TE PUAWAI

The Blossoming

The Professional Update for Registered Nurses

December 2019

TE PUAWAI

The Blossoming

Whakatauki

Kia tiaho kia puawai te maramatanga

"The illumination and blossoming

of enlightenment"

This whakatauki highlights the endeavours of the College of Nurses as an Organisation which professionally seeks enlightenment and advancement.

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Disclaimer

The College of Nurses Aotearoa (NZ) Inc provides Te Puawai as a forum for its members to express professional viewpoints, offer ideas and stimulate new ways of looking at professional practice and issues. However, the viewpoints offered are those of the contributors and the College of Nurses does not take responsibility for the viewpoints and ideas offered. Readers are encouraged to be both critical and discerning with regard to what is presented.

Editorial

Dr Mark Jones, FCNA(NZ), FACN
CNA(NZ) Board Co-Chair

Kia ora koutou katoa,

I am delighted to be writing this editorial as incoming Chair of the College and honoured to be taking up the position as representative of the 'non- Māori' membership alongside our other Chair Lorraine Hetaraka-Stevens who leads the 'Māori caucus'. In recognition of these terms for areas of representation sounding rather clunky work has been done to give them a rather more pertinent and reflective meaning as befits the overall kaupapa of the organisation. You can read more of this process within these pages. Lorraine and I will work in partnership to ensure that all members are well represented by the College and in its work. Of course, I want to thank Dr Kathy Holloway for a great job as Chair over the past 5 years, especially in revising our governance arrangements to ensure they are fit for the purpose of a modern membership organisation. The College goes from strength to strength and I am looking forward to working with Executive Director Prof Jenny Carryer in playing a part.

Whilst my foundational nursing degree was pretty comprehensive, it did have a leaning toward understanding how people are in the family and community, including those so-called social determinants of health, before moving to consider ill-health as an absence of their inability to live an optimum lifestyle rather than just being 'sick'. This led to a certain frustration for me and classmates not being allowed so much of a sniff of a hospital in year one, although the remaining three years of our programme certainly crammed in enough experience and learning as to how to care for people dealing with illness and disease. Yet, we did always tend to come back to the question as to how life situations set folks up to be unwell.

This beginning later honed through study of health policy and how people process health information to make health enhancing choices (or not) pretty much led to my focus on all things primary health care as the core element of my practice. When recruited to be Chief Nurse working with the Ministry 15 years ago an essential mandate was to draw on my background to enhance nursing participation in the ongoing roll out of the Primary Health Care Strategy. I don't need to remind you how many obstacles there were to full and equitable participation of our profession back then.

A great hope was the development of Primary Health Organisations (PHOs) intended to truly seek out and address health care needs, pretty much as I had been taught as an undergrad, whilst also wresting control of the 'primary care' system away from a model which at best represented a market enterprise and at worse a venal and systematic mechanism for maximising income from the taxpayer dollar. It wasn't that straightforward though and I still recall the horror after I inquired in a PHO management meeting what the initials 'IGU' stood for in a tabled document. I was told this was an income generation unit, otherwise known as a patient!

This was a decade ago and with a hundred or so PHOs culled to leave just 31, we would hope the best are left and the money wranglers have gone. Well yes, we have exemplary PHOs out there now doing their utmost to use government funding to provide not only the lowest cost of access to services, but also actually bothering to seek out and meet health care need amongst their community rather than just wait for sick people to come through the door of a GP office. However, behind the scenes of some, who claim not-for profit status, and even exist as tax minimal charities, there still lurks a money-spinning machine supposedly contracted to assist in the delivery of health services.

The delivery of publicly funded primary health care in Aotearoa today is anything but not for profit, and in my time as co-Chair I intend to work to help ensure that every dollar intended for care is used for that purpose, not for increasing the value of a shareholder portfolios. The College has for many years held a vision of 100% access, zero disparities. The actual utilisation of Government investment in primary health care is a critical factor in determining how much closer the country comes to the College vision of ensuring the greatest access to good health for all.

Next year is a particularly noteworthy year for nursing. It is not only 2020 The International Year of the Nurse, but the third and final year of the Global Nursing Now campaign. The College is taking an active role in these activities and we will be contacting you about regional and national events.

We have more details on page 11. A new website is about to be launched by Ministry of Health dedicated to the campaigns. This will be managed by the team at the Office of the Chief Nurse MoH, who are also leading a national steering group to manage campaign scheduling and events. Liz Manning and Lorraine Heteraka are both College reps on the national steering group, so if you have questions or ideas for the campaigns, please contact the College office.

Seeking Immediate Psychological Support Within A World of Long Waiting Lists

Can technology driven intervention, such as e-CBT Provide a solution?

Anna Elders MN, PGDip CBT, BN, RN

Originally published by NZ Doctor

just a thought

your mind, your way

“I really needed to see you eight weeks ago”. This is a common sentiment expressed during initial assessments with people presenting to psychological services.

People present to their GP and other health services with a variety of challenges and differing levels of distress hoping that help will come soon. A referral for psychological support is often made, however waiting for the first session to arrive is like waiting for that much-needed holiday sitting right at the end of the year. It never comes soon enough.

The largest practice-evidence gap in mental health

A much-respected colleague, Dr David Codyre recently said “access to the effective talking therapies, particularly Cognitive Behavioural Therapy, is the biggest practice-evidence gap that the mental health sector faces”. Cognitive Behavioural Therapy (CBT) is widely identified as a highly evidenced and effective first-line intervention for depression and anxiety disorders 1, 2 and forms an essential treatment component in other complex mental and physical health conditions. Despite our knowledge of this, a continued reliance on medication as the main stay of treatment for mental health conditions prevails. Funding and access to psychological support within primary care is generally improving, however waiting times are often too long and session numbers commonly limited to 4-6. This is often not enough to make a significant difference in the lives of people experiencing complex challenges with a history of significant childhood adversity.

People utilising secondary mental health services fare the worst of all in terms of access, with waits of months for therapy or no access offered whatsoever. With trauma and childhood adversity high within this population, lack of psychological support could be hypothesised as a significant contributor to a poor response to treatment or 'treatment resistance', increasing doses of medication and the sad and hope-diminishing 'revolving door' phenomenon. Through the wealth of significant research conducted looking at the impact of ACE's (Adverse Childhood Experiences) as a major predisposing feature in the development of mental health conditions [3, 4], we must move towards a trauma-informed approach within our mental health system. Focus needs to be prioritised on supporting the ongoing effects of trauma, rather than pathologising the 'symptoms' we seem more comfortable to identify and attempt to 'treat'.

Obstacles to psychological access

Aside from a heavy focus on pharmacological interventions in mental health, another obstacle to ensuring adequate delivery of psychological intervention has been a lack of workforce to deliver treatment. Talking therapies have over time been considered treatments only psychologists, psychotherapists and counsellors can deliver. Psychotherapist and counsellors seldom gain employment in publicly funded services and we find ourselves in the midst of strike action by our psychology colleagues for the first time in history due in part to being overworked.

The significant potential impact that more sizeable workforce groups such as nurses could make if empowered to deliver these treatments has only recently been realised. Post-graduate programmes in CBT are being opened to a range of health professionals, however role creation to allow for the delivery of higher intensity therapy does not necessarily always follow.

The reality is, it would take a significant number of years and considerable financial investment to train enough health professionals to deliver talking therapies in order to increase access on the scale required. Our new frontline mental health workforce in primary care will provide significant support in this endeavour, however they need to have access to effective, evidence-based tools to ensure they can become one of the solutions we so desperately need.

