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The United States Does *CAIR* About Cultural Safety: Examining Cultural Safety Within Indigenous Health Contexts in Canada and the United States

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Abstract

Purpose—This article examines the concept and use of the term *cultural safety* in Canada and the United States.

Design—To examine the uptake of cultural awareness, cultural sensitivity, cultural competence, and cultural safety between health organizations in Canada and the United States, we reviewed position statements/policies of health care associations.

Findings—The majority of selected health associations in Canada include cultural safety within position statements or organizational policies; however, comparable U.S. organizations focused on cultural sensitivity and cultural competence.

Discussion—Through the work of the Center for American Indian Resilience, we demonstrate that U.S. researchers engage with the tenets of cultural safety—despite not using the language.

Conclusions—We recommend that health care providers and health researchers consider the tenets of cultural safety.

Implications for Practice—To address health disparities between American Indian populations and non-American Indians, we urge the adoption of the term and tenets of cultural safety in the United States.

Keywords

cultural safety; participatory research; cultural competence

Cultural safety is a commonly used term within health care research and practice in Canada, New Zealand, and Australia (Aboriginal Nurses Association of Canada [ANAC], 2012;

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Brascoupé & Waters, 2009; Gerlach, 2007). Interestingly, despite many similarities in histories, governance, and health care systems between these three countries, health researchers and practitioners in the United States have not adopted the call for cultural safety. Though health researchers and practitioners in the United States frequently use similar sounding terms (e.g., cultural awareness, cultural sensitivity, and cultural competence), these terms lack cultural safety's political commitment to equity in health care research and delivery, which we argue is necessary to address health inequities between Indigenous and non-Indigenous peoples.

This article is a collaboration between Canadian and U.S. scholars that (a) examines the concept of cultural safety; (b) examines colonialism in Canadian and American contexts and the extent of the adoption of the term *cultural safety* by health professional organizations and researchers; (c) compares the uptake of cultural awareness, cultural sensitivity, cultural competence, and cultural safety between health organizations in Canada and the United States; and finally (d) demonstrates how (a major university's) Center for American Indian Resilience (CAIR), despite not using the term *cultural safety*, engages with the tenets of cultural safety through community-based participatory research (CBPR). To understand the nuances of cultural safety, in the next section we review cultural awareness, cultural sensitivity, cultural competence, and finally, cultural safety.

Review of Cultural Safety

Cultural safety is a concept that subsumes elements of cultural awareness, cultural sensitivity, and cultural competence (Brascoupé & Waters, 2009). Cultural awareness is essentially the basic acknowledgment of differences between cultures (ANAC, 2012; Baba, 2013). Cultural sensitivity builds on cultural awareness' acknowledgment of difference with the addition of the requirement of respecting other cultures (Baba, 2013). Cultural competence fuses both cultural awareness and cultural sensitivity to include the behaviors, attitudes, and policies that support effective work with diverse populations (Baba, 2013; Office of Minority Health, 2001). Cultural competence differs from cultural awareness and sensitivity by going beyond recognizing the "cultural other" and encouraging health providers and researchers to examine their own position, values, power, and culture. Brascoupé and Waters (2009) defined cultural competency as an educational process by which government and service providers develop their skills in applying cultural knowledge to the services they deliver. Despite its apparent strengths, ANAC (2012) noted that a significant limitation of cultural competence is the reduction of culture into a set of skills for which practitioners can gain knowledge. Furthermore, the focus in cultural competency is on learning rather than action.

The shortcomings of the aforementioned concepts and the blatant disparities between the health of Indigenous and non-Indigenous peoples led Maori nurse Irihapeti Ramsden (1993) to develop the concept of cultural safety. Papps and Ramsden (1996) argued that the goal of cultural safety is to challenge health care providers to recognize the various ways in which people experience life and understand the world. Ramsden and Spoonley (1994) encouraged health professionals to use cultural safety to analyze and address power relations among the individuals they serve. Gerlach (2007) explained, "in cultural safety terms 'culture' is

defined in its broadest sense and ‘safety’ is defined in relation to the responsibility of health professionals to protect their clients from anything which may risk or endanger their health and well-being” (p. 2). Cultural safety promotes the consideration of the historical, economic, and social contexts that affect an individual’s health care experience (Gerlach, 2007; National Collaborating Centre for Aboriginal Health, 2013). One important aspect of cultural safety is the practice of decolonization to address the legacy of colonialism. Decolonization efforts, such as the regaining of political, cultural, economic, and self-determination of Indigenous communities, are essential to improve the health of Indigenous populations (Mundel & Chapman, 2010). Decolonization efforts also include promoting indigenous languages to flourish at home and in educational settings to improve health literacy. The National Aboriginal Health Organization (2008) succinctly clarified that cultural safety “moves beyond the concept of cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and colonial relationships as they apply to healthcare” (p. 3)—and we would further add, to research.

