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Acknowledging colonialism in the room: Barriers to culturally safe care for Indigenous Peoples

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Abstract

Indigenous peoples worldwide continue to face health inequities compared to non-Indigenous populations. Frameworks like cultural safety can be used to mitigate these inequities; however, this is not widely implemented in healthcare settings. Thus, additional research into barriers to providing culturally safe care are critical. To address this need, we examined the existing barriers to culturally safe care for Indigenous peoples in Canada, and Māori in Aotearoa New Zealand, through the perspectives of key informants. Major issues identified by key informants included systemic racism, lack of organisational accountability and/or buy-in, ineffective health-provider education, funding, health system structure, undervaluing Indigenous knowledge, negative framing, terminology, and changes to the concept of cultural safety over time. When examined closely, systemic racism and ongoing settler colonialism are the key driving forces underpinning many of the barriers identified. Findings from this research point to barriers at every level and require a system-wide, intersectoral approach in order to provide culturally safe care for Indigenous peoples and advance Indigenous health equity.

Keywords

Indigenous health, health equity, health services, cultural safety, settler colonialism

Indigenous peoples worldwide continue to experience health inequities and negative care encounters, due to the historical impacts of colonisation and continued colonialism (Jacklin et al., 2017; Reading & Wien, 2009). The health inequities arising from the effects of colonisation include poorer health outcomes, disparities in the social determinants of health, racism, and marginalisation within the healthcare system (Adelson, 2005; Goodman et al., 2017; Nelson & Wilson, 2018; Reid et al., 2019). While Indigenous peoples' experiences in Canada and New Zealand are distinct to their location, they both must contend with settler colonialism—a specific form of colonialism in which settlers not only stake claim to resources within the territory, but also seek to erase Indigenous peoples physically and socially in order to settle on Indigenous lands (Battell Lowman & Barker, 2015; Tuck & Wang, 2012; Wolfe, 2006).

Recently, two important reports demonstrate the pervasiveness of racism for Indigenous peoples accessing healthcare. In Aotearoa New Zealand (Aotearoa), the *Wai 2575* report presented evidence of alleged breaches of Te Tiriti o Waitangi within the health sector, including institutional racism, Māori health inequities, limited funding for Māori health services and lack of support for services in line with Māori traditional values (Came et al., 2020; Oda & Rameka, 2012; Waitangi Tribunal, 2019). In Canada, the *In Plain Sight* report presented a thorough examination of the health system in British Columbia and aimed to examine Indigenous-specific racism within the healthcare system (Turpel et al., 2020). The Truth and Reconciliation Commission (2015) called upon the Canadian government to reduce the inequities in health outcomes between Indigenous and non-Indigenous people and to implement cultural safety training. The *Wai 2575* report (Waitangi Tribunal, 2019) called for additional support of Māori organisations that design and deliver culturally safe services.

Originating in Aotearoa, the concept of cultural safety was developed by Irihapeti Ramsden, a Māori nurse and academic. Building on her early work that focused on enabling "considered analysis of the historical, political, social and economic situations that were continuing to impact on the health of Māori people" (Ramsden, 2002, p. 98), Ramsden further developed the concept with the intention for nurses to "become aware of their social conditioning and how it has affected them and therefore their practice" (Ramsden, 2002, p. 2). While the initial focus of Ramsden's work was on nursing students, the concept has been broadened and applied to all health professionals.

The definition of culturally safe care has been reinterpreted since its initial conception. It is defined in the *In Plain Sight* report as occurring when:

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

Culturally safe care has been shown to improve patient experiences by making patients feel supported, creating safe spaces, and increasing access to Indigenous knowledge, cultural teachings, ceremony, and more (Browne et al., 2016; Churchill et al., 2020). Through creating positive experiences for patients and mitigating barriers to effective care, cultural safety can help to address persistent health inequities (Møller, 2016). Additionally, both the *Wai 2575* (Waitangi Tribunal, 2019) and *In Plain Sight* (Turpel et al., 2020) reports acknowledged that the inadequate services delivered in culturally unsafe environments have direct, negative effects on health and wellbeing outcomes.

