Te Kaunihera Rata o Aotearoa
Medical Council of New Zealand

TE OHU RATA O AOTEAROA MĀORI MEDICAL PRACTITIONERS TeORA

Cultural Competence Partnership and Health Equity Symposium

25 June 2019
Museum of New Zealand Te Papa Tongarewa

The theme of the symposium was *Mahia te mahi, hei painga mō te iwi, Getting the job done for the wellbeing of the people.*

Whakahaumaru i te iwi whānui, whakatuarā te kounga o te tikanga rata.

We protect the public and promote good medical practice.

CONTENTS

Introduction / Whakataki

Whakataki from Dr Curtis Walker

Dr Curtis Walker

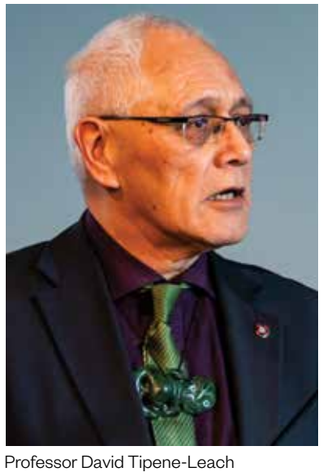
Assuring the safety and quality of the health care doctors provide is a key goal of the Medical Council. Central to delivering quality health care is delivering equitable health care to all our diverse populations. This requires doctors and healthcare organisations to be culturally safe.

Firstly, Council sincerely thanks Te ORA as our partner organisation in this kaupapa. I also acknowledge the many rangatira, past and present, who have developed our understanding of the importance of cultural safety and health equity. They are too numerous to list here, but include all of our speakers, and many of the attendees to the Symposium, as well as leaders from outside medicine, and those who are no longer with us, such as whaea Dr Irihapeti Ramsden, who led the way with her work in the nursing profession. Moe mai rā e ngā tīpuna.

A key message from the Symposium was the need to be brave, and to genuinely progress and reflect the latest research and thinking on cultural safety and health equity. The momentum generated has strongly influenced Council's revised Cultural Safety standard and the new *He Ara Hauora Māori: A Pathway to Māori Health Equity* resource statement.

I know that with a genuine commitment to best practice, the medical profession and associated health care organisations will embrace the concepts and knowledge from the hui, and put them into effective practice. Our patients and society expect nothing less.

Whakataki from Professor David Tipene- Leach



Professor David Tipene-Leach

Te ORA has been pleased to be working with the MCNZ over the past 3 years on the Cultural Competency and Health Equity project and the advent of this second Symposium was momentous. The acknowledgement by the wider profession of the place of cultural safety in our professional lives was well met by Te ORA doctors coming forth with their stories. I pay tribute to both the search for knowledge by the former and the sharing of personal experiences in the development of the pathway ahead by the latter.

But it is yet a pathway only - although the exploration of the next steps has already been bravely broached by some. It now needs to be trialed, documented, evaluated, revised and rearticulated in order for a firm programme of pro-equity agendas, activities and behaviours to come forth. We must maintain the momentum of that which is in our present locus of control, including the Council, the Colleges and our membership organisations – and colonise that which we do not control with the practical steps required to realise the notions of equity recently taken up again by the wider sector.

Whakataki from Joan Simeon

Joan Simeon

Improving cultural safety, partnership with Māori and health equity is a key strategic direction for the Medical Council. Our focus is on improved care for patients and better patient outcomes for Māori. We have a responsibility to work with doctors to encourage positive change and excellence in medical practice.

Council values its partnership with Te Ohu Rata o Aotearoa (Te ORA) and was pleased to jointly host a highly successful symposium focused on this important topic on 25 June 2019. This was a key event for us, along with our partners Te ORA, where many were able to come together and share knowledge, thought leadership, research and successful initiatives to a wide audience. We were privileged to hear from a diverse and learned group of speakers who have given us insight and guidance for our current and future work.

We were all challenged to be bold. Certainly, we are pleased that key messages from the symposium have already influenced Council's Statement on cultural safety.

I would like to thank those who gave their time and expertise for this special event and all those who are contributing across the health sector to this important work.

Whakawhetai ki a koutou kia nui.

Whakataki from Te Oraiti Reedy

Te Oraiti Reedy

He mihi maioha ki a koutou i runga i te aroha o rātou mā kua whetūrangitia, nō reira, rātou ki a rātou moe mai rā. He mihi nunui ki a tātou e hāpai nei i ō rātou wawata, tūmanako hoki, tēnā tātou katoa.

The Cultural Competence Partnership and Health Equity Symposium is a key milestone in the implementation of the Medical Council and Te ORA joint programme of work, the outcome of which highlights for all of us the importance of cultural competence and cultural safety in achieving equity and improving health outcomes for Māori.

We are indebted to, and acknowledge the expertise and commitment of our Māori medical practitioners, health academics and researchers, who contributed so generously to the Symposium and indeed this publication.

It is our hope that the Symposium has created a platform where we continue to share our progress, our achievements and our learnings as we work towards health equity.

"Mahia te mahi, hei painga mō te iwi. Manaakitia te iwi, whaangaingia te tangata. Kia mau ki te aroha, me te rangimārie" Kirihaehae Te Puea Hērangi

Cultural safety, partnership and health equity symposium 2019

Mihi Whakatau

The symposium brought together over 200 people from a broad range of organisations from across the health sector, both within New Zealand and from Australia. This included representatives from medical colleges, other regulatory authorities, District Health Boards, Primary Health Organisations, Non-Government Organisations, Ministry of Health, PHARMAC, ACC, unions, the Australian Medical Council and the Australian Health Practitioner Regulation Agency.

The theme of the symposium, Mahia te mahi, hei painga mō te iwi, Getting the job done for the wellbeing of the people was reflected in the presentations from a wide range of speakers. The aim was to build on the 2017 symposium and investigate ways of working together to improve cultural safety in order to work towards eliminating health inequities.

Minister of Health, Hon Dr David Clark

Dr Curtis Walker, John Whaanga, Hon Dr David Clark

Dr Curtis Walker, Richard Tankersley

Professor David Tipene-Leach, Dr Chayce Glass, Dr Rawiri Keenan, Dr Rhys Jones, Richard Tankersley

Perspectives Perspectives / Tirohanga

Te Ohu Rata O Aotearoa, Māori Medical Practitioners Association: Dr Rhys Jones

Dr Rhys Jones

Biography:

Dr Rhys Jones (nō Ngāti Kahungunu) is a Public Health Physician and Senior Lecturer at Te Kupenga Hauora Māori, University of Auckland. As Director of Teaching and Learning he oversees Māori Health curricula across a range of programmes in the Faculty of Medical and Health Sciences. His research interests include advancing Indigenous health education, and he recently led the Educating for Equity project, an international collaboration between investigators in Australia, Canada and Aotearoa. Rhys is also past chairperson of Te Ohu Rata o Aotearoa (The Māori Medical Practitioners Association).

Presentation summary:

Dr Jones' presentation outlined the systematic inequities in health care in Aotearoa, with poorer quality and outcomes for Māori driven by racism at different levels.

Health equity for Māori should be the primary goal of the healthcare system. In pursuing this goal we must approach inequity as a feature, not a bug; we will not fix inequity using a modified version of business-as-usual.

Rather we must dismantle colonial systems and redesign health care informed by Kaupapa Māori principles, centralising equity in all structures, policies and processes. That means sharing power authentically with structurally oppressed groups, including the power to hold the system to account.

It means having free, frank and fearless discussions about racism, colonialism and white privilege, and not allowing white fragility to sabotage pro-equity measures.

Ultimately, it means having zero tolerance for inequity, and zero tolerance for any elements within the system that uphold the inequitable status quo.

Achieving health equity

Dr Rhys Jones
Te Kupenga Hauora Māori, University of Auckland

Cultural Competence, Partnership and Health Equity Symposium
25 June 2019

@rg_jones

HEALTH & SCIENCE

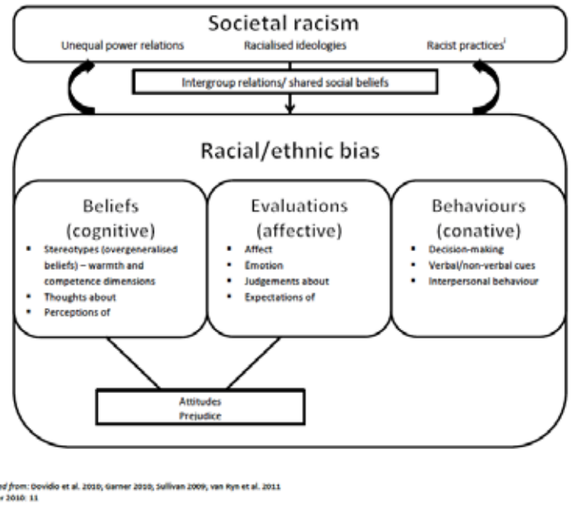
Study: Public health blighted by institutional racism

As a national campaign addressing New Zealand's attitude towards casual racism gets underway, newly-published research highlights another national shame: institutional racism in our public health sector. Teuila Fuatai reports.

Newsroom, 16 June, 2017.
https://www.newsroom.co.nz/2017/06/15/34278/study-points-to-institutional-racism-in-public-health-sector

The system isn't broken…

…it was built that way.



Adapted from: Dovidio et al. 2010; Garner 2010; Sullivan 2009; van Ryn et al. 2011
[1]Garner 2010: 11

"Inequity is immoral. We must do more than have it as item number 7.2 on our strategic plan."

Papaarangi Reid,
LIME Connection VII, 2017

The healthcare system has only one problem to solve…


Equity – the only thing that matters in rebuilding a failed healthcare system

"Health services must unapologetically make *health equity for Māori* the primary goal"

Jones B. Equity – the only thing that matters in rebuilding a failed healthcare system. NZ Doctor, 14 May 2019.

Study highlights racism Māori and Pasifika health experts feel on advisory boards

7 Mar, 2019 10:08am · 5 minutes to read

Māori and Pasifika health experts have reported racism and "tokenistic engagment" while participating in health advisory boards. Photo / File

NZ Herald, 7 March, 2019.
https://www.nzherald.co.nz/nz/news/article.cfm?c_id=1&objectid=12210378

Achieving health equity

- Share power authentically with structurally oppressed groups and promote Indigenous peoples' self-determination

Chin MH, King PT, Jones RG, et al. Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. Health Policy. 2018;122(8):837-53.

Achieving health equity

- Have free, frank and fearless discussions about the impacts of structural racism, colonialism and white privilege

Chin MH, King PT, Jones RG, et al. Lessons for achieving health equity comparing Aotearoa/New Zealand and the United States. Health Policy. 2018;122(8):837-53.

"Medical education has historically been complicit in furthering the goals of colonisation and perpetuating inequitable structures, processes and outcomes."

"As a first step, institutions need to acknowledge their historical and contemporary role in the colonial project, including acceptance of evidence that health professionals and health systems contribute to the maintenance of health inequities."