Cultural safety is a concept that has gained traction among health organizations, professionals, and researchers in Canada, New Zealand, and Australia (ANAC, 2009; Brascoupe & Waters, 2009; Ellison-Lochsmann, 2003; Polaschek, 1998), but has not garnered as much support in the U.S. context. In order to examine the uptake of cultural safety, it is crucial to understand the impact of colonialism on Indigenous peoples. To further understand this issue, we briefly examine the colonial history of Aboriginal peoples in Canada and of American Indians and Alaska Natives in the United States.

Colonialism and Health in Canada and the United States

Colonial relations, both past and present, affect the health of Indigenous peoples. As Loomba (2005) stated, the process of colonialism varied across the globe, but ultimately original inhabitants and newcomers were forced into complex and traumatic relationships, which resulted in the colonization of Indigenous people in the United States and Canada and a long legacy of colonial practices. A recent example of a colonial practice in the Canadian context is Indian residential schools (Czyzewski, 2011). Indian children were forcibly removed from their families and placed in residential schools by child welfare agencies (Bennett, Blackstock, & De La Ronde, 2005). It was a system meant to civilize and assimilate Indian people and to “kill the Indian in the child” (Truth and Reconciliation Commission of Canada, 2015, p. 130). Equally destructive, the United States instituted boarding schools and forced or kidnapped American Indian and Alaska Native children from their homes to attend these schools (Lomawaima & McCarty, 2006). The fallout from the aforementioned practices, along with many other traumatic acts of colonialism, led to a horrific legacy for Indigenous peoples, including poor health.

Indigenous communities on the North American continent thrived on cultural knowledge and the experience of living in their traditional homelands and maintaining a quality of life connected to the natural environment prior to contact with Europeans (Cajete, 2000). Through ceremonies, tradition, storytelling subsistent living, and languages, identities were formed that promoted conditions of health that would be defined in contemporary times as “healthy conditions.” However, colonial moments in the U.S. and Canadian history include

the “European settlement, exploitation, and dominance of separate ‘others’ that transformed social organization, cultural convention, and private life” (Stoler, 2001, p. 839). Through the dominance and practice of European colonization on Indigenous people, contemporary Indigenous peoples continue to experience the historical trauma afflicted through these assimilative practices (Solomon & Randall, 2014). Nevertheless, despite these experiences in both Canada and the United States, Indigenous peoples have demonstrated high levels of resilience. This is not to say that issues related to poor conditions of health are nonexistent, but to say that Indigenous communities have resources, including kinships, language and culture, available to address these conditions.

Despite evident resilience, health disparities between Indigenous and non-Indigenous residents in both countries are pronounced. For this reason, there is more work needed in health-related fields to narrow and ultimately close the gap between Indigenous and non-Indigenous peoples’ health. One way to achieve this is to identify practices in health research and practice that bridge the knowledge systems between these communities to promote CBPR research, indigenous sovereignty, and practices that are considerate and respectful of Indigenous peoples—that is, those that demonstrate cultural safety, which embodies cultural awareness, cultural sensitivity, and cultural competence.

Method

To compare the uptake of cultural awareness, cultural sensitivity, cultural competence, and cultural safety between the United States and Canada, we performed a review of position statements and policies of major health care associations in both countries. A significant inclusion criterion for our search was that there had to be a U.S./Canada equivalent to the organization for comparison purposes. As a result, we reviewed 12 associations: the Canadian Medical Association, American Medical Association, Canadian Public Health Association, American Public Health Association, Canadian Nurses Association, American Nurses Association, Aboriginal Nurses Association of Canada, National Alaska and Native American Indian Nurses Association, Indigenous Physicians Association of Canada, Association of American Indian Physicians, Canadian Institutes of Health Research, and National Institutes of Health—Minority Health and Health Disparities. To identify the associations’ uptake of cultural awareness, cultural sensitivity, cultural competence, and cultural safety, we searched online through policies; policy statements; position papers; association objectives, missions, and visions; core competencies for various health care practices; practice guidelines; and key concepts promoted by the associations. We used the following search terms to identify these documents: *cultural awareness, cultural sensitivity, culturally sensitive, cultural competence, culturally competent, cultural safety, culturally safe, cultural relevancy, culturally relevant, diversity, culture, Indigenous, Aboriginal, First Nation, Inuit, Métis, American Indian, and Alaskan Native*. All the associations had policies or position statements related to at least one of the four concepts, except for the American Medical Association.¹

