Blurred in Translation: Personal Histories and Institutional Roles in Diversity Policy Translation at a DHB
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Healthy Diversity project (2017-2019, UoA and UoW collaboration)

• Explores the everyday encounters among a racially and culturally diverse workforce in hospital settings in a New Zealand DHB

Data:

• DHB’s diversity-related documents

• Semi-structured interviews with:
  • Senior management and leadership (12)
  • Staff working in the hospitals (30) - 21 clinical / patient-facing and 9 non-clinical staff

Today’s presentation:

• Examines the translation of policy programmes for Māori (Treaty of Waitangi training) and culturally and linguistically diverse (CALD training) populations by healthcare workers in a hospital

• Based on discourse analysis of interview transcripts from clinical staff
• Ethno-cultural diversity and healthcare in NZ
• Policy translation: an overview
• Study context
• Analysis: Interpretation
  • Personal histories and position in NZ society
• Analysis: Workplace enactment
  • Professional position and personal histories
• Conclusion & Implications
The ethno-cultural diversity of New Zealand’s population continues to increase and there is growing recognition of the need for healthcare delivery to address this diversity.

District Health Boards (DHBs) have developed, or are developing, formal workplace policies and programmes that recognise the bicultural history of New Zealand and its multicultural population.

The policies and programmes respond to diversity in the patient population as well as healthcare workers.

How are these diversity-related policies and programmes translated within healthcare settings in everyday engagements with patients and among staff? With what implications?
Mainstream view of policy process

Policy developed by policy experts
Informed by rational and scientific knowledge

Implemented by policy providers
Administer the policy within appropriate institutions

Received by targets of the policy
Lives are then altered for the better

BUT policy translation is not an objective straightforward process, it involves the creation of meanings as it travels through different domains and actors.

Kingfisher (2013) “Policy projects are envisioned as from the beginning interested and invested; they involve constructing, rather than just responding to problems and categories of persons in need of intervention...[...]...recipients, too, far from being the passive receptacles... are actively engaged in interpreting, accommodating, resisting, and manipulating policy for their own ends”

Freeman (2009) Meaning can be lost in translation but also created by it
• One of the largest and most ethnically diverse DHBs in New Zealand
• Workforce diversity:
  • 7000+ staff
  • 76% female, 24% male

• Patient population diversity (2018-2019):
  • 10% Māori, 7% Pacific, 23% Asian, 61% Other
  • Asian population – fastest growing

• Key priorities for the DHB: ‘providing culturally appropriate healthcare to its diverse population and their families and addressing health inequities’
Māori Health – Treaty of Waitangi | CALD – Cultural Competency
---|---
Understanding Māori health inequities as a structural issue due to history of colonisation. | Learning about cultural differences to know how to effectively provide healthcare to CALD patients.

**Māori health Manager**

“the Māori population...is a priority population for the organisation because it’s different to the other diversity groups.....What makes it different is the Treaty, so the Māori population is a priority because not only do they have priority from a needs perspective, they’re also priority from a rights perspective”

“Why I don’t like Māori to be included into the diversity discussions is that sometimes it gets lost and sometimes we forget about the obligations that we have as a country and a system to the Māori population, in the first instance based on the Treaty, when you put it into the diversity conversation”
The image contains a table with two columns, each containing text from the document. The text is in English and discusses cultural safety and the Treaty of Waitangi. The table includes quotes from Christopher and Jasmine, with both being nurses. Christopher is described as an ethnic minority outsider, while Jasmine is described as an ethnic minority insider.

Christopher's quote: "Cultural safety, I’ve encountered a lot of this when I was in the Middle East because it’s a very strict country. I’ll always give you an example about two cultures. Let’s start with the Māori culture. It has been taught to us that you never put your feet or any dirty things on the table, you never just touch the head, you ask permission cos it’s disrespectful and then more sensitive issues. Then, for Arab Muslims, [...] if you’re a male nurse, it’s all right to look after a male patient but not a female patient but if you’re a female nurse, you can look after both...You cannot go to a patient on your own because there is a specific space that is deemed to be private and sensitive."