Jones R, Crowshoe L, Reid P, et al. Educating for Indigenous Health Equity: An International Consensus Statement. Acad Med. 2019;94(4):512-9.

- Institutions must engage in decolonisation
  - This is about dismantling colonialism as the basis of our values, practices and institutions
  - Also about reclaiming Indigenous ways of knowing, doing and being, and reassertion of Indigenous self-determination

Jones R, Crowshoe L, Reid P, et al. Educating for Indigenous Health Equity: An International Consensus Statement. Acad Med. 2019;94(4):512-9.

Key messages

- Health equity for Māori should be the primary goal of the healthcare system
- Inequity is a feature, not a bug
- Centralise equity in all structures and processes and ensure accountability
- Share power authentically and promote Māori self-determination
- Have free, frank and fearless discussions about racism, colonialism and white privilege

White fragility

- A state in which even a minimum amount of racial stress becomes intolerable, triggering a range of defensive moves:
  - Expression of emotions such as anger, fear & guilt
  - Argumentation, silence and avoidance
- These behaviours function to reinstate white racial equilibrium

Health Quality and Safety Commission: Kiri Rikihana

Kiri Rikihana

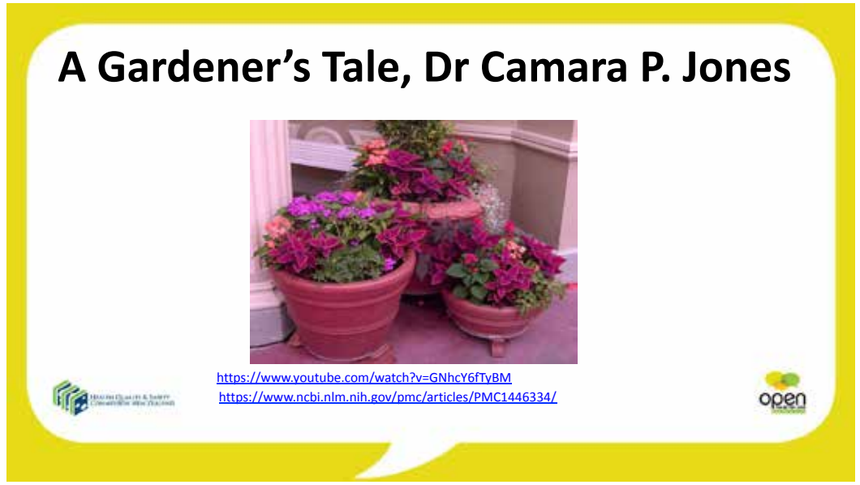
Biography:

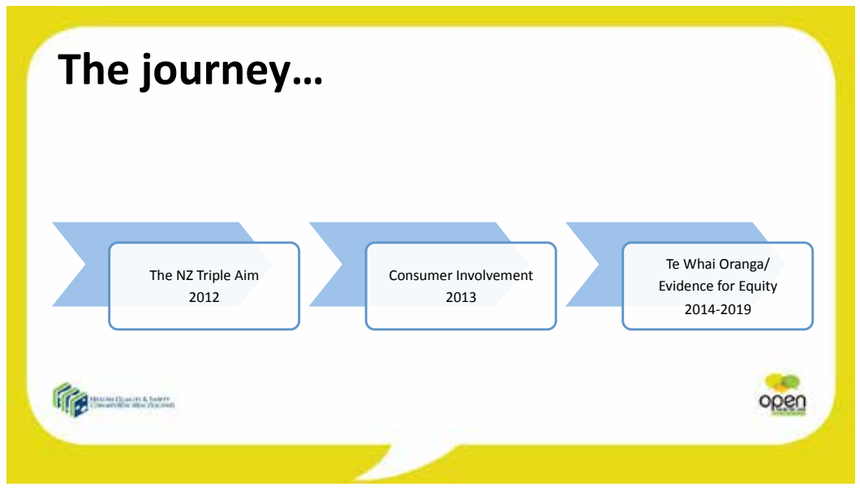
Kiri Rikihana is of Ngāti Raukawa, Te Ati Awa, and Ngāti Toa descent. Kiri is the Group Manager of the Mortality Review Committee Secretariat and Kaiwhakahaere Te Whai Oranga at the Health Quality & Safety Commission. Kiri is a lawyer by training and has a background in health law, governance and policy. Kiri is the Chair of the interagency health equity hub. The hub *Te iti me te rahi,* is a forum for health organisations to consider Māori health advancement, health equity and, more recently, the central role of Te Tiriti o Waitangi in the health sector. The mortality review committees are currently producing the Child & Youth Mortality Review Committee's 14th data report; Te Mauri: a rangatahi suicide equity report for Ngā Pou Arawhenua, the Child & Youth Mortality Review Committee (CYMRC) and the Suicide Mortality Review Committee (SuMRC); and Māori perioperative mortality with the Perioperative Mortality Review Committee.

Presentation summary:

Kiri's presentation drew from Dr Camara P Jones's work, *A Gardener's Tale.* She discussed how HQSC had prioritised and 'cultivated the soil' for Te Tiriti o Waitangi to be applied across all aspects of its work.

Attendees were encouraged to ask whether recruitment in their own organisations reflected an expectation that people had the skills and ability to respond to issues that affect Māori.



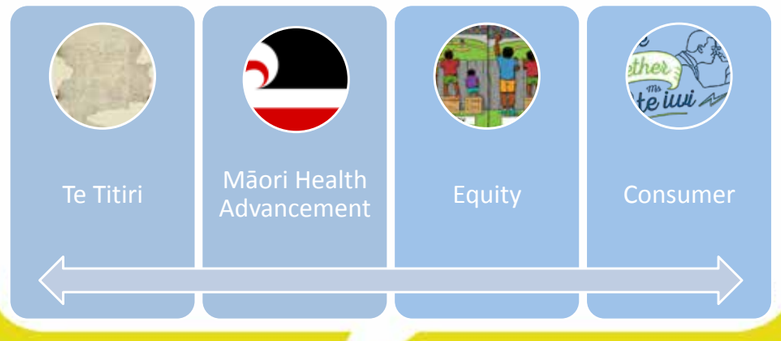


The relationship ....

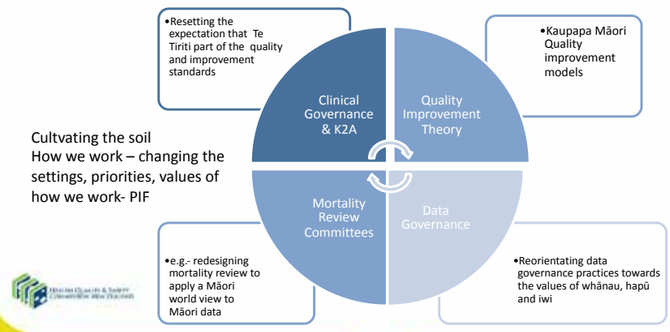
The Window 2019

https://www.health.govt.nz/our-work/populations/maori-health/he-korowai-oranga

Current state...



Te Tiriti applied?



Australasian College for Emergency Medicine: Dr Cat Tauri, Dr Inia Raumati, Dr Kim Yates, Dr Claire Manning.

Biographies:
Dr Cat Tauri

Te Atehaunui-a-Pāpārangi
ACEM Advanced Trainee
Capital and Coast DHB
ACEM Manaaki Mana Steering Group member

Dr Inia Raumati

Ngāti Mutunga, Te Atiawa, Ngāti Kahungunu
ACEM Advanced Trainee
Auckland DHB
ACEM Manaaki Mana Steering Group member

Dr Kim Yates FACEM

Te Aupouri, Te Rarawa, Tainui
Emergency Medicine Specialist, Director of Emergency Medicine Research, Waitemata DHB
Honorary Senior Lecturer, Centre for Medical & Health Services Education, University of Auckland
ACEM Manaaki Mana Steering Group member

Dr Claire Manning FACEM

Kai Tahu, Kati Mamoe, Waitaha
Emergency Physician
ACEM Manaaki Mana Steering Group member

Presentation summary:

The Manaaki Mana team of the Australasian College for Emergency Medicine (ACEM) presented highlights from Te Rautaki Manaaki Mana, ACEM's strategy for excellence in emergency care for Māori.

The team includes Māori health, tikanga and te reo experts, emergency nurses, emergency medicine specialists and trainees with ties to many different iwi.

The presentation outlined the journey undertaken while forming the strategy, beginning with a hui in March 2018, held at Te Manukanuka o Hoturoa Marae in Māngere Auckland. Dame Naida Glavish, Chief Advisor for Tikanga Māori at Auckland and Waitematā DHBs generously gifted the name Manaaki Mana for the strategy, and the hui led to the establishment of a rōpū whakahaere (steering group) to oversee the development of the strategy for ACEM.

The vision is that Emergency Departments in Aotearoa New Zealand will embody Pae Ora (healthy futures for whānau) providing excellent, culturally safe care to Māori, in an environment where Māori patients, whānau and staff feel valued, and where leaders actively seek to eliminate inequities.

The work wove the threads of the framework provided by He Korowai Oranga, the Māori Health strategy for Aotearoa New Zealand, into our Manaaki Mana pathways – the key elements being Pae Ora, Mauri Ora, Whānau Ora and Wai Ora.