The rise of e-mental health and e-CBT

For some time, researchers and clinicians have been exploring the feasibility of levering technology to help deliver evidence-based psychological treatments. With our ever-growing reliance on the internet as human beings to support self-diagnose and treatment seeking, it seems a sensible resource to look to.

The rise of computerised CBT began in 1990 with the first treatment manual being delivered via CD-ROM before advancing to online delivery in the late nineties. [5] Since inception, there have been well over 300 studies examining the efficacy of e-CBT in the treatment of PTSD, depression, anxiety disorders, bipolar disorder and in support of conditions such as chronic pain and diabetes. [6] A recent updated meta-analysis highlights e-CBT as an effective, acceptable and practical way to deliver treatment to large populations of people struggling with anxiety and depression. The meta-analysis of 64 studies found significant mean effect sizes showing superiority of e-CBT over control groups, a NNT of 2.34 and long-term benefit on follow-up of up to 18 months. [5]

A recent systemic review and meta-analysis comparing e-CBT to face to face treatment showed both can produce equivalent overall effects [9] and rates of acceptability and adherence are considered similar to those with face to face therapy. [5] These findings are significant when we consider the 25-50% adherence rates to antidepressants with people experiencing major depressive disorder 7 and the recent estimated NNT for antidepressants of 16. [8]

The benefits of e-CBT

Online or computerised CBT provides several significant benefits across the health sector. These include:

- Provision of immediately accessible, evidenced-based psychological treatment
- Ability to support large populations including those in rural and remote areas
- Low or no cost to service for users including savings on cost and time travelling
- Greater privacy, choice and flexibility in terms of accessibility
- The ability to revise content and 're-enter' treatment at any time
- An alternative to face to face therapy or an option for people on waiting lists
- The potential to focus more intense face to face treatment for those with greater complexity
- Significant cost-effectiveness to health care services
- A structured, evidence-based tool to assist delivery of mental health support by the wider workforce

New online tools such as Just a Thought, provide users with the option to complete courses either through a self-guided format or have the tool 'prescribed' by a clinician. The prescribed option allows for follow-up, monitoring and essential motivational support by the health care team along the way to increase adherence and outcomes. This particular new tool will allow for greater detection of commonly missed conditions such as social anxiety and OCD as further courses become available. It also enhances the ability for clinicians and support staff to monitor for increasing risk of suicide and deterioration through alerts generated through the system.

Assessing suitability for e-CBT

Whilst e-CBT may be supportive to a much wider group, it is likely these interventions will be of greater benefit to people with emerging or mild to moderate mental health challenges. People presenting with greater risk of suicide, severity or complexity in terms of co-morbidity and substance dependence may struggle to engage in online tools or may need greater support during use.

High user motivation and interest in use of online tools assists a natural engagement and adherence with courses, however there is a lot of research to show that contact with a support person may enhance motivation, adherence and outcomes in those who may not naturally select this form of help. [10]

The future of e-mental health in New Zealand

The rates of development of e-mental health tools is on the increase here in New Zealand and abroad. This is both exciting but also daunting for both users and clinicians in terms of choice. Clinicians and users need to be aware of important issues around tool selection such as level of evidence, quality of information, security and reliability. Currently evolving national frameworks and guidelines will be of great support in terms of selection, however currently available rating scales for both users and clinicians such as the MARS (Mobile App Rating Scale) and uMARS (User Mobile App Rating Scale) provide some assistance at this time.

With the growing use of the internet and social media, we will see more and more treatment being delivered online. New Zealand has some fantastic tools produced within our shores such as Sparx and The Quest – Te Whitianga, The Journal and the Lowdown and Just a Thought which has been redesigned based on the highly evidenced Australian tool, This Way Up.

E-CBT and other effective, evidenced mental health tools have significant potential in improving the wellbeing of New Zealanders. However, we will only see the full benefits optimised by a health sector that is willing to utilise them, developing a collaborative team approach with both fellow health care staff and the user themselves in order to cater delivery in a way that will be effective.

E-mental health tools serve as a flexible, accessible option for those who may wish to independently seek support. They hold the benefit of immediacy for people waiting for face to face therapy. They can assist in reducing therapist time spent on psychoeducation in face to face session so that more complex challenges can receive the focus needed. And for those who do not wish to receive support online, the tools will work to open up availability of face to face therapy in a way that we could not imagine without leverage of technology. Maybe the internet will not be our undoing as a society in the end. Maybe it will help to signpost us back to the most meaningful thing in life. Connection. A reconnection with ourselves, with our whanau and with our communities rather than the disconnect we are living in as we find ourselves stuck battling within our own minds.

References

(1) David, D., Cristea, I., & Hofmann, S. G. (2018). Why Cognitive Behavioral Therapy Is the Current Gold Standard of Psychotherapy. Frontiers in psychiatry, 9, 4. doi:10.3389/fpsyt.2018.00004

(2) Cuijpers P, Cristea IA, Karyotaki E, Reijnders M, Huibers MJ. How effective are cognitive behavior therapies for major depression and anxiety disorders? A meta-analytic update of the evidence. World Psychiatry (2016) 15(3):245–58.10.1002/wps.20346

(3) Dvir Y, Ford JD, Hill M, Frazier JA (2014) Childhood maltreatment, emotional dysregulation, and psychiatric comorbidities. Harv Rev Psychiatry 22:149–161

(4) Scott KM, Smith DR, Ellis PM. Prospectively Ascertained Child Maltreatment and Its Association With DSM-IV Mental Disorders in Young Adults. Arch Gen Psychiatry. 2010;67(7):712–719. doi:10.1001/archgenpsychiatry.2010.71

(5) G. Andrews, A. Basu, P. Cuijpers, M.G. Craske, P. McEvoy, C. English, et al.Computer therapy for the anxiety and depressive disorders is effective, acceptable and practical health care: An updated meta-analysis Journal of Anxiety Disorders, 55 (2018), pp. 70-78

(6) Kumar, V., Sattar, Y., Bseiso, A., Khan, S., & Rutkofsky, I. H. (2017). The Effectiveness of Internet-Based Cognitive Behavioral Therapy in Treatment of Psychiatric Disorders. Cureus, 9(8), e1626. doi:10.7759/cureus.1626

(7) Trivedi MH, Lin EH, Katon WJ. Consensus recommendations for improving adherence, self-management, and outcomes in patients with depression. CNS Spectr. 2007;12:S1-27

(8) Arroll Bruce, Chin Weng-yee, Martis Waldron, Goodyear-Smith Felicity, Mount Vicki, Kingsford Douglas, Humm Stephen, Blashki Grant, MacGillivray Stephen (2016) Antidepressants for treatment of depression in primary care: a systematic review and meta-analysis. Journal of Primary Health Care 8, 325-334.

(9) P. Carlbring, G. Andersson, P. Cuijpers, H. Riper, E. Hedman-Lagerlöf Internet-based vs. face-to-face cognitive behavior therapy for psychiatric and somatic disorders: An updated systematic review and meta-analysis Cognitive Behaviour Therapy, 47 (1) (2018), pp. 1-18

(10) D. Richards, T. Richardson Computer-based psychological treatments for depression: a systematic review and meta-analysis Clin. Psychol. Rev., 32 (4) (2012), pp. 329-342

Anna is a mental health nurse practitioner and cognitive behavioural therapist clinically based within a private psychiatric service and GP clinic in South Auckland. She is also an Honorary Teaching Fellow at the University of Auckland and the Clinical Lead for Just a Thought, a new online CBT tool recently launched by the Wise Group. Anna set up AnzaCBT, New Zealand’s CBT association to help raise the profile of talking therapies in New Zealand and has delivered various trainings to health professionals in CBT, trauma-informed care and psychological interventions across New Zealand.

