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Review

Cultural Safety for LGBTQIA+ People: A Narrative Review and Implications for Health Care in Malaysia

Kyle K. H. Tan [1,2,]* and Sai Ang Ling [3]

1 Faculty of Māori and Indigenous Studies, University of Waikato, Hamilton 3240, New Zealand
2 Trans Health Research Lab, School of Psychology, University of Waikato, Hamilton 3240, New Zealand
3 Department of Psychology, School of Medicine, International Medical University, Kuala Lumpur 57000, Malaysia; lingsaiang@imu.edu.my
* Correspondence: k.tan@waikato.ac.nz

Abstract: LGBTQIA+ people in Malaysia constitute a marginalised population as they are subjected to cisheterosexism that permeates every layer of society. Cisheterosexist ideologies in Malaysia find their eligibility on secular and religious laws that criminalise LGBTQIA+ identities, which have detrimental consequences on LGBTQIA+ people's mental health and their ability to access equitable health care. Existing literature has revealed limitations for healthcare providers to employ a blinded approach (i.e., treat everyone the same) and practise culturally competency when seeing LGBTQIA+ patients. In this narrative review, we compiled international evidence of culturally safe care for LGBTQIA+ people and outlined its relevance to interrogating power relationships within healthcare practices and structures. Our reviewed findings brought together five components of culturally safe care for LGBTQIA+ people: power-enhancing care; inclusive healthcare institutions; continuous education and research; promotion of visibility; and individualised care. These components set crucial milestones for healthcare providers to reflect on ways to equalise power dynamics in a provider–patient relationship. The applicability and implication of culturally safe healthcare in Malaysia are succinctly discussed.

Keywords: cultural safety; cultural competency; LGBT; LGBTQIA+; health care; Malaysia

1. Introduction

LGBTQIA+ is an umbrella term referring to people whose sexual orientations, gender identity, gender expression, or sex characteristics differ from conventional cisgender and heterosexual norms. In the multi-ethnic context of Malaysia, the diverse LGBTQIA+ populations also encompass people who adopt cultural-specific identities such as mak nyah and tongzhi that carry intricate historical, political, and social meanings [1]. In a study that explored the acceptance level of LGBTQIA+ people in 175 countries across different time points, the Global Acceptance Index ranked Malaysia in 133rd place in 2013, 89th in 2017, and 115th in 2020 [2]. Malaysia was one of the 57 countries that experienced a decline in ranking from 2017. The relatively poor attitudes towards LGBTQIA+ people, which are also perpetuated by healthcare providers such as doctors, nurses and counsellors [3–5], signal the persistence of structural barriers that prevent the meaningful inclusion of LGBTQIA+ people in many spheres of social, economic, and political life [2].

A burgeoning number of international research endeavours have collated evidence on health inequities between LGBTQIA+ people and their cisgender and heterosexual counterparts [6–8]. Health implications of LGBTQIA+ identities result primarily from people's experiences of social environment rather than related to biology, as studies have documented the effect of cisheterosexism manifesting as minority stressors (i.e., the discrimination and rejection that LGBTQIA+ people face) that contribute to heightened rates of depression and suicidality [6,9,10]. In Malaysia, the criminalisation of LGBTQIA+ people through both secular (i.e., Penal Code Act 574, which was passed down since British colonial rule) and

religious laws (i.e., Sharia law), and the religious condemnation of LGBTQIA+ identities has engendered ubiquitous cisheterosexism that pathologises (perceive LGBTQIA+ people as mentally disordered), marginalises (privilege cisgender and heterosexual people), and delegitimises (reinforce that sexuality and gender are binary concepts) noncisgender and nonheterosexual identities [11,12]. Cisheterosexism (or cisheterosexist norm) relegates LGBTQIA+ people to a minority position in Malaysia and has adverse consequences on LGBTQIA+ people's ability to access to social determinants of health (e.g., family support, employment, and healthcare services) [12–14].