The strategy was launched in May 2019 and can be found at:

https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand

Panel session

Australasian College
for Emergency Medicine

Te Rautaki Manaaki Mana

Excellence in Emergency Care for Māori

MAY 2019 – APRIL 2022

acem.org.au

Australasian College
for Emergency Medicine

Te Rautaki Manaaki Mana

Excellence in Emergency Care for Māori

MAY 2019 – APRIL 2022

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Manaaki Mana: the team

Kate Anson
Inia Tomas *Te Rarawa*
Kim Yates *Te Rarawa, Te Aupōuri, Tainui*
Claire Manning *Kai Tahu, Kati Mamoe, Waitaha*
Inia Raumati *Ngāti Mutunga, Te Atiawa, Ngāti Kahungunu*
Cat Tauri *Te Atehaunui-a-Pāpārangi*
John Bonning
Geoff Hughes
Marama Tauranga *Ngati Maniapoto, Tainui, Taranaki, Ngati Apa*
Tina Konia *Ngāi Tuhoe*
Riki Nia Nia *Ngāi Tūhoe, Ngāti Kahungunu*

Mahanga Maru *Ngāti Porou*
Ange Wadsworth ACEM Project Lead
Fin Bird ACEM Executive Director of Communications and Engagement
Leanne Shuttleworth ACEM New Zealand Office Manager

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	Māori version	English version
Article one	Māori allow the crown “te kawanatanga katoa” (governorship) over NZ	**Māori cede sovereignty** to the British crown
Article two	**Māori retain tino rangatiratanga** (absolute chieftanship/supremacy over lands and all treasured things)	Crown guarantees undisturbed possession over lands, forests, fisheries and other properties
Article three	Ōritetanga Māori given the same protections, rights and privileges as British subjects	Māori given the same protection, rights and privileges as British subjects

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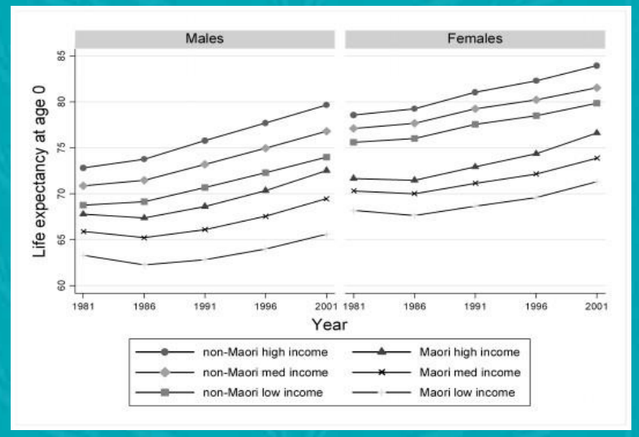
Life expectancy at birth for Māori and Non-Māori by income and gender



Trends in survival and life expectancy by ethnicity, income and smoking in New Zealand: 1980s to 2000s; *Kristie N Carter, Tony Blakely, Matthew Soeberg ;* New Zealand Medical Journal; 13th August 2010, Volume 123 Number 1320

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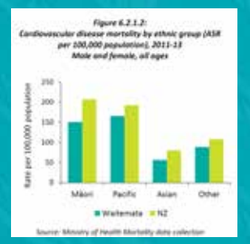
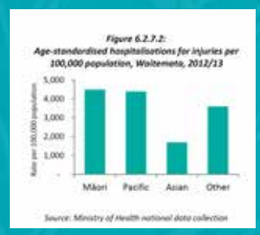
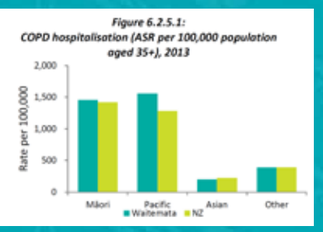
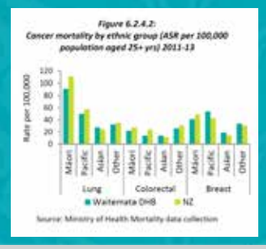
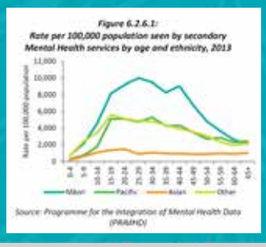
Waitematā DHB Health Needs Assessment 2017











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Manaaki Mana: the story begins…









Acknowledgements:
Kate Anson, Pip Stuart, Whetu Scott, Carol Dewes, Lisa Reddy, Moari Stafford, Whaea Taui

Videos of talks from hui: https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand

Manaaki Mana: the team

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Ange Wadsworth ACEM Project Lead
Fin Bird ACEM Executive Director of Communications and Engagement
Leanne Shuttleworth ACEM New Zealand Office Manager

Manaaki Mana: the process of creating a strategy



Manaaki Mana: values and vision

Manaakitanga

Whakamana

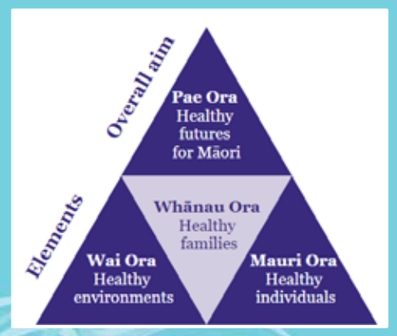
Tika me Pono

Whānaungatanga

Aroha

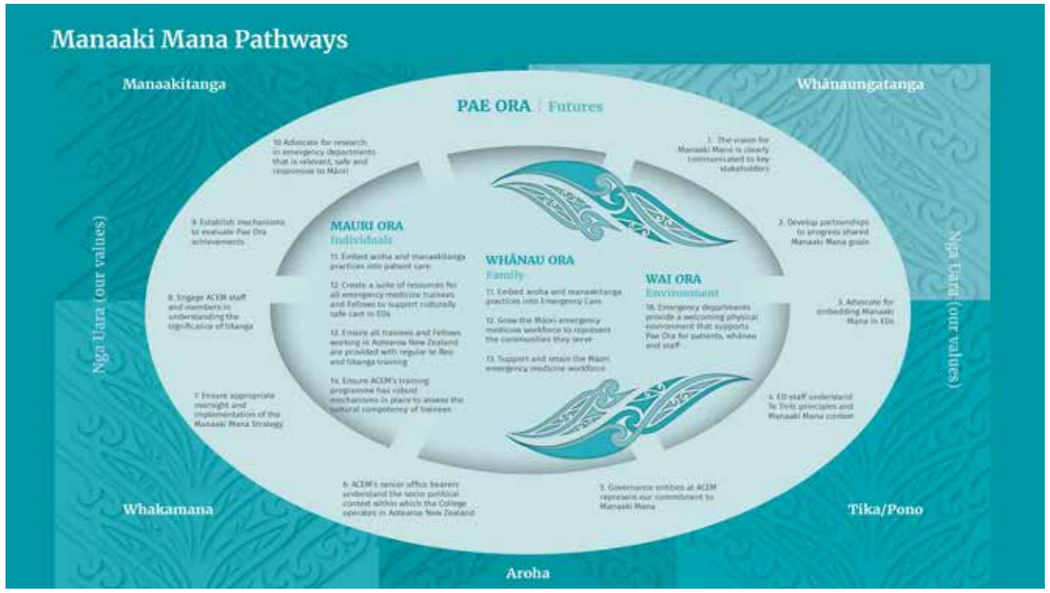
Emergency departments in Aotearoa New Zealand will embody Pae Ora, providing excellent, culturally safe care to Māori, in an environment where Māori patients, whānau and staff feel valued, and where leaders actively seek to eliminate inequities.

He Korowai Oranga



More Māori FACEMs

Manaaki Mana Pathways



Develop standards for equity & excellence

Train & grow a culturally safe workforce

acem.org.au

Enhance the ED environment

acem.org.au

So the journey continues:

https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-competency/Achieving-Equity-for-Maori-in-Aotearoa-New-Zealand

Or go to www.acem.org.au and search for Manaaki Mana

acem.org.au

Questions

with the Manaaki Mana Steering Group

Whāia te iti kahurangi, ki te tuohu koe
Me he maunga teitei

Seek the treasure that you value most dearly
If you bow your head, let it be to a lofty mountain

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Evolution of Cultural Competence

Medical Council of New Zealand: Joan Simeon

Joan Simeon

Biography:

Joan was appointed Chief Executive Medical Council of New Zealand in December 2017, having spent the past 14 years in various senior operational and strategic roles at Council.

Her most recent position was Strategic Programme Manager, responsible for developing and implementing the Council's strategic directions and plans.

Significant projects Joan has undertaken during this time include managing the review of prevocational medical training in 2011, which has since led the implementation of changes focused on improving the quality of education and training for interns. This work included developing the New Zealand Curriculum Framework, creating an electronic portfolio to record an intern's learning and provide guidance for addressing their development needs, and training for clinical supervisors.

More recently, Joan's work has been focused on promoting the competence of, and collegial support for, vocationally registered doctors. This includes work to develop a cultural competence framework in an effort to improve cultural safety for patients.

Joan has recently completed a Masters in Public Management through Victoria University of Wellington, focusing her study on the health sector. Joan also has a post-graduate qualification in Business Studies from Massey University.

Presentation summary:

Joan Simeon presented on the Council and Te ORA joint work programme and highlighted two initiatives. Firstly, the two Council documents that had been revised by the expert advisory and governance groups to reflect the evolution of cultural competence and a progression towards cultural safety. The documents highlighted the importance of health equity for all cultural groups, with a focus on Māori as tāngata whenua. Attendees were encouraged to take copies of the documents and provide feedback in hard copy or through the online survey.

The second piece of work was the gathering of baseline data as the first part of a full evaluation programme for cultural competence, partnership and health equity initiatives. A preferred supplier, Allen + Clarke, was chosen to undertake this work after a rigorous request for proposal process. Allen + Clarke gave a brief overview of the work they intended to undertake over the coming months.

Our strategic goals

- **Goal one -** Optimise mechanisms to ensure doctors are competent and fit to practise, including cultural competence and providing culturally-safe care with the aim of contributing to improved health outcomes and health equity.

- **Goal three –** Provide standards of clinical competence, cultural competence (including competencies that will enable effective and respectful interaction with Māori), and ethical conduct, and ensuring that the standards reflect the expectations of the public, the profession and stakeholders.

Joint Work Programme Council and Te ORA

Governance and Advisory Group Members

- Dr Curtis Walker
- Mr Andrew Connolly
- Prof. David Tipene-Leach
- Assoc. Prof. Papaarangi Reid
- Kim Ngārimu
- Joan Simeon
- Dr Rawiri Jansen
- Dr Rees Tapsell
- Prof. Alan Merry
- Dr Rhys Jones
- Aleyna Hall
- Raylene Bateman

Cultural competence & the provision of culturally-safe care

Aims

- Reflect current guidance while acknowledging concepts will continue to evolve
- Greater clarity on the required standards for doctors
- Health equity focus for all cultural groups, with a focus on Māori as tāngata whenua.
- Progression towards cultural safety

Our current initiatives

Joint Work Programme Council and Te ORA

- Revised documents to reflect the evolution of cultural competence
  - *Statement on cultural competence and the provision of culturally-safe care*
  - *Achieving best health outcomes for Māori: a resource*
- Baseline data capture and evaluation of initiatives

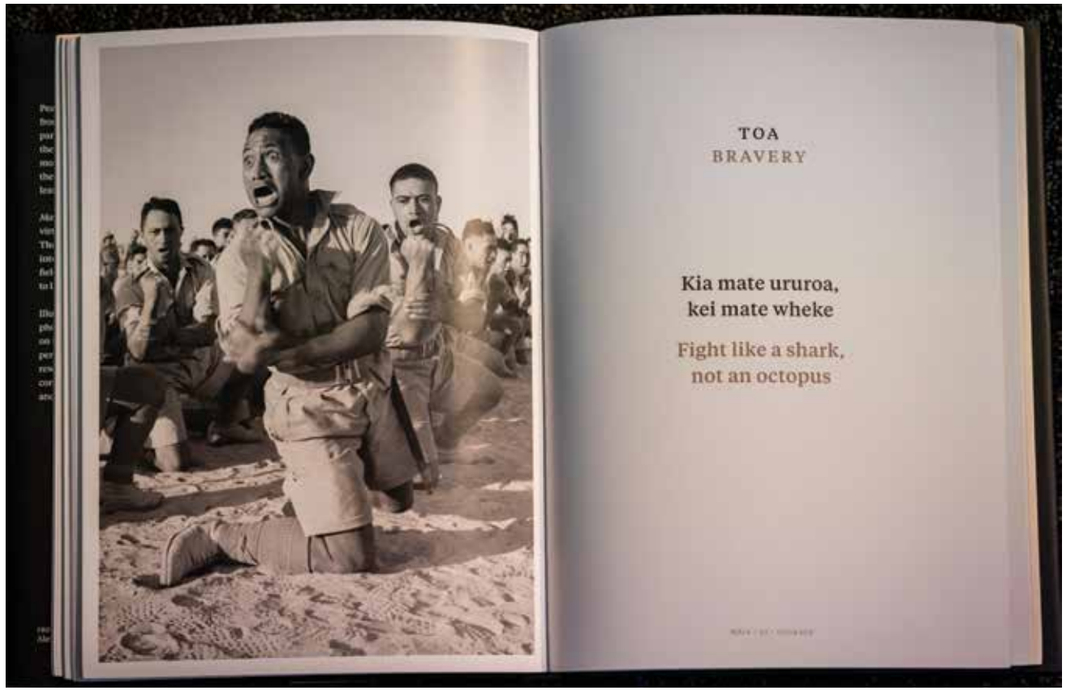
Council's documents

Process

- Literature review and recommendations provided by Associate Professor Elana Curtis and Te ORA
- Council documents reviewed
- Consultation May – July 2019
  - *Statement on cultural competence and the provision of culturally-safe care*
  - *Achieving best health outcomes for Māori: a resource*
- Use feedback to further inform statement.