Nursing Now Campaign and International Year of the Nurse

Article by Liz Manning RN BN MPhil FCNA(NZ)

2020 Year of the Nurse and Midwife

The 72nd World Health Assembly (WHA) in Geneva 2019 designated 2020 as The International Year of the Nurse and the Midwife.

The World Health Organisation (WHO) Executive Board in January 2019 drew attention to the vital role of nurses and midwives in achieving universal health coverage. Elizabeth Iro, WHO Chief Nursing Officer led the resolution for WHA to endorse 2020 as the Year of the Nurse and Midwife.

2020 Year of the Nurse and Midwife coincides with the 200th anniversary of the birth of one of the founders of modern nursing, Florence Nightingale and the completion of the Global Nursing Now campaign. Nursing Now is a three-year global campaign (2018-2020) which aims to improve health by raising the profile and status of nursing worldwide. Run in collaboration with the World Health Organization and the International Council of Nurses, Nursing Now seeks to empower nurses to take their place at the heart of tackling 21st Century health challenges and maximize their contribution to achieving Universal Health Coverage.

In New Zealand, the Office of the Chief Nurse, Ministry of Health is leading a steering group to co-ordinate, link and create nursing events for 2020. The New Zealand Midwifery events are being managed by the key national Midwifery groups.

Nursing Now

The Ministry of Health Chief Nursing Officer has signed up to the Nursing Now campaign as a national group on behalf of the nurses of Aotearoa, New Zealand. The criteria for registering as a national group and the global campaign structure is outlined below. New Zealand has registered as a national group which requires involvement of government, national nursing associations and young nurses.   NZNO has already signed up as a local group.

Helen Rook @helen_rook · 2d

Blustery morning at Parliament for the launch of Nursing Now Aotearoa New Zealand

Nursing now Global Campaign Structure

Anyone can create a local or student group!

Local & Student Groups

National Groups (must involve government, national nursing association & young nurses)

Regional Groups (collection of national groups in a geographic area)

Global Campaign

The global campaign team supports regional, national & local groups

Ministry of Health - Manatū Hauora
@minhealthnz

2020 is the International Year of the Nurse and Nursing Now campaigns, a perfect chance to celebrate nursing as a rewarding career choice in NZ. Here's Chief Nursing Officer Margareth Broodkoorn celebrating with other nursing leaders. #NursingNowAotearoa health.govt.nz/news-media/med...

By the end of 2020, we want to see the following goals achieved:

1. Greater investment in improving education, professional development, standards, regulation and employment conditions for nurses.

2. Increased & improved dissemination of effective & innovative practice in nursing.

3. Greater influence for nurses and midwives on global and national health policy, as part of broader efforts to ensure health workforces are more involved in decision-making.

4. More nurses in leadership positions & more opportunities for development at all levels.

5. More evidence for policy and decision makers about: where nursing can have the greatest impact, what is stopping nurses from reaching their full potential and how to address these obstacles.

Planned activities include:

- Local, regional and national events
- National marketing campaigns
- ‘Real heart, real smart’ campaign
- Year of the Nurse & Nursing Now champions
- The Nightingale Challenge

For more detailed information on Nursing NOW, refer to:

https://www.icn.ch/what-we-do/campaigns/nursing-now

https://www.who.int/hrh/news/2018/nursing_now_campaign/en/

Nursing now
New Zealand

Nursing now
Aotearoa

Whakaingoa Māori, Whakapiki Te Tikanga! Encompassing Māori Names in Raising our Aspirations!

Dr Aria Graham RN PhD
CNA(NZ) Board Member

From a Māori worldview, life and wellbeing are directed by complementary principles and practices. Tikanga and kawa are in place to guide humanity (te ira tangata) in symbiosis with the environment (te ao tūroa) and help us to make sense of and navigate a changing world (te ao hurihuri). An example would be the ceremony of pōhiri that is the ritual of encounter that one would experience being formally welcomed onto a marae by the tangata whenua (host / local people).

Tikanga and kawa delicately hold and ensure the preservation and progression of life and wellbeing according to te ao Māori (the Māori world). Aroha (love, acceptance, compassion) and manaakitanga (care, kindness, and hospitality) are among the many tikanga we hold dear as the Indigenous people of Aotearoa. As Māori, we can transfer these cultural protocols to contemporary situations operationalised through kawa.

Tikanga is wide-reaching, palpable, and inclusive. From a Māori viewpoint, there are many synergies with the underlying principles of the nursing profession. For instance, when two groups come together such as Māori and Pākehā nurses, we do so through an exchange of understandings and rituals that guide and protect our distinct and collective beliefs, values and aspirations. Authenticity in partnership comes from accepting and interweaving our principles and belief systems as normal and pragmatic, not as adjunct or othered.

The College of Nurses Aotearoa NZ (CNA) is committed to Te Tiriti o Waitangi particularly through purposeful, operationalised, applied actions. CNA is seeking to develop a more meaningful and authentic bi-cultural partnering to further strengthen and optimise our diversity. Reflecting on our make-up within the College and through a Māori lens, is an example of this commitment. In doing so, we are better placed to make a positive contribution toward the aspirations of: consumers requiring high quality care; the nursing profession who are leaders in health care delivery, science, research and academia; and the diverse communities who expect cultural, social, political and economically viable responsivity contextualised to their needs. Thus, tikanga Māori is recognised as a fundamental quality to how we continue to shape and advance our knowledge and skill base, goals and strengths.

Henceforth, the organisation is supporting the underlying kawa and tikanga in the CNA Board Caucuses to change current CNA Board titles to distinctive Māori titles. The caucuses are presently known as the ‘Māori Caucus’ and the ‘Non-Māori Caucus’ respectively. The Board agreed that renaming would reflect the organisation’s intent for cohesion and progressiveness and that there was no rationale to be separated by a Māori title for the Māori and an English title for the non-Māori. Complementary names for the caucuses in te reo Māori that derive from the same mātauranga (knowledge) and philosophical base epitomises the organisation’s vision, demonstrates seamlessness and acknowledges our value for each other, for mana whenua and the nursing profession.

The titles will capture the wairua (spirit) of a professional organisation that is ardent in understanding what whānau and communities want as equity and wellness, whilst recognising distinct and respective whakapapa and Te Tiriti o Waitangi obligations. From a Māori perspective, gifting names is hugely significant and ceremonial such as it is with the birth of a new baby, the opening of a building or blessing of a taonga. Therefore, installing the new names will be embedded in a process that will reinforce our cultural endeavours as an organisation. The names will be shared once a process has been formalised.

Encompassing Māori names is just part of the collaborative efforts that have started at CNA, which includes embedding Māoritanga throughout the organisation as we strive forward in professional excellence and inquiry, critiquing ourselves and others, and making natural what is indelibly the fabric of our beautiful home, Aotearoa.

Education Consensus Workshop

Article by Liz Manning RN BN MPhil FCNA(NZ)

An Education Consensus workshop is planned by the College of Nurses Aotearoa (NZ) on behalf of the National Nursing Organisations group (NNOg) for early 2020.