In line with minority stress theory [15], LGBTQIA+ people have higher healthcare needs than cisgender and heterosexual individuals due to the effects of cisheterosexism [11,16,17]. Transgender people in Malaysia may also seek consultation from mental health professionals (including counsellors and psychologists) before undertaking gender-affirming interventions, although this is not a requirement [18]. Yet Malaysian LGBTQIA+ people reported avoiding utilising mental health services because of the fear of discrimination related to their identity, mental health stigma (e.g., only the "crazy" seeks mental health treatment), and scepticism about professionalism (e.g., confidentiality issue) [11,17]. In the context where efforts or "therapies" to alter individuals' LGBTQIA+ identities to conform to the cisheterosexist norm are still condoned nationwide, Malaysian LGBTQIA+ people are also likely to express doubt about the effectiveness of healthcare services [17]. Moreover, Malaysian LGBTQIA+ people are susceptible to the platitude of "LGBTQIA+ broken arm syndrome" where health providers insensitively focus on LGBTQIA+ identities as the cause of mental health issues, albeit these people may be seeking care unrelated to their sexuality or gender [17,19].

1.1. Cultural Safety

At the time of writing, there are no standardised trainings and guidelines on provision of healthcare services for LGBTQIA+ people in Malaysia, despite researchers having highlighted the urgency to improve cultural competency for this profession [5,11,16,17]. LGBTQIA+ cultural competency entails health providers having a requisite understanding of sexuality and gender diversity and sociocultural factors that affect LGBTQIA+ health in order to provide culturally appropriate care [16]. However, there are a few critiques for the individual-level focused positioning of cultural competency; these include the placing of health professionals at the centre of the provider–patient relationship, the deficit-framing process that "others" LGBTQIA+ people, and the risk of accidentally lulling health providers into a falsely confident space to speak for the perceived needs of LGBTQIA+ people after acquiring LGBTQIA+ knowledge through a tick-box approach [20–22].

Nonetheless, the concept of "cultural competency" serves as a crucial first step towards achieving "cultural safety", a concept that was coined by Dr Irihapeti Ramsden in Aotearoa/New Zealand to address the long-term impact of colonisation and racism on Indigenous Māori health outcomes [22]. The Nursing Council of Aotearoa/New Zealand [23] commissioned Dr Ramsden to write the guidelines for cultural safety in nursing and midwifery education which defined cultural safety as:

> *The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.*

> *The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well being of an individual. (p. 7)*

A key difference between the concepts of cultural competency and cultural safety is the notion of "power", where the latter accentuates the experience of the recipient of

care [22]. Health providers working on a culturally safe framework engage in reflexivity by examining the inherent power dynamics when providing care and allow patients to determine whether a clinical encounter is safe [21,22]. Rather than practising a blinded approach that treats all clients as equal regardless of their cultural differences, a culturally safe health provider adopts a multiculturalist approach that consciously and carefully explores paradoxes of apparent differences in social positions [22,24]. Indeed, the understanding of health inequities affecting LGBTQIA+ people requires us to address the differential power in healthcare interaction and the broader health structures that are often informed by cisheterosexist norms [12,20]. With a commitment to achieve health equity, the application of cultural safety also expands beyond the provider–patient interface to challenge unjust policies and institutions that create unsafe healthcare environments [22,24].

1.2. Objectives

The concept of "cultural safety" is not new in Malaysia, as recommendations have been made to recognise the cultural needs of indigenous and minoritised ethnic groups [25]. However, there is a dearth of information on culturally safe care for LGBTQIA+ people in Malaysia, which contributes to the silencing of LGBTQIA+ need and anchoring of cisheterosexist stigma and stereotypes in health care [5,11,17]. As cultural safety focuses on the differences in the distribution of social power [22], this concept is pertinent to advance health equity for LGBTQIA+ people as a marginalised population in Malaysia. In this paper, we set out to conduct a narrative review of the conceptualisation of culturally safe care for LGBTQIA+ people in international literature. This review has implications for both local and international contexts as our findings offer a shared understanding of various components of cultural safety as an alternative framework to the narrowly focused concept of "cultural competence" that remains prevalent in the current LGBTQIA+ healthcare literature.

