

Décolonisation des soins infirmiers en santé sexuelle pour les femmes autochtones

Janet Kelly

Les infirmières et infirmiers qui s'efforcent d'offrir des soins de santé de qualité aux personnes et aux communautés autochtones d'Australie, de même que de travailler avec celles-ci, sont confrontés à des difficultés particulières. En raison de politiques et de pratiques de soin de santé passées ou présentes à caractère discriminatoire ou ne répondant pas à leurs besoins, de nombreuses femmes autochtones et leur famille se méfient des professionnels de la santé et du travail qu'ils effectuent. Il est par conséquent essentiel pour les infirmières et infirmiers d'élaborer en collaboration avec leurs collègues et leur clientèle autochtones des méthodes de travail respectueuses et adaptées sur le plan culturel. L'auteure du présent article traite de la façon dont les infirmières et infirmiers du Canada et d'Australie se sont inspirés des théories féministes postcoloniales, des épistémologies et méthodologies autochtones, ainsi que des modèles de la sécurité culturelle pour mettre au point une approche décolonisatrice et mieux adaptée des soins de santé et de la formation. Deux exemples pratiques issus du contexte australien permettent à l'auteure de mettre en évidence les difficultés et les avantages de l'intégration d'approches décolonisatrices à la pratique. Les similitudes et les différences entre les deux cas indiquent clairement la nécessité d'approches décolonisatrices souples et adaptées.

Mots-clés : Australie, Autochtones, soins infirmiers, santé

Decolonizing Sexual Health Nursing With Aboriginal Women

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Nurses striving to provide quality health care for and with Indigenous individuals and communities in Australia face particular challenges. Past and present discriminatory or non-responsive health-care practices and policies have caused many Aboriginal women and their families to mistrust health-care professionals and practices. It is vital that nurses develop culturally safe and respectful ways of working in partnership with Aboriginal colleagues and clients. The author discusses how nurses in both Canada and Australia have drawn on critical and postcolonial feminist theories, Indigenous epistemologies and methodologies, and models of cultural safety to develop a more responsive, decolonizing approach to health care and training. Two practice examples from the Australian context highlight both the challenges and the benefits of incorporating decolonizing approaches into practice. The similarities in and differences between situations reveal a clear need for responsive and flexible decolonizing approaches.

Keywords: Australia, Aboriginal, Indigenous, nursing, health

Introduction

The need for quality, effective, and responsive health care for Indigenous people in Australia¹ cannot be overstated. Like most Western countries, Australia has colonized and marginalized Indigenous people in health care and society (Taylor & Geurin, 2010). A complex interaction of poor access to the social determinants of health, including poor access to responsive health care, has led to a disproportionately high incidence of ill health among Aboriginal compared to non-Aboriginal Australians (Taylor & Guerin, 2010). The startling reality is that although Australia has a world-class health service, there is a life expectancy gap of 10 to 12

¹ In Australia, Indigenous people may refer to themselves as Aboriginal, Torres Strait Islander, or Indigenous. They may also go by their local community/cultural name — for example, Kaurna (people of Adelaide City) or Yolngu (people of Arnhem Land in the Northern Territory of Australia). In this article I use the term “Aboriginal,” the preference of the majority of people involved in the study, and “Indigenous,” to refer more broadly to Indigenous people in Australia. Both the Aboriginal cultural group and individual authors of each Indigenous methodology are included. The words “Aboriginal” and “Indigenous” and cultural group names are capitalized, which is the usual practice in Australia and is considered respectful.

years between Indigenous and non-Indigenous people (Australian Bureau of Statistics, 2010).

While there have been many improvements over the last 30 years, unacceptable health inequalities remain. Successive governments and health services have attempted to improve the health status of Aboriginal and Torres Strait Islander people through a variety of approaches, but these have largely involved ad hoc, unsustainable programs, developed and implemented without the partnership or support of local communities. In response to ongoing concerns, the National Strategic Framework of the National Aboriginal and Torres Strait Islander Health Committee (2003) advocated for a partnership approach involving Aboriginal and Torres Strait Islander individuals, communities, and organizations. This approach was to be underpinned by concepts of shared responsibility, full collaboration, cultural respect, teamwork, localized decision-making, capacity-building, holistic practices, and comprehensive primary health care. The challenge for nurses was working out how best to put it into action.