There are two significant pieces of work currently being undertaken that will impact nursing workforce and nurse preparation. The first is the Health and Disability System Review, currently in an interim form. Second is the Review of Vocational Education (ROVE) which will have an impact on nursing degree programmes, specifically those in Technical Institutes/ Polytechnics and Wānanga. These two large scale pieces of work have prompted the NNOg to consider how the nursing profession moves forward and whether the current supply model is meeting the industry demand for registered nurses or more importantly is able to shape the future nature of health service provision.

Both pieces of work offer significant change opportunities for nursing, nursing work and the nursing workforce. It is vital that the nursing profession occupies this space and creates its own direction, based on our understanding of how flexible, responsive, academically prepared and diverse the workforce needs to be to deliver care in the right way, in the right place at the right time.

A date for the workshop will be released as soon as possible..

The College of Nurses Board and staff wish all College members
a happy, safe and relaxing time over Christmas and New Year.

The College office will be closed from mid-day, 23 December 2019 until 15 January 2020.
Phone and e-mail messages will be checked occasionally.

Connections that link operational, clinical and development effectiveness within a bicultural context in Aotearoa New Zealand

Article by Cheryl Atherfold RN BN MHSc(Nurs) FCNA(NZ)

Abstract

The reality of practice for many nurses and other health professionals is fraught with dilemmas relating to their ability to deliver the best care with the time and resource available. Many factors influence this reality such as the availability of staff, skill mix, flow, demand, finance, resource constraint, physical environment and technical equipment. A significant amount of effort has been made to improve systems, safety, quality indicators and outcomes. However, the dilemmas remain. Understanding the interface between operational factors that influence the ability to provide clinical care effectively, and the way that staff are developed and prepared within the bicultural context is a key to the future. This paper focuses on how the connections between operational, clinical and development interplay to positively impact local population health outcomes within Waikato, Aotearoa New Zealand. Context, evidence from literature and experience, and facilitation form a mechanism for this consideration using the PARIHS framework. Bi-cultural models are linked to these elements providing examples that reflect connection as the key to effectiveness and sustainability and inform workforce preparedness.

Key words: Operational, Clinical, Development, Connection, Bicultural

Introduction and Focus

Anecdotal narrative from nurses and other clinicians describes a sense of disconnect between their voice and the ability to influence how systems work and allocated resource availability. There is acknowledgement that each part of the system intends to effectively deliver health care however, there are feelings of frustration about the perceived distance between clinical care, and the way systems decisions are made. Audit, reporting and analysis are understood as part of the picture, and often used in the place of the lived experience of the patient, nurse and other clinicians. Clinical governance has been profiled over many years as a means to ensure the clinical perspective is central to the way the organisation works. While Clinical Governance addresses many of these concerns a dominant discourse continues about a perceived disconnect.

The focus of this paper is to explore connection that does not naturally occur through structure, hierarchy and other mechanisms. This includes considering the interplay between operational drivers and development needs within a bi-cultural context for population health outcome.

Interdisciplinary clinicians (Nurses, Doctors, Midwives and Allied) describe their reality as conflicting as they endeavor to deliver an acceptable standard of care in time and resource pressured environs. Parallel to this are the efforts of the business and finance management teams whose function it is to align budget predictions, resource planning and payment sequencing in ways that best support accountabilities and service need often linked to operational perspectives.

Against this background is the disparity and inequity in health outcomes for vulnerable populations. These can be identified across geography, lifespan, location, ethnicity and poverty (Ministry of Health, 2018). In other words, they are often children and older people who live rurally in remote locations or within urban areas with inadequate housing, deprived circumstances and limited access. In New Zealand Maori are overrepresented in all of these categories and in all co-morbidities resulting in a 20 year negative variance in life expectancy (MOH, 2018). The Te Tiriti o Waitangi (TToW) provides a foundation and commitment for how we can operate to align political priorities to correct this by working in partnership to achieve participation and to protect what is considered valuable. Given that historic misapplication of these elements of the TToW has contributed significantly to the current poor health outcomes it is appropriate that we look to its intent to resolve and address current inequity (Berghan, Came, Coupe, Doole, Fay, McCreanor, & Simpson, 2017). The 'promoting action on research implementation on health service' (PARIHS) categories provide a helpful framework to reflects the interplay between many factors which align with the notion of connection (Kitson, Harvey, & McCormack, 1998; Manley, McCormack & Wilson, 2008; McCormack & McCance, 2017). . These being:

1. *Context*; incorporating culture, application of values, relationships, leadership, strategic goals, resource, power dynamics, evaluation, feedback, outcomes, economics and experience.

2. *Evidence*; from literature, research and practice experience.

3. *Facilitation*; of processes and development with internal and external stakeholders, as the means by which interdependence / interplay and action occur.

Discussion

Context: In acknowledging myself as a Pakeha nurse leader in Aotearoa New Zealand within the Waikato District Health Board setting, I am conscious of the disparity and inequity in health outcomes and the responsibility of working in a bi-cultural partnership to address these (Ministry of Health, 2018. TToW). This means that genuine partnerships are essential to enable me to lead and influence practice and organisational culture. My own journey is individual as well as collective as I strive to understand how to partner to equip nurses to achieve equity, to lead and facilitate clinical and cultural competence and advocate for a workforce to meet the needs of our people. Health needs in the Waikato region are complex and multi-faceted. This is due to the high proportion of Maori (23% whereas the national average is 15%), with 60% of people living rurally, and many people living in deprived urban and rural circumstances (Department of Statistics NZ, 2013, Waikato DHB, 2017, Waikato DHB, 2019). The extensive geographical spread of rural communities further challenges equity and access to health services. As a strategy to align with the population demographic, intentional growth in the percentage of Maori nursing graduates employed over 5 years has increased from 6% in 2013 to 23% in 2017 (Chris Baker & Lin Marriott, Waikato DHB, Personal Communication, 2019). While acknowledging this positive trend, workforce numbers alone are insufficient. Thus far development activity has incorporated professional and cultural identity, models of care and ways of working for Maori nurses. Including support for these elements in clinical and professional practice is a hall mark of the difference offered. Alongside the focused aspects for Maori nurses is the development of cultural and clinical competence for others. Both approaches are based on the Waikato DHB Nursing Professional Frameworks (Hayward, 2017) reflecting quality outcomes, clinical standards and leadership for patient care using participatory approaches (The Advisory Board Company, 2013; Benner, Sutphen, Leonard, Day, 2010).

In addition, assignment workload management measures and ‘Care, Capacity Demand, Management’ (CCDM) have shown the need for increased numbers of nurses (Ministry of Health, 2017). To recruit the necessary volume of nurses, an increased number of internationally qualified nurses (IQN’s) have joined the workforce requiring orientation to the Aotearoa, New Zealand bi-cultural context. While experience with their own and multi-cultural or cross-cultural relationships brings value, the concept of working in a bi-cultural partnership is new to IQN’s and requires transition support. Bi-cultural processes have facilitated this within mihi whakatau, or whakawhanaungatanga where connections are formed to become ‘part of us’.