¹Policies or positions statements of the various associations are available in the following references: Canadian Medical Association (2002, 2014), Canadian Nurses Association (2010, 2014, 2015), American Nurses Association (1991, 2015), Aboriginal Nurses Association of Canada (n.d.), Indigenous Physicians Association of Canada, & the Royal College of Physicians and Surgeons of Canada (2009), Association of American Indian Physicians (2015), Canadian Public Health Association (n.d.), American Public

Cultural Safety Adoption in Canada and the United States

Our review revealed that all but one of selected health organizations in Canada included the concept of cultural safety within position statements or organizational policies; however, comparable U.S. organizations focused on cultural sensitivity and cultural competence. Table 1 reviews the policies and practices of comparable Canadian and U.S. organizations.

Cultural Safety Uptake

U.S. health care organizations have not adopted the term *cultural safety* to the same extent as Canadian organizations. Although it is impossible to determine the exact reasons for this, below we explore two possible reasons: (a) historical and political factors and (b) the tenets may actually be put into practice but the language around cultural safety may not (yet) be used.

One reason why U.S. health care organizations have not adopted the concept of cultural safety as readily as Canada may be rooted in historical and political factors. The experience of colonization in the United States is somewhat different from in Canada. Canada is a Commonwealth country, whereas the United States is an independent nation. Therefore, Canadian residents' experiences of being governed from afar and their clear and ongoing connection to an imperial power (the United Kingdom) continue to this day. Because cultural safety is discussed and rooted in terms of colonialism (Reimer Kirkham et al., 2002; Smith, 1999; Smye & Browne, 2002), academics and scholars in the United States may not relate to cultural safety, or may not as readily identify the need for a process of decolonization in health care. Challenging existing power structures through the practice of cultural safety can result in both social and political consequences that organizations may not be willing or prepared to confront (Brascoupé & Waters, 2009; Ramsden, 2002). Indeed, the call to decolonize existing health care systems is politically charged in that they are predicated on the acknowledgment that existing systems are failing specific populations.

Second, we suggest that tenets of cultural safety may actually be adopted within the U.S. context, but the language used in articulating it may not engage with the term. For example, some organizations that state that they are engaged in the promotion of cultural competence may in fact be engaged in supporting culturally safe approaches to health care and research. The first author's experience with CAIR as a visiting scholar from Canada led us to believe that this explanation was the most likely. To investigate this argument, we draw on the research and praxis of CAIR.

CAIR, a collaborative effort between Northern Arizona University, the University of Arizona, and Diné College, is funded through a National Institutes of Health–National Institute on Minority Health and Health Disparities as an Exploratory Center of Excellence. The objective of CAIR is to support resilience building by (a) examining of community assets, including traditional knowledge, collective memory, and cultural strategies in teaching health behaviors and, supporting positive health outcomes; (b) documenting health

Health Association (2000, 2006), National Institutes of Health (2015), American Academy of Family Physicians (2015), Institute of Aboriginal Peoples' Health. (2013).

strategies and positive behaviors that are often not examined and recognized within public health research; and (c) integrating tribal Elders' wisdom, knowledge, and experience into current education and health promotion interventions. CAIR's members are committed to community engagement and community-based partnerships with American Indian communities in the southwest. Through this commitment, the Center supports and builds community capacity to develop and disseminate what it describes as "culturally competent" resources and programs to improve health outcomes. CAIR focuses on applying a resilience approach to health promotion and health policy. As such it defines resiliency as

The ability to move forward like a willow with renewed energy, with a positive outlook with attainable goals to achieve one's dreams, and overcome negative life experiences from current and past political and historical events, with the goal to reduce health disparities among American Indians.

