



Physical Activity for Older Aboriginal Adults: A Call for Cultural Safety

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Abstract

The Canadian Society for Exercise Physiology (CSEP) released new physical activity (PA) guidelines for Canadians in 2011, including those for older adults, which communicate the ways in which good health can best be achieved. In this paper, we argue that if we are to have PA guidelines for older adults in Canada, they need to be culturally safe for those who experience disproportionate levels of poor health: Aboriginal older adults. Within this paper, we examine the existing guidelines to determine if they are culturally safe. We show that despite qualitative evidence of the need for culturally safe PA opportunities for Aboriginal peoples, the Canadian PA Guidelines for Older Adults (CSEP, 2012) are not culturally safe for Aboriginal peoples. To address this shortcoming, we use health communication strategies to suggest ways in which the Guide, and in turn other PA resources, could be developed to be culturally safe.

Keywords: older adults, Aboriginal peoples, physical activity guidelines, cultural safety

Résumé

La Société canadienne de physiologie de l'exercice a lancé ses nouveaux guides de pratique de l'activité physique, incluant ceux pour les aînés. Ces guides décrivent diverses façons de développer une bonne santé. Dans ce texte, nous mettons de l'avant l'idée que, si de tels guides pour les aînés sont nécessaires, ils doivent être adaptés à la culture des aînés autochtones, car la proportion de ces aînés qui sont en mauvaise santé est disproportionnée. Nous examinons dans ce texte les guides existants pour déterminer s'ils sont bien adaptés à cette culture. Nous constatons que les Directives canadiennes en matière d'activité physique à l'intention des adultes de plus de 65 ans (SCPE, 2012) ne sont pas adaptés à la culture autochtone. En nous basant sur des stratégies de communication en santé, nous proposons des façons de rendre ces directives et autres ressources sur l'activité physique adaptés à cette culture.

Introduction

It is widely recognized that participation in physical activity (PA) has many benefits for Canadians (Public Health Agency of Canada [PHAC], 2011). PA is an important contributor to growth and development for children and youth, as well as for maintaining health and independence as we age (Paterson & Warburton, 2010; PHAC, 2011). While many people understand the benefits of PA, the Canadian population has relatively low PA rates (Statistics Canada, 2014b). Importantly, PA decreases as people age, with only 48% of adults over the age of 65 being moderately active or active (Statistics Canada, 2014b). Since about 75% of Canadian seniors (those over 65 years of age) have at least one chronic condition and about 25% of seniors have at least three or more chronic conditions (Canadian Institute for Health Information, 2011), these low PA rates are problematic given the importance of PA in reducing the risk of morbidity and mortality for older adults (Paterson & Warburton, 2010).

PA rates for Aboriginal seniors are not well documented, likely due to the fact that this population comprises a small portion of the total Aboriginal population at 6% (Statistics Canada, 2014a); however, Aboriginal older adults suffer from disproportionate rates of chronic disease and mental illness in comparison to their non-Aboriginal counterparts and have much lower life expectancy than non-Aboriginal peoples (Rosenberg, Wilson, Abonyi, Wiebe, & Beach, 2009). In comparison to non-Aboriginal men and women, First Nations peoples have lower life expectancies by 5.4 years for women and 6.1 years for men, Inuit peoples by 10.5 years for women and 14.4 years for men, and Métis peoples by 4.5 years for women and 5.1 years for men (Statistics Canada, 2013). Given PA's health promoting potential, we suggest that PA by/for/with Aboriginal older adults deserves greater scholarly attention.

The purpose of this paper is to determine if the *Canadian PA Guidelines for Older Adults* (Canadian Society for Exercise Physiology [CSEP], 2012), which are intended to be applicable for all older adults in Canada, are culturally safe for Aboriginal older adults. While we acknowledge that Canada is a multicultural country with many different cultural groups, in this paper we are mainly concerned with older Aboriginal adults. While some may argue that it is impossible for the PA guidelines to be culturally safe for every individual, we would contend that given the evidence of Aboriginal older adults' disproportionate poor health, this population warrants particular and concerted attention. Throughout this paper, we will understand PA as being holistically health-promoting; that is, as something that has the capacity to improve community, spiritual, mental, physical, and emotional health (Lavallée, 2007).

