

Nursing Programme 180 hp
Scientific methodology III, thesis.

Inequities in health care: lessons from New Zealand

- A qualitative interview study about the cultural safety theory

Orättvisor i sjukvården: lärdomar från Nya Zeeland

- En kvalitativ intervjustudie om teorin kulturell säkerhet

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ABSTRACT

BACKGROUND: According to the World Health Organisation, the indigenous Māori are reportedly the most marginalised ethnic group with the poorest health status in New Zealand. Cultural safety theory is a part of nursing programmes in New Zealand with the aim to reduce inequities within the health care system. **AIM:** The aim of this study is to illuminate nurses' views about the cultural safety theory in relation to inequities within the health care system in New Zealand. **METHOD:** A qualitative empirical approach based on semi-structured in-depth interviews was applied. Six interviews were conducted and data was analysed using Graneheim and Lundmans manifest content analysis. **RESULTS:** Two categories were identified and became representative as a result, Nursing Strategies and Working with Challenges. **CONCLUSION:** The findings in this study suggest that nurses' have an overall positive attitude towards working with cultural safety theory and believe the theory to be an opportunity to change attitudes, and be a potential tool to reduce inequities within the health care system. **CLINICAL RELEVANCE:** Illuminating nurses' perspectives about cultural safety can contribute to a better understanding of working with different cultures and hopefully reduce inequities within the health care system.

KEY WORDS: Cultural Safety, Inequity, New Zealand, Māori

SAMMANFATTNING

BAKGRUND: Enligt Världshälsoorganisationen är ursprungsbefolkning Māori den mest marginaliserade folkgrupp med sämst hälsostatus i Nya Zeeland. Teorin kulturell säkerhet är en del av sjuksköterskeprogrammen i Nya Zeeland med syfte att reducera orättvisor inom hälso- och sjukvården. **SYFTE:** Syftet med denna studie är att belysa sjuksköterskors syn på teorin kulturell säkerhet i förhållande till orättvisor inom hälso- och sjukvården i Nya Zeeland. **METOD:** Denna studie är byggd på en kvalitativ empirisk strategi, med semi-strukturerade djupintervjuer. Sex intervjuer genomfördes och data analyserades med hjälp av Graneheim och Lundmans manifest innehållsanalys. **RESULTAT:** Två kategorier identifierades och blev representativa som ett resultat, Omvårdnadsstrategier och Arbeta med utmaningar. **SLUTSATS:** Resultaten i denna studie visar att sjuksköterskor har en allmänt positiv inställning till att arbeta med teorin kulturell säkerhet och tror att teorin kan vara en möjlighet att förändra attityder samt vara ett potentiellt verktyg för att minska orättvisorna inom hälso- och sjukvården. **KLINISK RELEVANS:** Genom att belysa sjuksköterskors upplevelser av teorin kulturell säkerhet är förhoppningen att bidra till en bredare förståelse av att arbeta med olika kulturer och i förlängningen reducera orättvisorna inom hälso- och sjukvården.

NYCKELORD: Kulturell Säkerhet, Māori, Nya Zeeland, Orättvisor

GLOSSERY

BN - Bachelor of Nursing

IFRC – International Federation of Red Cross and Red Crescent Societies

Māori - Indigenous polynesian people of New Zealand

NCDs - Non-Communicable Diseases

OECD – Organisation for Economic Co-operation and Development

Pākehā - Non-māori people or for New Zealanders who are "of European descent"

The Treaty of Waitangi (Tiriti o Waitangi) - New Zealand's founding document. An agreement between representatives of the Crown and of Māori tribes.

WHO - World Health Organisation

TABLE OF CONTENTS

ABSTRACT	i
SAMMANFATTNING	ii
GLOSSERY	iii
INTRODUCTION.....	1
BACKGROUND.....	2
Indigenous people and human rights in New Zealand	2
New Zealand settlement and the Treaty of Waitangi.....	2
Maori health status	4
Cultural Safety.....	6
Competencies for nurses in New Zealand	8
PROBLEM STATEMENT	9
AIM	9
METHOD.....	10
Design.....	10
Sample.....	10
Interviews	11
Data analysis	12
Etichal considerations	13
RESULT	14
Nursing strategies	15
<i>Patient-nurse communication</i>	15
<i>Colleague encoragment</i>	16
<i>Cultural awareness</i>	16
Working with challenges	17
<i>Health disparities</i>	17
<i>Attitudes</i>	18
<i>Cultural differences</i>	18
<i>Cultural and spiritual needs</i>	19
DISCUSSION	20
Discussion of methods	20
Discussion of reults	22
CONCLUSION	25
CLINICAL SIGNIFICANCE	25
SUGGESTION FOR FURTHER RESEARCH	25
AUTHORS CONTRIBUTION	26

ACKNOWLEDGEMENT	26
REFERENCES	27
APPENDIX I.....	i
APPENDIX II	ii
APPENDIX III	iv

INTRODUCTION

Many countries across the globe experience disparities in health between their indigenous and non-indigenous population. The indigenous Māori of New Zealand are the most marginalized and deprived ethnic group with the poorest health status of all. Cultural safety has, since 1992, been a part of the nursing programmes in New Zealand with the aim to reduce inequities within health care for the indigenous-Māori population. Nevertheless, the disparities have not diminished, but rather increased. With a shared interest for different cultures and equal rights, the authors wanted to learn more about the nurses' experiences of working with cultural safety theory as a tool to reduce inequities within the health care system, which resulted in this study.

BACKGROUND

Indigenous people and human rights in New Zealand

Health disparities between indigenous and non-indigenous people can be observed all around the world (World Health Organization [WHO], 2009). WHO's (2007) understanding of indigenous includes people that identify themselves and are recognized by their community as indigenous. They demonstrate historical continuity with pre-colonial and/or pre-settler societies and have strong links to territories and surrounding natural resources and they have distinct social, economic or political systems. Improving their health has been an elusive goal for many decades but the disparities have not diminished, but rather increased (ibid.). The Lancet, through a publication series in 2006, has drawn international attention on the ill health of indigenous people in the world, considered as "one of the most urgent humanitarian issues of the twenty-first century" (Survival International, 2006). This is an unspoken injustice, a question about human rights violations and also against several of the International Federation of Red Cross and Red Crescent Societies fundamental principles (IFRC, 2016). Articles 1 and 2 in The United Nations Declaration on the Rights of Indigenous People [UNDRIP] states that indigenous people have "the right to the full enjoyment, as a collective or as individuals, of all human rights" and "the right to be free from any kind of discrimination in the exercise of their rights, in particular based on their indigenous origin or identity" (Brownlie & Goodwin-Gill, 2010, s. 296). In September 2014, after the UN's' first world congress for indigenous people, the committee underlined once again their commitment to ensure the indigenous peoples right to equal access to the highest attainable physical and psychological health (United Nations [UN], 2014). Indigenous people worldwide are currently estimated to represent about 370 million of the world's population (Gracy & King, 2009).

