Cultural respect and related concepts: a brief summary of the literature

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Introduction

Shortcomings in the way that the health care system addresses the needs of Australia's Indigenous peoples have been recognised for many years. This recognition almost certainly pre-dated the 1970s, but the establishment of the first Aboriginal community-controlled health service in Redfern (Sydney) in July 1971 was a clear expression of the need for health services to be much more accessible to Indigenous people [1-3].

As well as economic and geographic factors, the accessibility of health services to Indigenous people is influenced by a 'variety of sociocultural factors' [1, p108]. The importance of what has been termed a 'cultural chasm' between Indigenous people and health care providers [4] has been identified by numerous reports over the past 20-30 years [see, for example, 5, 6-8].

The various reports identified the lack of training needed to enable health professionals and other service providers to provide appropriate care for Indigenous peoples. The National Aboriginal Health Strategy Working Party, for example, noted in *A national Aboriginal health strategy* that 'scant attention has been paid in the content of health-related education programs to the relevance of cultural, traditional, political, and socio-economic factors of Aboriginal history and Aboriginal society to Aboriginal health and wellbeing' [6, p90]. As well as identifying the need for the appropriate education and training of health professionals and preparation to work in the field of Indigenous health, the Working Party highlighted the importance of relevant clinical experience as a part of formal studies (such as through placements in Aboriginal community-controlled health services, in remote communities or in other appropriate services) and for cultural aspects to be a part of continuing professional education.

The focus within Australia remained largely on the attributes of clinicians and other health care providers (in terms mainly of knowledge and experience) until the initial development in the Western Australia in the late 1990s of the concept of cultural security. The concept included not only 'a shift in emphasis from attitude to behaviour' [9, p26], but also an extension of the focus to include system-wide factors as well as individual characteristics.

The concept of cultural security was incorporated in the early 2000s in the concept of cultural respect. The latter concept was endorsed in February 2003 by a joint meeting of the Australian Health Minister's Advisory Council (AHMAC) and its Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH) as the 'guiding principle in policy construction and service delivery for utilisation by jurisdictions as they implement initiatives to address their own needs, in particular mechanisms to strengthen relationships between the health care system and Aboriginal and Torres Strait Islander peoples' [10, p3].

The Australian cultural respect framework benefited not only from the earlier work undertaken in Western Australia on cultural security, but also related developments in other countries – particularly the concepts of cultural safety in New Zealand and cultural competence in the United States. It is important, therefore, to provide a general review of cultural respect and related concepts.

This review

The purpose of this review, which is based largely on a literature review conducted as a part of a small project undertaken by Edith Cowan University's Centre for Indigenous Australian Knowledges for a Western Australian Health Service, was to outline briefly the nature and development of the concept of cultural respect, and to consider the relationship of cultural respect to similar concepts in other countries, particularly New Zealand and the United States. Being an overview of the relevant concepts, the review is selective, rather than a comprehensive. In particular, it does not direct attention to the actual application of the various concepts within specific contexts within Australia.[1]

After outlining the methodology used for the review, the development and content of cultural respect and related concepts in Australia is outlined. This is followed by summary details of the development and nature of cultural safety in New Zealand and cultural competence in the United States of America, and some brief concluding comments.

(A bibliography of all the literature identified – not just those references used in this review – is available separately.)

General methodology

The Australian Indigenous Health*Bibliography* was the initial source of information about cultural respect and related concepts in relation to Australian Indigenous peoples. The Health*Bibliography* includes details of almost 9,900 items, including journal articles, books and book chapters, government and other reports, and theses. Searches of Medline, ERIC, Health and society, Australasian Medical Index, Australian Public Affairs Information Service (APAIS), Cumulative Index to Nursing and Allied Health Literature (CINAHL), RURAL, and the National Library of Australia database were used to check the completeness of this bibliography in relation to Australian materials, and also to identify relevant international sources. The search terms used were: cultural security, cultural awareness, cultural sensitivity, cultural respect, cultural safety, cultural competence, education or train* + cultur*, and acculturat*. Relevant documents were recorded in a separate EndNote library.

