

# Cultural Competence: Facilitating Indigenous Voices Within Health Promotion Competencies

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## Abstract

Indigenous voices must inform health promotion strategies aiming to address significant and persistent Indigenous health inequities. Consequently, Indigenous knowledge and practice must inform capacity development tools such as health promotion competencies. To ensure Indigenous voices are heard, culturally appropriate consultations must be undertaken. This article analyzes the consultation process undertaken to develop the 2012 Aotearoa/New Zealand health promotion competency framework. Analysis was undertaken to identify aspects within the consultation process that facilitated participation by Māori, the Indigenous peoples of Aotearoa/New Zealand. This qualitative research study was undertaken with health promotion practitioners involved in the consultation process; data were obtained from individual semistructured interviews and analyzed using thematic analysis. Findings demonstrate that using culturally appropriate consultative approaches, and integrating Māori values within the consultation process, resulted in a culturally competent framework. Findings can inform future consultation processes undertaken with Māori alongside Indigenous populations and culturally diverse populations globally.

## Keywords

health promotion, competencies, Māori, indigenous, Aotearoa/New Zealand

## Introduction

Indigenous<sup>1</sup> health inequities are observed on a global scale (United Nations Development Programme, 2005) resulting in Indigenous people experiencing poorer health, increased disability, and reduced life expectancy than non-Indigenous people (United Nations, 2005). With approximately 370 million Indigenous people worldwide (The World Bank, 2016), these inequities are both a public health and human rights issue (Inter-Agency Support Group, 2014). Health promotion is effective in reducing Indigenous health inequities as the approach is based on the principles of equity, social justice, and empowerment (McCalman et al., 2014). Constructing a relationship between its values, practice, and people's right to health, health promotion improves health equity (Blaiklock & Kiro, 2015), acknowledges the role of autonomy and self-determination in improving health (Green & Tones, 2010), and complements Indigenous worldviews and values through a holistic view of health (Knibb-Lamouche, 2012).

## Competencies

Initially informing training (Masters & McCurry, 1990), competencies progressed to informing professional

registration, performance appraisals, and career pathways (National Mental Health Workforce Development Coordinating Committee, 1999). Within public health, they define the abilities required across the workforce (Public Health Agency of Canada, 2008) alongside the abilities required for specific roles (New Zealand College of Public Health Medicine, 2012).

The health promotion workforce has specific competencies that define the skills, knowledge, and behaviors for effective practice (Barry, Battel-Kirk, & Dempsey, 2012). Designed to empower the health promotion workforce, competencies inform quality improvement through bench-marking good practice, training, qualifications, human resource planning, staff development, recruitment, and selection (Health Promotion Forum of New Zealand, 2000). Acknowledged as vital to sustaining and developing effective practice, a competent health promotion workforce requires knowledge, skills, and abilities informed by policy, theory, and research (World

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Health Organization, 2009) alongside the ability to translate policy and research into effective practice (Barry, Battel-Kirk, & Dempsey, 2012). Defined as the development of knowledge, skills, commitment, structures, systems, and leadership to enable effective health promotion (Smith, Tang, & Nutbeam, 2006), capacity development has been identified by the World Health Organisation as key to achieving equitable health outcomes and improving Indigenous health (Jackson Pulver et al., 2010). While competencies have been identified as a tool that can make Indigenous public health programs and the workforce culturally safe (University of Victoria, 2017), it is concerning that there are no core competencies for public health practitioners working with Indigenous communities internationally (Hunt, 2015).

### *Health Promotion in Aotearoa/New Zealand*

Health promotion practice within Aotearoa/New Zealand is informed by both the Ottawa Charter for Health Promotion and the Treaty of Waitangi.<sup>2</sup> Two versions of the Treaty document were written, the English version known as the Treaty of Waitangi and a Māori version written in Te Reo Māori, the Māori language known as Te Tiriti o Waitangi. Within Aotearoa/New Zealand, there is a defined Māori health promotion practice that aligns itself closely with the Māori version of the Treaty. Based on articles within Te Tiriti that relate to governance, Māori control, self-determination, and equity, the approach differs from a western view of health promotion as it focuses on strengthening Māori identity and improving health through a positive, holistic approach that realizes Māori potential, intergenerational connectedness, and spirituality. Based on cultural values and practices, the approach aims to increase Māori participation within decision making (Ratima, 2010).