Within this paper, we first provide some definitions and context related to Aboriginal peoples in Canada. Next, we provide an overview of the concept of cultural safety, including how and why it was developed and what it entails, as well as an overview of the *Canadian PA Guidelines for Older Adults* (CSEP, 2012). We then summarize our methodology, which is an exploratory case study. Next, we evaluate the *Canadian PA Guidelines for Older Adults* (CSEP, 2012) through a cultural safety lens. Finally, we turn to health communication strategies to offer suggestions for the ways in which Aboriginal older adults and their knowledge of PA can be effectively included in the development of culturally safe PA resources.

Aboriginal Peoples in Canada

“Aboriginal peoples” refers to the original peoples of North America who are recognized by the federal government in the colonial Canadian constitution as First Nations, Métis, and Inuit (Indigenous and Northern Affairs Canada [INAC], 2015a). In Canada, First Nations peoples refer to Status and non-Status “Indian” peoples. While the Canadian federal government has a very homogeneous definition that refers to First Nations as a singular group, there are in fact 617 First Nations communities representing over 50 cultural and linguistic groups in Canada (INAC, 2015b), such as Cree, Dakota, Dene, Nakota, Saulteaux, Ojibway, Mi’kmaq, Maliseet, Innu, Blackfoot, Mohawk, Naskapis, and Algonquin, just to name a few. Inuit refers to the Aboriginal people of the Arctic. In Canada, there are four main regions where about 75% of Inuit peoples live: Inuvialuit (NWT and Yukon), Nunavut, Nunavik (Northern Quebec), and Nunatsiavut (Labrador) (INAC, 2015c). In these regions Inuktitut is the main language; however, there are different dialects within and between each region. In Canada, Métis peoples are those who are of historic Métis Nation ancestry, meaning a part of a distinct group of Aboriginal peoples who “emerged out of the relations of [First Nations] women and European men” (Métis National Council, 2011, p. 2). Métis peoples have a shared history, common culture, and a unique language (known as Michif, which has various regional dialects) and are largely based in western Canada (Métis National Council, 2011). There are over 1.4 million people in Canada who identify as an Aboriginal person (INAC, 2015a); however, it is important to understand the diversity of Aboriginal peoples with their various histories, languages, cultures, and traditions.

Cultural Safety

Numerous authors have argued that cultural relevance, cultural competence, cultural appropriateness, etc. are not particularly helpful approaches when dealing with cultural differences between non-Aboriginal healthcare providers and Aboriginal recipients (Baker & Giles, 2012; Brascoupé & Waters, 2009). First, these concepts are focused on the *process* of interactions between healthcare providers and recipients from the professionals’ point of views, rather than the successful *outcome* of interactions for the recipients (Brascoupé & Waters, 2009). Even if the healthcare providers are knowledgeable and understanding of the recipients’ culture, “this does not in itself ensure the effectiveness of the interaction” (Brascoupé & Waters, 2009, p. 28). Additionally, applying these concepts leaves the ability to exercise power in the interaction in the hands of the professional, whose own culture is rendered invisible, and which produces the recipient as a cultural Other (Baker & Giles, 2012; Brascoupé & Waters, 2009). Indeed, rather than acknowledging the interaction of two cultures, these concepts perpetuate the Othering of Aboriginal healthcare recipients, and the privileging of non-Aboriginal health providers (Baker & Giles, 2012). The notion of cultural safety was created to address these shortcomings.

Cultural safety is a concept that was developed by Maori nurse leaders and educators in New Zealand in response to the health disparities that exist between Maori and non-Maori peoples (Ramsden, 2002). In a healthcare context, cultural safety requires the examination of power relations that exist between healthcare providers and recipients (Anderson et al., 2003). It is often understood by deciphering what is culturally unsafe (Anderson et al., 2003); that is, any actions that devalue, depreciate, or disempower the cultural identity of an individual (Anderson et al., 2003). On the other hand, we can understand culturally safe practices as including those

actions “that recognize and respect the cultural identity of others and take into consideration their own needs and rights” (Anderson et al., 2003, p. 198).

A critical component of cultural safety is its connection with postcolonial theory, which encourages the examination of the unequal power relations that have resulted due to colonial legacies (McEwan, 2009). The postcolonial aspect of cultural safety allows us to examine and make visible the political, historical, economic, and social structures that are a result of colonialism and that have shaped the interactions of dominant Western cultures with Aboriginal cultures in healthcare (Anderson et al., 2003; Smye & Browne, 2002), and in the case of this paper, PA.

