021.pdf

Williams, D. (2016). *Measuring discrimination resource*. https://scholar.harvard.edu/files/davidrwilliams/files/measuring_discrimination_resource_june_2016.pdf

Williams, H. M., Percival, N. A., Hewlett, N. C., Cassady, R. B. J., & Silburn, S. R. (2018). Online scan of FASD prevention and health promotion resources for Aboriginal and Torres Strait Islander communities. *Health Promotion Journal of Australia, 29*, 31–38. https://doi.org/10.1002/hpja.8

Williams, R. (1999). Cultural safety – what does it mean for our work practice? *Australian and New Zealand Journal of Public Health 23*(2), 213–214. https://doi.org/10.1111/j.1467-842X.1999.tb01240.x

Wilson, C. R., Rourke, J., Oandasan, I. F., Bosco, C., On behalf of the Rural Road Map Implementation Committee, & Au nom du Comité sur la mise en œuvre du Plan d'action sur la médecine rurale. (2020). Progress made on access to rural health care in Canada [Progrès réalisés dans l'accès aux soins de santé ruraux au Canada]. *Canadian Family Physician*, *66*(1), 31–36.

Yeung, S. (2016). Conceptualizing cultural safety: Definitions and applications of safety in health care for Indigenous mothers in Canada. *Journal for Social Thought 1*(1). https://ir.lib.uwo.ca/jst/vol1/iss1/3

Young, T. K., Chatwood, S., Ng C., Young, R. W., Marchildon, G. P. (2019). The north is not all the same: Comparing health system performance in 18 northern regions of Canada. *International Journal of Circumpolar Health, 78*(1), 1697474. https://doi.org/10.1080/22423982.2019.1697474

APPENDIX A: CONCEPTS ACROSS CULTURAL SAFETY FRAMEWORKS

The following table summarizes health system domains arising from the literature or frameworks that examine organizational development in cultural safety (N.B.: frameworks utilizing the terminology "cultural competency" and "cultural humility" are also included, where those frameworks utilize these two concepts).

Theme	Key Functions and/or Actions	Sources
Data and Evidence	Measures are identified, data collected, and monitored; used to inform planning	1, 3, 7, 8, 9, 13, 14, 15, 18, 20, 21, 22, 23
	Culturally safe ways to assess Indigenous access and experience of services (including identification processes)	2, 8, 10, 14, 18, 21, 22, 23
	Cultural safety as a "lens" to evaluation; regular evaluation of cultural safety	2, 3, 4, 7, 8, 12, 14, 16, 21, 23
	Public reporting, accountability, and celebration	2, 3, 8, 9, 12, 14, 15, 18, 22, 23
	Cultural safety audits and assessments (at organizational and provider level)	3, 7, 9, 12, 14, 15, 16, 21, 23
Policy and Protocol	Cultural safety and/or equity "hardwired" into all policy	1, 2, 6, 7, 13, 14, 16, 17, 20, 23
	System or organization policy or definition of cultural safety	2, 3, 4, 14, 16, 21, 22
	First Nations protocols are followed	2, 4 ,6, 10, 14, 21
	Policies to address racism	2, 4, 14, 17, 21
	Policy incentives for cultural safety (e.g., health professionals billing; compensation for Indigenous healers)	3, 4, 13, 16
Incidents, Complaints, and Whistleblowing	Employee incident reporting on cultural safety	2, 3, 14, 15
	Complaints, feedback, and quality improvement processes (including processes that reflect Indigenous practices/approaches)	2, 3, 7, 8, 9, 12, 14, 15, 16, 18, 22, 23
Indigenous Perspectives and Practices	Recognition of unique definition of health and wellness	1, 3, 5, 8, 9, 12, 16, 19, 21
	Traditional practices integrated in health care services, treatment plans, and/or Indigenous-specific programming	1, 2, 4, 5, 6, 7, 8, 11, 13, 14, 15, 16, 17, 18, 21, 22, 23

