

Journal of Research in Nursing

<http://jrn.sagepub.com>

Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand

Ruth DeSouza

Journal of Research in Nursing 2008; 13; 125

DOI: 10.1177/1744987108088637

The online version of this article can be found at:
<http://jrn.sagepub.com/cgi/content/abstract/13/2/125>

Published by:

 SAGE Publications

<http://www.sagepublications.com>

Additional services and information for *Journal of Research in Nursing* can be found at:

Email Alerts: <http://jrn.sagepub.com/cgi/alerts>

Subscriptions: <http://jrn.sagepub.com/subscriptions>

Reprints: <http://www.sagepub.com/journalsReprints.nav>

Permissions: <http://www.sagepub.com/journalsPermissions.nav>

Citations (this article cites 9 articles hosted on the
SAGE Journals Online and HighWire Press platforms):
<http://jrn.sagepub.com/cgi/content/refs/13/2/125>

Wellness for all: the possibilities of cultural safety and cultural competence in New Zealand



**Journal of Research
in Nursing**
©2008
SAGE PUBLICATIONS
Los Angeles, London,
New Delhi and Singapore
VOL 13 (2) 125–135
DOI: 10.1177/
1744987108088637

Ruth DeSouza

Centre Co-ordinator/Senior Research Fellow

Centre for Asian and Migrant Health Research, National Institute for Public Health and Mental Health Research, AUT University, Auckland, New Zealand

Abstract Responses to cultural diversity in nursing need to consider the theory and practice developments of the profession, whilst also responding to broader social and historical process that prevent marginalised groups from utilising universal health services. A combination of approaches is suggested in this paper to meet these two imperatives. Cultural safety is one indigenous New Zealand nursing approach derived in response to inequalities for Maori, whereas cultural competence is an imported paradigm derived from a multicultural context. Furthermore, research and dialogue are required to examine points of complementarity and tension. This paper offers a beginning for this process.

Key words cultural diversity; New Zealand; cultural safety; cultural competence

Introduction

Indigenous Maori of New Zealand have a proverb “Taua raurau, Taku raurau, ka Ora te Iwi” which translates as ‘with your food and my food we will feed the people’. The development of innovative and institutional responses to cultural diversity in New Zealand hold much promise not only for local nursing theory and practice development, but also for interdisciplinary and international consideration. In this paper, I argue that a triangulation of approaches is required that addresses not only the theory and practice demands of the nursing profession but also the social and ethical imperatives that can rectify the unfair burden of health inequalities disproportionately affecting Maori and other ethnic groups.

Focussing on New Zealand and an indigenous response to diversity called cultural safety, I suggest that this political, structural and social approach, which values and

privileges the indigenous people of the land through a commitment to the Treaty of Waitangi is needed. However, international cultural competence paradigms can provide operational guidance for nurses and organisations in practice settings in a way that assists with the implementation of cultural safety rather than neutralises it. The article begins with a brief overview of the changing demographics of New Zealand, followed by a discussion of the unique status of Maori in New Zealand and their over-representation in negative health statistics which is thought to be directly related to colonisation. An overview of health issues for Pacific peoples and Asian communities is provided to contextualise the need for the implementation of responsive approaches to advance health for communities who experience barriers to accessing health services. Cultural safety is then outlined as an approach to rectify workforce issues that contribute to health disparities for Maori, with an in-depth discussion of Nursing Council of New Zealand principles that comprise cultural safety. The place of the Treaty of Waitangi in health is then discussed with a focus on partnership, protection and participation, and lastly the movement away from deficit models to a focus on health gain and development is promoted. It is suggested that both cultural safety and competence could be utilised to enhance access and responsiveness to marginalised communities.

