Tēnā koutou katoa. I was honoured to meet with you virtually and engage in important discussions about the realities affecting our Indigenous nurses. Unfortunately, I could not multi-task and answer these questions yesterday, but I am reflecting on these thoughtful questions as I sit in the sun, listen to the birds and the tamariki (children) next door playing in their small pool. Below, I have provided responses for the questions in the Chat function for yesterday's 53rd Marion Woodward Lecture.

Keep well and safe in these uncertain times. Ngā mihi nui Denise

Mona Lisa Bourque Bearskin 08:32 AM

Dear Dr. Wilson, thank you so much for your presentation. and sharing your lifes work. In light of the recent news here in Canada on voluntary self Idenficiation, have you developed any strategies for supporting voluntarry self identification to ensure autentic positioning and self location is accurate. Any specific accountablity policies or measures you might suggest. What do you think our Institutional respeonsiblities are in ensuring people are who they say they are?

RESPONSE

This is a good question because it seems to differ across the globe. First, I would position this issue within the context of ongoing colonisation and the destructive forces this has exerted on our social structures. This has meant that many Indigenous peoples have become disconnected from their cultural roots, or in some country's others determine who or what they can be (for example, blood quantum requirements). If as Indigenous peoples, we are serious about the protective and healing nature of cultural identity then we need to acknowledge that some people will be able to clearly position themselves as Indigenous and have strong cultural connections. For others this is less certain and more complex.

Here in Aotearoa, we self-identify as Māori with our whakapapa showing our Indigenous genealogy. However, it is recognised that some people because of their whānau histories they have lost their whānau links, particularly when there is state uplifting of children. The important factor is that they are supported and those with whakapapa knowledge may help connect them to their iwi (tribal nation).

Second, is the issue of authentication and being accountable to verify you are Indigenous. My personal view is that such processes are yet again a demonstration of further colonisation and harm to our Indigenous peoples. I have seen this play out in my travels when people are considered "not Indigenous enough" by their own Indigenous colleagues – this is something we need to be mindful of.

Heather Payrastre - Term 5, peds 08:54 AM

Hello Denise, thanks so much for your time. We are working on "indigenizing our curriculum" for our Bachelors of Nursing undergraduate program in British Columbia, Canada. One question that we are struggling to navigate, is when we explore the health of indigenous people, how do we navigate the population health that includes increased prevalence of T2DM, or increased presence of addictions, or higher incidence of domestic violence, without creating a negative or shaming narrative about first nations health? I would appreciate your perspective.

RESPONSE

An excellent question. Sadly, the negative statistics Indigenous peoples experience are our reality and we cannot ignore them – this is why we do the work that we do. Most Indigenous nurses here in Aotearoa are motivated into nursing to try and make a difference for our people and to help reduce the health inequities that they suffer. Importantly, we can improve the quality and safety of care Indigenous peoples receive in our health services, especially so they are culturally safe. I have found that oftentimes our Indigenous peoples do not know about or understand the gaps that exist between Indigenous peoples and other groups of people within our respective populations.

I always begin teaching and learning with a 'state of play' approach followed on by getting students to think about why the gaps and disparities in health outcomes exist. The ground-rules are being respectful in what we say, but also having the learning space as a safe space to undertake exploration of what we know and what we think we know. I find this is where qualitative research is helpful to bring in Indigenous people's experiences beside the statistics. Statistics provide us with the big-picture and do not necessarily evoke change beyond the initial horror about disparities that may exist. It is the stories that evoke change, and I have seen that occur in the domestic violence space following our E Tū Wāhine, E Tū Whānau research, which found that the universal approach used for family violence here

in Aotearoa does not serve our Indigenous women and children well (see: https://openrepository.aut.ac.nz/handle/10292/13068). There is always the odd person who responds with deficit explanations, negative stereotypes and racism. I do not take these off the table but rather get students to think about their feedback. For example, non-compliance – this issue exists for many people across our population regarding their tending to health issues. We explore realistically how the issue of non-compliance is a factor (refer to health literacy, to who is getting care and who is not, research around patient satisfaction, etc). We explore how our systems and structures are set up within the health system – we look at the reality, the evidence, etc. I find this sort of interrogative approach starts turning on lightbulbs and 'ah-ha!' moments amongst the students. I realise this is a very shallow look at what we do, but this is not about focusing on deficits etc but uncovering myths and misconceptions along with the racially based approaches inform people's thinking and fuel discrimination and racism that our people confront when they seek health care.

