Aotearoa New Zealand STI Management Guidelines for Use in Primary Care

STI guidelines: Māori Sexual Health Framework

These guidelines are supported by a framework that is committed to improving health outcomes and achieving health equity.

This draws from high level principles reflected in key policies and conventions focusing on Māori rights to enjoy good sexual and reproductive health. Within an Aotearoa New Zealand context, te Tiriti o Waitangi provides a fundamental basis for ensuring Māori experience equitable health outcomes.

An ongoing commitment to te Tiriti o Waitangi partners well with local support for international Indigenous health and wellbeing policy instruments, including the United Nations Declaration on the Rights of Indigenous Peoples.

The New Zealand Sexual Health Society (NZSHS) demonstrates an ongoing commitment to te Tiriti o Waitangi and international Indigenous health and wellbeing conventions through 2 primary mechanisms, including:

1. A commitment to te Tiriti o Waitangi, solidified through the inclusion of a specific clause within the NZSHS constitution describing how the principles of te Tiriti can be actioned to support Māori rights to enjoy good sexual health in Aotearoa New Zealand.
2. Endorsement of the 'Aotearoa Statement on closing the gaps on sexually transmitted infections (STIs), and bloodborne viruses among Indigenous peoples of Australasia'.

The principles included in the NZSHS constitution are mirrored in the Ministry of

Health framework, *Whakamaua – Te Tiriti o Waitangi*, acknowledging the origin of these principles, namely Wai 2575 and the Hauora Report. The principles are listed below along with summary descriptions:

- **Tino Rangatiratanga:** Providing for Māori self-determination and mana motuhake in the design, delivery and monitoring of health and disability services. Within the NZSHS constitution, tino rangatiratanga is not presented as a separate principle. Tino rangatiratanga is included as part of other principles (i.e. Active Protection). The description of tino rangatiratanga presented here is taken from the Ministry of Health Māori Health Action Plan 2020-2025.
- **Partnership:** Partnering with Māori based on equal power relationships, including the ability for Māori to retain autonomy, where Māori expressions and understandings of health and wellbeing directly influence decision making.
- **Active Protection:** Arising from the principle of partnership, active protection means ensuring that Māori tino rangatiratanga – with regard to having the right to decision making power – is protected.
- **Equity:** Equal standards of treatment applied to all populations can still produce inequitable outcomes. Equity is more than a focus on reducing inequalities or reducing disparities. Equity is a call to action where health needs are met with adequate, targeted responses.
- **Options:** The principle of options is jointly sustained by the principles of active protection, partnership, and equity. Māori have the right to exercise tino rangatiratanga, including choosing from a range of healthcare options that include well-resourced kaupapa Māori programmes and services.

These principles, along with the Aotearoa Statement, demonstrate NZSHS's commitment to ensuring that Māori health gain is achieved through a strengths-based approach centred on rangatiratanga (authority, ownership, leadership), and mana motuhake (self-determination, authority). The definitions of rangatiratanga and mana motuhake presented here are taken from the Health and Disability System Review (2020, p.38).

Cultural safety and cultural competency

The synergies that exist between the many frameworks that support Māori and Indigenous health demonstrate that a rights and equity-based perspective is the

primary lens through which Māori health is viewed. In line with this, more recent efforts to frame cultural approaches to healthcare provision have focused on the concept and practice of cultural safety.

Cultural safety exists within the wider context of rights and equity-based health care, recognising that health outcomes are tied to systemic disadvantage. The New Zealand Medical Council (2019) defines cultural safety as:

The need for doctors to examine themselves and the potential impact of their own culture on clinical interactions and healthcare service delivery.

The commitment by individual doctors to acknowledge and address any of their own biases, attitudes, assumptions, stereotypes, prejudices, structures, and characteristics that may affect the quality of care provided.

The awareness that cultural safety encompasses a critical consciousness where healthcare professionals and healthcare organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities.

In contrast, cultural competency focuses on acquiring knowledge of a patient's cultural distinctiveness – identifying how the culture of the other may impact on their health behaviours. One of the unintended outcomes of attempting to build cultural competency within a health workforce can be the development of limited and rigid definitions that support a 'tick-box' approach to representing cultural traits linked to specific populations (i.e. cultural essentialism). Learning about aspects of another's culture requires that more be done in order to move beyond assumptions of knowing the patient's cultural traits. The health professional's ability to self-reflect has been identified as an important component in this respect.