Demographics

New Zealand, traditionally a bicultural country, is becoming increasingly diverse in terms of ethnicity, religion and language, which has implications for its responsibilities to its indigenous population and its relationships with newer migrant and refugee communities. The 2001 Census noted that 67.6% of the population of people in New Zealand were European New Zealanders, 14.6% Maori, 6.9% Pacific peoples, 9.2% Asians, 0.9% Middle Eastern, Latin American and African people and 11.1% of people called themselves 'New Zealanders' (Statistics New Zealand, 2006). Of these groups of people, Asians are the fastest growing category, increasing by around 140% over the last 10 years. Their numbers are predicted to increase by 122% by 2021, whereas Pakeha^a will increase by 1%, Maori 28% and Pacific people 58% (Statistics New Zealand, 2006).

Maori health

Maori are the indigenous people of Aotearoa/New Zealand whose relationship with Pakeha is defined in Te Tiriti o Waitangi/The Treaty of Waitangi, a document signed in 1840 by the British Crown and Maori Chiefs. The Maori translation of Te Tiriti o Waitangi is acknowledged as the founding document of Aotearoa/New Zealand and forms the basis for biculturalism, which Sullivan (1994) defined as equal partnership between two groups, where Maori are acknowledged as tangata whenua^b. The principles of the Treaty of Waitangi are enshrined in health through the New Zealand Public Health and Disability Act 2000, and the duties and obligations of the Crown and its agents are to ensure that they:

- develop partnerships with Maori;
- both recognise and provide for Maori interests;

^a Maori word for person of European ancestry.

^b People of the land.

- are responsive to the needs of Maori;
- ensure equal opportunities for Maori including recognition and active support of kaupapa initiatives (Nursing Council of New Zealand, 2005; New Zealand Psychologists Board, 2006).

Despite their unique status in Aotearoa/New Zealand, Maori are over-represented in negative health care statistics and experience significant health disparities (Ajwani, et al., 2003). Like other ethnic groups, they experience barriers to access and inclusion, but importantly also face threats to their sovereignty and self-determination. Issues such as legal ownership of resources, specific property rights and fiscal compensation are also fundamental to Maori well-being. Reducing inequalities in health status for Maori is a prominent goal in the New Zealand Health Strategy, and accessible and appropriate services are a key objective (Ministry of Health, 2000a). He Korowai Oranga—Māori Health Strategy (Ministry of Health, 2002) has as one of its aspirations to ensure accessible and appropriate services for Maori. Access barriers for Maori include: cost, availability of quality care, culturally appropriate services, travel, referral patterns for major operations, the organisation of outpatient services and the assumptions of health professionals about the behaviour of Maori. The strategy recommends that both mainstream services are improved and Maori services developed. Maori providers play a pivotal part in improving access, and the effectiveness and appropriateness, of health and disability services, especially those that practise Maori views of health and healing (Ministry of Health, 2002).

Health disparities between Maori and non-Maori are thought to be strongly linked with health professional behaviour (McCreanor and Nairn, 2002; Bacal, et al., 2006). Research suggests that there are differences in access 'to' health care and 'through' health care for Maori (Ellison-Loschmann and Pearce, 2006). Maori become sicker for longer periods and have shorter lives (Bacal, et al., 2006). Maori are likely to experience fewer referrals and diagnostic tests than non-Maori. In primary care, Maori are seen for a shorter time, offered less treatment and prescribed fewer secondary services, such as physiotherapy. Compounding poor health outcomes are a paucity of Maori health professionals. Only 2.3% of medical practitioners are Maori (when Maori make up 14.6% of the population) meaning that Maori are more likely to be seen by non-Maori health professionals. However, initiatives are underway to improve Maori health workforce recruitment and retention through Maori leadership, mentorship, peer support and comprehensive support within study programmes and between the interfaces of school, study and work (Ratima, et al., 2007).