Evidence: This domain incorporates evidence both from literature and from experience. A range of evidence from the literature regarding operational management outlines the importance of organisational culture, structure for purpose, accountability, alignment, linkages, performance measures, resource and quality standards (Mennella, & Pravikoff, 2018; Health Quality & Safety NZ, 2018; Osei-Kyei, Chan, & Ernest, 2017; Sensoy & Diangelo, 2017; Howard, 2015; Hollnagel, Braithwaite & Mears, 2013; Gauld, 2003). Giving priority to these components prevents operational management defaulting to reactionary problem solving in what can be crisis circumstances. The specialist body of knowledge and skills for operational management is often assumed to be intuitive or automatic if you have other expertise (i.e. clinical). In other words if a person is effective clinically the expectation is they will also reflect strengths in operational management; this may not necessarily be the case. As with all disciplines there is a unique body of knowledge that informs the mastery of that particular function and valuing this for the operational context is key to reciprocal connection where clinical and operational expertise are applied (Howard, 2015). This does not exclude nurses and other clinical staff from growing their knowledge skill and expertise for operational management, or vice versa, however it does mean that the development for the particular skill set does need to be undertaken. For example; those nurses or clinicians desiring to become operational leaders, may undertake development to reflect the unique skills for operational management.

Anecdotal evidence from the experience of nurses and other clinicians profiles a narrative describing the frustration of not being able to influence operational decision making from their position in clinical care. It is noted that this causes a moral and professional conflict resulting in distress. Many note their reason for seeking career progression into operational management roles as a desire to make a difference and to advocate for patients and clinical care. They later describe that this goal becomes lost in the demands of their roles. Some describe the inability to positively influence outcomes from their practice. Largely this is due to a sense of busyness and pressure to manage their work and feeling distanced from where decisions are made about structure, systems and processes. Part of the dilemma of not being able to achieve the desired care for patients has been addressed by the MOH and DHB commitment to the principles of CCDM which prioritises safe staffing requirements for volume and skill mix (MOH, 2017). However, for changes in culture to build on the implementation of appropriate volume and skill mix, a structural connection that enables the voice of nurses and others providing clinical care to influence operational systems and processes is required. Professional supervision provides an opportunity for nurses and other clinicians to reflect, process practice and explore ways to develop individual skills and strategies for these complex and challenging situations (Ducat, Martin, Kumar, Burge & Abernathy, 2016). Many nurses and clinicians acknowledge that the objective of operational management teams is to serve the same overall goal to deliver the best care to patients. They see the operational contribution to this reflected in the way that structure, systems and resource are applied. The opportunity therefore remains to integrate the strengths of both operational and clinical interplay with effective development as part of the process.

Constructing a workforce to meet complex needs requires committed planning and acknowledgement of skill sets that reflect operational and clinical needs. Within nursing formal research has been used to evaluate early career nurses perceptions regarding clinical reasoning, leadership and quality processes acknowledging the interface between all aspects (McKillop, Atherfold & Lees, 2014; Dougherty, McKillop, Shaw, Atherfold, 2015) based on practice development methodology (McCormack, McCance, 2017; Manley, McCormack, Wilson, 2008). Students and early career nurses report that this improves their confidence and capability within practice and supports their career development. This equips and enables early career nurses in how they navigate challenging situations. It also provides a foundation from which a contemporary career development pathway can emerge with a sense of clinical skill, understanding of some operational context, agency and advocacy whilst understanding equity and the needs of the population (Hawkins, 2017; Sensoy & Diangelo, 2017).

Complimentary to workforce preparation, health services seek to navigate their way through increasingly complex contexts to improve patient experience and health outcomes by way of service responsiveness to demand and population need (Gauld & Horsburgh, 2015; Gauld, 2003; Howard, 2015). The tension between financial constraint and ever-increasing health costs has emerged as a dominant influence and does not reflect equity and the associated accountability between the clinical professional and operational components. Therefore, incongruence occurs between espoused priorities, and the mandate to deliver services (Howard, 2015). Addressing this requires expertise and mastery in all aspects of operational management, clinical care and development. Furthermore, there is an opportunity for the partnership, participation and protection principles of the TToW to be overt within such structures and systems for the New Zealand context (MoH, 2016; Berghan, Came, Coupe, Doole, Fay, McCreanor, & Simpson, 2017; Kingi, 2007).

Facilitation: Collectively the context and evidence domains of the PARIHS framework provide the opportunity to actively connect workforce capability and organizational systems that are in progress and development (Rycroft-Malone, Seers, Chandler, Hawkes, Crichton, Allen, Bullock, & Strunin. 2013). Facilitation of such a process enables in-depth consideration of the barriers and potential solutions in situations where known approaches, structure and hierarchies have not resulted in the desired outcome in meeting the health needs of our population (MoH, 2018). Essentially by engaging the voices of this narrative, both operational needs and accountability are addressed in crafting a contemporary workforce. Quality improvement processes integrated with development approaches are subsequently evidenced as effective and sustainable (Manley, Buscher, Jackson, O'Connor, & Stehling, 2017). This is likely to be because the facilitation domain links stakeholders to their context. This shifts the culture from hierarchical direction to co-design, collaboration and inclusion. This in turn contributes significantly to a positive workplace culture.

Facilitating connections within the Aotearoa New Zealand context can only be strengthened by incorporating learning from bi-cultural insights. An early example of this is Te Puea Herangi (also known as Princess Te Puea) of Tainui descent who lived 1863–1952 (King, 1977). Te Puea was influential in political and practical development of health care, aligning elements of TToW and Tikanga (Maori practices) to ensure best practice and outcomes for Maori. This was during a time where conscription and land confiscation had occurred, leaving poor resource and ability for people to remain healthy as swamp land was allocated in place of well-draining productive land and many people were imprisoned for not going to war. She advocated for release of those imprisoned, health care delivery and promotion, planning and purchasing the site at Turangawaewae and developing a Maori health facility reflecting clinical and cultural needs. Furthermore she formed connections with local and national government that resulted in advocacy and prioritization of the needs of her people. There is significant congruence between her very human journey which began over a hundred years ago, and the priorities of operational and clinical excellence in today's world.

Maria Baker's (2008) articulation of Te Arawhata o Aorua, bridging the tension between two worlds, provides further insight (Wilson & Baker, 2012). The elements of advocacy, understanding Maori world view, applying Tikanga and growing a Maori workforce to improve health outcome transcend across the century. Tensions described by Maori nurses include:

- Interpreting others cultural meaning and professional competence
- Often 'going beyond' to translate culture and care and facilitate patient
- Whanau (family) expectations

Many supports for addressing these tensions are reflected within other bi-cultural approaches, such as the Hui process which ensures effective connection via mihimihi, (greeting and engagement), whakawhanaungatanga (relationships – connections), kaupapa (purpose) and poroaki / whakamutanga (closing) (Lacey, Huria, Beckert, Gillies, & Pitama, 2011). Another model is the Meihana model which builds on the cultural process of connection, and incorporates environmental and health service components in conscious ways that manifest as partnership (Pitama, Huria, & Lacey, 2014). The additional perspective of the Meihana model is that as well as connecting the patient with support networks and a holistic approach, it incorporates the influences of colonization, marginalization, racism and migration which continue to impact equity.

In contrast to the example of Te Puea, and the Te Arawhata o Aoru, Hui and Meihana models (King, 1975, Wilson & Baker, 2012; Lacey, Huria, Beckert, Gillies, & Pitama, 2011; Pitama, Huria, & Lacey, 2014) is a systematic review of indigenous approaches for primary health care which did not discuss cultural practices to support engagement. The review was undertaken to scope barriers and enablers for Torres Straight Islanders (Gardner, Sibthorpe, Chan, Sargent, Dowden, & McAullay, 2018). The study showed the value of using continuous quality improvement to enable better access and uptake of health care provided there was engagement and community linkages. While cultural practices for engagement were not the focus of their systematic review, it does raise the question of whether the alignment of cultural practices could strengthen this. In considering the review by Gardner et al. (2018) alongside our bi-cultural environment in Aotearoa New Zealand a possible conclusion is that continuous quality processes are helpful in that the principles include both context and evidence and that by adding bi-cultural partnerships and practices engagement is enhanced. Furthermore, the journey to achieve partnership is both an individual one as well as an organisational approach as we work together in ways that bridge the tensions (Crawford, 2016; Panapa, 2015; Ducat et al, 2016).