Colleen Varcoe (she|her) 08:55 AM

thank you so much for being with us Denise! as you well know, there are many similarities between our colonial contexts and the impacts on Indigenous peoples. Since the early 1990s cultural safety has been formally embedded in nursing in Aotearoa - what are the lessons learned from that, and what do you advise nurses in Canada to do based on those lessons?

RESPONSE

Cultural safety was born out of concerns about our Indigenous Māori nursing students and whānau and the need to be culturally safe alongside of being physically, ethically, and legally safe. But along the way, the concept of cultural safety got highjacked by nursing, and while this may be cynical, has become a somewhat naval gazing exercise. Furthermore, we did not land on clear metrics about how we measure a nurse's cultural safety – it was seen by some as too hard. To be honest, I look back on time and believe that the social and political outcry that nursing would introduce cultural safety and that it was a concept from Māori focusing on Māori (initially) played a big part. Personally, for me early in my education career it can only be described as ugly because it unleashed racism across the nation. I often wonder if this, the broadening of Kawa Whakaruruhau into cultures, and the national backlash in some way became a deterrent for establishing these points. Interestingly, no other professional group within and outside of health had a similar experience. I think as nurses we needed to be a little more courageous. We need to evolve cultural safety – it is at the root of improving Indigenous health equity. We need people who are culturally safe to work with our people. For me, the lesson is about being courageous enough to develop metrics that involve our Indigenous whānau. Undoubtedly, as time goes by and we have more qualitative it highlights the importance of cultural safety and meeting people's cultural needs in terms of their family and their spirituality.

Shirley Sterlinger 09:01 AM

Wondering if we can get the references

RESPONSE

I will include these at the end of the questions and response.

Atussa B. Shabahang 09:01 AM

Thank you for your presentation Dr. Wilson. I am in the UBC MSN graduate program. I have been exploring the invisibility of indigenous people in Canada - the invisible loss of culture, language and land. How do nurses see the invisible and bring it to their practice?

RESPONSE

First, I think we need to stop the rhetoric "I treat all my patients the same". This provides a blanket over the patients and their families we encounter in health care settings and perpetuates Indigenous peoples being invisible. We talk person-centred and family-centred care, but in reality, it is my experience we centre everything around the health setting and the people that work within it, including their focus on lack of time. These concepts need to be rigorously examined and critiqued within the context of Indigenous peoples, and we need to truly define what being family-centred means from an Indigenous perspective. That is, our worldviews that differ from the dominant cultural and health worldviews; shift our focus from individuals to the collective whānau because for Indigenous peoples individuals are

part of a whole, for instance. Fundamentally, I believe we need to provide nurses with a historical and contemporary realities of colonisation for Indigenous peoples and position this within the impacts of wellbeing, health and the occurrence of racism (which is a tool of colonisation). Then we need nurses to apply this to their practice. I set assessment activities around this – such as critical analysis of not only social determinants of health and wellbeing but also cultural determinants.

Elsie Tan 09:05 AM

Whakawhetai koe Dr. Wilson for infusing the Maori language into the presentation and bringing your exceptional mana to today's session.

RESPONSE

Thank you Elsie for your kind words. I greatly appreciate these.

Elsie Tan 09:06 AM

My questions is how does one help students reconcile with the knowledge they bring about Indigenous health and context and practicing in an environment that continues to create barriers?