The health of Pacific peoples

Pacific peoples represent over 20 different cultures and comprise 6% of the New Zealand population. Compared to the total New Zealand population, Pacific peoples have poorer health status, are more exposed to risk factors for poor health and experience barriers to accessing health services (Ministry of Health and Ministry of Pacific Island Affairs, 2004). Pacific peoples in New Zealand have a life expectancy at birth of approximately 62.5 years, about 4 years less than the national average (Ministry of Health and Ministry of Pacific Island Affairs, 2004). In addition, Pacific peoples are the least likely of any ethnic group to access primary care; their rates of avoidable deaths and hospitalisations and ambulatory-sensitive hospitalisations are higher than non-Pacific populations (Ministry of Health, 2004). There is a need to improve access

for Pacific peoples to specialist services, such as acute and elective services (Ministry of Health, 2000b). Thus, better access to more effective primary health care, relevant disability services and specialist services are important interventions.

Innovative health models that promote holism and continuity have been developed to address Pacific health concerns (Crawley, *et al.*, 1995; Puluotu-Endeman, 1997; Tamasese, *et al.*, 1997). Two key mechanisms have been advanced to improve social and economic outcomes for Pacific peoples. These are to improve 'the responsiveness and accountability of public sector agencies to Pacific health needs and priorities, and to build the capacity of Pacific peoples, through provider, workforce and professional development, to deliver health and disability services and to develop their own solutions to health issues' (Mental Health Commission, 2001, p. 15). In addition to increasing the responsiveness of mainstream services, 'for Pacific by Pacific' services are advocated to strengthen Pacific provider infrastructures and increase capacity and capability. Such amendments will provide Pacific peoples with both incentive and opportunity to access high-quality and culturally competent health care and disability support services (Ministry of Health, 2000b).

The health of Asian peoples

Within the category Asian in New Zealand, Chinese people are the largest ethnic group, making up 2.2% of the total New Zealand population, followed by Indian people who are the second largest at 1.2% (Statistics New Zealand, 2002). Research on barriers to access to services has identified communication difficulties and knowledge gaps (DeSouza and Garrett, 2005). Earlier research identified language and a variety of cultural barriers to accessing health services (Abbott, *et al.*, 2000; Abbott, *et al.*, 2003). Evidence is growing that Asians under-utilise health services (Scragg and Maitra, 2005):

- Asians are less likely than other New Zealanders, Maori and Pacific peoples to have visited a health practitioner (or service) when they are first unwell;
- Asians are less likely than Europeans to visit a health practitioner (general practitioner, specialist, nurse or complementary healer) about a chronic disease;
- Asian women are less likely than other New Zealand women to have had a mammogram or cervical screening test in the last 3 years;
- Asians are less likely than all New Zealanders to use any type of telephone helpline in the previous 12 months.

Cultural safety

Cultural safety has been an indigenous nursing response to the poor recruitment and retention of Maori nurses (Nursing Council of New Zealand, 2002). The concept was introduced into nursing and midwifery curricula by the Nursing Council of New Zealand in 1992, and it has led to an expectation that nurses practise cultural safety. The focus is on health professional behaviours and institutional responses rather than consumers, and there is an emphasis on the recipient of care describing whether services rendered are safe or unsafe. Put simply, 'unsafe practitioners diminish, demean and disempower those of other cultures, whilst safe practitioners recognize, respect and acknowledge the rights of others' (Cooney, 1994, p. 6).

Nursing Council of New Zealand's (2005, p. 4) definition of cultural safety is:

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.

Cultural safety has been broadened to apply to any person or group of people who may differ from the nurse/midwife because of socioeconomic status, age, gender, sexual orientation, ethnic origin, migrant/refugee status, religious belief or disability (Ramsden, 1997), but the focus remains primarily on ethnicity (Nursing Council of New Zealand, 2005). In New Zealand, the cultural safety model has been integral to nurse education for over 10 years.