2. Materials and Methods

We conducted electronic database searches in April 2022 on Scopus and PsycINFO using "cultural safety" and "LGBTQ" as key terms. We also included a range of LGBTQIA+ terms to expand our searches (see Table S1). During the period between 2011 and 2022, we located a total of 19 articles that were published in English. After filtering out studies that were duplicates (*n* = 3), irrelevant to LGBTQIA+ people (*n* = 5), that did not provide a definition of cultural safety (*n* = 1), ten studies were included in our analyses. An inductive thematic analysis [26] was carried out to identify the components of culturally safe care for LGBTQIA+ people.

3. Results

While most studies have introduced the concept of "cultural safety", there were two specific studies that delineated a framework of culturally safety for LGBTQIA+ people; these included the five "P" tenets by Mukerjee et al. [20] and four components of care by Crameri et al. [27].

3.1. Existing Cultural Safety Frameworks

Mukerjee et al. described cultural safety for LGBTQIA+ people using five "P" tenets [20]. These comprise (1) partnerships: Providers to provide collaborative care and transfer power to patients by respecting their knowledge and experiences; (2) personal activities of daily living (ADLs): Providers to explore and understand daily activities of life and survival that LGBTQ individuals engage in as they face marginalisation within society and incorporate these experiences into clinical care; (3) prevention of harm: Providers to engage in mutual learning and understand what the patient needs to stay safe; (4) patient centring: Providers to provide the means to achieve healthcare as decided by the patient and help to move towards goals that fit into patients' lives; and (5) purposeful self-reflection: Providers to involve in a process of uncovering one's own biases and blind spots that may interfere

with the provider–patient relationship and take accountability to deal responsibly with these internal processes. The five "P" tenets frame healthcare providers as an active tool in fostering health equity and social justice by reducing the power distance between the providers and patients.

Crameri et al. proposed four components of culturally safe care as fundamental aspect of LGBTQIA+ inclusive practice [27]. These involve the understandings of (1) LGBTQIA+ histories and impacts: Providers to recognise the historical institutionalised discrimination affecting different age cohorts of LGBTQIA+ people; (2) LGBTQIA+ safety needs: Providers to explore specific and practical needs of LGBTQIA+ people including how supportive networks can provide a safe space to access care; (3) power imbalances: Providers to address the imbalance of power and advocate for the rights of LGBTQIA+ people; and (4) organisational leadership: Providers to develop clear and explicit guidelines on LGBTQIA+ inclusive practice, commit to ongoing education on components of cultural safety, and make specific reference to expectations of LGBTQIA-inclusive service delivery throughout recruitment processes.

Table 1 summarises the definitions of cultural safety that we extracted from international literature. None were written from a Southeast Asia perspective. The following subsections detail the common themes across reviewed studies. These themes are not necessarily mutually exclusive as they revolve around challenging the long-standing discourses of power and authority that permit the thriving of cisheterosexism in health care.

Table 1. Definition of cultural safety from international literature.

Authors (Year)	Definition
Allwright, Goldie [28]	Cultural safety is "an outcome of care that results from providers who respectfully engage with clients and who recognise and address power imbalances (p. 553)." Cultural safety requires leaders in healthcare structures to reflect on past and present relationships between health professionals and the broader community and should be supported to acknowledge and act on power imbalances.
Baldwin, Dodge [29]	Cultural safety seeks to improve the health of minority populations through addressing "the role of institutions and social structures in perpetuating health disparities and, further, tasks both providers and institutions with addressing the social inequity that is reproduced within health care" (p. 1302). Cultural safety "places the shared responsibility of the provision of quality care on providers, the systems they work in, and the larger institutions of medicine, through which to approach these changes (p. 1311). Cultural safety involves recognising "both the social marginalisation and the cultural expertise of [LGBTQIA+] people, creating—with the input of [LGBTQIA+] people—and practicing standards that are cognisant of [LGBTQIA+] diversity and responsive to patients' [LGBTQIA+] identities, and actively monitoring for unintended biases and micro-aggressions by providers and staff" (p. 1313).
Carrier, Dame [30]	Cultural safety involves developing a baseline of knowledge about indigenous and ethnic LGBTQIA+ culture and recognising that some individuals are affected by intergenerational trauma due to colonial process, racism, and stigmatisation. Healthcare providers ought to examine and address their own assumptions and biases about LGBTQIA+ people and dismantle barriers that exist for these patients. Carrier et al. also recommended healthcare providers to foster a feeling of welcomeness and to dismantle stress for patients to enhance the therapeutic relationship.
Crameri, Barrett [27]	Cultural safety "builds on cultural awareness and cultural sensitivity ... [and] is characterised by individual staff reflecting on their own values and beliefs and the services they provide" (p. 21).
Davies, Robinson [31]	Cultural safety promotes "a health care environment that is safe for people: where there is no assault, challenge or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge and experience of learning, living and working together with dignity and truly listening" (p. 225).