Cultural safety involves the understanding of “the ways in which [dominant] Western biomedical cultures and ideologies have shaped healthcare discourses, and silenced other voices” (Anderson et al., 2003, p. 197). It is founded on the premise that due to influential social structures that impact the exchange of health information, individuals providing care may view patients from the non-dominant culture(s) as “different” and their own culture as the “norm” (Baker & Giles, 2012). Within a cultural safety context, healthcare providers should critically reflect on their own personal beliefs, values, and history that they bring into the interaction, rather than imposing their own beliefs and values on patients knowingly or unknowingly (Anderson et al., 2003).

The cultural safety approach, we argue, can and should be extended to the development and implementation of health-promoting PA opportunities for older adults. While not a healthcare setting per se, health promotion through PA plays an important role in maintaining and improving individuals’ health and, as such, should be considered to be a crucial part of the larger context in which healthcare occurs. As a result, a developer or implementer of PA opportunities must also understand his/her interactions with clients as needing to be culturally safe if they are to be successful.

Giles and Darroch (2014) have called for culturally safe PA to be made a priority in health promotion practices and programs. They argued that while there has been a significant amount of research conducted with cultural safety and healthcare, little to no research has examined “how cultural safety can be achieved within a physical activity context” (Giles & Darroch, 2014, p. e318). Responding to this call, in this paper we investigate PA and cultural safety for Aboriginal older adults, specifically through an examination of the *Canadian PA Guidelines for Older Adults* (CSEP, 2012), which are a significant component of government-endorsed PA promotion for older adults in Canada.

Canadian Physical Activity Guidelines

With Canadians’ PA levels decreasing and the prevalence of chronic disease increasing, PA guidelines have been developed to help Canadians to be more active and combat disease (Tremblay, Kho, Tricco, & Duggan, 2010). In an attempt to increase the PA levels of Canadians, and thus improve health, CSEP, with support from PHAC, released new PA guidelines for Canadians in early 2011 (PHAC, 2014).

Guidelines for PA have been available in Canada since 1998; however, the revision of these past Canadian PA guidelines for adults, older adults, and children began in 2006. The goal was to develop updated (and now the current) PA guidelines that reflected the latest science on PA. This process occurred in four phases. Phase 1 included a Think Tank meeting, which was organized by CSEP and PHAC and held in November 2006, of PA experts who were largely

involved in the development of the first set of guidelines. The goals of this meeting were to discuss the existing guidelines, to examine the marketing of the guidelines, to share current research on adherence to PA guidelines, to identify benefits and limitations to the existing guidelines, to consider the necessity of guidelines for specific groups, and to commence a review of Canada's PA Guidelines and Guides (Tremblay et al., 2010). To address the questions raised at the Think Tank, research was undertaken by these PA experts and papers were written based on the results.

Of note, at the Think Tank, participants were advised that members of the Aboriginal community identified that the original guidelines needed to be more culturally appropriate (Sharratt & Hearst, 2007). Prior to the Think Tank, intermediaries working in Aboriginal communities were interviewed by Phoenix Strategic Perspectives (2006), a commercial consultant firm, to help to determine if and how the guidelines could be tailored for Aboriginal people (Adams, 2006). The results indicated that the interviewees felt that the guidelines should be tailored for Aboriginal peoples given that the then current guidelines were not deemed to be relevant for this population, did not include traditional and cultural activities, and were not presented in a way that reflected Aboriginal peoples' learning styles (Adams, 2006; Phoenix Strategic Perspectives, 2006).

Phase 2 began in March 2007, when the PA experts met to review the papers that were written to address the questions raised during the Think Tank. These papers were subsequently published in a special joint supplement of the *Canadian Journal of Public Health* and *Applied Physiology, Nutrition and Metabolism*, including a paper about Aboriginal peoples' PA. The authors of this paper advised that there was "yet no scientific evidence to justify creating different PA recommendations for this group" (Young & Katzmarzyk, 2007, pp. S157-S158). The authors did mention, however, that the process initiated by CSEP, Health Canada, and PHAC was an important step for the eventual inclusion of a section dedicated to Aboriginal peoples (Young & Katzmarzyk, 2007). After this article was published, however, the development of a section or a distinct guide for Aboriginal peoples did not come to fruition, though attempts (in which the second author was involved) were made.

In December 2007, CSEP submitted "Future Directions: PA Measurement and Guidelines in Canada" to PHAC, which included a plan to update the current PA guidelines (Tremblay et al., 2010). Phase 3 began when CSEP and PHAC decided to move forward in the development of the new guidelines by performing systematic reviews of PA recommendations for specific population segments, behaviour change factors for PA, and effective PA messaging (Tremblay et al., 2010). Phase 4 consisted of the final writing and release (January 24, 2011) of the new guidelines (CSEP, 2012), their implementation in a various healthcare settings, and their dissemination to the general public.