This article considers how postcolonial feminist theories and Indigenous methodologies may help nurses to develop new ways of understanding and enacting partnerships and active decolonization. Examples are given to illustrate how Western theories and Indigenous methodologies can be respectfully combined to inform nurses in culturally safe practice.

The Australian Context

Australia's colonization of Aboriginal and Torres Strait Islander peoples, past and present, mirrors colonization in many parts of Canada, New Zealand, and the United States (Australian Health Ministers' Advisory Council, 2004). In Australia, initial violent clashes were followed by denial of personal, cultural, and land rights and discrimination and marginalization in society generally. Until 1967, Indigenous people were not formally recognized as citizens of Australia (Human Rights and Equal Opportunities Commission, 1991). Unlike in New Zealand and parts of Canada, in Australia there are no treaties to enforce standards of care and inclusion. For the last 200 years, the lives of Aboriginal and Torres Strait Islander people have been highly regulated, with many experiencing misguided and racist government policies and practices, such as having their children removed on the basis of race (Hampton & Mattingley, 1998). This denial of basic human rights led to a profound mistrust of health and support services, which continues for many Indigenous people today (Taylor & Guerin, 2010). Complicating the situation is the fact that most nurses currently practising in Australia have received little or no cultural

training in health care and education beyond basic “cultural awareness” sessions (Downing & Kowal, 2011). With such limited knowledge and training with regard to colonization effects, and with few strategies in place to counter the negative portrayal of Aboriginal people in the media, intercultural relationships in health-care settings often involve miscommunication and misunderstanding (Dwyer et al., 2011).

Let us now turn to two cultural models in use.

Cultural Awareness

In Australia, cultural training has predominantly drawn on a “cultural awareness” framework for educating workers about an “Other” Indigenous culture. This “recipe” approach has been limiting, for a number of reasons. First, the emphasis on teaching *about* Indigenous people and their health-care needs in a particular social-cultural context has fed into colonizing beliefs and stereotypes and has positioned Aboriginal peoples as having fixed and static cultures that are entirely knowable and visible to the observer. It has reinforced cultural difference and created a cultural chasm, leaving some nurses so confused and so hesitant about interacting with specific cultural groups that they avoid interactions with Indigenous patients (Downing & Kowal, 2011). Second, cultural awareness training avoids a critical gaze on the culture of health professionals and the health-care system itself, reinforcing the dominant ideology as the norm (Taylor, 2003). This can result in nurses having a false sense of “cultural knowledge” based on assumptions and misunderstandings, which they then incorporate into their practice (Browne & Varcoe, 2006). For example, a nurse may confuse the cultures of Indigenous peoples with the culture of poverty into which they have been driven (Ramsden, 2003, p. 6). Finally, cultural awareness without a critical reflective component enables racist and discriminatory practices to go unchallenged (Downing & Kowal, 2011). Also of concern in Australia is the heavy reliance on cultural awareness training for individual nurses and other health professionals as the main method for developing responsive cultural care, with little emphasis on organizational and structural change. This places unreasonable emphasis on individuals, when the underlying issues for access and equity are often of a systemic nature (Downing & Kowal, 2011).

Cultural Safety

Slowly, the emphasis of cultural training in Australia is changing to more critical and decolonizing approaches, with cultural safety being the model that has gained most traction in nursing. Cultural safety, a nursing model developed by Maori nurses in Aotearoa/New Zealand, promotes respectful partnership between a client and a nurse/midwife underpinned by social justice, critical, feminist, and postcolonial (neocolonial)

theories and treaty rights (Ramsden, 2002). Cultural safety focuses on the “knowledge and understanding of the individual nurse or midwife rather than on attempts to learn accessible aspects of different groups. It is based on the belief that a nurse or midwife who can understand their own culture and theory of power relations can be culturally safe in any context” (Nursing Council of New Zealand – Te Kaunihera Tapuhi o Aotearoa, 2002, p. 8). Thus, cultural safety is positioned beyond cultural awareness and cultural sensitivity. Instead of focusing on the learning rituals, customs, and practices of a group in a “checklist” approach, it alerts practitioners to the complexity of human, social, and political behaviours and interactions.

