

# **Pacific Cultural Competencies Framework**

**District Health Boards**

**Draft 4**

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## 1.0 Introduction

Pacific peoples have been in Aotearoa/New Zealand for more than a century and have contributed significantly to the political, social and cultural fabric of this society.<sup>1</sup> Furthermore, Pacific peoples presently influence and will continue to influence the demographic pattern, sociocultural features and overall health status of Aotearoa/New Zealand in the future as the population increases and ages.<sup>1</sup>

According to Statistics New Zealand, the Pacific population is projected to reach 414,000 in 2021. This is an increase of 152,000 or 58 percent over the estimated resident population of Pacific ethnicity of 262,000 at 30 June 2001. Furthermore, the Pacific share of the total population is projected to rise from 7 percent in 2001 to 9 percent in 2021. In the same period, Pacific peoples will make up 9.2 percent of the New Zealand population by 2021 compared with 6.7 percent in 2001.<sup>2</sup> Subsequently, health professionals can expect to care for clients from Pacific backgrounds during the course of their vocation.

Therefore, existing health service systems need to be adapted to positively acknowledge the beliefs and practices of the diverse Pacific populations in Aotearoa/New Zealand and Pacific communities encouraged and supported to develop more effective and innovative models of healthcare delivery.<sup>1</sup> A fundamental element for providing excellence in planning, development and service delivery to Pacific peoples, is a well trained and skilled workforce. Such a workforce needs to be directed and supported by the development of cultural competencies and best practice guidelines.

It is recognised that cultural competencies are a process not an end point. Thus, with the ongoing development of Pacific cultural competency framework standards there is an equally important need for the health sector to provide ongoing training in cultural competence and cultural awareness. There is also the need to create mechanisms for the evaluation of competence-based practice and organisational competency. For instance, it may be that on an individual level, the non-Pacific health professional needs to be aware of how best to engage appropriate skill or knowledge to ensure Pacific clients receive the best healthcare (i.e. the use of interpreters). Subsequently, on an organisational level, DHBs need to provide this support (i.e. remuneration for interpreters).

## 2.0 Who are we Talking About?

### 2.1 Pacific Peoples

The label 'Pacific Peoples' includes groups with a range of ethnic affiliations and include many people with more than one ethnicity.<sup>3</sup> The term 'Pacific' in this report primarily refers to the New Zealand population with South Pacific ethnic origin from Samoa, Cook Islands, Tonga, Niue, Tokelau, Fiji and Tuvalu.

Migration has provided spaces for a wide array of people to engage in dialogue about what it means to be a Pacific person.<sup>4</sup> Given that Pacific peoples occupy different social locations and encompass a range of backgrounds and experiences there are, unavoidably a range of views about what it is to be a Pacific person.<sup>4</sup> For instance:

*... There is no generic 'Pacific community' but rather Pacific peoples who align themselves variously, and at different times along ethnic,*

*geographic, church, family, school, age/gender, island-born/New Zealand born, occupational lines or a mix of these.*<sup>5</sup>

The term 'New Zealand born' (NZ-born) recognises both Pacific descent and local upbringing and an identity shared with other Pacific young peoples. The social and material experiences of Pacific NZ-born peoples are diverging in terms of the significant differences in the ways they perceive themselves and the equal importance placed upon their Pacific identity.<sup>4</sup>

The term Pacific encompasses diversity that reflects that:

- § each Pacific group has its own language, etiquette and protocols;
- § ethnic specific identities and accountabilities exist within families and ethnic specific communities;
- § there are similar and different historical and political relationships with Aotearoa/New Zealand;
- § there are multiple world views and diverse perceptions of illness, treatment and prevention; and
- § there are diverse belief systems including cultural and religious factors which influence behaviour and attitudes towards well-being.

There are commonalities and these include:

- § belief in Christianity;
- § mythology;
- § communal land ownership;
- § genealogical based identity;
- § extended family accountability; and
- § beliefs that well being and illness are linked to obligations to extended family being met or not being met.

### **3.0 What Are We Talking About?**

A number of terms need to be defined in the context of this framework. The definitions chosen reflect and emphasise the experiences of Pacific peoples in Aotearoa/New Zealand rather than the experiences of Pacific peoples in their own homeland.