Cultural safety goes beyond describing the practices of other ethnic groups, because such a strategy can lead to a checklist mentality that essentialises group members (Nursing Council of New Zealand, 2002). Furthermore, a nurse having knowledge of a client's culture could be disempowering for a client who is disenfranchised from their own culture, and could be seen as the continuation of a colonising process that is both demeaning and disempowering (Ramsden, 2002) or appropriating (Allen, 1999). Culturally safe nurses focus on self-understanding and the emphasis is on what attitudes and values nurses bring to their practice. A key tenet is that 'a nurse or midwife who can understand his or her own culture and the theory of power relations can be culturally safe in any context' (Nursing Council of New Zealand, 2002, p. 8). Ramsden (2002) describes a progression towards culturally safe practice in three steps as follows:

1. cultural awareness, which involves understanding that there is difference;
2. cultural sensitivity, where difference is legitimated and leads to self-exploration;
3. cultural safety is the outcome of nursing and midwifery education, where safe service is defined by recipients of care.

Principles of cultural safety

Four main principles are central to cultural safety. Principle one focuses on improving the health status of New Zealanders and emphasises health gains and positive health outcomes. In addition, it requires that nurses acknowledge the beliefs and practices of those who differ from them through age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief and disability (Nursing Council of New Zealand, 2005). Principle two focuses on a culturally safe nursing workforce by emphasising the significance of power relationships and the need for nurses to undertake a careful process of institutional and personal analysis of power relationships. It also involves empowering the users of the service and ensuring that nurses recognise their own diversity and how this might impact on any person who differs in any way from themselves. Lastly, this principle emphasises moving beyond tasks to being relationship focussed and

responsive to the diverse needs of service users in such a way that it is defined as being safe by the recipient of care.

Principle three requires a broad application of cultural safety to encompass recognising inequalities within health care interactions that are reflective of historical and social inequalities in health. It also asks that cause and effect relationships of history, political, social and employment status, housing, education, gender and personal experience upon people who use nursing services are addressed. It insists that the legitimacy of difference and diversity in human behaviour and social structure is accepted, together with accepting that the attitudes and beliefs, policies and practices of health and disability service providers can act as barriers to service access. Lastly, this principle includes quality improvement in service delivery and consumer rights.

Finally, principle four states that cultural safety has a close focus on the nurse as a bearer of his/her own culture, history, attitudes and life experiences and the response other people make to these factors. It challenges nurses to examine their practice carefully; recognising that the power relationship in nursing is biased toward service providers and that there is a need to balance power relationships in practice so consumers receive an effective service.

Cultural safety also includes an emphasis on preparing nurses to resolve any tension between the cultures of nursing and the people using services so as to provide equitable, effective, efficient and acceptable service delivery, which minimises risk to people. Lastly, self understanding as well as the rights of others and legitimacy of difference should provide the nurse with the skills to work with all people who are different from them.

The Treaty of Waitangi/Te Tiriti o Waitangi and Maori health

In understanding the place of cultural safety in nursing education and practice, it is important to consider the relationship between the Treaty of Waitangi/Te Tiriti o Waitangi, Maori health and cultural safety in New Zealand (Nursing Council of New Zealand, 2005). The principles of the Treaty encapsulate notions of partnership, protection and participation (Royal Commission on Social Policy, 1988).

- Maori self-determination and the right to development, autonomy and authority.
- Partnership and the notion of health as a taonga (treasure) that must be protected through ensuring that services are appropriate and acceptable.
- Beliefs and practices are acknowledged and diversity within Maori is noted.
- The rights of Maori to equitable access and participation are prominent leading to equality of outcomes.

Nurses should be active Treaty partners who are able to critically analyse the treaty and apply its principles. In terms of Maori health, there is a turning away from the dominant discourses of deficit and the individualising of health concerns, to the advancement of the notion that poor health for Maori is a result of the processes of colonisation and the loss of cultural beliefs, practices and language (Nursing Council of New Zealand, 2005; Swindells, 2006) In alignment with policy agendas where there is a desire to achieve balance between 'realising potential' and 'remedying deficit' (Swindells, 2006), Maori health gain and development is prioritised, and there is a focus on reducing and eliminating health inequalities that affect Maori. Nursing has

a social mandate to improve access for Maori in all aspects, to be responsive and to ensure the Treaty forms the basis of practice. Essentially, the Treaty has a unique place in nursing practice in New Zealand and is fundamental to improving Maori health.