In the next section, we will provide examples of how CAIR, through CBPR and assets-based approaches to examining resiliency, engages with the main tenets of cultural safety, despite not using the term.

CAIR and the Uptake of Cultural Safety

CAIR's engagement with cultural safety stems from its following practices: the use of CBPR, the acknowledgment that American Indian epistemologies differ from mainstream medical and health promotion models, the promotion of decolonization of research through a focus on resilience of American Indians, acknowledgment of tribal sovereignty, and finally, the transformation of public health education, practice, and policy through knowledge translation efforts.

CBPR and CAIR—One way to ensure that research is relevant for communities is to engage in CBPR, which is the approach CAIR researchers take (Banks et al., 2013). CBPR, if conducted in a manner that remains true to its tenets, has been identified as an approach that can address and reduce health disparities (Andrews, Newman, Cox, & Meadows, 2011). CBPR can promote the acknowledgment and validation of differing epistemologies, which is crucial in providing culturally safe care and, we argue, conducting research that is relevant to Indigenous populations' health.

One of the main tenets of cultural safety is to recognize and address unequal relations of power (Brascoupe & Waters, 2009), which is also a goal of CBPR (Banks et al., 2013). Within CAIR, community members are equal partners in the research process from the initiation of the research question to the development of a manuscript. The relationships between the various stakeholders are crucial to the effectiveness and outcomes of the work. In many cases of CBPR, the equitable relations of power between all stakeholders do not go beyond rhetoric (Castleden, Mulrennan, & Godlewska, 2012). CAIR, however, remains true to the goals of CBPR. The community members involved in each project determine the issues and are major contributors to developing solutions and strategies grounded in community knowledge—therefore meeting the standard for cultural safety. As National Aboriginal Health Organization (2008) stated, cultural safety "within an Indigenous context means that the educator/practitioner/professional, whether Indigenous or not, can

communicate competently with a patient in that patient's social, political, linguistic, economic, and spiritual realm" (p. 4).

The democratizing of the research process is also evident through the engagement with American Indian communities and through CAIR policies. One such policy ensures that whenever a project is presented at an academic or community conference, a member of the research team and a community representative co-present the work. Furthermore, dissemination of research findings requires approval and official "sign-off" from all partners with regard to whom, how, and the target audience to which the information is disseminated. CAIR's commitment to the democratization of knowledge production is further enhanced with a focus on supporting and developing community-based American Indian researchers, including students. The training of community members can result in the strengthening of the skills and assets within a community and can provide bidirectional benefits for both community members and researchers.

Reflexivity is an essential component of CBPR; it is also central to cultural safety (Ramsden, 2002). Reflexivity is a bidirectional process to identify, understand, and address challenges around personal, professional, and political issues that may arise in the research process (Alley, Jackson, & Shakya, 2015). CBPR requires reflexivity throughout the research process, ensuring that researchers seriously reflect on their positionality and its effects on the research. Banks et al. (2013) suggested that to address positionality, joint research workshops and training sessions with a wide range of stakeholders aid in the development of "mutual understanding and share different assumptions, experiences, knowledge, and skills" (p. 275).

Similar to CBPR, reflexivity within cultural safety aims to ensure that researchers or health care providers reflect on their positions and how they may influence outcomes (Wilson, 2014). CAIR hosts meetings and workshops that bring together researchers and community members to develop the skills of all stakeholders and to understand the issues as they pertain to both parties. Specifically, new investigator partnership workshops, hosted annually, support community-based researchers with both financial and human resources. New investigators (who include both established researchers and community members) are mentored by senior CAIR research leaders to learn asset- and resilience-based approaches to designing collaborative health promotion projects. All the projects are overseen by CAIR's Community Advisory Board (CAB) and Executive Advisory Board (EAB), which provide support, input, and guidance on all CAIR-related projects. The CAB and EAB meet four times per year, and composed of American Indian health leaders, researchers, and health care professionals who serve and represent tribal communities. Both EAB and CAB meet face-to-face once a year with CAIR investigators, students, and new investigators. The CAB and EAB ensure that American Indian values are respected throughout the research and health promotion efforts' development and dissemination.

Differing Epistemologies—CAIR acknowledges that American Indian epistemologies differ from mainstream medical and health promotion models. This recognition and the subsequent steps taken to address American Indian understandings of health ensure that the research outcomes are more likely to meet community members' needs and the tenets of

cultural safety. Mainstream health research agendas run the risk of further marginalizing peoples by ignoring Indigenous world-views and epistemologies.