#### **3.1 Culture**

There are two distinctions of culture:

| <b>Material Element</b>   | <b>Non-material Element</b>   |
|---|---|
| Such as objects which people create and assign meaning to. <sup>6</sup> | Includes language, beliefs, ideas, rules, customs, myths and skills. <sup>6</sup> |

For the purpose of this framework, there is a focus on the non-material element of culture. Culture influences the ways in which we see, understand and respond to physical and social phenomena.<sup>6,7</sup> In addition:

*...Culture remains as process; not fixed, not predetermined: constructed by individuals, expressive of interplay between individual subjectivities and collective objectivities.<sup>8</sup>*

Culture therefore, is seen as dynamic and fluid in nature. This framework alludes to the lens Pacific peoples use in order to make sense of their social and physical environments and their place in them, particularly with regard to their health needs.<sup>6</sup>

### **3.2 Competency**

Competency is broadly defined as the ability to do something well or effectively.<sup>9</sup> A high degree of competency which constitutes effective performance in a defined role, is marked by knowledge, attitudes and skills.<sup>10</sup> Competency in the health sector is thus the ability to effectively produce knowledge and skill to a required standard in order to produce excellence in quality healthcare with the ability to transfer this knowledge and skills to new and differing contexts.

### **3.3 Cultural Competency**

Cultural competency is defined as the ability of individuals and systems to work or respond effectively across cultures in a way that recognises and respects the culture of the person, family, community or organisation being served.

### **3.4 Organisational Competency**

Organisational competency is the ability of an organisation to effectively deploy and manage its resources in order to produce a desired outcome. The outcome in this case is Pacific cultural competency.

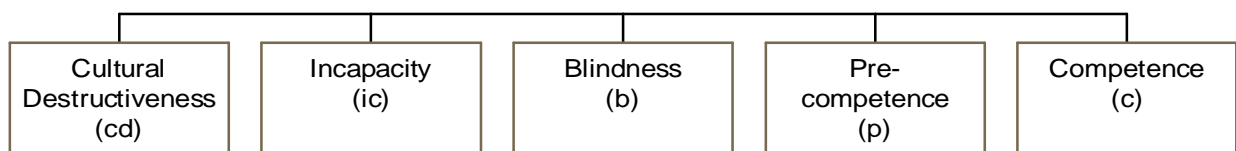
### **3.5 Pacific Cultural Competency**

Pacific cultural competency is the ability to understand and appropriately apply cultural values and practices that underpin Pacific people's worldview and perspectives on health and like, culture is dynamic.

## **4.0 Continuum of Cultural Competence**

It may be appropriate to look at a continuum of cultural competence developed by James Mason.<sup>11</sup> Mason's continuum measures competence of individuals and organisations is based on five progressive steps.

### **Mason's Continuum of Competence (1993)<sup>11</sup>**



- § *Cultural Destructiveness*: The most negative end of the continuum is indicated by attitudes, policies, and practices that are damaging to individuals and their cultures.
- § *Incapacity*: The system or organisation does not intentionally seek to be culturally ruinous or destructive; however, the system may lack the capacity to assist different cultures of individuals and/or communities
- § *Blindness*: At the midpoint of the continuum, the system and its organisations provide services with the expressed intent of being unbiased. They function as if the culture makes no difference and all the people are the same.
- § *Pre-competence*: Individuals and organisations move toward the positive end of the continuum by acknowledging cultural differences and making documented efforts to improve.
- § *Competence*: The most positive end of the continuum is indicated by acceptance and respect of cultural differences, continual expansion of cultural knowledge, continued cultural self-assessment, attention to the dynamics of cultural differences, and adoption of culturally relevant service delivery models to better meet needs.

## 5.0 Why Should DHBs be Culturally Competent?

In reference to the Ministry of Health's National Pacific Cultural Competencies Draft Framework,<sup>12</sup> there are reasons why health professionals and health service providers should be culturally competent. An apt summation of these tenets are as follows:

1. culture and language have a significant impact on influencing the way in which Pacific peoples choose to respond to, and access health services; and
2. knowledge of Pacific language, and culture, irrespective of birthplace, are required in order to work with Pacific peoples accessing health services by respecting their values and beliefs and their families culture, as it is central to their wellbeing.