Maori nurses (particularly Ramsden, 2002) describe how many Pakeha (non-Maori) nurses and other health-care providers brought with them (often unconsciously) their assumptions, stereotypes, and prejudices from the dominant society, leading to unsafe care for Indigenous people, many of whom already viewed the health-care system with distrust. Ramsden encouraged Pakeha nurses to not blame the victims of historical processes for their plight but to question the issues impacting on their ill health and to be open-minded, flexible, and self-aware. Rather than caring for people *regardless* of their differences, she encouraged nurses to provide care *regardful* and in recognition of their differences and life circumstances (Ramsden, 2002). She sought ways to engage nurses and other health professionals and alert them to the colonial past and present but not lose them in historical guilt.

Many aspects of cultural safety are relevant to the Australian context, even though Australia, like many parts of Canada, is a multicultural rather than a bicultural society, with no treaties in place on which to measure commitment to improved health and social services for Indigenous people (Taylor & Guerin, 2010). The principles of social justice and decolonization embedded in cultural safety make it applicable and transferable to both countries. Recently in Canada, nurse researchers have explored cultural safety as a means to draw attention to power imbalances and inequitable social relationships in health care, promoting both systemic change and individual and practitioner change (Browne et al., 2009). In doing so, they have provided new perspectives on the complexities, ambiguities, and tensions inherent in transferring the concept of cultural safety to practice and have developed a knowledge translation process and strategy to enable nursing staff and administrators to critically reflect on the structures, discourses, and assumptions within their health-care system. This work and the theoretical frameworks being developed offer new understandings with respect to decolonizing approaches. In both countries, nurses have found a combination of postcolonial and

feminist theory and Indigenous methodologies most responsive to their needs.

Building a Decolonizing Theoretical Framework

Postcolonial and Feminist Theories

When nurses and other health professionals combine concepts of post-colonial theory and feminism, they create a powerful critical framework that enables a consideration of gender, class, socio-economic, and power differences in many forms, as well as in relation to colonization. Postcolonialism describes “issues of domination and colonization, race, racialization, culture and ‘Othering’ in Indigenous health and other settings” (Browne, Smye, & Varcoe, 2005, p. 21). When combined with feminism it leads to a broader humanistic approach that enables health professionals to work respectfully within the complex and multiple aspects of health care and equity.

However, a balance is needed between using social categories such as colonization, gender, age, skin colour, occupation, and class to explore and explain shared experiences of people experiencing similar social and historical events and stereotyping people as marginalized, disadvantaged, and/or victims by virtue of their social or racial standing (McConaghy, 2000). It is critical that we seek to understand the nature of specific oppressions at specific sites. By widening the theoretical possibilities, from *postcolonial* with an emphasis only on colonization, to *postcolonial feminism*, we run less risk of making assumptions about what is happening in any given health-care encounter. In presuming that there is a shared experience of colonization among Aboriginal women, health providers could overlook important differences, unique experiences, and personal agency.

In addition, both Aboriginal and non-Aboriginal and both health professional and community women are situated in complex and ambiguous positions, experiencing differing levels of capacity, resistance, and agency at different times and in different situations (Browne et al., 2005; McConaghy, 2000). Complex relationships and changing dynamics lead to intercultural health-care encounters that are rarely predictable or the same. Health-care interactions involve the coming together of two or more people, each with his or her own culture, history, priorities, and concepts of knowledge and power, either consciously or unconsciously. In order to understand this more fully, non-Indigenous nurses may benefit from shared Indigenous knowledge and methodologies.

