Cultural safety and its importance for Australian midwifery practice

Author

Phiri, Jasten, Dietsch, Elaine, Bonner, Ann

Published

2010

Journal Title

Collegian

Version

Accepted Manuscript (AM)

DOI

10.1016/j.colegn.2009.11.001

Cultural safety and its importance for Australian midwifery practice.

Abstract:

Cultural safety is an important concept in health care that originated in Aotearoa (New Zealand) to address Maori consumer dissatisfaction with nursing care. In Australia and internationally, midwives are now expected to provide culturally safe midwifery care to all women. Historically, Australia has received large numbers of immigrants from the United Kingdom, European countries and the Middle East. There have also been refugees and immigrants from South-East Asia, and most recently, from Africa. Australia continues to become more culturally diverse and yet to date no studies have explored the application of cultural safety in Australian midwifery practice. This paper explores how cultural safety has evolved from cultural awareness and cultural sensitivity. It examines the importance of cultural safety in nursing and midwifery practice. Finally, it explores the literature to determine how midwives can apply the concept of cultural safety to ensure safe and woman centred care.

Key Words

Cultural safety; midwifery; women; Australian migrants, refugees

Introduction

Australia is a multicultural nation with migrants and refugees from over 200 countries who practice more than 115 religions and speak more than 180 different languages (Australian Department of Immigration, 2008; Australian Bureau of Statistics, 2007; Johnstone & Kanitsaki, 2007). Women accessing maternity services in Australia have very diverse needs and these may be unknown to the midwives providing care. The provision of culturally safe midwifery practice is essential if health outcomes for women and their newborn infants are to be optimised.

Cultural diversity may relate to social context, religion and/or gender, as well as ethnic background. The concept of cultural safety is a broad one that aims to identify and protect the culture of groups. Internationally, much has been written about transcultural nursing, cultural competence and cultural safety when providing nursing care (Baker, 2006, Betancourt, Green, Carrillo & Ananeh-Firempog 11; Chenowethm, Jean, Goff & Burke, 2006; De & Richardson, 2008; Johnstone & Kanitsaki, 2007; Leininger, 2002; Narayanasamy, 2003). There have been studies concerning the concept of cultural safety in human services. These studies have investigated the meaning of cultural safety and its evolution (Belfrage, 2007; Bin-Sillik, 2003; Dowell, Grampton & Parkin; 2001; Ramsden, 1993; Ramsden, 2002; Wepa, 2001; Wepa, 2003), cultural safety in health and nursing care (Chrisman, 2007; Jacobs & Boddy, 2008; Richardson, 2003), and the promotion of

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cultural safety when providing health care (Gilles, 2007; Hughes & Hood, 2007; Lipson, 2007).

Culturally appropriate nursing care has been widely explored in the literature (Belfrage, 2007; Chrisman, 2007; Purnell & Paulanka, 2003; Ramsden, 2002; Richardson, 2003; Wepa, 200, 2003, 2005) however it is not well known what has been written about midwifery and cultural safety. A search of multiple electronic databases, including CINAHL, MEDLINE, Health Science, SocINDEX, and Psychology and Behavioural Sciences, from 1980 to 2008 was carried out. This period is relevant when establishing current and salient midwifery research concerning cultural safety, as cultural safety emerged in the nursing literature during the 1980s. To facilitate the search, key words and terms, including *cultural safety*, *cultural competence*, *cultural respect, cultural security, immigrant, refugees* and *women* were used in conjunction with midwifery.

No previous research was located in the literature which specifically examined cultural safety in midwifery care. We were however able to locate six studies involving women from various multicultural backgrounds and their experiences of accessing midwifery care in Australia. These studies explored the midwifery care provided to Aboriginal and Torres Strait Islander Australians (Kruske, Kildea & Barclay); the experience of pregnancy, labour and birth of Thai women in Australia (Liamputtong & Naksook, 2004); Vietnamese, Turkish and Filipino women's views about care provided during labour and birth in Australian maternity units (Small, Yelland, Lumley, Brown

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& Liamputtong, 2002); antenatal care for African refugees (Carolan & Cassar, 2007); the meaning and experiences of motherhood among Afghan immigrant women living in Australia (Tsianakas & Liamputtong, 2007); and the perceptions of pregnant African women attending maternity services in Melbourne (Carolan & Cassar, 2008).