This document seeks to provide a conduit for supporting, guiding and providing a methodical approach for organisations to develop policies and practices that will assist and fortify Pacific and mainstream health providers in the delivery of culturally safe/appropriate health services to Pacific people. It is envisaged that it will complement and enhance clinical practice.

It is also important to note that as highlighted in the National Pacific Cultural Competencies Draft Framework, the development of a Pacific cultural competencies framework recognises a shared view by Maori and the diverse Pacific populations as to the significance of language and protocols in the wellbeing of its peoples. This current framework is an essential process in the continual dialogue with Tangata Whenua and adds support to the world view/s articulated by Tangata Whenua.

## **5.1 What Outcomes are being Sought?**

Pacific cultural competency outcomes include:

- § the assistance in ensuring effective and responsive healthcare practice and continual relationship building between the health sector and Pacific peoples;
- § guaranteeing that assessment, diagnosis and treatment are efficacious for Pacific peoples;
- § that the collation and analyses of reliable data develops knowledge, strength and risk factor identification, prevention and intervention initiatives and health policy catering to Pacific peoples;
- § acknowledging the diversities of Pacific people's language, beliefs, values and behaviour towards prevention and maintenance of health and wellbeing, diagnosis, treatment and recovery in planning and delivery of services;
- § that the delivery of training programmes assist and fortify Pacific and mainstream health providers;
- § maintaining that a high quality of service delivery for Pacific peoples is accomplished and sustained;
- § enhancing coordination of primary, secondary and support services;
- § the acknowledgement that contemporary and Pacific traditional health practices co-exist;
- § receptiveness to existing and future demographic changes for a rapidly growing and youthful Pacific population;
- § reducing inequalities and health disparities and improving the health status of Pacific peoples within Aotearoa/New Zealand;
- § increasing collective wellbeing;
- § meeting legislative and regulatory requirements; and
- § minimising
- § the likelihood of malpractice.

As the health profession develops Pacific cultural competencies, then the organisation must have the ability to measure those competencies. The development of outcome measures needs to go hand in hand with the development of these standards.

## **6.0 What Should DHBs Value, What Should DHBs Know, What Should DHBs do?**

### **6.1 What Should DHBs Know and Value?**

#### *6.1.1 Pacific Cultural Values*

Traditional Pacific cultural values evolved in village/island environments where co-operation and communalism was necessary for survival. The fundamental unit of communalism was the extended family and it was this unit that owned the resources (land), organised production (agriculture and fishing) and distributed the results of

production (food). The individual participated in this community to ensure his/her survival and was totally accountable to this unit. In return the extended family was totally responsible for the care of the individual.

The values generated by a Pacific society are inclusive of:

- § Co-operation with the group
- § Loyalty to the group
- § Conformity to the group
- § Respect for the group
- § Acknowledging and respecting status within the group

All these values mean that the individual is emotionally constructed through socialisation to be *happy to defer* to the group, to *find happiness in the approval* of the extended family group.

It may be that in liberal welfare states such as New Zealand decreases the dependence of individuals on family for survival and for care during periods of unwellness and thereby decrease the individual's need to participate in extended family activities and to be accountable to family. The individual depends on the collective of taxpayers to meet many of the material needs that had been met by extended families in Pacific island societies. In this situation other values then emerge that are to do more with the expression of individuality than accountability and conformity to the family group.

### 6.1.2 Waitemata DHB Values

The following are values of Waitemata DHB

- § Openness
- § Integrity
- § Compassion
- § Respect
- § Customer focus

Pacific cultural values and the values of Waitemata DHB are not incompatible. The main difference is that the individual is the unit that the DHB addresses itself to, its customer is the individual. The cultural diversity within Pacific communities means that customer focus will include a range from the extended family, to the nuclear family, to a significant other and to the individual.

### 6.1.3 What Should the Individual Health Worker Know?

On the basis of Campinha-Bacote's (2002) model - 'The Process of Cultural Competence in the Delivery of Healthcare Services' there are five constructs of cultural competence being: cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire.<sup>13</sup> On an individual level, the health worker should seek to have in place the following:

- § *Cultural awareness*: is the process of conducting self-examination of one's own biases towards other cultures and involves in-depth exploration of one's cultural and professional background. It is also being aware of documented

ethnic discrimination in healthcare delivery.