Current PA Guidelines for Older Adults

The revised PA guidelines included those for older adults. The overall objective of the PA guidelines for older adults was to "provide the rationale for intensity and volume of aerobic physical activities, and for the adjunct of resistance (strength) training...on functional outcomes including physical limitations, disability, and cognitive losses" (Tremblay et al., 2010, p. 7). The guidelines addressed the relationship of PA and functional outcomes for older adults and the influence of training programs on functional outcomes. The target population for the older adults' guidelines was described as healthy adults aged 65 years to less than 85 years (Tremblay et al., 2010).

The current guidelines for older adults 65 years and older suggest that older adults should accumulate at least 150 minutes of moderate to vigorous activity PA every week, in bouts of ten minutes or more; do muscle and bone strengthening exercises at least two days a week; and perform activities that improve balance and prevent falls (CSEP, 2012). Moderate intensity exercises include those that cause older adults to “sweat a little and to breathe harder,” while vigorous intensity exercises include those that cause older adults to “sweat and be out of breath” (CSEP, 2012, p. 10). The guidelines suggest activities such as joining a community urban poling or mall walking group, going for a brisk walk around the block after lunch, walking the dog after dinner, training for and participating in a charity run/walk, or taking dance classes (CSEP, 2012). Within the guidelines, it is suggested that following these recommendations will lead to many physical benefits, such as reducing the risk of heart disease and premature death and improving or maintaining body weight, bone health, and functional independence (CSEP, 2012). To conduct our analysis of whether or not the new PA guidelines for older adults are culturally safe for Aboriginal older adults, we used a case study methodology.

Methodology

Yin (1994) described an exploratory case study as “an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident” (p. 13). The purpose of a case study is for the researcher to understand a social situation, event, program, activity, etc. in a single or multiple social setting(s) (Bloor & Wood, 2006). The reasons for conducting a case study may be to describe the social phenomenon or to generate or test a certain theory through the case (Bloor & Wood, 2006). To determine if PA opportunities targeted at older adults are culturally safe for Aboriginal older adults we used the *Canadian PA Guidelines for Older Adults* (CSEP, 2012) as our case.

Analyzing the Guidelines through a Cultural Safety Lens

The target population in the older adult guidelines is extremely general. The guidelines adopt a one-size-fits-all approach, despite the fact that it has been shown that diverse approaches to culture need to be considered and employed in successful health interventions (Giles, Castleden, & Baker, 2010; Giles, Strachan, Doucette, Stadig, & The Municipality of Panguitung, 2013), and despite the findings from Phoenix Strategic Perspectives (2006) that the past guidelines did not meet Aboriginal peoples’ needs. We argue that, counter to Young and Katzmarzyk’s (2007) assertion that there is no scientific evidence that shows that specific guidelines would be beneficial for Aboriginal populations, specific PA guidelines are needed for Aboriginal older adults. While there may be limited quantitative evidence that specifically suggests the need for such guidelines, there is significant qualitative evidence that suggests the necessity of PA guidelines that address the needs of Aboriginal peoples (Forsyth, 2007; Lavallée, 2007; Paraschak, 1998; Paraschak & Thompson, 2014) and, thus, the development of culturally safe PA guidelines. Indeed, though the exercise *prescription* aspect of the guidelines might be the same across different groups, the *framing* of the messages need to take culture into account.

To further analyze cultural safety in relation to the *Canadian PA Guidelines for Older Adults* (CSEP, 2012), here we adapt and apply Smye and Browne’s (2002) approach to cultural safety in understanding mental health policies for Aboriginal people in Canada to PA. Using this approach, Smye and Browne’s (2002) suggested that in the development of culturally safe

opportunities one should ask “a series of moral questions about the ‘rightness’” (p. 49) of policies. For example, within the context of the PA guidelines for older adults, a cultural safety approach encourages us to ask questions such as, “do the guidelines fit well with Aboriginal older adults’ understandings of PA?”, “are Aboriginal peoples’ worldviews represented in the guidelines?”, “is Aboriginal older adults’ knowledge incorporated in the development of the guidelines or is Western knowledge the privileged and dominant form of knowledge?”, and “how can we ensure that the guidelines fit well with Aboriginal worldviews and how can we include Aboriginal knowledge of PA in the guidelines”? Considering these questions allows us to understand how the guidelines are culturally safe or culturally unsafe.