In all six studies women did not explicitly report or even imply feeling cultural safe and neither did the researchers discuss the importance of cultural safety. Given that no previous research was found, the remainder of this paper discusses how cultural safety has evolved and describes its importance for and application to midwifery care.

Concept of cultural safety

Cultural safety was developed in the context of nursing theory and is widely discussed in terms of health care practices (Richardson, 2003; Wepa, 2001). Cultural safety was introduced in Aotearoa/New Zealand in the late 1980s in response to improving Maori wellbeing, reducing the impact of colonisation and reducing culturally inappropriate practices in health care (Dowell, Crampton & Jeffs, 2001; Jacobs & Boddy, 2008; Papps & Ramsden, 1996). Maori health status was directly linked to colonising practices and the development of a culturally safe framework was primarily a political response to marginalisation (Johnstone & Kanitsaki, 2007). Influencing this ideology was the Treaty of Waitangi, which set up the impetus for power to shift from health care providers to health care recipients (Thompson, 2003; Wepa,

2001). Health service planning and delivery was to consider the cultural needs of Maori people in New Zealand.

The term cultural safety essentially concerns a broad understanding of respect, support, empowerment, identity and upholding human rights (Duffy, 2001; Grant-Mackie, 2007; Robb & Douglas, 2004; Richardson, 2003). Cultural safety has been identified as a framework that when used in nursing, midwifery and other health professions gives recognition to power imbalances, which are often inherent in relationships between health care providers and recipients (Dowd, Eckermann & Jeffs, 2005; Puzan, 2003; Ramsden, 2002). Cultural safety involves protecting beliefs, practices and values of all cultures.

To understand the concept of cultural safety, there is a need to first explore the meaning of culture, cultural awareness and cultural sensitivity. Culture has been defined as the sum or totality of a person's learned or behavioural traits, a complex whole that includes knowledge, beliefs, art, morals, customs, and capabilities acquired by a given group of people (Dowd et al., 2005; Nursing Council of New Zealand [NCONZ], 2005; Irvine, 2002; Ramsden, 2002; Wepa, 2001, 2003, 2005). Matsumuto and Jaung (2004) believe that culture is a concept that defines systems of rules, beliefs, attitudes, values and behaviours which are shared by a group, taught across generations, and are relatively stable although capable of change across time. In contrast, Schaller and Crandal (2004) argue that culture is dynamic and changing; it cannot be uniformly shared and people within any given cultural group may not know or

share the same cultural beliefs, morals and customs. We believe this is true in Australia, particularly as the multicultural population continues to rise (Australian Department of Immigration, 2008). Even when women share the same national heritage they are likely to be culturally diverse (Carolan & Cassar, 2008; Chalmers & Hashi, 2000; Wiklund, et al., 2000).

Evolution of cultural safety

The concept of cultural safety evolved from cultural awareness and cultural sensitivity (Ramsden, 1993; 2002; Richardson, 2003). Williams (1999) purports that cultural safety "extends beyond cultural awareness and sensitivity" and Eckermann et al. (2006) consider cultural awareness and cultural sensitivity as important foundations for the attainment of cultural safety. Figure 1 illustrates that cultural safety builds upon cultural awareness and cultural sensitivity in developmental stages. The midwife as a care provider ought to understand the practical applications of cultural awareness and cultural sensitivity in order to address cultural safety issues.

Figure 1: Cultural safety Developmental stages.