Indigenous Methodologies

Indigenous methodologies offer non-Indigenous nurses new ways of understanding expectations and behaviours within intercultural health-

care interactions. In postcolonial Australia and Canada, Western and Indigenous epistemologies (ways of thinking) can be used together or in parallel in respectful and mutually beneficial ways. However, a distinction must be made between the two and how they interact in relation to the history of Western dominance (Browne et al., 2005). Postcolonial Indigenous discourse not only stems from Indigenous knowledge but also challenges non-Aboriginal people to re-evaluate their own colonial frameworks of interpretation, portrayals, and inclusion or exclusion of Indigenous knowledge (Smith, 2003). I will discuss two Aboriginal Indigenous methodologies that have been shared with a non-Aboriginal audience for the purpose of improving relationships in Australia and beyond (Ungunmerr, 1993; Yunggirringa & Garnngulkpuy, 2007). These methodologies provide nurses with pragmatic and decolonizing ways of levelling the playing field and sharing knowledge in intercultural interactions. The first is Ganma, or genuine knowledge-sharing, and the second is Dadirri, which involves deep, reflective, compassionate listening.

Ganma — knowledge-sharing. Ganma is a concept of genuine two-way sharing of knowledge between Aboriginal and non-Aboriginal people described by the Yolngu people of Arnhem Land in the Northern Territory of Australia (Pyrch & Castillo, 2001). It is a way for people from different cultures and backgrounds to share deeply without losing their integrity. Using a phenomenon that occurs naturally on their lands as a metaphor, the Yolngu people describe what happens when two different kinds of water or knowledges meet and mix together: A river of water from the sea (Western knowledge) and a river of water from the land (Aboriginal knowledge) engulf each other upon flowing into a common lagoon and becoming one. In coming together, the streams of water mix across the interface of the two currents and “foam” is created. This foam represents a new kind of knowledge that can be shared (Yunggirringa & Garnngulkpuy, 2007). “Essentially, Ganma is a place where knowledge is (re) created” (Pyrch & Castillo, 2001, p. 380). This imagery provides a conceptual framework for how Aboriginal people and non-Aboriginal nurses can work collaboratively in postcolonial Australia, mindful and in respect of their separate and combined experiences, backgrounds, and knowledges. Water, like knowledge, has memory, and “when two different waters meet to create Ganma, they diffuse into each other, but they do not forget who they are, or where they came from” (Pyrch & Castillo, 2001, p. 380). To give up or ignore one’s history is to risk losing one’s integrity; strength comes from understanding where we have been. Ganma describes ways that people can connect and work with each other “deeply” and respectfully, creating new knowledge that is not *yours* or *mine* but *ours*. Creating foam requires more than a joining of intellect

and egos; in order to hear the quiet sounds of foam, one needs to listen with one's heart, *to be aware of the experiencing, not just the experiences* (Yunggirringa & Garnggulkpuy, 2007). It involves a deep understanding of who we are, what we have to offer, and how we can engage with others in respectful relationships in postcolonial Australia. The first step involves listening deeply to each other.

Dadirri — listening to one another. Many Aboriginal people discuss the importance of deep, respectful listening and building connections with each other. Atkinson (2002) highlights the role of deep listening in healing and positive change in postcolonial Australia. She refers to the concept of Dadirri, an inner deep listening shared by the Ngangikurungkurr people of the Northern Territory. Dadirri is a quiet, still awareness, similar to contemplation (Ungunmerr, 1993). It is non-obtrusive observation, quietly aware watching, where people are recognized as being unique, diverse, complex, and interconnected, part of a community where all people matter and all people belong.

Dadirri is an inward as much as an outward journey, an awareness of one's own *beliefs, influences, assumptions, intrusions, decisions, and choices* and how these impact on health-care interactions. Dadirri can lead health professionals to "act with fidelity in relationship to what has been heard, observed and learnt" (Atkinson, 2002, p. 18), to understand the pain beneath anger, what a body says when a tongue cannot, and to listen with one's heart as well as one's ear. Using Dadirri, practitioners can acknowledge and support the courage and hope of people, to move beyond common (and often misguided) understandings, to add another layer of healing and responsiveness to health care. Both Ganma and Dadirri provide guidance for nurses on how to interact respectfully in intercultural situations.