Every attempt was made to locate and collect all relevant literature, much of which is in the so-called 'grey literature'.[2] A considerable body of grey literature was identified and collected, but it is likely that some other useful sources have not been identified.

These mechanisms of identifying relevant materials were supplemented by targeted searches using standard Internet search engines, particularly Google. In many cases, these searches were informed by clues gained from perusal of previously collected materials.[3] In other cases, reports and other materials were identified by searching relevant Internet sites (such as the National Center for Cultural Competence at Georgetown University in the United States).

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1 Readers interested in exploring these aspects are referred to 'Review of cultural training for GPs working in Aboriginal and Torres Strait Islander health', an excellent review prepared for the Australian Department of Health and Ageing by the Royal Australian College of General Practitioners' National Rural Faculty, and to Williams R (1999) Cultural safety: what does it mean for our work practice? *Australian and New Zealand Journal of Public Health*;23(2):213-214. Based largely on its review, the Royal Australian College of General Practitioners (RACGP) is supporting 'cultural safety training' workshops, detailed of which are available on the RACGP website (http://www.racgp.org.au/document.asp?id=16585).

2 Grey literature was defined at the Fourth International Conference on Grey Literature as 'that which is produced on all levels of government, academics, business and industry in print and electronic formats, but which is not controlled by commercial publishers' (New York Academy of Medicine, 2002). The grey literature may include: reports (progress and advanced reports, technical reports, statistical reports, etc.), theses, conference proceedings, technical specifications and standards, non-commercial translations, bibliographies, technical and commercial documentation, and official documents not published commercially (primarily government reports and documents).

3 For example, the bibliography of a journal article or grey literature item may include reference to an unpublished report, a copy of which may be available as a PDF document on the Internet.

The development of cultural security and related concepts in Australia

Introduction

In response to *A national Aboriginal health strategy* and the other reports, increased attention was directed to cultural training for people working in Indigenous health. The focus of most of this training has been on cultural awareness – 'a sensitivity to the similarities and differences that exist between two different cultures, and the use of (this) sensitivity in effective communication with members of another cultural group' [11, p4].

Cultural awareness

The nature of cultural awareness programs varies considerably, ranging from brief lecture and/or workshop formats to ongoing programs involving field trips and/or excursions. The main focus of most cultural awareness programs is: (1) to increase participants' awareness of the various cultural, social and historical factors applying to Indigenous peoples generally, and to specific Indigenous groups and/or communities; and (2) promote self-reflection about the participant's own culture, biases, and tendency to stereotype. In so doing, it is expected that participants will gain a better appreciation of the diversity of values, beliefs and behaviours. Reflecting the definition of cultural awareness, the term 'cultural sensitivity' has also been used for the type of cultural training [12].

Despite the enthusiasm for – and proliferation of – cultural awareness programs, it became apparent that they did not always lead to better care (and outcomes) for Indigenous people. This was because awareness was not always accompanied by the skills necessary 'to interact and communicate sensitively and effectively with Aboriginal clients' [13]. Also, it was recognised that awareness and skills need to be reflected in the actual behaviour of health providers. (The increasing recognition of the need for much more than just awareness paralleled similar developments in other countries – cultural safety in New Zealand and cultural competence in the United States – which will be discussed below.) As well, cultural awareness programs focused on individuals working within the health system, and directed little, if any, attention to the system itself. So, despite many years of cultural awareness training, the health system was characterised by:

- the disjointedness of the system's approach to managing diversity including the limited opportunity for an organised assessment of organisational, clinical and administrative practices to ensure that an Aboriginal client's cultural values are not offended or ignored;
- the lack of specific knowledge about the cultural variables of different cultural groups and how these might be translated into doing things differently;
- the high turnover of staff, particularly in remote areas;
- the difficulties for graduates of awareness/sensitivity programs to effect change in clinical or organisational practice, including the implied expectation that aware individuals will effect and manage change; and
- the lack of any monitored self-assessment by providers of the cultural awareness of services offered and the concomitant absence of accountability to funders and owners [14, p13].