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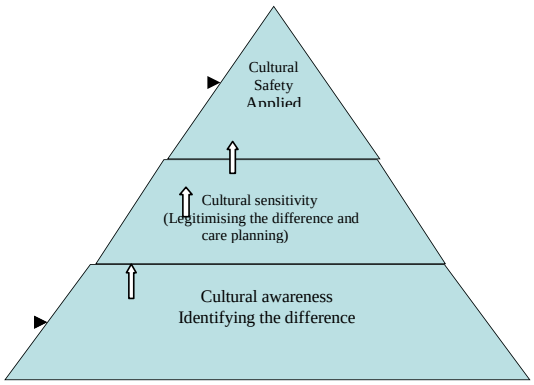

Cultural awareness, the first stage, involves the appreciation of diversity and understanding differences, particularly those cultural characteristics that are externally visible, such as dress, music and physical characteristics (Belfrage, 2007; Coffin, 2007; Rummens, 2003; Purnell & Paulanka, 2003; Charisman, 2007; Lipson, 2007). Being aware of cultural difference is considered the first step toward cultural safety (Ramsden, 1992). For instance midwives who are culturally aware ought to acknowledge that the women they provide care for have individual cultures, varied religious backgrounds and that these may have implications for their pregnancies, birthing expectations and requirements (Kennedy & Murphy-Lawless, 2003; Schneider, 2002).

Cultural sensitivity, the next stage, acknowledges the legitimacy of difference and then encourages self-exploration of personal attitudes to ensure they are not detrimental to an individual with a different background (Culley, 2006; Nursing Council of New Zealand, 2005; Robb & Douglas, 2004; Rummens, 2003; Wepa, 2001). For the midwife, cultural differences between the practitioner and the woman are identified and legitimised. This is achieved when midwives recognise that they are responsible for assessing and responding appropriately to the woman's cultural expectations and needs when planning care.

Dowd et al. (2005), Ramsden (2002) and Richardson (2003) agree that cultural safety is an extension of cultural awareness and sensitivity. They also acknowledge that while cultural awareness and cultural sensitivity are important, they do not facilitate culturally safe midwifery care. The application

of cultural safety ensures that culturally appropriate care centres on a woman's cultural requirements. The achievement of culturally safe midwifery care and its evolvement from cultural awareness and cultural sensitivity can be illustrated by using an example of a woman who prefers a female midwife. When a midwife identifies a woman's cultural need, that is being culturally aware. Planning the woman's care around her specific need for a female caregiver is being sensitive to her specific needs. When the organisation ensures the woman is not assigned a male midwife or any other male caregiver, they are practising culturally safe midwifery care. While the assigning of male midwives is not a standardised policy and procedure, it is an illustration of applying cultural safety. This action may appear small to an organisation, however it is important to a woman and her family. Coffin (2007) considers the action discussed in this illustration as one practical example of working with individuals to apply cultural safety.

Cultural safety centres, on the basic human rights of respect, dignity, empowerment, safety and autonomy. The term cultural safety was defined in 1996 by the NCONZ as the "effective nursing of a person/family from another culture by a nurse who has undertaken a process of reflection on their own cultural identity with recognition of the impact of the nurses' culture on nursing practice" (NCONZ, 1996, p 9).

Cultural security takes the concept of cultural safety a step further in that it legitimises and values cultural differences to ensure no harm is caused and ultimately links understandings and actions (Bin-Sillik, 2003; Coffin, 2007;

Richardson, 2003; Thomson, 2004). According to Coffin (2007), cultural security is the highest but hardest level to achieve; hence it is important for midwives to first achieve cultural safety when providing care to women. Cultural safety and security are two discrete entities but with a similar philosophical foundation (Andrews & Boyd, 2006; Chrisman, 2007; Mays, Siantz & Viehweg, 2002). However, for the purposes of this paper and in an endeavour to avoid confusion, cultural security is not explored further and the remainder of the paper examines cultural safety.

Australian Health

Johnstone and Kanitsaki (2007) argue that the health status of racial and ethnic minority groups, including immigrants and refugees, is poorer than that of the local population of the country they are living in. In Australia there are disparities in health among minority racial, ethno-cultural and Indigenous groups, and most recently, new immigrants and refugees (Allotey, 2003; Australian Bureau of Statistics [ABS] & Australian Institute of Health and Welfare, 2005 [AIHW]; Wepa, 2005). This is despite the fact that Australians are one of the healthiest populations and have access to a world class health system (ABS & AIHW, 2008; AIHW, 2007; Department of Health, South Australia, 2004).