In New Zealand the UNDRIP was first voted against and was described as "toothless" by the country's minister of Māori Affairs (New Zealand Government, 2007). After opposing the declaration for almost three years the New Zealand government endorsed it in 2010 (ibid.).

New Zealand settlement and the Treaty of Waitangi

The Māori are the indigenous people of New Zealand. Māori people came to New Zealand from eastern Polynesia between 1200 and 700 years ago (Anderson et al., 2006). The first documented contact between Māori and Europeans occurred in 1769, which at the time of

James Cook's historical expedition consequently triggered the first waves of British colonisation.

In 1840, the Māori accepted a political alliance with the British Empire and signed the Treaty of Waitangi (Anderson et al., 2006). It was supposed to guarantee their rights and protections (ibid.). At that time, it is estimated that the Māori population consisted of about 100 000 people compared to 2000 settlers (Pool, 1991). The treaty was written in both English and Māori. Substantive differences came to light between the two versions of the treaty, which resulted in different interpretations regarding rights and obligations for the different concerned parties (Anderson et al., 2006). Subsequently the promises made supposedly by the treaty of the Māori were not respected. By the end of the 19th century the Māori had, like many other indigenous people around the world, become a colonized minority. Losing almost all of their land, it had devastating consequences on their traditional food sources. The Māori people were left into poverty, marginalized and discriminated in many aspects from the colonial state (ibid.). By 1901, the demographics profile New Zealand had dramatically changed. The population of almost 800 000 settlers was now outnumbering the Māori with population that had dropped to less than 40 000 people (Pool, 1991).

The primary instrument through which Māori were to keep their rights as an indigenous people was through The Treaty of Waitangi (Anderson et al., 2006). However, continuing disparities in health between the Māori and non-Māori population suggests that health rights were not protected, as guaranteed under the treaty. In the 1970s, rising awareness of the treaty was a result of growing Māori frustration and aspiration for a more equal health system, and it has been recognized as a fundamental point in the government's relationship to Māori. The treaty is not yet included in policy legislation, however, and disparities in health still exist despite the treaty's aim (ibid.). Today Māori in New Zealand constitutes around 14% of the population, which is one of the largest proportions of indigenous populations within a country (Theunissen, 2011).

Distinctions between Māori and non-Māori were, and still are, important for state policy (Pearson, referred in Te Ara, 2011b). These lead to official classifications, which in early New Zealand census were based on racial assessment of blood ties. In 2000 the census statistics changed and were based on subjective identification of ethnicity and therefore

ethnicity became self-perceived. Ethnic groups are defined as, for example, a shared name and sense of common ancestry or origins, common cultural elements such as language or religion, a community of interests and feelings or a common place of geographic origin (ibid.).

Māori health status

Indigenous people who suffered from colonization and land loss have the worst overall health status in their own nations (WHO, 2009). These trends can also be identified among Aboriginal people in Australia, Guarani people in Brazil and First Nation People in North America (ibid.), and reports claim indigenous-Māori being the most marginalized and deprived ethnic group, with the poorest health status over all within their own country (Ministry of Health, n.d). In New Zealand there are significant and longstanding inequities in health between Māori and Pākehā (Harris, Cormack & Stanley, 2013).

During the 1700's, life expectancy for Māori was more than 30 years, which at that point was more than that of people of Britain (Anderson et al. 2006). But with imperialism came also new diseases such as measles and tuberculosis, bringing an increase to the death rates among Māori (Pool, referred at Te Ara, 2011a). The British imperialism stretched as far as to regulate Māori rights and discrimination against Māoris native language in schools (Kunitz, 1994.). This also led to poor health outcomes (ibid.). However, Māori's loss of land and socioeconomic context was also of importance (ibid.). According to Kunitz (1994) the indigenous people who were able to keep their land did not die from disease to the same extent as those who lost their land. In 1891 Māori life expectancy fell to 25 years for men and 23 years for women. Fifty percent of Māori who died were children (Pool, referred at Te Ara, 2011a). In 1938 the Māori overall health status gradually started to recover, probably influenced by the introduction of social welfare systems and national healthcare schemes (Pool, 1991). Life expectancy has consistently increased among Māoris since the 1950s' but 73 years for Māori males and 77.1 years for females is still a long way from 80.3 and 83.9 years for non-Māori males and females (Ministry of Health, 2015).

Still today, Māori in New Zealand have a higher prevalence rate of chronic diseases than non-Māori, such as cancer, diabetes, cardiovascular disease and asthma (Ministry of Health, 2015). Māori also experience a higher and also increasing burden of non-communicable

diseases and injuries (Cormack, Purdie and Robson, 2007) while it is decreasing among other New Zealanders (Survival International, 2010). It has been reported that Māori experience a greater number of obstacles regarding access to health care services (Jansen, Bacal & Crengle, 2008). This includes socioeconomic deprivation, which consequently impacts on affordability and accessibility, in reference to transportation costs, taking time off work etc. In addition, it has also been stated that Māori tend to have a slower treatment process and lengthy waiting times (ibid.). Ellison-Loschmann and Pearce (2006) also describes how doctors rarely refer Māori to specialists and surgical services, when compared to non-Māori. Cormack et al. (2007) presents that even though Māori are 9% more likely to develop cancer, they are 77% more likely to die from it in comparison to non-Māori. Additionally, the waiting time for treatment is suggested to be longer for Māori patients than non-Māori (Hill et al., 2010).

Four major areas for explaining the inequalities in health between the Māori and non-Māori population have been suggested (Ellison-Loschmann & Pearce, 2006). These are socioeconomic factors, lifestyle factors, access to health care and discrimination. It is useful to consider these factors separately, however, they should be regarded as a linked set of factors (ibid.). Discrimination is closely related to various indicators of poor health and a clear link can be seen between the racial discrimination of Māori people and their poor health (Oda & Rameka, 2012). Research suggests that racism, and self-reported experience of racial discrimination, may be a major determinant of health, according to a New Zealand Health Survey (Ministry of Health, n.d). In this study Māori reported the highest prevalence (34%) of racial discrimination, both physical and verbal, as well as unfair treatment based on their ethnicity (ibid.). According to Jansen et al. (2008) Māori also had the highest number of self-reported racial discriminatory experiences with health care professionals and that it is obvious that Māori health status is affected by the design of the health care system. It is a health system that is apparent based on equality like most OECD countries but unfortunately not based on equity. Which subsequently means that there is no room for Māori cultural needs and their unique perspective on health. Furthermore, Māori feel that their cultural perspective on health is undermined by Pākehā dominance and therefore exhibit greater resistance towards trusting and engaging in services (Cram, Smith & Jonstone, 2003).