There were two main responses to the recognition that a cultural awareness program was, by itself, inadequate. First, cultural awareness programs needed to be complemented by training to provide health professionals with the skills required to perform specific tasks [13]. (It was recognised also that to be effective in delivering services to Indigenous people the awareness and skills needed to be accompanied by the motivation of health professionals to be successful in their interactions with Indigenous clients.) The second response – the call for

'cultural security' [14] – involves a shift in focus, from the attributes of the health professional to the attributes of the health system and the interactions between professionals and clients.

Cultural security

Cultural security is defined as 'a commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration' [14, p3]. Achievement of cultural security would require 'administrative, clinical and other service domains of the health system [to] be systematically reviewed to ensure that their operation appropriately incorporates culture in their delivery' [14, p10].[4]

Importantly, cultural security represents 'a shift in emphasis from attitude to behaviour' [9, p26], focusing as it does on practice, skills and behaviour of the health system as well as individuals within it [14]. The approach also acknowledges the need to combine cultural security with technical/scientific excellence.

Reflecting its system-wide focus, development of a culturally secure health system would require:

- workforce development – education of professional and other staff to ensure their competence in cultural as well as technical aspects;
- workplace reform – incorporation of cultural values and practices in clinical, public health, administrative and management practices and pathways. The requirement for cultural security would need to be included in funding agreements;
- additional resources – to provide for workforce development and the extra costs of ensuring culturally secure workplaces;[5]
- data collections and feedback mechanisms – for monitoring and accountability, and to provide feedback to individuals, Indigenous communities, the Government and the public; and
- public engagement – fostering community awareness of the value and implications of cultural diversity in the health service [14, pp16-17].

(It is worthwhile noting that, even though this approach focuses on the needs of Indigenous people, the need for culturally security applies to all clients of the health system who differ in some substantial manner from 'mainstream' Australia. A clear example is clients from culturally and linguistically diverse (CALD) backgrounds.)

The concept of cultural security doesn't appear to have been widely adopted by itself, and has only really featured in documents from Western Australia [14]and, to a lesser extent, the Northern Territory [16]. Importantly, however, the concept has been incorporated into a broader concept, that of cultural respect.

Cultural respect

As noted above, the work undertaken in Western Australia on cultural security provided the foundation for *Cultural respect framework for Aboriginal and Torres Strait Islander health, 2004-2009* [10].

Cultural respect is defined as the 'recognition, protection and continued advancement of the inherent rights, cultures and traditions of Aboriginal and Torres Strait Islander peoples' [10,

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4 The term 'cultural security has sometimes used in conjunction with 'cultural safety' (see section 4).

5 An analysis of the costs of services provided by the Derbarl Yerrigan Health Service, Perth's Aboriginal community-controlled health service, estimated that for every dollar spent on 'mainstream equivalent' services 75 cents were required for 'culturally secure aspects of care' Wilkes, Houston and Mooney, 2002 [15].

p7]. It is achieved 'when the health system is a safe environment for Aboriginal and Torres Strait Islander peoples and where cultural differences are respected' [10, p7]. It builds on the commitment embodied in the definition of cultural security (see above).

The cultural respect framework recognises a number of principles that have been incorporated into major recent documents (such as the 2003 *National Strategic Framework for Aboriginal and Torres Strait Islander Health* [17]):

- Holistic approach – acknowledging the relationships between physical, spiritual, cultural, emotional and social wellbeing, community capacity and governance;
- Health sector responsibility – improving Indigenous health is a core responsibility and a high priority for the whole of the health sector;
- Community control of primary health care services – supporting the Aboriginal community-controlled health sector;
- Working together – the need for partnerships between government, non-government and private organisation within and outside the health sector;
- Localised decision-making – local Indigenous communities should define their health needs and priorities and arrange for them to be met in a culturally appropriate manner;
- Promoting good health – health promotion and illness prevention are core activities for services;
- Building capacity of health services and communities – in terms of: cultural knowledge; clinical expertise; physical, human and intellectual infrastructure; leadership; governance; and financial management;
- Accountability – reciprocal accountability between governments (for long-term resource allocation) and health services (effective use of funds and health outcomes).