Putting Theories Into Practice

I will now share my experiences of bringing together the concepts of Ganma and Dadirri, cultural safety, and postcolonial feminism in nursing practice, made possible through master's and doctoral studies in nursing from 2000 to 2011 and through clinical practice. These studies received ethical approval from the Aboriginal Health Council of South Australia, the South Australian Department of Health, and Flinders University. All stages were guided by an Aboriginal women's reference group comprising Elder and younger community women and Aboriginal health and research professionals. I will share two situations and challenges as well as my responses and reflections. The first involves working with a young Aboriginal woman in a remote location and the second involves supporting the attempts of an Aboriginal colleague to preserve her own cultural

safety and that of Aboriginal trainees during a time of organizational change.

Knowledge-Sharing in Clinical Practice

I have had the privilege of flying to a remote area of South Australia to provide nursing care at the same women's health clinic two to four times a year over 15 years. Relationships of trust developed over time between the local Aboriginal Elder women, Aboriginal health workers (health professionals who provide primary health care), and me. After a while, the women began to share stories of past colonization and negative health-care practices, including children being removed from their families, young women being given injectable contraception without their consent, and Aboriginal people being denied access to equitable health care and treatment options. These stories were told with the understanding that I would listen deeply (Dadirri), reflect, and conduct my clinical practice accordingly (using Ganma).

During one clinic, a young Aboriginal woman came requesting contraception. Being mindful of past negative practices, I began a two-way discussion regarding her level of understanding about her contraception options, her priorities and preferences, and whether she had any known medical issues. She indicated a general knowledge and no particular preferences and reported seeing a doctor recently after having fainted. I wondered aloud if the fainting event could indicate an underlying health concern that might impact on the contraception method she should choose and asked if she knew the reason for the fainting. She looked at me intently and paused. I could sense her weighing up the situation and I waited patiently (reminding myself of the importance of taking my time and listening to what is spoken and unspoken). After a while, she said, "Well, actually, it ended up that it was a cultural and spiritual thing, not a medical thing." She explained that the doctor at the local hospital had declared her medically fit and healthy but her family had determined that the fainting was spiritually linked and arranged for appropriate ceremonies to be held.

As she awaited my reply, I realized that what I said and did next would be a turning point in the consultation. Three options came to mind. I could ignore the spiritual aspect as not clinically relevant. I could ask curious questions about her spiritual experiences, which might not be appropriate for a non-Aboriginal person to ask. Or I could respectfully incorporate the information she was sharing into the discussion. With Ganma in mind, I chose the third option and inquired whether these cultural and spiritual aspects would impact on her choice of contraception method. I explained that if, for example, she took the contraceptive pill, her periods would come at set times rather than moon

times. She was not sure whether this would impact on her spiritual journey and said that she would need to speak with the Aunties (Elder women) about it.

Being also mindful of her immediate contraceptive needs, I then asked if she would like some condoms to provide immediate contraceptive cover until she was able to make a fully informed decision. She replied that her partner was a “Traditional man.” Again, I was unsure what the significance of this was, so I asked if her partner was okay with wearing condoms. She said she wasn’t sure but would take some and see. We discussed condom technique and the importance generally of women protecting against sexually transmitted infections as well as pregnancy. I told her about the high rates of chlamydia for all young people, regardless of cultural background and location. At the end of the consultation, the young woman left with contraception-option pamphlets and a supply of condoms.

On reflection, I felt that this consultation had provided opportunities for my clinical nursing knowledge and the client’s personal and cultural knowledge to swirl together in an intercultural knowledge exchange (Ganma). We had preserved and respected the integrity of our own and each other’s knowledges while creating new mutual knowledge, or foam — in this case, the contraceptive options most suited to her physical, economic, cultural, and spiritual needs. The concept of Dadirri had instilled in me the importance of taking the time to listen deeply and react carefully and respectfully to the information shared. Critical awareness of colonization and marginalization practices generally, and those involving the women of this community specifically, as well as knowledge about teenage pregnancy and infection rates, alerted me to the spoken and unspoken nuances of providing quality contraception options for this young Aboriginal woman. Supporting her wish to be fully informed, both clinically and culturally, while meeting her immediate and long-term needs was of great importance. There were also specific structural supports to ensure that the consultation was conducted in a culturally safe manner. The clinics were held within an Aboriginal Community Controlled Health Service, allowance was made for longer appointments, and a well-respected Aboriginal health professional was available for further discussion and contraception provision.