Cultural Safety

The concept and theory called cultural safety was developed in the 1980s in New Zealand (Nursing Council of New Zealand, 2011). It arose from Māori nurses response to indigenous Māori people's negative experiences in the health and nursing system and to the de facto discrimination that occurred towards the Māori population Richardson & Carryer, 2005). Cultural safety challenged racist and discriminatory structures in the New Zealand society that prevented these groups participating in important decision-making processes that affected their lives at all levels of society. The theory became a part of changing the unsustainable social structure by the issue of racism and its effect on health care (ibid.).

Cultural safety has been taught in Bachelor of Nursing (BN) and midwifery programmes since 1992 and is a requirement for registrations examinations (Elder, Evans & Nizette, 2013). The guidelines of the theory were initially written by Irihapeti Ramsden (ibid.) and aims to prepare nurses to develop a cultural safety approach, by letting nurses identify their attitudes and values that may consciously or unconsciously occur towards other cultures (Buscemi, 2011). It also aims to transform these attitudes by tracing them to their origins and objectively reflect and evaluate their effects in nursing practice (Nursing Council of New Zealand, 2011). Cultural safety claims that a nurse who could objectively evaluate his or her own culture and be familiar about the theory of power structures, is also a culturally safe nurse in all contexts (Elder et al., 2013). There are three steps towards becoming culturally safe in nursing practice; step one is *cultural awareness*, which is recognizing that there are differences between cultures. The second step is called *cultural sensitivity*, where students start to analyse their own realities and the impact that this may have on others. The third and final step is *cultural safety*. This is the outcome of nursing education and is necessary to be able to give a safe service for the patients. However, it is not the nurse who determines the issue of safety, it is the patients who decide whether they feel safe with the care that has been given (Ramsden, 1992). In addition, cultural safety education includes teaching New Zealand's history, the effects of colonization on the present-day health status among Māoris and knowledge about the Treaty of Waitangi.

Furthermore, the theory has underpinned four principles. Principle one aims to improve the health status among all New Zealanders (Nursing Council of New Zealand, 2011). Thereby

through nurses acknowledging beliefs and actions of those whom may differ from them by age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief or disability (ibid.) Principle two enlightens the importance of identifying power relations between the nursing practitioner and those on the receiving end of it and preparing nurses to understand the cultural diversity. Principle three describes the importance of recognising inequalities within health care interactions and the effect of history, politics, social and employment status, gender and personal experience. Principle four aims to clarify cultural safety's focus on understanding the impact of the nurses own culture, attitudes and history followed by the response of other people to these factors (ibid.). Being culturally safe, however, does not entail being an expert on different cultures (Ramsden, 2002). Teaching nurses and/or midwives about ethno-specific groups or to become Māori experts, is noted by Ramsden (2002) to be a way to further disempower Māori.

During the mid-90s, criticism grew towards the theory of cultural safety, as it was perceived rather as an outlet to express racist attitudes than to open up for reflection and discussion on the subject (Richardson et al., 2005). Many questioned the appropriateness of nursing students learning about power structures, culture and racism in a healthcare context (Chateau, 1992). The critical voices claimed that cultural safety instead led to aspiring nurses slipping ever further away from the idea of curing diseases, to be trained in “airy-fairy quasi-psychological subjects” (Chateau, 1992, s.98) and to being indoctrinated with specific political views. A committee was eventually put together to investigate the relevance of cultural safety education within the nursing profession. In the committee’s opinion, the cultural safety education was of importance, but as a concept it had major flaws and shortfalls in regards to the training. After the review the nursing council of New Zealand revised cultural safety guidelines to appease the rising public concern about the theory privileging Māori. Today, almost 25 years later, the theory is still an integral part of nursing education in New Zealand. However, the survival of the theory has been discussed as a question of whether it is possible to conceptualize, critically develop and apply even outside of New Zealand and Australia (Gerlach, 2012).

Competencies for nurses in New Zealand

The Nursing Council of New Zealand is the responsible authority that governs the practice of nurses and its primary focus lies in public safety (Nursing Council of New Zealand, 2012). They have outlined a Code of Conduct to complement legal obligations and set standards describing the behaviour and conduct nurses are expected to uphold. They aim to provide guidance in appropriate practice for all nurses and failure to uphold these standards could lead to disciplinary measures. The Code is not a Code of Ethics, describing ethical values of the nursing profession. It rather underlines standards towards which all nurses are expected to adhere, such as respect, partnership, trust and integrity. Eight principles are based on these values and are all equally important. Principle two specifies, “Respect the cultural needs and values of health consumers” (ibid.).

Cultural safety education emphasizes with the Code of Conduct. It has been considered a necessity for the nursing profession in New Zealand, to understand the socio-political forces that affect health and the relationship between a patient and their healthcare professionals (Richardson et al., 2005). Nurses play a vital role in Māori, as well as all patients, compliance and health outcome. The importance of incorporating cultural safety, patient-centred care and Māori-centred frameworks to support nurses in their work to improve the health status of Māori is also emphasized by Theunissen (Theunissen, referred in Ratima, Weatford & Wikaire, 2006).

PROBLEM STATEMENT

A large number of reports and studies regarding indigenous people worldwide, warn about the more limited access to health care compared to the non-indigenous population. In New Zealand, Māori population still suffers from a lower physical and mental health status. Nurses in New Zealand have, since the 80s, worked towards raising cultural awareness and this mainly through the implementation of the theory of cultural safety into the national nursing programmes. However, inequities remain. Previous studies have described cultural safety as a theory with significant potential, but it has also been criticised for indoctrinating nurses with specific political views, or "force-feeding culture". Cultural safety's' ambition is to improve the overall health status among all New Zealanders. However, no study to our knowledge has within the last five years aimed to illuminate practicing nurses' perspectives about the theory as a framework to improve the inequity among the population.

AIM

The aim of this study is to illuminate nurses' views about the cultural safety theory in relation to inequities within the health care system in New Zealand.

METHOD

Design

In this study, a qualitative empirical approach based on semi-structured in-depth interviews was applied. Qualitative interviews as a data collection method are described as a suitable way for the understanding of people's lived experiences of a phenomenon or a situation (Danielson, 2012). Additionally, empirical studies are suggested when the aim is to gain understanding of a specific phenomenon (Priebe & Landström, 2012).