Baseline data capture for Cultural Competence, Partnership and Health Equity Initiatives

- Council has commissioned Allen + Clarke to complete the first stage of evaluation of Cultural Competence, Partnership and Health Equity Initiatives – Baseline data capture



Allen + Clarke: Marnie Carter, Pounamu Aikman

Marnie Carter

Biographies:

Allen + Clarke is a respected New Zealand consultancy that specialises in policy, research and evaluation, and secretariat and programme support services. A key component of thier work is undertaking evaluation and research to inform future policy and programme development. Their staff are experienced in implementing research methods to document baseline data and assessing cultural competence and cultural safety. They also have considerable experience in working with health sector stakeholder organisations.

Founded in 2001, the company is managed by two Directors, Matthew Allen and Paul Houliston, who share ownership with six senior staff (including Marnie Carter, the proposed project co-lead). They have approximately 50 staff in total. Allen + Clarke works extensively for a range of government and non-government agencies in New Zealand, Australia, as well as international organisations in the Pacific and Asia.

Marnie Carter

Marnie is the project co-lead, along with Shirley Simmonds, on the project to capture baseline data on cultural competence and cultural safety of doctors working in New Zealand, commissioned by the Medical Council of New Zealand in partnership with Te ORA.

Marnie is responsible for leading the development of the evaluation measures framework, evaluation tools, analysis and reporting.

She holds a Bachelor of Arts and PGDipSSER (with Distinction), and her background is as a research and evaluation specialist. She has 10 years' experience in conducting evaluations of health policies and programmes. This includes the evaluations with similar aims and methodologies to that sought by Council and Te ORA, such as the recently completed Evaluation of the Healthy Homes Initiative, and the current evaluation of the Mobility Action Programme, both commissioned by the Ministry of Health. Marnie has strong technical evaluation skills and is experienced in creating robust evaluation measurement and criteria frameworks and translating these into feasible data collection techniques. She is an expert at interpreting complex datasets into accessible and practical evaluation findings.

Pounamu Aikman

Pounamu Aikman (Ngāti Maniapoto, Tainui, Ngāti Awa, Ngāi Te Rangi)

Pounamu is a qualitative co-analyst on the baseline data capture project and is responsible for supporting the qualitative component of the data collection. He will play a key role in engagement with Māori evaluation participants.

Pounamu holds a Bachelor of Arts (1st Class Hons) and a Master of Arts (with Distinction).

He is a qualitative researcher at Allen + Clarke, with a background in Māori and Indigenous Studies. He has a strong sense of cultural awareness and has lectured in both Māori Studies and Pacific Island Studies.

Pounamu has strong written skills and a track record of publications, having developed an active repertoire of research informed by Kaupapa Māori methodologies, including ethnographic and participant observations methods.

Presentation summary:

The Medial Council of New Zealand (Council), in joint partnership with Te Ohu Rata o Aotearoa (Te ORA), has embarked on a programme of work to reduce the health inequities that exist between Maori and Pākehā populations to improve the health outcomes of Maori.

Council and Te Ohu Rata o Aotearoa (Te ORA) is working in partnership to:

- strengthen cultural competence, including understanding the role and responsibility in the causes of, and possible solutions to, health inequity
- improve cultural safety for patients
- improve the support and cultural safety for those members of the profession who identify as Māori
- increase understanding of cultural influences, in order to improve health outcomes.

The evaluation should determine whether the initiatives within the work programme have achieved the desired outcomes and provide lessons and data to inform future work.

This project is the first phase of the evaluation work to establish the current status (baseline data) of cultural competence of doctors practising in New Zealand and the cultural safety of people receiving health services from those doctors.The data collected will be specific to Māori. This data will be used as a basis to assess impact of change over time.

BASELINE DATA CAPTURE FOR CULTURAL COMPETENCE, PARTNERSHIP AND HEALTH EQUITY INITIATIVES

OUTLINE OF APPROACH

ALLEN+CLARKE

Research approach

A carefully crafted and culturally appropriate methodological approach...

- **Guided by Mahi Tahi**
  - Working in collaboration with Council and Te ORA
  - Grounded by a whānau reference group
  - Providing our team with Māori cultural support
- **with Kaupapa Māori-informed case studies**

...led by experienced qualitative and quantitative Māori and Pākehā evaluators...

Marnie Carter

Shirley Simmonds

...using an in-depth exploration of health data sets, complemented with four site-based case studies...

- Develop a kawa whakaruruhau framework
- Interviews with key stakeholders in the health sector
- Survey of DHBs and PHOs
- Kaupapa Māori-informed case studies
  - Interviews with DHB and PHO personnel, and Māori and non-Māori doctors
  - Engagement with Māori patients
  - Poster installation

...to help document baseline data on the kawa whakaruruhau initiative

ALLEN + CLARKE

Mahi tahi

Ehara tōku toa i te toa takitahi; he toa takitini kē.

Our team

Matt Allen

Marnie Carter

Shirley Simmonds

Kataraina Pipi

Sean Hanna

Carolyn Hooper

Pounamu Aikman

Nick Preval

ALLEN + CLARKE

University of Auckland: Associate Professor Elana Curtis

Associate Professor Elana Curtis

Biography:

Elana Taipapaki Curtis, FNZCPHM, MD, MPH, MBChB, is a Māori (Te Arawa) public health medicine specialist and Associate Professor in Māori Health at the University of Auckland. She is the Director Vision 20:20 that includes academic leadership of the Faculty of Medical and Health Sciences' Hikitia Te Ora - Certificate in Health Sciences (bridging/foundation education), Māori and Pacific Admission Scheme (admission and retention support) and the Whakapiki Ake Project (Māori recruitment). She has recently completed her Doctorate of Medicine (MD) focused on indigenous health workforce development and has been involved in Kaupapa Māori Research investigating indigenous and ethnic inequities within tertiary and health care contexts including: breast cancer, cardiovascular disease, emergency department care and racism within clinical decision making.

She has multiple international and national awards including a Commonwealth Fund Harkness Fellow in Health Care Policy, a Māori TV Matariki Te Tupu-ā-Rangi Award for Health and Science, a LIMELite Award for Excellence in Indigenous Health Education Research (Leaders in Indigenous Medical Education) and an Ako Aotearoa National Tertiary Teaching Excellence Award (Kaupapa Māori Category).

She has recently completed work on cultural competency and cultural safety to inform Te Ohu Rata o Aotearoa's positioning and recommendations to the Medical Council of New Zealand.

Presentation summary:

Associate Professor Elana Curtis presented findings from an international literature review. Her findings support the use of cultural safety and critical consciousness rather than narrow notions of cultural competence and acquiring knowledge about 'other cultures'.

Her recommendations included that healthcare professionals and healthcare organisations engaged in ongoing self-reflection and self-awareness and held themselves accountable for providing culturally-safe care, as defined by the patient and their communities.

This includes the evaluations with similar aims and methodologies to that sought by Council and Te ORA, such as the recently completed Evaluation of the Healthy Homes Initiative, and the current evaluation of the Mobility Action Programme, both commissioned by the Ministry of Health. Marnie has strong technical evaluation skills and is experienced in creating robust evaluation measurement and criteria frameworks and translating these into feasible data collection techniques. She is an expert at interpreting complex datasets into accessible and practical evaluation findings.

Current research and rationale for the evolution of cultural competence

Associate Professor Elana Curtis (Te Arawa)

Cultural competence, partnership and health equity Symposium

Wellington

25 June 2019

Background Context

- "Cultural competency" in health professional licensing legislation, accreditation standards, and training programmes.
- Mixed definitions and understandings of cultural competency and cultural safety, and how best to achieve them.

Methods

- International literature review on cultural competency and safety.
  - Medline, Psychinfo, Cochrane SR, ERIC, CINAHL, Scopus, Proquest, Google Scholar, EbscoHost and grey literature.
- Search terms
  - cultural competence (cultural safety, cultural awareness, cultural competence, cultural diversity, cultural understanding, knowledge, expertise, skill, responsiveness, respect, transcultural, multicultural, cross-cultur*); education (Educat*, Traini*, Program*, Curricul*, Profession*, Course*, Intervention, Session, Workshop, Skill*, Instruc*, program evaluation); Health Provider (provider, practitioner, health professional, physician, doctor, clinician, primary health care, health personnel, health provider, nurse); Health Services Indigenous (health services indigenous, ethnic* Minorit*, indigenous people*, native people).

Results

- A total of 51 articles were identified via the search, additional 8 articles identified via opportunistic searching.
- A total of 59 articles were used to inform this literature review.