- § *Cultural knowledge:* is the process in which the healthcare professional seeks and obtains an information base regarding the worldviews of diverse Pacific cultural and ethnic groups as well as biological variations, diseases and health conditions and variations in drug metabolism found among ethnic groups (biocultural ecology).
- § *Cultural skill:* is the ability to conduct a Pacific cultural assessment and collecting the relevant cultural data regarding the client's presenting problem as well as accurately undertaking a Pacific culturally-based physical assessment.
- § *Cultural encounter:* is the process which encourages the healthcare professional to directly engage in face-to-face cultural interactions and other types of Pacific encounters with clients from culturally diverse backgrounds in order to adapt to existing Pacific beliefs about a cultural group and to prevent possible stereotyping.
- § *Cultural desire:* is the spiritual and fundamental construct of cultural competence that provides the energy source and foundation for one's journey towards cultural competence.<sup>13</sup> It is the motivation of the healthcare professional to "want to" engage in the process of becoming culturally aware, culturally knowledgeable, culturally skilful and seeking cultural encounters in relation to working with Pacific peoples; not the "have to."

The key, is for the health worker to have the capacity to critically apply these competencies in the delivery of quality care for Pacific peoples.<sup>14</sup> It is acknowledged that a health professional may not attain the level of cultural skill. However, this is necessary in the encounter with a Pacific patient/client/person as it is the application of the other four constructs and components that will make the clinical encounter effective. For instance, Pacific cultural skill is attained by the organisation through the employment of culturally skilled Pacific persons.

### 6.1.3 Specific Knowledge Components

There are several dimensions that contribute to the holistic perception of a Pacific person's well-being. Obtaining Pacific cultural knowledge about a client's health-related beliefs and values require understanding of their world view. The clients' world views will elucidate how they interpret their illness and how it moulds their thinking, doing, and being.<sup>15</sup> The following knowledge components must be considered when working with Pacific people.<sup>16</sup>

|  |   |
|--|---|
| <p><b>Family:</b> Most Pacific People's families are extended families. The family is the centre of the community and way of life. The family provides identity, status, honour, roles, care and support for their people.</p> | <p><b>Dignity:</b> Pacific Peoples, like all cultures, believe in the dignity and integrity of people, specifically the dignity of their extended family. When they relate to one another, particularly in formal situations, they respect and maintain the dignity of others, others' family as well as their own.</p> |
| <p><b>Communality:</b> Most Pacific peoples are communal people. The way of viewing the world and doing things is mostly driven by what is</p>   | <p><b>Respect:</b> Pacific Peoples learn from an early age to show respect when they relate to one another. Children are taught to respect their</p>  |

|  |  |
|--|--|
| <p>commonly perceived as acceptable to the community. They also draw strength and confidence from communal beliefs.</p>  | <p>parents, elders and anyone who is older than they are. Also, they are expected to respect those in positions of authority and leadership. Respect is also earned through services to the family and community.</p>                          |
| <p><b>Unity:</b> Keeping the community and families together as a united entity is an important duty for Pacific Peoples, especially those with leadership roles. This is because strength, wealth and pride come from their sense of belonging and staying united. Together, they feel strong and powerful, but alone, they feel isolated, weak and lost.</p> | <p><b>Humility:</b> Pacific Peoples are expected to be humble and show humility when they relate with one another. Humility and humbleness are leadership qualities. They are important in the process of delivering an important message.</p> |

In conjunction with both the Waitemata District Health Board Pacific Mental Health Cultural Competency Standards (2002) and the Ministry of Health's National Pacific Cultural Competencies Drafts, specific knowledge components should include:

- § Health and Wellbeing - DHBs should have an understanding of the relationship between health and wellbeing and the ability to fulfil family obligations as well as attaining an understanding of the relationship between health and religious and/or spiritual beliefs.
- § Family and Community - DHBs must understand the key features of Pacific families including structure and decision making processes and to understand how best to ensure familial authority, community leadership, and health sector leadership can be facilitated.
- § Social and Economic Factors - DHBs need to understand the environmental social, cultural economic challenges that affect family wellbeing, to recognise the relationship between socio-economic status and the health status of Pacific populations, to understand the demographic features of Pacific populations, and have the ability to identify the economic barriers to health services access.
- § Treaty of Waitangi - DHBs must understand the key themes and events within the Treaty of Waitangi that contribute to the context within which health and wellbeing is conducted in Aotearoa/New Zealand, and to recognise that the relationship between *tangata whenua* and Pacific peoples is defined by the cultural values held by both Maori and Pacific peoples and is defined by the Treaty of Waitangi.
- § Culture and Custom - DHBs must understand the relationship between the living and the spiritual world of ancestors both in its pre-Christian indigenous understanding and its post and current Christian interpretation, to acquire a sensitivity to the variety of possibilities for meaning that each Pacific individual gives to their experience, to recognise the concept and practices of *tapu* and the consequences of the violation of *tapu*, being aware of traditional healing practices, to understand that Pacific peoples hold a range of different perspectives, values and beliefs about illness.
- § Communication - DHBs must recognise that communication must be in the language best understood by the individual, family or community, clients and their families.

Organisations that recruit Pacific peoples are likely to benefit from the cultural competency of their staff to provide additional services for Pacific peoples. However, remuneration often does not reflect the extra duties required of staff with these cultural competencies. Furthermore, Pacific peoples who are expected to provide cultural expertise in responding to Pacific health issues should be appropriately trained. While cultural competencies are often as critical as clinical expertise to ensure that a patient fully understands the implications of their illness and the impact of treatment options, support from a clinical base is also essential. Despite having cultural competencies, untrained Pacific peoples may not appreciate the complexities of health conditions.<sup>14</sup>

#### 6.1.4 Skills Required

As mentioned earlier, cultural skill is the ability to gather relevant cultural data regarding the client's presenting problem as well as accurately undertaking a culturally-based clinical assessment.<sup>15</sup> Since Pacific peoples are relational peoples it is imperative to establish who you are and the basis of your relationship on cultural grounds before any consequential tasks can be undertaken. Establishing who you are is of equal importance to Pacific peoples as ascertaining what you know and how you can assist. Creating this relationship can be time consuming, yet once established will have a positive and beneficial impact and be part of the healing process for the client.<sup>17</sup>

Many educational settings are problematic in that they limit the formation of communities of practice through requiring that skills be taught in isolation and out of context. Consequently students/trainees have no sense of being within a community and that there is no process for making progress in learning through socially shared cognitions.<sup>18</sup> Acknowledging the value placed on respect and acting appropriately is a skill and is regarded as the key component to successful interpersonal engagement between Pacific peoples as well as cross-cultural engagement between Pacific and non-Pacific peoples.<sup>12</sup> For example, respect may be shown through the skill of creating relationships by:

- § knowing the structure of the groups and acknowledging the key people in the right order;
- § expressing your appreciation for the opportunity to meet;
- § acknowledging past interactions;
- § sharing some personal information about yourself that may have some connection with the group or with the purpose of the meeting; and
- § once an emotional/spiritual connection is made, then the business at hand can be addressed.

Skills in establishing and maintaining relationships with Pacific clients may entail: the use of Pacific greetings or language, where appropriate; communicative and interviewing skills applicable to Pacific clients; identifying when and how prayer should be used; offering hospitality (food, refreshments); focusing on the client to provoke oral dialogue; allowing the client to express in their own words their stories; assuring client confidentiality. In relation to managing Pacific cultural and professional boundaries skills may involve: strategies to manage cultural/family obligations and experiences; allows input from the client's family with consent of the client; and gets cultural support and/or training when needed.<sup>17</sup>

## 6.2 What Should DHBs do, in order to be Culturally Competent Organisations?

Organisational competency is the ability of an organisation to effectively deploy and manage its resources in order to produce a desired outcome. The outcome in this case is Pacific cultural competence.

A Pacific culturally competent organisation will seek to have the capacity to:

- § equip health care providers with knowledge, tools and skills to better understand and manage sociocultural issues in the clinical encounter;
- § communicate to its clients in their language of preference;
- § have systems and processes that facilitate understanding and respect of values, beliefs and practices;
- § incorporate these values, beliefs and practices in its service delivery;
- § deliver their service in the context of their clients' socio-economic reality;
- § correctly identify Pacific clients in its demographic, epidemiological and clinical outcome data base; and
- § document the organisation's progress towards becoming culturally competent.