Concerns about cultural safety

Cultural safety has been a highly political development in New Zealand, and it experienced a trial by media, where Pakeha have been constructed as disadvantaged victims of political correctness (Wepa, 2001). There is concern that despite being a compulsory component of nursing and midwifery education, little research-based evidence is available to demonstrate an improvement in cultural appropriateness and responsiveness of New Zealand health care services or the improvement in the health and care of Maori (Johnstone and Kanitsaki, 2007). Johnstone and Kanitsaki (2007) add that they remain concerned about the seemingly narrow focus on biculturalism and the lack of theorising and critique. However, one could argue that if New Zealanders cannot have a relationship with one 'other', how they can have relationships with many 'others' (Butt, 2005).

Cultural competence

The term 'Cultural competence' originates from Transcultural Nursing developed by Madeleine Leininger. Borrowing from anthropology, the aim was to develop a model that encouraged nurses to study and understand cultures other than their own (Leininger, 1995). The significance of cultural competence as a concept in New Zealand has grown with the introduction of the Health Practitioners Competence Assurance Act (2003). Cultural competence can be defined as 'the ability of systems to provide care to patients with diverse values, beliefs and behaviours, including tailoring delivery to meet patients' social, cultural and linguistic needs' (Betancourt, et al., 2002, p. v). In the following section, I propose some operational strategies for increasing responsiveness to diverse groups using a cultural competence framework of clinical competence, organisational cultural competence and systemic cultural competence (Betancourt et al., 2002).

Clinical cultural competence

Clinical cultural competence refers to the relationship between health providers and clients (Betancourt, et al., 2002) and can be enhanced through staff training and workforce development, outreach to marginalised communities and developing standards, measures and indicators. Hiring staff that reflect the community that they serve can enhance access to services; however, ensuring that staff receive education and training in culturally appropriate service delivery at all levels (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000) within mainstream services is also necessary. Some organisations, such as the Accident Compensation Corporation (ACC), suggest the need for staff to be familiar with Maori concepts and customs, preferences for care, communication skills, health frameworks, models of health and training (Accident Compensation Corporation, 2004; Accident Compensation Corporation, undated). However, such an approach conflicts with cultural safety, which emphasises self-knowledge. Communication skills are outlined as being fundamental to client satisfaction with care and acceptability of treatment and establishing effective face-to-face relationships.

Developing bilingual outreach workers whose role is specifically education and training within the respective community, can enhance access to services and improve participation in treatment decisions. Developing standards, measures or indicators can increase accountability to stakeholders through reporting back against key indicators. It is also important to develop responsiveness strategies for emerging communities, through undertaking baseline reviews or self-assessments of diversity activities and integrating appropriate measures into internal audits, performance improvement programmes, patient satisfaction assessments and evaluations. Such an undertaking would result in identifying opportunities for improvement and the development of areas for further action, programmes and activities. Consumer and community surveys could also be developed that are culturally appropriate and other methods of obtaining input can also assist in quality improvement activities.

Organisational cultural competence

Organisational cultural competence involves strategies that maximise diversity and incorporate leadership and workforce issues. Specifically, ethnic matching and working with communities. The lack of diversity in health care leadership and the workforce has been identified as a barrier to culturally competent care, and studies have shown that health care quality and racial and ethnic diversity are linked (Betancourt, *et al.*, 2002). In addition, there is an increasing call for people to receive services from people who are 'in tune' or match culturally and who reflect the client group they serve. Importantly, organisations should put in place strategies to recruit, retain and promote diverse staff at all levels (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). However, without structural change and critical reflection on how structures work to serve dominant groups this strategy could be a token nod to diversity without enhancing cultural competence at all.