Literature

44	**Polaschek NR.** Cultural safety: a new concept in nursing people of different ethnicities. Journal of Advanced Nursing 27(3): 452-457.	1998	New Zealand	Descriptive review
45	**Price EG, et al.** A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. Academic Medicine 80(6): 578-586.	2005	USA	Systematic review
46	**Ramsden I.** Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu. A thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy in Nursing. Department of Nursing. Wellington, Victoria University of Wellington Doctor of Philosophy in Nursing: 211.	2002	New Zealand	Thesis
47	**Ratima M, et al.** Cultural competence for physiotherapists: reducing inequalities in health between Maori and non-Maori. New Zealand Journal of Physiotherapy 34(3): 153-159.	2006	New Zealand	Perspective/viewpoint article
48	**Richardson A, et al.** Expressions of cultural safety in public health nursing practice. Nursing Inquiry 24(1).	2017	New Zealand	Primary qualitative research
49	**Richardson S.** Aotearoa/New Zealand nursing: from eugenics to cultural safety. Nursing Inquiry 11(1): 35-42.	2004	New Zealand	Review article
50	**Ringer J.** Cultural safety and engagement: Keys to improving access to care. Healthcare Management Forum 30(4): 213-217.	2017	USA	Descriptive article
51	**Rowan MS, et al.** Cultural competence and cultural safety in Canadian Schools of Nursing: A mixed methods study. International Journal of Nursing Education Scholarship 10(1).	2013	Canada	Research article
52	**Shen Z.** Cultural Competence Models and Cultural Competence Assessment Instruments in Nursing: A Literature Review. Journal of Transcultural Nursing 26(3): 308-321.	2015	USA	Descriptive review
53	**Smye V, Browne A.** 'Cultural safety' and the analysis of health policy affecting aboriginal people. Nurse Researcher (through 2013) 9(3): 42-56.	2002	Canada	Descriptive article
54	**Tervalon M, Murray-Garcia J.** Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor & Underserved 9(2): 117-125.	1998	USA	Perspective/viewpoint article
55	**Truong M, et al.** Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Services Research 14: 99.	2014	Australia	Systematic review (19 articles)

Defining Cultural Competency

Cultural Competency

- Broad concept
- Early definition

  "Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations." (Cross et al., 1989)

Lack of Shared Understanding

- Multiple terms
  - *cultural awareness*; *cultural sensitivity*; *cultural humility*; *cultural security*; *cultural respect*; *cultural adaptation*; *transcultural competence*; *transcultural effectiveness*.
- Most viewing CC in terms of gazing at the 'exotic other' v.s. evidence of inequities and professional complicity
- Variations in policy uptake across the sector
- Unclear what interventions are required

Defining Cultural Safety

Cultural Safety

Kawa Whakaruruhau - Cultural Safety

*a focus for the delivery of quality care through changes in thinking about **power relationships and patients' rights**.* (Papps & Ramsden, 1996, p.493)

Dr Irihapeti Ramsden

Cultural Safety

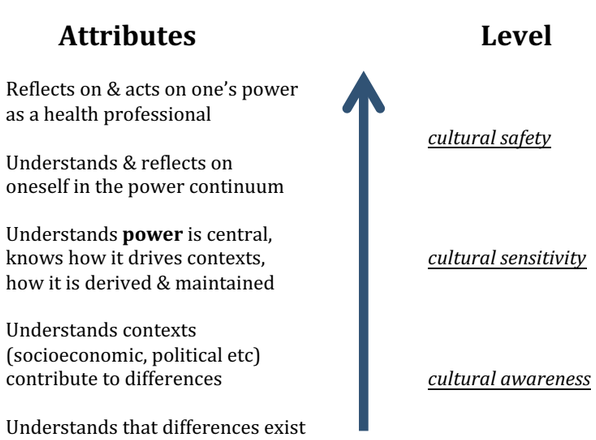
- Rejection of transcultural nursing

  The skill for nurses and midwives does not lie in knowing the customs of ethnospecific cultures. Rather, cultural safety places an obligation on the nurse or midwife to provide care within the framework of recognizing and respecting the difference of any individual. (Ramsden & Papps, p.493-494)

- Places an emphasis on the health worker understanding their own culture and identity

  Thus, cultural safety is concerned with both systemic and individual change with the aim of examining processes of identity formation and enhancing health workers' awareness of their own identity and its impact on the care they provide to people from indigenous cultural groups. (Downing, Kowal et al. 2011, p.249)

Continuum or Paradigm Shift?



Critical Consciousness

- *by "critical self-reflection," we do not mean a singular focus on the self, but a stepping back to **understand one's own assumptions, biases, and values,** and a shifting of one's gaze from self to others and conditions of injustice in the world. This process, coupled with resultant action, is at the core of the idea of critical consciousness.*

  (Kumagai and Lypson 2009, p. 783)

Why a narrow understanding of CC may be harmful

- Perpetuates 'othering', cultural stereotyping, homogenises indigenous peoples into a collective 'they'
- Promotes cultural essentialism
- Ignores power differentials
- Perpetuates deficit discourses, victim blaming
- Neglects structural analysis
- Suggests there is an 'end point'

Proposed CS Definition

Proposed CS Definition

- In doing so, cultural safety encompasses a ‘critical consciousness’ where health professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.

- Cultural safety requires health professionals and their associated healthcare organisations to influence healthcare to reduce bias and improve equity within the workforce and working environment”.

Proposed CS Definition

- Cultural safety requires health professionals and their associated healthcare organisations to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.

- This requires individual health professionals and healthcare organisations to acknowledge and address their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients.

Recommendations

Recommendations 1

- Focus on achieving health equity, with measurable progress towards this endpoint;
- Be centred on *cultural safety* and *critical consciousness* rather than narrow based notions of *cultural competency;*
- Apply *cultural safety* within a healthcare *systemic/organizational* context in addition to the *individual* health provider-patient interface;

Recommendations 2

- Focus on *cultural safety* activities that extend beyond acquiring knowledge about 'other cultures'
- Address biases and stereotypes;
- Frame *cultural safety* on power relationships and inequities within health care interactions that reflect historical and social dynamics.
- Includes formal training curricula across all training/practice environments, systems, structures, and policies.

What can 'you' do for CS?

- Mandate evidence of engagement and transformation in *cultural safety* activities as a part of vocational training and professional development;
- Include evidence of cultural safety (of organisations and practitioners) as a requirement for accreditation and ongoing certification;
- Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes);

What can 'you' do for CS?

- Require *cultural safety* training and performance monitoring for staff, supervisors and assessors;
- Acknowledge that *cultural safety* is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous health.
- Mauriora!

Acknowledgments

- Co-authors: Rhys Jones, David Tipene-Leach, Curtis Walker, Belinda Loring, Sarah-Jane Paine, Papaarangi Reid.
- BJ Wilson, Matire Harwood.
- Te ORA members who reviewed the original report.

Supplemetary Table: Evidence sources identified from the literature review

	Author(s) and Title	Year	Country	Type of article
1	**Alizadeh S, Chavan M.** Cultural competence dimensions and outcomes: a systematic review of the literature. Health & Social Care in the Community 24(6): e117-e130.	2016	Australia	Systematic review
2	**Beach MC, et al.** Cultural competence: A systematic review of health care provider educational interventions. Medical Care 43(4): 356-373.	2005	USA	Literature review, 34 studies included.
3	**Betancourt JR, Greean AR, Carillo JE.** Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches. The Commonwealth Fund.	2002	USA	Primary research
4	**Betancourt JR, et al.** Defining Cultural Competence: A Practical Framework for Addressing Racial/Ethnic Disparities in Health and Health Care. Public Health Reports 118(4): 293-302.	2003	USA	Literature review
5	**Betancourt JR, et al.** Cultural competence and health care disparities: key perspectives and trends. Health Affairs 24(2): 499-505.	2005	USA	Key informant interviews
6	**Blanchet Garneau A.** Applying cultural safety beyond Indigenous contexts: Insights from health research with Amish and Low German Mennonites. Nursing Inquiry 25(1).	2018	Canada	Perspective/viewpoint article
7	**Blanchet Garneau A, Pepin J.** Cultural competence: a constructivist definition. Journal of Transcultural Nursing 26(1): 9-15.	2015	Canada	Literature review
8	**Blanchet-Cohen N, Richardson/Kinewesquao C.** Foreword: fostering cultural safety across contexts. AlterNative: An International Journal of Indigenous Peoples 13(3): 138-141.	2017	Canada	Editorial
9	**Brascoupé S, Waters C.** Cultural Safety: Exploring the Applicability of the Concept of Cultural Safety to Aboriginal Health and Community Wellness. Journal of Aboriginal Health 5(2): 6-41.	2009	Canada	Literature review and case-studies
10	**Browne AJ, et al.** Cultural safety and the challenges of translating critically oriented knowledge in practice. Nursing Philosophy 10(3): 167-179.	2009	Canada	Knowledge-translation study (using cultural safety in practice)
11	**Chang ES, et al.** Integrating cultural humility into health care professional education and training. Advances in Health Sciences Education 17(2): 269-278.	2012	USA	Perspective/viewpoint article
12	**Clifford A, et al.** Interventions to improve cultural competency in health care for Indigenous peoples of Australia, New Zealand, Canada and the USA: a systematic review. International Journal for Quality in Health Care 27(2): 89-98.	2015	Australia	Literature Review (16 articles)
13	**Cross TL, Bazron BJ, Isaccs MR.** Towards a Culturally Competent System of Care: A Monograph on Effective Services for Minority Children Who Are Severely Emotionally Disturbed. Washington DC: CASSP Technical Assistance Centre, Georgetown University Child Development Center.	1989	USA	Report
14	**Darroch F, et al.** The United States Does CAIR About Cultural Safety: Examining Cultural Safety Within Indigenous Health Contexts in Canada and the United States. Journal of Transcultural Nursing 28(3): 269-277.	2017	USA	Policy/literature review in USA and Canada
15	**Dell EM, et al.** Cultural Safety and Providing Care to Aboriginal patients in the Emergency Department. CJEM Canadian Journal of Emergency Medical Care 18(4): 301-305.	2016	Canada	Perspective/viewpoint article
16	**DeSouza R.** Wellness for all: The possibilities of cultural safety and cultural competence in New Zealand. Journal of Research in Nursing 13(2): 125-135.	2008	New Zealand	Perspective/viewpoint article
17	**Doutrich D, et al.** Cultural Safety in New Zealand and the United States: Looking at a Way Forward Together. Journal of Transcultural Nursing 23(2): 143-150.	2012	USA	Key informant interviews
18	**Downing R, et al.** Indigenous cultural training for health workers in Australia. International Journal for Quality in Health Care 23(3): 247-257.	2011	Australia	Literature review
19	**Duke J, Connor M, Mceldowney R.** Becoming a culturally competent health practitioner in the delivery of culturally safe care: A process oriented approach. Journal of cultural diversity 16(2):40-49.	2009	New Zealand	Perspective/viewpoint article
20	**Eriksson C, Eriksson L.** Inequities in health care: lessons from New Zealand : A qualitative interview study about the cultural safety theory. Thesis. The Red Cross University College in Stockholm, Sweden.	2017	New Zealand/Sweden	Primary qualitative research
21	**Fleming T, et al.** Impact of a continuing professional development intervention on midwifery academics' awareness of cultural safety. Women And Birth: Journal Of The Australian College Of Midwives 30(3): 245-252.	2017	Australia	Intervention study
22	**Gibbs KA.** Teaching Student Nurses to be Culturally Safe: Can It Be Done? Journal of Transcultural Nursing 16(4): 356-360.	2005	New Zealand	Perspective/viewpoint article
23	**Govere L, Govere EM.** How Effective is Cultural Competence Training of Healthcare Providers on Improving Patient Satisfaction of Minority Groups? A Systematic Review of Literature. Worldviews on Evidence-Based Nursing 13(6): 402-410.	2016	USA	Systematic review, 7 studies included.
24	**Grote E.** Principles and Practices of Cultural Competency: A Review of the Literature. Canberra: Indigenous Higher Education Advisory Council (IHEAC), Australian Government, Department of Education Employment and Workplace Relations.	2008	Australia	Literature review & key informant interviews
25	**Hall M, Guidry J.** Literature Review of Cultural Competence Curriculum within the United States: An Ethical Implication in Academic Preparational Programs. Education in Medicine 5(1): e6-e13.	2013	USA	Literature review (16 articles)
26	**Healey P, et al.** Cultural adaptations to augment health and mental health services: a systematic review. BMC Health Services Research 17.	2017	Canada	Systematic review (69 reports and studies)
27	**Hook JN, et al.** Cultural Humility in Psychotherapy Supervision. American Journal of Psychotherapy 70(2): 149-166.	2016	USA	Primary research
28	**Hook JN, et al.** Cultural humility: Measuring openness to culturally diverse clients. Journal of Counseling Psychology 60(3): 353-366.	2013	USA	Primary research
29	**Horvat L, Horey D, Romios P, Kis-Rigo J.**Cultural competence education for health professionals. Cochrane Database of Systematic Reviews 2014, Issue 5. Art. No.: CD009405. DOI: 10.1002/14651858.CD009405.pub2.	2014	Australia (Cochrane Review)	Systematic review
30	**Kirmayer LJ.** Rethinking cultural competence. Transcultural Psychiatry 49(2): 149-164.	2012	USA	Editorial
31	**Kumagai A, Lypson M.** Beyond cultural competence: Critical consciousness, social justice, and multicultural education Academic Medicine 84(6): 782-787.	2009	USA	Perspective/viewpoint article
32	**Laverty M, et al.** Embedding cultural safety in Australia's main health care standards. Medical Journal of Australia 207(1): 15-16.	2017	Australia	Perspective/viewpoint article
33	**Leininger M.** Culture Care Theory: A Major Contribution to Advance Transcultural Nursing Knowledge and Practices. Journal of Transcultural Nursing 13(3): 189-192.	2002	USA	Descriptive review
34	**Lin CJ, et al.** Cultural competence of healthcare providers: A systematic review of assessment instruments. Journal of Nursing Research 25(3): 174-186.	2017	Taiwan	Systematic review (57 articles)
35	**Maier-Lorentz MM.** Transcultural nursing: its importance in nursing practice. Journal of Cultural Diversity 15(1): 37-43.	2008	USA	Perspective/viewpoint article
36	**Main C, et al.** Cultural safety and cultural competence: what does this mean for physiotherapists? New Zealand Journal of Physiotherapy 34(3): 160-166.	2006	New Zealand	Perspective/viewpoint article
37	**Malat J.** The appeal and problems of a cultural competence approach to reducing racial disparities. Journal of General Internal Medicine 28(5): 605-607.	2013	USA	Editorial
38	**McGough S, et al.** Experience of providing cultural safety in mental health to aboriginal patients: A grounded theory study. International Journal of Mental Health Nursing 27(1): 204-213.	2018	Australia	Primary qualitative research
39	**McLennan V, et al.** Creating Culturally Safe Vocational Rehabilitation Services for Indigenous Australians: A Brief Review of the Literature. The Australian Journal of Rehabilitation Counselling 22(2): 93-103.	2016	Australia	Literature review (vocational rehab)
40	**Miller S.** Cultural humility is the first step to becoming global care providers. JOGNN - Journal of Obstetric, Gynecologic, and Neonatal Nursing 38(1): 92-93.	2009	USA	Editorial
41	**Milne T, et al.** Development of the Awareness of Cultural Safety Scale: A pilot study with midwifery and nursing academics. Nurse Education Today 44(Supplement C): 20-25.	2016	Australia	Primary research
42	**Papps, E. Ramsden, I.** Cultural safety in nursing: the New Zealand experience. International Journal for Quality in Health Care 8(5): 491-497.	1996	New Zealand	Descriptive review
43	**Phiri J, et al.** Cultural safety and its importance for Australian midwifery practice. Collegian 17(3): 105-111.	2010	Australia	Perspective/viewpoint article