The framework recognises the key role that knowledge and awareness and skilled practice and behaviour play in underpinning strong relationships between Indigenous people and communities and the health agencies involved in Indigenous health and their employees [10, pp10-11]. Together, these three dimensions – knowledge and awareness, skilled practice and behaviour, and strong relationships – should contribute to the achievement of equitable outcomes for Indigenous individuals and communities.

Included in *Cultural respect framework for Aboriginal and Torres Strait Islander health, 2004-2009* are some practical examples of culturally respectful strategies:

- Ensuring that Indigenous people using hospital and other health services have the opportunity of accessing interpreter services (involving trained and accredited interpreters);
- Consultation with local communities to reach agreement on the main language groups for that area; and
- Public hospitals should (1) try to physically co-locate Indigenous patients from the same language groups; (2) provide Indigenous patients access to traditional healers (if requested); and (3) have written protocols for Indigenous maternal and birthing health [10].

Importantly, the framework provides guidance for its implementation in the following areas: governance; policy and planning; purchasing/contracting; records and data; information; research; education and training; human resource management; environmental health; population health; primary care; acute care; coordinated care; mental health; oral health; aged care; and palliative care [10, pp14-16].

Each State and Territory has committed to the framework for five years. It is understood that the various jurisdictions are working on implementation of the framework, with progress to be monitored annually at a joint SCATSIH/AHMAC meeting.[6]

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6 It is possible that the various jurisdictions have developed substantial implementation plans, but, at the time of

Developments in other countries

The impact of sociocultural factors on accessibility to health care has also attracted increasing attention in other countries, including New Zealand (Indigenous peoples), Canada (Indigenous peoples) and the United States (Indigenous peoples and other 'minorities') [see, for example, 12, 18]. This attention has led to the recognition that health professionals need to address cultural issues for them to effectively address the health needs of their patients.

As was the case in Australia, the initial focus was on aspects like cultural awareness and cultural sensitivity. In New Zealand and the United States, the focus tended to move beyond these aspects rather earlier than it did in Australia. From around 1990, increasing attention in New Zealand was directed to cultural safety. The focus in the US shifted from cultural sensitivity to cultural competence in the 1980s and 1990s [12, p202]. The following sections summarise briefly cultural safety and cultural competence.[7]

Cultural safety

Recognition that cultural awareness and cultural sensitivity were inadequate approaches to ensuring that Maori people in New Zealand received appropriate health care resulted in adoption of the term 'cultural safety', which had been first suggested in 1988 at the Hui Waimanawa [19].[8,9] Initial use of the term related only to Maori people and was restricted largely to nursing and midwifery. Over time, its use was widened to include other cultural groups, and the current New Zealand Nursing Council's definition is:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability [20, p4].

This definition is accompanied by the comment that 'the nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and wellbeing of an individual' [20, p4].

Evolution in New Zealand of the concept of cultural safety involved consideration of its relationship to transcultural nursing, an American movement that commenced in the 1950s [21].[10] This consideration involved a 'struggle to retain cultural safety as something different and unique to New Zealand' [21, p23]. Transcultural nursing was seen as focusing on the attributes to the nurse, with an emphasis on cultural sensitivity in dealing with patients from different cultural backgrounds with 'no consideration of a power imbalance in the health-care setting' [21, p22]. In contrast, cultural safety is defined by those who receive the care,

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writing this review, Western Australia appears to be the only jurisdiction that has made its plan publicly available. The failure of jurisdictions to publicise these developments, and of SCATSIH to release details of its monitoring process, must raise some doubts about the levels of commitment to full implementation of the cultural respect framework.

7 There is also useful material related to these areas for Indigenous people in Canada, but this review will focus on the developments in New Zealand and the United States.

8 The Hui (the Maori word for meeting) was a major national gathering of over 100 participants, including people involved in nursing training and Maori nursing students.

9 There is a substantial literature on cultural safety. Only a few key documents have used to provide this brief summary, which provides a framework for considering the relationship between cultural security, cultural respect, cultural safety and cultural competence.

