Title

Exploring the Experiences of Basque Women and Gender Non-normative Individuals with Healthcare in the Basque Country: A Critical Ethnography

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Exploring the Experiences of Basque Women and Gender Non-normative Individuals with Healthcare in the Basque Country: A Critical Ethnography

by
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Dedication

This work is the result of a journey of accumulated experiences, knowledge transmission, and resilience passed on throughout generations which have given me the strength and motivation to complete this manuscript hoping that it will open a path of healing and understanding to present and future generations.

I would especially like to thank all the women who have guided me and cared for me throughout this journey. From our ancestors who were burned at the stake for refusing assimilation and are a constant reminder of the importance of staying truthful to who we are, to the women of the Basque diaspora who through the transmission of our culture and language gave me, and so many others, roots and a home away from home, and to all Basque women in the Basque Country who continue fighting for freedom in all aspects of their lives, I am endlessly grateful.

To the feminist and LGTBI+ rights movements who have helped me understand and question the established order and have opened the door for so many people worldwide to dream outside of restrictive and oppressing sexual and gender norms, this work would not have been possible without the historical and current contributions made by these movements, which I deeply appreciate.

Next, I would like to thank Indigenous communities globally for helping me understand and identify the actions and consequences of colonialism, as well as our shared history of trauma, resistance, and survival. It is essential to acknowledge that we are still here, and that we are not alone. Finally, I dedicate this work to all the Indigenous communities that were annihilated or forced into assimilation. May our recognition today help the world appreciate the significance of revitalizing Indigenous cultures and languages in the path to decolonizing our bodies and minds.

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My gratitude extends to the Faculty at the UCSF PhD Nursing program and the Social and Behavioral Sciences Department for the funding opportunity to undertake my studies. My appreciation also goes to the *Leavitt Scholarship Award*, *Harrington Health Policy Scholarship***,** and *Consejo General de Enfermería* who have provided funding for this study. A special thank you to all participants who so generously shared their time and stories that made it possible to complete this work. Finally, I am deeply grateful to my friends and family. Without their understanding and encouragement in the past few years, it would have been impossible for me to complete this study.

Exploring the Experiences of Basque Women and Gender Non-normative Individuals with Healthcare in the Basque Country: A Critical Ethnography

Garbiñe Elizegi Narbarte

Abstract

Background: Ethnic minority women, including Basque women, experience communication and language problems, as well as cultural discrimination during healthcare encounters compared to non-minority populations. Gender non-normative individuals who are members of Indigenous and ethnic minority communities also experience increase discrimination and violence that lead to poor health outcomes in healthcare compared to their non-minority counterparts. There are approximately 300-400 million Indigenous peoples in the world living in 90 countries. Europe is home to over 100 ethnic minority groups which form many of Europe´s stateless nations. The Basque Country is one of many examples of Europe´s stateless nations which is home to the Basque Indigenous/ethnic minority population. While several European countries have several official languages and the continent is home to a multitude of regional and ancestral languages and cultures, the number of studies regarding the impact of culture and language in healthcare is scarce.

Objectives: The purpose of this dissertation was to explore the experiences of Basque Women and Gender Non-normative Individuals (BWNN) with healthcare in the Basque Country. The two aims of this dissertation were to map and summarize the available literature related to experiences with culturally safe care among Indigenous and ethnic minority women in Europe (Aim 1), and to explore the experiences of BWNN with healthcare and identify the barriers and facilitators to implement culturally safe practices in the Basque Country (Aim 2).

Methods: For Aim 1 a scoping review was conducted to synthesize the existing literature related to experiences with culturally safe care among Indigenous and ethnic minority women in Europe. For Aim 2 a critical ethnographic approach was used to conduct semi-structured interviews, health clinic observations, and focus groups to identify barriers and facilitators to implement culturally safe practices in the Basque Country.

Results: A scoping review yielded four articles for inclusion. The review showed that Indigenous and ethnic minority populations in Europe experience discrimination and receive suboptimal healthcare services. This marginalization is related to power relations within the healthcare encounter and the healthcare system. Data regarding the implementation of cultural safety in Europe is limited, which can indicate a lack of awareness regarding the importance of cultural safety and the importance of culture, racism, and biases in healthcare related to ethnic minorities. The critical ethnographic study provided important insights into barriers and facilitators to culturally safe healthcare for BWNN. *Euskalfobia* (overall rejection to Basque culture) in the healthcare system and gender bias and discrimination during the healthcare encounter were identified as major themes. Invisibilizing Basque language and culture, normalization of *euskarafobia*, (negative attitude or rejection to the Basque language), and the devaluation of cultural healing practices were identified as barriers for culturally safe healthcare for BWNN while language and cultural concordance was considered a facilitator for the first major theme. For the second major theme, barriers to culturally safe healthcare are knowledge transmission gap regarding women's health issues, discrimination based on sexual or gender identity, and obstetric/gynecological violence, while promoting autonomy over healthcare services is a facilitator.

Conclusions: Overall, the findings of this dissertation present strong evidence of significant barriers to culturally safe healthcare experienced by BWNN. They also provide key insights to

facilitate the implementation of culturally safe practice within the Basque context that can provide direction for further research, policy changes and clinical practice.

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List of Abbreviations

BAC= Basque Autonomous Community

BWNN= Basque women and gender non-normative individuals

IEMW = Indigenous and ethnic minority women

CHAPTER 1: Introduction

According to the United Nations (2018), there are approximately 300-400 million Indigenous people in the world living in 90 countries. They speak a majority of the world's approximate 7,000 languages and represent 5,000 different cultures. Globally, Indigenous and ethnic minority groups encounter discrimination in access to high quality healthcare and other advantageous social determinants of health (Curtis et al., 2019). Across the diverse landscape of Indigenous and ethnic minority groups, they share common difficulties such as lack of access to social services, gaps in social protection coverage and higher inequalities in healthcare outcomes (United Nations, 2018).

Research indicates that ethnic minority groups overall and ethnic minority women, in particular, experience communication and language problems, cultural and religious differences, and discrimination during healthcare encounters compared to non-minority populations (Toh & Shorey, 2023; Watson et al., 2019). Women's healthcare experiences are shaped by their cultural background, place of origin, geographic location, and access to healthcare services (Huffstetler et al., 2021).

Contributing factors to suboptimal healthcare and discrimination against ethnic minorities include a general lack of awareness and inadequate training of healthcare workers on the significance of culture and language in healthcare delivery. Achieving cultural safety requires healthcare workers to go beyond cultural awareness and cultural competence, focusing on the importance of power dynamics and patients' rights (Curtis et al., 2019). Unlike previous approaches, cultural safety, which is grounded in critical social theory, emphasizes that ethnic minority and Indigenous groups are often treated as outsiders, rather than as equal partners in healthcare. This creates barriers to quality care. Cultural safety advocates for reshaping these

power imbalances by fostering relationships based on mutual trust, respect, and the recognition of patients' knowledge and values (Evans et al., 2019). Cultural safety aims to provide improved care by acknowledging differences, decolonizing, addressing power relationships, promoting reflexivity, and acknowledging patients' right to decide if a clinical encounter is safe (Laverty et al., 2017; Papps & Ramsden, 1996).

Europe is home to over 100 ethnic minority groups (Cole, 2011), many of which represent stateless nations (Friend, 2012). These groups are distinguished from other minorities in their claim for self-determination (Cordell & Wolf, 2016). A notable example is the Basque Country, where the Basque ethnic minority is divided between the Spanish and French nation-states **(Figure 1.1)**. Identified as one of Europe's Indigenous peoples (Gupta, 2005), the Basques boast a unique language and culture that have thrived for thousands of years (Reyner, 2013).

-One of Europe´s stateless nations
-Total Population of 3,193,513 in 2020.
-Seven provinces divided in two nation-states (Spain and France).
-Three different administrative entities (Nafarroa, Basque Autonomous Community (BAC), Department Pyrenees Atlantique

Figure 1.1
Map of the Basque Country in Europe
Note: Adapted from *Basque Country location and provinces in Europe map*, by Wikimedia Commons, 2014, https://en.m.wikipedia.org/wiki/File:Basque_Country_Location_and_Provinces_in_Europe_Map.svg. Licensed under Creative Commons 2014 by Wikimedia Commons.

Despite facing significant challenges, including systemic government repression targeting their educational system and the enforcement of a monolingual political framework for centuries, the Basque language and culture have persevered, much like other Indigenous and cultural minority groups around the globe (Irujo & Miglio, 2013). This imposition is also evident in the current healthcare system, where finding bilingual professionals who speak Basque is still challenging (Committee of Experts of the European Charter for Regional or Minority Languages, 2024; Montes Lasarte et al., 2021). Consequently, Basque individuals often struggle to communicate with healthcare providers in their preferred language (Petralanda Mendiola, 2018), putting them at a disadvantage in understanding and making informed healthcare decisions.

The Basque people's distinct culture and language (*Euskara*) are central to their identity (Zabala et al., 2020). In the Basque Country, 15.35% of the population speaks *Euskara* as their primary language, while 29.62% understand it; however, only 12.6% use it outside their homes (Sociolinguistic Cluster, 2020) **(Figure 1.2)**. Consequently, the Basque community, as a linguistic and ethnic minority faces challenges in preserving their cultural identity in the face of dominant Spanish and French cultures (Zabala et al., 2020).

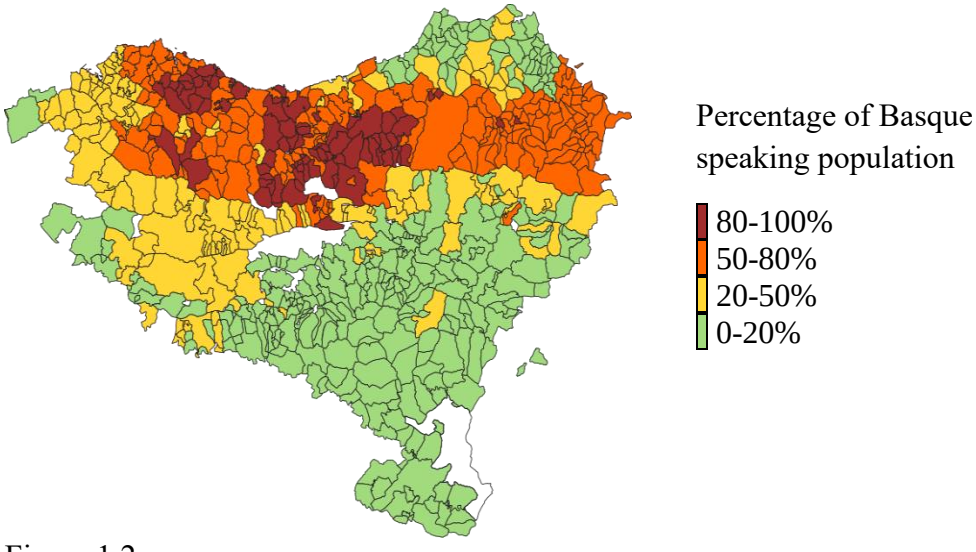

Figure 1.2
Sociolinguistic Map of the Basque Country by Municipalities
Note: Adapted from *Euskaldunen ehunekoaren mapa, Nafarroako Gobernuaren eta Eusko Jaurlaritzaren VI. Inkesta Soziolinguistikoen datu berrienen arabera*, by Wikimedia Commons, 2022, https://eu.m.wikipedia.org/wiki/Fitxategi:Basque_%25_%28most_recent%29.svg. Licensed under Creative Commons 2022 by Wikimedia Commons.

Although many European countries have multiple official languages and more than 50% of Europeans are bilingual, the continent is also home to numerous regional and ancestral languages. However, research on the impact of culture and language on healthcare in European countries remains limited (Kemenade, 2018). The lack of consensus in definition and application of cultural competence, cultural safety and related terms, and the recent implementation of cultural safety has derived in a scarcity of research studies focused on the experiences of ethnic minority groups with cultural safety, more so in the European context. Research regarding the experiences of ethnic minority populations with culturally safe healthcare in Europe is essential to close the gap in knowledge regarding ethnic minority discrimınatıon in healthcare and effectively design health policy to improve the healthcare experiences of ethnic minorities.

The aims of the research study were to map and summarize the available literature related to experiences with culturally safe care among Indigenous and ethnic minority women in Europe (Aim 1) and to explore the experiences of BWNN with healthcare and identify the barriers and facilitators to implement culturally safe practices in the Basque Country (Aim 2).

We initially conducted a scoping review to explore the extent of literature and map and summarize the evidence related to experiences with culturally safe care among adult Indigenous and ethnic minority women (IEMW) in Europe. This review included all studies written in any language with abstracts in English evaluating experiences of healthcare encounters with IEMW within European territory. Four qualitative studies related to experiences with culturally safe care among adult IEMW in Europe were identified. Three studies specifically utilized cultural safety as a framework and one study referred to the need for "culturally appropriate" assistance for racial and ethnic minority students. However, the definition of culturally appropriate care proposed included key tenets of cultural safety.

Second, we applied a qualitative study design, utilizing a critical ethnographic qualitative approach to address forementioned specific aims to analyze the cultural and sociopolitical factors that shape the experiences of BWNN with healthcare in the Basque Country. The study was conducted throughout the Basque province of Nafarroa in collaboration with the Department of Health, Basque women´s and feminist organizations, Basque LGBTI+ community and institutional organizations, and Basque language organizations within the province. We used interviews, focus groups, observations, and collected field notes as data collection methods. As primary researcher, my position as a Basque working-class feminist activist with more than a decade of experience as a Registered Nurse working with patients from the researched community facilitated community participation and access to data.

This research identified barriers and facilitators to culturally safe healthcare for BWNN in the Basque setting. The findings provide insight on the multiple obstacles BWNN face to culturally safe healthcare as well as guidance on the implementation of practices that promote culturally safe healthcare encounters.

In this dissertation, we explored the experiences of BWNN with culturally safe healthcare in the Basque Country. We organized the dissertation content in five chapters. The introductory chapter outlines the background and significance of the research topic, provides a historical context, defines the goals of the study, explains the rationale and methodology for the studies conducted, and synthesizes the structure of the study. In Chapter 2, we present how we conducted a scoping review of the existing literature on the experiences of Indigenous and ethnic minority women with culturally safe healthcare in Europe. The third and fourth chapters present the design and findings of the critical ethnographic study conducted to explore the experiences of BWNN in the Basque province of Nafarroa. The third chapter focuses on the barriers and facilitators to culturally safe healthcare related to culture and language while the fourth chapter focuses on outcomes connected to gender bias and discrimination during the healthcare encounter. Chapter 5 provides a summary of the findings reported in each chapter as well as guidance for future research and practice that could lead to the implementation of culturally safe healthcare in the Basque Country.

References

Cole, J. (2011). *Ethnic groups of Europe: An encyclopedia*. ABC-CLIO.

Committee of Experts of the European Charter for Regional or Minority Languages. (2024). *Sixth evaluation report on Spain* (MIN-LANG (2024)17; p. 142). Council of Europe.

Cordell, K., & Wolf, S. (Eds.). (2016). *The Routledge handbook of ethnic conflict* (2nd ed.). Routledge. https://www.routledge.com/The-Routledge-Handbook-of-Ethnic-Conflict/Cordell-Wolff/p/book/9780367237257

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Evans, C., Tweheyo, R., McGarry, J., Eldridge, J., Albert, J., Nkoyo, V., & Higginbottom, G. M. A. (2019). Seeking culturally safe care: A qualitative systematic review of the healthcare experiences of women and girls who have undergone female genital mutilation/cutting. *BMJ Open*, *9*(5), e027452. https://doi.org/10.1136/bmjopen-2018-027452

Friend, J. (2012). *Stateless nations: Western European regional nationalisms and the old nations*. Springer.

Gupta, A. (2005). *Human rights of indigenous peoples*. Isha Books.

Huffstetler, A. N., Ramirez, S. I., Dalrymple, S. N., & Mendez Miller, M. H. (2021). Women's health and gender-specific considerations. *Primary Care: Clinics in Office Practice, 48*(1), 117–129. https://doi.org/10.1016/j.pop.2020.09.008

Irujo, X., & Miglio, V. (2013). *Language rights and cultural diversity*. Center for Basque Studies.

Kemenade, S. (2018). *Enjeux des services sociaux et de santé en contexte bilingue ou multilingue national* [Challenges of Social and Health Services in a Bilingual or Multilingual National Context]. Revue de littérature produite pour le Secrétariat national du Consortium national de formation en santé, Ottawa. http://cnfs.net/wp-content/uploads/2015/06/revue-litt—Rature-sant—Et-bilinguisme-FINAL.pdf

Laverty, M., McDermott, D. R., & Calma, T. (2017). Embedding cultural safety in Australia's main health care standards. *Medical Journal of Australia, 207*(1). https://www.mja.com.au/journal/2017/207/1/embedding-cultural-safety-australias-main-health-care-standards

Montes Lasarte, A., Arauzo, X., & Zarate Sesma, J. (2021). The Basque paradigm shift: From legislative language policies to person-centred care. *Minorités linguistiques et société, 15–16*, 198. https://doi.org/10.7202/1078482ar

Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: The New Zealand Experience. *International Journal for Quality in Health Care*, *8*(5), 491–497. https://doi.org/10.1093/intqhc/8.5.491

Petralanda Mendiola, B. (2018). *Zirkuitu elebidunerantz lehen pausua* [First Steps Towards a Bilingual Circuit]. BAT Soziolinguistika Aldizkaria, 108(3), 43–60.

Reyner, J. (2013). Giving Language Rights Meaning: Revitalizing Basque, Navajo, and Other Indigenous Languages and Cultures. In *Language Rights and Cultural Diversity* (pp. 223–244). Center for Basque Studies.

Sociolinguistic Cluster. (2020). *Euskararen datu soziolinguistikoen biltegia* [Sociolinguistic database on Euskera]. Retrieved May 10, 2020, from http://www.soziolinguistika.eus/edb/index.php?erakus=aurkezpena

Toh, R. K. C., & Shorey, S. (2023). Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation. *Women and Birth*, *36*(1), 30–38. https://doi.org/10.1016/j.wombi.2022.06.003

United Nations. (2018). *Indigenous peoples and ethnic minorities: Marginalization is the norm*. In *The report on the World social situation 2018* (pp. 97–108). UN. https://doi.org/10.18356/14642ccc-en

Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLOS ONE*, *14*(1), Article 1. https://doi.org/10.1371/journal.pone.0210587

Zabala, J., Conejero, S., Pascual, A., Alonso-Arbiol, I., Amutio, A., Torres-Gomez, B., Padoan De Luca, S., & Telletxea, S. (2020). Basque ethnic identity and collective empowerment: Two key factors in well-being and community participation. *Frontiers in Psychology, 11*, 606316. https://doi.org/10.3389/fpsyg.2020.606316

Wikimedia Commons. (2014). *Basque Country location and provinces in Europe map* [Map]. Wikimedia Commons. https://en.m.wikipedia.org/wiki/File:Basque_Country_Location_and_Provinces_in_Europe_Map.svg

Wikimedia Commons. (2022). *Sociolinguistic map of the Basque Country by municipalities* [Map]. Wikimedia Commons. https://eu.m.wikipedia.org/wiki/Fitxategi:Basque_%25_%28most_recent%29.svg

CHAPTER 2: Experiences of Indigenous and Ethnic Minority Women with Culturally Safe Healthcare in Europe: A Scoping Review

Abstract

Worldwide, Indigenous and ethnic minority women encounter discrimination in access to high quality healthcare and other advantageous social determinants of health. Cultural safety is the concept of proactively considering social, economic, and political situations, and power relationships in healthcare. By identifying ways in which culturally unsafe healthcare practices can intensify institutional discrimination and replicate traumatic experiences in historically oppressed populations, interventions may be crafted to improve patient experiences and outcomes. The purpose of this paper is to conduct a scoping review of research on experiences with culturally safe healthcare among adult Indigenous and ethnic minority women in Europe. All research articles within Europe, without set date parameters, addressing the experiences of individuals who self-identify as adult women or gender non-normative individuals who are members of Indigenous or ethnic minority communities were included. A total of four peer reviewed articles were identified for this scoping review. Participants in four studies described healthcare providers' lack of knowledge of their culture and healthcare needs. The studies suggest that this lack of knowledge may lead to patient sentiments of inferiority, prejudice, increased barriers to access care, inadequate healthcare intervention and ineffective healthcare service. The articles propose the implementation of cultural safety to close the gap of health disparities in Indigenous and ethnic minority populations. There are limited data on the implementation of cultural safety in Europe, potentially indicating a lack of awareness regarding the concept of cultural safety or its core tenets, as well as regarding the importance of culture, racism and biases in healthcare related to ethnic minority populations. Overall, this scoping

review reiterates the gap in research and knowledge in the implementation of culturally safe healthcare in Europe.

Keywords: Ethnic minority, cultural safety, women, gender non-normative, healthcare

Introduction

Worldwide, Indigenous and ethnic minority women encounter disparities in their exposure to social determinants of health, as well as access to high quality healthcare (Curtis et al., 2019; Toh & Shorey, 2023). While these distinct groups are highly diverse (i.e., language, culture, migration status, origin, etc.), they share common challenges such as higher levels of poverty, lack of access to social services, gaps in social protection coverage and higher inequalities in healthcare outcomes (United Nations, 2018). Europe is home to over 100 ethnic minority groups (Cole, 2011), which form many of Europe's stateless nations (Friend, 2012) and are distinguished from other minorities in their claim for self-determination (Cordell & Wolf, 2016). The Basque Country, which is administratively divided in two nation-states (Spain and France) (Urla, 2012) or Sápmi which is divided in four nation-states (Finland, Norway, Sweden and Russia) (Lantto, 2010) are examples of many stateless nations in Europe.

Research indicates that while all Indigenous, and ethnic minority groups experience communication/language problems, cultural and religious differences, and discrimination during healthcare encounters this problem is even more pronounced in women within these groups (MacIntosh et al., 2013; Toh & Shorey, 2023; Watson et al., 2019). A woman´s origin, culture, geographic background, and access to healthcare can impact their experiences (Huffstetler et al., 2021). Consequently, minority women have a unique perspective of women´s healthcare issues that are not adopted by other groups, which can create isolation and could function as an impediment to social action or health behaviors considered acceptable by the majority of women (Kumanyika et al., 2001).

Many minority language speakers and non-hegemonic cultures are denied access to quality healthcare services due to the power differentials that exist between the minority and dominant cultures. According to Roche (Roche, 2019), language oppression, as a form of domination, is

comparable to oppression related to race, color, national origin, or ethnicity. While several European countries have several official languages, more than 50% of Europeans are bilingual, and the continent is home to a multitude of regional and ancestral languages, the number of studies regarding the impact of culture and language in healthcare is scarce (Kemenade, 2018). Aside from studies performed on the Catalans, Sami, and Swedish community in Norway that address healthcare service issues in bilingual settings, other European studies regarding language and healthcare have mainly focused on immigrant populations and lack of standardized tools for other groups (Kemenade, 2018).

The concept of cultural safety has been promoted by Maori nurses working in Aotearoa within a colonial context, and other Indigenous, and ethnic minority communities in Australia and Canada (Narbarte et al., 2021). Few studies regarding cultural safety have been conducted in Europe (Kemenade, 2018). According to Curtis et al. (Curtis et al., 2019), in addition to the power differential arising from language and culture, other contributing factors include an overall lack of awareness and training of healthcare workers regarding the importance of culture and language associated with a particular group within the healthcare delivery system. In these situations, therapeutic relationships between a healthcare worker and a patient are particularly at risk of intended or unintended bias. For safe and quality care to be implemented, healthcare workers need to work towards both cultural safety and critical consciousness. The role of health workers and healthcare systems in generating and sustaining these inequities is progressively undergoing scrutiny (Curtis et al., 2019).

Cultural safety is the concept of proactively and consciously considering social, economic and political situations, and power relations in healthcare, acknowledging that culturally unsafe healthcare practices can intensify institutional discrimination and replicate traumatic experiences in historically oppressed populations (Ramsden, 1993). Cultural safety addresses the power

imbalances between practitioners and patients through the process of reflexivity. That is, health care providers, and health systems, must acknowledge and address their own cultural biases and recognize that each individual's dignity must be valued. Cultural safety is a concept that derives from critical social theory and asserts that established methods such as, 'cultural awareness' or 'cultural competence', which are often applied in healthcare, neglect to address power relationships, which are historically unbalanced between migrant and/or Indigenous, and ethnic minority groups and healthcare providers and services (Evans et al., 2019). As such, Indigenous, and ethnic minority groups are often perceived as the 'other,' rather than as an ally whose knowledge and values can positively contribute to the patient-provider relationship or improve healthcare services. Culturally safe practice, on the other hand, focuses on relationships of both mutual and reciprocal trust and respect (Evans et al., 2019). Healthcare organizations and authorities must also be held accountable for delivering culturally safe health care that meets the needs of individuals and their communities (Curtis et al., 2019).