RESPONSE

Good question with no easy answer. The socialisation of new registered nurses in practice environments cannot be underestimated, because the pressures of being a junior among experienced seniors and new nurses wanting to conform can be quite powerful. However, including how to respond to and resist these pressures and the development of strategies is crucial. Also, reinforcing what sound quality practice looks like within Indigenous health contexts so students have a good understanding of this. The other concept to interrogate is time, as it is often used as a barrier to instituting different ways of practising. However, time spent in offering quality and safe nursing care can save time later when issues that could have been prevented occur for Indigenous people. For instance, not spending the time to ensure health information is delivered in chunks and can understood and applied to enable the self-management of type 2 diabetes. When important information is not understood, it can result in serious complications. These are some thoughts.

Kathleen Lounsbury 09:10 AM

Kathleen Lounsbury, RN, MSN Kwakwak'awakw from Alert Bay and Kingcome Inlet Trinity Western University Sessional instructor: what strategies do you envision to measure cultural competency among nursing professionals beyond Sanyas and other training modules?

RESPONSE

First we need to define what we mean by cultural competency and its parameters. Cultural competency, I believe, is a combination of our **knowledge about ourselves**, about the people in our community and for Indigenous people's understanding their historical and current realities | **what we do (our actions) –** what we do in practice and how we interact with Indigenous people and why this may be so | **how we integrate** an Indigenous person and their family's cultural needs and practices into a plan of care. Second, cultural competency is not about knowing someone's culture, but knowing ourselves and how we respond, and also what we do. I have developed some areas to look at with the KAI model I mentioned yesterday.

I undertake an activity with students that entails dividing a piece of paper into quadrants: What I **think** about Indigenous peoples… | What I **feel** about Indigenous peoples… | What I **know** about Indigenous peoples… | What I **need to know** about Indigenous peoples. I encourage students to not think about their answers and to list their thoughts honestly – no one is going to judge them, and it is for their learning, but what we get out of this is some good direction for learning.

A good strategy would be to get together and use a wānanga or a talking circle to identify the key measurable features for cultural competency in your region. I would also include Indigenous elders and cultural experts for the cultural wisdom and their lived realities.

Kathleen Lounsbury 09:27 AM

Along with this, curricular-wise, one Indigenous class is not enough, how do we layer indigenous ways of knowing throughout the nursing curriculum in BC/Canada?

RESPONSE

You are right one Indigenous class is insufficient. At AUT, we have three hauora Māori papers and are about to embark on developing two more papers to for a minor in our new Bachelor of Health Science degree structure. However, the nursing curriculum content is to some degree dictated by Nursing Council who approves the nursing curricula. It has one dedicated Māori health paper. We are in the process of weaving mātauranga Māori through all our health programmes, so it is not just one-off papers plonked somewhere in the curriculum and then not reinforced. This may mean some papers will remain as they are (e.g. human anatomy and physiology) but others will have relevant Indgienous ways of knowing and being included.

Given the Māori, Pacific, and disability health ienquities in Aotearoa and the focus of the restructuring of our health system that aims to improve health equity for these groups we can no longer just offer Western and biomedical knowledge.

Tricia she/her 09:30 AM

I deeply appreciate the words about trying to be an ally in a good way. Do any of the panelists have particular recommendations for people who seek to be good allies?

RESPONSE

This is a good question. It is helpful to think about the relationship allies would have with Indigenous people, and what each brings to that relationship space. This space should be one whereby what Indigenous people and allies bring to the space is not contestable. Thus, good allies would be **respectful** of Indigenous aspirations and needs and the need for Indigenous people having control on how these can be realised. Good allies would be **willing to listen and be guided** and think about their role in creating space for Indigenous self-determination occur, and the sharing of resources to enable Indigenous aspirations to be realised. So often, our allies talk about us for us whether inadvertent or intentional – the outcome is that we often get silenced and become invisible and where good intentions can go awry.