Historically, Māori public health was based on effective well-established systems that were weakened by colonization, reducing Māori confidence in their worldviews and leadership, focusing medical approaches on health, and outlawing Māori traditional medicine (Signal, Ratima, & Raeburn, 2015). However, changes in Māori health development that continue to this day commenced with increased Māori political activism during the 1960s and 1970s and increased Māori-focused health initiatives during the 1980s. The Māori origins of the Cultural Safety movement also arose at this time with the first kawa whakaruruhau (cultural safety) guidelines written in response to safety, recruitment, and retention issues within nursing of Māori nurses (Nursing Council of New Zealand, 2011). The 1990s also witnessed increased value of Māori health promotion and consequently an increased number of Māori health approaches informed by the Treaty of Waitangi principles and a market-driven competitive health sector. This resulted in increased health services being governed, owned, and delivered by and to Māori (Signal et al., 2015). More recently, the 2008 National government coalition with the Māori political party resulted

in the development of the Whanau Ora programme. This programme was a cross government approach integrating health, education, and social services to improve family outcomes (Ministry of Health, 2015), which continues to deliver health promotion across Aotearoa/New Zealand in 2017.<sup>3</sup>

Today, Māori health promotion negotiates Māori and Western worlds, profiting from the strengths of generic and Māori approaches and an increased Māori health promotion workforce that is increasingly confident in their Māori identity (Ratima, Durie, & Hond, 2015). This increased value for Māori health promotion practice is consistent with an increased respect for Māori culture, knowledge, and beliefs within society (Willmott-Harrop, 2006). Treaty-informed institutional structures have increasingly positioned Māori within political and legislative processes. These began in the 1860s with the creation of dedicated Māori parliamentary seats (Cape York Institute, 2014), followed by the formation of the 1975 Waitangi Tribunal to redress the Crown for past violations and the recognition of Te Reo Māori as an official language in 1987 (Cape York Institute, 2014). More recently, Māori health promotion and both The Treaty of Waitangi and Te Tiriti o Waitangi are observed within Aotearoa/New Zealand government policy and legislation that refers to Māori health, such as the New Zealand Public Health & Disability Act 2000. The act requires that District Health Board<sup>4</sup> initiatives be informed by the Treaty of Waitangi principles, namely, partnership, participation, and protection (Ministry of Health, 2012). Within health promotion, these principles are a framework, enabling Māori to gain control over their health through having an ongoing relationship with the Crown (government), being involved in all aspects of society, and having an equitable health status to non-Māori (Waa, Holibar, & Spinola, 1998).

### *Health Promotion Competency Developments in Aotearoa/New Zealand*

Consistent with international health promotion workforce developments (Barry, Battel-Kirk, Davison, et al., 2012), health promotion practice within Aotearoa/New Zealand is informed by health promotion competencies. Initially prompted by 1997 conference discussions, the Ministry of Health [MOH] contracted the Health Promotion Forum (HPF) to lead the development of a health-promotion competency framework. Following 2 years of extensive consultation, a competency framework informed by Te Tiriti o Waitangi, and the values-, ethics-, knowledge-, and skills-based clusters necessary for health promotion practice in Aotearoa/New Zealand, was published in 2000 (Health Promotion Forum of New Zealand, 2000).

Despite being recognized internationally as an appropriate framework for a diverse and global audience (Battel-Kirk, Barry, Taub, & Lysoby, 2009), postpublication consultations undertaken by HPF clarified that future

competencies required more content and context related to Māori values and Te Tiriti o Waitangi (Rance, 2009). Consequently, in 2010, the MOH contracted HPF to develop competencies that could truly strengthen the capability and capacity of the workforce (Rance & Tu'itahi, 2011). Following 2 years of consultations, a reviewed health promotion competency framework was published in 2012.

### *The Current Study*

The Health Promotion Forum of New Zealand, an organization founded on the principles of Te Tiriti o Waitangi and the Ottawa Charter, was contracted to develop the health-promotion competency framework. The consultation process led by the Health Promotion Forum of New Zealand is analyzed to explore whether Māori values and cultural practices were considered and implemented within the consultation process to develop the 2012 Aotearoa/New Zealand health-promotion competency framework. Aspects of the consultation process that facilitated participation by the Māori health promotion workforce are analyzed.