Despite global attempts to increase patient safety and care quality, improving safety for Indigenous and ethnic minority populations has lacked sufficient attention and thus, remains an under researched area. As argued by Chauhan (2020), patients from Indigenous, and ethnic minority groups continue to feel unsafe, experience discrimination, lack appropriate interpreting services and have inadequate knowledge of the healthcare settings/systems during healthcare encounters (Chauhan et al., 2020). Therefore, the purpose of this scoping review is to analyze and summarize the available literature related to experiences with culturally safe care among Indigenous and ethnic minority women (IEMW) in Europe.

Materials and Methods

Protocol and Registration

This scoping review will follow the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) Extension for Scoping Reviews (PRISMA-ScR), which includes a 27-item checklist (see Appendix A; Tricco et al., 2018).

Eligibility Criteria

This review included studies involving IEMW from all European countries and stateless nations. Studies addressing the health care experiences of IEMW who self-identify as Indigenous or as members of an ethnic minority group have been included. Excluded were studies where the participant was not the recipient of the healthcare service, or if the study focused only on the experience of the healthcare professional (Harding et al., 2021). No publication date restrictions were applied. Inclusion and exclusion criteria are shown in **Table 2.1**.

Table 2.1
Scoping Review Inclusion and Exclusion Criteria

	Inclusion Criteria	**Exclusion Criteria**
Sample	Adult Indigenous/ethnic minority women and gender non-normative individuals exposed to culturally safe healthcare in Europe.	Under 18 years old. Studies of Indigenous/ethnic minority women and gender non-normative individuals outside of Europe.
Phenomenon of Interest	Indigenous, and ethnic minority women and gender non-normative individuals´ experiences with culturally safe healthcare in Europe.	Studies examining experiences of healthcare providers only. Studies that do not address the Indigenous or ethnic or do not include women
Design	Literature review and research articles	Protocols, opinion pieces, anecdotal reports, editorials, news articles, and dissertations.
Evaluation	Patient's experiences with quality of care, language, and cultural safety during a healthcare encounter.	Studies focused only on social determinants of health which do not address the historical content and power relations within the healthcare encounter. Studies focused on patient safety regarding adverse events, medication errors, diagnostic errors.
Research Type	All research studies, meta-analysis, meta-synthesis, systematic reviews, and scoping reviews	Non-databased papers
Report Characteristics	Full texts available in all languages with abstracts in English No publication date restrictions	Protocols, opinion pieces, anecdotal reports, editorials, news articles, dissertations

For this study, we defined culturally safe care as safe, quality care as defined by the participant and/or their community (Harding et al., 2021). Studies that did not focus on the core tenets of cultural safety such as relationship of community, cultural identity and power relations were excluded (Harding et al., 2021). Due to the diverse use and overall lack of consensus with regards to the concepts of cultural safety and related terms, studies which also address concepts such as cultural competency, cultural humility have been considered if previously defined inclusion criteria were met (Curtis et al., 2019).

Information Sources

The five databases searched for relevant studies were PubMed, CINAHL (EBSCOhost), Embase, Web of Science, and Epistemonikos.

Search

A professional librarian assisted in the development of a systematic search strategy utilizing a combination of Medical Subject Headings (MeSH) and related terms to identify studies on experiences of Indigenous and ethnic minority women and gender non-normative individuals with culturally safe care within the European territory (See Appendices B, C, D, E, and F). Only full text research articles were included. Protocols, opinion pieces, anecdotal reports, editorials, news articles, and dissertations were excluded from the search **(Table 2.1)**. The initial search was conducted between March 15 and May 15 of 2023 and was updated in July of 2024 (Ndarukwa et al., 2019).

Selection of Sources of Evidence

All identified articles were imported into Zotero (Zotero, 2023) [Computer software] to perform an initial removal of duplicate articles. The articles were subsequently imported to Covidence software (Covidence Systematic Review Software, 2023) to prepare for title and abstract review and to create data charts. The articles selected for screening were examined by the lead researcher (G.E.) and a secondary reviewer (S.B.) who independently screened the articles by title and abstract, following the established eligibility criteria (Ndarukwa et al., 2019). Full text articles that were assessed as possibly meeting eligibility criteria on the initial screening were then reviewed to evaluate full eligibility criteria.

Data Charting Process

Data extraction and charting was conducted by utilizing an adapted Covidence software application incorporating items defined in the Joanna Briggs Institute (JBI) Manual for Evidence Synthesis of Scoping Reviews (Aromataris & Munn, 2020). Following JBI guidelines, data items were incorporated and revised as necessary in an iterative process to guarantee inclusion of relevant data.

Data Extracted

Data extracted included the following study characteristics: country of origin; year; aims; participants; setting; sampling criteria; age; and gender. In addition, the methodology used (i.e., data collection and analysis), and key findings/outcomes were also extracted**.**

None of the selected articles included the experiences of gender non-normative individuals who were also members of Indigenous or ethnic minority communities. Due to the limited number of articles exclusively focusing on the experiences of Indigenous and ethnic minority women, all studies meeting the above criteria were included if there were any women participants included, i.e., as part of the sample even if not exclusively.

Critical Appraisal of Individual Sources of Evidence

This scoping review did not include a quality appraisal. Scoping reviews are intended to supply an overview, or "map" evidence relative to the phenomenon of interest, rather than critically appraising and synthesizing data related to a specific question. Therefore, quality appraisals are generally not included in scoping reviews (Munn et al., 2018).

Synthesis of Results

To provide a broad overview of the research topic, all results pertaining to the studied concepts and experiences that were reported in the literature were also reported in this review. Each study´s sample, aims, methodology, outcomes, and key findings were summarized and analyzed by both reviewers.

Selection of Sources of Evidence

Following the scoping review framework outlined above, multiple databases and reference lists were searched to produce a broad list of relevant studies **(Figure 2.1)**. The primary search resulted in a total of 170 articles found in the following databases: PubMed (n = 40); CINAHL (n = 28); Embase (n = 4); Web of Science (n=98), and Epistemonikos (n = 0). An additional nine articles were retrieved from additional sources, such as reference lists and broad web-based searches conducted prior to this review, increasing the total to 179 articles. Subsequently, 28 duplicates were identified manually and by using the Zotero software. Therefore, the remaining 151 articles were scanned to review the title and abstract for possible inclusion. Title and abstract screening resulted in the removal of 117 (77%) articles, which produced the retrieval of 34 (23%) articles. After reading in full the 34 remaining articles, additional exclusions were conducted for studies that did not address cultural safety (n = 23; 68%), or core tenets thereof, such as relationship of community, cultural identity and power relations (n = 3; 9%) or did not specifically address the experiences of participants (n = 4; 12%). Ultimately, four articles were retained for this scoping review.

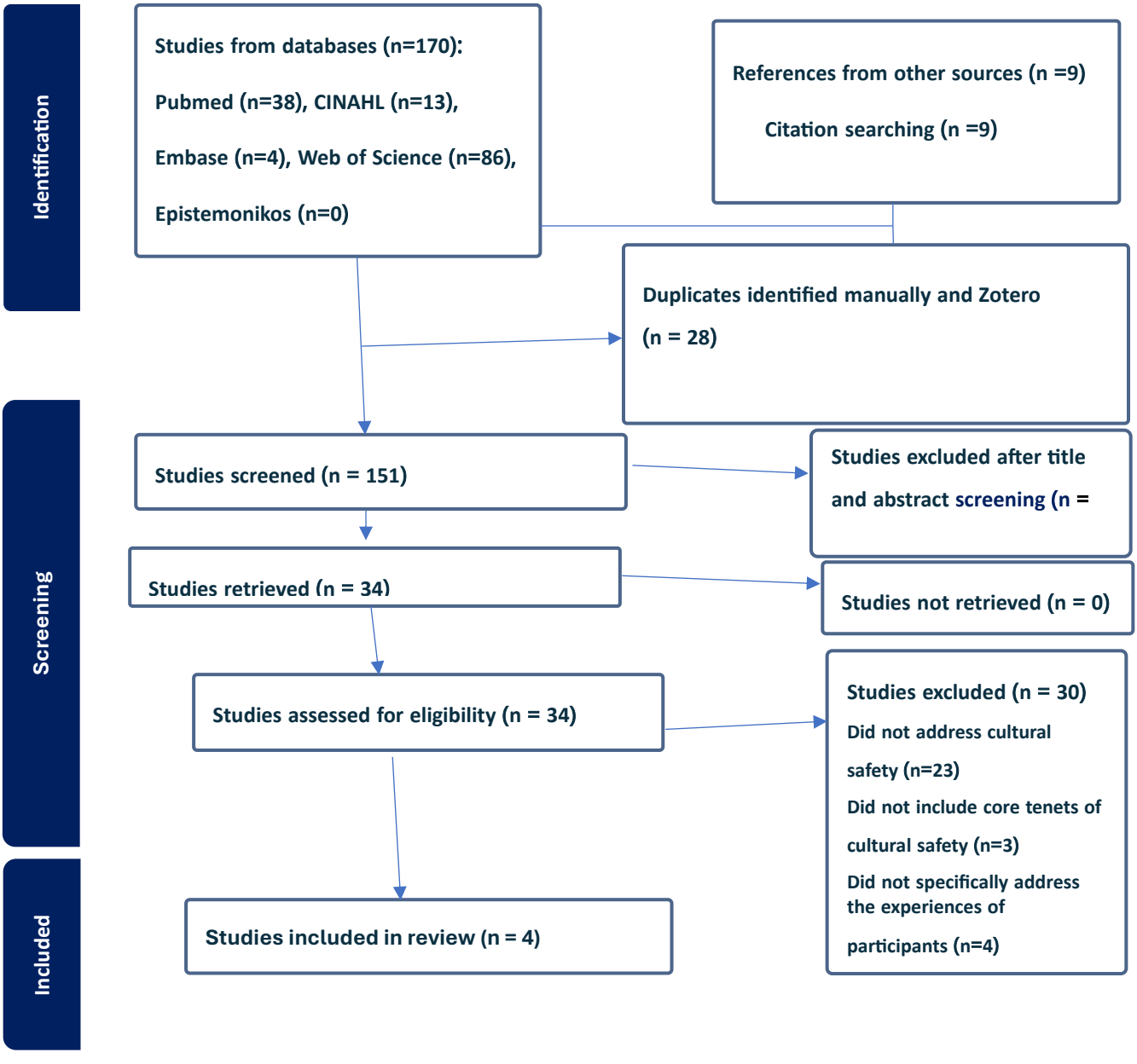

Figure 2.1

Flow Diagram of Evidence Search

Characteristics of Sources of Evidence

All four studies were published in English in peer-reviewed international open access journals. Two were articles from a journal that specializes in circumpolar health and has a specific interest in Indigenous peoples (Mehus et al., 2019; Ness & Munkejord, 2022). One article was published in a journal focused on qualitative research studies related to health and well-being (Olaniyan & Hayes, 2022), and one was published in a journal that publishes a wide variety of research studies that cover all aspects of medicine and healthcare (del Pino et al., 2022).

Samples

Sample size of participants varied from eleven (Mehus et al., 2019) to forty-eight (Olaniyan & Hayes, 2022) **(Table 2.2)**. Two articles (Mehus et al., 2019; Ness & Munkejord, 2022) include Sami participants in Norway. Olaniyan and Hayes (Olaniyan & Hayes, 2022) incorporated 48 Black British (n = 32) and South Asian-British (n = 16) students from racial and ethnic minority backgrounds living in the United Kingdom, who were attending a higher education institution. Thirteen participants had a current professional diagnosis of depression (n = 8), anxiety (n = 4) or bipolar disorder (n = 1), 21 had self-defined mental health problems and 25 had prior help-seeking experiences. Del Pino, et al. (del Pino et al., 2022) included 16 adult Romani women (RW) aged between 23 and 62 who had contact with the public health system. Samples were obtained through purposeful, convenience and snowball sampling.

Table 2.2

Characteristics of Sources of Evidence

Study ID	**Origin/Country**	**Title**	**Setting**	**Participants**
Mehus et al. (Mehus et al., 2019)	Hammerfest, Norway	Exploring why and how encounters with the Norwegian health-care system can be considered culturally unsafe by North Sami-speaking patients and relatives: A qualitative study	Two inland Sami administrative municipalities in northern Norway.	North Sami participants (n=11), self-identified Sami-speaking and Sami. Women (n=9), Men (n=2). Mean age (47.5) years, 56.5 for men and 45.5 for women. Former patients (n=4) or relatives to a patient (n=7).
del Pino et al. (del Pino et al., 2022)	Almeria (Andalusia-Spain)	Romani Women and Health: The Need for a Cultural-Safety Based Approach	Peripheral area of the city of Almeria (Spain), in an area of medium-low socio-economic level with slums and deficient city maintenance and hygiene.	16 Romani women who had contact with the Public Health System. Medium-low socio-economic status. Mean age (38.4) mean # of children (4.8). 12 participants married, one single, and one widowed.
Ness and Munkejord (Ness & Munkejord, 2022)	Norway	"All I expect is that they accept that I am a Sami" an analysis of experiences of healthcare encounters and expectations for future care services among older South Sami in Norway	Participants from scattered communities in rural parts of Mid- and Northern Norway.	Older, self-identified, South Sami (n=12), women (n=5), men (n=7). Aged between 67 and 84 years (mean age n=74). All had background from reindeer herding families. All had experience with the healthcare system as a care receiver.

(Table 2.2 Continued)

Study ID	Origin/Country	Title	Setting	Participants
Olaniyan and Hayes (Olaniyan & Hayes, 2022)		Just ethnic matching? Racial and ethnic minority students and culturally appropriate mental health provision at British universities	Two neighboring British Higher Education Institutions. Both institutions are selective and high performing.	UK domiciled racial and ethnic minority students (n=48). Women (n=30; 62.5%) Men (n=18; 37.5%). Black British (n=32) and South Asian-British background (n=16). 13 participants with current professional diagnosis of mental illness, 21 with self-defined mental health problems and 25 with prior help-seeking experiences.

Design and Methodology

Qualitative methodologies were used in all four studies **(Table 2.3)**. A constructivist grounded theory (CGT) approach was used in two studies (Ness & Munkejord, 2022; Olaniyan & Hayes, 2022), and interpretive phenomenology (IP) was used in another study (del Pino et al., 2022). Mehus et al. (Mehus et al., 2019) conducted a qualitative explorative descriptive study. Semi-structured qualitative interviews were conducted in all four studies followed by data coding and thematic analysis.

Synthesis of Evidence

Results of Individual Sources of Evidence

Outcomes and key findings of interest are summarized in **Table 2.3**, which briefly identify the aims, methodology, outcomes, and key findings. To contextualize findings, main outcome themes were also included in the synthesis.

Three studies specifically utilized cultural safety as a framework to address power relations between healthcare workers and patients situated in a historical context of racism and discrimination which results in sub-optimal healthcare delivery (del Pino et al., 2022; Mehus et al., 2019; Ness & Munkejord, 2022). Olaniyan and Hayes (Olaniyan & Hayes, 2022) refer to the need for "culturally appropriate" assistance for racial and ethnic minority students. However, the definition of culturally appropriate care proposed in the study by the authors and participants include concepts such as reflexivity, structural racism, power relations and cultural acknowledgment which are also key tenets of cultural safety (Mehus et al., 2019).

Participants in all four studies describe a lack of knowledge of healthcare providers regarding their culture and consequently their healthcare needs. This lack of knowledge may lead to sentiments of inferiority, prejudice, (Ness & Munkejord, 2022) increased barriers to access

care, inadequate healthcare intervention and ineffective healthcare service (del Pino et al., 2022). In one study, participants refer to the lack of diversity in the university's support service staff to be a barrier to mental health help-seeking on campus (Olaniyan & Hayes, 2022). Although for some participants ethnic matching or sharing an ethnic and cultural background with providers was crucial, they would rarely advocate for this to be the only solution to the problem. For British South Asian participants ethnic matching would potentially generate conflict and judgement from their extended community if the provider was also a member of this community. Ethnic matching was also viewed as a "bailout" for White medical health s and keeping them from engaging in racial differences (Olaniyan & Hayes, 2022).

Key findings in the evaluated studies included the proposal of various measures to implement culturally safe healthcare with the affected populations. Regarding ways to overcome cultural discordance, in the case of Romani women, incorporation of intercultural mediators and Romani health professionals were proposed to build bridges between Romani and non-Romani people. For Sami participants "standardized services" within the Norwegian system may contribute to masking discrimination and hopes for the future of participants are that they would be "accepted" and "respected" as Sami (Ness & Munkejord, 2022).

To overcome health system's organizational barriers the social determinants of health, difficulty of access to healthcare services, prejudice, and cultural differences must be addressed to improve healthcare outcomes for the Romani collective and health interventions with the Romani community must consider the principles of cultural safety (del Pino et al., 2022). For racial and ethnic minority participants the findings demonstrate the need for increased sensitivity in the way mental health support is provided in higher education institutions, and participants advocate for a "person specific" approach that allows various ways to provide culturally appropriate care (Olaniyan & Hayes, 2022). Highlighting the concept of culturally safe care as a

goal at individual, group and institutional level is recommended including addressing power imbalances and inequitable social relationships in healthcare (Mehus et al., 2019).

Table 2.3

Aims, Methods, and Key Findings of Sources of Evidence

Study ID	Aims	Methodology/Methods	Outcomes	Key Findings
Mehus et al. (Mehus et al., 2019)	To explore how Sami-speaking patients and relatives experience healthcare encounters	Methodology: Qualitative explorative, descriptive study. Data collection: Semi-structured interviews were conducted. Data was collected in two inland Sami administrative municipalities in northern Norway from April to October 2015. Data analysis: Content analysis was performed using a conceptual lens of cultural safety.	Data analysis resulted in two outcome groups: 1) Contributions to the feeling of being culturally safe 1.1 Meeting Sami-speaking staff and patients 1.2 Having Sami activities and symbols in hospitals. 1.3 Meeting staff that listen and spend time with patients. 1.4 Having interpreting services. 1.5 Having the feeling of being home. 1.6 Meeting other Sami-speaking patients 2) Contributions to the feeling of being culturally unsafe 2.1 Not using Sami language and not being allowed to speak Sami in public. 2.2 Feeling violated, invisible and vulnerable without Sami music, art and handcraft. 2.3 Staff talking above your head and giving no information. 2.4 Neglect of Sami language and no offer of interpreting service 2.5 Not feeling at home. 2.6 No one to speak Sami with	-All participants described suboptimal experiences of what was identified as cultural safety in healthcare due to limited use of Sami language or professional interpreters, and perceived discrimination. -This experience was perceived at an institutional, group, and individual level. -There were limited Sami-speaking staff, staff did not reflect on the importance of interpreting for patient safety, there is no cultural validation of medical tests, interpreters were not prepared for healthcare encounters, and Sami art and music were less present in hospitals outside Sami areas. -Highlighting the concept of culturally safe care as a goal at individual, group and institutional level was recommended. -This includes addressing power imbalances and inequitable social relationships in healthcare.

(Table 2.3 continued)

Study ID	Aims	Methodology/Methods	Outcomes	Key Findings
del Pino et al. (del Pino et al., 2022)	To delve into the perceptions of Romani Women on their health beliefs and experiences with health services and their health professionals as well as the role of Romani Women in the health of their community.	Methodology: Qualitative study using an interpretative phenomenological approach. Data collection: Semi-structured interviews were conducted in October 2021. Data Analysis: Data was analyzed through coding and thematic analysis.	Themes: Romani Identity, Social and Economic Conditions, Health and Sickness Concepts, Experiences with Health Services. Categories: Construction of the Romani Woman Identity, Difficulties in Life, Health and Sickness Beliefs, Barriers Health System Access	-RW played a significant role in their community, which made them essential participants in any collective health promotion program. -Romani cultural elements were not recognized by health professionals creating conflict in the healthcare setting. -Lack of knowledge of healthcare professionals regarding Romani beliefs resulted in inadequate health intervention and ineffective healthcare service. -Prejudice and stereotyping were present during the healthcare encounter and it increased the barriers to healthcare access for Romani Women. -Incorporation of intercultural mediators and Romani health professionals was proposed to close build bridges between Romani and non-Romani people. -Addressing the social determinants of health, difficulty of access to healthcare services, prejudice, and cultural differences was recommended to improve healthcare outcomes for the Romani collective. -Health interventions with the Romani community must consider the principles of Cultural Safety.
Ness and Munkejord (Ness & Munkejord, 2022)	1) To forward empirical knowledge of how older Sami experience healthcare encounters in Norway and what they expect in terms of future care services 2) To forward understanding of how more culturally safe services could be offered to the Sami population	Methodology: Qualitative, interpretative and constructivist grounded theory research design. Data collection: Semi-structured in-depth interviews were conducted. Data analysis: Reflexive thematic approach was used to analyze the data.	Themes: 1) Ambivalent healthcare encounters 1.1 "Sometimes we feel deprioritized." 1.2 "Sometimes we just don't understand each other" 1.3 "They don't know anything about us." 2) Future expectations about healthcare services in the municipality 2.1 "I hope they will accept me"	-Healthcare encounters were experienced as culturally ambivalent by South Sami care receivers. -Participants felt deprioritized and misunderstood in healthcare encounters. -Healthcare professionals did not have enough time for the participants -When participants encountered a "nice" general practitioner they tried to see this specific practitioner. -Healthcare professionals did not know anything about Sami culture and their history, this occasionally led to ignorance and prejudice. -This lack of knowledge could have led to a feeling of inferiority amongst Sami patients. -"Standardized services" may contribute to masking discrimination. -Hopes for the future of participants were that they would be "accepted" and "respected" as Sami.

(Table 2.3 continued)

Study ID	Aims	Methodology/Methods	Outcomes	Key Findings
Olaniyan and Hayes (Olaniyan & Hayes, 2022)	To explore how racial and ethnic minority students define culturally appropriate support and the approaches they view to be effective in promoting help-seeking	Methodology: Qualitative study using constructive grounded theory principles. Data collection: Semi-structured interviews were conducted between December 2018 and November 2019; 22 in-person interviews, and 26 phone interviews.	1) Participants consistently recognize the lack of diversity to be a barrier to mental health help-seeking on campus. 2) Although for some participants ethnic matching was crucial, they would rarely advocate for this to be the only solution to the problem. 3) For British South Asian participants ethnic matching would be harmful. 4) Ethnic matching was also viewed as a "bailout" for White mental health practitioners and keeping them from engaging in racial differences. 5) This would also leave the responsibility of solving health inequalities within the affected individuals and communities. 6)Practitioners should engage in reflexivity and address the potential impact of their own culture in their practice 7) Beyond their background, participants desire a "person specific" approach	-The findings demonstrated the need for increased sensitivity in the way mental health support is provided in higher education institutions. -Findings demonstrated more than one recommended way to provide culturally appropriate care. -Majority of participants perceived ethnic matching or sharing a common background with providers beneficial. However, it is considered insufficient unless it is based on structural reform. -Campus mental health services were structured from a white Eurocentric perspective which was perceived as an accessibility barrier for REM students.

Discussion

This review identified four sources related to experiences with culturally safe care among adult IEMW in Europe. All articles were peer-reviewed and published in English in international journals. Although all of the articles included women as participants, only one article was exclusively exploring the experiences of ethnic minority women (del Pino et al., 2022), and none of the articles addressed the experiences of gender non-normative individuals.

In terms of sampling, all articles were published within the last five years, indicating the innovative standing of the implementation of cultural safety in health care. It also detects the scarcity of research addressing cultural safety within the European context. The samples varied in size, demographic characteristics of participants, and cultural backgrounds. This variety supports previous research encouraging the implementation of cultural safety interculturally (Blanchet Garneau et al., 2017).

Most articles in this review emphasized the necessity for implementation of cultural safety to close the gap of health disparities in Indigenous and ethnic minority populations. Participants in the reviewed studies referred feeling diminished, demeaned, and disempowered, which are considered the 3D´s of culturally unsafe practice (Lavoie et al., 2022). Proposed measures to implement culturally safe healthcare in the studied settings included addressing the health disparities, power relations, and cultural aspects within the healthcare system. These findings coincide with research highlighting the importance of emphasizing the differences between healthcare workers and patients that influence care, and work to reduce any aggression on the patient's cultural identity as a way to implement culturally safe healthcare (Curtis et al., 2019).