10 There is a very substantial literature on transcultural nursing, with one journal, the *Journal of Transcultural Nursing*, devoted to the movement. The movement has been most influential in the United States and Canada. As well its influence in nurse-patient relationships, the movement has made a major contribution to the development of the concept of cultural competence.

extending beyond cultural awareness and cultural sensitivity [20, 21].[11] Importantly, cultural safety 'provides consumers of nursing services with the power to comment on practices and contribute to the achievement of positive health' [20, p7].

Cultural competence

The focus within the United States on how the health system could reduce health disparities between the general population and various so-called 'minority' groups (including African American ('blacks'), 'Latinos', Native Americans and Alaskan natives, and other minority groups) has resulted in an emphasis on cultural competence.[12]

There a number of working definitions of cultural competence, most of which emphasise the need for health systems and providers to be aware of and responsive to patients' cultural perspectives' [22, p3]. One definition is:

> Cultural competence is a set of behaviours and attitudes and a culture within business or operation of a system that respects and takes into account the person's cultural background, cultural beliefs, and their values and incorporates them in the way health care is delivered to that individual [22, p3].

With its emphasis on the health system and people working within it, the delivery of culturally competent care involves:

- Organisational cultural competence – the health leadership and workforce needs to reflect the racial and ethnic diversity of the population. This aspect could be addressed by: (1) encouraging/supporting programs to increase the participation of 'minority' professionals in influential positions in the health system; (2) increasing participation of minorities in the health workforce; and (3) community representatives should be involved on boards, committees, focus groups, etc.
- Systemic cultural competence – the need to eliminate systemic barriers, such as the lack of interpreter services or culturally appropriate health promotion and other resources. This aspect could be addressed by: (1) on-site interpreters being available in health settings where a significant proportion of clients has limited English proficiency; (2) health materials reflecting the level of health literacy, language proficiency, and cultural norms of the population served; (3) systemic cultural competence interventions being a part of contracting requirements; (4) monitoring the extent to which health organisations address the need for systemic cultural competence; (5) research into problems relating to the lack of systemic cultural competence;
- Clinical cultural competence – cultural knowledge, skills and behaviours are essential in delivery quality care to all patients. Patient empowerment is also an important aspect of cultural competence. This aspect could be addressed by: (1) mandatory cross-cultural training being integrated into all training and continuing professional development of health professionals; (2) quality improvement efforts incorporating appropriate methods to assess the needs of minority populations; and (3) development of programs to assist minority clients 'navigate' the health system and become active partners in clinical and other encounters [22].

The concept of cultural competence has been evolving in the United States since at least 1989, the first instance of the term appearing in a publication [23]. The concept has attracted such attention that there are now at least two centres dedicated to the concept – Georgetown University's National Center for Cultural Competence, whose mission is 'to increase the

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11 Similarly, the concept of cultural security extends beyond cultural awareness and cultural sensitivity, and is defined by those receiving the care.

12 There is a very substantial literature on cultural competence. Only a few key documents have used to provide this brief summary, which provides a framework for considering the relationship between cultural security, cultural respect, cultural safety and cultural competence.

capacity of health and mental health programs to design implement, and evaluate culturally and linguistically competent service delivery systems' [24], and the Center for Linguistic and Cultural Competence in Health Care within the US Government's Office of Minority Health [25].

A recent analysis of the concept has suggested that it possesses a number of attributes: cultural awareness, cultural knowledge, cultural understanding, cultural sensitivity, cultural interaction, cultural proficiency and cultural skill [26]. The analysis identified all of these attributes as components of cultural competency, but that cultural congruence – the provision of care 'that is meaningful and fits with cultural beliefs and lifeways … refers to the use of emic (local cultural knowledge and lifeways) in meaningful and tailored ways that fit with etic (largely professional outsiders' knowledge' – is a closely related concept [26, pp10-11]. The concept was used initially in relation to the capacity of individual health professionals, but now relates also to systems and organisations (see above). The author concludes that cultural competence can 'best be identified as a non-linear dynamic process that is never ending and ever expanding. It is built on increases in knowledge and skill development related to its attributes' [26, p5].

Another US nursing researcher argues that cultural desire, defined as 'motivation to "want to" engage in the process of becoming culturally aware, culturally knowledgeable and culturally skilful, and seeking cultural encounters', is the 'key to unlocking cultural competence' [27, p239].