Despite the potential for culturally safe care to reduce health inequities, it has not been widely implemented in healthcare systems, and remains absent from health policy, despite calls for its

implementation (Truth and Reconciliation Commission, 2015). This research project explored the challenges associated with providing culturally safe care for Indigenous peoples of Canada and Māori of Aotearoa through the perspectives of key informants. We suggest that understanding the existing barriers is an important step to aid in the development of wise practices, identifying areas of improvement for health services, and increasing the quality of care for Indigenous peoples in both study locations.

Methods

This work is part of a larger study on culturally safe care for Indigenous peoples in Canada and Māori of Aotearoa that examined barriers to and opportunities for enhancing cultural safety in healthcare. This article focuses specifically on the research as it relates to barriers to culturally safe care. Ethics approval for this project was granted by the Lakehead University Research Ethics Board (approval #1468273).

A qualitative approach was chosen for this project to understand the complex relationships between the barriers, facilitators and contributing factors, including societal, cultural and political norms. The benefit of qualitative methodology for this project is captured by Hammarberg et al (2016), who write that "'qualitative methods are used to answer questions about experience, meaning and perspective" (p. 499).

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

Qualitative interviews (n = 13) were completed using Zoom software from November 2020 to March 2021. One interview contained two participants, for a total of 14 research participants. Interview sessions varied based on participant feedback and ranged from approximately 30 minutes to 1 hour and 45 minutes in duration.

Physicians, nurses, academics and organisational directors or leaders, hereafter referred to as key informants, were interviewed to understand the barriers to and opportunities for enhancing the provision of culturally safe care for Indigenous peoples. Semistructured interviews included questions to understand perspectives on defining cultural safety, access barriers, contributing factors, effectiveness of cultural safety education, implementation of cultural safety, and the next steps for cultural safety in a healthcare context. In this article, Indigenous peoples included First Nations, Inuit and Métis Peoples in Canada, and Māori of Aotearoa.

All interviews were audio and video recorded, transcribed and coded using NVivo 12 software. In addition, handwritten notes were taken to capture additional detail about tone, body language and other considerations that prompted later reflection (Creswell & Poth, 2017). These notes were used to support data stemming from interviews and as a starting point for further analysis.

Thematic analysis was guided by the framework developed by Braun and Clarke (2006) and followed an iterative process informed by grounded theory. Initial codes were developed based on

interview transcripts and accompanying notes and were reviewed and refined in subsequent iterations. Thematic nodes that emerged during analysis were structured around the key cultural safety objectives, as outlined by Ramsden (2002). The nodes were related to policy and practice, healthcare organisation structure, relationships and implementation of cultural safety.

Findings

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

Organisational barriers

In describing the existing barriers to culturally safe care, participants often described challenges at an organisational level. Several subthemes in relation to organisational barriers emerged, including policy and practice, and structural barriers.

Policy and practice

Participants discussed barriers related to policy and practice that prevent effective, culturally safe care within healthcare organisations and postsecondary institutions that train healthcare providers. A common theme among participants was a lack of organisational accountability, both within organisations and at a higher level. In many instances, participants referred to a need for external accountability for organisations through governing or regulatory bodies. This was seen as especially important because, as several participants suggested, regulatory bodies currently do not adequately hold organisations and healthcare staff accountable. This can in turn lead to lower standards across organisations, contributing to unsafe care. As one participant mentioned:

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

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

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

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

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

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

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

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

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

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

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

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

Structural barriers

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

In education, most participants identified issues with the way cultural safety is taught. Many participants mentioned that health-provider education is ineffective and inadequate, or misguided, inconsistent and not meaningful, among others. Several participants pointed to the structure of the education programs as a barrier. As one participant shared:

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

Another participant shared a similar sentiment:

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

Participants also took issue with the content and organisation of cultural safety training programs. Several felt that programs were not locally contextualised, applied a pan-Indigenous framework, and were therefore ineffective:

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

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

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

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

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

Another participant echoed this sentiment and shared:

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

Finally, participants also discussed how the structure of the healthcare system itself creates a barrier to culturally safe care. In many cases, participants referred to limited appointment times, an

emphasis on budgets, and a system that is run more like a business than a service with a focus on patient-centred care, which all create barriers to culturally safe care. Several participants shared comments to this effect:

> These systems are all so busy, overrun, under-resourced, so if it's not seen as a really important issue, nothing's gonna happen. (Participant #3, CAN)

> Whether it's the system … and how it is designed in a way which is transactional … that filters all the way down, I guess, to the doctor or the nurse who is told that they've got 20 appointments that need to be kept and filled and so the transactional part of care means that you can't necessarily practice culturally safe because some people need more of your time, and some people need less. (Participant #7, NZ)

In addition to these structural barriers, participants also identified barriers at a systemic level that often represent the distal cause of the organisational barriers.

Systemic barriers

Systemic barriers emerged through two subthemes: implementation of cultural safety and relations between Indigenous and non-Indigenous groups. These themes were additionally framed through discourse on Eurocentrism, systemic racism, undervaluing Indigenous knowledges, inequities, negative framing, attitudes, and understanding the historical, political and social context of Indigenous peoples.

Implementation of cultural safety

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

> It's bigger than culture and I always draw people's attention to the term "safety" that's in that definition. Those two pieces together, it's important that people understand why both terms are there in the definition. (Participant #3, CAN)

> In talking about that language, I think we still get caught up in using terms interchangeably and I know for myself, I don't correct people. People talk about cultural appropriateness, cultural sensitivity, cultural competence, and then cultural safety, and they seem to use those terms interchangeably. It just goes to show that learning has to catch up in some of those circles. (Participant #5, CAN)

> New Zealand sadly did move away from cultural safety, it now uses a language of cultural responsiveness. Personally, I think that's wussing out because for me it was around safety [keeping] people alive or dead … At the same time, the language of cultural safety is one that's so much easier for people to approach than racism, racism gets peoples' backs up so fast. (Participant #6b, NZ)

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

> Kawa Whakaruruhau, which Irihapeti Ramsden promoted, got taken from being a Māori concept and inclusive and got put into a box which was packaged and delivered out educationally to the

> wider nursing fraternity, but it was changed. It's—we call it a mauri, so its life force or its essence was changed from conception to policy writing in the way it got implemented. (Participant #10, NZ)

These challenges around the terminology of cultural safety and within the way people conceive of it represent fundamental barriers to implementing culturally safe care. The way the concept has been changed also speaks to the relationship between Indigenous and non-Indigenous people.

Relations between Indigenous and non-Indigenous peoples

Many participants specifically mentioned settler colonialism as a systemic barrier. They highlighted settler colonialism in the way that systems are designed and the procedures within them. As one participant explained:

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

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

> I think our education system has conditioned us, and all people, to believe that Indigenous people are inferior by denying or elevating the settler explorer history. (Participant #3, CAN)

> Our health system is set up to make Pākehā[1] ordinary, not Māori being ordinary, and that's the fundamental problem 'cause it just makes no sense the way the system runs, and you see it all the time when you interact with health services. (Participant #6a, NZ)

> Societal worldviews at the moment are normalised to seeing white people at the top and brown people at the bottom. We see it in the justice system, criminal proceedings, the way that police treat people, social profiling. (Participant #8, NZ)

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

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

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

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

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

> Our tōhunga were seen as our healers, our experts in that space … we had a tōhunga suppression act come in, in I think 1907—back in the 1900s—and aligning to that, we had the quackery act that came in at the same time. The quackery act for me was kind of the start of not being allowed to use rongoā Māori or the stuff that we know that is natural medicine for us, so that prevented a lot of things happening, and then they brought in Florence Nightingale's system. (Participant #9, NZ)