Results

“Do the guidelines fit well with Aboriginal older adults’ understandings of PA?” The current guidelines mainly focus on the physical health benefits of PA, whereas Aboriginal peoples have unique cultural perspectives on health and PA. Aboriginal peoples often take a wholistic perspective that includes physical, spiritual, emotional, and mental dimensions of health and the balance and interconnectedness of these various aspects of health (Graham & Leeseberg Stamler, 2010; Lavallée, 2007). Aboriginal concepts of health go beyond just the self and include family, community, and the environment (Levesque, Li, & Bohémier, 2013). Similarly, a wholistic approach to PA by/for/with Aboriginal peoples involves “the development of the whole person, balancing the physical, mental, emotional, cultural, and spiritual aspects of life” (Canadian Heritage, 2005, p. 3). PA can play important roles in improving emotional, mental, physical, and spiritual health for Aboriginal peoples (Canadian Heritage, 2005; Lavallée, 2007); however, the guidelines only consider the physical benefits and thus employ a Eurocentric focus.

“Are Aboriginal peoples’ worldviews represented in the guidelines?” Additionally, *The Canadian PA Guidelines for Older Adults* (CSEP, 2012) are largely informed by dominant Western PA discourses that recommend and encourage the improvement and maintenance of individual health. Within the guidelines, being active is seen as something that promotes physical health and the guidelines disregard the influence that PA has on community health, spiritual health, cultural continuity, and family health. The suggested activities focus on individual behaviours that are meant to improve individual health, such as walking, participating in a charity run, or taking a dance class (CSEP, 2012). They do not encourage or promote these activities as a way to spend time with and improve the health of family members or to bring communities together to be active in cultural activities.

“Is Aboriginal older adults’ knowledge incorporated in the development of the guidelines or is Western knowledge the privileged and dominant form of knowledge?” While there were Think Tanks, research papers, and many discussions throughout the development of the guidelines, it is important to note that there is no mention of consulting Aboriginal older adults in the guidelines’ development. By not taking Aboriginal perspectives on health and PA into account, not considering Aboriginal older adults’ knowledge of PA, and not including input from the intended recipients into the guidelines, the guidelines fail to be culturally safe.

We argue that a cultural safety lens ought to be used to revise the *Canadian PA Guidelines* (CSEP, 2012), and PA opportunities in general, because of the historical, social, and political structures that are embedded in and shape Aboriginal peoples’ health and PA (Brascoupé & Waters, 2009; Smye & Browne, 2002). Understanding these structures will allow

guideline developers and guideline users to address the power relations that are involved in prescribing PA for Aboriginal older adults without their knowledge and input. Developers need to be aware of the dominant Western discourses that permeate current guidelines and need to understand how the guidelines can be informed by non-dominant understandings of PA and health. Guidelines that are guided by a culturally safe framework will not only encourage health professionals to recognize and respect Aboriginal older adults' knowledge of PA and health at a micro level, but will also encourage policymakers to understand the macro political, social, and economic structures that shape current policies (Smye & Browne, 2002).

To examine the final question, “how can we ensure that the guidelines fit well with Aboriginal worldviews and how can we include Aboriginal knowledge of PA in the guidelines,” we turn to the health communication literature.

Cultural Safety and Health Communication Approaches

PA guidelines are essentially health communication tools that are used to tell the public what its members ought to be doing in terms of PA. In order to offer constructive insight into how *The Canadian PA Guidelines for Older Adults* (CSEP, 2012), and other PA resources and opportunities that are intended to be for all older adults in Canada, might be made to be culturally safe for Aboriginal older adults, we turn to health communication approaches that have been identified as strategies that enhance the relevance and appropriateness of health interventions for non-dominant populations. Kreuter, Lukwago, Bucholtz, Clark, and Sanders-Thompson (2003) identified five such strategies: peripheral, evidential, linguistic, constituent-involving, and sociocultural strategies. Peripheral strategies are those that use fonts, colours, themes, and images that are representative of the target population for communication materials (Kreuter et al., 2003). In the guidelines, a peripheral approach could be used by including Aboriginal people in the images and by using colours and themes that are meaningful for and consistent with Aboriginal cultures. Evidential strategies are those that present data about a given problem for a certain group (Kreuter et al., 2003). Including data in the guide that show that Aboriginal older adults suffer from more health problems – some of which could be alleviated or eliminated through PA - than their non-Aboriginal counterparts or the ways in which Aboriginal health can be improved through PA are examples of the employment of an evidential approach.