Development of the concept has been accompanied by considerable attention in the US to cultural competence education [see, for example, 28], standards [see, for example, 29, 30], and tools for the assessment of cultural competence [31-35].

The concept of cultural competence originated in the United States, but has been adopted to various degrees in other countries.

Its adoption in Australia has been quite limited. For example, a research paper prepared for the 2002 national review of nursing noted the need for 'direction … about what aspects of multicultural health are needed for cultural competency' and the need to provide culturally competent care [36, p155], but the final report did not explicitly mention the term. Similarly, the concept does not appear to have been adopted widely in the field of medical education, with the only reference to cultural aspects in the Australian Medical Council's 'Attributes of medical graduates' being that, 'At the end of basic medical education, students should demonstrate … respect for community values, including an appreciation of the diversity of human background and cultural values' [37].[13] The *Indigenous health curriculum framework*, released recently by the Committee of Deans of Australian Medical Schools, does not use the term 'cultural competence', but the breadth of its content is consistent with the concept [38]. The Royal Australasian College of Physicians' Health Policy Unit recognises that cultural competency and cultural safety 'go far beyond notions of cultural awareness and cultural sensitivity' and notes that cultural competence 'must be integrated in the delivery of health services in order to reduce the institutionalised racism that maintains current Indigenous health standards' [39].

In contrast to the limited adoption of the concept in Australia, the requirement for cultural competence has been incorporated in an Act of the New Zealand Parliament, the *Health Practitioners Competence Assurance Act 2003* [40, 41]. Section 118 of the Act provides for 'each authority appointed in respect of a health profession … to set standards of clinical competence, cultural competence, and ethical conduct to be observed by health practitioners

13 The Australian Medical Council is the national standards advisory body for medical education and training. It is responsible for accreditation of medical schools, medical courses and specialist medical training in Australia and New Zealand.

of the profession' and 'to recognise, accredit, and set programmes to ensure the ongoing competence of health practitioners' [40].

In addressing this requirement, the New Zealand Medical Council has produced a discussion document that sets out a proposed framework for ensuring the cultural competence of New Zealand doctors [42]. Reflecting its major commitment to cultural safety, the Nursing Council of New Zealand has linked the requirement for cultural competence with this commitment [20, 43, 44].

Concluding comments

This section explores briefly the relationships between the cultural respect framework, which incorporates cultural security and has been adopted for use within Australia, with cultural safety and cultural competence.

Importantly, both cultural respect (including cultural security) and cultural safety are focused on the perspectives of Indigenous people receiving health care. In contrast, the focus of cultural competence is on aspects of the health care system – organisationally, systemically and individually. As well, the scope of cultural competence is much broader than cultural respect and cultural safety, with its attention to all people in a population who differ significantly from the mainstream. However, despite the differences in focus and scope, the concepts are virtually inseparable, being effectively the two sides of a coin.

In many ways, cultural respect and cultural safety will only be achieved when the various aspects of the health care system are culturally competent. This recognition is embodied in the *Cultural respect framework for Aboriginal and Torres Strait Islander health, 2004-2009* – the need for cultural competence is mentioned in many of the areas for which the framework provides implementation guidance [10].

Based on the US experience, achievement of a culturally competent health system will require progress in the three areas identified above and in the action agenda outlined in the Cultural Respect Framework – organisational, systemic and individual (including clinical). This progress will need to be guided by specific educational initiatives, agreed standards to be met, and mechanisms for assessing achievement of these standards. These aspects will need to be developed specially for Indigenous people within the Australian health care system, but this development could well benefit from close scrutiny of the various materials developed over many years in the United States and New Zealand.

It is to be hoped that the five-year commitment that AHMAC has made to the Cultural Respect Framework is matched by a commitment to its full implementation through the development of appropriate educational, standards-setting and assessment processes at organisational, systemic and individual levels of the health care system in Australia.