The following chart identifies the main domains and indicators of organisational cultural competence in relation to that domain as well as rationale for the inclusion of the particular domain.

| Domain        | Rationale  | Measures/Indicators  |
|---------------|--|--|
| Governance    | Ensure that organisational cultural competence is understood and is incorporated into decision making at a strategic level.  | Resources allocated for attaining cultural competence in organisation.<br><br>Pacific consumer and community perspectives are understood by governance.  |
| Management    | Ensure organisational cultural competence is understood and management takes responsibility for developing and implementing processes to create cultural competence within their area of responsibility in the organisation. | Identified Pacific peoples who are involved in the development of policy, allocation of resources, design of services and protocols for engaging Pacific patients and their families effectively.                  |
| Communication | Ensure that clinical decisions are informed by correct and adequate information and that clients/families are informed and participate in decision making about their care.  | Number of staff who are competent in a Pacific language<br><br>Job descriptions that identify this competency as part of their professional function<br><br>Acknowledgement of language competency in remuneration |

|                   |  |   |
|-------------------|--|---|
|                   |  | <p>policies.</p> <p>Service Specific cultural awareness training for non-Pacific staff.</p> <p>Cross-cultural communication training for all staff who interface with Pacific patients.</p> <p>Training in the correct pronunciation of Pacific names in place.</p> <p>Cultural competence training for Pacific staff.</p>  |
| Human Resources   | HR processes for recruitment, retention and development of Pacific staff are implemented.  | <p>Advertising targets Pacific population.</p> <p>Interviewing process allows for both clinical and cultural competence to be demonstrated.</p> <p>Mechanisms for staff support and staff development in place.</p>   |
| Service Delivery. | Policies and practices to ensure that service delivery recognises and responds to the socio-economic reality of Pacific people are in place.                             | <p>Service hours are flexible allowing Pacific people to access services at times that do not conflict with the requirements of having to earn an income and when transport is available to them.</p> <p>Communication policies and practices for Pacific people who do not have telephones or who are not literate in English in place.</p> <p>Information available in Pacific languages.</p> |
| Information       | Ensure that policies and practices to ensure that there is correct identification of Pacific clients in the demographic, epidemiological and clinical outcome data base. | <p>Information system allow for the recording of Pacific ethnicities</p> <p>Clients are identified as Samoan, Cook Island Maori, Tongan, Niuean, Fijian, Tokelaun and Tuvalu.</p>   |

|            |   |   |
|------------|---|---|
|            |   | Training on how to sensitively ask ethnicity questions.           |
| Evaluation | Ensure that processes are in place to evaluate progress towards attainment of organisational cultural competency. | Evaluation tool for measuring organisational cultural competence. |

### *6.2.1 Training as an essential component of attaining organisational cultural competence*

Pacific cultural competence is a capacity that DHBs need to have. This does not mean that every individual employee needs to be culturally competent and this would not be possible, but it means that the organisation need to have resources to ensure that it discharges its responsibilities towards its Pacific patients effectively, and so the organisation achieves cultural competence. The responsibility for ensuring that this does happen lies with management in relation to planning, service design, resource allocation, training and evaluation.

The two main areas of responsibility are service design and training, both of non-Pacific and Pacific personnel to be culturally competent. This allows for cultural competencies to become embedded in the performance of clinical functions and in the system of service delivery.

### *6.2.2 Epistemology and Pedagogy*

Training is based and derived from a particular epistemology<sup>+</sup> and related pedagogy.\* A training program should be based on an epistemological view, which encompasses a particular pedagogical approach, and in the context of this framework the epistemological and pedagogical approach should reflect the Pacific values identified.

### *6.2.3 Epistemology*

The terms Indigenous knowledge and Pacific epistemology are used interchangeably. The indigenous perspective has been argued to be an inclusive, holistic, and inter-disciplinary way of thinking which encourages being of service, participation in community and valuing inter-personal relationships.

Epistemological nuances include familial and collective roles, responsibilities and ownership, influences and definitions of Pacific patterns of individual and group behaviour, Pacific values, Pacific notions of time, Pacific understandings of knowledge and its value, of ownership of things tangible and intangible, of gender, class and age relations and the like.<sup>5</sup> Thus, to effectively engage Pacific and non-Pacific peoples in Pacific cultural competencies, such epistemological underpinnings must be acknowledged.<sup>5</sup>

<sup>+</sup> Epistemology is philosophical theory of knowledge. In other words, ways of knowing.