44	**Polaschek NR.** Cultural safety: a new concept in nursing people of different ethnicities. Journal of Advanced Nursing 27(3): 452-457.	1998	New Zealand	Descriptive review
45	**Price EG, et al.** A systematic review of the methodological rigor of studies evaluating cultural competence training of health professionals. Academic Medicine 80(6): 578-586.	2005	USA	Systematic review
46	**Ramsden I.** Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu. A thesis submitted to the Victoria University of Wellington in fulfilment of the requirements for the degree of Doctor of Philosophy in Nursing. Department of Nursing. Wellington, Victoria University of Wellington Doctor of Philosophy in Nursing: 211.	2002	New Zealand	Thesis
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48	**Richardson A, et al.** Expressions of cultural safety in public health nursing practice. Nursing Inquiry 24(1).	2017	New Zealand	Primary qualitative research
49	**Richardson S.** Aoteaoroa/New Zealand nursing: from eugenics to cultural safety. Nursing Inquiry 11(1): 35-42.	2004	New Zealand	Review article
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51	**Rowan MS, et al.** Cultural competence and cultural safety in Canadian Schools of Nursing: A mixed methods study. International Journal of Nursing Education Scholarship 10(1).	2013	Canada	Research article
52	**Shen Z.** Cultural Competence Models and Cultural Competence Assessment Instruments in Nursing: A Literature Review. Journal of Transcultural Nursing 26(3): 308-321.	2015	USA	Descriptive review
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54	**Tervalon M, Murray-Garcia J.** Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor & Underserved 9(2): 117-125.	1998	USA	Perspective/viewpoint article
55	**Truong M, et al.** Interventions to improve cultural competency in healthcare: a systematic review of reviews. BMC Health Services Research 14: 99.	2014	Australia	Systematic review (19 articles)

56	**Watt K, et al.** Developing cultural competence in general practitioners: an integrative review of the literature. BMC Family Practice 17.	2016	Australia	Systematic literature review (50 articles)
57	**Wepa D.** An exploration of the experiences of cultural safety educators in New Zealand: an action research approach. Journal of Transcultural Nursing 14(4): 339-348.	2003	New Zealand	Primary qualitative research
58	**Whaley AL.** Cultural sensitivity and cultural competence: toward clarity of definitions in cross-cultural counselling and psychotherapy. Counselling Psychology Quarterly 21(3): 215-222.	2008	USA	Literature search, psychology focused.
59	**Wilson D, Neville S.** Culturally safe research with vulnerable populations. Contemporary Nurse 33(1): 69-79.	2009	New Zealand	Descriptive review

Culturally-safe practice in action

University of Otago: Associate Professor Suzanne Pitama

Associate Professor Suzanne Pitama

Biography:

Suzanne Pitama (Ngāti Kahungunu) is the Associate Dean (Māori) and Associate Professor at the University of Otago, Christchurch.

Suzanne joined the University of Otago in 2001 from a clinical background in child psychology. She has since developed a keen interest in medical education and completed her PhD (Otago) on examining the place of indigenous health within medical education.

Suzanne is the Hauora Māori Faculty Representative on the University of Otago Faculty of Medicine Curriculum Committee. In this role Suzanne chairs the Hauora Māori sub-committee, whilst also contributing to other areas within the medical education field including the curriculum mapping, the culture, self and diversity working group and has an interest in measuring social accountability.

Suzanne has a passion for teaching, winning a University of Otago teaching award in 2014, a national AKO Aotearoa tertiary teaching in excellence award in 2015 and the 2015 Prime Ministers Supreme Award for tertiary teaching excellence.

Suzanne is also the Director of the Māori/Indigenous Health Institute (MIHI) and has been involved in Māori health research for 18 years. She is currently leading an Health Research Council-funded project that is focusing on the prevalence of cardiovascular disease in Māori communities and is a co-investigator on an international collaboration project (New Zealand, Australia and Canada) looking at the role of medical education in addressing health disparities (Educating for Equity).

Suzanne is also involved in a number of other research projects based within the University of Otago, Christchurch focussed on indigenous experiences in the health system and patients living with chronic illnesses. She is a keen advocate for Kaupapa Māori based methodologies and has interests in child mental health, medical curriculum development and Māori health community based projects.

Suzanne is a member of the New Zealand Health Research Council (HRC) and Chairs the HRC Māori Health Committee.

Presentation summary:

Associate Professor Suzanne Pitama presented on her work in the design, development, and implementation of the Hauora Māori curriculum for medical students.

She highlighted the two models used in their curriculum as the Hui Process and Meihana model. These models make up the core content of the curriculum and are tailored to meet all learning outcomes.

She presented a range of learning methods used to engage students in the Hauora Māori curriculum and spent time discussing the merits of simulation and hybrid simulation to align with the learning theory of ‘see one, do one, teach one’. She had found using the Hui Process, and Meihana model supported students to navigate both their own, clinical, and system bias.

The MIHI team has also recently implemented a Hauora Māori curriculum tailored for Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) which has just finished its second-year cohort. She discussed that the RANZCOG course cantered on providing practical advice and guidance for demonstrating Hauora Māori competencies within clinical practice.

Other medical and health professional colleagues have completed the general health professional course offered by MIHI. Feedback on cultural safety is sought from communities on the care they received. Cultural safety is a critical component of social accountability between the medical school and Māori health community stakeholders.

University of Auckland: Dr Sandra HotuUniversity of Auckland: Dr Sandra Hotu

Dr Sandra Hotu

Biography:

Dr Sandra Hotu (Ngāti Maniapoto, Ngāti Ruanui) lives in Auckland and divides her time between working as a Respiratory Physician at Auckland District Health Board and as a Senior Lecturer at The University of Auckland. Sandra is currently completing her studies towards a PhD.

Her doctoral research has designed and tested a model of care which addresses health inequities for Māori with chronic airways disease, but has potential for application across many chronic diseases.

In 2015, Sandra was awarded a Respiratory Fellowship from Auckland District Health Board and a Clinical Research Training Fellowship from the Health Research Council of New Zealand / Asthma and Respiratory Foundation NZ.