Overall, these comments highlight how the current model fails to recognise unique cultural backgrounds and perpetuates inequities against Indigenous people. For many participants, limited understanding of the historical, social and political context Indigenous peoples face also created a significant barrier. This was often connected to racial bias in the way that historical events have been presented, often in ways that present settlers in a more positive light. As one participant shared:

> I think New Zealand hasn't told those stories, they're not part of our national consciousness. We tell stories of Captain Cook arriving … and I mean we have street names here named after the Parihaka story,[2] street names of the politician who led the invasion. They get streets named after them and so if you don't know the story, you just think you live on Bryce Street. (Participant #2, NZ)

Another participant expanded on this with a specific example:

> Florence Nightingale was very anti-Indigenous peoples and actually her healthcare was about mopping their brow as they died … so effectively the model that she was operating on was around the extinction of Indigenous people … That's caused a whole lot of problems because people don't want to believe that Florence, who helped out in the Crimean war and helped many soldiers, actually was seeing the death and devastation of Indigenous peoples … that re-writing of history is incredibly important. (Participant #8, NZ)

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

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

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

As several participants shared:

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

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

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

As one participant shared:

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

Many participants shared examples of stereotypes that underpin these racist attitudes. Examples of stereotyping Indigenous patients and staff shared by participants were:

> We see the first question in ER is "How much do you drink?" and "Are you sure you don't drink?" by every person that they see through that healthcare journey. (Participant #3, CAN)

> For us, we've had a really tough last few years with the amount of social media abuse, like "Māori nurses sit on their fat a***s, grow weed and smoke drugs". (Participant #9, NZ)

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

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

Importantly, as several participants pointed out, this racism can also impact healthcare staff both as victims of racism and as challengers of racism. As one participant shared, it can be very difficult for staff to address racism within the health system, due to uneven power differentials:

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

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

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

Discussion

As both The Truth and Reconciliation Commission (2015) and Waitangi Tribunal (2019) highlight, health inequities between Indigenous and non-Indigenous people are significant and require immediate attention. Both reports have identified cultural safety as a key tool in addressing these inequities; however, as this research has demonstrated, the barriers to providing culturally safe care for Indigenous peoples are numerous and extensive.

Underpinning these barriers is the ongoing structure of settler colonialism.The intention of settler colonialism is to erase Indigenous peoples physically and socially (Wolfe, 2006), which has led to health disparities, an uneven distribution of benefits, and uneven power differentials (Wylie et al., 2021). This is important to consider when interpreting the results of this study because, as Nelson and Wilson (2018) write, "Indigenous people's reported barriers to accessing health care are not fully comprehensible without bringing settler colonialism into the analysis" (p. 22).

Barriers in organisational practice, lack of accountability, inadequate education, racism and discrimination, Eurocentrism, and challenges around implementation of cultural safety were all identified by key informants. A lack of accountability at the organisational level contributes to unsafe care environments. These comments were aligned with previous work that has also described the need for organisational accountability and mandates around cultural safety (Desouza, 2008; Wylie et al., 2021). To achieve cultural safety, Curtis et al. (2019) recommends "healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards achieving health equity" (p. 14).