This article is based on a small, qualitative study comprising interviews undertaken with health promotion practitioners based in Aotearoa/New Zealand. The study addresses two key research questions:

**Research Question 1:** Were Indigenous cultural values and practices used within the Aotearoa/New Zealand competency consultations? If so, how were they used?

**Research Question 2:** What is the significance of using Indigenous values and cultural practices within consultation processes for Māori?

The study was undertaken to inform future consultation processes with Māori and Indigenous populations, and ethnically diverse populations globally. The findings should also inform the proposed 2018 review of the Aotearoa/New Zealand competency framework.

The study is part of a wider research project undertaken by the author consisting of a cross-country review of international health promotion competency frameworks, namely, the Australian, Canadian, Aotearoa/New Zealand, and European CompHP<sup>5</sup> competency frameworks. The analysis considered the competency development processes, the consultation approaches undertaken, and the participants involved.

### **Method**

This qualitative research study was undertaken to identify what aspects within the competency development consultation process facilitated Māori participation. Semistructured interviews were undertaken with five national health promotion leaders. Considered experts in the field of health promotion due to their national leadership roles, all participants had previously participated within the competency consultation

process. Although the number of participants was small, their participation and contribution were rich and beneficial to the study. Participants were identified from competency development reports stored at HPF due to their leadership and ongoing participation in the development of the 2012 health-promotion competencies framework. Consisting of three females and two males, the sample size was small, which is characteristic of qualitative data (Patton & Cochran, 2002). Participants self-identified as Māori, Pasifika, New Zealand European, and over 40 years of age. Participants were selected as those most likely to provide useful data (Patton & Cochran, 2002) and information rich in relation to the topic of interest (Palinkas et al., 2013), namely, the development of the 2012 competency framework.

As the research aimed to explore what aspects of the consultation approach had enabled Māori to participate, Māori were purposively sampled, resulting in three Māori participants. Interviews were undertaken face-to-face, or via SKYPE and telephone. All interviews were audio-taped and transcribed verbatim.

Data was analyzed using thematic analysis; widely used within qualitative data analysis, the approach was chosen to identify, analyze, and report themes within the data to answer the research question (Braun & Clarke, 2006). Each of the five interviews were conducted and recorded following participants' consent and transcribed verbatim. A six-phase process guided analysis consisting of becoming familiar with the data, undertaking coding, searching for themes, reviewing the themes, defining and naming the themes, and then finally writing up the information (Braun & Clarke, 2006). An inductive thematic analysis was undertaken, enabling the researcher to find unique codes within the data; consequently, the coding and theme development were directed by the content of the data. Emergent codes related to aspects within the consultation process that had enabled meaningful Māori participation, namely, an inclusive approach and consideration of Māori values within the process. Subthemes related to the consideration of tikanga Māori practices, provision of adequate consultation time, empowerment, and equity within the process. As the researcher was non-Māori, a Senior Māori colleague reviewed the analysis to ensure data presented were culturally appropriate. The research was part of a master in public health qualification; consequently, analysis was checked and validated by a master's supervisor. Ethics approval was gained from the University of Auckland's Human Participants Ethics Committee (UAHPEC), Reference 012951. Participants were given a description of the research and the voluntary nature of participation alongside their right to withdraw from the study at any time.

### **Findings**

Participants were interviewed because of their previous participation in the competency consultation process; consequently, all participants were able to provide detailed

responses informed by the process. All participants identified that it was the use of cultural practices and consideration of Māori values that had facilitated Māori participation within the consultation process. Prominent themes related to the consultation approaches undertaken included the values of empowerment and equity within the process.

### *Use of Cultural Practices Within the Consultation Process*

Some participants had participated in the Māori-specific workshops while others had participated in more diverse consultation opportunities. Regardless of participants' contributions to consultations, all emphasized that culturally appropriate practices had been utilized. All participants identified that *tikanga*<sup>6</sup> Māori practices had been used within the consultation process, clarifying that the use of such practices was significant for Māori, as these practices are embedded in Māori culture. An element of *tikanga* that participants emphasized was how the practice of *manaakitanga*<sup>7</sup> (hospitality) had supported discussions, developed relationships, and enabled conversations to take place.