Conclusion

In concluding, this review has stimulated discussion about connections as the link between operational, clinical and development effectiveness. The TT0oW along with bicultural models applied in practice provide a cornerstone of how these connections can be developed with integrity to deliver equitable outcomes for our population (Pitama, Huria, & Lacey, 2014; Wilson & Baker, 2012; Lacey, Huria, Beckert, Gillies, & Pitama, 2011; King, 1977). Recognising mastery of unique bodies of knowledge and skill provides a foundation for integration including bi-cultural expertise, structure for purpose, accountability, alignment, linkages, performance measures, resource, quality standards and clinical care (Quality & Safety NZ, 2018; Hawkins, 2017; Osei-Kyei, Chan, & Ernest, 2017; Howard, 2015; Hollnagel, Braithwaite & Mears, 2013; Gauld, 2003). Workforce planning and development can incorporate the components of context, evidence and facilitation within the PARIHS framework to achieve co-designed sustainable outcomes (McCormack, & McCance, 2017; McCormack & Wilson, 2008). From such a foundation we can see Kotahitanga (stronger together) realised in ways that meet the needs of our communities.

References

Baker, C. & Marriott, L. (2019) Personal Communication.

Baker, M. (2008). Te arawhata o aorua [Bridging two worlds: A grounded theory study]. (Unpublished Master's thesis). Massey University, Auckland, New Zealand. https://mro.massey.ac.nz/bitstream/handle/10179/1043/02whole.pdf?sequence=1&isAllowed=y

Benner, P., Sutphen, M., Leonard, V. & Day, L. (2010). Educating nurses: A call for radical transformation. The Carnegie Foundation. San Francisco. Josie Bass.

Berghan, G., Came, H., Coupe, N., Doole, C., Fay, J., McCreanor, T. & Simpson, T. (2017). Te Tiriti o Waitangi-based practice in health promotion. Auckland, New Zealand: Stop Institutional Racism. https://trc.org.nz/sites/trc.org.nz/files/ToW%20practice%20in%20HP%20online

Crawford, H. (2016). Pakeha journey towards bi-cultural practice through guilt, shame, identity and hope. Aotearoa New Zealand Social Work, 28,(4), 80-88. https://anzswjournal.nz/anzsw/article/view/300

Department of Statistics NZ. (2013) National Census. https://www.stats.govt.nz/

Dougherty, L., McKillop, A., Shaw, K. & Atherfold, C. (2016). Reaching their potential: Perceived impact of a collaborative academic – clinical partnership programme for early career nurses in New Zealand. Nurse Education Today, 36,145151, doi:10.1016/j.nedt.2015.09.005

Ducat, W., Martin, P., Kumar, S., Burge, V. & Abernathy, L. (2016). Oceans apart yet, connected: Findings form a qualitative study on professional supervision in rural and remote allied health services. Australian Journal of Rural Health, 24, 29-35. doi:10.1111/ajr.12192

Gardner, K., Sibthorpe, B., Chan, M., Sargent, G., Dowden, M. & McAullay, D. (2018). Implementation of continuous quality improvement in Aboriginal and Torres Strait Islander primary health care in Australia: a scoping systematic review. BMC Health Services Research, 18,(541).doi.org/10.1186/s12913-018-3308-2

Gauld, R. (2003). Continuity amid chaos: Health care management and delivery in New Zealand. Dunedin: University of Otago Press.

Gauld, R. & Horsburgh, S. (2015). Are some health professionals more cognizant of clinical governance development concepts than others? Findings from a New Zealand study. Journal of Public Health, 38 (2), 363–370. doi:10.1093/pubmed/fdv045

Hawkins, S. (2017). Senior nurses' understanding of health equity. Unpublished thesis, University of Auckland. New Zealand. http://hdl.handle.net/2292/36811

Hayward, S. (2019). Nursing at Waikato DHB 2017-2021: Expectations, professional development frameworks and nursing strategic aims. Waikato DHB. https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Strategies/b98b975c0a/Nursing-at-Waikato-DHB.pdf

Hollnagel, E., Braithwaite, J. & Wears, R. (2013). Resilient health care. FL, USA: CRC Press.

Howard, G. (2016). The Accountable Organisation. New Zealand. Author. https://www.accountablehealthorg.co.nz/about-Author-Dr-Grant-Howard.html

King, M. (1977) Te Puea: A life. New Zealand. Penguin books.

Kingi, T. R. (2007). The Treaty of Waitangi: A framework for Māori health development. New Zealand Journal of Occupational Therapy, 54(1), 4-10. https://www.questia.com/library/journal/1G1-168587637/the-treaty-of-waitangi-a-framework-for-maori-health

Kitson, A., Harvey, G. & McCormack, B. (1998). Enabling the implementation of evidenced based practice: a conceptual framework. Quality in health care. 7,(3), 149-158. doi:10.1136/qshc.7.3.149

Lacey, C., Huria, T., Beckert, L., Gillies, M. & Pitama, S. (2011) The Hui Process: a framework to enhance the Doctor – Patient relationship with Māori. Viewpoint Article. New Zealand Medical Journal, 124, (1347). Retrieved from: https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2011/vol-124-no-1347/view-lacey

McCormack, B. & McCance, T. (2017). Person-centered practice in nursing and health care theory and practice. UK, Wiley Blackwell.

McKillop, A., Atherfold, C. & Lees. G. (2014) The Power of Synergy: An academic / clinical partnership for transformational change. Advances in Nursing. http://dx.doi.org/10.1155/2014/605835

Manley, K., Buscher, A., Jackson, C., O'Connor, S. & Stehling, H. (2017). Overcoming synecdoche: Why practice development and quality improvement approaches should be better integrated. International Practice Development Journal, 7,(1).12. doi.org/10.19043/ipdj.71.012

Manley, K. McCormack, B. & Wilson, V. (2008). International Practice Development and Health Care. United States, Wiley-Blackwell.

Mennella, H. & Pravikoff, D. (2018). Benchmarking and Best Practices. CINAHL Nursing Guide, December 7, 81-85.

Ministry of Health. (2016). New Zealand Health Strategy. https://www.health.govt.nz/publication/new-zealand-health-strategy-2016

Ministry of Health. (2017). Care Capacity Demand Management Programme. https://www.ccdm.health.nz/

Ministry of Health. (2018). Achieving equity in health outcomes. https://www.health.govt.nz/publication/achieving-equity-health-outcomes-highlights-selected-papers

New Zealand Health Quality Safety Commission. (2018). https://www.hqsc.govt.nz/

Osei-Kyei, R., Chan, A. & Ernest, E. (2017). A fuzzy synthetic evaluation analysis of operational management critical success factors for public-private partnership infrastructure projects. Benchmarking,24,(7).2092-2112. doi:http://dx.doi.org/10.1108/BIJ-07-2016-0111

Panapa, K. (2015). Te Noho Kotahitanga: Putting the 'Critical" back in Biculturalism. Unpublished Thesis. New Zealand, Unitec. https://researchspace.auckland.ac.nz/docs/uoa-docs/rights.htm

Pitama, S., Huria, T. & Lacey, C. (2014). Improving Māori health through clinical assessment: Waikare o Te Waka o Meihana. New Zealand Medical Journal, 127, (1393). https://www.nzma.org.nz/journal/read-the-journal/all-issues/2010-2019/2014/vol-126-no-1393/viewpoint-pitama

Rycroft-Malone, J., Seers, K., Chandler, J., Hawkes., Crichton, N., Allen, C., Bullock, I & Strunin. (2013). The role of evidence, context, and facilitation in an implementation trial: Implications for the development of the PARHIS framework. Implementation Science, 8, (28), 2-13. doi: 10.1186/1748-5908-8-28.