Sample

Prior to arrival in New Zealand, contact with two people had been initiated. These two people became the author's gatekeepers. A gatekeeper is of significance as she/he has knowledge about the chosen population and environment and can therefore find the most appropriate informants for the aim of the study (Polit & Beck 2006). Gatekeeper 1 in this study is a practicing nurse and gatekeeper 2 is a family friend with nursing contacts. An information letter (Appendix I) about the study's aim and a short background of the authors were sent to the gatekeepers. They thereby provided the authors with contact details to suitable nurses/informants.

According to Lundman and Hällgren-Graneheim (2008) it is preferable to use a wide selection of informants such as gender, age and working experience. The inclusion criterion for this study was to be a nurse with a Bachelor of Nursing degree from any of New Zealand's BN programmes. The exclusion criterion was nurses with less than two years of working experience. None of the asked nurses declined participation or chose to withdraw during the interviews.

The informants were represented by a total of six nurses, two males and four females. Three of them were Māori nurses and three were non-Māori nurses. The youngest informant was 24 years old and the oldest 56 years old. The informants working experience differed from 3 years to 34 years. All of the nurses had cultural safety as a part of their education programme, except for the oldest nurse who had cultural safety education after becoming a registered nurse. The informants were born and worked in different parts of the country, and none of them worked in the same department. They were also located on both the north and the south island, in rural areas as well as in a big city such as Auckland. Two nurses worked at a health

clinic with community nursing, the third worked with elderly people and the fourth within general medicine. The fifth worked at an emergency ward and the sixth nurse worked with cancer support.

Interviews

The data was collected through semi-structured in-depth interviews, and to encourage the informants to answer more spontaneous, open-ended questions were chosen. Semi-structured questions also aimed to illuminate the nurses' views of the theory cultural safety in relation to health inequities in New Zealand. Kvale and Brinkmann (2014) describes qualitative in-depth interviews as an effective design in the way of seeking to understand the world from the informants' point of view and in that way develop the meaning of human experience. The spoken word and the descriptions of experiences can then be used as an object for analysis (ibid.). Furthermore, semi-structured in-depth interviews are advocated by Polit and Beck (2006), when the questions asked are broad. The semi-structured interviews were conducted with a prepared guideline, which helped to make the interviews well structured and easy to compare (Green & Thorogood, 2014). The interview guide includes five personal/background questions and ten open-ended reflective/main questions with, if needed, follow up questions (see Appendix II). Follow up questions were designed as "*Could you please tell me in what way...?*" or "*Could you please elaborate...?*".

A pilot interview was conducted in Sweden before the interviews with the informants, as advocated by Danielson (2012). Partly, this was to validate the interview questions, but also so the authors would have the opportunity to become familiar with the interview situation. After the pilot-interview was complete, a revision of the interview guide was considered necessary, due to some of the questions lacking relevance to the aim of the study. One questions was reformulated and two questions did not sufficiently capture the aim of the study and were removed and another questions was added (see last question in Appendix II). The material from the pilot interview is not included in this study.

The interviews were conducted between the 12th-22th of November 2016 and took approximately 20-30 minutes per informant. Three of the interviews were conducted face-to-face and three were conducted over the phone. The authors were both present during the face-to-face interviews and their roles during the interview were determined in advance. Both had

the opportunity to be the interviewer and note taker. When conducting the phone interviews only one of the authors was present, so as to avoid confusion for the informant. Before each interview, the authors clarified the aim of the study and any possible questions the informants had, in order to reduce the risk of misunderstanding. The interviews were all recorded with a mobile phone to give the interviewer the opportunity to focus on what the informer said and follow up with relevant questions if needed. The recording also gave the freedom to include how something was said, and not just what was said (Bryman, 2011).

Data analysis

All recorded interviews were, in its entirety in connection with each individual interview, listened to as a whole four times before being transcribed word for word by the authors. The transcriptions were written into an electronic text document, saved and only accessible to the authors. Graneheim and Lundmans (2004) method of manifest content analysis was thereafter applied which is described as suitable due to the small number of informants in the study. To gain a better understanding of the transcribed data the content was read through repeatedly and thereafter divided and identified into meaning units, which according to Graneheim and Lundman (2004) is the sentences or paragraphs that is related by their content and context. The meaning units were thereafter condensed into condensed meaning units. The condensed meaning units were abstracted and labelled with a code after discussions and reflection between the researchers. The codes were then arranged systematically into sub-categories and categories (ibid.) It is of great significance to have the aim of the study in mind during the analysis process (ibid.). The authors thereafter investigated how the transformed meaning units relate to each other to be able to analyse how the general structure of the phenomenon could be described. An example of the process is presented in figure 1, on the next page.