In terms of the systemic barriers that influence health equity for Māori, it has been noted that encouraging practitioners to grow awareness of the culture of the patient may do little to intervene at the points where health inequities are created. Put another way, a clinician's focus on other cultural groups does little to address the primary causes of inequity including unequal power dynamics and unexamined privilege, unequal distribution of the social determinants of health, marginalisation and institutional racism. Through a cultural safety approach, the health practitioner is instead encouraged to consider the impact of their own culture and worldview on

clinical interactions.[1]

A cultural safety approach encourages clinicians to invest in building knowledge of health inequities in terms of both rates of disease and determinants of health (i.e. what causes health inequities?). Doing so supports cultural safety in practice through developing a focus on what affects the individual, the wider whānau and the community.

It is important to note that inequities exist in terms of STI testing and therefore treatment. Research has shown Māori experience proportionally lower testing rates relative to rates of disease.[2,3,4] This lower rate subsequently leads to more undetected and therefore untreated disease. The reasons for this testing rate are complex and may include a paucity of investment in culturally appropriate strategies that focus on education and health promotion, limited access to culturally appropriate services, individual clinician competencies and clinician-patient relationships. Māori, and particularly young Māori, carry a significantly higher burden of disease. For example, Māori rates of gonorrhoea are 289 per 100,000 while Pacific rates are 323 per 100,000 compared with 83 per 100,000 for European/Other. Rates of chlamydia among Māori are 1394 per 100,000 followed by 1361 per 100,000 for Pacific peoples compared with 400 per 100,000 for European/Other (See ESR Sexually Transmitted Infection (STI) surveillance Dashboard). Additionally, Māori women now account for the highest proportion of syphilis cases among women in Aotearoa New Zealand and Māori babies are worst affected.[5] Despite Māori carrying a higher burden of disease, testing rates, and therefore treatment, are proportionally low. It is important to bear this in mind when consulting with Māori, and particularly young Māori, in a primary healthcare setting.

Cultural safety in practice

Understanding how cultural safety is conceptualised on its own will not be enough to encourage a shift in clinical practice to support equitable health outcomes. This understanding needs to make its way into everyday practice and policy. In general, the principles of rangatiratanga and mana motuhake are supported by an approach to health care that allows individual patients, whānau and the community to define culturally safe practice and engage in decision making about their own care. It is important to acknowledge that there is diversity within

individuals and their cultural practices.

Recent research focused on measuring the level of cultural safety in practice in Aotearoa New Zealand provides some helpful examples of how the process of patient and health practitioner interaction can be enhanced. Suggested approaches included:

- Recognising that Māori patients and whānau are more satisfied with health care when they feel listened to
- Engaging Māori patients and whānau in decision making about their own health care
- Extending consultation times: allowing for relationship building between clinician and patient.[6]

Importantly, the research also identified that health professionals would often make assumptions about the health literacy levels of Māori patients which interrupts opportunities to include patients in decision making. In terms of health literacy, cultural safety encourages health practitioners to consider their own limitations as a measure of literacy within the context of clinical interactions.[7]

The health practitioner's ability to form a connection with Māori patients and whānau is also supported by frameworks designed to help relationship building. The Hui process[8] and the Meihana model are two examples of how health practitioners can apply the principles of cultural safety in a clinical setting when working with Māori patients and whānau, to aid in improving health outcomes.

The Hui process is a framework developed to guide clinical interaction, specific to Māori, in the doctor – patient relationship. The Meihana model, based on the Māori health framework Te Whare Tapa Wha, is a clinical history-taking model that supports health practitioners to gain a broader understanding of Māori patients' presentations. The evidence shows that the Hui process and the Meihana model can be used by practitioners, and all patients would derive benefit from practitioners being trained in the use of these practices.

Points from the Hui Process that may support the health practitioner to form connections in this context include:

- **Mihi**: Taking the time to establish a connection; putting time into

introductions and sharing identifying information (both health practitioner and patient), helps to establish stable ground for discussing the health issue at hand. Relationship building as a first step can support good communication.

- **Whakawhanaungatanga** or 'connecting at a personal level' includes the health practitioner drawing on their own understanding of te Ao Māori and engaging with the patient and whānau in terms of their beliefs, values and experiences.
- **Kaupapa**: Having set the scene for connecting with the patient and whānau, the clinician can proceed with clinical history taking but is encouraged to consider health status in the wider context of colonisation and equity (see the Meihana Model for further information about framing Māori health status).
- **Poroporoaki**: Ensuring that there is a shared understanding between the patient and health practitioner; the patient is set up for a successful treatment pathway including feeling comfortable returning for further discussion, information and treatment.

As mentioned, tino rangatiratanga and mana motuhake are important principles that underpin a cultural safety approach. A clinical process that is based on making strong connections between the patient and health practitioner can enhance patient participation in decision making which ultimately supports better health outcomes.

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Endorsement: These guidelines have been endorsed by the Blood Borne Viruses and Sexually Transmitted Infections Standing Committee (BBVSS).

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