Between a Rock and a Hard Place: Cultural (Un)safety in the Workplace

The second example involves a culturally unsafe situation for an Aboriginal nurse colleague and trainees and my partially successful attempt to address it. Before beginning, I should provide contextual and background information, particularly for a Canadian audience. In Australia, many Aboriginal community groups and individuals hold

specific cultural values regarding single-gender gatherings. Multi-generational, single-gender meetings were traditionally, and in many places are still, held at designated times and locations. Single-gender camps held in more remote areas may stipulate that no person of the other gender be allowed within a certain distance of the campsite. The preference for single gender may or may not extend to health-education and health-care encounters, depending on the nature of the discussion or situation, the people present, and their relationship with each other. For example, in a recent study Aboriginal women from a remote area indicated that they would attend women's health screening or education sessions only if female practitioners were available and there were no men in the vicinity, whereas if the situation was life-threatening, or if there was only one specialist available, the need for care might take priority over gender — the specialist is then placed in a *genderless specialist role*; other women indicated that their relationship with a practitioner was more important than their gender (Dwyer et al., 2011).

The Aboriginal nurse colleague and I were in the early stages of organizing an Aboriginal women's reproductive and sexual health course for Aboriginal primary health care workers. My role as a non-Aboriginal nurse was co-writer and co-facilitator of the sessions on female anatomy and physiology. The Aboriginal nurse served as project coordinator. She worked closely with Aboriginal Elders, health professionals, and community women across the state of South Australia, designing a course that would meet their individual and collective training and cultural needs. In return, the Elder women invited her to take part in their women's ceremonies and gatherings. With this involvement came the expectation that she would uphold cultural values related to Aboriginal-specific discussions about sexual and women's health, both personally and in the workplace, which she did. The first two training sessions were well attended and were evaluated by the participants, some of whom were senior Elder women, as being culturally safe and respectful (Kelly, 2004).

Following this success, our health service employed an Aboriginal male health professional and began planning for an Aboriginal men's sexual health course. My colleague was asked to assist him with the planning. Being mindful of her cultural obligations, she determined that she could provide advice about the structure, process, and content of the course within the office environment without compromising her personal or cultural values. Some time later, however, a new team leader determined that the Aboriginal nurse should be present during the men's sexual health course to support the male worker, as this was common practice in the other (non-Aboriginal) sexual health courses. My colleague explained that it would be culturally unsafe for her to publicly position herself, as an Aboriginal woman, in an Aboriginal men's sexual

health course covering anatomy and physiology, sexual concerns, and infections. She had “danced with the Elders” and participated in specific ceremonies, and so could not be publicly involved in “men’s business.” The team leader disputed this, arguing that such strict gender rules were necessary only “out bush,” where men’s and women’s camps were held separately, and not in an urban location. The Aboriginal nurse and I put forward the argument that our statewide courses should meet the deepest cultural needs of all Aboriginal people attending from across the state, rather than follow the business-as-usual practices of our organization. In addition, we argued, Aboriginal employees should be encouraged to work in culturally safe ways, with their relationships and responsibilities to communities acknowledged and respected. These arguments fell on deaf ears and my colleague became more and more distressed as the date for the men’s course drew near, to the point where she contemplated resigning.

As a last resort, my colleague and I arranged for me to take her place in the men’s course. This would meet the organizational expectation that the male professional be supported, but because I was a non-Aboriginal woman the impact on cultural safety would not be as great. While neither of us was comfortable having any female health professional present during the Aboriginal men’s course, we felt powerless as employees and this seemed the best solution.

Our actions were not without repercussions. The next time I met local, city-based Elder women, they questioned my involvement in the men’s course and reprimanded me, saying that I should not have been involved (Kelly, 2009). I explained that we felt there were no other options, that it came down to either the Aboriginal nurse or I becoming involved. If it was the Aboriginal nurse, she would lose the support of her community and the Elders. If it was I, I might no longer be able to work in the area but I would not be losing the respect of my own community. The Elder women accepted my reasoning, saying, “Okay, but don’t do it again.” Then one of them said, “You’ve come a little bit over to where I am, for you to understand what we do and how we feel about things a bit. It’s not fair for someone to say, ‘You go back over the line and you don’t do what these people here tell you. You do what I tell you — I’m your boss’” (Kelly, 2009).