Jasmine's quote: "...although it’s focused towards Māori, the Treaty of Waitangi rights, it’s actually all throughout the whole population...We still offer it and still use the framework for all the other ethnic groups... E.g., participation, so we always encourage, not just for the Māori population to participate in their care, it’s for all the other patients and families that walk-through”

"I think they’re [Treaty of Waitangi and CALD training] essentially the same thing, it’s just being culturally aware and culturally sensitive. It’s just that the Treaty of Waitangi sets up a basis or a foundation for us as a stepping stone to widen our understanding, I think...I just don’t exactly see it as separate but I see it as a stepping stone.”
Interpretation - personal histories

JOHN

• Pākehā, mental health nurse
• Completed in nursing qualification in NZ, has worked in nursing for just over 20 yrs.
• At the current DHB for 3.5 yrs.
• Grew up in NZ. Went to predominantly Māori and Pacific Island school, so he was a minority as a Pākehā
• Has Māori friends and is interested in learning about the colonial history and Treaty. Didn’t consider himself “superior or racist”.

JOHN (privileged insider; nurse)

“The one at [the polytechnic], the woman who presented it, didn’t have that skill and they presented it in a very challenging way, which has the opposite effect really from what’s desired, as opposed to making you take it on board. You go, “Hang on a minute, I didn’t actually do anything and what you other fellas need to remember, is that you were eating each other before we came along and there was no microwaves.”
No, I always think that, in some part, I think it is difficult being a Pākehā and carrying some burden of shame or guilt for that. I don’t really because […] that’s just the way the world has been time immemorial.”
**Workplace Enactment: clinical staff**

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<th>DANIELLE (privileged insider; nurse)</th>
<th>KAMAL (ethnic minority outsider; nurse)</th>
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<td>“Yeah, definitely, especially being in somewhere like ED, where you get so many different cultures. It’s important to recognise that balance and the boundaries, that different cultures have different needs. <em>With Māori, you don’t put the same pillow for the head as the feet and understanding that if you do that, then you may get some backlash.</em> It’s little things sometimes that make a big difference in things.”</td>
<td>“Yeah, we can see differences, like pillow cases. Over there, it’s very culturally inappropriate if I use a different colour pillow because. <em>We have got a blue and white. Over there, blue for leg and those body fluids when you use that and white is absolutely for the head, so that you can keep them both separate.</em> However, in here, even in Māori culture, people from the same culture, they don’t consider it as a big issue.”</td>
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<td>SUE (privileged outsider; nurse manager)</td>
<td>CLAIRE (privileged outsider; nurse manager)</td>
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<td>“....As a nurse from overseas, who just didn’t wanna get it wrong, you feel very stressed and don’t want to offend anybody. [...] I’ve learned how Māori have been impacted across the years through health, especially cardiology, obviously. Now, I’m the manager here and it’s only been 18 months, it’s like what can I do to make a little bit of change? [...] How can I make this a place where people can leave and tell their families, “Actually, it wasn’t as bad as I thought?” There is some acknowledgement of being Māori there, so it feels like a safe place to be. That’s what I’ve been working on the last year or so”</td>
<td>“...the African philosophy and Ubuntu and Suffano are the two African humanistic values that sit underneath any practise as a person living in Africa...one of which is I see you and then, I am here, because you are here. That's what the two values mean and that's how I practise my nursing. With patients, I'm here because they're here and I see them and I don’t see them as just another piece on the widget line. I see them as the person they are, whatever their context, whatever their culture, whatever their orientation, whatever the place they are in their life. It doesn’t matter to me, so I come from that place of being”</td>
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Conclusion & Implications

• Distinct agendas and politics behind Treaty of Waitangi and CALD cultural competency trainings are blurred in translation by staff in the hospital.Translations are uneven across the organisation and individuals.

• Translations are influenced by individual’s social location: the intersection of their personal history, social position in NZ, and their professional position in the DHB.

• Intersecting positions inform individual’s investment in policy training and their translation.
  • Interpretation:
    • Insider/outsider, privileged/ethnic minority
  • Workplace enactment:
    • Frontline clinical staff versus managers – different roles and responsibilities
    • Personal histories can also constrain enactments

Implications?
• A ‘one size fits all’ approach to diversity-related training is inadequate.
• Equity and diversity initiatives need to respond to social & institutional factors and take an intersectional approach to training.
Questions?