Collaborative and participatory partnerships have been identified as a mechanism for facilitating community involvement that takes into account community interests, aspirations and needs. This could take the form of both formal and informal processes (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000), integrating services into community centres to make them more accessible and visible. Creating opportunities for governance roles to enhance participation and provide strategic advice on issues related to Maori, Pacific or Asian communities. Other consulting strategies could be community advisory meetings, ad hoc community meetings, focus groups and informal conversations. Involvement and input could also be into policy, marketing, evaluation and communication strategies (United States Department of Health and Human Services' (HHS) Office of Minority Health (OMH), 2000). Partnerships could also be developed for assertive outreach and developing communication strategies with communities.

Systemic cultural competence

At the system level, the structures of the health care system are attended to and include strategies, such as ethnicity data collection and strategic planning. Ethnicity data collection can assist in the planning of improvements to services by comparing access to services and outcomes of care. Furthermore, ethnicity data collection provides a mechanism for monitoring the demographics of clients, which in turn can reflect staff recruitment strategies, which then reflect the demographics of the community

being served. The cornerstone of ethnicity data collection as a means of ensuring that health outcomes are improved and health disparities reduced is reinforced in the New Zealand Health Strategy (Ministry of Health, 2000a), where information management and technology are viewed as pivotal to the wellbeing of communities. Improving the quality of information assists health outcomes by providing timely and relevant clinical information as well as providing communities with better access to information about their health or health care services, which can contribute to decision-making regarding local health services. To this end, a standardised national approach to ethnicity data collection has been developed to assist this (Ministry of Health, 2003).

Strategic planning provides a mechanism for defining the activities, policy and goals that are relevant, as well as to identify, monitor, and evaluate system features that may warrant implementing new policies or programs consistent with the overall mission. In New Zealand District Health Boards (DHBs) are responsible for ensuring the provision of publicly funded health and disability support services for the population of a specific geographic area. The election process for DHBs ensures that community voices are present in decision-making. Appointments to boards ensure that Maori membership is proportional to the number of Maori in the DHB's resident population and that gender and ethnic mixes are considered. Each DHB also has three statutory advisory committees made up of members of the public and DHB board members. Consultation with each DHB's population is required when District Strategic Plans are written (Ministry of Health, 2006).

Linguistic competence

Neither cultural safety nor cultural competence incorporate linguistic competence. English language proficiency is key to accessing services for English as additional language speakers (DeSouza and Garrett, 2005). Linguistic competence could be achieved by providing bilingual/bicultural staff; foreign language interpreting services; having link workers/advocates; materials developed and tested for specific cultural, ethnic, and linguistic groups; translation services including those of: (a) legally binding documents (for example, consent forms), (b) hospital signage, (c) health education materials, (d) public awareness materials and campaigns; and ethnic media in languages other than English, for example, television, radio, internet, newspapers and periodicals (Szczepura, 2005).

Conclusions

There are areas where cultural safety and cultural competence are philosophically in tension with each other. For example, cultural competence emphasises learning about the culture of the patient, whereas cultural safety emphasises the importance of recognition of oneself as a culture and power bearer. Cultural safety has developed in a context of political and media critique, whereas cultural competence is a more neutral and less political mechanism for addressing the needs of diverse groups in New Zealand. Cultural competence does not seek societal transformation as cultural safety does through an insistence on the repositioning of institutions and the need to address the power inequalities that structure society. Further discussion, negotiation and research are required to explore the relevance and application of each approach. Returning to the proverb that this article began with, our baskets will become fuller and our people fed when we take advantage of the options available to us and in this case both

paradigms have value in providing practical and theoretical mechanisms for enhancing and advancing the well-being of communities in Aotearoa.

Key points

- Innovative and institutional responses to cultural diversity in New Zealand hold promise for local nursing theory and practice development as well as interdisciplinary and international consideration.
- A political, structural and social approach such as cultural safety which values and privileges the indigenous people of the land through a commitment to the Treaty of Waitangi is fundamental.
- International cultural competence paradigms can provide operational guidance for nurses and organisations in practice settings that can complement the implementation of cultural safety.