Through its dedication to CBPR and principles of cultural safety, CAIR ensures the development of creative resources in local languages and contexts. Two excellent examples of this are digital storytelling and a children's book about renal dialysis, both of which were student-supported research projects. In the first project, four American Indian individuals and their families were brought together to create digital stories of resilience about their experiences living with a disability (CAIR, n.d.). A collaborative process engaging participants in storytelling resulted in illuminating narratives of the intersections between culture, education, and disability. Through the storytelling format participants also shared coping with the process of acceptance, loss, denial, and diagnoses of having a disability. Each individual was then trained how to use technology to produce their narrative into a digital story. The stories produced are narratives that counter the deficit-based, stigmatizing ideologies of disability and speak of personal assets that each individual found to identify resilience. Each participant increased his or her awareness of his or her own resilience, thus increasing self-advocacy.

A second project completed by an American Indian student through CAIR was a video teaching patients and physicians about culturally competent care with American Indian populations. The video aims to teach health professionals how to provide appropriate care while simultaneously teaching American Indian patients to be engaged and empowered through interactions with health professionals, both aims that align with principles of cultural safety. Brascoupé and Waters (2009) conceptualized cultural safety "as a paradigm shift focuses on the role of the recipient, not as a passive receiver of services, but a powerful player in a relationship" (p. 12); clearly, such a video aims to achieve cultural safety through a realignment of relations of power between American Indian patients and non-Indigenous doctors.

The emphasis of CAIR members' research is to create tangible and measurable benefits for the community, which is directly in line with goals of cultural safety to enhance the care for marginalized peoples and improve overall health outcomes (Brascoupé & Waters, 2009). The aforementioned CAIR projects demonstrate the uptake of culturally safe tenets through community involvement through every phase of the project. This engagement ensures that the needs of the community are addressed and that issues of power are constantly assessed.

Decolonization Through Resilience—CAIR promotes the decolonization of the research process through focusing on the resilience of American Indians. Through an assets-based approach to research and health promotion, the CAIR research model moves away from more paternalistic, deficit-based models of research and health care (Oberly & Macedo, 2004). Smith (1999) argued that problematizing Indigenous people in research negatively affects Indigenous peoples. Tang and Browne (2008) raised the issue that epidemiological profiles of marginalized peoples, specifically Indigenous women in Canada, can further stigmatize and pathologize people. CAIR's focus on American Indian resilience is a novel approach to improving the health of American Indians by focusing on the success

of individuals and communities. Decolonization and challenging colonial, paternalistic ways of conducting research align with tenets of cultural safety.

CAIR also aims to transform public health education, practice, and policy. Cultural safety involves challenging existing systems that oppress marginalized peoples (ANAC, 2009). CAIR's innovative assets-based approach to research has unveiled how American Indian individuals and communities define and draw on resilience. The focus on resilience and positive outcomes through this work challenges the status quo of typical Western research approaches. CAIR's asset-based approach and findings have and continue to be translated into culturally safe health promotion strategies and tools that can be adopted by other communities. One such tool that was developed under the CAIR umbrella was the "Toolkit for Community-Engaged Wellness Mapping" (Hardy et al., 2014). This tool was developed as part of a CBPR approach to data collection as well as capacity building between researchers and community members. Community-engaged wellness mapping requires the participants to create a map with symbols, stick figures, words, color-coding, and so on, of everything they associate with wellness in their communities. The map provides a starting point for discussion and data analysis. Hardy et al. (2014) explained the benefits of this mapping toolkit as a time effective way to gather a variety of data from a group of participants. This resource allows for the "elicitation of unanticipated data" (p. 6) and enables researchers to connect with participants who may otherwise be unlikely to share their thoughts. The authors further pointed out that this tool allows new researchers with limited training to engage in the research processes of data collection and analysis. Such a tool reveals what community members identify as strengths and resilience within their own communities. Thus, CAIR directly and indirectly challenges stereotypical images of American Indians and structural racism, clearly demonstrating a culturally safe approach to health care.