Most of the proposed measures focused on healthcare provider training or reflexivity. However, few measures addressed the institutional responsibility for the implementation of

the proposed measures and policies. This conflicts, to some degree, with studies that highlight the need to embed cultural safety at both individual and institutional levels (Browne et al., 2009), to avoid the risk of ignoring contexts by avoiding to draw from critical theoretical perspectives (Blanchet Garneau et al., 2017).

Most findings present ethnic matching or cultural and language concordance as an important aspect to improve cultural safety during the healthcare encounter. However, reviewed studies address that this is not as beneficial if cultural and historical contexts are disengaged. This matches research highlighting the significance of maintaining focus on providing a safe environment for Indigenous and ethnic minority patients, as defined by the community, during the healthcare encounter, which is one of the essential origins of cultural safety (Heckenberg, 2020).

Overall, the reviewed studies acknowledge the lack of culturally safe care in distinct Indigenous and ethnic minority communities within Europe. There is also agreement in the lack of consensus with the use of cultural safety and related terms such as cultural competence, cultural awareness, cultural sensitivity, and culturally appropriate care (Curtis et al., 2019; Olaniyan & Hayes, 2022), as well as risks of oversimplifying the concept by depriving it from critical theoretical perspective (Browne et al., 2009). Finally, there is a scarcity of research regarding culturally safe care in the European context and a need to promote the implementation of its practice.

Limitations

Although several databases were searched it is possible that data from unpublished studies such as dissertations have been overlooked by this scoping review. The lack of studies uniquely focusing on IEMW further limited the opportunity to explore gender disparities or inequalities and their relationship with culturally safe healthcare.

Conclusions

This scoping review shows that Indigenous and ethnic minority populations in Europe experience discrimination and receive suboptimal healthcare services. This appears to be related to power relations within the healthcare encounter and the healthcare system. Overall, this scoping review reiterates the necessity for further studies to promote the implementation of cultural safety in Indigenous and ethnic minority in the European context.

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References

Aromataris, E., & Munn, Z. (Eds.). (2020). *JBI manual for evidence synthesis*. JBI Evidence Synthesis. https://doi.org/10.46658/JBIMES-20-01

Blanchet Garneau, A., Farrar, H., Fan, L., & Kulig, J. (2017). Applying cultural safety beyond Indigenous contexts: Insights from health research with Amish and Low German Mennonites. *Nursing Inquiry, 25*(1), e12204. https://doi.org/10.1111/nin.12204

Browne, A. J., Varcoe, C., Smye, V., Reimer-Kirkham, S., Lynam, M. J., & Wong, S. (2009). Cultural safety and the challenges of translating critically oriented knowledge in practice. *Nursing Philosophy: An International Journal for Healthcare Professionals*, *10*(3), 167–179. https://doi.org/10.1111/j.1466-769X.2009.00406.x

Chauhan, A., Walton, M., Manias, E., Walpola, R. L., Seale, H., Latanik, M., Leone, D., Mears, S., & Harrison, R. (2020). The safety of health care for ethnic minority patients: A systematic review. *International Journal for Equity in Health*, *19*(1), 118. https://doi.org/10.1186/s12939-020-01223-2

Cole, J. (2011). *Ethnic Groups of Europe: An Encyclopedia*. ABC-CLIO.

Cordell, K., & Wolf, S. (Eds.). (2016). *The Routledge handbook of ethnic conflict* (2nd ed.). Routledge. https://doi.org/10.4324/9781315760273

Covidence systematic review software (Version Veritas Health Innovation). (2023). [Computer software]. Veritas Health Innovation. www.covidence.org

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

del Pino, F., Arrogante, O., Gallego-Gomez, J., Simonelli-Munoz, A., Castro-Luna, G., & Jimenez-Rodriguez, D. (2022). Romani women and health: The need for a cultural-safety-based approach. *Healthcare, 10*(2), 128. https://doi.org/10.3390/healthcare10020271

Evans, C., Tweheyo, R., McGarry, J., Eldridge, J., Albert, J., Nkoyo, V., & Higginbottom, G. M. A. (2019). Seeking culturally safe care: A qualitative systematic review of the healthcare experiences of women and girls who have undergone female genital mutilation/cutting. *BMJ Open*, *9*(5), e027452. https://doi.org/10.1136/bmjopen-2018-027452

Friend, J. (2012). *Stateless Nations: Western European Regional Nationalisms and the Old Nations*. Springer.

Harding, J., MacKinnon, K., Sangster-Gormley, E., & Gordon, C. (2021). Indigenous peoples' positive experiences of culturally safe health care: A qualitative systematic review protocol. *JBI Evidence Synthesis*, *19*(9), 2434–2440. https://doi.org/10.11124/JBIES-20-00181

Heckenberg, S. (2020). Cultural safety: A model and method that reflects us, respects us and represents us. *Journal of Australian Indigenous Issues*, *23*(3–4), 48–66. https://doi.org/10.3316/informit.670824249864168

Huffstetler, A. N., Ramirez, S. I., Dalrymple, S. N., & Mendez Miller, M. H. (2021). Women's Health and Gender-Specific Considerations. *Primary Care: Clinics in Office Practice*, *48*(1), 117–129. https://doi.org/10.1016/j.pop.2020.09.008

Kemenade, S. (2018). *Enjeux des services sociaux et de santé en contexte bilingue ou multilingue national* [Challenges of Social and Health Services in a Bilingual or Multilingual National Context]. Revue de Littérature produite pour le Secrétariat

national du Consortium national de formation en santé, Ottawa. http://cnfs.net/wp-content/uploads/2015/06/revue-litterature-sante-et-bilinguisme-FINAL.pdf

Kumanyika, S. K., Morssink, C. B., & Nestle, M. (2001). Minority Women and Advocacy for Women's Health. *American Journal of Public Health*, *91*(9), 1383–1392.

Lantto, P. (2010). Borders, citizenship and change: The case of the Sami people, 1751–2008. *Citizenship Studies*, *14*(5), 543–556. https://doi.org/10.1080/13621025.2010.506709

Lavoie, J., Stoor, J., Rink, E., Cueva, K., Gladun, E., Larsen, C., Akearok, G., & Kanayurak, N. (2022). Cultural competence and safety in circumpolar countries: An analysis of discourses in healthcare. *International Journal of Circumpolar Health, 81*(1), 2055728. https://doi.org/10.1080/22423982.2022.2055728

MacIntosh, T., Desai, M. M., Lewis, T. T., Jones, B. A., & Nunez-Smith, M. (2013). Socially-Assigned Race, Healthcare Discrimination and Preventive Healthcare Services. *PLOS ONE*, *8*(5), e64522. https://doi.org/10.1371/journal.pone.0064522

Mehus, G., Bongo, B., Engnes, J., & Moffitt, P. (2019). Exploring why and how encounters with the Norwegian health-care system can be considered culturally unsafe by North Sami-speaking patients and relatives: A qualitative study based on 11 interviews. *International Journal of Circumpolar Health, 78*(1), Article 1612703. https://doi.org/10.1080/22423982.2019.1612703

Munn, Z., Peters, M. D. J., Stern, C., Tufanaru, C., McArthur, A., & Aromataris, E. (2018). Systematic review or scoping review? Guidance for authors when choosing between a systematic or scoping review approach. *BMC Medical Research Methodology*, *18*, 143. https://doi.org/10.1186/s12874-018-0611-x

Narbarte, G. E., Gabantxo, I. E., & Gonzalez, N. A. (2021). *(AR) Erizaintza euskaraz: Jarduteko edota ikasteko aukera eta oztopoen azterketa* [(AR) Nursing in Basque: An

Analysis of Opportunities and Barriers for Practice or Learning]. https://www.inguma.eus/produkzioa/ikusi/ar-erizaintza-euskaraz-jarduteko-edota-ikasteko-aukera-eta-oztopoen-azterketa

Ndarukwa, P., Chimbari, M. J., & Sibanda, E. N. (2019). Protocol on a systematic review of qualitative studies on asthma treatment challenges experienced in Sub-Saharan Africa. *Systematic Reviews*, *8*(1), 149. https://doi.org/10.1186/s13643-019-1068-7

Ness, T., & Munkejord, M. (2022). "All I expect is that they accept that I am a Sami" an analysis of experiences of healthcare encounters and expectations for future care services among older South Sami in Norway. *INTERNATIONAL JOURNAL OF CIRCUMPOLAR HEALTH*, *81*(1). https://doi.org/10.1080/22423982.2022.2078472

Olaniyan, F.-V., & Hayes, G. (2022). Just ethnic matching? Racial and ethnic minority students and culturally appropriate mental health provision at British universities. *International Journal of Qualitative Studies on Health and Well-Being*, *17*(1), 2117444. https://doi.org/10.1080/17482631.2022.2117444

Ramsden, I. (1993). Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing Praxis in New Zealand Inc*, *8*(3), 4–10.

Roche, G. (2019). Articulating language oppression: Colonialism, coloniality and the erasure of Tibet's minority languages. *Patterns of Prejudice*, *53*(5), 487–514. https://doi.org/10.1080/0031322X.2019.1662074

Toh, R. K. C., & Shorey, S. (2023). Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation. *Women and Birth*, *36*(1), 30–38. https://doi.org/10.1016/j.wombi.2022.06.003

Tricco, A. C., Lillie, E., Zarin, W., O'Brien, K. K., Colquhoun, H., Levac, D., Moher, D., Peters, M. D. J., Horsley, T., Weeks, L., Hempel, S., Akl, E. A., Chang, C., McGowan, J., Stewart, L., Hartling, L., Aldcroft, A., Wilson, M. G., Garritty, C., Straus, S. E.

(2018). PRISMA Extension for Scoping Reviews (PRISMA-ScR): Checklist and Explanation. *Annals of Internal Medicine*, *169*(7), 467–473. https://doi.org/10.7326/M18-0850

United Nations. (2018). Indigenous peoples and ethnic minorities: Marginalization is the norm. In United Nations, *The Report on the World Social Situation 2018* (pp. 97–108). UN. https://doi.org/10.18356/14642ccc-en

Urla, J. (2012). *Reclaiming Basque: Language, nation, and cultural activism*. University of Nevada Press.

Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLOS ONE*, *14*(1). https://doi.org/10.1371/journal.pone.0210587

Zotero (Version Corporation for Digital Scholarship). (2023). [Computer software]. Corporation for Digital Scholarship. https://www.zotero.org

CHAPTER 3: Cultural and Language Discrimination in Healthcare as Experienced by Basque Women and Gender Non-normative Individuals in the Basque Country

Abstract

Basque women and gender non-normative individuals are a part of an Indigenous and ethnic minority culture, thus more likely to be exposed to discrimination and sub-optimal healthcare services. This study explores their experiences with healthcare and identifies the barriers and facilitators to implement culturally safe healthcare practices in the Basque Country. We used a critical ethnographic approach to conduct 37 semi-structured interviews, 36 hours of health clinic observations, and four focus groups. Using a thematic analytic approach, we find that *euskalfobia* in the healthcare system presents a major barrier to culturally safe healthcare through the normalization of *euskarafobia*, systematic invisibilizing of Basque language and culture, and the devaluing of cultural healing practices. Language and culturally concordant care, acknowledgement of cultural healing practices and training regarding the concept of cultural safety at an individual and institutional level can facilitate the implementation of cultural safety in the Basque context.

Keywords: Ethnic minority, Indigenous, cultural safety, gender non-normative, women, healthcare

Background

Globally, Indigenous and ethnic minority women face discrimination in their exposure to social determinants of health and their access to high-quality healthcare (Curtis et al., 2019). Gender non-normative individuals within these communities also report experiencing discrimination and violence, leading to poor health outcomes (Chan et al., 2023). This contributes to greater disparities, such as higher rates of poor mental health and lower self-rated physical and mental well-being (Teti et al., 2021). While these groups are highly diverse in terms of language, culture, migration status, and origin, they share common challenges rooted in the legacy of colonialism (United Nations, 2018).

Europe is home to over 100 ethnic minority groups (Cole, 2011), which form many of Europe´s “stateless nations” (Friend, 2012), including the Basque Country. Basque people, over 3.1 million (Gaindegia, 2020), are divided in two nation-states (Spain and France). Basques are an Indigenous group, with their own language and culture that date back thousands of years (Gupta, 2005; Reyner, 2013). Like other Indigenous and ethnic minority populations, Basques have faced centuries of consistent and prolonged oppression (Irujo & Miglio, 2013). During the XIV-XVII centuries, oppression manifested through witch-hunt and dispossession of communal land and Indigenous knowledge (Federici, 2004). During the French Revolution, minority languages were associated with "ideological backwardness, narrow-minded provincialism, and fanatical politics" (Urla, 2012). Under the Spanish dictatorship (1939–1978), strict anti-Basque policies were enforced, with Basque speakers being punished and humiliated for their cultural and language practices. French and Spanish elites both considered the Basque language insignificant, while nation-states saw regional languages and identities, like Basque, as threats to national unity (Irujo & Miglio, 2013).

Despite sustained repression, primarily through the educational system and the imposition of monolingual Spanish and French political systems, the Basque language and

culture have endured (Irujo & Miglio, 2013). The current healthcare system reflects this imposition, where bilingual professionals who speak Basque are rare (Committee of Experts of the European Charter for Regional or Minority Languages, 2024; Montes Lasarte et al., 2021). Thus, Basques are rarely able to communicate with healthcare workers in their preferred language (Petralanda Mendiola, 2018), a disadvantage when understanding choices and making healthcare decisions. More than a system of communication, language is a means to establish trusting relationships, thus important within the healing process. Research emphasizes the positive effects maintaining and reviving Indigenous languages have in the physical and collective health of Indigenous communities (Hodge & Nandy, 2011; Nez Henderson et al., 2005; Oster et al., 2014).

Basques' distinctive culture and language (*Euskara*) reinforces their collective identity (Zabala et al., 2020). Basque speakers (*Euskaldunak*) whose preferred language is *Euskara* constitute 15.3% of the Basque Country's population, with 29.6% of Basque Country residents in having some *Euskara* knowledge, but only 12.6% practice it outside the home environment (Sociolinguistic Cluster, 2020). Therefore, Basques are a linguistic and ethnic minority, whose language and cultural identity are in a disadvantaged position in comparison to the two dominant cultures (Spanish and French) within the Basque Country (Zabala et al., 2020).

Language is the most prominent aspect of Basque cultural transmission (Bullen, 2003). Historically, Basque women played a crucial role in preserving and transmitting language, customs, and traditions (Bullen, 2003). While resistance to recognize this role remains, contemporary Basque women have gained increased visibility in cultural life. However, those who adopt non-traditional gender roles still face negative personal and social repercussions. Social constructs of language, nation, and gender are frequently used to establish boundaries and shape personal identities (Echeverria, 2003).

Many minority language speakers and non-hegemonic cultures are denied access to quality healthcare services due to the power differentials that exist between minority and dominant cultures. According to Roche (2019), language oppression, as a form of domination, is comparable to oppression related to race, national origin, or ethnicity. Curtis et al. (2019) state that in addition to the power differential arising from language and culture, other contributing factors include an overall lack of awareness and training of healthcare workers regarding the importance of culture and language associated with a particular group, placing providers-patient therapeutic relationships at risk of intended or unintended bias.

The concept of cultural safety has been promoted by Maori nurses working in Aotearoa within a colonial context (Papps & Ramsden, 1996). Cultural safety is the practice of proactively considering patients' social, economic, political situations, and power relations in healthcare, while acknowledging that lack of such consideration can intensify institutional discrimination and replicate traumatic experiences in historically oppressed populations (Ramsden, 1993). Cultural safety derives from critical social theory and asserts that established methods such as, 'cultural awareness' or 'cultural competence', currently applied in healthcare, neglect to address power relationships, which are historically unbalanced between migrant, Indigenous, and/or ethnic minority groups and healthcare providers and services (Evans et al., 2019). As such, Indigenous and ethnic minority groups are often perceived as the 'other,' rather than as an ally whose knowledge and values can contribute evenly to a relationship, or to service the healthcare systems. Cultural safety focuses on relationships of both mutual reciprocal trust and respect (Evans et al., 2019). Therefore, healthcare providers must acknowledge that an individual's dignity must be recognized and highlighted; address their own biases, and engage in reflexivity (Curtis et al., 2019). Implementation of safe and quality care requires healthcare workers to work towards both

cultural safety and critical consciousness, and healthcare organizations and authorities must be accountable for delivering culturally safe healthcare (Curtis et al., 2019).

Understanding the healthcare experiences of Basque women and gender non-normative individuals (BWNN) in the Basque Country, particularly in relation to cultural safety, can improve nursing practices, guide health policy, and deepen the understanding of cultural safety for Indigenous, ethnic minority women, and gender non-normative individuals. This research aims to explore the healthcare experiences of BWNN and identify the barriers and facilitators to implementing cultural safety in the Basque healthcare system.

Intersectionality Theory

Since Kimberlé Crenshaw (1989), a U.S. critical legal race scholar, first coined the concept of "intersectionality," it has become broadly used in social science and health research (Njeze et al., 2020). Black feminist, Latina, post-colonial, Indigenous, and queer academics and activists have generated knowledge addressing the interconnected identities and processes that form human experiences for decades (Bunjun, 2010; Collins, 1990; Valdes, 1997; Van Herk et al., 2010).

Intersectionality is also an extensively utilized theoretical framework in women and gender studies. The core principles of intersectionality emphasize that systems of power, such as race, class, ethnicity, gender, and other forms of hierarchy, are interrelated and co-construct one another. Intersectionality focuses on how these intersecting systems of power influence and reinforce interconnected social inequalities. These overlapping power dynamics create complex and interdependent forms of oppression, shaping the lived experiences of individuals and communities based on their unique social positions within these structures (Collins, 2019).

Intersectionality, aimed to contest and transform power dynamics, examines the experiences of marginalized women which can lead to the promotion of cost-effective health interventions and health policy (Ghasemi et al., 2021). Intersectionality is essential to public health and healthcare because rather than ignoring the complex interactions that are instrumental to comprehend social disparities, it welcomes this complexity (Bowleg, 2012). We conducted our analysis with intersectionality theory in mind, focusing on examining displayed systemic structures of oppression and how they are experienced by BWNN within the health system.

Method

We used a critical ethnographic approach to describe the cultural and sociopolitical factors that shape the experiences of BWNN with healthcare. Critical ethnography emphasizes raising awareness in the aspiration to produce social change (Polit & Beck, 2012). It focuses on the social, cultural, political and historical contexts, while providing a holistic approach to exploring the connections between various forms of power and the evidence supporting empowerment-based practices (Al-Hamad et al., 2022). This approach promotes a critical analysis of power differentials and inequalities as well as continuing communication with communities experiencing discrimination and oppression (Al-Hamad et al., 2022).

Critical ethnography and intersectionality each have strengths, and their combination creates synergies. Building on these synergies, we use critical ethnography and intersectionality to explore the experiences of BWNN in healthcare settings. Through critical ethnography, we seek to capture the lived realities of BWNN by engaging directly with their experiences and observing the ways institutional practices and policies affect their lives. Intersectionality provides a framework to analyze how power systems intersect and overlap creating unique experiences of discrimination for BWNN. By combining these approaches,

our research aims to uncover the complex layers of marginalization within the Basque healthcare system, while amplifying the voices of BWNN to promote more equitable practices and policies.

Setting

This study was conducted in Nafarroa, a Basque province, where Law 18/1986 regulates the populations' linguistic rights, dividing it in three linguistic zones called "Basque speaking area", "mixed zone" and "non-Basque speaking area." (Irujo & Urrutia, 2008). Basques are distributed in seven provinces, three in the French state, and four in Spanish state, ruled by distinct administrative entities (Urla, 2012), and three different entities that manage healthcare. *Osasunbidea* is the organization that manages the healthcare system in Nafarroa.

Ethical Considerations

We used pseudonyms to protect participant identities and obtained participants' formal written consent prior to their involvement. This study was undertaken in partnership with the Department of Health of the Government of Nafarroa, and its corresponding ethics committee (Record # PI_2022/104), and was approved by the University of California San Francisco Institutional Review Board (IRB #22-36656).

Participants and Recruitment

Our research team included five women: four nurses (two Basque-speaking, one Latina, one White of Eastern European descent) and one Black American sociologist. Observations, individual interviews and focus groups were conducted in Basque by the principal researcher (GE). Prior to initiating the recruitment process we established relationships with community members, Basque women's and feminist organizations, the Basque LGBTI+ community, institutional organizations, and Basque language groups. We distributed a flyer, in Basque, with the approval of the health department of Nafarroa and the

management teams of six public healthcare clinics across the province. It was also sent to local feminist, LGTBI+, and women´s groups, and Basque cultural associations through WhatsApp with a brief message explaining the purpose of the study and the eligibility criteria (i.e., self-identified as Basque woman or gender non-normative individuals, 18 years and older, who speaks and understands Basque and had used the healthcare system at least three times within the last year as a patient or as a caregiver). The term gender non-normative individual is a term used within Basque institutions and was agreed upon with members of the Basque LGTBI+ community to identify individuals whose identity is different from the gender assigned to them at birth, including trans and non-binary individuals. Individuals who expressed interest were asked to contact the principal researcher. We used purposive and snowball sampling, recruiting from November 2022 through April 2024.

Research occurred in public healthcare clinics, cultural centers, on Zoom, and in private settings, depending on participants' preferences. We observed six public healthcare clinics, both in rural and urban areas, throughout Nafarroa. Two focus groups took place at a cultural association, one in the library of an *Ikastola* (school), and another in a participant's home.

Data Collection and Analysis

We developed one semi-structured interview guide and one focus group guide. The interview guide addressed the socio-cultural background of the participants, caring experiences, healthcare experiences, cultural and gender identity, and their preferred care options. The focus group was used as a method of member checking as well as assessing if participants had experienced fear during the healthcare encounter. We also used a Qualtrics (Qualtrics, 2024) socio-demographic questionnaire to gather participants' information on age, ethnicity, employment and educational status.

We conducted a total of 37 in-depth interviews, in Basque, both via Zoom and in person, between November 2022 and April 2024. The interviews lasted between 23 and 80 minutes. We deidentified the collected data to guarantee confidentiality. We transcribed the data verbatim using Aditu Elhuyar, a transcription software, and a transcriptionist. Once the interviews were transcribed, a translator translated the data from Basque to English, and the principal researcher revised all transcripts to ensure accuracy.

Since data collection and analysis occurred concurrently, emergent categories and themes guided the ensuing recruitment and data collection decisions. After the analysis of the first 8 interviews, we decided to recruit more participants from areas where Basque language is used less as well as participants with diverse sexual and gender identities to obtain broader information regarding the healthcare experiences of BWNN and improve the application of intersectionality to the study. Participant recruitment concluded when saturation was reached, emerging codes and categories became repetitive and could be included in previously identified themes.

Upon completing all individual interviews, we invited all participants to join one of four focus groups. A total of 24 participants accepted the invitation, 12 were unable to participate due to scheduling conflicts, personal reasons, and one participant sadly passed away before the focus groups. We held the focus groups in all three classified Basque linguistic zones of Nafarroa. Two focus groups took place in urban areas where Basque is considered semi-official. Another was held in a region where Basque has official status, and one in an area where Basque is not recognized as an official language. The in-person focus groups lasted between 58 and 85 minutes and were transcribed and translated as per previous procedure.

Aligned with critical ethnography, we conducted 36 hours of non-participant observations in six healthcare settings, two in each linguistic zone. These observations took place after we contacted managers within each of the facilities and obtained permission from the Department of Health. The observations were carried out in open public areas, such as admission and waiting rooms and focused on cultural, language, and gender-related expressions and interactions. We observed interactions between healthcare workers and patients, cultural expressions within the healthcare centers (including music, decoration, healthcare promotion flyers, and reading material), and language used within the facilities. Each observation session lasted approximately 120 minutes and was conducted three times in each facility between December 2023 and March 2024. We took field notes during the observations and throughout the study, which we later integrated into the data analyses.

We followed a multi-step process to become thoroughly familiar with the data. We classified and indexed the data into more manageable units for easier review. We classified our field notes in a similar way. We used ATLAS.ti software to identify patterns and analyze relationships within the data. We defined and labeled sections of the text to establish codes. Extensive memo writing afforded a deep analysis of emerging themes. We then examined these codes for repetition, analogies, and differences to identify themes emerging from the data. Throughout the coding process we engaged in peer debriefing and consultation to identify the main themes and subthemes and to consider alternative data interpretation. As themes emerged, analysis triangulation was used by converging data obtained from individual interviews, focus groups, field notes, and observation to form thematic statements.