\* Pedagogy is principles and methods of instruction; activities of educating, instructing or teaching; and activities that impart knowledge or skill.

## 6.2.4 Pedagogy

The Freirean concept of dialogue is similar in some aspects to Pacific styles of conversation. Naming one's experience and placing that voiced experience in context, is the essence of dialogue.<sup>19</sup> As opposed to discussion, dialogue is characterised as a type of speech that is humble, open, and focused on collaborative learning. It is communication that can awaken consciousness and prepares people for collective action. This is much akin to 'Pacific dialogue.'

For example, the art of story-telling is an old Samoan skill, particularly of myths and legends which were a part of oral literacy and traditional education. Story-telling is a practical and situational teaching style which has educational implications of a social, psychological and spiritual nature.<sup>20</sup> Story-telling, serves a significant purpose which includes the handing down of cultural and moral values, the acquisition of cognitive skills of comprehension, listening and critical thinking, numeracy skills, concepts of height, depth and volume, music skills through the chanting of legends, geography skills like the spatial distribution of places, flora and fauna. After a hard days work, we were lulled to sleep by the chanting of the legends.<sup>20</sup>

Another style of communication is the Tongan concept of *po talanoa* (to talk through the night), in its inclusiveness, the emphasis is on equality, it brings enjoyment and in this enjoyment is empowerment. It also grants hope that all health professionals will come to experience cross-cultural learning as beneficial for themselves as well as fundamental for the successful engagement of people from a different cultural background from their own.

Pacific communities are communal and cooperative. On the other hand, this may be contradicted by western educational training, with its focus upon individual strengths and practices. Furthermore, with the increasing Pacific NZ-born and multi-ethnic populations traditional Pacific worldviews may not necessarily be relevant to the context of contemporary Aotearoa/New Zealand. Subsequently there may be a mismatch in training practices on various levels.

Pedagogy is situated in trainees' realities and subjectivities but *"at the same time, takes them beyond their current horizons to consider perspectives and issues that they would not normally entertain"*.<sup>21</sup> Pacific pedagogies enable Pacific peoples to reconstruct for themselves appropriate and matching pedagogies, which is complementary to their cultural practices. The purpose of training may include:

- § familiarising and guiding health professionals as to the intention and appropriate use of the framework;
- § link the framework to the Pacific health strategies currently implemented;
- § assist health professionals in incorporating the framework in to their work environment and core business; and
- § link the content of the framework with the reality and experiences of Pacific families and individuals.<sup>12</sup>

Cultural competence is a vital link between the theoretical and practice knowledge base that defines health professional expertise.

## 7.0 Evaluation

### 7.1 The Need for Evaluation

Evaluation represents another way in which pedagogical content knowledge is used. Evaluation is the reasoned consideration of how well project/programme/service goals and objectives are being achieved. Agencies and professional health organisations need to advance cultural competence by supporting the evaluation of culturally competent Pacific service delivery models and setting standards for cultural competence within these settings. A Pacific culturally competent health sector needs to be aware of and vigilant about the dynamics that result from cultural differences and similarities between workers and clients. This may include monitoring cultural competence among health workers (agency evaluations, supervision, in-service training, and feedback from clients).

#### 7.1.1 Types of Evaluation

The types of evaluations which may be used to assess the Pacific cultural competence of health providers and training packages may include:

a. *Formative evaluation*

May be undertaken to ensure that Pacific cultural competency training packages and service delivery are well planned, soundly based and responsive to emerging information about its feasibility, appropriateness and effectiveness. One method of achieving these aims may include consultative input via information gathered and feedback from key stakeholders.

b. *Process evaluation*

Refers to the documentation and analysis of the way Pacific cultural competency service delivery and/or training packages are delivered in practice. Once delivered it is to be expected that service delivery/training sessions may be shaped and modified by people and unforeseen circumstances in ways that cause the actual service delivery or training in practice to look different to ideal Pacific cultural competency training/service delivery plans. This information is necessary in order to adequately interpret service delivery/training impacts, and should enable aspects of the service delivery/training packages to be replicated in the future. Process evaluation may include evaluating and documenting whether:

- All parts of the service delivery/training components are reaching all parts of the target audience;
- Participants are satisfied (or not) with the service delivery/training;
- All activities in the service delivery/training are being implemented; and;
- All material and components of the service delivery/training packages are of good quality (or not).

c. *Impact Evaluation*

Is an evaluation plan developed in consultation with stakeholders and participants to determine what was meaningful and possible for Pacific cultural competency service delivery/training in terms of process, impact and outcome results. Not only by assessing the impact of the service delivery/training for

participants but also information on ways to improve the service delivery/training package. It is essential to document the positive and negative consequences of the Pacific cultural competency service delivery/training package. The objective may be designed to determine if implementation of the service delivery/training resulted in changes in the reported knowledge, attitudes and behaviours of participants and changes to their working environment.