Karakia (prayer) before hui(gathering), having kai(food) afterwards is part of manaakitanga, it is not just being a good host, it's all those things that come with manaakitanga friendship and whanaungatanga.<sup>8</sup> Kai plays a huge part of who we are as Māori. (Participant 4 Māori, female)

A preferred way of consulting for Māori is face to face. The fact that this approach was facilitated and planned for within the consultation process was highlighted by a participant who emphasized how the approach was valued by the Māori health promotion workforce and facilitated Māori participation.

From the Māori point of view, the face-to-face meetings were very important. I think it gave Māori a feeling that they were well involved in the development of competencies. (Participant 2, Māori, male)

A couple of participants wished to highlight that the culturally appropriate consultation approach was undertaken as this was the correct way of doing things. Participants wished to emphasize that this approach was appropriate for Aotearoa/New Zealand and was not something that was questioned.

Participants also wished to emphasize that consultation approaches were chosen purposefully and informed by known approaches that would facilitate Māori participation and, therefore, were not undertaken in a tokenistic way. It was important for participants that Māori health promoters were not invited to participate as a tick box exercise but were invited throughout the process as their contribution was valued; consequently, Māori-specific workshops were also

offered to gather Māori Indigenous knowledge and experience.

... appropriate consultation processes for Māori was discussed, this item was always about using the appropriate process. (Participant 5, Māori, female)

From the onset, we were assured that Māori would feed into the development of the competencies, and they were a key element throughout. (Participant 2, Māori, male)

### *Adequate Consultation Time*

All participants highlighted that the time allocated to the consultation process was significant to Māori cultural practice. The provision of adequate consultation time within the consultation process was acknowledged by all participants as appropriate; it related to the two-year time period allocated to the consultation process and the nonrushed approach within consultation workshops. A couple of participants highlighted that the considered time allocation had facilitated Māori discussions and enabled a culturally appropriate consultation to take place.

There was a good length of time to sit down and wānanga (discuss) to talk about different competencies particularly pertaining to Māori. Māori worldview those sorts of things we express throughout the process. (Participant 4, Māori, female)

If finished sooner, certain elements might not have been covered so there is a danger that those important Indigenous elements might have been missed. (Participant 2, Māori, male)

### *Application of Māori Values Within the Consultation Process*

A couple of participants indicated that the consultation approach supported Māori empowerment as the process enabled Māori to exercise control by having a voice throughout. Participants illustrated that the facilitation of Māori specific consultations workshops was one way in which the consultation process facilitating Māori worldviews to be heard. Participants illustrated that this approach was undertaken because Māori health promotion knowledge was valued, and resulted in locating Māori health promotion within the competency framework.

... it's their human right to have their cultural knowledge considered, included, and done in the right way as well. (Participant 1, Pacific, male)

Having input into the competencies was another way of ensuring that the Māori voice was heard in the development of health promotion. (Participant 2, Māori, male)

All participants emphasized that equity related to how the consultation process had valued members of the health

promotion workforce without formal health promotion and public health qualifications. All members of the HPF national workforce database were contacted and invited to participate in the consultation. It was this action alongside ensuring that the process was not led by academics and academic institutions that participants highlighted as being equitable; it had enabled the voice of the diverse health promotion workforce to be heard.

Participants emphasized that the inclusive approach of inviting the diverse workforce to participate had enabled Māori participation. Participants were particularly forthright in emphasizing that it was these approaches that made the Aotearoa/New Zealand process unique from other international competency consultation processes. Participants emphasized that valuing and hearing from grass roots health promoters was important.

There could have been a danger that academia could have taken over the process, we know a lot of Māori working in health promotion might not be at that level never the less they would have had some valuable input. (Participant 2, Māori, male)

They don't come with a piece of paper but they were valued and they were deemed to be important. (Participant 5, Māori, female)

As a result of the equitable and inclusive approach undertaken that facilitated the voice of the grass roots workforce, a couple of participants wished to propose that the Aotearoa/New Zealand process could be an example of best practice that could inform consultations with Indigenous populations internationally.