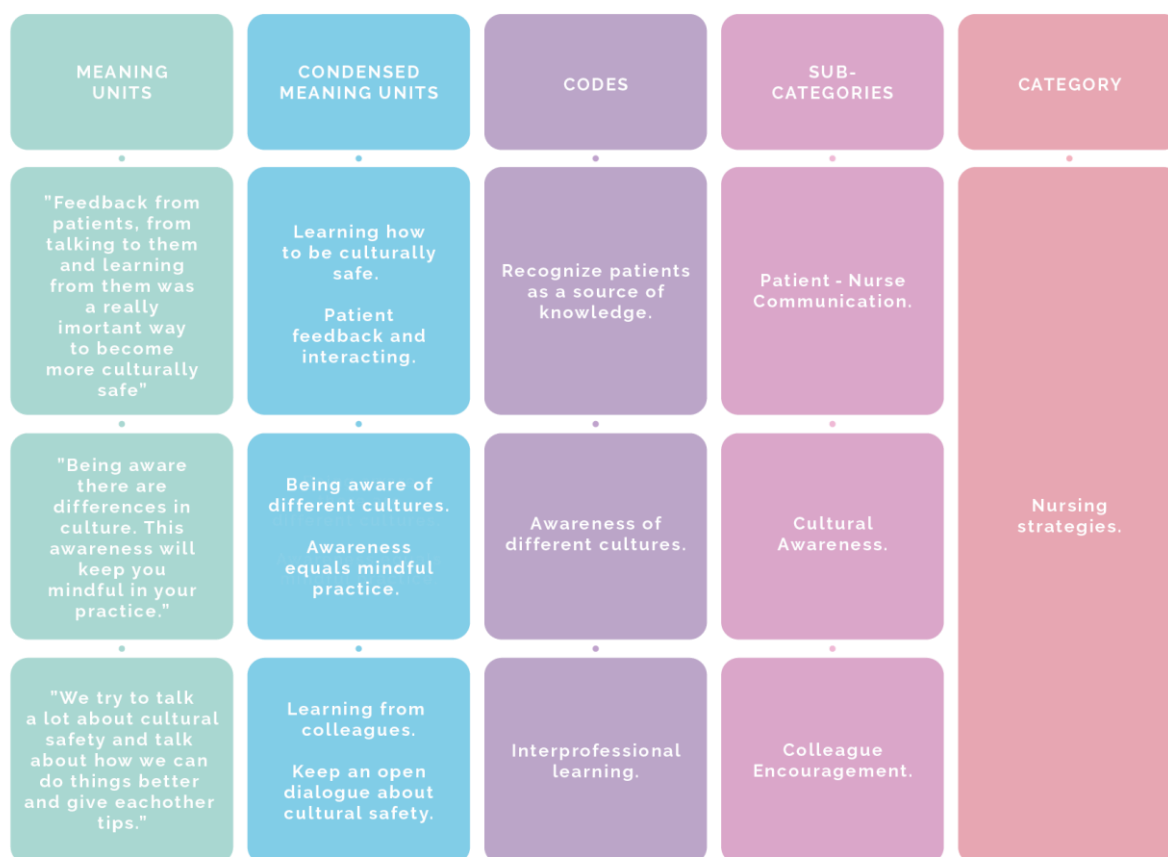


Figure 1. Example of the analyzing process.

Ethical considerations

The Helsinki Declaration of 1964 lays down ethical rules for research on humans (Declaration of Helsinki, 2013). It describes how research should be conducted before, during and after a study to protect the informants privacy and confidentiality. *“Every precaution must be taken to protect the privacy of research subjects and the confidentiality of their personal information”* (Privacy and Confidentiality, para 1). This was considered in this study by giving each informant information about the purpose and structure of the study as well as their role as informants (Appendix I). The authors did seek each informants consent which included information about their right to withdraw their participation at any time (Appendix III). The informants were informed that all the data would be anonymous, kept safe and that the authors were the only ones with access until the data was destroyed. The data collected was going to be used in the current study only. The report is written in English in order to insure that the informers can access the result of the study.

Prior to initial contact with the two gatekeepers, the Swedish Red Cross University College approved the ethical conditions of the study. The written consent form (Appendix) and interview guide was reviewed and accepted by the authors tutors before used in the current study.

RESULT

Altogether, the findings revealed two main categories and seven sub-categories, accordingly to the aim. This presented in figure 2, below.

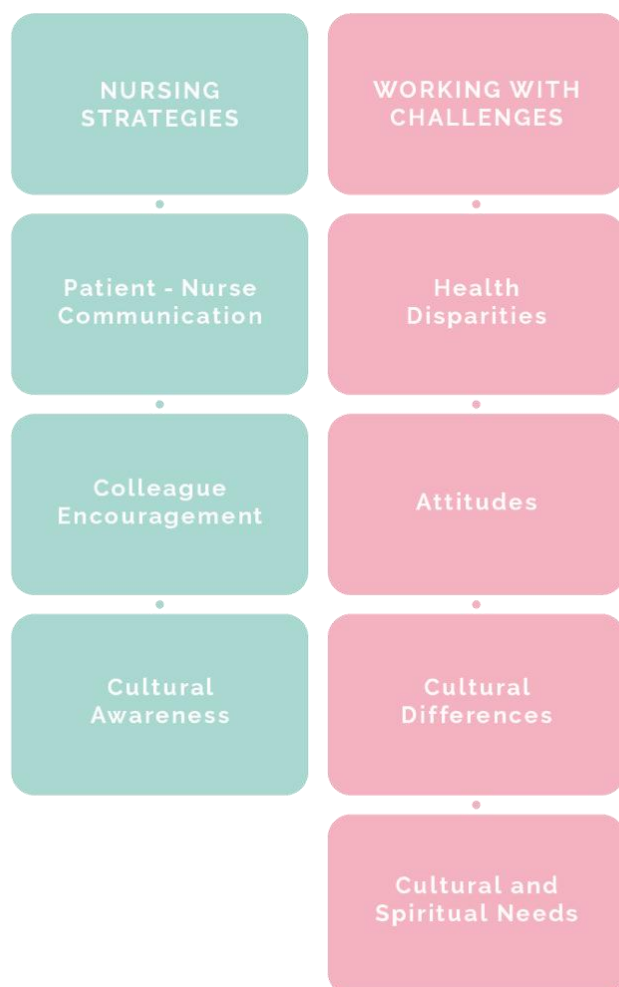


Figure 2. Categories and sub-categories.

Nursing strategies

When asked to describe cultural safety, the nurses stressed the importance of using it as a *strategy* in their profession. The nurses reflected in different ways how they in their profession worked towards a more culturally safe approach with their patients.

Communication between nursing staff as well as with patients was acknowledged. Although, without a nurse's own awareness and understanding of his/her own behaviour and attitudes, the communication was not of value.

Patient-nurse communication

Communication with patients was the most prominently mentioned strategy used to ensure giving patients the best possible health care, regardless of their cultural background. Using patients as a source of knowledge, regarding differences in cultural backgrounds and having an open dialog with patients were the main focus. Feedback from patients became a way for the nurses' to feel comfortable about giving the right care to their patients. They would initiate dialogues by asking patients about their wishes regarding treatments, prominently aiming to identify the patient's will and get the best possible health outcome.

“... to put things in a way that they [Māori] can understand from a cultural viewpoint will increase the odds for them coming out of it with a better experience with healthcare services”

When interacting with patients and getting them engaged in their own health the nurses' described being able to achieve a more equal care. Even though nurses have their own expertise they didn't feel like the patients couldn't be a resource to attain best possible health outcome. One nurse meant that it was not possible to force the Pākehā-model of health care on Māori. Rather it was needed for nurses to understand and communicate the Māori-models of health care, which was the only way to ensure patient compliance. Another nurse underpinned the purpose of communication as a way of respect and “upholding their dignity”, to help them in the best possible way.

Colleague encouragement

The nurses also described the experiences they had of cultural safety with their colleagues. Four of the nurses expressed the importance of reflecting together with their colleagues, nursing staff as well as inter-professional. One of the nurses meant that being able to feel supported and confident enough to ask colleagues when questions arose were of great importance. This to be able to reflect on how to work towards best possible health outcomes, regardless of what cultural background their patients might have. Also to keep an open dialog between you and your colleagues was valid.

“I contribute to cultural safety by sharing with my workmates and colleagues what I know about my own culture. People are coming to me and saying: What am I not doing right? How can I do this better?”

To feel encouragement by your colleagues was a way to work towards “doing things better”. Exchanging stories and reflect about challenging situations where cultural barriers were involved, were highlighted as the best way to understand how to work towards patient perceived inequities with their health care. Experienced problems with communication between colleagues were only mentioned in relation to other professions, such as doctors or psychiatrists. Two nurses mentioned that they believed nursing staff had in general, a broader understanding of how to meet and treat people from all sorts of backgrounds, and because of studying how to be aware of the cultural differences among the population.