Presentation summary:

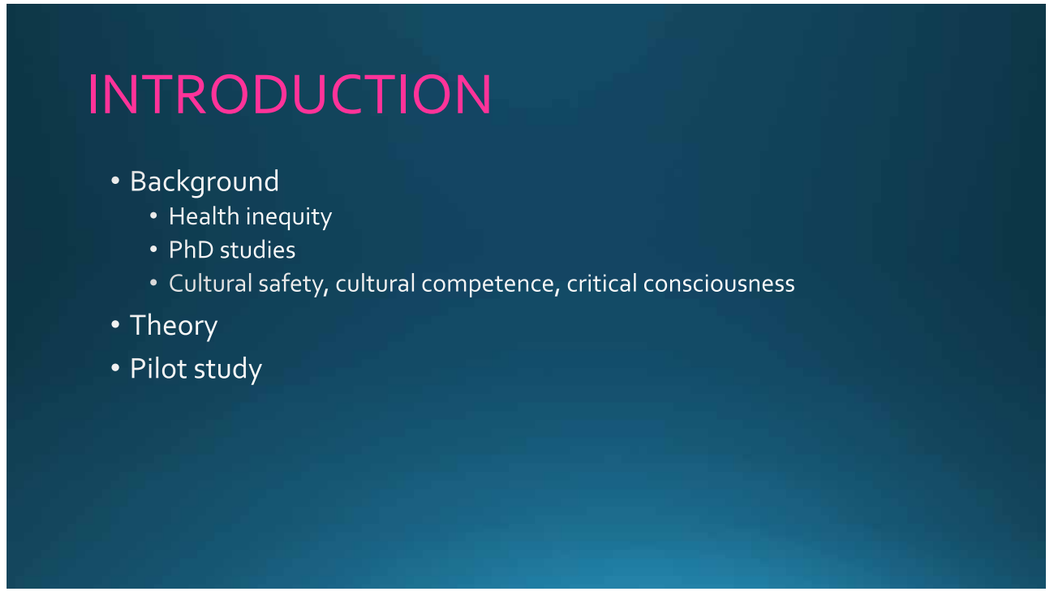
Dr Sandra Hotu presented on a person and whānau-centred approach for Māori with chronic airways disease.

The findings from her PhD studies demonstrated the practical application of culturally-safe clinical practice in the setting of specialist respiratory services.

Dr Hotu presented a novel model of healthcare delivery which begins with developing a 'critical consciousness' whereby clinicians recognise the role of colonisation in Maori health inequity, the mismatch in ideologies and assumptions underlying mainstream health structures and practices, and the role of health professionals to challenge rigid health structures and practices to advance health equity.

A 'critical consciousness' can facilitate whakawhanaungatanga, or building relationships with the goal to develop a therapeutic alliance, based on trust. Within the therapeutic alliance, education and support for chronic disease self-management can be delivered effectively.

The novel model of care, which was trialled in a pilot study in Māori with chronic airways disease, showed improvement in participant engagement, knowledge, sense of control and perception of cultural safety. Furthermore, this approach enhanced a person and whanau-centred approach to healthcare delivery.



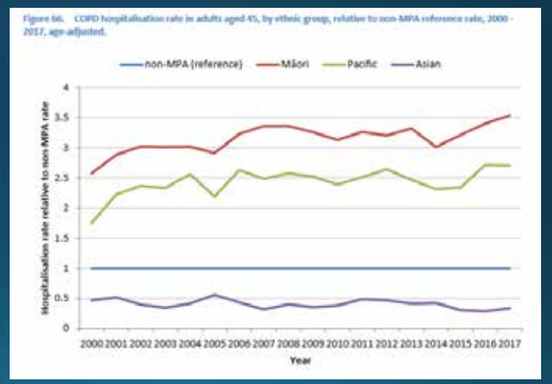
BACKGROUND

CHRONIC AIRWAYS DISEASE

- COPD
- Asthma
- Bronchiectasis

HEALTH INEQUITY

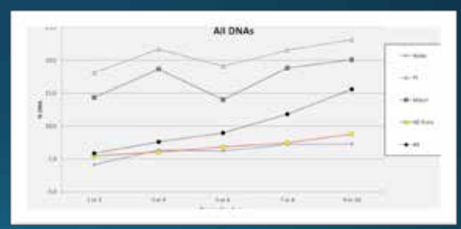
- Prevalence
- Morbidity
- Mortality



Source: Telfar-Barnard et al 2019

ENGAGEMENT WITH HEALTH SERVICES

- ADHB respiratory clinic DNAs 2000-2014



CAUSES FOR MĀORI HEALTH INEQUITY

- COLONISATION & RACISM
  - Hegemony
  - Embedded into structures and practices in our society, invisible without a critical lens
  - "Just the way it is"

SOLUTIONS

- Address social determinants of health
- Mainstream health services
  - Access (structural barriers)
  - Attitudes (cultural competence, cultural safety, critical consciousness)
  - Communication
- Indigenous-specific interventions

PHD STUDIES

INTERVIEWS

Semi-structured interviews with 17 Māori with chronic airways disease and their whanau

FOCUS GROUPS

1. Participants from semi-structured interviews
2. Respiratory nurse specialists
3. Respiratory physicians
4. Physiotherapists
5. General practitioners
6. Funding and planning (Auckland District Health Board)

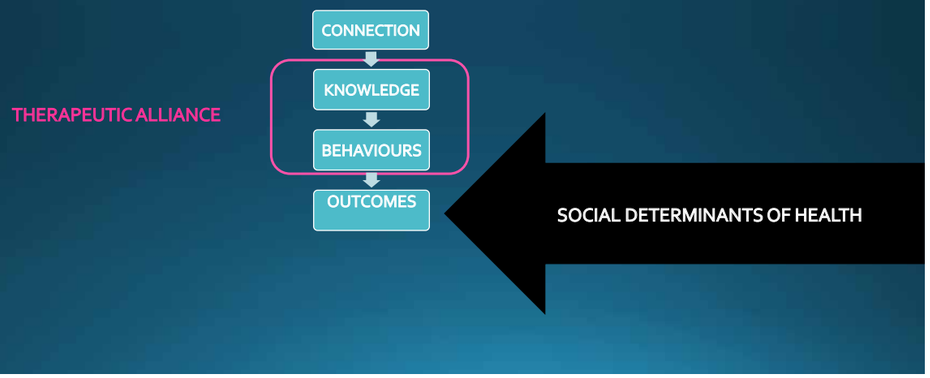
INTERVENTION

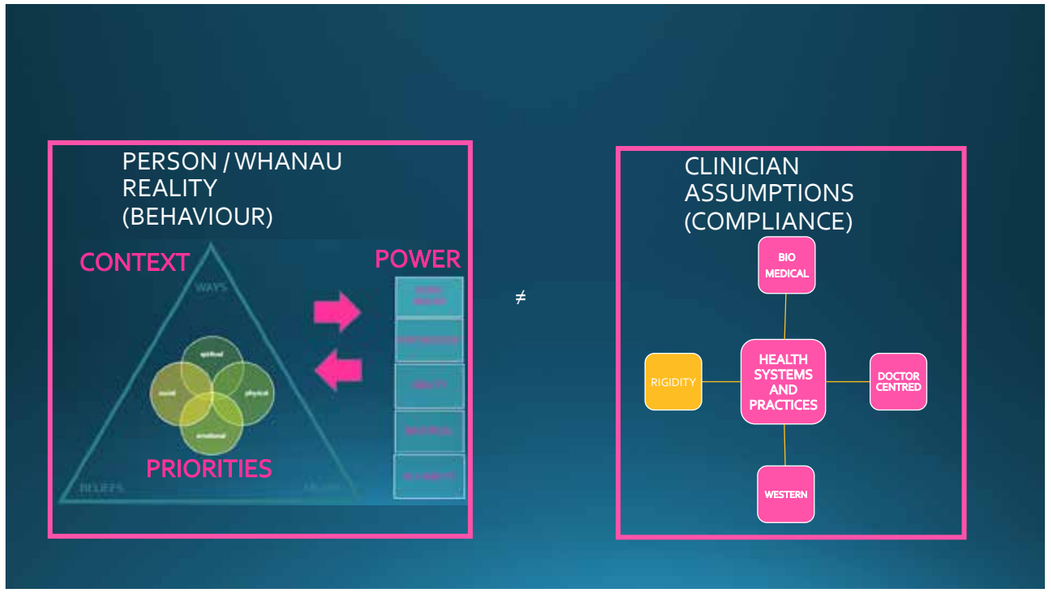
Pilot, feasibility intervention study

PHD STUDIES

- METHODOLOGY
  - Kaupapa Māori
  - Constructivist Grounded Theory

CHRONIC DISEASE MANAGEMENT

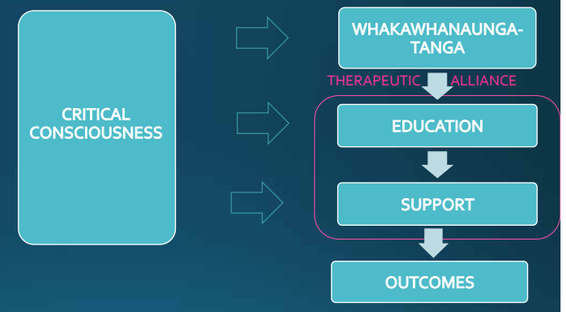




THEORY

SOLUTIONS

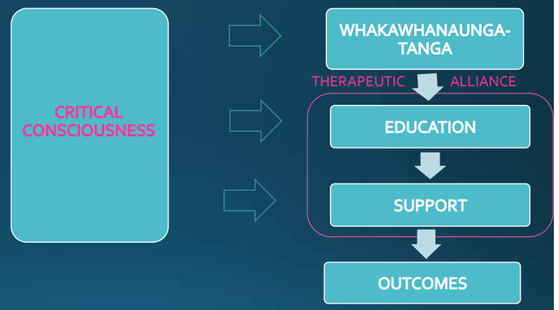
1. Critical consciousness
2. Whakawhanaungatanga
3. Education
4. Support
5. Outcomes



SOLUTIONS

CRITICAL CONSCIOUSNESS (attitude/orientation)

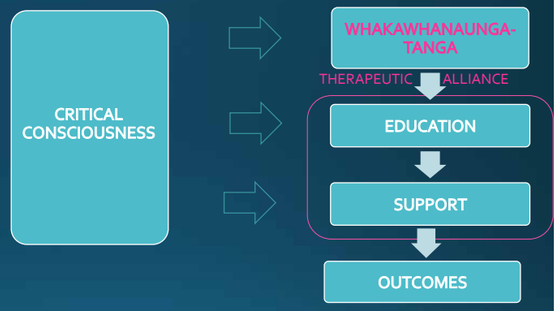
1. Understand role of **COLONISATION** in Māori health inequities
   - Hegemony, blind privilege, racism
2. Understand the **MISMATCH** in ideologies and assumptions underlying mainstream health structures and practices
3. Understand the role of health professionals to challenge **RIGID** health structures and practices to advance health equity



SOLUTIONS

WHAKAWHANAUNGATANGA

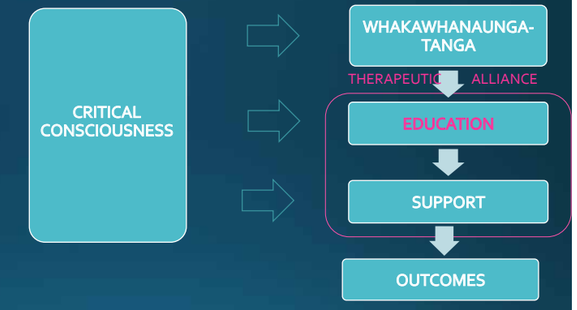
- Critical consciousness
- Establish TRUST
  - Normalise Māori ways to form a connection
    - Whakawhanaungatanga - Person/whanau-focussed (vs disease focussed)
    - Māori healthcare workers
- Individual/whanau generated goals to align with clinical goals
- Time
- Flexibility