Table 1. *Cont.*

Authors (Year)	Definition
Kellett and Fitton [32]	Cultural safety "presents a framework that moves beyond a reduction of complex individual experience to a list of assumed qualities, and the need to understand a group is replaced with acceptance" (p. 4). Kellet and Fitton emphasised the reflexivity aspects of cultural safety, noting that healthcare providers ought to "be aware of the social inequalities and biases that have historically affected individuals from this group, as well as cognisant of their own biases and assumptions, and the power (im) balance that in necessarily present in any professional encounter" (p. 4). They further described cultural safety as an emancipatory approach that can lead to advocacy and challenging of cisheteronormativity at interpersonal and institutional levels of healthcare delivery.
Lerner, Martin [33]	Cultural safety utilises a framework that "encourages genuine acceptance of individuals rather than more common efforts to understand a group by reducing their complex experiences to a list of assumptions" (p. 423). Cultural safety "promotes caring for the unique experience of each individual and does not assume that the provider understands a [LGBTQIA+] patient's situation . . . and expects providers to think about how they can adapt care to best support the individual [LGBTQIA+] person at the specific time they are providing them care" (p. 423). In order to implement a cultural safety lens, Lerner et al. outlined three factors that healthcare providers should be aware of: 1. Social inequities and biases that have historically harmed [LGBTQIA+] people; 2. Own biases and assumptions about [LGBTQIA+] people; 3. The power imbalance that presents within any professional encounter with providers.
Mukerjee, Wesp [20]	Cultural safety involves "understanding histories, safety needs, power imbalances and the influence of staff values and beliefs on service delivery" (p. 4). Cultural safety is "defined by the patient rather than the healthcare provider and . . . requires that healthcare providers prioritise the patient narrative, build community partnerships, and reflect upon the inherent existing power imbalances involved in patient care" (p. 4).
Ross, Hammond [34]	Cultural safety has a reflexive focus which calls for structures to reflect on their cultural norms and create opportunities for more inclusive, equitable, and just practices.
Whitney, Greene [35]	Cultural safety prioritises "the safety of clients in interactions as opposed to the competency of the clinician" (p. 2). Healthcare providers working on a culturally safe framework need "to not only be aware of cultural difference, but also consider historical and contemporary power relationships and implement reflective practice" (p. 2).

3.2. Power-Enhancing Care

A cornerstone of cultural safety is the notion of power sharing to address power imbalances that arise from the dominance of cisheterosexism in health care [20,28,29,31]. Culturally safe healthcare providers engage in ongoing reflective practices that examine the impact of their biases stemming from societal cisheterosexism on provider–patient relationships [20,29,35]. Through recognising the powerlessness of LGBTQIA+ patients and the power of providers, providers can utilise their position to help shift the framing of health inequities, from "the impact of LGBTQIA+ identity" to the more precise "the impact of cisheterosexism" [20]. Being cognisant of power dynamics also offers an opportunity for providers to empower LGBTQIA+ people who, as a population, have been historically marginalised and to build on resiliency aspects of LGBTQIA+ people to counteract the effect of cisheterosexism [27]. The powerlessness of LGBTQIA+ patients can be attenuated when healthcare providers normalise conversations around LGBTQIA+ experiences and take active steps to learn about patients' health needs (rather than waiting to be educated) [32].