It is fundamental to recognise inequalities that people face. Lack of recognition may result in culturally unsafe practice that is likely to lead to physical, emotional, spiritual, social and cultural damage to individuals, families and communities. Importantly, cultural safety concerns “the right to

have culture validated through teaching of health practice that does not put culture and values and beliefs of people at risk" (Wepa, 2001: 14). Recognition of inequalities experienced by Indigenous people since colonisation, new immigrants and refugees is fundamental when providing culturally safe care (Australian Indigenous Doctors Association, 2004; Allotey, 2003; Correa-Velez, Gifford & Bice, 2005; Spence, 2003).

Australia has failed to make substantial improvements in the overall health of the Aboriginal and Torres Strait Islander population (ABS & AIHW, 2005; Australian Indigenous Doctors Association, 2004). Life expectancy for Aboriginal and Torres Strait Islander (ATSI) Australians remains approximately 20 years lower for males and 19 years lower for females than non-Indigenous Australians (ABS, 2007; Allotey, Manderson & Reidpath, 2002; Centre for Culture Ethnicity & Health, 2003; Correa-Velez, Gifford & Bice, 2005). The overall gap between ATSI and non-Indigenous Australians continues to widen (ABS & AIHW, 2008). This health inequity is in contrast to New Zealand, which has narrowed the gap between Maori and non-Maori life expectancy to less than six years (Ajwani et al., 2003; Department of Health, South Australia, 2004; New Zealand Ministry of Health, 2004).

Variables contributing to life expectancy inequity relate to diverse and complex cultural expectations as well as physical and mental health problems. There is increasing evidence to suggest that culturally diverse populations in Australia do not receive an appropriate level of culturally safe care, (e.g. in

diagnosis, treatment, health promotion, preventive services), compared with the general population (Allotey, 2003; Correa-Velez, Gifford & Bice, 2005).

Cultural Safety in Nursing and Midwifery

Cultural safety is not synonymous with transcultural nursing. Transcultural, cross-cultural and intercultural care are, however, terms that are often used interchangeably and are primarily concerned with cultural interactions (Leininger, 2002; Robb & Douglas, 2004). These terms are predecessors to the principle of cultural safety. The concept of transcultural care was developed by the American nurse theorist, Leininger in response to a lack of understanding by nurses in the United States of migrants and their health needs (Leininger, 1984; Chrisman, 2007; Gillies, 2007; Lipson, 2007). Leiningers' theory acknowledged health behaviours and beliefs of those from different cultures, with a goal to provide culturally specific care. Although Leininger acknowledged that the health care ideologies of dominant cultures conflict with other cultures, her theory has been criticised for not recognising the possible power imbalances that exist between cultural groups (Purnell & Paulanka, 2003; Helman, 2001; Eckermann et al., 2006; Grant-Mackie, 2007). This is particularly the case when the dominant cultural group imposes health care practices and beliefs without consideration of another's beliefs or needs. In Australia, for example, Eckermann (et al. 2006) argue that when the colonists arrived, they took over and became a dominant group; forcing Indigenous Australian's to accommodate to a different world view. The application of cultural safety provides a framework to assist practitioners to legitimise the cultural differences of people and acknowledge that treating all

people in the same way will most likely result in inappropriate care (Anderson, Perry, Blue & Browne, 2003; Andrews, 2006; Ramsden, 1993, Ramsden, 2002; Wepa, 2001).

Cultural safety was integrated into nursing education in the 1990s, and is a requirement for registration in Aotearoa/New Zealand (Papps & Ramsden, 1996; Gage & Hornblow, 2007; Richardson, 2003; Wepa, 2005). The NCONZ incorporated cultural safety into nursing standards in 1992 as a specific requirement for nursing registration (NCONZ, 2005). Australia has followed suit and integrated cultural safety into nursing and midwifery curricula (Australian Nursing & Midwifery Council [ANMC], 2006; Department of Education, Science & Training, 2001; Gillies, 2007; Lusk, Russell, Wilson-Barnett & Rodger, 2001).