## 8.0 Conclusion

Pacific peoples in Aotearoa/New Zealand contribute significantly to the political, social and cultural fabric of this society.<sup>1</sup> Pacific peoples influence and will continue to influence the demographic pattern, sociocultural features and overall health status of Aotearoa/New Zealand in the future as the population increases and ages. Given that Pacific peoples occupy different social locations and encompass a range of backgrounds and experiences whether Island born, NZ-born, or multi-ethnic, unavoidably there are a range of views about what it is to be a Pacific person.<sup>4</sup>

Consequently, the health care sector needs to be adapted to positively acknowledge the beliefs and practices of the diverse Pacific populations in Aotearoa/New Zealand and Pacific communities encouraged and supported to develop more effective and innovative models of healthcare delivery.<sup>1</sup> A fundamental element for providing effective healthcare for Pacific peoples is a well trained and skilled workforce. Such a workforce needs to be directed and supported by the development of cultural competencies and best practice guidelines. Subsequently, this has led to the development of the current Pacific Cultural Competency Framework.

Pacific cultural competency is the ability to understand and appropriately apply cultural values and practices that underpin Pacific people's worldview and perspectives on health and like, culture is a process and not an endpoint. It is important that both individuals and organisations in the health sector acquire Pacific cultural competencies as a) culture and language have a significant impact on influencing the way in which Pacific people's choose to respond to, and access health services; and b) knowledge of Pacific language, and culture, irrespective of birthplace, are required in order to work with Pacific peoples accessing health services by respecting their values and beliefs and their families culture, as it is central to their wellbeing.

This current framework seeks to provide a conduit for supporting, guiding and providing a methodical approach for organisations to develop policies and practices that will assist and fortify Pacific and mainstream health providers in the delivery of culturally safe/appropriate health services to Pacific peoples. It is envisaged that it will complement and enhance clinical practice.

The two main areas of responsibility are service design and training, both of non-Pacific and Pacific personnel to be culturally competent. This allows for cultural competencies to become embedded in the performance of clinical functions and in the system of service delivery. Consequently, this means that there is a need for ongoing training in cultural competence and cultural awareness and a creation of mechanisms for the evaluation of

competence-based practice and organisational competency.

In addition, agencies and professional health organisations need to advance cultural competence by supporting the evaluation of culturally competent Pacific service delivery models and setting standards for cultural competence within these settings. This may include monitoring cultural competence among health workers (agency evaluations, supervision, in-service training, and feedback from clients).

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## **Appendix**

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### **Auckland District Health Board**

Phillip Keleti  
Aseta Redican  
Louisa Ryan  
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Catherine Poutasi

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Lee Pearce

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Akesa Burling  
Rachel Enosa-Saseve  
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Sosefo Teu  
Leapai Tusani  
Maika Veikune

### **Consultant**

Liz Bowen-Clewley

### **Hutt Valley District Health Board**

Tofa Suafolo Gush  
Joy Sipeli

### **Ministry of Health**

Geneva Harrison  
Manase Lua  
Jenny Moore  
Therese Weir

**Waikato District Health Board**

Tony Brown

**Waikato Pasifika Health Trust**

Peta Karalus

Grace Mitchell

Leota Scanlan

Reverend Kora Tuaiti

Isabelle White

**Waitemata District Health Board**

Dr Frances Agnew

Jacinta Apelu

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Sieni Lagaluga-Seve

Di Lemm

Bruce Levi

Kirk Mariner

Louise Miller

Toni O'Connor

Kathleen Samu

Johnny Siaosi

Taitoko Tafa

Vicky Tariou

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Levao Seupule Tiava'asu'e

Tutogi To'o

Mereana Worth

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Estelle Muller