Concerns raised by participants about healthcare provider education, including scope, the limited effectiveness of one-off training and the need for continuous learning, were also consistent with other work (Curtis et al., 2019; Desouza, 2008; Ewen et al., 2012; Sylvestre et al., 2019; Wylie et al., 2021). Limited diversity in education was brought up by participants, and while this was not specifically in reference to cultural safety education, it highlights an important gap in the educational system. Research has demonstrated that in Canadian universities, racialised and Indigenous professors are underrepresented, paid less than white professors and hired at lower rates (Henry et al., 2017; Ramos & Li, 2017). Similar data has been found in Aotearoa universities where from 2012 to 2017, the proportion of Māori academics was between just 4.2% and 5.1% (McAllister et al., 2019). This data suggests that the structure of the education system perpetuates racial hierarchies and facilitates biases by minimising the voices of racialised groups, which—when applied to postsecondary healthcare training—creates barriers to cultural safety education earlier in the process. It also suggests that educational systems have been developed and are governed by colonisers, which privileges coloniser ways of knowing while marginalising or ignoring Indigenous knowledge systems (Booker, 2020; Møller, 2016; Stanton, 2012). This is one of the many ways that settler colonialism continues to shape the experience of Indigenous peoples.

Overall, limited or ineffective cultural safety education does not adequately prepare providers to interact with Indigenous people, which results in a failure to address the biases healthcare providers may have and power differentials present within a healthcare setting. This leads to an unsafe environment for Indigenous peoples seeking care (Møller, 2016).

Several of the barriers mentioned by participants in this research also tie into larger issues of power differentials that lead to health inequities and are a key component of cultural safety (Browne, 2017; Dell et al., 2016; Josewski, 2012; Kurtz et al., 2018; Richardson, 2004). Because of racial bias and devaluing of Indigenous knowledges, healthcare spaces are often unsafe, leading to power imbalances where Indigenous peoples in staff and patient roles may be unable to speak out against racism (Harding, 2018; Kidd et al., 2020; Mpalirwa et al., 2020). This can also foster mistrust and impact care-seeking behaviours (Browne et al., 2011; Monchalin et al., 2020; Wylie & McConkey, 2019), all of which may exacerbate existing health inequities.

The examples of negative framing and stereotypes discussed by participants ties into the larger issue of negative societal perceptions of Indigenous people, which are ultimately built on a foundation of systemic racism. This systemic racism and negative perception of Indigenous peoples can be seen in press coverage on missing or murdered Indigenous women in Canada. In this media, Indigenous women are often subjected to dehumanising stereotypes, in contrast to missing white women, who have been often described with positive adjectives such as devout, caring and gifted (Gilchrist, 2010). This relates to the way that settler colonialism has positioned Indigenous peoples in relation to non-Indigenous peoples. In some instances, the impact of racism within the healthcare system may lead to devastating consequences (Allan & Smylie, 2015). Because of how deeply entrenched racism is within the structure of our healthcare system, it directly impacts healthcare experiences for Indigenous people, contributes to culturally unsafe care environments and undermines the quality of care for Indigenous peoples (Jacklin et al., 2017; Manhire-Heath et al., 2019; Reading & Wien, 2009).

Conclusion

This study has identified a host of barriers to culturally safe care for Indigenous peoples, based on the perspectives of key informants in Canada and Aotearoa.

To address the ongoing barriers to health equity faced by Indigenous peoples, a systemwide approach to change is required. When examined closely, systemic racism and ongoing settler colonialism are the key driving forces underpinning many of the barriers identified in this research. Cultural safety, however, seeks to disrupt the logics of settler colonialism by addressing unequal power differentials and forcing healthcare providers to confront their own attitudes and biases. To create meaningful change, a systemwide approach underscored by intersectoral collaboration is required. Improvements within the education sector, additional buy-in and accountability within healthcare organisations, broader implementation of cultural safety, and broader recognition of the impacts of anti-Indigenous racism are key components of a successful strategy.

If work can be done to address existing barriers identified in the current study and implement meaningful change through intersectoral collaboration, perhaps we can make progress towards dismantling the settler colonial system that continues to marginalise Indigenous peoples.

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[1] The term *Pākehā* is used to describe New Zealanders of European descent, or "white" New Zealanders.
[2] About 1600 troops invaded the western Taranaki settlement of Parihaka, which had come to symbolise peaceful resistance to the confiscation of Māori land. For more, see https://nzhistory.govt.nz/occupation-pacifist-settlement-at-parihaka