SOLUTIONS

EDUCATION

- Critical consciousness
- Within therapeutic alliance based on trust
- Teach-back method tailored to needs



SOLUTIONS

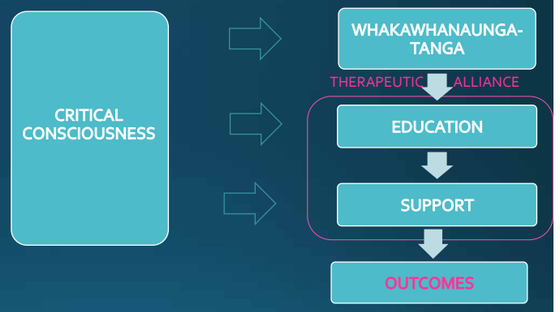
SUPPORT (to self manage)

- Critical consciousness (context, priorities, assumptions)
- Tailor management plan
  - Medications
    - Cost, technique
  - Lifestyle change
  - Action plan
  - Clinic attendance
- Time
- Flexibility

SOLUTIONS

OUTCOMES

- Align personal/financial/ whanau/ spiritual goals with clinical goals



PILOT STUDY

PILOT STUDY

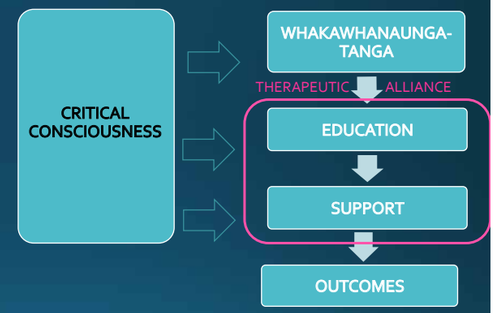
- RESEARCH QUESTION AND PRIMARY OUTCOMES

- Can a novel approach to chronic airways disease management for Māori improve
  - **Engagement** in a **culturally safe** manner
  - Improve **knowledge** about chronic airways disease and self management
  - **Sense of control** over chronic airways disease

METHODS

- 6 weeks

- Study team:
  - SH
  - WF



FINDINGS

- 10 PARTICIPANTS
  - Age range 50 – 73
  - Socioeconomic deprivation
  - All had missed at least one respiratory outpatient clinic appointment (5 years)

FINDINGS

- PRIMARY OUTCOMES
  - **ENGAGEMENT**
    - Completion rate 100%
  - **CULTURAL SAFETY, PATIENT REPORTED EXPERIENCE**
    - 99.6%
    - "YES DEFINITELY"
      - Respected, valued, understood, listened to, comfortable to ask questions, understandable
  - **KNOWLEDGE**
    - Statistically significant improvement in knowledge
      - Immediately post session
      - At completion of study (although lower than immediately post session)
  - **SENSE OF CONTROL OVER DISEASE**
    - Statistically significant improvement

FINDINGS

- SECONDARY OUTCOMES
  - CLINIC ATTENDANCE
    - Respiratory clinic with SH
      - **4 participants 100%, 1 participant 66% attendance rate**
    - Non-respiratory clinic
      - 3 participants 100%, 2 participants 0%, 1 participant 30%

Reflections

- Whakawhanaungatanga
  - Develop trust (patients feel valued, understood, known)
  - Impact on research team
    - Empathy ++
    - "Extra mile"
    - Greater understanding of context and ability to tailor management plan
- Education
  - Simple strategies still too complicated
  - Time, reinforcement
  - Role for peer educators
- Need the whole package
- Outreach services essential

Reflections

Get it right for Māori , get it right for everyone

SUMMARY

- MISMATCH
- SOLUTIONS
  1. CRITICAL CONSCIOUSNESS
  2. WHAKAWHANAUNGATANGA AND THERAPEUTIC ALLIANCE
  3. EDUCATION
  4. SUPPORT
  5. ALIGN GOALS

ACKNOWLEDGEMENTS

- **Participants and whanau**

- Research team
  - Professor John Kolbe - The University of Auckland, Auckland District Health Board
  - Dr Matire Harwood - Te Kupenga Hauora Maori, The University of Auckland, Auckland District
  - Wendy Fergusson - Auckland District Health Board
  - Health Board
  - Dr Chris Lewis - Auckland District Health Board
- Funding
  - Auckland District Health Board - Respiratory Services – Research Fellowship
  - Health Research Council of New Zealand, Asthma and Respiratory Foundation - Clinical Research Training Fellowship
  - Asser Trust - Grant to undertake qualitative research

Royal New Zealand College of General Practitioners: Dr Rawiri Keenan

Dr Rawiri Keenan

Biography:

E ngā mana, e ngā reo tēna koutou
He uri o Te Atiawa rāua ko Taranaki iwi
Ko Rāwiri Keenan tōku ingoa

Based in the Waikato/Hamilton Dr Keenan is a GP who has worked in rural and urban settings. In addition to his clinical work, he has worked for Pinnacle Midlands PHO (2010-2016) and most recently for the Royal New Zealand College of General Practitioners (2014-2019).

Last year Dr Keenan was awarded a Health Research Council Foxley fellowship. For this he is looking at equity-focused activities in GP training and practice accreditation. While based at the University of Waikato, it is very much a piece of work informed by the college and its Māori strategy.

Presentation summary:

Dr Keenan presented on Te Whare Tohu Rata/ RNZCGP, the college's Māori strategy (https://rnzcgp.org.nz/RNZCGP/Advocacy/M%C4%81ori_health_strategy.aspx) which it has had for many years.

Dr Keenan said that at times it could seem like a lot of words and no actions but outlined that the document had been much like the Minister of Health's letter of intent. It could and had been used to keep board and others honest to the intent of the strategy.

When there were ideas to move forward, the Māori health and cultural safety agenda were often challenged, but the board and college had agreed to the strategy, which helped keep focus.

That strategy had been the key tool to allow access to data for completing the Foxley fellowship Dr Keenan has been awarded (http://www.hrc.govt.nz/funding-opportunities/recipients/dr-rawiri-keenan). Dr Keenan outlined that there were still many struggles in implementing of cultural competence/safety training in private business model of general practice in an already stretched primary care system.

Foxley Fellowship

- University of Waikato
- RNZCGP

General Practice Education Programme (GPEP)

- Audits of Medical Practice
- Community Activities

Aiming for excellence

- Cultural Competence and Treaty of Waitangi Training
- Māori Health Plans

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

General Practice Education Programme (GPEP)

Audit of medical practice

- 'a **<u>systematic, critical analysis</u>** of the quality of the doctor's own practice that is used to **<u>improve clinical care and/or health outcomes</u>** or to confirm that current management is **<u>consistent</u>** with the current available **<u>evidence or accepted consensus guidelines</u>**' (MCNZ)

- The GP will demonstrate the ability to use practice ethnicity data to identify and, where appropriate, address potential inequalities between Māori and non-Māori (RNZCGP Curriculum)

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Ihu Waka Ihu Whenua Ihu Tangata

Not rest on past wins – so much more we need to do

Not take for granted hard work of mainly Māori doctors in pushing the agenda

Still other areas i.e. CME, staff

Still a lot of fear? Obstruction? Ignorance?

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

Resistance to audit is not just in medicine

- "He wasn't happy about me running the audit in the first place. Told me it indicated a lack of self confidence."
- "Bullshit," Reacher said. "We did stuff like that all the time."
- "Audits build self-confidence," Neagley said. "That was our experience. Better to know something for sure than just hope for the best."

The Royal New Zealand College of General Practitioners
Te Whare Tohu Rata o Aotearoa

General Practice Education Programme (GP EP)

Community based activities

- 5 per 6 month attachment
- Community based vs community engaged

Opportunity for widening scope/vision of health

- Guidance for teachers
- Guidance for registrars

Aiming for excellence

Foundation & Cornerstone

- Practice accreditation
- Cost held primarily by small business owners
- Little differentiation in workload by 1 vs 10 Dr practice
- Recently enforced to receive capitation and be a teaching practice

Aiming for excellence

- Māori Health Responsiveness
  - Māori Health Plan
  - Treaty of Waitangi Training for all staff
- Cultural Diversity
  - Cultural Competence Training for all staff
  - But who is assessing and what are they assessing against

Struggles

- Resistance
  - Streched health system
  - Challenging the status quo
  - Fear of unknown
  - Fear of spotlight/ critque – the black box that is a consult
- Workforce and capacity to deliver training
  - Snakes and Ladders
  - 50:50 NZ vs IMG in GPEP
  - Funding ? many GP's but not much HWNZ$, compulsory training is self funded
- Workfocre and capacity of assessment
  - Māori assessors and GP teachers
  - Safe learning enviroments

Closing comments / Whakamutunga

John Whaanga

John Whaanga

Biography:

John is affiliated to Ngāti Rākaipaaka, Ngāti Kahungunu and Ngāti Rongomaiwahine. In 2018, John was acknowledged in parliament for his work in successfully negotiating a $100 million Treaty of Waitangi settlement for Ngā Iwi me Ngā Hapū o Te Rohe o Te Wairoa – this was the culmination of over 30 years' work.

John began his career in the Department of Conservation in 1989 (working on Treaty of Waitangi policy and negotiations), before moving on to the Ministry of Education (Māori Education Group) in 1991.

John originally joined the Ministry of Health in 1993, as a foundation member of the then newly-established Māori Health Directorate, Te Kete Hauora. He then spent six years working in the Ministry, culminating in management roles in both public health and Māori health (as Manager, Te Kete Hauora).

In the last six years, John has undertaken a number of significant roles in tertiary education, including as: Chief Advisor Wānanga, Tertiary Education Commission; Deputy Chief Executive, Te Wānanga o Aotearoa; and Chief Operating Officer, Taratahi Institute of Agriculture.

Closing comments:

John Whaanga provided summary comments drawing on presentations made during the day. He shared the words of Maya Angelou when reflecting on the theme of courage: *"Courage is the most important of all virtues, because without courage you can't practise any other virtue consistently."*

John also reflected on the need to progress from cultural competency to cultural safety, noting Irihāpeti Ramsden's view that treating people with dignity and respect was a fundamental that all involved in health should live by.

He also noted that reducing Māori health inequities was best undertaken directly, not indirectly.

Finally, John said it was important to continue our journey to address Māori health aspirations and needs, recalling the words of Sir James Henare: *"Kua tawhiti kē tō hāerenga mai kia kore e hāere tonu. He nui rawa ōu nei mahi kia kore e mahi tonu."* (We've come to too far not to go further. We've done too much not to do more.)