In Australia, midwifery students are expected to demonstrate competency in providing culturally safe care before they are eligible to apply for registration with the various state regulatory boards (ANMC, 2006; Australian College of Midwives, 2006). The Australian Competency Standards for the Midwife [ANMC], 2006) clearly states that midwives must ensure their midwifery practice is culturally safe (Domain 3, Competency 10). To provide culturally safe care it is essential that midwives respect and embrace the relationship between cultural safety and health outcomes for women from diverse cultural backgrounds.

Given the above, it is apparent that cultural safety has not received previous priority in nursing and midwifery curricula despite the push for holistic practice (Hughes & Hood, 2007). A recent qualitative study by Johnstone and Kanitsaki (2007) showed that nurses were not aware of the term cultural safety. With few exceptions, most of the participants had not heard of the term or understood the principles of cultural safety prior to receiving information about the project unless they had previously practised in New Zealand. Given the explicitly stated midwifery competency associated with cultural safety, it is highly likely that a similarly study to Johnstone and Kanitsaki involving midwives would presumably identify the lack of understanding of cultural safety in midwifery practice.

Cultural safety in midwifery practice

The process of moving toward cultural safety in midwifery must acknowledge the uniqueness of the relationship between a midwife and a woman. This relationship is enhanced when there is continuity of care. Eckermann et al. (2006) describe this unique interaction or relationship as a convergence of two cultures, that is the professional culture of the midwife and the culture of the woman. It is likely that this interaction will encourage the development of trust between a midwife and a woman (Saultz, 2003; McCourt, Stevens, Sandall & Brodie, 2006). It is this trust which enables women to form positive partnerships with their midwives.

The application of cultural safety to midwifery practice encourages midwives to evaluate power differentials and their impact in terms of their own individual

practice, and to reflect on the consequences of their actions. It takes courage to question innate practices, such as the inappropriate practice of treating all women the same regardless of cultural needs. Each and every woman accessing midwifery care in Australia should be individually assessed to identify relevant cultural needs and to ensure those needs are met.

The importance of the midwife establishing the woman's cultural needs during the assessment process is essential to the development of a culturally safe relationship. This skill has been discussed extensively in nursing care (Chrisman, 2007; Johnstone & Kanitsaki, 2007; Mays et al., 2002; Hughes & Hood, 2007). Individual women need to be carefully and considerately asked to define their own cultural needs. Deery and Kirkham (2006) and Chrisman (2007) advise nurses to move away from the Western derived biomedical discourse which is highly prescriptive and this advice is equally pertinent to midwives. Importantly, midwives must engage women individually and respond appropriately to a woman's cultural expectations and needs (Saultz, 2003; Walsh, 2007).

Midwives and nurses need to acknowledge that their position in the health care system, as well as their beliefs and experiences, may have an impact on women and how culturally safe or unsafe women feel (Irvin, 2002). Ramsden (2002) and Dowd et al. (2005) argue that the majority of nurses would be aware that individual people have different cultural backgrounds, yet nurses frequently do not incorporate individual cultural needs into routine practice. We also suggest that many midwives have also been socialised into

assuming control as part of their role as a health professional and may fail to identify and legitimise the cultural identity of the women they care for.

Strategies to help ensure culturally safe midwifery practice

Cultural safety puts the woman at the centre of midwifery care by identifying her needs and establishing a partnership built on trust. Culturally safe midwifery care strategies would incorporate optimal communication, building sound relationships and acknowledging women's cultural preferences. Clear, value free, open and respectful communication is fundamental in identifying and acknowledging the woman's requirements when planning care (Eckermann et al., 2006; De & Richardson, 2008; Ramsden, 2002). For example, providing culturally safe midwifery care for non-English speaking women in Australia can be challenging due to communication difficulties (Centre for Culture Ethnicity & Health, 2003). Previous studies (Carolan & Cassar, 2008; Straus, McEwen & Hussein, 2007) report that women who speak limited English feel removed from the management of pregnancy and birth processes due to their inability to communicate effectively with midwives and other health professionals. Establishing effective communication between a woman and her midwife is essential for determining how cultural safe care can be instituted.