Cultural awareness

“Safety is a strange word. It’s basically, to me, safety is awareness”

The most frequently used word, when answering any question during the interviews, was awareness. “It’s important to be aware of your patient” was an expression frequently used, which did not refer to being aware of your patient group in general but rather to be aware of your patient's culture, whatever it might be. To be aware of patients differing ways of thinking and to not be judgemental as a health practitioner towards other people's culture were found to be of most importance. Awareness is highly regarded as a nursing quality.

“As long as you understand yourself and you understand that other people have different ways of thinking and be aware of that and not pushing my own beliefs onto other people”

To be aware of a patient's culture and beliefs could sometimes be difficult. Sometimes, ones own workload is, as mentioned by one nurse, an obstacle to “getting it right.” Also being aware of his or her own biases and recognising that it can be hard to set them aside sometimes were reflected on. But even so, the nurses felt confident in always striving for improvement.

Working with challenges

When reflecting on cultural safety in relation to health disparities and inequities in New Zealand the nurses thought cultural safety was in some ways a good tool to overcome some of the inequities. However, some nurses also clarified that even though it may be useful in their practice, it is not enough to assure equal health care and change structural difficulties in general. Further work has to be done. Changing negative attitudes, meeting cultural and spiritual needs are just some examples that were mentioned during the interviews.

Health disparities

All nurses acknowledge health disparities in New Zealand as fact and an on-going issue for the country. One nurse even described New Zealand as having “a hard disparity” and that Māori tend to fall into the lower brick of the scale of socioeconomic status, which consequently also affected their overall health status. All nurses stated cultural safety as a good tool to reduce inequities in health. However, one nurse said that although she thought it was a good tool to use, she also said that it wasn't enough. Two nurses described cultural safety theory as a good start to get Māori into the health care system, but that further work to reduce disparities is necessary.

“...[cultural safety is] one of the areas you need to address to help reduce the inequities we have in New Zealand. We have a lot of other ways to fight disparities but cultural safety is definitely an important part of it”

Furthermore the nurses expressed a worry about Māori not having the same accessibility to “things” that for most other New Zealanders were available. That was defined as one of the

reasons for the inequities in health. One nurse did underpin that the cultural safety theory's' main purpose was to be inclusive the theory was therefore a tool to reset some of the inequities within the health care system.

Attitudes

Overall, the nurses in this study found cultural safety as something good and rewarding in their practice. The majority had a positive attitude towards the theory, even though it was mentioned as “not enough” to overcome structural health disparities. Although, four of the nurses mentioned that the attitudes towards cultural safety could differ between nurses, and this especially during university years. Some students had expressed their disapproval with learning about a theory that wouldn't affect them. One nurse stated that she, during one class, felt that the questioning about the theory was nothing but “white privilege”.

“A lot of [nursing] students were, and especially Pākehā students were like “why are we learning about this? How does this affect us? We don't need to...” A lot of white privilege I felt...”

It was also mentioned from a historical point of view, that attitudes towards cultures that differ from ones own, are still a problem, not just in health care in New Zealand but all over the world. One nurse did explain how during her years in practice has seen colleagues intentionally or unintentionally put their own beliefs onto patients, and how that has caused a lot of hurt.

Cultural differences

When reflecting on health disparities within the country the nurses recognized that cultural differences have an impact on how patients perceive and adapt to health services. One nurse described New Zealand as a multicultural society, growing, and still learning how to be more mindful about patient's cultural backgrounds. Two nurses stressed how they always, during their work, were careful not to push their own beliefs onto patients, as this is what makes the health care system in New Zealand feel too exclusive to some. Therefore understanding cultural differences as a fact, not a problem, was of importance.

“There’s inequity because there’s a way of Pākehā to respond to health care and the path they take and the way they engage is different from Māori...”

Another mentioned how some nurses in her department unreflectively assume that their patients think and want the same thing as them. Thus thinking about the way you deliver health care is paramount, and do not make assumptions about your patients wishes. Treating without being aware of the differences is an issue within the health care system, she specified. Another nurse stated:

“If you’re denying someone of their culture it’s essentially to isolate some, and by isolating someone is no way to get beneficial health outcomes”

Cultural and spiritual needs

Māori has a model of health that has four important cornerstones to their philosophy of holistic health and wellbeing. These are physical, spiritual, family and mental health. It was mentioned that this differs from ordinary western medical practice and that two nurses had experienced situations where they felt they could not meet the needs of their patients due to this.

“We have alternative therapies, like remedies, song and prayers. They [māori] prefer that to western medicine because they believe they have been brought up on that...”

One of the Māori nurses said that her grandmother would rather visit a Māori Health Clinic further away from her home, than get treated by her local practitioner. This is due to her feeling that her local health clinic does not fully understand her. She would rather speak her native language, which is not possible at her nearest clinic, and felt that western medicine does not meet her needs to the fullest. All nurses did agree that Māori traditions are different in a health care context. Some nurses reflected on how frustrated they felt when the health care system wasn’t flexible enough to meet the needs of all patients, including Māori.

DISCUSSION

Discussion of methods

Aiming to illuminate nurses' views about the cultural safety theory in the context of inequities within the health care system in New Zealand, a qualitative method with semi-structured in-depth interviews was applied. This to let the informants reflect and describe their experiences with their own words and consequently capture specific and detailed information from the informants' point of view. All of the research findings trustworthiness has been evaluated according to Graneheim and Lundman (2004). To demonstrate the various aspects of trustworthiness of the findings in this qualitative study, using manifest content analysis will therefore be discussed in aspects of transferability, credibility and dependability.

For qualitative interview studies the adequate number of informants is based on the reach of saturation during data collection, i.e. when no new categories emerge during interviews (Mason, 2010). Due to this study's limited timeframe it was decided beforehand to limit the number of informants to six. Though, if a greater number of informants had taken part and more interviews had been conducted, new categories might have appeared. Consequently, this means that the study might not have reach saturation during data collection, which creates a limitation in transferability of the result. However, informants chosen with various experiences might contribute to addressing a greater variety of aspects within the research questions (Patton, as referred in Graneheim & Lundman, 2004). Therefore, to have informants from different parts of the country was regarded as of value and has contributed to the transferability of the result.

Other factors influencing the result are the in- and exclusions criterion for participation in the study. Exclusion criteria were nurses with less than two years of working experience, as being able to provide detailed, reflected experience were essential for the validity of the study.

According to Lundman and Hällgren-Graneheim (2008) it is preferable to use a wide selection of participants with different experiences to better understand and explain a certain area. For that reason, the authors choose to not exclude participants by gender or age with the aim to enhance the transferability. During the recruitment of the informants both gatekeepers gave the suggestion to interview both Māori nurses and non-Māori nurses. Inclusion criteria were nurses with a Bachelor of Nursing in New Zealand where cultural safety is a subject studied in their three year long study programme.