I am aware of how we have right from Day 1 included Indigenous knowledge, acknowledged the rights of tangata whenua compared to Canada or for that Australia. We are not imposing our model we design a model that is inclusive and collaborative. (Participant 1, Pacific, male)

It kind of reasserts our own values as a nation in that we value the Māori Indigenous element. So the hope for me is to use the competencies to inform how other nations may do the same thing. (Participant 2, Māori, male)

## Discussion

The study was undertaken to identify what consultation approaches had enabled Indigenous voices to be heard. The findings are valuable as they identify culturally appropriate approaches that can inform the development of an appropriate capacity-development tool. While the research undertaken focused on Māori, the findings are relevant to other Indigenous communities due to the Indigenous customs and traditions prioritized within the consultation process that are common to many if not all Indigenous communities (Harmsworth, 2002).

To reduce inequities, the health promotion workforce and, consequently, capacity development tools such as health promotion competencies need to be culturally competent. To identify whether the Aotearoa/New Zealand 2012 competency framework was culturally competent and appropriate for Māori, two key research questions were asked, namely, whether Indigenous cultural values and practices were positioned within the Aotearoa/New Zealand competency consultations and what is the significance of using Indigenous values and cultural practices within consultation processes for Māori?

The main theme illustrated by the research related to the range and significance of *tikanga* Māori cultural practices positioned within the consultation process. Māori *tikanga* practices are significant for Māori as they describe the practices, protocols, and ethics for what is right for Māori, and relates to Māori values or what is "good" (Hudson, 2004). *Tikanga* practice identifies the appropriate ways of behaving and acting (Mead, 2003), while *tikanga* values are a framework through which Māori can engage and develop relationships (Hudson, 2004).

The research identified that the consultation process had positioned the Māori value of *manaakitanga* within the practices used. This practice is not only important for this research but Māori research generally as it ensures that participants feel comfortable and safe to participate within the consultation process. The sharing of kai (food) that was provided within consultation workshops facilitates the safety of participants as food is an aspect of *manaakitanga* that enhances the mana (status) of the host, lifts the tapu (sacred or restricted), and allows matters to become noa (unrestricted). In practice, this means that food becomes a vehicle that brings people together, while the sharing of food removes restrictions that can keep people separate and lifts restrictions on matters to be discussed. Within consultations, food moves proceedings from the formal to the informal and paves the way for good discussions (Tipene-Matua, Phillips, Cram, Parsons, & Taupo, 2012).

Other traditional Māori practices were emphasized by participants within the consultation process that safeguard participants. They were the face-to-face consultations, hospitality, and relationship building. It is these approaches that make the Māori research processes unique and help safeguard the research process, the knowledge produced, and the researchers, participants, and communities involved (Jones, Crengle, & McCreanor, 2006). This practice of *manaakitanga* is significant as it focuses on positive human behavior, respecting others, and being prepared to listen to other people's arguments (Mead, 2003). Related to how people are cared for, treated, and how relationships are nurtured, *manaakitanga* has been described as the most important aspect of the consultation process for Māori (Barlow, 1991).

*Kanohi kitea* (face to face) literally means "a face seen" (Mead, 2003); it relates to the importance of meeting people face to face to build trust and relationships. Within the

context of research, it has been described as being prepared to show one's face and share of oneself (Jones et al., 2006). These planned and considered face-to-face approaches were significant as face-to-face interactions are the preferred consultation approach by Māori that are more likely to result in more effective Māori input (Ministry of Health, 1997).

The Māori principle of *whakawhanaungatanga* (relationship building) was also emphasized as important within the research. Referring to allowing time and space to build relationships (Jones et al., 2006), *whakawhanaungatanga* is informed by Māori ethics that prioritize collectives and the outcomes of the group rather than the individual. It also relates to a group of people with a shared vision or purpose (Delany, Ratima, & Morgaine, 2015) and is significant for research and consultations as the principle relates to sincere collaboration and power sharing (Ritchie, 2003).