References

1 Anderson I (1988) Koorie health in Koorie hands: an orientation manual in Aboriginal health for health care providers. Melbourne: Koorie Health Unit, Health Department Victoria

2 Briscoe G (1982) The development of Aboriginal medical services. Panacea;13(1 [May]):5-8

3 Saggers S, Gray D (1991) Aboriginal health and society: the traditional and contemporary Aboriginal struggle for better health. North Sydney: Allen and Unwin

4 Kamien M (1981) Aboriginal health care: between givers and receivers: a cultural chasm. Current Affairs Bulletin:14-22

5 House of Representatives Standing Committee on Aboriginal Affairs, Ruddock PM (1979) Aboriginal Health. (No.60/1979) Canberra: The Parliament of the Commonwealth of Australia

6 National Aboriginal Health Strategy Working Party (1989) A National Aboriginal health strategy. Canberra: Department of Aboriginal Affairs

7 Royal Commission into Aboriginal Deaths in Custody (1991) Royal Commission into Aboriginal Deaths in Custody: final report. Canberra: Australian Government Publishing Service

8 House of Representatives Standing Committee on Family and Community Affairs (2000) Health is life: report on the inquiry into Indigenous health. Canberra: The Parliament of the Commonwealth of Australia

9 Northern Territory Department of Health and Community Services (n.d.) Aboriginal health and families - a five year framework for action: Part A, Building better services. Retrieved 3 May 2005 from http://www.nt.gov.au/health/comm_health/abhealth_strategy/apact/parta.pdf

10 Australian Health Ministers' Advisory Council - Standing Committee for Aboriginal and Torres Strait Islander Health Working Party (2004) Cultural respect framework for Aboriginal and Torres Strait Islander health, 2004-2009. Adelaide: Department of Health, South Australia

11 Queensland Health (2001) Aboriginal and Torres Strait Islander cultural awareness training: revised minimum standards. [Brisbane]: Queensland Health

12 Smedley BD, Stith AY, Nelson AR, Committee on understanding and eliminating racial and ethnic disparities in health care, Board on Health Sciences Policy, eds. (2003) Unequal treatment: confronting racial and ethnic disparities in health care. Washington, DC: The National Academies Press

13 Dench McClean Pty Ltd (1999) Review of cultural awareness training: effectiveness of cultural awareness training. Sydney: New South Wales Health Department

14 Western Australian Department of Health (n.d.) Aboriginal cultural security: a background paper. Retrieved 17 February 2005 from http://www.aboriginal.health.wa.gov.au/htm/aboutus/Cultural%20Security%20Discussion%20Document.pdf

15 Wilkes T, Houston S, Mooney G (2002) Cultural security: some cost estimates from Derbarl Yerrigan Health Services. New Doctor;77(Winter):13-15

16 Northern Territory Department of Health and Community Services (n.d.) Aboriginal health and families - a five year framework for action. Retrieved 10 May 2005 from http://www.nt.gov.au/health/comm_health/abhealth_strategy/apact/apacttoc.shtml

17 National Aboriginal and Torres Strait Islander Health Council (2003) National Strategic Framework for Aboriginal and Torres Strait Islander Health: framework for action by governments. Canberra: National Aboriginal and Torres Strait Islander Health Council

18 Young TK (1994) The health of Native Americans: towards a biocultural epidemiology. New York: Oxford University Press

19 Ramsden I (2005) Towards cultural safety. In: Wepa D, ed. Cultural safety in Aotearoa New Zealand. Auckland, New Zealand: Pearson Education New Zealand:2-19

20 Nursing Council of New Zealand (2005) Guidelines for cultural safety, the Treaty of Waitangi and Maori health in nursing education and practice. Retrieved 4 May 2005 from http://www.nursingcouncil.org.nz/Cultural%20Safety.pdf

21 Papps E (2005) Cultural safety: daring to be different. In: Wepa D, ed. Cultural safety in Aotearoa New Zealand. Auckland, New Zealand: Pearson Education New Zealand:20-28

22 Betancourt JR, Green AR, Carrillo E (2002) Cultural competence in health care: emerging frameworks and practical approaches. New York, NY: The Commonwealth Fund

23 Cross T, Bazron B, Dennis K, Isaacs M (1989) Towards a culturally competent system of care. Washington, DC: Georgetown University Child Development Centre