Providing foreign language interpreters is an obvious strategy to improve communication with women who have limited ability to speak and/or understand English (Atkin, 2008; Bentham, 2003; Gray, 2008). There is, however, an overall scarcity of interpreters as well as a lack of suitable

interpreters for non-English speaking women accessing midwifery services in Australia and this may result in males being used as interpreters. Betancourt et al. (2003) found that a lack of a culturally appropriate interpreting service is associated with increased client dissatisfaction, poor comprehension, poor compliance, and ineffective health care. In particular, special care should be taken to ensure that male interpreters are not engaged to interpret for women whose culture prohibits male health professionals to be involved in midwifery care. For some women from diverse cultural or religious backgrounds, the sharing of gynaecological, pregnancy and birthing information is a highly sensitive matter. Some women may feel extremely stressed when sharing such information with males other than their partners (Burnett & Fassill, 2002; Harper-Bulman, 2002). Women who find themselves in this situation report feeling emotionally traumatised and disempowered; they find it extremely difficult to express themselves openly to males, whether the male is an interpreter, midwife or medical practitioner (McLeish, 2002; Islington Somali Community, 2000).

Building sound relationships with pregnant women is another important strategy in the provision of culturally safe midwifery care. The use of continuity of midwifery care would support the establishment of effective interpersonal relationships between a woman and her midwife. Midwives need to be alert to the possibility that some women settling in Australia may have undergone female genital mutilation (Chalmers & Hashi, 2000; Logan, 2007) or have been raped and sexually tortured (McLeish, 2002; Dietsch & Mulimbalimba-Masururu, 2006). These women are particularly vulnerable and feel more

traumatised if they receive care from multiple midwives. Continuity of care facilitates the development of trust and a positive relationship between the woman and her midwife (Homer et al., 2008; Walsh, 2007) and it is one practical strategy to apply culturally safe midwifery care.

The caseload midwifery model ensures that a woman receives continuity of care from the same midwife. This midwife would undertake through assessment including cultural requirements, and then plan cultural safe and appropriate care (Homer et al., 2008; Kennedy & Murphy, 2003; Stevens & McCourt, 2002). In fostering positive relationships, caseload midwifery practice facilitates the development of a complex interpersonal relationship between a midwife and a woman which is characterised not only by trust but also by a sense of shared responsibility as well (Saultz, 2003). We believe this model of care which ensures that a woman has a known midwife will enable the provision of cultural safe care.

As previously suggested, some women prefer female care providers (Carolan & Cassar, 2008; Tsianakas & Liamputtong, 2008); this is true for those women who have experienced female circumcision and female genital mutilation (Logan, 2007; Straus et al., 2007; Wiklund et al., 2000). Two previous studies (Bulman & McCourt, 2002; Chalmers & Hashi, 2000) have found that circumcised women perceived the practice of letting males provide care for them as harsh and offensive to cultural values. It is for these reasons that both health organisations and midwives are being encouraged to respond sensitively to such situations and provide women with cultural safe care.

Conclusion

As a matter of urgency, the strategies highlighted in this paper ought to be promoted to ensure cultural safety in midwifery practice. Midwives practising in Australia need to identify and acknowledge that cultural differences exist between themselves and all women. Cultural safety requires midwives firstly to engage in self reflection of their values, attitudes and beliefs in order to recognise that power imbalances occur during everyday midwifery practice. This should be followed by the establishment and implementation of a culturally safe, continuity of midwifery care model. Lastly due to the increasing multiculturalism of Australia, research is urgently warranted which examines the provision of culturally safe midwifery care in Australia.

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