Transformation of Public Health Through Education—Perhaps one of the most important ways in which CAIR promotes cultural safety in health is through the promotion and encouragement of more American Indian peoples entering into the health field. CAIR supports and leads the Summer Research Enhancement Project Program where 12 to 15 American Indian undergraduate students ranging in age from 19 to 30 years come from various tribal community colleges and state community colleges and/or universities. The students attend a 10-week fully funded internship at Diné College on the Navajo Reservation to develop their skills to conduct research pertaining to health promotion and disease prevention. In the first phase of the program, students receive intensive training in public health, ethics and research methods, epidemiology, statistics, resilience, and health promotion and disease prevention approaches. The second phase of the program places the students in internships in or near their home communities at health care or educational institutions where they participate in various ongoing public health and health research-related projects and collect data related to their research. The third phase of the program requires that all the students return to Diné College to learn the skills to analyze the data they have collected in their communities. The students present their findings to community members and academics and share their experiences with the program on the final day of the program. In 2015, several students created resilience digital storytelling about their

educational journey. This program demonstrates CAIR's commitment to the preparation of American Indian students for careers in public health and health research, which will in turn strengthen and benefit American Indian communities. With more American Indian students in public health and health research, there is increased likelihood that culturally safe care and research will be carried out because of their personal knowledge and lived experiences. Thus, despite describing itself as promoting cultural competence, it is clear that CAIR goes beyond cultural competency and engages with cultural safety.

Advancing Cultural Safety in the U.S. Context

CAIR is in a unique position to advance cultural safety in the U.S. context. The initiation of the discussion of cultural safety within the United States is the first step in acknowledging the importance of this concept for Indigenous populations and for health care providers and researchers. Cultural safety has been brought to the forefront of health care and research discussions within Canada, New Zealand, and Australia, and the benefits for advancing the tenets of this term are evident: addressing respect for cultural forms of engagement, addressing power issues and structural inequities, improved care for Indigenous peoples, and ultimately improved health outcomes.

As such, we suggest identifying nursing leaders who understand and value the language and tenets of cultural safety to create a task force to garner support for cultural safety in a U.S. context. Furthermore, it would be crucial to identify organizations such as National Alaska Native American Indian Nurses Association (NANAINA, n.d.) or National Association of Indian Nurses of America (NAINA) and community-based nurse researchers who work with Indigenous populations to lead the task force. We suggest that the task force review the steps taken and literature developed by organizations within Canada, New Zealand, and Australia to promote and standardize cultural safety in nursing. The task force could then solicit endorsement from other key nursing organizations, culminating in the development of core competencies for nursing students to formalize cultural safety in nursing education.

Certainly, in the United States there is the need to go beyond culturally competent health care and health-related research. Evidence of ongoing health disparities between American Indians and non-American Indians show the necessity of using new approaches to address this persistent problem. Indeed, there is a need to closely analyze power differentials, institutional discrimination, and historical factors that have shaped and continue to shape health outcomes for American Indian populations.

Conclusions

To address health disparities between American Indian populations and non-American Indians in the United States, health care providers and health researchers must consider the tenets of cultural safety in both health care and health research. It is evident that there are inconsistencies in the language around cultural safety. As identified in our examination of health organizations, there is varied use of the terms *cultural awareness*, *cultural sensitivity*, *cultural competency*, and *cultural safety*. We argue that the adoption of the term *cultural safety* might more accurately capture some of the research that is being conducted and

health care that is delivered in the United States, or serve as a best practice toward which researchers and practitioners can aim. Culturally safe researchers and health care providers demonstrate a strong commitment to decolonization and equity in health research and delivery, both of which are needed to address current health disparities experienced by American Indians.

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Table 1

Cultural Awareness, Cultural Competence, and Cultural Safety Organization Comparisons.

Organization	Cultural awareness	Cultural sensitivity	Cultural competency	Cultural safety
Canadian Medical Association	✓	✓	✓	✓
American Medical Association	×	×	×	×
Canadian Public Health Association	×	✓	✓	✓
American Public Health Association	×	✓	✓	×
Canadian Nurses Association	×	✓	✓	✓
American Nurses Association	✓	✓	✓	×
Aboriginal Nurses Association of Canada	×	✓	✓	✓
National Alaskan Native American Indian Nurses Association	×	✓	×	×
Indigenous Physicians Association of Canada	✓	✓	✓	✓
Association of American Indian Physicians	×	✓	×	×
Canadian Institutes of Health Research	×	✓	×	×
National Institutes of Health—Minority Health and Health Disparities	×	×	✓	×