Researcher Positionality

My position as the principal researcher derives from my experience as a Basque working-class feminist activist with more than a decade of experience as a nurse working with

patients from the researched community. My understanding of BWNN´s historical gender and cultural oppression has influenced the study approach. I acknowledge my standpoint as a Basque woman, nurse, and researcher and recognize how my positionality has entailed conducting this research from a position of power and privilege. This perspective has also provided me with the opportunity to use the resources, skills and privileges available to me to provide accessibility to the experiences of those whose stories are invisible to the social majority (Madison, 2020), in this case, the stories of BWNN. During and prior to the fieldwork I have been living within the studied community for decades. Prior and during the study, I collaborated with local and national feminist, cultural and language associations and established meaningful and trustworthy relationships. As a nurse I have been an employee in the public healthcare system which has also favored a collaborative environment during the research process. As a member of the community, I have consciously practiced reflexivity throughout the research process by evaluating my position in the community and how this could affect the research process.

Findings

The study's 37 participants included 35 who self-identified as women, one identified as non-binary, and one preferred not to respond. Participants ranged from 22 to 84 years of age (median of 49.6 years). Twenty-eight participants identified as heterosexual, seven as bisexual, one as non-heterosexual, and one did not respond. For racial and ethnic identity, 29 participants identified as *Euskaldun* (Basque-speaking person), four identified as *Euskaldun* and *Nafar* (Native inhabitant or person who identifies their origins to Nafarroa), one identified as *Nafar*, one identified as *Nafar, Euskaldun* and Spanish, one identified as multiracial, and one did not respond. Participants´ formal educational levels ranged from 8-12th grade (n = 5), technical school (n = 8), 3-year university degree (n = 3), 4–5-year university degree (n = 13), post-graduate degree (n = 2), other (n = 5), and one did not respond. For employment status

19 participants were employed, seven were retired, three were self-employed, three were unemployed, two were on disability, and two did not specify.

We will describe *euskalfobia,* meaning the overall rejection to Basque culture (Elhuyar Foundation, n.d.) in the healthcare system as an overarching theme and normalization of *euskarafobia*, invisibilizing the Basque language and culture, and devaluing of cultural healing practices as underlying theme. Most participants reported experiencing different forms of *euskalfobia* from the highest organizational level to the lowest operational level of the healthcare system, creating unique experiences of discrimination for BWNN.

Normalization of Euskarafobia

Euskarafobia is a term describing a negative attitude or rejection towards the Basque language (Elhuyar, n.d.). According to Arbelaitz (2022), as a linguistic community, *euskarafobia*, describes a conscious and political attitude that marginalizes a vulnerable minority in society. This is not a unique oppression against Basques; it happens when multiple languages coexist within the same geography. Persecution is often tied to a lack of sovereignty, and major empires have historically exercised brutal violence against marginalized groups (Arbelaitz, 2022).

Data revealed an overall atmosphere of normalized oppression towards Basque language and culture within the healthcare system and beyond, i.e. experiences occurring outside the healthcare system were transferred into it. Participants of different ages and regions had stories of being mistreated and threatened with physical violence for speaking Basque within the school system or on the street.

Bianditz, a 22-year-old woman, works as a supervisor at a children's play center, and collaborates with high school students to promote after-school activities in *Euskara*. She lives in a city in the southern part of the province, where most of the population speaks *Erdara*

(Non-Basque language). Her experiences with the healthcare system have primarily involved visits to the gynecologist, for routine check-ups or for acute concerns. She reports that these experiences have been negative, as she feels her concerns were not taken seriously. Discussing language and cultural issues in the healthcare system, Bianditz notes that "many people are against *Euskara*" in her area. She described, during a focus group, a recent event where her acquaintances were threatened with physical violence for speaking Euskara in public, leading Bianditz to admit that she often tries to conceal her *Euskaldun* identity for fear of being mistreated or prejudged.

> A few weeks ago, two acquaintances walked down the street and, said “agur” [Hello, in Basque] to each other, and a group went after them to beat them up. With situations like that ... I rarely speak *Euskara* to a doctor or in a supermarket, because I don't dare unless there’s somebody I know.

Bianditz's experience is shaped by intersectional oppression. As a young woman, she is describing not being taken seriously which is commonly experienced by women during healthcare encounters. Being *Euskaldun* and living in an area where her language and culture are rejected enhance this experience of marginalization, as she encounters *euskarafobia* daily and potentially during healthcare encounters. The healthcare system is not exempt of prejudice, and often reproduces systemically embedded oppressive structures of power such as patriarchy and cultural/linguistic supremacy. Bianditz’s fear of being mistreated due to her ethnicity conveys that healthcare workers may, consciously or unconsciously, reproduce society’s prejudices. Thus, her ability to receive optimal healthcare services is limited and it raises concern regarding how structural oppression operates within institutions.

Participants also reported several instances where they were mistreated or discriminated against for using their language or identifying as *Euskaldun*. They described

experiencing prejudiced attitudes and comments from healthcare workers for speaking *Euskara* with their children. Iholdi, a 52-year-old woman who works as a teacher, lives in the northern part of the province, a predominantly *Euskaldun* municipality. She has had multiple interactions with the healthcare system, both as a patient during her pregnancies and childbirth, and as a caregiver for family members. She recalls an incident at the hospital where a doctor was treating her son, and she had to translate because her son did not understand Spanish. The doctor expressed disapproval of her son's inability to speak Spanish, Iholdi felt as though her son was being portrayed as uneducated and her abilities as a mother were being questioned, creating tension during the healthcare encounter.

> And we went there, and a woman (doctor) said, *"open your mouth*" and "open your mouth" (Basque) I said to (son), and so she started… *"How old is this child?"* and *"5"* and… *"It's time for him to learn to speak Spanish."* And I told her, *"Well, I don't know..." "And in school do they not learn Spanish?" "No,"* I told her, that they spoke only in Basque, but I told her to relax. That he would learn Spanish, that I also always studied in Basque and that I knew Spanish perfectly, as I was speaking." … "She went into my personal life and was basically saying that my son was "uneducated" because he did not know Spanish. [italized represent Spanish language quotes]

Iholdi finds herself in a vulnerable position due to her concern for her child's illness and need for healthcare services. This vulnerability is heightened when she perceives rejection toward her identity and culture. She anticipates and fears *euskarafobia***,** having come to normalize it as part of her interactions with *Erdaldun* healthcare workers. Her concern shifts to how intense this rejection will be in each encounter.

> Imagine how far I've gone, I mean, almost to settle if they don't give us a bad look or a look of disdain, to settle with that. Sometimes they treat you badly because you are

> speaking Basque with your son who does not understand Spanish. But what the fuck is that?

During one of the focus groups, as we were reflecting about these experiences and what participants feel as they experience *euskarafobia*, Iholdi identifies this feeling as fear:

> And concerning the language… I mean, I'd certainly call it fear. Afraid to say the first word in *Euskara*. Afraid of their reaction, because the last time was horrible, not because they spoke *Erdara*, no, but because my son did not know *Erdara*...

Iholdi's experience is shaped by overlapping factors of gender, ethnicity and power relations within the healthcare system. She is simultaneously encountering gender scrutiny as a mother, linguistic discrimination as an *Euskaldun*, and institutional prejudice in a healthcare system dominated by *Erdaldun* norms. Iholdi's experience illustrates how numerous experiences of subordination intersect to create magnified discrimination (Hay et al., 2019) for BWNN.

Normalization of *euskarafobia* increases existing power relations between healthcare workers and patients, leading to high tension and frustration during healthcare encounters. Participants' experiences demonstrate the lack of cultural safety in healthcare, where linguistic and cultural discrimination enhances their vulnerability and leads to feelings of judgment. To implement cultural safety in the Basque healthcare setting, systemic oppression, as well as its historical roots, must be addressed at all levels.

On the other hand, most participants agree that language and cultural concordance is necessary and positive in their healthcare experience. Participants refer feeling closeness, joy, openness and tranquility when language and cultural concordance occurs. Nahia, a 39-year-old woman who lives in a small village in eastern Nafarroa, is a teacher and recalls how

having *Euskaldun* healthcare workers care for her during childbirth was key to a positive experience.

> … during my pregnancy for example, well, I was lucky because the midwives were *Euskaldun* and that changed everything for me... being there, in that environment, talking in *Euskara* and without being judged… It might be the sweetest memory I have from childbirth, I felt like at home.

Nahia's feeling of being "like at home" indicates a profound sense of comfort and security during her birthing experience, which is crucial given the stress many birthing individuals encounter during childbirth. Her experience highlights a deep sense of well-being and connection, which extends beyond sharing her language and culture with the healthcare worker; it encompasses a sense of belonging and safety that underscores the idea of being in place (Rhodus & Rowles, 2023).

Language and cultural concordance can reduce the likelihood of ethnic discrimination and bias, while increasing patient satisfaction during healthcare encounters. Therefore, language and cultural concordance could mitigate the negative effects of cultural and linguistic discrimination and play a crucial role in facilitating the implementation of cultural safety in the Basque setting.

Invisibilizing the Basque language and culture in the healthcare system

When we asked participants how they perceived the value of their culture and language within the healthcare system, most participants agreed that their language and culture were either undervalued or not valued at all. This sentiment was consistent throughout Nafarroa, regardless of the official status of the Basque language in different regions. Several factors contribute to this sense of undervaluation: the scarcity of healthcare workers who recognize the Basque language and identity, the absence of Basque cultural expressions—

such as Basque music or symbols—within healthcare settings, and legislation that imposes geographical restrictions on the linguistic rights of Basque speakers (Irujo & Urrutia, 2008). Together, these conditions create the foundation for invisibilizing the Basque language and culture within the healthcare setting. The following narratives illustrate this lack of recognition and invisibilization.

Eihara, a 48-year-old woman, is a Basque language teacher currently on medical leave, recovering from a surgery which increased her recent exposure to the healthcare system. She lives in a city in the southern part of the province, where the Basque-speaking population is a minority and linguistic rights of Basque speakers are not legally recognized, despite United Nations and European authorities affirming the "inalienable right" to use a language in private and public life (Pons Parera, 2008). This restriction means that no healthcare providers are required to speak or understand *Euskara*. Eihara identifies the practical repercussions of this law affecting her experience within the healthcare system. She refers to requesting her appointment reminders to be sent to her in *Euskara* as the only sign of the presence of her language or culture within the healthcare system:

> Of course, here I cannot, directly… go to the health center or hospital speaking *Euskara*… I asked for them [reminders] to be in *Euskara* but, of course, then I go with the letter to the nurse and the nurse does not understand anything, and once they told me, “I don’t know in what language you have this, do you want me to change it to Spanish?” And I told them, “No, no… that’s *Euskara* and I asked for that change. And there, for example, I felt, well, on the one hand, good, because I set my identity on the table and, well, I don't think they were embarrassed. On the other hand, bad, you say, well I have to give an explanation… because I receive a letter in my own language, and I also have to make a double effort, on the one hand for having to request the

change and on the other hand, because I had to ask them to leave it like that, that I don't want it to be in another language.

Eihara is aware of the limitations and restrictions she faces during healthcare encounters, as a conversation with her doctor in her own language is not an option. However, she presents the letter as a means of asserting her identity and making it visible. This denial, in turn, restricts her linguistic rights and enhances her experience of discrimination.

Aloña, a 52-year-old woman, is on disability due to a chronic illness and is a frequent user of the healthcare system. She lives in a small village in the northern part of the province in a municipality where over 70% of the population are Basque speakers. She has regular follow-up visits with her primary care provider in her hometown, and with specialists in the city. She believes her language and culture are not valued and explains how she rarely encounters providers who are *Euskaldun*. Aloña attributes this to a structural problem related to the deliberate decision of the healthcare system to not require healthcare workers to speak her language.

So well, from 0 to 10 I would say 0. Yes, that's how I live it, because I can see that among all the doctors that treat me, it's a big coincidence to have an *Euskaldun* one… I mean, in the health system that I use, none of the doctors…would be able to treat me in *Euskara*.

For Aloña, the limited opportunity to speak her language during healthcare encounters produces a general sentiment of hopelessness, anger and frustration:

So, it's a bit hopeless. So, at the same time, you go for some results or to run some tests or for I don't know what and well, with that hopelessness you set all that aside. Your anger or your happiness, or it doesn't matter, I live all that from hopelessness. Yes, I feel there are no options.

Aloña faces significant disadvantages during her interactions with the healthcare system. Relying on these services to maintain her health, she feels she has no option but to endure the marginalization imposed by the healthcare system replicating *euskalfobia* by not requiring healthcare workers to have a knowledge of Basque language and culture.

Auza is a self-employed 40-year-old non-binary individual. They live in a small town in the northern part of the province where most of the population is *Euskaldun*. They are currently seeking gender affirming care with initial encounters with their primary care provider and multiple follow-up appointments with specialists. Their experience has been especially challenging due to the limited number of specialists in gender-affirming care, which reduces the likelihood of finding *Euskaldun* providers in this field. Although Auza has conveyed to the healthcare system that being able to express themselves in *Euskara* is a necessity, all their specialists have been *Erdaldun.* For Auza, the most difficult part of their experience has been to realize how their language and culture are invisible to the healthcare providers caring for them. Auza understands that this invisibility is a result of structures of oppression manifested through the power relations between them and the healthcare workers during their encounters, which allow healthcare workers to be active or passive participants of this structural oppression. *"*For me the biggest difficulty is the people or the system that don't see what being *Euskaldun* is.*"* For Auza, there is a persistent attempt by *Erdaldun* healthcare workers to deny the existence of their culture and language, whether consciously or unconsciously. Auza feels this lack of acknowledgment undermines their ability to be themselves. The negative impact of this denial is even more pronounced when a power relation exists, which occurs during the healthcare encounter. *"*From a position of power, it is in their interest to make it disappear, or they don't want this reality to exist, so they will do whatever using their power." Auza believes that a healthcare worker's lack of knowledge of

their language and culture goes beyond merely having to communicate in a language they are not fluent in; it also signifies a deliberate attempt at cultural erasure.

> So, what happens to me over and over in the health system is, that if the person that takes care of me doesn't know *Euskara*, I need to adapt to their situation, because they can't adapt to mine. Because my situation [being *Euskaldun*] doesn't exist in their world. So then, in that difficulty … I can't be myself and I show a part of what I am. And with that, if it needs to be done, you go ahead, but sure, for me, it's not going to be satisfying.

Auza describes this experience of invisibility as oppressive and restricting. Not being able to express themselves in their language results in not being able to make their identity visible, which leads to an unpleasant and unsatisfying healthcare experience. Participants´ experiences reveal how multiple overlapping power dynamics at a micro level (patient-provider interaction, healthcare inequality and discrimination) intersect with macro level structures (patriarchy, ableism, transphobia, homophobia, colonialism) (Bowleg, 2012) to produce experiences of discrimination for BWNN. These interactions take place in an environment of connected systems and structures of power such as laws, policies, state governments and the healthcare system (Hankivsky, 2014). In this case, invisibilization of Basque language and culture occurs at multiple levels of the healthcare system. This includes legislation that restricts the linguistic rights of *Euskaldun* patients, a public healthcare system that does not require workers to be knowledgeable about Basque language and culture, and *Erdaldun* healthcare workers who reinforce these discriminatory policies during medical encounters.

During the observations we perceived the dominance of Spanish language and culture throughout all healthcare centers, regardless of the official presence of Basque language and culture. *Euskara*, when present, is secondary, mostly in posters and signs related to province-

wide campaigns. Signs originating from healthcare centers, particularly those intended to communicate with patients in reception areas or consultation offices, are typically only in Spanish. We observed very few culturally significant signs, pictures, or decorations related to Basque culture or language, (e.g., farmhouses, sheepherding, sports, dances, carnival). Only one center in the 'Basque-speaking' region displayed Basque culture—a collection of photos showing local people from different historical periods. Additionally, in several healthcare centers, the background music played was mostly in English or Spanish.

Observations reinforced participants' perceptions that the Basque language and culture have decreased visibility. These findings coincide with other Indigenous/ethnic minority communities whose cultural norms and expressions are considered invisible, neglected and unknown to the majority of healthcare workers (Mehus et al., 2019; Ness & Munkejord, 2022). This invisibility reflects a form of *euskalfobia* that lays the groundwork for cultural erasure, particularly in the Basque culture, where the focus has been on language eradication. Language eradication parallels dehumanization; just as dehumanization can lead to genocide, the degradation of a language—and its speakers—can result in “linguicide” (Irujo & Miglio, 2013).

As we listened to healthcare workers and patients speaking, we noticed that *Euskara* was more common in the rural northern part of the province, coinciding with majority *Euskaldun* population municipalities. However, even there, Spanish dominated, even among *Euskaldun* workers. We also observed *Euskaldun* patients switching to Spanish when communicating with monolingual Spanish-speaking healthcare workers. In the healthcare centers in the central and southern areas of the province, we rarely heard patients or healthcare workers speaking *Euskara*. The decreasing visibility of the Basque language and cultural expressions coincide with the official status of the language having decreased recognition and the *Euskaldun* population being a minority. Structural violence of linguistic

erasure is gradual, as it fosters assimilation not only by prohibiting certain languages but also by making preferred options impractical while rendering undesirable options convenient and rewarding (Roche, 2019).

To implement cultural safety in the Basque healthcare system, it is essential to recognize the existence of the Indigenous ethnic minority and their right to culturally safe healthcare. The invisibility and discrimination of the Basque language and culture within the healthcare system present significant barriers to achieving this goal.

Devaluing of cultural healing practices

Another important cultural component of health for BWNN is the use of healing practices. Most participants acknowledged the existence of cultural healing practices transmitted throughout generations. However, participants perceive that this knowledge is being threatened by the current healthcare system's rejection of these practices. Auza, whom we met earlier, notes that devaluing of cultural healing practices is yet another facet of cultural erasure experienced through various levels of oppression throughout history.

> That knowledge has been there until recently, and now few people know it. It's disappearing for a reason; it's not considered in the system because of something. But if there are things that work, why are they not in the system? … Well, if there is some knowledge of this kind, of a culture that is now oppressed, imagine what would happen in an era where it was even more oppressed. Probably, they made that wisdom disappear on purpose. Because it's a strategy to make that culture disappear. I connect it with that, I don't know.

By questioning the exclusion of these practices from the healthcare system, Auza directs attention to the power structures that prioritize Western medicine while attempting to erase healing traditions rooted in Indigenous knowledge. Auza's insight agrees with research

that understands devaluation of cultural healing practices as an example of how healthcare systems are complicit in medical colonialism which has systematically interrupted Indigenous knowledge transmission through cultural erasure (Pilarinos et al., 2023).

Most participants admit using cultural healing practices and, on many occasions, prefer them over Westernized medicine. Participants however are reluctant to share this information with their healthcare providers for fear of being judged or scolded, as they perceive promotion of Western medicine as the only option to healing. This leads to miscommunication and lack of transparency during the healthcare encounter as well as the avoidance of using the healthcare system.

Maddi is a 39-year-old woman living in a small town in the northern region of the province, where the majority of the population is *Euskaldun*. She works as an education support specialist. Although she has used the healthcare system sporadically over the years, Maddi and her family prioritize using cultural healing practices when available. For Maddi, it is common to initially address health issues through these cultural practices and combine them with Western medicine as needed:

> I remember one time; my fistula was up on my back … and I went to the doctor in an emergency, and I told them I was using San Juan ointment … Because I first use those things I have handy, and those are the things I have handy, right? And then if I see they're not working, … I go, well, to the health center. And I didn't really like their reaction, right? They told me "Well, well, if you want, keep using it", but like that, as if it worked for nothing, right? So that last time, when my fistula came out again, I went to the doctor, and I was using the San Juan ointment, but I didn't tell them. In the end, why am I going to tell them?

A lack of training and knowledge about cultural healing practices lead many practitioners to advise against their use, dismiss them, or to fail to recognize their therapeutic effects. In Maddi's experience gender dynamics, cultural erasure, and systemic bias within the healthcare system overlap and contribute to an environment of distrust that could contribute to negative health outcomes.

Amalur, a 57-year-old woman, was born and raised in a large town in the center of Nafarroa, where she still lives. This area falls within the "mixed zone" of the province, where Basque language has limited legal recognition. She works part-time as a porter at a cultural center and part-time in a school dining room. Although her grandparents occasionally used Basque words, *Euskara* was not spoken at home, so Amalur learned the language as an adult. She has had various experiences with the healthcare system, both as a caregiver for her parents and children, and occasionally as a patient. Amalur notes that cultural healing practices, common in her region, are considered an important part of local traditions. For Amalur, cultural healing practices are closely related to community knowledge transmission and community interdependence. She shares an experience where a neighbor, whom she didn't know personally, visited her home to offer local remedies for her osteoarthritis, which he had learned about from the community.

> One day this retired man came here, to my home, … I did not know him, I just knew who he was, and "damn, I have heard that you have osteoarthritis, and look…" He brought me herbs and a paper saying how to make the cream. "I mean, I heard about your problem so here you are." I mean, how we take care of each other, right?

Amalur emphasizes that the significance of cultural healing practices goes beyond their medicinal properties. They represent shared knowledge within the community,

emphasize the collective aspect of healing and highlight the importance of community members caring for one another, a key part of their cultural identity.

Most participants support and respect the use of cultural healing practices and advocate for their inclusion as an option within the healthcare system. Many suggest that the system should offer a combination of treatments, allowing access to different healing practices without placing the financial burden on patients.

Laiene, a 43-year-old woman who works as a teacher and lives in a predominantly *Euskaldun* area in western Nafarroa, was raised using cultural healing practices alongside Western medicine. She believes the healthcare system lacks a holistic approach, a gap that could be addressed by integrating these cultural practices.

> Well, I think public health ought to also be maybe a bridge, right? … I think it should be more integrated, including the health system, right? Well, with those herbs, the same, I don't know if that person is with the therapist, I don't know, right? In a more comprehensive way this holism of the person, right? and that knowledge of culture too, I think are very useful, right?

Overall, the devaluing of cultural healing practices by healthcare workers and the healthcare system leads to a lack of trust and poor communication during healthcare encounters. Participants see this devaluation as a sign of disdain toward their culture and collective knowledge. They associated this rejection with the absence of a holistic approach in Western medicine, which does not fully meet their healthcare needs. The devaluation of cultural healing practices is not isolated but is tied to broader systems of marginalization that affect how participants access and experience healthcare. A gradual understanding of cultural healing practices through healthcare worker training and research could be a key step toward implementing cultural safety in healthcare for BWNN.

Discussion

During interactions with healthcare workers and clinic leadership prior to starting data collection, several providers expressed the belief that BWNN did not face discrimination. However, our findings reveal that BWNN not only experience discrimination based on gender, ethnicity, and other factors, but that these systems of power overlap and intersect with multilevel oppressive structures. These structures are reproduced through normalization of *euskarafobia*, invisibilizing Basque language and culture and devaluing cultural healing practices within the healthcare system, creating a unique negative experience for BWNN. Marginalization of linguistic minorities lead to members of these communities experiencing discrimination, linguistic oppression, and assimilation (Roberts et al., 2007).

Power unbalance between patients and healthcare workers is manifested throughout health literature (Green et al., 2018; Noyes, 2022; Ocloo et al., 2020; Odero et al., 2020). This study made visible the interrelatedness of privilege and oppression within the experiences of BWNN in healthcare, and the importance of assessing the interrelation and generation of situations of marginalization or privilege for the researched community (Hay et al., 2019). BWNN experience marginalization within the healthcare system due to their position as Indigenous and ethnic minority people, who are also in a position of vulnerability as patients or caregivers which coincide with other historically oppressed communities´ experiences, explained by intersectionality theory (Crenshaw, 1991; Hankivsky, 2014).

The implementation of cultural safety can enhance BWNN's experiences by considering their specific socio-economic and political contexts, as well as the power dynamics in healthcare (Ramsden, 1993). In this study, barriers and facilitators to culturally safe care. i.e. quality care as perceived by the participants and their communities (Harding et al., 2021), have been identified based on the unique experiences of BWNN. Invisibilizing

Basque language and culture is a major barrier to implement cultural safety in the Basque healthcare setting. Implementation of cultural safety requires structural changes within all levels of the healthcare system including coordinated pathways of care, organizational changes and healthcare worker training, (Laverty et al., 2017) acknowledgement of the existence of an Indigenous ethnic minority, and promotion of the understanding of their right to receive culturally safe care.