Tina Revai, she/her, FNHA 09:48 AM

To build on Heather's questions/comments, and Tania's very important poin that nurses are largely the system, teaching and building competencies/indicators, beyond those that are biomedical and/or task focused, without equal commitment/articulation of understanding how structural violence works, historically and present day and our commitments, actions to disrupt this at all levels, personal, interperson, and system level - it seems we fall back to status quo. Are there any examples of nurse or healthcare provider frameworks for education, professional practice that help make that shift?

RESPONSE

These observations are so right. When I reflect on achieving this sort of change, we need to critically interrogate our structures and systems (and the people within them) that perpetuate the status quo and look at how we can restructure and redefine these. It may be that these will look and function in totally different ways. Tinkering with something that does not work does not achieve the necessary change. There also needs to be a critical review of the people leading this change – it is my observation that expecting the nursing leadership who is responsible for the status quo does not effect change. So, it is thinking about who needs to be around the change table (including people who can think outside the square and who are willing to alter plans when they are found not to work) to evoke the necessary change, and there should be a balance of Indigenous peoples. Change also needs to be embedded into the structures and systems so they do not become person or people-dependant.

References

Anderson, A., & Spray, J. (2020). Beyond awareness: Towards a critically conscious health promotion for rheumatic fever in Aotearoa, New Zealand. *Social Science & Medicine, 247*, 112798. https://doi.org/https://doi.org/10.1016/j.socscimed.2020.112798

Cormack, D., Stanley, J., & Harris, R. (2018). Multiple forms of discrimination and relationships with health and wellbeing: Findings from national cross-sectional surveys in Aotearoa/New Zealand. *International Journal for Equity in Health, 17*, 26. https://doi.org/10.1186/s12939-018-0735-y

Haar, J., & Martin, W. J. (2021). He aronga takirua: Cultural double-shift of Māori scientists. *Human Relations, 0*(0), 00187267211003955. https://doi.org/10.1177/00187267211003955

Harris, R., Cormack, D., Tobias, M., Yeh, L.-C., Talamaivao, N., Minster, J., & Timutimu, R. (2012). Self-reported experience of racial discrimination and health care use in New Zealand: Results from the 2006/07 New Zealand Health Survey. *American Journal of Public Heath, 102*(5), 1012-1019. https://doi.org/10.2105/AJPH.2011.300626

Mitchell, M., & **Wilson, D.** (2019). Family and cultural care of the critically ill patient. In L. Aitken, A. Marshall, & W. Chaboyer. (Eds), *Critical care nursing* (pp. 171-204, 4th ed.). Elsevier Australia.

Reid, P., Robson, B., & Jones, C. (2000). Disparities in health: Common myths and uncommon truths. *Pacific Health Dialog, 7*(1), 38-47.

Wepa, D., & Wilson, D. (2019). Struggling to be involved: An interprofessional approach to examine Māori whānau engagement with healthcare services. *Journal of Nursing Research and Practice, 3*(3), 01-05. https://doi.org/http://doi.org/10.37532/jnrp.2019.3(3).1-5

Wilson, D. (2008). The significance of a culturally appropriate health service for Indigenous Maori women. *Contemporary Nurse, 28*(1-2), 173-188. https://doi.org/10.5172/conu.673.28.1-2.173

Wilson, D. (2017). *Ngā Manukura o Āpōpō Programme Evaluation Report: 2015-2016*.

Wilson, D., & Barton, P. (2011). Indigenous hospital experiences: A New Zealand case study. *Journal of Clinical Nursing, 21*(15-16), 2316-2326. https://doi.org/10.1111/j.1365-2702.2011.04042.x

Wilson, D., Mikahere-Hall, A., Sherwood, J., Cootes, K., & Jackson, D. (2019). *E Tū Wāhine, E Tū Whānau: Wāhine Māori keeping safe in unsafe relationships*. AUT Taupua Waiora Māori Research Centre. https://openrepository.aut.ac.nz/handle/10292/13068

Wilson, D., Barton, P., Warbrick, I., & Mikahere-Hall, A. (To be submitted). Managing diabetes is "easier said than done": Unmet needs of Indigenous people with diabetes engaging with health services.