Sensoy, O. & Diangelo, R. (2017). "We are all for diversity, but…" How faculty hiring committees reproduce whiteness and practical suggestions for how they can change. Harvard Educational Review, 87, (4), 557-580. doi: 10.17763/1943-5045-87.4.557

Te Tiriti o Waitangi.

The Advisory Board Company. (2013). A new starting point for workforce planning. Author. https://www.advisory.com/Research/HR-Advancement-Center/Studies/2013/A-New-Starting-Point-for-Workforce-Planning-Toolkit

Waikato DHB. (2019). Health Systems Plan. New Zealand. https://waikatodhb.cwp.govt.nz/assets/Docs/About-Us/Key-Publications/Plans/7bf3d1e7ca/Waikato-Health-System-Plan-Te-Korowai-Waiora.pdf

Waikato DHB. (2016). Healthy people excellent care: Waikato District Health Board Strategy. Hamilton, New Zealand.

https://www.waikatodhb.health.nz/assets/Docs/About-Us/Key-Publications/Strategies/4750ac5a11/Waikato-

DHB-Strategy-2016.pdfWilson, D. & Baker, M. (2012). Bridging the tension of two worlds. Maori Mental Health Nursing. Qualitative Health Research, 22, (8), 1073-1082. doi.org/10.1177/1049732312450213

Health Policy Workshop for Nurses 30/31 October 2019

Article by Liz Manning RN BN MPhil FCNA(NZ)

This year saw the first ever Aotearoa New Zealand Health Policy workshop for Nurse Leaders. The aim of the workshop was to introduce nurse leaders to the concepts of health policy, funding, networking and some key resources which can aid health policy engagement and development.

Developed by Liz Manning, Operations Manager for the College, the workshop was facilitated and delivered by Liz Manning, Dr Mark Jones and Ngaira Harker. Dr Kathy Holloway kindly made a room available at Victoria University, Wellington Hospital. Andrea Bond, College Executive Administrator was an invaluable support.

The workshop was attended by 22 nurse leaders from a diverse range of providers and work environments. The group were engaged and enthusiastic to take part in workshop activities, while learning from each other and the speakers over the two days.

The workshop was supported by some significant experience including:

Michele Rumsey: Director, World Health Organization, Collaborating Centre for Nursing, Midwifery and Health Development, Sydney

Hew Norris: Senior Analyst, NZ Treasury

Michael Thompson: Vote analyst, NZ Treasury

Pooja Patel: Vote Manager, NZ Treasury

Professor Jenny Carryer: Massey University and Executive Director, College of Nurses (NZ)

Todd Krieble: Deputy Chief Executive, New Zealand Institute of Economic Research (NZIER)

Feedback on the 2 days was overwhelmingly appreciative, reinforcing the need for nurses to engage more with this subject. In fact, attendees, facilitators and speakers alike all took something new away from this workshop. Feedback examples included:

“Just a message to say how much I enjoyed and learned from the workshop last week. Occasionally a learning opportunity comes along that gets it right in every aspect and the aha of learning occurs in multiple ways. This did not happen by accident – there was evidence of thoughtful planning, detailed execution and great outcomes. And to top it off there was a great group of attendees I think as Nurses we are good on strategy and optics – however the workshop provided the essential TACTICS and HEALTH POLICY -that I think many of us have not been sufficiently exposed to.”

"From start to finish the two days were organised extraordinarily well. The content was tailored superbly to the audience, and space for engagement was well facilitated and meaningfully dealt with. The quality of speakers was excellent, and supported to overall agenda nicely. I appreciate the background work that has gone on to present such a high quality, engaging, important message. Well done! You should be so proud."

The College will aim to keep in touch with the attendees with any new policy information, articles and updates.

Front row: Kathy Holloway, Michele Rumsey, Liz Manning, Mark Jones, Jenny Carryer, Ngaira Harker.

Standing: Attendees.

We are very grateful to the speakers for making time for this new innovation. We believe we have made some significant professional connections and will be endeavouring to build on this success using a collaborative model, in the coming year.

Health Research Council Postdoctoral Fellowship Application Success

Dr Aria Graham

I am delighted and honoured to be awarded an Erihapeti Rehu-Murchie Fellowship for a postdoctoral research project beginning January 2020. The title of the project is Māmā e Mamia - piloting a marae-based wellbeing model for pēpi and māmā Māori, which is based on the findings of my PhD completed in 2018 through Victoria University Wellington. The PhD was called 'Tika Tonu – Young Māori Mothers' Experiences of Wellbeing Surrounding the Birth of their First Tamaiti', which explored the lived realities and experiences of young Māori mothers through their own perspectives and stories.

Young Māori women who are pregnant or mothers are heavily stereotyped and problematised in society, although little is understood through a non-deficit kaupapa Māori lens about wellbeing, pregnancy and motherhood, from their perspective. My PhD study revealed among other significant findings, that young Māori women who are pregnant or mothers: revere the wellbeing of their tamaiti and hold their tamaiti central to their own wellbeing; thrive with the support of trusted, reliable and confident women especially their mothers; value whānau whether biological or a 'family' shaped according to their needs; and flourish with a connection to te ao Māori particularly through whānau, whenua and wairua.

Māmā e Mamia (Mamia) will utilise and actualise the knowledge gained from the PhD to support and nurture the wellbeing of young mothers from a distinctly cultural, social and spiritual setting whilst reinforcing the connection between mother and child. The postdoctoral fellowship is for three years and will be located in Te Matau-a-Māui (Hawke's Bay) at Waipatu Marae for any mother for whom the kaupapa resonates. Women and whānau from across the community will be asked to support Mamia, to foster and expound the love and compassion we possess as community, whānau, hapū and iwi, for the holders of our future: our mothers. During the postdoctoral tenure, I will be exploring and developing an integrated kaupapa Māori methodology that views programmes and social interventions as inherently complex operating in different ways for different people in different contexts under varying circumstances.

During my PhD, I was very fortunate to have been awarded a doctoral scholarship with the HRC and I am again honoured to have been successful with a postdoctoral fellowship; he mihi nui ki te Health Research Council of New Zealand. I have been very humbled to have received the support of ngā māmā Māori; Ngāti Kahungunu Iwi Incorporated, Victoria University School of Nursing, Midwifery and Health Science and the Māori Faculty, Tūruki Māori Health Workforce and Henry Rongomau Bennett Foundation; my whānau, friends and community.

I am employed as a fulltime researcher for Whakauae Research Services who are the only iwi-owned Māori health research centre in Aotearoa. I am surrounded and supported by experienced researchers and leaders in mahi that support the aspirations of whānau and iwi Māori across Aotearoa, and who also make a significant impact across Indigenous and international communities. I hope to serve the nursing profession and Māori nursing well as a member of the College of Nurses Board Māori Caucus. “He reo aroha pātai ana mai - He aha tau e, pirangi nei?"