Linguistic strategies are those that make health communication tools more accessible by translating the materials into the languages of the target population (Kreuter et al., 2003). The guidelines could be translated into various Aboriginal languages to make them more accessible for Aboriginal older adults. Constituent-involving strategies are those that are developed through collaboration with members of the target population, especially those who are well respected and have influence in that group (Kreuter et al., 2003), while sociocultural strategies are those that ensure “a group’s cultural values, beliefs, and behaviours are recognized, reinforced, and built upon to provide context and meaning to information and messages” (Golob, Giles, & Rich, 2013, p. 50) about PA. We argue that constituent-involving and sociocultural strategies are especially important in the development of culturally safe health communication tools. By including Aboriginal older adults in the development of PA communications, it is likely that the communications will be more representative of their culture. For example, such communications might, for example, better communicate the importance of family and community health in Aboriginal cultures (Kirmayer, Simpson, & Cargo, 2003) and put more focus on these benefits than on individual health benefits. By taking into account these health communication strategies, we can see the ways in which culturally safe guideline could be developed.

Importantly, we recognize that there is great diversity among Aboriginal peoples in Canada and do not want to risk homogenizing Aboriginal older adults. As such, it might be most appropriate to develop tailored messages/content for First Nations, Inuit, and Metis peoples, and there may be the need for different messages/content for different communities within these larger populations.

Conclusion

PA rates among older adults in Canada are low, with less than half of the population aged 65 and over considered to be active or moderately active (Statistics Canada, 2014b). PHAC and CSEP revised the previous PA guidelines for Canadians to address these low PA rates and to make the guidelines more relevant and effective in improving and encouraging PA participation and thus improving population health. While it is important to have guidelines available for older adults to influence their PA participation, we believe that throughout the revision of the guidelines, a key component was overlooked: creating culturally safe guidelines for Aboriginal older adults that recognize their history with colonialism and include their wholistic perspectives toward health and PA. Indeed, if we are to improve PA rates and morbidity and mortality rates throughout Canada, directing resources to those that suffer a disproportionate burden of ill-health seems both reasonable and ethical. Despite claims that there is a lack of evidence to support the development of guidelines specific for Aboriginal populations, many authors have discussed the importance of PA programs that specifically address the diverse needs of Aboriginal peoples. With the potential that PA has in further colonizing Aboriginal peoples, culturally safe guidelines are especially important.

Cultural safety has been mainly used in a healthcare context; however, Giles and Darroch (2014) argued that, as an important part of health promotion, cultural safety should be extended into PA. In order to create culturally safe PA resources that are intended for all older adults in Canada, we need to take into account the historical, social, economical, and political structures that shape Aboriginal older adults' health and PA. Specific to PA guidelines, a culturally safe approach would encourage guideline developers to focus on the differential uptake of PA by different groups, such as Aboriginal older adults; this would then frame the need to have Aboriginal peoples guide the development of culturally safe guidelines and to use health communication strategies to aid in this development. It is important to note that while working towards culturally safe guidelines is a significant first step, only the participants (i.e. Aboriginal older adults) can decide if the guidelines are actually culturally safe; hence, their inclusion in the development is essential.

While cultural safety has typically focused on the power relations between two individuals, Brascoupé and Waters (2009) asserted that cultural safety must be demonstrated at an institutional level; as such, broader institutional change needs to occur in organizations/institutions that are concerned with PA, such as CSEP or PHAC, if they are to be positioned to produce culturally safe resources. The notion of cultural safety is worth exploring in other areas related to PA and health, including its relevance to physical and health education, recreation, and sport. It is important for non-Aboriginal educators, practitioners, policy-makers, governing bodies, and institutions to critically reflect on the power, beliefs, and histories that they bring to the development of PA resources and opportunities.

Research has demonstrated that improved health outcomes for Aboriginal peoples can be achieved through Aboriginal peoples' involvement in and control of health policies and program

(Brascoupé & Waters, 2009; Giles et al., 2010). This extends to processes that inform the development of resources. For the *Canadian PA Guidelines* (CSEP, 2012) to be more effective in improving the health of Aboriginal older adults, they need to be representative of the intended recipients' cultures and values, which can be accomplished by including Aboriginal older adults and their knowledge of health and PA in the development and implementation of PA opportunities. Thus, in light of attempts to address one of the many by-products of colonialism, the poor health of Aboriginal older adults – which represents a growing but also marginalized group in Canadian society – we call for the development of culturally safe PA guidelines.

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