References

- Abbott, MW, Wong, S, Giles, LC, Wong, S, Young, W, Au, M. (2003) Depression in older Chinese migrants to Auckland. *Aust. N. Z. J. Psychiatry* **37**: 445–451.
- Abbott, MW, Wong, S, Williams, M, Au, MK, Young, W. (2000) Recent Chinese migrants' health, adjustment to life in New Zealand and primary health care utilization. *Disabil. Rehabil.* **22**: 43–57.
- Accident Compensation Corporation. (2004) Summary Guidelines on Maori Cultural Competencies for Providers. Wellington: Accident Compensation Corporation.
- Accident Compensation Corporation (undated) Service Delivery for Maori. Wellington: Accident Compensation Corporation.
- Ajwani, S, Blakely, T, Robson, B, Tobias, M, Bonne, M. (2003) Decades of Disparity Ethnic Mortality Trends in New Zealand 1980–1999. Wellington: Ministry of Health.
- Allen, DG. (1999) Knowledge, politics, culture and gender: a discourse perspective. *Can. J. Nurs. Res.* **30**: 227–234.
- Bacal, K, Jansen, P, Smith, K. (2006) Developing cultural competency in accordance with the Health Practitioners Competence Assurance Act. *N. Z. Fam. Physician* **33**: 305–309.
- Betancourt, JR, Alexander, R, Green, Carrillo JE (2002) Cultural Competence in Health Care: Emerging Frameworks and Practical Approaches. New York: The Commonwealth Fund.
- Butt, D, Green, Carrillo JE (2002) "Biculturalism as Multiculturalism (in monocultural New Zealand)" Presentation to "Biculturalism or Multiculturalism?" conference, University of Canterbury, 2 September 2005. Available <http://www.dannybutt.net/acp/2005/09/04/biculturalism-as-multiculturalism/>
- Cooney, C. (1994) A comparative analysis of transcultural nursing and cultural safety. *Nurs. Pract. N. Z.* **9**: 6–12.
- Crawley, L, Pulotu-Endemann, FK, Stanley-Findlay, RTU. New Zealand Ministry of Health (1995) Strategic Directions for the Mental Health Services for Pacific Islands People. Wellington, New Zealand: Ministry of Health.
- Desouza, R, Garrett, N. (2005) Access Issues for Chinese people in New Zealand. Auckland: Auckland University of Technology and Accident Compensation Corporation.
- Ellison-Loschmann, L, Pearce, N. (2006) Improving access to health care among New Zealand's Maori Population. *Am. J. Public Health* **96**: 612–617.
- Johnstone, MJ, Kanitsaki, O. (2007) An exploration of the notion and nature of the construct of cultural safety and its applicability to the Australian health care context. *J. Transcult. Nurs.* **18**: 247–256.
- Leininger, M. (1995) *Transcultural Nursing: Concepts, Theories, Research & Practice*. New York, London: McGraw-Hill.
- McCreanor, T, Nairn, R. (2002) Tauwiwi general practitioners' talk about Maori health: interpretative repertoires. *N. Z. Med. J.* **115**
- Mental Health Commission. (2001) Pacific Mental Health Services and Workforce: Moving on the Blueprint. Wellington: Mental Health Commission.
- Ministry of Health. (2000) The New Zealand Health Strategy. Wellington: Ministry of Health.
- Ministry of Health. (2000b) The Pacific Health and Disability Action Plan. Wellington: Ministry of Health.
- Ministry of Health. (2002) Te Puawaitanga: Māori Mental Health National Strategic Framework. Wellington: Ministry of Health.
- Ministry of Health. (2003) Health and Disability Sector Ethnicity Data Protocols. Wellington: Ministry of Health.
- Ministry of Health. (2004) Tupu Ola Moui: The Pacific Health Chart Book 2004. Wellington: Ministry of Health.
- Ministry of Health. (2006) Frequently Asked Questions About District Health Boards. Wellington: Ministry of Health.
- Ministry of Health/Ministry of Pacific Island Affairs. (2004) Tupu Ola Moui: The Pacific Health Chart Book 2004. Wellington: Ministry of Health.
- New Zealand Psychologists Board. (2006) Cultural Competencies for Psychologists Registered Under the