The findings of this study highlight the systemic existence of *euskarafobia* which make it difficult for staff and management to recognize and acknowledge discrimination incidences, resulting in a generalized belief that they do not occur. BWNN participants connect the normalization of *euskarafobia* in healthcare with the historical oppression of the Basque community. To implement cultural safety in the Basque setting, the historical roots of *euskarafobia* need to be addressed. It is necessary to identify the power structures that enables its promotion, and a systemic approach to expand healthcare workers' awareness of this unconscious bias by identifying it, preventing it and creating structures to eliminate it (Ness & Munkejord, 2022).

Findings demonstrate how discrimination experienced and normalized outside of the healthcare setting is replicated within it. These results align with the concept of cumulative discrimination which indicates that when an individual or community have lived countless forms of marginalization throughout history, preceding experiences may condition current events (Ness & Munkejord, 2022). Participants refer experiences of being dismissed as uneducated and ignorant by healthcare workers, leading participants to avoid healthcare services for fear of being judged or mistreated during the healthcare encounter. This finding aligns with other studies examining the experiences of ethnic minority groups, whose health concerns are frequently dismissed and devalued by providers lacking cultural knowledge, leading to a reluctance to seek care (Fante-Coleman et al., 2022).

Participants perceived that healthcare workers' devaluing and dismissing cultural healing practices was related to an overall devaluation of participants' cultural beliefs. This aligns with other Indigenous community experiences that feel their beliefs are being ignored which intensifies mistrust in Westernized healthcare (Pilarinos et al., 2023). This study also shows that most BWNN participants use cultural healing practices in search of a holistic approach to health based on community kingship. Research proposes blending westernized and cultural healing practices by including both sources of knowledge in the development of a healthcare system that will benefit all communities (Marsh et al., 2015). The gradual introduction of cultural healing practices into the healthcare system in combination with Westernized medicine practice is considered by participants as an optimal and comprehensive approach.

Although language and cultural concordance is not guaranteed within the Basque healthcare system, this study shows that when language and cultural concordance occurs increased trust, sense of belonging, and satisfaction is perceived. Studies emphasize the importance of language concordance to improve health outcomes (Hsueh et al., 2021; Seale et al., 2022).

Limitations

Limitations of this study include data collection in *Euskara* and data analysis in English. As every language provides unique perspective and understanding there is a possibility that essential parts of data might have been lost through translation. We mitigated this by reading the transcripts in *Euskara* and the English translation. This study was conducted in only one of the seven Basque provinces therefore results may not be generalizable to other Basque regions. Although the study included Basque women and

gender non-normative individuals, the study sample mostly included heterosexual cis-gender women, which led to an underrepresentation of sexual and gender minorities.

Conclusions

This qualitative study explored the experiences of BWNN with healthcare in the Basque Country, contributing to fill a gap in research in this area within the European setting. This study highlights harmful prejudice and discrimination experienced by BWNN in the healthcare setting due to their preferred language and marginalized position as members of an Indigenous ethnic minority community, which could lead to negative health outcomes. However, findings also provide guidance to practices, including language and cultural concordance, acknowledgement of cultural healing practices and training regarding the concept of cultural safety at an individual and institutional level which may act as facilitators to the implementation of cultural safety in Basque Country.

References

Al-Hamad, A., Forchuk, C., Oudshoorn, A., & McKinley, G. P. (2022). The Potential of Merging Intersectionality and Critical Ethnography for Advancing Refugee Women's Health Research. *ANS. Advances in Nursing Science*, *45*(2), 143–154. https://doi.org/10.1097/ANS.0000000000000404

Arbelaitz, L. (2022, March 27). *Mintza gaitezen hizkuntza zapalkuntzaz* [Let's Talk About Language Oppression]. Larrun, 272, 30–33. https://www.argia.eus/larrun/272

Bowleg, L. (2012). The problem with the phrase "women and minorities": Intersectionality—An important theoretical framework for public health. *American Journal of Public Health, 102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750

Bullen, M. (2003). *Basque gender studies.* https://scholarworks.unr.edu//handle/11714/5053

Bunjun, B. (2010). *Feminist organizations and intersectionality: Contesting hegemonic feminism.* Atlantis: Critical Studies in Gender, Culture & Social Justice, 34(2), 115–126.

Chan, A., Pullen Sansfaçon, A., & Saewyc, E. (2023). Experiences of discrimination or violence and health outcomes among Black, Indigenous and People of Colour trans and/or nonbinary youth. *Journal of Advanced Nursing, 79*(5), 2004–2013. https://doi.org/10.1111/jan.15534

Cole, J. (2011). *Ethnic groups of Europe: An encyclopedia.* ABC-CLIO.

Collins, P. H. (1990). *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment* (2nd ed.). Routledge. https://doi.org/10.4324/9780203900055

Collins, P. H. (2019). *Intersectionality as critical social theory.* Duke University Press.

Committee of Experts of the European Charter for Regional or Minority Languages. (2024). *Sixth evaluation report on Spain* (MIN-LANG (2024)17; p. 142). Council of Europe.

Crenshaw, K. (1989). Demarginalizing the intersection of race and sex: A Black feminist critique of antidiscrimination doctrine, feminist theory and antiracist politics. *The University of Chicago Legal Forum, 1989*(1), 139–167. https://doi.org/10.4324/9780203912332-4

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241. https://doi.org/10.2307/1229039

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health, 18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Echeverria, B. (2003). Language ideologies and practices in (en)gendering the Basque nation. *Language in Society, 32*(3), 383–413. https://doi.org/10.1017/S0047404503323048

Elhuyar Foundation. (n.d.). *Euskarafobia* [Basque language phobia]. Hiztegiak Elhuyar. Retrieved October 25, 2024, from https://hiztegiak.elhuyar.eus/eu_es/euskarafobia

Elhuyar Foundation. (n.d.). *Euskalfobia* [Basque culture phobia]. Hiztegiak Elhuyar. Retrieved October 25, 2024, from https://hiztegiak.elhuyar.eus/eu_es/euskalfobia

Evans, C., Tweheyo, R., McGarry, J., Eldridge, J., Albert, J., Nkoyo, V., & Higginbottom, G. M. A. (2019). Seeking culturally safe care: A qualitative systematic review of the healthcare experiences of women and girls who have undergone female genital mutilation/cutting. *BMJ Open, 9*(5), e027452. https://doi.org/10.1136/bmjopen-2018-027452

Fante-Coleman, T., Wilson, C. L., Cameron, R., Coleman, T., & Travers, R. (2022). 'Getting shut down and shut out': Exploring ACB patient perceptions on healthcare access at the physician-patient level in Canada. *International Journal of Qualitative Studies on Health and Well-Being, 17*(1), Article 2075531. https://doi.org/10.1080/17482631.2022.2075531

Federici, S. (2004). *Caliban and the witch: Women, the body and primitive accumulation*. Autonomedia.

Friend, J. (2012). *Stateless nations: Western European regional nationalisms and the old nations.* Springer.

Gaindegia. (2020). *Biztanleria osoa* [Total population]. http://gaindegia.eus/index.php/eu/datuak/demografia/biztanleria-osoa

Ghasemi, E., Majdzadeh, R., Rajabi, F., Vedadhir, A., Negarandeh, R., Jamshidi, E., Takian, A., & Faraji, Z. (2021). Applying intersectionality in designing and implementing health interventions: A scoping review. *BMC Public Health, 21*(1), 1407. https://doi.org/10.1186/s12889-021-11449-6

Green, A., Abbott, P., Davidson, P. M., Delaney, P., Delaney, J., Patradoon-Ho, P., & DiGiacomo, M. (2018). Interacting with providers: An intersectional exploration of the experiences of carers of Aboriginal children with a disability. *Qualitative Health Research, 28*(12), 1923–1932. https://doi.org/10.1177/1049732318793416

Gupta, A. (2005). *Human rights of indigenous peoples*. Isha Books.

Hankivsky, O. (2014). *Intersectionality 101*. Vancouver: Institute for Intersectionality Research & Policy.

Harding, J., MacKinnon, K., Sangster-Gormley, E., & Gordon, C. (2021). Indigenous peoples' positive experiences of culturally safe health care: A qualitative systematic review protocol. *JBI Evidence Synthesis, 19*(9), 2434–2440. https://doi.org/10.11124/JBIES-20-00181

Hay, K., McDougal, L., Percival, V., Henry, S., Klugman, J., Wurie, H., Raven, J., Shabalala, F., Fielding-Miller, R., Dey, A., Dehingia, N., Morgan, R., Atmavilas, Y., Saggurti, N., Yore, J., Blokhina, E., Huque, R., Barasa, E., Bhan, N., … Rao Gupta, G. (2019). Disrupting gender norms in health systems: Making the case for change. *The Lancet*, *393*(10190), 2535–2549. https://doi.org/10.1016/S0140-6736(19)30648-8

Hodge, F. S., & Nandy, K. (2011). Predictors of wellness and American Indians. *Journal of Health Care for the Poor and Underserved*, *22*(3), 791–803. https://doi.org/10.1353/hpu.2011.0093

Hsueh, L., Hirsh, A. T., Maupomé, G., & Stewart, J. C. (2021). Patient–Provider Language Concordance and Health Outcomes: A Systematic Review, Evidence Map, and Research Agenda. *Medical Care Research and Review*, *78*(1), 3–23. https://doi.org/10.1177/1077558719860708

Irujo, X., & Miglio, V. (2013). *Language Rights and Cultural Diversity*. Center for Basque Studies.

Irujo, X., & Urrutia, I. (2008). Basque in the Foral Community of Navarre (CFN). In *The legal status of the Basque language today: One language, 3 administrations, 7 different geographies and a diaspora* (pp. 197-220). Eusko Ikaskuntza

Laverty, M., McDermott, D. R., & Calma, T. (2017). Embedding cultural safety in Australia's main health care standards. *Medical Journal of Australia, 207*(1), 4–10. https://doi.org/10.5694/mja16.00701

Madison, D. S. (2020). *Critical Ethnography: Method, Ethics, and Performance*. SAGE Publications, Inc. https://doi.org/10.4135/9781071878965

Marsh, T. N., Coholic, D., Cote-Meek, S., & Najavits, L. M. (2015). Blending Aboriginal and Western healing methods to treat intergenerational trauma with substance use disorder in Aboriginal peoples who live in northeastern Ontario, Canada. *Harm Reduction Journal*, *12*, 14. https://doi.org/10.1186/s12954-015-0046-1

Mehus, G., Bongo, B., Engnes, J., & Moffitt, P. (2019). Exploring why and how encounters with the Norwegian health-care system can be considered culturally unsafe by North Sami-speaking patients and relatives: A qualitative study based on 11 interviews. *International Journal of Circumpolar Health, 78*(1), Article 1612703. https://doi.org/10.1080/22423982.2019.1612703

Montes Lasarte, A., Arauzo, X., & Zarate Sesma, J. (2021). The Basque Paradigm Shift: From Legislative Language Policies to Person-Centred Care. *Minorités Linguistiques et Société*, *15–16*, 198. https://doi.org/10.7202/1078482ar

Ness, T., & Munkejord, M. (2022). "All I expect is that they accept that I am a Sami": An analysis of experiences of healthcare encounters and expectations for future care services among older South Sami in Norway. *International Journal of Circumpolar Health, 81*(1), Article 2078472. https://doi.org/10.1080/22423982.2022.2078472

Nez Henderson, P., Jacobsen, C., & Beals, J. (2005). Correlates of Cigarette Smoking Among Selected Southwest and Northern Plains Tribal Groups: The AI-SUPERPFP Study. *American Journal of Public Health*, *95*(5), 867–872. https://doi.org/10.2105/AJPH.2004.050096

Njeze, C., Bird-Naytowhow, K., Pearl, T., & Hatala, A. R. (2020). Intersectionality of Resilience: A Strengths-Based Case Study Approach With Indigenous Youth in an

Urban Canadian Context. *Qualitative Health Research*, *30*(13), 2001–2018. https://doi.org/10.1177/1049732320940702

Noyes, A. L. (2022). Navigating the Hierarchy: Communicating Power Relationships in Collaborative Health Care Groups. *Management Communication Quarterly*, *36*(1), 62–91. https://doi.org/10.1177/08933189211025737

Ocloo, J., Goodrich, J., Tanaka, H., Birchall-Searle, J., Dawson, D., & Farr, M. (2020). The importance of power, context and agency in improving patient experience through a patient and family centred care approach. *Health Research Policy and Systems*, *18*(1), 10. https://doi.org/10.1186/s12961-019-0487-1

Odero, A., Pongy, M., Chauvel, L., Voz, B., Spitz, E., Pétré, B., & Baumann, M. (2020). Core Values that Influence the Patient-Healthcare Professional Power Dynamic: Steering Interaction towards Partnership. *International Journal of Environmental Research and Public Health*, *17*(22), 8458. https://doi.org/10.3390/ijerph17228458

Oster, R. T., Grier, A., Lightning, R., Mayan, M. J., & Toth, E. L. (2014). Cultural continuity, traditional Indigenous language, and diabetes in Alberta First Nations: A mixed methods study. *International Journal for Equity in Health*, *13*, 92. https://doi.org/10.1186/s12939-014-0092-4

Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: The New Zealand Experience. *International Journal for Quality in Health Care*, *8*(5), 491–497. https://doi.org/10.1093/intqhc/8.5.491

Petralanda Mendiola, B. (2018). Zirkuitu elebidunerantz lehen pausua. *BAT Soziolinguistika Aldizkaria*, *108*(2018 (3)), 43–60.

Pilarinos, A., Field, S., Vasarhelyi, K., Hall, D., Fox, E. D., Price, E. R., Bonshor, L., & Bingham, B. (2023). A qualitative exploration of Indigenous patients' experiences of

racism and perspectives on improving cultural safety within health care. *CMAJ Open*, *11*(3), E404–E410. https://doi.org/10.9778/cmajo.20220135

Polit, D. F., & Beck, C. T. (2012). *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. Wolters Kluwer Health/Lippincott Williams & Wilkins.

Pons Parera, E. (2008). International legislation and the Basque language. In *The legal status of the Basque language today: One language, three administrations, seven different geographies and a diaspora*. Cenarrusa Foundation.

Qualtrics. (2024). *Qualtrics XM* [Software]. Qualtrics. https://www.qualtrics.com

Ramsden, I. (1993). Cultural safety in nursing education in Aotearoa (New Zealand). *Nursing Praxis in New Zealand Inc*, *8*(3), 4–10.

Reyner, J. (2013). Giving Language Rights Meaning: Revitalizing Basque, Navajo, and Other Indigenous Languages and Cultures. In *Language Rights and Cultural Diversity* (pp. 223–244). Center for Basque Studies.

Rhodus, E. K., & Rowles, G. D. (2023). Being in Place: Toward a Situational Perspective on Care. *The Gerontologist*, *63*(1), 3–12. https://doi.org/10.1093/geront/gnac049

Roberts, G. W., Irvine, F. E., Jones, P. R., Spencer, L. H., Baker, C. R., & Williams, C. (2007). Language awareness in the bilingual healthcare setting: A national survey. *International Journal of Nursing Studies*, *44*(7), 1177–1186. https://doi.org/10.1016/j.ijnurstu.2006.03.019

Roche, G. (2019). Articulating language oppression: Colonialism, coloniality and the erasure of Tibet's minority languages. *Patterns of Prejudice*, *53*(5), 487–514. https://doi.org/10.1080/0031322X.2019.1662074

Seale, E., Reaume, M., Batista, R., Eddeen, A. B., Roberts, R., Rhodes, E., McIsaac, D. I., Kendall, C. E., Sood, M. M., Prud'homme, D., & Tanuseputro, P. (2022). Patient–physician language concordance and quality and safety outcomes among frail home

care recipients admitted to hospital in Ontario, Canada. *CMAJ*, *194*(26), E899–E908. https://doi.org/10.1503/cmaj.212155

Sociolinguistic Cluster. (2020). *Euskararen datu soziolinguistikoen biltegia* [Sociolinguistic database on Euskera]. http://www.soziolinguistika.eus/edb/index.php?erakus=aurkezpena

Teti, M., Kerr, S., Bauerband, L. A., Koegler, E., & Graves, R. (2021). A Qualitative Scoping Review of Transgender and Gender Non-conforming People's Physical Healthcare Experiences and Needs. *Frontiers in Public Health*, *9*, 598455. https://doi.org/10.3389/fpubh.2021.598455

United Nations. (2018). *Indigenous peoples and ethnic minorities: Marginalization is the norm*. In *The report on the World social situation 2018* (pp. 97–108). UN. https://doi.org/10.18356/14642ccc-en

Urla, J. (2012). *Reclaiming Basque: Language, nation, and cultural activism*. University of Nevada Press.

Valdes, F. (1997). *Foreword Poised at the Cusp: LatCrit Theory, Outsider Jurisprudence and Latina/o Self-Empowerment*.

Van Herk, K. A. V., Smith, D., & Andrew, C. (2010). Identity matters: Aboriginal mothers' experiences of accessing health care. *Contemporary Nurse*, *37*(1), 57–68. https://doi.org/10.5172/conu.2011.37.1.057

Zabala, J., Conejero, S., Pascual, A., Alonso-Arbiol, I., Amutio, A., Torres-Gomez, B., Padoan De Luca, S., & Telletxea, S. (2020). Basque Ethnic Identity and Collective Empowerment: Two Key Factors in Well-Being and Community Participation. *Frontiers in Psychology*, *11*, 606316. https://doi.org/10.3389/fpsyg.2020.606316

CHAPTER 4: Gender Bias and Discrimination in Healthcare as Experienced by Basque Women and Gender Non-normative Individuals in the Basque Country

Abstract

The Basque Country is one of Europe's many stateless nations and home to the Basque Indigenous population. As members of an Indigenous and ethnic minority culture, Basque women and gender non-normative individuals risk suboptimal healthcare services and outcomes because of gender bias and discrimination. This study explores their experiences with healthcare services and identifies the ways in which gender bias and discrimination serve as a barrier to culturally safe healthcare in the Basque Country. We used critical ethnography and triangulated data from 37 semi-structured interviews, health clinic observations, 4 focus groups, and document analysis. We used thematic analysis to identify overarching themes using transcripts and field notes. We find that gender bias and discrimination are central to the healthcare experiences of Basque women and gender non-normative individuals. These issues manifest in various ways: knowledge transmission gap regarding women's health, discrimination based on sexual and/or gender identity, and the presence of obstetric and gynecologic violence. Meanwhile, promoting participants' autonomy during healthcare encounters is a key facilitator. Participants report numerous instances of discrimination, which act as barriers to the implementation of culturally safe care. Promoting gender equity and participants' autonomy can help facilitate culturally safe healthcare experiences in the Basque setting.

Keywords: Ethnic minority, Indigenous, cultural safety, gender non-normative, women, healthcare

Background

Indigenous and ethnic minority groups face a considerable disadvantage in healthcare experiences and outcomes when compared to non-minority populations. These experiences of social inequality in healthcare are even more noticeable among Indigenous and ethnic minority women (MacIntosh et al., 2013; Toh & Shorey, 2023; Watson et al., 2019). Women's healthcare experiences are significantly conditioned by their origin, culture, geographic background, and access to healthcare (Huffstetler et al., 2021). Gender non-normative individuals who are members of Indigenous and ethnic minority groups also report increased discrimination and violence that lead to poor health outcomes compared to their non-minority counterparts (Chan et al., 2023).

Restrictive gender norms have a significant impact on society, especially in healthcare, where gender inequalities contribute to higher mortality and morbidity rates globally (Kapilashrami, 2018; Sen & Ostlin, 2008). Gender inequality in healthcare occurs in a variety of forms, such as differential exposure to disease, discriminatory beliefs, and biases in health systems, which transform into health risk. It often presents as violence against women, and increased level of stress and anxiety among women due to their socially assigned role as caregivers, and among transgender individuals whose non-conformity to gender roles endures social sanction (Crespí-Lloréns et al., 2021; Shannon et al., 2019).

Basque women and gender non-normative individuals (BWNN) as members of an Indigenous and ethnic minority group, are uniquely positioned to experience discrimination within healthcare settings (Chan et al., 2023; Watson et al., 2019). However, no evidence of studies related to Basque Non-normative individuals or Basque women's experience in healthcare as an ethnic minority have been found. Given the dearth of literature exploring the healthcare experiences of BWNN, analyzing their common experiences with healthcare in the

Basque Country can help fill this gap in knowledge and inform ways to improve nursing practice and healthcare overall, propose and design health policies, and develop a better understanding of cultural safety for Indigenous and ethnic minority women and gender non-normative individuals. In the next section we provide a brief overview of the historical context in which BWNN healthcare experiences are situated followed by a definition of the concept of cultural safety.

The Basque Country, one of Europe's stateless nations (Cole, 2011; Friend, 2012) is administratively divided between two nation-states (Spain and France), and is home to the Basque Indigenous population. Between the 14th and 17th centuries, prior and during the subjugation of Indigenous populations in America, working class Europeans faced dispossession of the commons, branding, and witch hunts, with over 80% of those tried and executed for witchcraft being women (Federici, 2004). European women's resistance consisted of maintaining transmission of traditional healing knowledge and challenging the oppressive sexual and gender norms imposed by the new order (Federici, 2004).

The witch hunts, which were used to suppress women-led grassroots movements that challenged the established order and helped shape communal life (Federici, 2004), had a significant impact on the Basque region (Machielsen, 2019). Historically, Basque women have played a crucial role in transmitting Basque culture and language. However, their contributions to preserving and passing on this culture across generations have frequently been overlooked (Bullen, 2003). Nevertheless, in recent times, they have gained a more prominent role in society by overcoming societal challenges, contesting traditional gender roles through participation in cultural events that were historically off-limits to them, and organizing to create opportunities for women to unite around political issues (Echeverria, 2003).

In view of enhanced global attention focused on health inequities affecting Indigenous and ethnic minority populations, healthcare organizations are under increased pressure to provide a health care system that delivers appropriate and equitable care (Curtis et al., 2019). There is a growing acknowledgement for healthcare workers to consider the importance of patients' backgrounds, beliefs, and values to provide compassionate and holistic care (Schill & Caxaj, 2019). Cultural safety is considered to have a unique potential to guide healthcare organizations and healthcare workers in achieving respect, social justice and health equity in healthcare delivery and clarify the necessary principles and practical steps to implement this approach in healthcare organizations and workforce development (Schill & Caxaj, 2019).

The concept of cultural safety has been promoted by Maori nurses and midwives working within a colonial context to provide nursing practice that would reflect and include the perspective of the Indigenous minority in their country (Engnes et al., 2021; Papps & Ramsden, 1996). Cultural safety entails self-awareness of healthcare workers' own culture and an analysis of positions of power that can condition cultural values of certain communities (Schill & Caxaj, 2019). Cultural safety is therefore a holistic and collective approach where all individuals feel safe, learn cooperatively with dignity, and experience active listening (Curtis et al., 2019). Cultural safety is a framework where healthcare workers acknowledge individual's dignity and address their own biases, and healthcare organizations and institutions support and hold themselves accountable for providing culturally safe healthcare as defined by individuals and their communities (Curtis et al., 2019).

The purpose of this study is to explore healthcare experiences from the perspective of BWNN and identify the barriers and facilitators to implementing cultural safety in the healthcare system in the Basque Country.

Method

Study Design

We used a critical ethnographic approach to describe the cultural and sociopolitical factors that shape the experiences of BWNN with healthcare in the Basque Country. Critical ethnography emphasizes the different perspectives and intersectional ways through which inequities can be seen (Bhattacharya, 2017). Critical ethnography also facilitates directing the research study in the assessment of how the legacy of colonialism impacts gender, and ethnicity and how it contributes to power relations in healthcare and health disparities among Indigenous and ethnic minority women (Wakewich et al., 2016). We used critical ethnography to have a closer understanding of the experiences of BWNN while conducting a critical analysis intended to discover how these perceptions relate to larger power structures (Al-Hamad et al., 2022).

Theoretical Framework

This study is informed through the lens of intersectionality theory. Intersectionality is an extensively utilized theoretical framework in women and gender studies. The theory posits that systems of power such as gender, ethnicity, race, sexuality and others overlap and intersect and manifest large-scale structures of oppression and privilege such as sexism, racism, and heteronormativity (Crenshaw, 1991). These interactions take place in an environment of connected systems and structures of power (e.g., laws, policies, state governments and other political and economic unions, religious institutions, media). Among these proceedings, are interrelated arrangements of privilege and oppression framed by colonialism, imperialism, capitalism, racism, homophobia, ableism and heteropatriarchy (Hankivsky, 2014).