Theme	Key Functions and/or Actions	Sources
Leadership, Governance, and Administration	First Nations involvement in governance, leadership, prioritization, and decision making (including reciprocal accountability, budgeting, research)	1, 3, 4, 5, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 20, 21, 22
	Indigenous equity and cultural safety as a "lens" to all strategic decisions	2, 8, 13, 14
	Visible leadership commitment and responsibility (including in mission statement)	2, 3, 7, 8, 10, 12, 13, 14, 16, 18, 21, 22, 23
Planning	First Nations involvement in strategic and service planning	1, 2, 3, 4, 7, 9, 13, 14, 15, 16, 18, 21
	First Nations and cultural safety reflected as a priority in strategic and service planning	1, 6, 7, 8, 9, 11, 14, 15, 21
	Cultural safety strategies/workplans	2, 3, 7, 10, 12, 13, 14, 15, 16, 21
Human Resources	Training and ongoing skills development (at all levels, including Board)	1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 18, 20, 21, 22, 23
	Cultural safety competencies built into job descriptions, recruitment, and ongoing HR management/performance	2, 7, 8, 12, 13, 14, 15, 16, 18, 20
	Recruitment and retention of Indigenous employees	2, 3, 4, 7, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23
Partnership and Engagement	Formalized partnerships and processes with Indigenous communities and organizations	1, 2, 3, 4, 5, 7, 8, 9, 10, 12, 13, 14, 17, 21, 22
	Dialogue with Indigenous communities, organizations, and people	1, 2, 3, 7, 8, 10, 12, 13, 14, 15, 16, 21, 22, 23
	Communications strategy to raise awareness about Indigenous peoples, racism, and/or cultural safety, including organizational expectations and tools	2, 3, 8, 12, 14, 16, 18, 21, 23
	Partnerships and coalitions to increase spread across sector/system	3, 7, 8, 13, 18
	Cultural competency/safety in print and communications materials	7, 10, 12, 14, 23
	Tailored outreach and community education initiatives	7, 8, 10, 17, 18, 21, 23
Health Services	Tools and guidelines are developed to support culturally safe services	2, 7, 8, 9, 11, 12, 14, 15, 16, 18
	Accreditation	2, 3, 4
	Navigators/navigation	1, 2, 8, 11, 14, 17, 18
	Registration and intake processes	2, 3, 8, 14
	Continuity of care/wholistic care/integration with community services	1, 2, 3, 5, 6, 8, 13, 14, 19, 21
	Language interpretation	7, 9, 11, 12, 14, 15, 16, 18, 21, 22
	Proactive/personalized care	19, 23, 21
Physical Spaces	Welcoming for Indigenous peoples; include visual representations and signage of Indigenous culture, language; healing rooms	1, 2, 3, 4, 6, 7, 8, 9, 10, 12, 13, 14, 15, 16, 18, 19, 21, 23

Sources (see References for full bibliographic information):

1. First Nations Health Authority et al., 2019
2. Provincial Health Services Authority, 2016
3. Tripartite Committee on First Nations Health Executive Working Group on Cultural Safety and Humility, 2016
4. National Aboriginal and Torres Strait Islander Health Workers Association (NATSIHWA), n.d.
5. Yeung, 2016
6. Brascoupé & Waters, 2009
7. Betancourt et al., 2003
8. Vancouver Coastal Health & First Nations Health Authority, 2014
9. Weech-Maldonado et al., 2012
10. Australian Indigenous Doctors' Association, n.d.
11. Walker et al., 2010
12. State of Victoria, Department of Health, 2009
13. Browne et al., 2016
14. Lawrence, 2017
15. Chin, 2000
16. Canadian Foundation for Healthcare Improvement et al., n.d.
17. Federation of Saskatchewan Indian Nations, n.d.
18. Northwest Territories Health and Social Services, 2019
19. Gomersall et al., 2017
20. Simmonds et al., 2020
21. Indigenous Primary Health Care Council, 2021
22. Australian Government, 2019
23. Western Health, 2019

APPENDIX B: THEMES OF CULTURALLY SAFE EXPERIENCE

The following table identifies themes arising from literature that examines the experience of culturally safety, culturally safe care, and/or interaction with a culturally humble health care professional. Note that articles specifically examining cultural unsafety were also included, where the authors explicitly describe the opposite/inverse experience as reflective of cultural safety. This can and should supplement existing surveys and indicators related to the experience of racism and common forms of anti-Indigenous stereotyping and discrimination (see Turpel-Lafond, 2020b).