3.3. Inclusive Healthcare Institutions

Power imbalances are apparent in the healthcare institutions for LGBTQIA+ people [27]. The lives of LGBTQIA+ people are constrained through cisheterosexist health structures and practices that pathologise their diverse sexual and gender identities; these include gatekeeping models that compel transgender people to obtain a "gender dysphoria" diagnosis prior to being granted access to gender-affirming care, normalising surgeries for intersex people, and sexual orientation and gender identity change efforts or conversion

practices [27]. Cisheterosexism perpetuated by health structures and providers exemplifies attempts to assert position of authority over LGBTQIA+ people who are powerless when accessing health care [27,30].

Healthcare leaders play paramount roles in recognising and advocating for the dismantling of institutional barriers that negatively affect health outcomes of LGBTQIA+ people [25,28]. The LGBTQIA+ population consists of diverse sexuality and gender groups with different health needs and experiences of care [20]. Some steps that are useful in demonstrating an institution's commitment to culturally safe care are developing specific LGBTQIA+ health strategies and action plans, utilising LGBTQIA+ inclusive language on all documentation, promoting institutional diversity by having various LGBTQIA+ representation in promotional material, and actively recruiting staff who identify as LGBTQIA+ [27,30]. A wide range of strategies are to be employed to consult with LGBTQIA+ organisation and community leaders of different backgrounds (e.g., ethnicity and region) so that they can help to inform whether the health care structures and service deliveries are culturally safe [27].

An institutional leadership based on cultural safety can mitigate the power imbalances caused by the pervasiveness of negative stereotypes and misinformation about LGBTQIA+ people in health structures [30]. The creation of safe space, including allowing LGBTQIA+ people to bring their supportive networks to health care, can help to ease tension and the fear of entering culturally unsafe spaces to receive care [30]. However, healthcare providers should not assume that family members are the primary care providers for all LGBTQIA+ people as some have not disclosed their identities and may prefer to seek support from "families of choice" such as friends [27].

3.4. Continuous Education and Research

It remains an institutional issue for healthcare providers to not be introduced to LGBTQIA+ knowledge, wherein Baldwin et al. described it as "a bug of medical training, rather than a failing on the side of providers" [29]. A lack of LGBTQIA+ education and formal resources to prepare healthcare providers to work in LGBTQIA+ affirming spaces can compromise their ability to provide culturally safe care [29]. LGBTQIA+ education programmes for healthcare providers are to cover topics such as diversity within LGBTQIA+ groups, the unique challenges and strength of LGBTQIA+ people, reflection of power imbalances, and the impact of providers' own values and beliefs on the quality of care [32]. Alongside other LGBTQIA+ inclusive contents, the aforementioned topics ought to be included in the accreditation standard and other licensure examinations of all health professions [32].

Research pathways should be presented for healthcare providers who are interested to delve into social determinants of health and wellbeing of LGBTQIA+ people and incorporate findings to inform healthcare education [32]. Education on culturally safe care for LGBTQIA+ people is a step forward towards raising awareness on the entrenched cisheterosexism in healthcare settings and inviting healthcare providers to act as allies in advocating for inclusive institutional changes within organisation and practicum settings where students undertake placements [32]. Information on the provision of culturally safe care, including how to create a welcoming environment, should also be passed on to non-medical staff at healthcare settings such as administrative staff members, who make the first impression of healthcare settings [29].

3.5. Promotion of Visibility

The needs of LGBTQIA+ people are largely invisible in healthcare services. In this void, healthcare delivery for LGBTQIA+ people can be guided by providers' own values, resulting in ad hoc approaches that are not culturally safe [27]. The erasure of LGBTQIA+ people can be observed in application forms that allow for only two gender options, which invisibilise transgender people when providers assume that all patients are heterosexual or think sexuality is irrelevant to care during healthcare interaction [31]. Consequently, many

LGBTQIA+ people choose not to disclose their identities as they perceive that the providers to have little understanding of culturally safe care. The fear of disclosing and non-disclosure of identities can form major barriers to LGBTQIA+ people to receive early preventive health care [31]. See Section 3.2 for examples of how inclusive organisational leadership can promote the visibility of LGBTQIA+ people as consumers of healthcare services.