Utilizing an intersectional lens acclimates researchers to the multifaceted systems of power that define participants´ experiences in different socio-cultural settings, and how relationships between social position and power reproduce health inequities (Cayir et al., 2021). Intersectionality is crucial to public health and healthcare because it embraces the complex interactions necessary to understand social disparities (Bowleg, 2012), especially when focusing on a historically oppressed population, such as women and gender non-normative individuals in the Basque Country. We conducted our analysis with this theoretical framework in mind, focusing on identifying and examining the systemic structures of oppression experienced by BWNN within the healthcare system.

Setting

The setting of this study is the Basque province of Nafarroa, one of the seven provinces of the territory known as *Euskal Herria* (Basque Country). The three northern provinces are located within the French department of *Pyrénées Atlantiques.* The four southern provinces are divided in two autonomous communities within the Spanish state: the Basque Autonomous Community (*Araba, Bizkaia, and Gipuzkoa*) and *Nafarroa* (Urla, 2012), where *Osasunbidea* is the organization that manages its healthcare system.

Sampling and Recruitment

Our research team consisted of five women: four nurses—two Basque-speaking, one Latina, and one White of Eastern European descent—and a Black American sociologist. Individual interviews and focus groups were conducted in Basque by the principal researcher (GE), a Basque-speaking woman. We recruited participants using purposive and snowball sampling methods. We created a recruitment flyer in Basque that targeted individuals meeting the eligibility criteria: self-identified Basque women or gender non-normative individuals aged 18 and older, who speak and understand Basque, and have utilized the healthcare system

at least three times in the past year, either as patients or caregivers. We chose the term gender non-normative individual in consultation with members of the Basque LGBTI+ community, as it is used by Basque institutions to describe those whose identity differs from the gender assigned to them at birth, including transgender and non-binary individuals. We distributed the flyer physically in public healthcare clinics and shared it via WhatsApp among local feminist, LGBTI+, and women's groups, as well as Basque cultural associations. The recruitment process took place from November 2022 through April 2024.

Sample

The study involved 37 participants, of whom 35 self-identified as women, one as non-binary, and one chose not to disclose their gender. Participants' ages ranged from 22 to 84, with a median age of 49.6 years. In terms of sexual orientation, 28 participants identified as heterosexual, 7 as bisexual, one as non-heterosexual, and one did not respond. Regarding racial and ethnic identity, 29 participants identified as *Euskaldun* (Basque-speaking), 4 identified as both *Euskaldun* and *Nafar* (a native or someone with roots in the Basque province of Nafarroa), 1 identified solely as *Nafar*, 1 identified as *Nafar, Euskaldun*, and Spanish, 1 identified as multiracial, and 1 did not provide a response. The participants' educational backgrounds varied: 5 had completed 8th to 12th grade, 8 attended technical school, 3 held 3-year university degrees, 13 had 4- or 5-year university degrees, 2 had post-graduate degrees, 5 selected "other," and one did not respond. Regarding employment, 19 participants were employed, 7 were retired, 3 were self-employed, 3 were unemployed, 2 were on disability, and 2 did not specify their status **(Table 4.1)**.

Table 4.1

Participants' Characteristics

Characteristic	Detail
Total Participants	37
Gender Identity	35 women, 1 non-binary, 1 chose not to disclose
Age Range	22 to 84 years
Median Age	49.6 years
Sexual Orientation	28 heterosexual, 7 bisexual, 1 non-heterosexual, 1 no response
Racial/Ethnic Identity	29 *Euskaldun*, 4 *Euskaldun* and *Nafar*, 1 *Nafar*, *1 Nafar*, *Euskaldun*, and Spanish, 1 multiracial, 1 no response
Educational Background	5 completed 8th-12th grade, 8 attended technical school, 3 had 3-year degrees, 13 had 4- or 5-year degrees, 2 had post-graduate degrees, 5 "other," 1 no response
Employment Status	19 employed, 7 retired, 3 self-employed, 3 unemployed, 2 on disability, 2 no response

Data Collection

We developed a semi-structured interview guide and a focus group interview guide. The interview guide explored participants' socio-cultural backgrounds, caring experiences, healthcare experiences, cultural and gender identities, and preferred treatment options. After analyzing the content of the interviews, we created the focus group guide to facilitate member checking and to investigate whether participants experienced fear during their healthcare encounters. Additionally, we used a Qualtrics (Qualtrics, 2024) socio-demographic questionnaire to collect information about participants' age, ethnicity, employment, and educational status.

We conducted a total of 37 in-depth interviews in Basque between November 2022 and April 2024. Participants signed written informed consent before the interviews, which lasted between 23 and 80 minutes. To ensure confidentiality, we deidentified the collected data. The interviews were then transcribed verbatim with the help of Aditu Elhuyar, a Basque language transcription and translation software, and a transcriptionist, before translation and data analysis. After transcription, a translator converted the data from Basque to English and we reviewed all transcripts as to verify accuracy.

Data Analysis

Since data collection and analysis occurred concurrently, emergent categories and themes guided subsequent recruitment and data collection strategies. Participant recruitment concluded when saturation was reached, emerging codes and categories became repetitive and could be included in previously identified themes.

After completing the individual interviews, we invited all participants to join one of four focus groups. A total of 24 participants engaged in the focus groups, while 12 were unable to participate due to scheduling conflicts or personal reasons, and one participant sadly passed away before focus groups were conducted. We held two focus groups at cultural association sites, one at an *Ikastola* (Basque school), and another at a participant's home. The in-person discussions lasted between 58 and 85 minutes and were transcribed and translated according to the previously established procedures. Additionally, we conducted 36 hours of ethnographic observations in six distinct healthcare settings. These observations were conducted with the agreement of team managers within each facility and in collaboration with the department of health. We observed cultural, language, and gender-related expressions and interactions in each facility, focusing on open public areas such as admission and waiting rooms. We noted interactions between healthcare workers and patients, cultural expressions

within the healthcare center (music, decorations, healthcare promotion flyers, reading material), and language use within the facility. Each observation lasted approximately 120 minutes and was conducted three times between December 2023 and March 2024 in each facility. We also included field notes collected during the observations and throughout the study in the data analyses.

A multi-level process was conducted to familiarize myself with the data. We organized the data by classifying and indexing in categories, creating more manageable units for revised by co-authors. We classified field notes in a similar manner. To assist in detecting patterns and analyzing relationships within the data, we utilized ATLAS.ti software. We defined and labeled sections of the text to establish codes (Charmaz, 2014). These codes were examined for repetition, analogies, and differences to identify emerging themes. Throughout the coding process, we engaged in peer debriefing and consultation to identify main themes and subthemes while considering alternative interpretations of the data. Memos written during the data collection and analysis process contributed to the final main themes. As themes emerged, we used analysis triangulation by converging data from individual interviews, focus groups, field notes, and observation to form thematic statements (Grove & Gray, 2019; Polit & Beck, 2012).

Ethical Considerations

We used pseudonyms to protect participant identities and obtained formal written consent from each participant prior to their involvement. We conducted the study in collaboration with the Health Department of Nafarroa and its corresponding ethics committee (Record # PI_2022/104), and it was approved by the University of California, San Francisco (UCSF) Institutional Review Board (IRB #22-36656).

Researcher Positionality

As the primary researcher I considered my insider status as a Basque working-class feminist activist and nurse working with patients from the researched community by practicing continuous reflexivity. I critically observed how this position may have shaped the decisions I made throughout the research process (Cayir et al., 2021). During the fieldwork my position facilitated collaboration with local and national feminist, cultural, and language associations and eased the establishment of meaningful and trustworthy relationships. As a registered nurse and employee in the public healthcare system my position allowed a collaborative environment during the research process. This position sometimes could potentially create mistrust with participants, as I was seen as part of the system they were criticizing, and with fellow healthcare workers, who viewed me as someone scrutinizing their work.

During the interviews my positionality as a researcher and healthcare worker entailed conducting this research from a position of power and privilege. During the interviews I was concerned that participants might perceive I was conducting this research for personal interests. I acknowledged the benefits of conducting this research for my academic goals and I discussed with the participants how this research could improve healthcare experiences for BWNN. Several participants referred being grateful that I was conducting this study and addressing the topics they were concerned about within the healthcare system. This position of privilege provided me with the opportunity to use the resources, skills and privileges available to me to provide accessibility to the experiences of those whose stories are invisible to the social majority (Madison, 2020), in this case the stories of BWNN.

Findings

Many participants expressed experiencing gender bias and discrimination during the healthcare encounter. This discrimination often interwinds with the oppression related to cultural identity and language which enhances the experience of marginalization of BWNN in the healthcare setting. Through participants´ shared experiences, we identified three themes; knowledge transmission gap regarding women's health issues, discrimination based on sexual or gender identity, and obstetric and gynecological violence as barriers to the implementation of cultural safety. Acknowledging participants' autonomy during the healthcare encounter was identified as a facilitator to culturally safe health care services.

Given that gender is central to the main finding, it's important to note that the Basque language, in its most used form, does not mark gender. Therefore, unless specifically highlighted by participants, the gender of healthcare workers remains unidentified. However, it's also worth noting that within *Osasunbidea*, the public healthcare organization in Nafarroa, more than 65% of doctors and over 92% of nurses are women (Nafarroako Gobernua, 2022). This indicates that gender bias and discrimination in healthcare are not isolated issues tied solely to the individual identities of healthcare providers; rather, they are embedded within broader systemic structures of power.

Knowledge transmission gap regarding women´s health issues

Overall, participants felt there was a significant gap in knowledge transmission about their health, particularly concerning women's health issues. This gap manifested in several ways. On one hand, participants perceived healthcare workers as reluctant to share knowledge about their medical conditions or those of their dependents. On the other hand, many felt that the healthcare system does not prioritize women's health, leading to insufficient research and knowledge in this area. Additionally, they also observed a disruption in the transmission of

knowledge across generations within the community, contributing to a general lack of basic understanding about women's bodies. To bridge this gap, participants often turned to self-education, sharing information with community members, using the internet, or attending community-organized events. As we will discuss below, participants expressed frustration and insecurity about this knowledge gap, which they perceive as a form of gender bias and discrimination.

Ainara is a 49-year-old Basque woman. She has had several temporary jobs throughout her life, and she is currently working as a server in the hospitality industry. She was born and raised in a large Basque city but moved to a rural valley in the northern part of Nafarroa in her early twenties. One of the reasons she decided to move was to be able to raise her children in an *Euskaldun* environment. She has a son in his early twenties who is dependent due to complications suffered after brain surgery, and a teenage daughter. She has had multiple experiences in the healthcare system during her pregnancies, childbirth, and most recently while caring for her son during his recent illness. She has had to take upon herself most of the burden for her son's care and has experienced great frustration due to a gap in knowledge transmission regarding her son's treatment and recovery. Ainara feels that there is a gap in knowledge transmission from the healthcare system to patients and family members, which obstructs her ability to make informed decisions.

> … for example, things that come after surgery… I didn't expect to see my son like that, and I wasn't ready. And they don't give you any information about what his process should be… at least, what we are going to see, because the fact that my son's reasoning or understanding was that of a 3 year old, I didn't know how long that was going to go on. And nowadays I have had to ask for rehab for (son). Because neither the health center or the specialists, who need to know what kind of damage they have and what tools they have to help with it, they haven't given us any information.

Ainara also perceives a gap of knowledge, especially when it comes to women's health issues. This overall knowledge gap, which she finds incomprehensible—especially in areas like maternity and childbirth, since they are experiences, women have had throughout history—has led to a deep mistrust of the healthcare system. During her pregnancy, Ainara realized how little she and the previous generations around her knew about pregnancy and childbirth.

> [Pregnancy] It's what we've most known about women. We've always been there, and not the same effort is made with woman, [even]with something that is so common. I would ask my mother, did you know this? Was your pregnancy like this? Did you have this information? And no, we didn't know… somehow you obtain certain information, and you're like, I am learning this now and I haven't heard about this anywhere?… I see that women are in the background and it's true…

As a working-class woman, she faces unfavorable working conditions in a highly feminized profession, putting her at a social and economic disadvantage in caring for her son. Additionally, as a Basque woman, she bears increased responsibility and social scrutiny as a mother and caregiver. Ainara connects her lack of access to knowledge to a broader reluctance among healthcare workers to share knowledge, especially about women's health issues like pregnancy and childbirth. This limits her ability to make informed decisions about her own health and her son's. She attributes this to a longstanding gap in knowledge transmission about women's health, which has persisted across generations and is related to an interruption of cultural knowledge transmission. This aligns with research indicating that this gap in understanding arises from a historically androcentric perspective in health sciences that has frequently overlooked women's health (Valls-Llobet, 2020), as well as a disruption in the transmission of knowledge about women's bodies that dates back to the European witch hunts (Federici, 2004; Nausia Pimoulier, 2012). She perceives that the healthcare system, which

should support her healing process, is instead reinforcing the patriarchal norms she encounters in her daily life. As a result, she expresses her distrust of the healthcare system. Through an intersectional lens, Ainara's experience illustrates how multiple forms of oppression—classism, sexism, and cultural supremacy—intersect with larger power structures such as capitalism, internal colonialism, and patriarchy, increasing her vulnerability as both a patient and a caregiver.

Several participants criticize the gap of knowledge transmission from the healthcare system regarding symptoms of menopause. There is also a sentiment that this gap of knowledge transmission is related to how the healthcare system does not emphasize on women's health issues as much as it does on men's. The following exemplar illustrates the perception of an overall lack of knowledge about this issue among participants.

Eihara is a 48-year-old Basque language teacher currently on medical leave. Although she spent part of her childhood in an *Euskaldun* area in the northern part of the province, at the age of 10 she moved with her family to a city in the southern part of the province, where Basque speakers are a minority**.** Recent gynecological surgery has led to an increase in her interactions with the healthcare system. This experience has been frustrating for her, not only because she is unable to obtain health information in *Euskara*, but also because she perceives there is an overall gap of knowledge transmission throughout her healing process. She has often felt that information was either withheld or that her condition was downplayed. Even after changing gynecologists, she noticed little improvement. Eihara believes that this lack of communication and transparency reflects a structural issue within healthcare, which she sees as creating a bias against women during healthcare encounters. She perceives a significant gap in women's knowledge about their bodies, using menopause as an example. She believes

this gap is linked to the social undervaluation of women, resulting in decreased interest and research efforts within the healthcare system:

> I think there's not much information… we have some changes in our body with menopause and some special needs that until that moment weren't there. And women still don't know, even if they're menopausal, what the different things they can do or whatever… I think some basic things are considered, but some everyday life things are still not taken into account. And then I'm sure that if men were going through menopause, everything would have been investigated… I'm sure about it.

As an ethnic minority woman, Eihara navigates the healthcare system with increasing frustration about multiple communication barriers. On one hand, she struggles because she is prevented from communicating with healthcare workers in her language; on the other, she is not receiving the information necessary to understand her disease process, which impedes her ability to make informed decisions about her health. Eihara's efforts to change practitioners did not lead to different outcomes, indicating that the problem extends beyond individual attitudes or behaviors and is rooted in institutionalized sexism within the healthcare system. She connects this gap in knowledge transmission specifically to women's health issues, highlighting that it is a common experience among women. This experience reinforces her belief that the healthcare system fails to meet her needs and enhances her experience of discrimination.

Participants feel that they are left in the dark regarding what to expect during this period of life and this knowledge gap creates unnecessary anxiety and concern regarding their health because they can relate these symptoms with possible illnesses. Eihartze's experience is an example of how this knowledge gap can create additional anxiety in an already stressful situation.

Eihartze is a 52-year-old Basque woman living an hour's drive from the city in the eastern part of the province. She is a teacher currently on disability while recovering from lymphoma. Eihartze resides with her husband and their youngest child, who is 14 years old. She also has two older children who live in the city. Additionally, she alternates caregiving duties for her elderly parents with her sisters, as her parents also reside in the city. Eihartze's experiences with the healthcare system have intensified over the past few years as both she and her oldest son have received cancer treatment. She has struggled with the gap in knowledge transmission regarding both her own illness and her son's. For Eihartze, it is crucial to be informed, she connects the gap in knowledge transmission to the power dynamics within healthcare encounters. She states, "It's key to me to be informed. Information is power, and they know it …" After completing her chemotherapy treatment, she began to experience symptoms of menopause. Eihartze felt that not knowing chemotherapy could lead to premature menopause increased her anxiety and confusion:

> I mean the side effects caused by the chemotherapy… You don´t know how you are going to be mentally or the physical consequences or that your period disappears from one day to the next … One of the symptoms is to sweat, right? All of a sudden, I started with hot flashes and sweating, starting with chemo, right? And I was thinking shit, shit! What is this? And when I found out that clearly that… it was a consequence of menopause. Sure, I was grateful because it's not lymphoma anymore… my two options were, my lymphoma is back on or it's menopause. So, between those two options, the fact that it was menopause, was like, that´s good, right? But nobody explained anything to me.

Eihartze has an increased emotional and physical load. While she is caring for her sick son, the rest of her children, and her parents she is also dealing with her own illness. Living in a rural area at a long driving distance makes it more difficult for her and her family to access

specialized health services which she currently needs. However, the main cause of her frustration and anxiety during this experience is the gap in knowledge transmission and how this increases the power difference between her and her doctor. For Eihartze, the withholding of knowledge is a conscious act that reinforces the power difference between her and healthcare workers, perpetuating the hierarchical structure of the healthcare system.

A gap in knowledge transmission regarding women's health issues is recurrent in participant's experiences. This gap is seen as being tied to the historical and systemic oppression of women, which is also reflected in the healthcare system. The failure to transmit knowledge is viewed as a means of reinforcing power imbalances within healthcare encounters, leading to unsafe experiences for participants. Consequently, the gap of knowledge transmission in women's health is a significant barrier to culturally safe healthcare for BWNN.

Discrimination based on sexual or gender identity

Participants report bias and discrimination based on sexual and gender identity throughout their healthcare experiences. The following stories illustrate how gender bias influences treatment and diagnosis, while gender discrimination reinforces power imbalances and fosters distrust in the healthcare system.

Iholdi, a 52-year-old Basque woman, works as a teacher at a local high school in a predominantly *Euskaldun* area of Nafarroa. Though generally in good health, she has had several encounters with the healthcare system, both as a patient and a caregiver. Iholdi strongly identifies with her Basque heritage and describes herself as having a strong personality, which she knows can sometimes be perceived as threatening by male practitioners. She believes that male healthcare workers often feel challenged when women,

like herself, question their authority. Iholdi sees this defensiveness, rooted in her gender identity, as similar to the rejection she experiences for being *Euskaldun*:

> They imagine that I'm going to complain, or that I won't shut up, or… that I'm going to say what I think, right? And that, they don't like it. I think that a lot of men… with women they have, docile women, obedient… with them, it's easier, right? Because in those situations they have the power… And with some specific doctors, I notice that they want to use and mark their power. "You, be quiet, you're the sick one, and I give the orders." …it seems to me that since they are with a woman they are in a defense-attack situation and that your word is not worth the same.

Iholdi compares this sentiment to what she experiences due to perceived cultural discrimination.

> And that's what happens to me, the same thing, and then when you talk and the one in front of you is *Euskaldun*, there is a connection, and then there is something, right? There's a connection or a distance. For being woman or being *Euskaldun*… But because of being woman and *Euskaldun* it's clear, clear. For better or worse, but yes, yes, there's a big change.

Iholdi's experience illustrates how the interconnectedness of systems of power and the use of the hierarchal structure of the healthcare system to enhance power relations significantly condition her experience. As a confident Basque woman, she feels that male practitioners are defensive when women like her question their authority, particularly because she does not meet the patriarchal expectation of the "docile" or obedient woman. Iholdi compares this experience to cultural discrimination she faces for being *Euskaldun*, noting a distinct difference in interactions with healthcare workers depending on whether they share

her ethnic background. Iholdi's gender and ethnicity concurrently influence how she is treated, leading to gender and ethnic bias and discrimination.

Participants also noted that physical ailments or expressions of stress were often misdiagnosed as psychological conditions, such as anxiety or depression. This echoes literature suggesting that Western medicine tends to over diagnose women with depression and anxiety (Bacigalupe & Martín, 2021), a bias rooted in the historical dismissal of women's health concerns as secondary or trivial (Valls-Llobet, 2020).

Amalur is a 57-year-old Basque woman who works part-time as a porter and part-time in a school dining room. She lives in a large town in the center of Nafarroa where the *Euskaldun* population is a minority. Amalur lives in the center of town in a house that has belonged to her family for several generations with her husband and two sons. She has deep roots in the area and has previously expressed her preference to use cultural or other alternative healing practices. However, she also uses the public healthcare system as needed. She recalls an incident where she was having stomach aches mostly in the afternoon. She went to see her GP to see if they could help her with the pain. The GP was dismissive regarding her symptoms and directly diagnosed her with anxiety.

> Look, okay, it's true that I'm a bit nervous, I know it… I mean, I think I can still handle my mind, so it's not that. And, yes, they gave me pills for anxiety. Of course, I didn't take them. In the end I went to the osteopath, … And well, that's it, I took fennel, and so on and it went away. So, regarding women, well, if you are a woman, you have a responsibility, sons, grandad or dad… You already have that anxiety. And I said, "damn, it's not that."

Amalur believes that being a woman involves an increased caregiving role, which adds a certain level of anxiety to her life. However, she feels that her healthcare provider is

dismissing her physical symptoms, assuming they stem from anxiety and her caregiving responsibilities, despite her insistence otherwise. Amalur's experience reflects common biases women face within the healthcare system, where emotional stress from overburdened caregiving roles is often linked to psychological illness, leading to physical ailments also being dismissed or portrayed as exaggerations (Valls-Llobet, 2020). Amalur identifies this bias and opts to search for alternate healing practices within her community which she considers a safe and effective alternative to a healthcare system where she feels prejudged and is unable to meet her healthcare needs.

Several participants also reported feeling judged for their sexual practices. During healthcare encounters, providers often assume that participants are engaged in monogamous, heterosexual relationships, with a focus on intercourse. Sexual education is based on this presumption, leading to discrimination and judgment against those with diverse sexual practices. Participants are also aware that, despite belonging to an ancient culture where women historically held more social power than in neighboring communities (Bullen, 2003), their society is currently strongly influenced by dominant heteropatriarchal norms. The following exemplar shows how participants experience discrimination based on sexual identity concurrently with ethnic discrimination creating increased marginalization for BWNN.

Laiene, a 43-year-old Basque woman working as a teacher, lives in a predominantly *Euskaldun* area in western Nafarroa. She has used healthcare services both as a caregiver for her parents and as a patient, primarily for gynecological issues and follow-up appointments. Laiene emphasizes the importance of having healthcare practitioners who share her culture and language. As a woman, she also values healthcare professionals with a feminist perspective on health. However, her experiences reveal that she has often felt judged for her sexual practices:

> There I've felt judged, in relation to my sexual relationships, right? Well, if you don't have a steady partner, and I've felt judged because then many practices are directed to heterosexuals, right? No one asks you or not, right? Some assumptions for me are very disturbing, and then I've felt judged.

She describes how she anticipates potential discriminatory attitudes based on any negative perceptions healthcare workers may hold regarding her gender, sexual, or ethnic identity.

> And I always ask, and do you know Basque? "No, eh" Aix, always that, -- fuck, right? That has always been the first question. Do you know Basque? No? And the second concern was well, they don't know, they´re not *Euskaldun* (Basque-speaking), let´s see how they treat me as a woman, right? It's been those two landmarks for me. And often, both have not been good. Because they are not *Euskaldun.* And other times, being *Erdaldun* (non-Basque speaking), the interaction has been good, but other times the interaction has not been good either, and I've felt judged.

Laiene's experience illustrates how various forms of oppression overlap to shape her encounters with the healthcare system. She anticipates that heterosexism and cultural/language supremacy will influence her healthcare experience. Additionally, she recognizes the interconnectedness of her identities, believing that a positive healthcare experience depends on a feminist perspective that acknowledges her position as an ethnic minority woman. For Laiene, every aspect of her identity is significant and contributes to her overall experience; it's not a matter of prioritizing one category over another. This aligns with a broader intersectional feminist approach to healthcare. Intersectionality understands that social categories like gender, ethnicity, race, and socio-economic status are interconnected and complex rather than independent and unidimensional (Bowleg, 2012). Intersectionality

recognizes that various systems of power intertwine to shape individual experiences and power dynamics, which cannot be understood simply by adding up each category (Bowleg, 2012).