24 National Center for Cultural Competence (n.d.) NCCC home. Retrieved 17 February 2005 from http://gucchd.georgetown.edu/nccc/index.html

25 Center for Linguistic and Cultural Competence in Health Care (2003) Background: the origins of OMH and the CLCCHC. Retrieved 17 February 2005 from http://www.omhrc.gov/cultural/background.htm

26 Rosenjack Burchum JL (2002) Cultural competence: an evolutionary perspective. Nursing Forum;37(4):5-15

27 Camphina-Bacote J (2003) Cultural desire: the key to unlocking cultural competence. Journal of Nursing Education;42(6):239

28 Gilbert MJ (2003) A manager's guide to cultural competence education for health care professionals. Woodland Hills, CA: The California Endowment

29 Office of Minority Health (US Department of Health and Human Services) (2001) National standards for culturally and linguistically appropriate services in health care. Washington, DC: Office of Minority Health

30 Gilbert MJ (2003) Resources in cultural competence education for health care professionals. Woodland Hills, CA: The California Endowment

31 Goode T, Jones W, Mason J (2002) A guide to planning and implementing cultural competence organization self-assessment. Washington, DC: National Center for Cultural Competence, Georgetown University Child Development Center

32 Andrulis D, Delbanco T, Avakian L, Shaw-Taylor Y (n.d.) Conducting a cultural competence self-Assessment. Retrieved 27 May 2005 from http://www.consumerstar.org/pubs/Culturalcompselfassess.pdf

33 National Center for Cultural Competence (n.d.) Cultural Competence Health Practitioner Assessment (CCHPA): Overview/purpose. Retrieved 27 May 2005 from http://gucchd.georgetown.edu/nccc/pa.html

34 Association of American Medical Colleges (n.d.) Tool for assessing cultural competence training (TACCT). Retrieved 27 May 2005 from http://w3admin.ilearning.com/coursepath/AACP/sg41A_L82D_E9F/Track/PR534_P508_2352/_resources_/53A_929Q_247_3ieh/CCE.pdf

35 Health Resources and Services Administration (US) (2001) Potential measures/indicators of cultural competence [Attachment 3 of Health Resources and Services Administration study on measuring cultural competence in health care delivery settings: a review of the literature]. Retrieved 25 May 2005 from http://www.hrsa.gov/OMH/cultural/attachment3.htm

36 National Review of Nursing Education (2002) National review of nursing education 2002: our duty of care. Canberra, ACT: Department of Education, Science and Training

37 Australian Medical Council (n.d.) Attributes of medical graduates. Retrieved 10 May 2005 from http://www.amc.org.au/accredgoals.asp

38 Phillips G (2004) CDAMS Indigenous health curriculum framework. Sydney: Committee of Deans of Australian Medical Schools

39 Royal Australasian College of Physicians (2004) An introduction to cultural competency. Retrieved 17/2/2005 from http://www.racp.edu.au/hpu/policy/indig_cultural_competence.htm

40 Government of New Zealand (2003) Health Practitioners Competence Assurance Act 2003. Retrieved 10 May 2005 from http://www.legislation.govt.nz/browse_vw.asp?content-set=pal_statutes

41 New Zealand Ministry of Health (2005) Health Practitioners Competence Assurance Act 2003. Retrieved 10 May 2005 from http://www.moh.govt.nz/hpca

42 Medical Council of New Zealand (2005) Assuring medical practitioners' cultural competence: a discussion document produced for the Medical Council of New Zealand by the Health Services Research Centre/Te Hikuwai Rangahau Hauora, School of Government, Victoria University of Wellington. Retrieved 3 May 2005 from http://www.mcnz.org.nz/portals/1/news/culturalcompetence.pdf

43 Nursing Council of New Zealand (2004) Standards for the registered nurse scope of practice. Retrieved 4 May 2005 from http://www.nursingcouncil.org.nz/standardsrn.pdf

44 Nursing Council of New Zealand (2005) Competence assessment form. Retrieved 4 May 2005 from http://www.nursingcouncil.org.nz/COMPETENCE%20ASSESSMENT%20FORM%20RN.pdf