3.6. Individualised Care

Health providers are overwhelming guided by the belief that if they "treat everyone the same", all patients are likely to receive adequate care [27]. However, some LGBTQIA+ people have specific histories (e.g., discrimination and rejection at healthcare settings) that influence their perception of healthcare providers while others avoid accessing healthcare due to fear of discrimination [27]. Crameri et al. asserted that a blinded approach of treating everyone equally risks further isolating LGBTQIA+ people as an already marginalised population by discrediting the causes of unmet healthcare needs and health inequities [27]. On the contrary, culturally safety encourages providers to reflect on the healthcare privilege of cisgender and heterosexual people that conventionally possess and to bridge the gaps by rendering equitable care [27]. Rather than making assumptions about the collective health needs of LGBTQIA+ people, providers working on a culturally safe framework provides individualised care that cater to the needs of each patient [31]. An individualised approach of care also centres the voices of LGBTQIA+ service users during a healthcare interaction so that they can determine the type of care needed [20].

4. Discussion

This review synthesised studies that have discussed components of culturally safe care for LGBTQIA+ people in the last decade and examined their applicability to the Malaysian healthcare context. Although cultural safety has its origins in indigenous nursing care [22], there is support and rationale for applying this concept for LGBTQIA+ people as a population who experience mental health disparities due to barriers to access equitable care [17,20]. A community-based study by Justice for Sisters et al. found that 50.4% of LGBTQIA+ participants had reported the severe impacts of anti-LGBTQIA+ narratives (including statements by politicians, law change, hate speech online, and media sensationalism) on their mental health, stress level, and exposure to discrimination [36]. With the rising anti-LGBTQIA+ rhetoric in Malaysia, it is undoubtedly of major importance for LGBTQIA+ people to be able to access healthcare services equitably.

Premising on Mukerjee et al.'s culturally safety framework that aspires to provide a comprehensive approach to care through challenging the status quo power relations [20], we outlined five components of culturally safe care: power-enhancing care; inclusive healthcare institutions; continuous education and research; promotion of visibility, and individualised care. These components serve as essential steps towards mitigating the power imbalances in healthcare services that may be offered through Malaysian healthcare institutions (including hospitals, clinics, and healthcare organisations), where cisheterosexist ideologies and the biomedical understanding of health dominate [11,17]. The "authority" position of Malaysian healthcare providers is often left unchallenged which leads to low healthcare usage amongst LGBTQIA+ people due to fear of culturally unsafe environments [17]. Mukerjee et al. have also warned against the over-emphasis of a lack of cultural safety rather than the presence of cultural safety that may obscure our attention to the role of healthcare providers in creating culturally safe healthcare through the 5P tenets [20].

Culturally safe care for LGBTQIA+ people aligns with the affirmative approach of empowering LGBTQIA+ individuals who have been long affected by social injustices [1]. However, the implementation of cultural safety framework ought to account for the specific local context. As LGBTQIA+ remains a criminalised identity in Malaysia, the collection of data on sexuality and gender identity information may be a less justifiable option if LGBTQIA+ people have no intention to disclose their identity or when confidentially cannot be guaranteed. Misgendering in health care is also a common issue affecting transgender

and non-binary people in Malaysia due to barriers in changing gender marker on identity documents [36]. A health provider can initiate the conversation by disclosing their name and pronouns and then enquiring about patients' preferred pronouns.

Likewise, while we described the benefits of increasing LGBTQIA+ representation in decision-making boards of healthcare institutions above, this is not always a feasible option given the limited number of healthcare providers who are proudly out as LGBTQIA+. In this regard, we recommend leaders in healthcare institutions to form a partnership with local LGBTQIA+ community groups to design a culturally safe guideline of care. The criminalisation of LGBTQIA+ people in Malaysia also hinders funding acquisition for conducting LGBTQIA+ research, and researchers may expose participants (as well as themselves) to harassment by authority officers if no support is sought from LGBTQIA+ organisations [1].