Laine's exemplar highlights various forms of gender bias and discrimination that intertwine with participants' experiences of ethnic marginalization. Healthcare workers often act as conscious or unconscious perpetuators of overlapping oppressive structures, replicating heterosexist and culturally oppressive values that exacerbate the discriminatory experiences of BWNN. Thus, gender bias and discrimination present significant barriers to achieving culturally safe healthcare.

Obstetric and gynecological violence

Another important finding is that participants report numerous experiences of obstetric and gynecological violence. Obstetric violence is defined as the control exerted by healthcare professionals over women's bodies and reproductive processes reflected in dehumanizing treatment and the excessive medicalization of natural functions resulting in a loss of autonomy and the freedom to make choices about their own bodies and sexuality, thus adversely affecting women's overall quality of life (Annborn & Finnbogadóttir, 2022). Gynecological and obstetric violence include inappropriate or non-consensual acts, feelings of guilt for questioning certain procedures, sexist behavior during gynecological consultations, and the performance of painful procedures without offering anesthesia during or after childbirth (Committee on Equality and Non-Discrimination, 2019).

A recurrent issue that emerged during the interviews was the focus of maternity in women's health. Participants have been judged either for not wanting to give birth, or for when they decided to give birth. This continuous judgement is connected to the lack of respect for BWNN's right to make decisions regarding their bodies and a continuous attempt

to control their reproductive freedom. The following testimony is an example of how the idea of giving birth is repeatedly emphasized to participants.

Auza is a 40-year-old non-binary individual, they are self-employed and reside in a small town in the northern part of the province, where most of the population speaks *Euskara*. Although they are currently seeking gender affirming care, Auza perceives that their encounters with the gynecological services both prior and during their transition have insisted on focusing on fertility although they insisted that they did not wish to give birth.

> … you could see it over and over again in the way I was being treated. Somehow, I was losing fertility, because I was getting older and as I was being treated as a woman, …this was above everything else. And I could say that I'm not going to have children, I will never have them, I'm not going to give birth, but even though, …they will continue with that logic all the time… And when I started transitioning, the same thing. At the time they explained the hormone issue, I clearly stated that fertility was not important for me, and even though they continued insisting.

On the one hand, while being treated as a woman, Auza faces a common social pressure that is experienced by women which is related to the belief that every woman, by default, is socially expected to accept maternity as their destiny and main life goal (Annborn & Finnbogadóttir, 2022). This belief is reinforced by the historical idealization of motherhood in Basque culture, which persists to some extent today (Bullen, 2003). On the other hand, as a non-binary individual, Auza experiences ongoing marginalization due to healthcare workers making constant assumptions and misconceptions about their body and reproductive desires. These assumptions exemplify how gender non-normative individuals encounter microaggressions in gynecological settings that undermine their lived experiences (Pulice-Farrow et al., 2022). Auza's experiences as a Basque gender non-normative individual

are shaped by heterosexist and transphobic norms that are structurally embedded in both the healthcare system and their culture.

There are also several accounts of participants that felt judged and mistreated for requesting or refusing certain practices. Participants refer experiencing retaliation for refusing specific treatments or giving birth in a certain way. Obstetric and gynecological violence is more common during childbirth, when women and birthing individuals are in a particularly vulnerable position (Annborn & Finnbogadóttir, 2022). The following testimony is an example of this occurrence.

Graxi is a 39-year-old Basque woman who is currently on maternity leave after the birth of her first child. She lives with her partner and child in an apartment on the outskirts of the provincial capital. Her interactions with the healthcare system have primarily involved fertility treatments before her pregnancy, prenatal care, and her birthing experience. Graxi chose to have a home birth, assisted by community midwives. While the birth itself went smoothly, the delivery of her placenta was delayed, prompting her to visit the emergency room with her partner and baby. Upon arrival, Graxi encountered retaliation and contempt towards her beliefs, which she attributes to her decision to deliver at home, despite her gynecologist's advice against it due to her high-risk pregnancy. Graxi clearly identifies her experience as obstetric violence.

> And then they gave me stitches, and well I had no anesthesia, no epidural, I mean, everything was natural, and when they were giving me the stitches it was really painful, and I was like please “give me something” and “Well, since you don’t want anything” and I was like “…it’s not that I want nothing”, I mean, I don’t want to have pain, I mean, one thing does not take away the other. And I told them “No, no, give me as much as you can of the local one” I mean, I am not saying I want you to put me

> asleep to give me stitches, but give me as much local anesthesia as possible. And the pain was horrible, I was screaming and screaming…

Graxi later had a rectal palpation where she felt she was treated roughly.

> And he said, we needed to check if the anus is alright, so he put his finger into my anus. And well, they are things, that need to be done with more or less gentleness, and well for me this man, did not have a lot of gentleness, not for one thing, neither for the other.

After these events Graxi decided she was ready to return home with her child. Hospital staff considered that her child was at risk and insisted on keeping the child overnight. Graxi refused and decided to go home with her child. Upon discharge healthcare workers refused to provide the documentation for Graxi to be able to register her child at the registrar's office stating they had not witnessed the birth which led to unnecessary distress and multiple bureaucratic issues for her family.

> Well, for me the thing that happened to us is obstetric violence, and then I read the violent acts that happen and yes, without any doubt women, …that they don't let woman decide how they want to give birth…, if I decided that I wanted to give birth at home, it is because I felt a free person and more empowered at home than in some hospital.

Graxi's experience reflects multiple forms of obstetric violence, where she is consistently judged and punished for asserting her right to make decisions about her own health and that of her child. The healthcare practitioner inflicts unnecessary physical harm by performing aggressive procedures, such as administering stitches without anesthesia and conducting a forceful rectal exam. This physical abuse is compounded by the psychological and emotional distress caused by the failure to register her child's birth. Graxi attributes this

treatment to retaliation linked to her beliefs, exemplifying the dismissal of cultural birthing practices—a common experience among Indigenous women facing medical colonization (Pilarinos et al., 2023). By advocating for a home birth, Graxi asserts her right to autonomy in healthcare, which provides her with a sense of empowerment and safety. While obstetric violence poses a significant barrier to cultural safety, promoting patients' autonomy in healthcare can act as a crucial facilitator.

Another form of gynecological violence is evident in the social and institutional pressure placed on women to breastfeed. Alaia, a 44-year-old Basque woman, lives with her partner and two children in a small, predominantly *Euskaldun* village in the northern part of the province. Her experiences with healthcare services have been both as a patient and as a caregiver for her children and parents. Alaia has expressed a preference for female and *Euskaldun* providers, as they make her feel calmer and safer. She recalls an incident where she felt pressured to continue breastfeeding, even though it was painful for her, and she had already decided to stop. Alaia went to her follow-up appointment with the midwife alone. The midwife, who was male and *Erdaldun*, asked her why she hadn't brought her baby. After she explained that she had decided to no longer breastfeed. The midwife responded:

> …you need to suffer a little so that things turn out better after, you know?" And I said, but I can't, …psychologically I'm not doing well at all, and I decided, …and I always thought that if I couldn't, I wouldn't breastfeed, but at the moment, when it was my turn, it was really complicated. Because in the end, it looks like you are a bad mom, because you don't breastfeed, you know? Well, but, always, you don't know how much he insisted. You don't know how much he insisted!

Alaia's experience illustrates multiple levels of discrimination. Alaia presents to the healthcare encounter in a vulnerable position due to the psychological distress caused by not

being able to breastfeed her child. Upon arrival she encounters an *Erdaldun* practitioner which forces her to express herself in a language that she does not feel comfortable in. The practitioner instead of reassuring Alaia, puts pressure on her to breastfeed which increases the discomfort and stress she is already experiencing. This pressure results in shaming and instilling feelings of guilt which is a form of gynecological violence. Alaia's experience reinforces research findings that perceived pressure to breastfeed leads to increased stress and anxiety as well as feelings of guilt and shame for the mother (Grattan et al., 2024).

These testimonies presented reveal the pervasive nature of obstetric and gynecological violence experienced by women and gender non-normative individuals. These accounts highlight the judgment, mistreatment, and lack of autonomy imposed by healthcare professionals in reproductive matters. Participants consistently faced social and institutional pressures, such as being judged for their reproductive choices, enduring painful medical procedures without adequate anesthesia, and experiencing retaliation for asserting their rights. Additionally, non-binary individuals like Auza face further marginalization due to assumptions about their reproductive desires. Cultural expectations surrounding maternity and breastfeeding also contribute to this violence, as seen in the cases of Graxi and Alaia.

Ultimately, these experiences emphasize the importance of promoting patient autonomy in healthcare. Autonomy in healthcare decision-making refers to an individual's ability to make unrestricted choices for themselves and their dependents, with full access to relevant information and services (Idris et al., 2023). The principle of respect for autonomy requires healthcare providers to acknowledge individuals' rights to hold personal views and make choices based on their values (Lindberg et al., 2014). This aligns with the need for healthcare workers to be trained in reflexivity and assessing their biases to ensure cultural safety.

Discussion

Results from this study highlight various forms of gender bias and discrimination experienced by BWNN during the healthcare encounter. A gap in knowledge transmission regarding women's health issues is a major impediment for BWNN to receive optimal health services and leads to sentiments of mistrust towards the healthcare system. Findings show a scarcity of knowledge transmission from the healthcare system to participants regarding childbirth and menopause amongst other women's health issues which is understood as another indicator of the insufficient significance provided to women's health. These findings coincide with research indicating decrease knowledge regarding women´s health due to a historically dominant androcentric perspective in health sciences (Valls-Llobet, 2020). Additionally, findings indicate an intergenerational gap of knowledge transmission at a community level, related to historical colonial and patriarchal oppression (Federici, 2004; Mujika Garate, 2023). Therefore, the implementation of culturally safe healthcare requires culturally specific procedures, research, and methods to increase information and knowledge focused on the needs of BWNN.

Bias based on sexual and gender identity is another finding of this study. Numerous studies show how gender bias in healthcare is an important social determinant of health and has detrimental health effects (Shannon et al., 2019). Findings revealed unwanted prescription of anxiolytics or delay in diagnosis related to healthcare workers' preconceived perception of participants' mental status (Bacigalupe & Martín, 2021). This finding coincides with existing evidence revealing gender bias in diagnosis criteria and treatments, where women are adversely affected by gender bias in the therapeutic attempt and face increased diagnostic delays (Carrillo et al., 2023).

Study results also highlight discrimination with patients seeking gender affirming care or those who reveal sexual practices that fall outside of the binary heterosexual norm. Motherhood is insisted upon by healthcare workers and judgement regarding when and how women should become mothers is evident. This encouragement arises from the prevailing belief that society inherently expects women to regard motherhood as their primary life goal (Annborn & Finnbogadóttir, 2022). This belief is further reinforced by the idealization of motherhood in Basque culture (Bullen, 2003). As with other Indigenous cultures, many of the views about Basque women and their historical role in society were not recorded or were written by non-Indigenous men with a patriarchal and colonialist perspective. This perspective which was a crucial instrument to cultural genocide, internalized sexism and patriarchy (Baskin, 2020), also within Basque society, contribute to the experience of discrimination for BWNN. There is an overall attempt to condition and control women's bodies through social pressure implemented through healthcare workers from a position of power conditioning participants ability to freely make decisions regarding their bodies.

All these findings respond to practices based on restrictive gender norms that promote gender inequality which is consequently transformed into health risks (Shannon et al., 2019). Consequently, discrimination based on gender and sexual identity is also a significant barrier to culturally safe healthcare for BWNN. To overcome this barrier promoting patients' autonomy in healthcare, gender-sensitivity educational interventions and health policies aimed at the reduction of gender inequities in health (Chilet-Rosell & Hernández-Aguado, 2022) as well as introducing updated conceptualizations regarding gender affirmation care and sexual identity are ways to identify and address gender bias and discrimination within the healthcare system.

Gynecological and obstetric violence is a worldwide phenomenon that has been disregarded and includes inappropriate and non-consensual acts, painful interventions and

sexist behavior (Perrotte et al., 2020). Findings in this study indicate that it is a phenomenon also occurring within the Basque setting and needs to be addressed from the unique perspective of BWNN. Study results show that BWNN are subject to sexist behavior, non-consensual acts including unconsented penetration and judgement regarding their choices of treatment. Although most of these experiences occur during childbirth, other medical interventions during gynecological examinations are also perceived as forms of invisible violence and gender discrimination (Annborn & Finnbogadóttir, 2022). Findings indicate that these experiences frequently coincide with ethnic and linguistic discrimination, highlighting the need to expand our understanding of marginalization through intersectional frameworks that consider various aspects of identity and overlapping power structures (Scott et al., 2023). Diminishing these marginalizing experiences will be necessary to overcome obstacles to culturally safe healthcare for BWNN.

Participants highlight the importance of being able to make informed decisions regarding their health and their bodies. Current research shows that women's autonomy to make decisions regarding their health significantly improves health outcomes. Empowering women in healthcare decision making and appropriate use of healthcare services can decrease morbidity and mortality rates in women and their children (Idris et al., 2023). Study results show that BWNN experience increase satisfaction and confidence when they can make informed decisions regarding their birthing experience or choosing amongst different types of therapeutic treatments, including their children's. The principle of respecting autonomy requires healthcare workers to recognize patients' rights to make decisions based on their own values (Lindberg et al., 2014). To achieve this, healthcare workers must be trained in self-reflection and bias awareness, which is essential for delivering culturally safe care.

Limitations

Limitations of this study include that although data was conducted in *Euskara* data analysis was performed in English. The unique perspective and understanding provided by each language may have led to the loss of essential parts of data through translation. We attempted to alleviate this by reading the transcripts in *Euskara* and the English translation. This study was only conducted in the province of Nafarroa therefore results may not be generalizable to other Basque regions. Although the study included Basque women and gender non-normative individuals, the study sample mostly included heterosexual cis-gender women, which may signify an underrepresentation of gender and sexual minorities.

Conclusions

This qualitative study explores the experiences of BWNN with healthcare in the Basque Country, contributing to fill a significant gap in research in this area within the European setting. Findings from this study highlight harmful prejudice and discrimination experienced by BWNN due to their marginalized position related to gender and ethnicity in the healthcare setting. This is concerning given that these experiences lead to sub-optimal healthcare. However, findings also provide guidance to practices, promoting women's autonomy in healthcare services and promoting non-biased gender equity in healthcare which may act as facilitators to culturally safe healthcare for BWNN. These results offer insight into potential knowledge gaps in nursing practice and emphasize the need to integrate cultural safety into nursing education and practice within the Basque context.

References

Al-Hamad, A., Forchuk, C., Oudshoorn, A., & Mckinley, G. P. (2022). Listening to the Voices of Syrian Refugee Women in Canada: An Ethnographic Insight into the Journey from Trauma to Adaptation. *Journal of International Migration and Integration*, 1–21. https://doi.org/10.1007/s12134-022-00991-w

Annborn, A., & Finnbogadóttir, H. R. (2022). Obstetric violence: A qualitative interview study. *Midwifery, 105*, 103212. https://doi.org/10.1016/j.midw.2021.103212

Bacigalupe, A., & Martín, U. (2021). Gender inequalities in depression/anxiety and the consumption of psychotropic drugs: Are we medicalising women's mental health? *Scandinavian Journal of Public Health*, *49*(3), 317–324. https://doi.org/10.1177/1403494820944736

Baskin, C. (2020). Contemporary Indigenous women's roles: Traditional teachings or internalized colonialism? *Violence Against Women, 26*(15–16), 2083–2101. https://doi.org/10.1177/1077801219888024

Bhattacharya, K. (2017). *Fundamentals of Qualitative Research: A Practical Guide*. Routledge. https://doi.org/10.4324/9781315231747

Bowleg, L. (2012). The Problem With the Phrase Women and Minorities: Intersectionality—an Important Theoretical Framework for Public Health. *American Journal of Public Health*, *102*(7), 1267–1273. https://doi.org/10.2105/AJPH.2012.300750

Bullen, M. (2003). *Basque Gender Studies*. https://scholarworks.unr.edu//handle/11714/5053

Carrillo, I., Lopez-Pineda, A., Pérez-Jover, V., Guilabert, M., Vicente, M. A., Fernández, C., Gil-Guillen, V. F., Orozco-Bletrán, D., Chilet-Rosell, E., Luzon Oliver, L., Astier-Peña, M. P., Tella, S., Carratalá-Munuera, C., & Mira, J. J. (2023). Epidemiological

study on gender bias and low-value practices in primary care: A study protocol. *BMJ Open*, *13*(5), e070311. https://doi.org/10.1136/bmjopen-2022-070311

Cayir, E., Spencer, M., Billings, D., Hilfinger Messias, D. K., & Robillard, A. (2021). Working Against Gender-Based Violence in the American South: An Analysis of Race, Ethnicity, Gender, and Sexuality in Advocacy. *Qualitative Health Research*, *31*(13), 2454–2469. https://doi.org/10.1177/10497323211041327

Chan, A., Pullen Sansfaçon, A., & Saewyc, E. (2023). Experiences of discrimination or violence and health outcomes among Black, Indigenous and People of Colour trans and/or nonbinary youth. *Journal of Advanced Nursing*, *79*(5), 2004–2013. https://doi.org/10.1111/jan.15534

Chilet-Rosell, E., & Hernández-Aguado, I. (2022). Solving gender gaps in health, what else is missing? *Gaceta Sanitaria*, *36*(1), 45–47. https://doi.org/10.1016/j.gaceta.2021.10.002

Cole, J. (2011). *Ethnic Groups of Europe: An Encyclopedia*. ABC-CLIO.

Committee on Equality and Non-Discrimination. (2019). *Obstetrical and gynaecological violence* (p. 14). Council of Europe. https://www.bing.com/search?FORM=AFSCWO&PC=AFSC&q=Obstetrical+and+gynaecological+violence

Crenshaw, K. (1991). Mapping the Margins: Intersectionality, Identity Politics, and Violence against Women of Color. *Stanford Law Review*, *43*(6), 1241. https://doi.org/10.2307/1229039

Crespí-Lloréns, N., Hernández-Aguado, I., & Chilet-Rosell, E. (2021). Have Policies Tackled Gender Inequalities in Health? A Scoping Review. *International Journal of Environmental Research and Public Health*, *18*(1), 327. https://doi.org/10.3390/ijerph18010327

Curtis, E., Jones, R., Tipene-Leach, D., Walker, C., Loring, B., Paine, S.-J., & Reid, P. (2019). Why cultural safety rather than cultural competency is required to achieve health equity: A literature review and recommended definition. *International Journal for Equity in Health*, *18*(1), 174. https://doi.org/10.1186/s12939-019-1082-3

Echeverria, B. (2003). Language ideologies and practices in (en)gendering the Basque nation. *Language in Society*, *32*(3), 383–413. https://doi.org/10.1017/S0047404503323048

Engnes, J. I., Sivertsen, N., Bongo, B. A., & Mehus, G. (2021). Sámi and Norwegian nurses' perspectives on nursing care of Sámi patients: A focus group study on culturally safe nursing. *International Journal of Circumpolar Health*, *80*(1), 1948246. https://doi.org/10.1080/22423982.2021.1948246

Federici, S. (2004). *Caliban and the Witch: Women, the Body and Primitive Accumulation*. Autonomedia.

Friend, J. (2012). *Stateless Nations: Western European Regional Nationalisms and the Old Nations*. Springer.

Grattan, R. E., London, S. M., & Bueno, G. E. (2024). Perceived pressure to breastfeed negatively impacts postpartum mental health outcomes over time. *Frontiers in Public Health*, *12*. https://doi.org/10.3389/fpubh.2024.1357965

Grove, S. K., & Gray, J. R. (2019). *Understanding nursing research: Building an evidence-based practice* (7th ed.). Elsevier.

Hankivsky, O. (2014). *Intersectionality 101*. Vancouver: Institute for Intersectionality Research & Policy.

Huffstetler, A. N., Ramirez, S. I., Dalrymple, S. N., & Mendez Miller, M. H. (2021). Women's Health and Gender-Specific Considerations. *Primary Care: Clinics in Office Practice*, *48*(1), 117–129. https://doi.org/10.1016/j.pop.2020.09.008

Idris, I. B., Hamis, A. A., Bukhori, A. B. M., Hoong, D. C. C., Yusop, H., Shaharuddin, M. A.-A., Fauzi, N. A. F. A., & Kandayah, T. (2023). Women's autonomy in healthcare

decision making: A systematic review. *BMC Women's Health*, *23*(1), 643. https://doi.org/10.1186/s12905-023-02792-4

Kapilashrami, A. (2018). How serious are global health leaders about gender equality? *BMJ*, *361*, k1462. https://doi.org/10.1136/bmj.k1462

Lindberg, C., Fagerström, C., Sivberg, B., & Willman, A. (2014). Concept analysis: Patient autonomy in a caring context. *Journal of Advanced Nursing*, *70*(10), 2208–2221. https://doi.org/10.1111/jan.12412

Machielsen, J. (2019). The Making of a Teen Wolf: Pierre de Lancre's Confrontation with Jean Grenier (1603–10). *Folklore*, *130*(3), 237–257. https://doi.org/10.1080/0015587X.2019.1587935

MacIntosh, T., Desai, M. M., Lewis, T. T., Jones, B. A., & Nunez-Smith, M. (2013). Socially-Assigned Race, Healthcare Discrimination and Preventive Healthcare Services. *PLOS ONE*, *8*(5), e64522. https://doi.org/10.1371/journal.pone.0064522

Madison, D. S. (2020). *Critical Ethnography: Method, Ethics, and Performance*. SAGE Publications, Inc. https://doi.org/10.4135/9781071878965

Mujika Garate, M. (2023). *Euskararen arritmia* [The arrhythmia of Basque]. Elkar.

Nafarroako Gobernua. (2022). *Emakumeen eta Gizonen arteko I. Berdintasun Plana* [First Equality Plan between Women and Men]. Gobierno Abierto Navarra. https://gobiernoabierto.navarra.es/eu/gobernantza/planak-eta-programak-gobernu-eraginak/emakumeen-eta-gizonen-arteko-i-berdintasun-plana

Nausia Pimoulier, A. (2012). Mujeres solas y brujería en la Navarra de los siglos XVI y XVII. *Revista internacional de los estudios vascos = Eusko ikaskuntzen nazioarteko aldizkaria = Revue internationale des ètudes basques = International journal on Basque studies, RIEV*, *Extra 9*, 216–239.

Papps, E., & Ramsden, I. (1996). Cultural Safety in Nursing: The New Zealand Experience. *International Journal for Quality in Health Care*, *8*(5), 491–497. https://doi.org/10.1093/intqhc/8.5.491

Perrotte, V., Chaudhary, A., & Goodman, A. (2020). "At least your baby is healthy": Obstetric violence or disrespect and abuse in childbirth occurrence worldwide: A literature review. *Open Journal of Obstetrics and Gynecology, 10*(11), 1482–1499. https://doi.org/10.4236/ojog.2020.10110139

Pilarinos, A., Field, S., Vasarhelyi, K., Hall, D., Fox, E. D., Price, E. R., Bonshor, L., & Bingham, B. (2023). A qualitative exploration of Indigenous patients' experiences of racism and perspectives on improving cultural safety within health care. *CMAJ Open*, *11*(3), E404–E410. https://doi.org/10.9778/cmajo.20220135

Polit, D. F., & Beck, C. T. (2012). *Nursing research: Generating and assessing evidence for nursing practice* (9th ed.). Wolters Kluwer Health/Lippincott Williams & Wilkins.

Pulice-Farrow, L., Lindley, L., & Gonzalez, K. A. (2022). "Wait, What Is That? A Man or Woman or What?": Trans Microaggressions from Gynecological Healthcare Providers. *Sexuality Research and Social Policy*, *19*(4), 1549–1560. https://doi.org/10.1007/s13178-021-00675-7

Qualtrics. (2024). *Qualtrics XM* [Software]. Qualtrics. https://www.qualtrics.com

Schill, K., & Caxaj, S. (2019). Cultural safety strategies for rural Indigenous palliative care: A scoping review. *BMC Palliative Care*, *18*(1), 21. https://doi.org/10.1186/s12904-019-0404-y

Scott, S. B., Gaska, K. A., Knopp, K., Do, Q. A., & Yang, J. P. (2023). Sexual Minority Women and Discriminatory Health Care Experiences: An Intersectional Evaluation Across Race and Ethnicity. *Women's Health Issues*, *33*(2), 160–166. https://doi.org/10.1016/j.whi.2022.10.007

Sen, G., & Ostlin, P. (2008). Gender inequity in health: Why it exists and how we can change it. *Global Public Health*, *3 Suppl 1*, 1–12. https://doi.org/10.1080/17441690801900795

Shannon, G., Jansen, M., Williams, K., Cáceres, C., Motta, A., Odhiambo, A., Eleveld, A., & Mannell, J. (2019). Gender equality in science, medicine, and global health: Where are we at and why does it matter? *The Lancet*, *393*(10171), 560–569. https://doi.org/10.1016/S0140-6736(18)33135-0

Toh, R. K. C., & Shorey, S. (2023). Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation. *Women and Birth*, *36*(1), 30–38. https://doi.org/10.1016/j.wombi.2022.06.003

Urla, J. (2012). *Reclaiming Basque: Language, nation, and cultural activism*. University of Nevada Press.