Another major theme illustrated within the research related to empowerment and equity. Participants illustrated that the consultation approaches undertaken were equitable as they valued hearing the voice from members of the workforce without public health and health promotion qualifications. Participants were clearly aware that there was an element of the workforce that could provide valuable knowledge and insight into the competency frameworks but had no formal qualifications. This inclusive approach was also significant for Māori as data illustrate that the Māori public health workforce has fewer tertiary qualifications than the non-Māori workforce (Ratima, 2010). Māori organizations also generally have less qualified health promoters than in government Public Health Units (Lovell, Egan, Robertson, & Hicks, 2015). With a lack of a clear qualification or career pathway (Health Promotion Forum of New Zealand, 2012), the health promotion workforce within Aotearoa/New Zealand is diverse with health promoters coming from a range of backgrounds and holding a variety of roles. These include community leader, educator, and health advocate (Signal et al., 2015). Such diversity is consistent with a lack of clear identity and diversity of job titles, qualifications, experience, backgrounds, and training witnessed within health promotion globally and illustrates the necessity for distinct health promotion knowledge, skills, and competencies for effective health promotion practice (Barry, Battel-Kirk, & Dempsey, 2012).

A limitation of the research was that only leaders in the field were interviewed rather than including the perspectives of health promotion practitioners at the grass roots level. The research was also limited as it did not explore whether the competency framework developed has been effective in improving health outcomes for Māori.

## Conclusion

The study has examined a health promotion competency development process with an Indigenous lens and a unique focus that identifies consultation approaches that enable

meaningful Indigenous participation. The competency framework and consultation approach is a lens through which to understand Māori sensitivity within Aotearoa/New Zealand.

The research findings illustrate that the consultation process undertaken to develop the 2012 Aotearoa New Zealand health promotion competency framework facilitated Māori participation through using culturally appropriate consultation processes. Findings illustrate that Indigenous knowledge, values, and practices were valued and prioritized within consultation approaches. The consultation approaches used were purposefully chosen to facilitate Indigenous participation that went beyond having Indigenous representatives present and participating in name only but resulted in meaningful participation. Consequently, the competency framework is culturally appropriate and unique for the Aotearoa/ New Zealand context. It has the potential to effectively develop a culturally competent health promotion workforce.

To support future competency developments, the consultation process undertaken can be presented as an example of best practice. Although the study focuses on the Aotearoa/ New Zealand context, the findings are relevant to other Indigenous populations, namely, populations that share the experiences of colonization and disruption from their cultural practices.

Further research is now required to identify whether the use of a culturally competent health promotion framework has been effective in improving the health of Māori within Aotearoa/New Zealand.

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## Notes

1. Although a definitive definition of Indigenous has not been accepted by the United Nations, a common definition relates to "peoples those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. The new arrivals later became dominant through conquest, occupation, settlement or other means" (United Nations Permanent Forum on Indigenous Issues, n.d.).
2. The Treaty of Waitangi is the founding document of Aotearoa/ New Zealand signed in 1840 by representatives of the British government and some Māori tribes. Differing opinions on the intentions and obligations of the versions range from a view that the treaty formalized a relationship to recognize and protect

Māori values, traditions, and practices (Cram, 2003) to a view that the treaty enabled colonization (Metge, 1990). Despite ongoing debate, the promotion and protection of Māori health is central to both versions indicating that they are both useful frameworks for Māori health development (Kingi, 2007).

3. Māori experience higher rates of chronic diseases, including cancer, diabetes, cardiovascular disease, and asthma than non-Māori. Māori life expectancy for Māori males is 73.0 years compared with 80.3 years for non-Māori males and 77.1 years for Māori females compared with 83.9 years for non-Māori females (Ministry of Health, 2015). These inequities are persistent, on the increase for Māori (Marriott & Sim, 2014), and consistent with Indigenous global health inequities (United Nations Development Programme, 2014).
4. District Health Boards are responsible for providing or funding the provision of health services in their district.
5. The CompHP competencies are part of a wider European project that has developed competencies, professional standards, and an accreditation system for health promotion practice and knowledge (International Union for Health Promotion and Education, n.d.).
6. *Tikanga* (n.d.) relates to correct procedures, custom, lore, and protocol, and the way values and practices have developed over time and are deeply embedded in the social context (<http://maoridictionary.co.nz/search?keywords=tikanga>)
7. *Manaakitanga* (n.d.) refers to hospitality and generosity, and care for others (<http://maoridictionary.co.nz/search?keywords=manakitanga>)
8. *Whanaungatanga* (n.d.) relates to relationship, kinship, and a relationship through shared experiences and working together, which provides people with a sense of belonging (<http://maoridictionary.co.nz/search?keywords=whanaungatanga>)

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