In Malaysia, most LGBTQIA+ people's identity is closely intertwined with their ethnic/racial and religious backgrounds [37]. Culturally safe health care for LGBTQIA+ people, thus, cannot treat identities as divisible components. Echoing Crameri et al.'s recommendation [27], all healthcare providers can engage in power-enhancing care by learning the specific health needs of LGBTQIA+ people. Our reviewed studies evidenced examples of crucial support for LGBTQIA+ patients; these include health providers possessing adequate knowledge of minority stress [15], demonstrating an understanding of the heterogeneous needs of each patient, and involving in advocacy work of LGBTQIA+ human rights. Health professionals are seen as authoritative figures in a healthcare institution in Malaysia, and such a norm exerts an expectation for service users to conform to the unjust structures and be silent about discriminatory practices (including those that lead to culturally unsafe care for LGBTQIA+ patients) [17]. In light of the disparity in power roles, it is recommended that healthcare providers expand beyond mere understanding of cultural competency by regularly reflecting upon their practices to improve on provision of culturally safe care.

Limitation and Recommendation for Future Research

Only two electronic databases were referred to during our literature search; future studies can employ a wider range of databases to monitor the development of culturally safe care guidelines for LGBTQIA+ people over time. Our search was also limited to papers published in the English language, and other reviews should consider exploring the notion of "cultural safety" in another language. In this article, our reference to "LGBTQIA+" as a collective group risks obscuring the experiences of LGBTQIA+ people who are also disproportionately affected by intersecting forms of social marginalisation. We concur with the intersectionality theory that the notion of power should be examined as a "complex matrix" that also accounts for oppressions related to racism, classism, and ableism embedded in health institutions [38]. Our proposed cultural safety framework for Malaysian LGBTQIA+ people has not considered structural injustices beyond cisheterosexism; future research is required to address this limitation.

In view of the scant number of studies, we do not claim that we have identified every specific component of culturally safe care for LGBTQIA+ people but, rather, view these results as providing an initial sketch of the care required to bridge power differences in a provider–patient relationship. We treat this study as providing a promising first step in this direction and urge future research to expand on culturally safe care for different LGBTQIA+ subgroups and to evaluate the experiences of LGBTQIA+ people as recipients of care. Meanwhile, Mukerjee et al.'s [20] published book is a useful reference for readers who wish to understand how cultural safety can be enacted with diverse groups of LGBTQIA+ people. Furthermore, our review falls short of analysing the applicability of culturally safe care during a telehealth session. Despite the Malaysian Government's exertion of access restriction to LGBTQIA+ websites, online platforms such as social media prevail amongst Malaysian LGBTQIA+ people to explore and express their identities [39]. Therefore, online platforms remain crucial for Malaysian LGBTQIA+ people (especially true during the

COVID-19 pandemic) to seek health support, and more studies are needed to understand the dynamics of power-sharing in an online medium.

5. Conclusions

Health institutions in Malaysia are not value-neutral. Despite that there are guidelines in place to promote a blinded approach of the care for all healthcare users, it is apparent that healthcare structures and providers continue to uphold power over LGBTQIA+ people who are marginalised by cisheterosexism [17]. In this instance, a blinded approach to care stands in contrast with a culturally safe framework that seeks to address the power imbalances within healthcare interactions and structures. Compared to cultural competency, which only necessitates providers to learn about cultures of other groups, culturally safe care serves as an ideal framework to empower LGBTQIA+ people by focusing on the individual's healthcare needs. Such a focus matters for LGBTQIA+ people in Malaysia, who are treated as a political football and subjected to cisheterosexism across various fronts (e.g., media, legal system, and education system). Health professionals and researchers are privileged to redress the ramifications of oppression on health and wellbeing through an equity framework, and we should leverage our relatively powerful position in institutions to advocate for the implementation of culturally safe care for LGBTQIA+ people. While LGBTQIA+ people experience cisheterosexism in general society, this population can develop resilience and positive mental health and wellbeing if barriers to access equitable and culturally healthcare are dismantled.

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