The pilot interview performed prior to the data collection, as recommended by Danielson (2012), was needed and did improve the interview guide. After evaluating the result of the pilot interview, two questions did not sufficiently capture the nurses' view on cultural safety in relation to health disparities and were therefore removed. One question was re-written due to misleading words and another added to make the guide more comprehensible and relevant for the study's aim. The pilot interview was not included in this study's result. Though the interview guide might have been improved and more in tune with the aim of the study, the authors felt after the last interview that it was in some ways better conducted as a whole than the first one. As concurred with Malcolm Gladwell (2008) suggestions in *Outliners*, apparently the need for 10 000 hours to achieve mastery in a field seems to be true. This may have affected the study's dependability.

A semi-structured interview is designed with open questions, which don't follow a particular pattern, and the researcher adapts to what is coming up during the interview (Danielsson, 2012). The informants therefore had to formulate their own answers and explain their thoughts and experiences, which increases the credibility of the study. In the process the authors have been aware that previous experience as well as an understanding of the study's purpose can shape the process and the outcome, which can be viewed as both an advantage and a disadvantage (Patton, as referred in Graneheim & Lundman, 2004). The advantage lays in the interviews being able to be conducted on a different level, as the authors did not have to familiarize themselves with the subject. However, it could also be seen as a disadvantage, since it might have driven the interviews and the questions that were asked in the direction the authors wanted instead of in a way that was fully open and without preconceptions.

Three interviews were conducted face-to-face with both authors present. Having both authors present during the interviews seemed appropriate as it can contribute to a more reflective understanding of the data (Redman-MacLaren et al., 2014) and the author's lack of experience of data collection through semi-structured interviews. Though, the presence of more than one author can also make the informant more reserved, and potentially affect his or hers answers in a negative way (Redman-MacLaren et al., 2014). The authors did therefore strive to be as relaxed and make the interview become more of a conversation, as recommended by Danielson (2012). The remaining three interviews were conducted over the phone. This was not planned but both authors felt it was worth conducting the interviews anyway to be able to

get all six informants to participate as planned. Disadvantages with telephone interviews such as distractions and loss of non-verbal data (Opdenakker, 2006), as well as reported advantages as allowing the informant to feel more relaxed and sometimes able to disclose sensitive information (Chapple, as referred in Novick, 2008) were taken in consideration before making a final decision on if to proceed. These interviews were conducted by only one author, in order to avoid confusion for the interviewee and to create a more conversational feel. If the interviews various designs have reflected the results is difficult to say.

All the interviews were audio recorded and transcribed word for word. The transcriptions were read through repeatedly and individually to achieve an understanding of the big picture, as well as to find relevant meaning units. To increase credibility of the study, all data were also analysed separately and then thereafter the result was discussed between the authors (Danielsson, 2012). The informant's exact language was used without changing the grammar at both transcriptional and citation, as advocated by Hall (2014) since it increases the understanding of the informants own opinion. Further, Graneheim and Lundman (2004) states that the use of quotes also adds to the study's credibility and provide a greater understanding for the results. Yet, twice after transcribing the interviews, the authors discovered a nuance in the answer that had not been perceived during the interview. A follow up question could have been asked to capture a deeper understanding of the informant's answers. Why this failed in these cases can be traced to the fact that English is not the author's' native language.

Discussion of results

The aim of this study is to illuminate nurses' views about the cultural safety theory in relation to inequities within the health care system in New Zealand. The findings suggest that the nurses in this study have an overall positive attitude towards working in accordance with the guidelines of the cultural safety theory. It also shows that the nurses believe the theory to be an opportunity to change attitudes and be a potential tool to reduce inequities within the health care system that are experienced by the Māori population. When asked to describe what cultural meant and was to them the nurses gave more and less the same definition. Even though they all agreed it was broad in its interpretation they all mentioned words as beliefs, values, traditions and a sense of belonging. Cultural therefore implies those definitions in this study.

In relation to overcoming inequities within the health care system, the nurses in this study all described cultural safety as a theory worth working in accordance with, though some underpinned the fact that it is not sufficient by itself to surmount all obstacles that lay ahead. It was explained that cultural safety was a most vivid part of the nurses' practices' and by learning about the theory also becoming more aware about how to meet, adapt and take differences in culture into consideration. Thus, postcolonial theory emphasises that in order to get a broader understanding and to be able to recognise and address the effect of culture and cultural differences in a health care context, more than awareness is required (Downing & Kowal, 2011). As shown in this study, nurses repeatedly came back to the need to be "aware" and how that enabled them to provide more health equity. As discussed in Downing and Kowal (2011) what might not be required as awareness of indigenous cultures, but rather the process of culture and how the discourse and knowledge of culture are "used in colonial systems to obtain and maintain the power of the dominant culture" (Downing & Kowal, 2011, s. 10). In cultural safety training nurses will go through three steps towards becoming culturally safe in nursing practice according to Ramsden (1992). Step one is cultural awareness - the recognizing there is differences in culture. Whether referring to cultural safety as being aware might suggest that the nurses have not grasped the theory to the fullest. Though, the nurses participating in this study also described the theory in tune with the original ideas about what the theory is aiming for. Therefore the authors do not see the term aware as a contradiction to what the theory is, but rather as it has become a way for the nurses to embrace and implement the theory in their practice as nurses.

Not to be able to provide an equitable health care service for indigenous people may result in patients rather going a long way to get a more appropriate care than to seek help in the nearest hospital with the risk for discrimination. A possible outcome from not feeling safe in the meeting with a health practitioner is to avoid the service until a more difficult intervention is needed. One of the Māori nurses described how her grandmother still rather visits a Māori Health Clinic further away from her home than to get treated by her local practitioner since she does not feel understood and treated in the same way in that clinic. In the Māori health clinic she was able to speak her native language and could get a treatment that was better suited for her needs than western medicines would or could. In this study it also became clear that among the opinions of the nurses there were a variety of factors that influenced and could explain health inequities between Māori and non-Māori. One of them was the accessibility to

healthcare. During the interviews, some of the nurses mentioned that Māori did suffer from the lack of access to healthcare to a greater extent than other New Zealanders. Māori has, still today, a higher prevalence rate of chronic diseases and they also experience a higher and increasing burden of non-communicable diseases than non-Māori. In addition they tend to have a slower treatment process and a longer waiting time compared to the non-Māori. Though, when reflecting on cultural safety in their practice the nurses didn't feel the theory was able to do anything about structural problems that has been set in the health care system as a whole.