At that moment I was reminded that while the Elders understood and embraced the principles of Ganma and decolonization, our team leader did not. Following this meeting, the Elder women contacted our employers and met with them to discuss their concerns. A positive outcome was that a culturally safe approach for both staff and future participants was developed, largely due to the initiative of these Elder women.

As an employee, colleague, and nurse researcher collaborating with Aboriginal women, I was caught between a rock and a hard place. The act of Dadirri, deep listening, had enabled me to grasp the devastating impact of this situation for my colleague, her communities, and the course participants. As described by Atkinson (2002), once I had heard and understood, once I listened with my heart as well as my ear, I had an informed responsibility to act. The series of actions I took, however, were limited in their overall effectiveness. While they helped my colleague specifically, my involvement in the men's course threatened the very concepts of cultural safety that I meant to uphold. While in the end the Elder women intervened, with a good outcome, there was no mechanism in place for them to become involved earlier or for us to seek their assistance earlier. This example highlights the need for organizations and systems to embed the principles of community engagement and cultural safety into their employment, training, and everyday practice. Workers and nurses alone cannot uphold cultural safety; there has to be structural and policy support as well.

Discussion: Embedding Decolonizing Practices

Nurses in Canada and Australia face similar challenges in providing quality, responsive, and safe health care and access for Indigenous people. Past and present colonization policies and practices in both countries have significantly impacted on the health and well-being of Indigenous people and their willingness to engage with health-care professionals and systems. Many of the culturalist models currently in use in nursing education and health care focus on the perceived cultural beliefs and values of the "Other" instead of critically reflecting on health-care structures and approaches and the ideologies of health professionals and administrators. This has led to a continuation of inflexible and at times misguided health-care practices and policies (Browne et al., 2009; Downing & Kowal, 2011). Also, in Australia particularly, there is a reliance on narrowly focused cultural awareness training of individuals to resolve issues of access and inequity, without significant system and operational changes and without strategies to combat racism (Downing & Kowal, 2011).

In contrast, cultural safety is a cultural model specifically developed to address the social, structural, and power inequities that underpin health inequalities/disparities (Smye, Josewski, & Kendall, 2010). Although the model originated in New Zealand and is closely linked to treaty rights and biculturalism, its underlying principles of social justice and critical inquiry make cultural safety transferable and applicable to other settings and countries. Nurses in both Australia and Canada have begun drawing on cultural safety to develop new ways of addressing inequities and bar-

riers to quality health care for Indigenous people. However, structural and ideological barriers in both countries have impacted on the introduction of cultural safety into health-care education and practice. In Canada, Browne and colleagues (2009) found a need for a social justice curriculum for practice and a philosophical stance of critical inquiry at both the individual and the institutional level. In Australia, similarly, philosophical and fixed ideologies have at times curtailed the cultural safety potential of nurses and programs (Taylor & Guerin, 2010). Nurses in both countries are striving to overcome the barriers to putting cultural safety into practice, and there is great value in sharing knowledge and strategies between the two countries.

Bringing postcolonial and feminist theories and Indigenous methodologies together creates a theoretical framework to address ongoing oppression and complex intercultural interactions. An awareness of the differing levels of capacity, resistance, and agency among both staff and community members, and of new and shifting levels of access, offers insights into barriers and possible ways forward. Indigenous methodologies such as Ganma knowledge-sharing and Dadirri deep listening offer nurses and health services insights and strategies for enacting effective health care across cultures. These involve both interpersonal aspects of providing clinical care and training programs and the management and organizational structures and support needed to ensure that adequate time, space, policies, and training are provided. The importance of including Aboriginal people in true partnership and decision-making is clear.

Conclusion

This article has discussed the need for health care to be both flexible and responsive in order to meet the needs of Aboriginal individuals and communities in postcolonial Australia and Canada. Non-Aboriginal nurses who are mindful of past and present inequities, who adopt a theoretical framework such as postcolonial feminism informed by Indigenous methodologies, and who embed cultural safety strategies into their practice are well placed to move towards the decolonization and increased equitability and accessibility of health care.

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