DeSouza *Wellness for all: The possibilities of cultural safety and cultural competence in New Zealand*

- Health Practitioners Competence Assurance Act (2003) and Those Seeking to Become Registered. Wellington: New Zealand Psychologists Board.
- Nursing Council of New Zealand. (2002) Guidelines for cultural safety, the Treaty of Waitangi and Maori Health in Nursing and Midwifery Education and Practice. Wellington: Nursing Council of New Zealand.
- Nursing Council of New Zealand. (2005) Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice. Wellington: Nursing Council of New Zealand.
- Ramsden, I. (2002) Cultural safety: implementing the concept—the social force of nursing and midwifery. In: Whaiti, PT, McCarthy, M, Durie, A. (eds), *Mai i rangiatea*. Auckland, New Zealand: Auckland University Press and Bridget Williams Books.
- Ramsden, I. (2002) Cultural safety and nursing education in Aotearoa and Te Waipounamu. Unpublished PhD Wellington, Victoria University.
- Ratima, MM, Brown, RM, Garrett, NKG, Wikaire, EI, Ngawati, RM, Aspin, CS, Potaka, UK. (2007) Strengthening Maori participation in the New Zealand health and disability workforce. *Med. J. Aust.* **186**: 541–543.
- Royal Commission on Social Policy. (1988) *Future Directions, Vol. II*. Wellington: Royal Commission on Social Policy.
- Scragg, R, Maitra, A. (2005) *Asian Health in Aotearoa: An Analysis of the 2002–2003 New Zealand Health Survey*. Auckland: The Asian Network Incorporated.
- Statistics New Zealand. (2002) *Census Snapshot: Cultural Diversity*. Wellington: Social and Population Statistics Group of Statistics New Zealand.
- Statistics New Zealand. (2006) *QuickStats National Highlights: Cultural Diversity*. Wellington: Social and Population Statistics Group of Statistics New Zealand.
- Szczepura, A. (2005) Access to health care for ethnic minority populations. *Postgrad Med J* **81**: 141–147.
- Sullivan, K. (1994) Bicultural education in Aotearoa/New Zealand. In: Manson, H. (ed), *New Zealand Annual Review of Education/Te arotake a tau o te ao o te mataurangi i Aotearoa*. Wellington, New Zealand: Victoria University.
- Swindells, C. (2006) *Te Puni Kokiri Presentation: Setting the Scene*. Wellington: National Diversity Forum.
- United States Department of HealthHuman Services' (HHS) Office of Minority Health (OMH). (2000) *Assuring Cultural Competence in Health Care: Recommendations for National Standards and an Outcomes-Focused Research Agenda*. Washington District of Columbia: Office of Minority Health.
- Wepa, D. (2001) *An Exploration of the Experiences of Cultural Safety Educators* School of Social Policy & Social Work. Palmerston North: Massey University.

Ruth DeSouza (Dip. Nurs., Grad. Dip. Adv. Nurs., MA) is a senior research fellow with a passionate interest in issues relating to migrants and refugees and their incorporation and engagement in a bicultural society. She is a researcher and educator with experience drawn from a background in mental health nursing, teaching and counselling. Ruth is actively involved in community activities related to mental health and to migrants. She is the co-ordinator of the Aotearoa Ethnic Network (AEN) and editor of the AEN Journal, a Councillor of the New Zealand Asian Studies Society, board member of the Asia New Zealand Foundation, Deputy Chair of the West Auckland Living Skills Homes Trust Inc. (WALSH Trust), Executive committee member of the Refugee Council of New Zealand and Board member of the Counties Manukau District Health Board.

E-mail: ruth.desouza@aut.ac.nz