Valls-Llobet, C. (2020). *Mujeres invisibles para la medicina* (3rd ed.). Capitán Swing Libros S.L.

Wakewich, P., Wood, B., Davey, C., Laframboise, A., & Zehbe, I. (2016). Colonial legacy and the experience of First Nations women in cervical cancer screening: A Canadian multi-community study. *Critical Public Health*, *26*(4), 368–380. https://doi.org/10.1080/09581596.2015.1067671

Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLOS ONE*, *14*(1). https://doi.org/10.1371/journal.pone.0210587

CHAPTER 5: Discussion

Although there are global efforts to enhance patient safety and quality of care, the needs of Indigenous and ethnic minority populations have not received adequate focus, resulting in a significant gap in research. Patients from these groups often feel unsafe, encounter discrimination, lack access to appropriate interpreting services, and have limited understanding of the healthcare settings and systems during their healthcare interactions (Chauhan et al., 2020). This experience of marginalization is exacerbated for Indigenous and ethnic minority women (Toh & Shorey, 2022; Watson et al., 2019). The purpose of this dissertation was to explore the experiences of Basque Women and Gender Non-normative individuals (BWNN) with healthcare in the Basque Country. It aims to contribute to close the gap in knowledge regarding Indigenous and ethnic minority discrimination in healthcare and effectively provide guidance for the implementation of culturally safe healthcare in the Basque setting.

In Chapter 2, I discussed the results of a scoping review focused on the existing evidence on Indigenous and ethnic minority women's experiences with culturally safe healthcare in Europe. I found that while recent studies highlight the importance of cultural safety in healthcare, particularly for Indigenous and ethnic minority populations in Europe, research remains limited. The reviewed articles emphasize the need for culturally safe practices to address health disparities, power relations, and cultural aspects within the healthcare system and promote respect for patients' cultural identities. However, challenges persist in ensuring institutional accountability and integrating both individual and systemic changes. The lack of consensus on key terms and the tendency to oversimplify cultural safety by depriving it from critical theoretical perspective further complicates its implementation. Moving forward, there is a critical need for more research and practical efforts to embed cultural safety at all levels of healthcare, ensuring that care is both inclusive and respectful of diverse cultural contexts.

In Chapter 3, we discussed that while healthcare workers and clinic leadership, when first approached for consent to use the facilities, perceived that BWNN did not face discrimination within the healthcare system. However, study findings indicate that BWNN experience significant discrimination related to their gender, ethnicity, and language, which intersects with broader oppressive structures. This discrimination manifests as *euskalfobia*, where the Basque language and culture are marginalized, and cultural healing practices devaluated. The power dynamics in healthcare create an unequal relationship between healthcare providers and patients, which is compounded by the unique challenges faced by Indigenous and ethnic minority women, as explained through intersectionality theory.

Implementing cultural safety in healthcare for BWNN requires an understanding of their socio-economic and political contexts, as well as addressing the barriers that contribute to their marginalization. The study identifies that *euskalfobia* exists at multiple levels within the healthcare system, resulting in the invisibilization of Basque culture and language. This lack of recognition leads to neglect of BWNN linguistic rights and poses significant obstacles to culturally safe care. Structural changes within the healthcare system, such as improved coordination, organizational reform, and enhanced training for healthcare workers, are necessary to promote cultural safety and recognize the rights of Indigenous ethnic minorities.

Findings emphasize the normalization of *euskarafobia*, which creates an environment where discrimination goes unacknowledged, leading to the belief that it is nonexistent. BWNN participants link this normalization to the historical oppression of the Basque community and express feelings of being devalued and dismissed by healthcare providers. Many participants prefer cultural healing practices, viewing them as a holistic complement to Western medicine. The study suggests that integrating cultural healing practices with conventional healthcare can enhance service delivery for all communities. Furthermore,

language and cultural concordance are critical for fostering trust and satisfaction among BWNN, underscoring the need for the healthcare system to prioritize these aspects in its efforts to provide culturally safe care.

In Chapter 4, findings highlight the various forms of gender bias and discrimination faced by BWNN during healthcare encounters. Participants perceive a significant gap in knowledge transmission from the healthcare system regarding women's health issues, such as childbirth and menopause. This deficiency is perceived as a reflection of the historical androcentric bias in health sciences. Moreover, the study also uncovers an intergenerational gap in knowledge transmission at the community level, stemming from historical colonial and patriarchal oppression. Consequently, implementing culturally safe healthcare requires culturally specific procedures, research, and methods to increase knowledge transmission focused on the needs of BWNN.

Another crucial finding is the presence of bias related to sexual and gender identity within the healthcare system. Gender bias is identified as a critical social determinant of health that can lead to adverse health outcomes. The study reveals instances of unwanted prescriptions and diagnostic delays based on healthcare workers' preconceived notions of patients' mental health and dismissiveness of BWNN health issues. Additionally, BWNN often face discrimination and societal pressure regarding motherhood, which is reinforced by cultural norms. These restrictive gender norms and the patriarchal perspective within Basque society contribute to further discrimination against BWNN, impacting their ability to make decisions about their bodies and health.

The study also emphasizes the phenomenon of gynecological and obstetric violence, which includes inappropriate and non-consensual medical practices, and indicates that it is present in the Basque context. BWNN experience sexist behaviors, unconsented acts, and

judgment regarding their treatment choices, often exacerbated by ethnic and linguistic discrimination. To address these issues, the study suggests that promoting BWNN's autonomy during healthcare encounters can enhance their healthcare experiences and outcomes. By recognizing the importance of autonomy and implementing gender-sensitive policies, healthcare systems can better serve the needs of BWNN and work towards reducing health disparities.

In sum, this study demonstrated that Indigenous and ethnic minority populations in Europe, particularly BWNN face discrimination and receive suboptimal healthcare services. These issues are closely tied to power differences within the healthcare system and highlight a concerning lack of awareness regarding cultural safety, discrimination, and biases affecting ethnic minority groups. The findings indicate that BWNN experience harmful prejudice related to their preferred language and marginalized status, leading to negative health outcomes. However, the study also offers practical recommendations for enhancing healthcare, such as promoting language and cultural concordance, acknowledging cultural healing practices, and providing training on cultural safety at both individual and institutional levels. Additionally, it emphasizes the importance of supporting women's autonomy and ensuring gender equity in healthcare services. Overall, this research underscores the critical need to integrate cultural safety into nursing education and practice in the Basque context, while also calling for further studies to promote cultural safety for Indigenous and ethnic minority populations across Europe.

Future Directions

This work highlights critical future directions for implementing culturally safe healthcare in the Basque setting and outlines several significant policy implications. First, there is a pressing need for additional research that examines the impact of language barriers,

cultural discordance, and gender on healthcare outcomes for BWNN populations. Future studies should specifically explore how language and cultural differences contribute to discrimination within healthcare settings and examine the role of cultural safety training in reducing these disparities, ultimately enhancing the experiences of both patients and healthcare workers.

To support these efforts, healthcare organizations and educational institutions must prioritize the development of cultural safety training and education. Research is needed to explore Basque Country healthcare workers' perceptions and attitudes towards Basque language and culture. Cultural safety training for healthcare workers should address the historical roots of cultural supremacy and sexism, helping providers understand how these issues continue to affect BWNN patients today. Further, embedding cultural safety into healthcare sciences curricula at the university level—particularly within nursing and medical programs—would prepare future healthcare workers to respond more effectively to the diverse needs of BWNN.

The findings of this study call out for comprehensive policy reforms to create a more equitable healthcare environment for BWNN. Policies that protect linguistic rights and prevent gender and ethnic discrimination are essential. For example, laws that uphold the linguistic rights of the Basque population and directly address ethnic discrimination can significantly contribute to a more inclusive healthcare system. Policies that ensure cultural and language concordance—such as enabling healthcare workers to communicate with patients in their preferred language and equipping them with adequate cultural understanding—can also help reduce experiences of discrimination for BWNN individuals. Additionally, policies that address gender bias and discrimination as a healthcare disparity and

promote training in gender equity for healthcare workers can lay a foundation for implementing cultural safety practices in the Basque setting.

Since the findings reveal that overlapping structures of oppression are systematically present in healthcare, these policies must be applied at all levels within the system. This requires establishing clear guidelines and standards for cultural safety, directly addressing gender and ethnic biases, and enforcing cultural safety across healthcare delivery. Engaging both the healthcare sector and the broader BWNN community in these discussions is essential. Sharing these findings widely can raise awareness, stimulate further research, and encourage healthcare workers to reflect on their own practices. Educating BWNN communities about their rights in healthcare can empower them to advocate for more inclusive practices, increasing their satisfaction and trust in healthcare systems.

Finally, a focus on cultural safety in nursing education and practice represents a pivotal step toward more equitable healthcare. By equipping nurses with the skills and knowledge to address the unique needs of BWNN patients, this approach can improve patient outcomes and foster a more inclusive healthcare environment overall.

References

Chauhan, A., Walton, M., Manias, E., Walpola, R. L., Seale, H., Latanik, M., Leone, D., Mears, S., & Harrison, R. (2020). The safety of health care for ethnic minority patients: A systematic review. *International Journal for Equity in Health*, *19*(1), 118. https://doi.org/10.1186/s12939-020-01223-2

Toh, R. K. C., & Shorey, S. (2023). Experiences and needs of women from ethnic minorities in maternity healthcare: A qualitative systematic review and meta-aggregation. *Women and Birth*, *36*(1), 30–38. https://doi.org/10.1016/j.wombi.2022.06.003

Watson, H., Harrop, D., Walton, E., Young, A., & Soltani, H. (2019). A systematic review of ethnic minority women's experiences of perinatal mental health conditions and services in Europe. *PLOS ONE*, *14*(1), Article 1. https://doi.org/10.1371/journal.pone.0210587

Appendix A:

Prisma Checklist

Table. PRISMA-ScR Checklist

Section	Item	PRISMA-ScR Checklist Item
Title	1	Identify the report as a scoping review.
Abstract		
Structured summary	2	Provide a structured summary that includes (as applicable) background, objectives, eligibility criteria, sources of evidence, charting methods, results, and conclusions that relate to the review questions and objectives.
Introduction		
Rationale	3	Describe the rationale for the review in the context of what is already known. Explain why the review questions/objectives lend themselves to a scoping review approach.
Objectives	4	Provide an explicit statement of the questions and objectives being addressed with reference to their key elements (e.g., population or participants, concepts, and context) or other relevant key elements used to conceptualize the review questions and/or objectives.
Methods		
Protocol and registration	5	Indicate whether a review protocol exists; state if and where it can be accessed (e.g., a Web address); and if available, provide registration information, including the registration number.
Eligibility criteria	6	Specify characteristics of the sources of evidence used as eligibility criteria (e.g., years considered, language, and publication status), and provide a rationale.
Information sources*	7	Describe all information sources in the search (e.g., databases with dates of coverage and contact with authors to identify additional sources), as well as the date the most recent search was executed.
Search	8	Present the full electronic search strategy for at least 1 database, including any limits used, such that it could be repeated.
Selection of sources of evidence†	9	State the process for selecting sources of evidence (i.e., screening and eligibility) included in the scoping review.
Data charting process‡	10	Describe the methods of charting data from the included sources of evidence (e.g., calibrated forms or forms that have been tested by the team before their use, and whether data charting was done independently or in duplicate) and any processes for obtaining and confirming data from investigators.
Data items	11	List and define all variables for which data were sought and any assumptions and simplifications made.
Critical appraisal of individual sources of evidence§	12	If done, provide a rationale for conducting a critical appraisal of included sources of evidence; describe the methods used and how this information was used in any data synthesis (if appropriate).
Summary measures	13	Not applicable for scoping reviews.
Synthesis of results	14	Describe the methods of handling and summarizing the data that were charted.
Risk of bias across studies	15	Not applicable for scoping reviews.
Additional analyses	16	Not applicable for scoping reviews.
Results		
Selection of sources of evidence	17	Give numbers of sources of evidence screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally using a flow diagram.
Characteristics of sources of evidence	18	For each source of evidence, present characteristics for which data were charted and provide the citations.
Critical appraisal within sources of evidence	19	If done, present data on critical appraisal of included sources of evidence (see item 12).
Results of individual sources of evidence	20	For each included source of evidence, present the relevant data that were charted that relate to the review questions and objectives.
Synthesis of results	21	Summarize and/or present the charting results as they relate to the review questions and objectives.
Risk of bias across studies	22	Not applicable for scoping reviews.
Additional analyses	23	Not applicable for scoping reviews.
Discussion		
Summary of evidence	24	Summarize the main results (including an overview of concepts, themes, and types of evidence available), link to the review questions and objectives, and consider the relevance to key groups.
Limitations	25	Discuss the limitations of the scoping review process.
Conclusions	26	Provide a general interpretation of the results with respect to the review questions and objectives, as well as potential implications and/or next steps.
Funding	27	Describe sources of funding for the included sources of evidence, as well as sources of funding for the scoping review. Describe the role of the funders of the scoping review.

JBI = Joanna Briggs Institute; PRISMA-ScR = Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews.
* Where *sources of evidence* (see second footnote) are compiled from, such as bibliographic databases, social media platforms, and Web sites.
† A more inclusive/heterogeneous term used to account for the different types of evidence or data sources (e.g., quantitative and/or qualitative research, expert opinion, and policy documents) that may be eligible in a scoping review as opposed to only studies. This is not to be confused with *information sources* (see first footnote).
‡ The frameworks by Arksey and O'Malley (6) and Levac and colleagues (7) and the JBI guidance (4, 5) refer to the process of data extraction in a scoping review as data charting.
§ The process of systematically examining research evidence to assess its validity, results, and relevance before using it to inform a decision. This term is used for items 12 and 19 instead of "risk of bias" (which is more applicable to systematic reviews of interventions) to include and acknowledge the various sources of evidence that may be used in a scoping review (e.g., quantitative and/or qualitative research, expert opinion, and policy documents).

Appendix B: Search strategy by database

#	PubMed. The searches were completed on July 2, 2024. No date limits were applied to the searches. Title/Abstract	
	Search Syntax	**# of Articles**
1	**(**Culturally safe care OR cultural safety OR cultural awareness OR culturally conscious OR cultural competencies OR cultural competence OR cultural sensitivity OR cultural competencies [MeSH] OR cultural competence [MeSH] OR cultural sensitivity [MeSH])	96,100
2	(Indigenous OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority OR ethnic minority [MeSH] OR ethnic minorities [MeSH] OR racial minorities [MeSH] OR racial minority [MeSH])	81,696
3	(Europe OR Russia OR Germany OR United Kingdom OR France OR Italy OR Spain OR Ukraine OR Poland OR Romania OR Netherlands OR Belgium OR Czech Republic OR Czechia OR Greece OR Portugal OR Sweden OR Hungary OR Belarus OR Austria OR Serbia OR Switzerland OR Bulgaria OR Denmark OR Finland OR Slovakia OR Norway OR Ireland OR Croatia OR Moldova OR Bosnia and Herzegovina OR Albania OR Lithuania OR Macedonia OR Slovenia OR Latvia OR Estonia OR Montenegro OR Luxembourg OR Malta OR Iceland OR Andorra OR Monaco OR Liechtenstein OR San Marino OR Holy See OR Andalusia OR Galicia OR Asturias OR Basque OR Aragon OR Catalonia OR Brittany OR Normandy OR Occitania OR Guernsey OR Jersey OR Cornwall OR Wales OR Man OR Scotland OR Flanders OR Wallonia OR Lorraine OR Alsace OR Romansch OR Savoy OR Aosta OR Piedmont OR Liguria OR Corsica OR Sardinia OR Bavaria OR Friesland OR Faroe OR Samiland OR Sami OR Swedes OR Aland Islands OR Livonia OR Voro OR Scania OR Danes OR Kashubia OR Sorbia OR Silesia OR Moravia OR Transdniestria OR Szekely land OR Napolitania OR Istria OR Lombardy OR Roma)	458,944
4	women OR gender	1,589,430
	#1 AND #2 AND #3 AND #4	**40**

Appendix C: Search strategy by database

#	CINAHL. The searches were completed on July 2, 2024. No date limits were applied to the searches. Title/Abstract	
	Search Syntax	**# of Articles**
1	**(**Culturally safe care OR cultural safety OR cultural awareness OR culturally conscious OR cultural competencies OR cultural competence OR cultural sensitivity OR cultural competencies OR cultural competence OR cultural sensitivity)	5,255
2	(Indigenous OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority)	19,017
3	(Europe OR Russia OR Germany OR United Kingdom OR France OR Italy OR Spain OR Ukraine OR Poland OR Romania OR Netherlands OR Belgium OR Czech Republic OR Czechia OR Greece OR Portugal OR Sweden OR Hungary OR Belarus OR Austria OR Serbia OR Switzerland OR Bulgaria OR Denmark OR Finland OR Slovakia OR Norway OR Ireland OR Croatia OR Moldova OR Bosnia and Herzegovina OR Albania OR Lithuania OR Macedonia OR Slovenia OR Latvia OR Estonia OR Montenegro OR Luxembourg OR Malta OR Iceland OR Andorra OR Monaco OR Liechtenstein OR San Marino OR Holy See OR Andalusia OR Galicia OR Asturias OR Basque OR Aragon OR Catalonia OR Brittany OR Normandy OR Occitania OR Guernsey OR Jersey OR Cornwall OR Wales OR Man OR Scotland OR Flanders OR Wallonia OR Lorraine OR Alsace OR Romansch OR Savoy OR Aosta OR Piedmont OR Liguria OR Corsica OR Sardinia OR Bavaria OR Friesland OR Faroe OR Samiland OR Sami OR Swedes OR Aland Islands OR Livonia OR Voro OR Scania OR Danes OR Kashubia OR Sorbia OR Silesia OR Moravia OR Transdniestria OR Szekely land OR Napolitania OR Istria OR Lombardy OR Roma)	378,111
4	women OR gender	534,308
	#1 AND #2 AND #3 AND #4	**28**

Appendix D: Search strategy by database

#	Embase. The searches were completed on July 2, 2024. No date limits were applied to the searches. Title/Abstract	
	Search Syntax	**# of Articles**
1	**(**Culturally safe care OR cultural safety OR cultural awareness OR culturally conscious OR cultural competencies OR cultural competence OR cultural sensitivity OR cultural competencies OR cultural competence OR cultural sensitivity)	6,700
2	(Indigenous OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority)	75,738
3	(Europe OR Russia OR Germany OR United Kingdom OR France OR Italy OR Spain OR Ukraine OR Poland OR Romania OR Netherlands OR Belgium OR Czech Republic OR Czechia OR Greece OR Portugal OR Sweden OR Hungary OR Belarus OR Austria OR Serbia OR Switzerland OR Bulgaria OR Denmark OR Finland OR Slovakia OR Norway OR Ireland OR Croatia OR Moldova OR Bosnia and Herzegovina OR Albania OR Lithuania OR Macedonia OR Slovenia OR Latvia OR Estonia OR Montenegro OR Luxembourg OR Malta OR Iceland OR Andorra OR Monaco OR Liechtenstein OR San Marino OR Holy See OR Andalusia OR Galicia OR Asturias OR Basque OR Aragon OR Catalonia OR Brittany OR Normandy OR Occitania OR Guernsey OR Jersey OR Cornwall OR Wales OR Man OR Scotland OR Flanders OR Wallonia OR Lorraine OR Alsace OR Romansch OR Savoy OR Aosta OR Piedmont OR Liguria OR Corsica OR Sardinia OR Bavaria OR Friesland OR Faroe OR Samiland OR Sami OR Swedes OR Aland Islands OR Livonia OR Voro OR Scania OR Danes OR Kashubia OR Sorbia OR Silesia OR Moravia OR Transdniestria OR Szekely land OR Napolitania OR Istria OR Lombardy OR Roma)	598,318
4	women OR gender	2,295,501
	#1 AND #2 AND #3 AND #4	**4**

Appendix E: Search strategy by database

#	Web of Science. The searches were completed on July 2, 2024. No date limits were applied to the searches. Title/Abstract	
	Search Syntax	**# of Articles**
1	**(**Culturally safe care OR cultural safety OR cultural awareness OR culturally conscious OR cultural competencies OR cultural competence OR cultural sensitivity OR cultural competencies OR cultural competence OR cultural sensitivity)	46,880
2	(Indigenous OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority)	155,725
3	(Europe OR Russia OR Germany OR United Kingdom OR France OR Italy OR Spain OR Ukraine OR Poland OR Romania OR Netherlands OR Belgium OR Czech Republic OR Czechia OR Greece OR Portugal OR Sweden OR Hungary OR Belarus OR Austria OR Serbia OR Switzerland OR Bulgaria OR Denmark OR Finland OR Slovakia OR Norway OR Ireland OR Croatia OR Moldova OR Bosnia and Herzegovina OR Albania OR Lithuania OR Macedonia OR Slovenia OR Latvia OR Estonia OR Montenegro OR Luxembourg OR Malta OR Iceland OR Andorra OR Monaco OR Liechtenstein OR San Marino OR Holy See OR Andalusia OR Galicia OR Asturias OR Basque OR Aragon OR Catalonia OR Brittany OR Normandy OR Occitania OR Guernsey OR Jersey OR Cornwall OR Wales OR Man OR Scotland OR Flanders OR Wallonia OR Lorraine OR Alsace OR Romansch OR Savoy OR Aosta OR Piedmont OR Liguria OR Corsica OR Sardinia OR Bavaria OR Friesland OR Faroe OR Samiland OR Sami OR Swedes OR Aland Islands OR Livonia OR Voro OR Scania OR Danes OR Kashubia OR Sorbia OR Silesia OR Moravia OR Transdniestria OR Szekely land OR Napolitania OR Istria OR Lombardy OR Roma)	2,938,194
4	women OR gender	1,926,479
	#1 AND #2 AND #3 AND #4	**98**

Appendix F: Search strategy by database

#	Epistemonikos. The searches were completed on July 2, 2024. No date limits were applied to the searches. Title/Abstract	
	Search Syntax	**# of Articles**
1	**(**Culturally safe care OR cultural safety OR cultural awareness OR culturally conscious OR cultural competencies OR cultural competence OR cultural sensitivity OR cultural competencies OR cultural competence OR cultural sensitivity)	3
2	(Indigenous OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority OR ethnic minority OR ethnic minorities OR racial minorities OR racial minority)	20,634
3	(Europe OR Russia OR Germany OR United Kingdom OR France OR Italy OR Spain OR Ukraine OR Poland OR Romania OR Netherlands OR Belgium OR Czech Republic OR Czechia OR Greece OR Portugal OR Sweden OR Hungary OR Belarus OR Austria OR Serbia OR Switzerland OR Bulgaria OR Denmark OR Finland OR Slovakia OR Norway OR Ireland OR Croatia OR Moldova OR Bosnia and Herzegovina OR Albania OR Lithuania OR Macedonia OR Slovenia OR Latvia OR Estonia OR Montenegro OR Luxembourg OR Malta OR Iceland OR Andorra OR Monaco OR Liechtenstein OR San Marino OR Holy See OR Andalusia OR Galicia OR Asturias OR Basque OR Aragon OR Catalonia OR Brittany OR Normandy OR Occitania OR Guernsey OR Jersey OR Cornwall OR Wales OR Man OR Scotland OR Flanders OR Wallonia OR Lorraine OR Alsace OR Romansch OR Savoy OR Aosta OR Piedmont OR Liguria OR Corsica OR Sardinia OR Bavaria OR Friesland OR Faroe OR Samiland OR Sami OR Swedes OR Aland Islands OR Livonia OR Voro OR Scania OR Danes OR Kashubia OR Sorbia OR Silesia OR Moravia OR Transdniestria OR Szekely land OR Napolitania OR Istria OR Lombardy OR Roma)	484
4	women OR gender	456,418
	#1 AND #2 AND #3 AND #4	**0**

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