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**MOVING
SYSTEMS TO
CULTURAL SAFETY**

Cover Page Artwork:

“A walking person, a route, a pathway in connection with nature and others.”

Author: Juan Carlos Rodriguez, 2019. jc.rodriguez@utoronto.ca

Waakebiness-Bryce Institute for Indigenous Health

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May 2019

Editorial

Moving and enhancing system change

All Indigenous peoples across the globe have experienced multiple historical colonial aggression and assaults. In Canada and the USA for example, education was used as a tool of oppression for Indigenous peoples through residential school. Child welfare, health and health care, and forced land relocation are also sites of intensive and invasive harms.

Health services continue to be a site of systemic and personal oppression for Indigenous peoples across Canada and the world (Reading 2013). For many years, Indigenous peoples have faced discrimination and racism when accessing biomedical health care. Implementation of colonization in Canada, Australia, New Zealand, and elsewhere, have been well documented to adversely influence aspects of health in many Indigenous communities worldwide and linked to high rates of mental health, education, and employment challenges (see Loppie & Wein, 2009; Mowbray, 2007; Paradies, Harris, & Anderson, 2008); these traumas are rooted attempts in cultural extermination and deep-set pains in regard to identity and well-being (Stout & Downey, 2006; Thurston & Mashford-Pringle, 2015).

In Canada, the Indian Act (1876) outlawed Indigenous healing practices and traditional healers, traditional healing ceremonies, such as sweat lodge, smudging, potlatch, and more, and the use of traditional medicines. These systemic legislative changes to Indigenous peoples' lives effectively made illegal the practice of traditional health and wellness for Indigenous peoples and replaced them with ineffective and underused biomedical mental health service (Loppie & Wein, 2009). Currently, healing and health promotion for Indigenous peoples who are surviving colonial traumas can begin through the reconnection and the relationship with current Indigenous traditional knowledge as well as through reducing experiences of personal and systemic racism and oppression within biomedical health care (Richmond, Ross, & Bernier, 2007).

Research by Stewart (2016; 2017) and others (Allan & Smylie, 2015; Smylie & Anderson, 2006) has shown a generally poor Indigenous experience of health and mental health services, despite efforts

to enhance cultural competency and culturally based service by Indigenous organizations and some biomedical community health centres and hospitals.

There has been an evolution of cultural care in Canada and worldwide. Despite well-meaning efforts to create cultural awareness and sensitivity, initially in the 1980s, among health care providers, little has been done to improve the health care system until Maori nurses in New Zealand introduced “cultural safety”. Papps and Ramsden (1996) described cultural safety as having knowledge about the context and culture of people who are culturally different from the self in a way that acknowledges and addresses social and political power inequities toward a goal of self-determination for the patient and decolonization for the health care provider.

Cultural safety is defined by Papps and Ramsden (1996) as high-quality health care for individuals of diverse ethnicities in that it addresses value and identity difference, uses empathic listening and speaking, and holds health care providers to self-reflection in this process, and has an overarching goal of empowerment, advocacy, and collaboration.

Researchers and practitioners in health have suggested that employing a Western paradigm of both health and education with Indigenous peoples is a form of continued colonial oppression...and this continues to perpetuate intergenerational trauma (see Gone, 2004; Smylie, 2001; Stewart 2008). Cultural safety as both a framework and practice offer both health researchers and practitioners an alternative to colluding with a current colonial biomedical western system. As with any new framework, prescribed goals and processes will be required to measure and consider its success.

However, it is urgent that these new program and evaluations, like the practice of cultural safety itself, be based in Indigenous cultural values and knowledges and not biomedical western edicts, as all these have successfully proven is that all western biomedical programs and interventions have not worked with Indigenous peoples everywhere in the world. This issue shares articles about programs and research that strive towards this type of resistance to collusion and an adherence to practice grounded in Indigenous knowledges and cultural safety.

Miigwetch/Thank you,

Dr. Suzanne Stewart & Dr. Angela Mashford-Pringle,
Co-Editors

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