According to Kumanan and Krech (2011) 80% of non-communicable diseases could be prevented through primary prevention. To address this, a focus has to be set on the social determinants of health, such as the conditions where people are born, live, grow up and work. In this study, in the state of primary prevention, some nurses mentioned that it can be possible, when working culturally safe, to be able to see, detain and keep more vulnerable patient groups, such as Māori. The health care system is beneficial for some parts of the population more than for others and in many countries, progress has been made to address the problem with non-communicable diseases but there is an unequal uptake of interventions that has led to non-communicable diseases still being the major cause of health inequities and social inequalities (ibid.). Stephens, Porter, Nettleton and Willis (2006) states in their study that access to health care is constrained by financial, geographic and cultural barriers and that indigenous people are low on the government's' lists. One nurse said, in line with Stephens et al., that Māori do tend to fall into the lower brick of socioeconomic status and that also affects their health. He clarified that even though services are available, Māori are often reluctant or afraid to use them since they are likely to feel discriminated. Equal access to healthcare for everyone might be implied in the country it does not mean that it is equitable (ibid.). Additionally, the Māori model of health differs from the western way of practicing medicine; this includes different remedies, alternative therapy, song and prayers. Goold, Turale, Miller and Usher (2002) state in their study, that health workers who do not have the "knowledge or skills to deal with indigenous people cannot provide an adequate health service to indigenous people". Further, Ramsden (2002) states that the culture of indigenous people is often confused to be the culture of poverty. To improve the health for indigenous people it is important to not only look for the causes behind but to also have a new approach to meet this differences.

CONCLUSION

The findings in this study suggest that the nurses' have an overall positive attitude towards working in accordance with the guidelines of the cultural safety theory. This study also shows that the nurses believe the theory to be an opportunity to change attitudes and be a potential tool to reduce inequities within the health care system that is experienced by the Māori population. Still, there are nurses that question the theory and its relevance, since they do not think that it affects them and their work. Nurses have an important role in working towards a more equal and inclusive health care and according to this study it is suggested that cultural safety can be a tool to achieve that.

CLINICAL SIGNIFICANCE

When working towards reducing inequities within the health care system it is of great importance to recognize what key factors that will contribute to that goal. By illuminating nurses' perspectives of cultural safety can lead to a better understanding for working with the theory in clinical practice. This study will hopefully keep opening up for conversations and reflections about what possibilities and obstacles that lays ahead for future nurses when working with different cultures.

SUGGESTION FOR FURTHER RESEARCH

Factors that may be an obstacle to achieve a more equitable health care for the population in New Zealand is important to detect. Due to this study's' limitation further research in the field is needed to enable the improvements needed. Cultural safety has been understood to be a meaningful tool to work towards health disparities for the nurses in this study, but to gather a broader perspective on the obstacles ahead, a study of a more comprehensive patient-perspective would be of value.

AUTHORS CONTRIBUTION

Both authors have been working together throughout the process of this paper. Some parts have been written individually but all parts were processed in consultation. Both authors contributed equally to the final product and are standing by the result.

ACKNOWLEDGEMENT

The authors would like to express their gratitude to Deirdre Burrows and Alexander Williams. Their help with getting in contact with informants was of main importance and greatly appreciated. The authors would also like to thank our supervisors Stéphanie Paillard-Borg and Borg and Mia Kraft for constructive feedback and guidance during this process.

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APPENDIX

Appendix I

INFORMATION LETTER

Preliminary name:

Cultural Safety – how and for whom is a theory relevant?

Students:

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Tutors:

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First of all, a big thanks for participating in our bachelor thesis report. The aim of our study is to explore nurses' attitudes towards Cultural Safety, a theory well implemented in the nursing profession around New Zealand. Therefore we will ask you questions about your thoughts and experiences about this theory.

We who will conduct the interviews are Linn Eriksson and Cecilia Eriksson – nursing students from The Red Cross University College in Stockholm, Sweden.

By the time of the interview you as a respondent will be given a form of consent. Your participation in this study is voluntary and you will, at any time during the interview, be able to deny participation and withdraw at any time.

The study will be conducted by semi-structured interviews, approximately 20-30 minutes long. The interviews will be recorded, transcribed and stored until our study is complete. The data will be totally anonymous, kept safe and Linn and Cecilia Eriksson are the only ones with access until the data will be destroyed.

The results will be presented to students at The Red Cross University College and published in DiVA, a database for nursing research. If desired, a copy of the report can be provided before final submission.

Appendix II

Interview guide

All interviews will be conducted through the guide below.

To start the authors will present a short repetition of the study's aim and ethical considerations. The interview will include semi-structured questions that will be the same for all participants. If needed some follow-up questions can be asked.

Information about:

- ❖ Anonymity
- ❖ If desired, a copy of the report can be provided before final submission
- ❖ The interview will be recorded
- ❖ The informant may skip questions or finish the interview when/if he or she so wishes

Background data

- ❖ Age?
- ❖ Gender?
- ❖ How many years have you worked as a nurse?
- ❖ Where do you work?
- ❖ Which department do you work in?
 - which patient groups do you meet in that department?

Main questions

- ❖ What is culture to you?
- ❖ How would you describe cultural safety?
- ❖ What would you say is the purpose of cultural safety?
- ❖ Do you reflect on cultural safety during a workshift?
 - in what situations?
- ❖ Can you describe how and if you encouraged to work culturally safe by your colleagues? Both within the nursing profession as well as interprofessional.
- ❖ Do you see a need for further training in cultural safety?

- ❖ Would you say cultural safety has been a working tool in your profession?
- If yes, in what way?
- ❖ Would you say cultural safety is an important tool/base for you in your nursing profession?
- ❖ What do you believe is your role as a health care giver when it comes to reducing inequities within health care system?
- ❖ Would you say that cultural safety is a tool to reduce inequity within the health care system?
-If yes, in what way? -If no, why not?
- ❖ Finally, if any, can you describe a situation where cultural safety was of importance in meeting with a patient?

Follow-up questions

- ❖ Could you please tell me in what way?
- ❖ Could you please elaborate that?
- ❖ Do you mean....?
- ❖ How?

Appendix III

WRITTEN CONSENT

I have read and understood the participation information sheet and have had the opportunity to ask the researchers, Linn Eriksson and Cecilia Eriksson, any questions if needed.

I hereby give my consent to participate in an interview regarding the study “Cultural Safety – how and for whom is a theory relevant”.

As a participant I am aware of;

- ❖ That my participation is voluntary.
- ❖ That I can choose to withdraw my consent at any time.
- ❖ That my anonymity will be contained
- ❖ That the interview will be recorded

I hereby give my consent to participate in the study above:

Date: _____

Signature _____