Key Words, Concepts & Themes		Sources
Respect	Mutual respect	1,5,6,7,14,16,17
	Feel respected	7,11,12,14,19,20,22,23,24
	Provider supports client dignity	7,16,20
	Feel valued	5,18
	Provider showing respect	8,11,13,20,22,24
Identity	Cultural identity and teachings acknowledged, valued, respected/identity not undermined/affirmation of identity	1,3,5,6,7,10,11,12,13,14,15,16,17,18,19,20,22,23,24
Empowerment and Equity	Partnership/negotiation/reciprocity/balance of power/equality/mutual/cooperation/equitable	1,4,5,6,7,10,11,12,13,15,16,17,18,19,20,22,23
	Client self-determination	5,6,11,13,17,18
	Client empowerment	1,3,5,10,11,15,17,18,19,22,23,24
	Client able to voice perspective/feeling heard	7,10,11,12,14,21,22,23,24
	Provider does not show attitude of superiority	1,2,3,4,5,7,8,11,13,14,18,19,20,22
	Client as equal partner in decision making/ involvement in decision making	6,7,11,14,15,16,20,22,23,24

Key Words, Concepts & Themes		Sources
Safety	Free of racism	2,11,13,14,17,18,20,22,24
	Feel safe	3,6,7,10,14,16,17,18,20,21,22
	Trust technical expertise of provider	16
Relational	Relational/connected	5,9,10,17,18,21,22
	Open-minded/flexibility	1,3,4,22
	Kindness/lateral kindness	11,12,13,22,23
	Caring/compassion	1,11,19,22
	Provider shows empathy	7,16,17,22
	Family included	24
	Provider recognizes diversity of Indigenous cultures and peoples	9,13,17,18,23
Reciprocity	Two-way health literacy, shared learning	5,6,11,13,14,16,17,22
	Provider shows open-mindedness, curiosity, interest, listening	1,4,8,11,13,15,17,22
	Provider shows understanding of colonialism and its impacts	1,3,7,9,13,14,18,19,20,23
	Effective communication	1,6,10,13,15,16,21,22,23,24

Sources (see References for full bibliographic information):

1. Baba, 2013
2. Allan & Smylie, 2015
3. Nursing Council of New Zealand, 2011
4. Baker & Giles, 2012
5. Yeung, 2016
6. Brascoupé & Waters, 2009
7. Health Council of Canada, 2012
8. Hook et al., 2013
9. McEldowney & Connor, 2011
10. Australian Human Rights Commission, 2011
11. Browne & Fiske, 2001
12. Hole et al., 2015
13. First Nations Health Authority, 2016
14. Tripartite Committee on First Nations Health Executive Working Group on Cultural Safety and Humility, 2016
15. National Aboriginal Health Organization, 2008
16. Mander & Miller, 2016
17. Williams, 1999
18. FASD Evaluation, 2012
19. Shah & Reeves, 2015
20. Goodman et al., 2017
21. Green et al., 2018
22. Gomersall et al., 2017
23. Simmonds et al., 2020
24. Australian Government, 2019

sharing knowledge · making a difference

partager les connaissances · faire une différence

ᖃᐅᔨᒃᑲᐃᖃᑎᒌᓃᖅ · ᐱᕚᓪᓕᖅᑎᑦᑎᓂᖅ

National Collaborating Centre for Indigenous Health

Centre de collaboration nationale de la santé autochtone

FOR MORE INFORMATION:
UNIVERSITY OF NORTHERN BRITISH COLUMBIA
3333 UNIVERSITY WAY, PRINCE GEORGE, BC, V2N 4Z9

1 250 960 5250
NCCIH@UNBC.CA
NCCIH.CA