Moving House or Changing Job

Please remember to update your contact details with the College office

Email: admin@nurse.org.nz

Breast Cancer in Aotearoa New Zealand

By Sue Claridge

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“Breast cancer is the most frequently diagnosed cancer and the leading cause of cancer-related death among women worldwide.”[1]

Breast Cancer at a Glance

Breast cancer is the most frequently diagnosed cancer in New Zealand women and is on the increase.
Together with Australia, New Zealand women have the highest cumulative risk of breast cancer, at 10.16%, compared with the rest of the world.
Globally, breast cancer incidence is increasing. In part this has been attributed to decreased childbearing and breast-feeding, increased environmental hormone exposure, and detrimental dietary and lifestyle changes, including increasing levels of obesity and less physical activity.
In New Zealand, the increase in incidence is almost entirely among Māori women, while among non-Māori incidence is relatively stable.
Three lifestyle factors may make a significant contribution to the higher and in- creasing incidence in Māori women: tobacco use, heavy single session alcohol consumption and obesity.
Since 1997 the mortality rate has steadily declined in both Māori and non-Māori women; however, Māori bear a disproportionate burden of loss of life from breast cancer.
Those living in the areas of highest deprivation also bear a disproportionate burden in both incidence and mortality.

Breast cancer is by far the most significant cancer for women’s health in New Zealand (see Figure 1). More than twice as many women are diagnosed with breast cancer every year compared with the second most prevalent cancer (colorectal cancer). Fortunately, the mortality rate for number of diagnoses is relatively low compared with colorectal and lung cancer. However, at 668 deaths in 2016, breast cancer is the second most common cause of cancer death in New Zealand women behind lung cancer (819 deaths), and is the fifth most common cause of death behind ischaemic heart disease (2002 deaths), cerebrovascular disease (1410 deaths) and chronic lower respiratory diseases (876 deaths), and lung cancer.[2]

So significant is the impact of breast cancer, it is the second most diagnosed cancer worldwide, after lung cancer, with 2.089 million new diagnoses (11.6% of all new cases) in 2018,[4] despite the fact that breast cancer predominantly affects only 50% of the population (a small percentage occurs in men; in New Zealand in 2016 0.48% of new breast cancer diagnoses were in men).

Breast cancer has the fifth highest mortality rate globally, causing 6.6% (627,000) of cancer deaths worldwide in 2018.[4]

New Zealand and Australia together have the highest cumu lative risk of breast cancer at 10.16% (compared with North America 9.32% and Western Europe 9.90%; South-Central Asia has the lowest risk at 2.81%).[5] Lowest mortality is found in Eastern Asia (0.93% cumulative risk) while New

Zealand and Australia together have mortality risk of 1.37%. The highest mortality rates are in Melanesia with a cumulative risk of 2.73% (Fiji has the highest mortality rate worldwide).[5]

The highest risk of breast cancer is in the most developed countries. Those countries with a very high human development index (HDI) have a cumulative risk of 8.16%, while areas with low HDI have a cumulative risk of 3.40%.[4] Conversely, mortality rates are highest in low HDI areas at 1.78% cumulative risk. Lowest mortality is found in high HDI countries (1.12% cumulative risk). The highest development status does not confer the greatest protection of dying from breast cancer, as very high HDI countries only have the second lowest mortality rate at 1.44% cumulative risk.

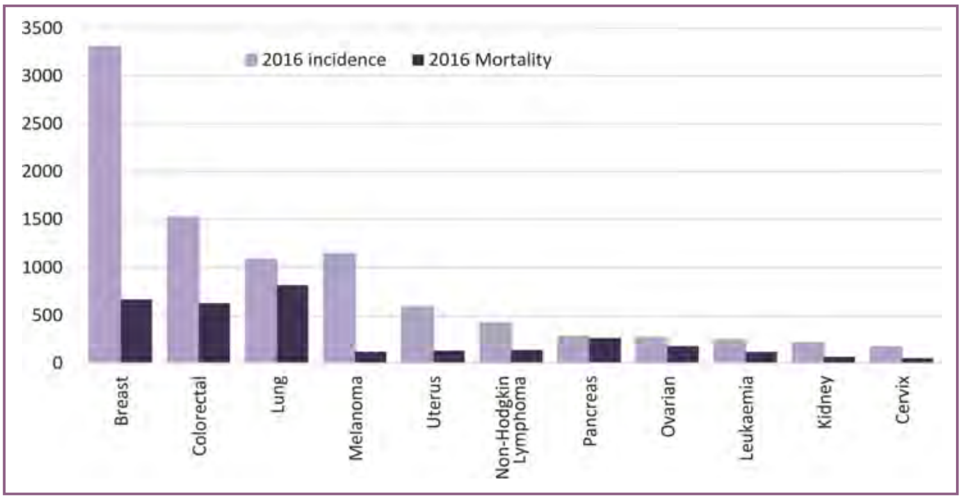

Figure 1 Incidence of and mortality from the most prevalent cancers in New Zealand women in 2016.[3]

Breast Cancer in New Zealand

Over time the age-standardised* rate of breast cancer diagnoses in New Zealand has increased (see Figure 2). Mortality has been improving over this period with a general, albeit slow, downward trend. The mammography screening programme, BreastScreen Aoteroa (BSA), was introduced in 1999, and was responsible for a spike in diagnoses in 1999 and 2000. The age range covered by BSA was extended from 50-64 years to 45-69 years in 2004 and this change was likely responsible for another, smaller spike in diagnoses in 2005. However, despite this the overall trend has been a steady increase in incidence over time.

The slight dip in incidence against the overall trend in increasing incidence, in 2003 and 2004 may have been as a result of research that showed a strong link between hormone replacement therapy (HRT) for treating menopausal symptoms and increased breast cancer risk (see article this edition on page 10), and a subsequent drop in the use of HRT.[3] That the significant reduction in HRT use of 70% contributed to the drop in incidence in 2003 and 2004 is disputed in the limited discussion in the medical literature[7], and difficult to prove. However, the reduction in HRT use is likely to have modified the rate of increase in incidence over a longer period of time, that is, the increase may have been steeper without the reduction in use of HRT.

The incidence of breast cancer globally is increasing[8, 9] – due in part to decreased childbearing and breast-feeding, increased exogenous[†] hormone exposure, and detrimental dietary and lifestyle changes, including increasing levels of obesity and less physical activity.[5] However, the 2014 IARC World Cancer Report8 found that incidence rates had plateaued in some developed countries and in some had even declined (e.g. Spain and among white Americans).

Between 2014 and 2017, there was a sustained, gradual downward trend in incidence in New Zealand (see Figure 2) but it remains to be seen if this will continue and may or may not be part of the natural fluctuation in incidence rates seen in the past.

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[*] Age-standardized rates – usually of incidence or mortality – adjust for differences in population age distribution by applying the observd age-specific rate for each population to a standard population. ASRs allows accurate comparison year by year based not only on the actual and changing population of women in NZ, but the changing and varying populations in difference age-groups.

[†] exogenous hormones are external or environmental sources of hormones sometimes referred to as EDCs or endocrine Disrupting Compounds, such as synthetic oestrogen as found in chemicals, such as phthalates and bisphenol A (BPA) among many hundreds of others. External or environmental sources of oestrogen are also known as xenoestrogens.

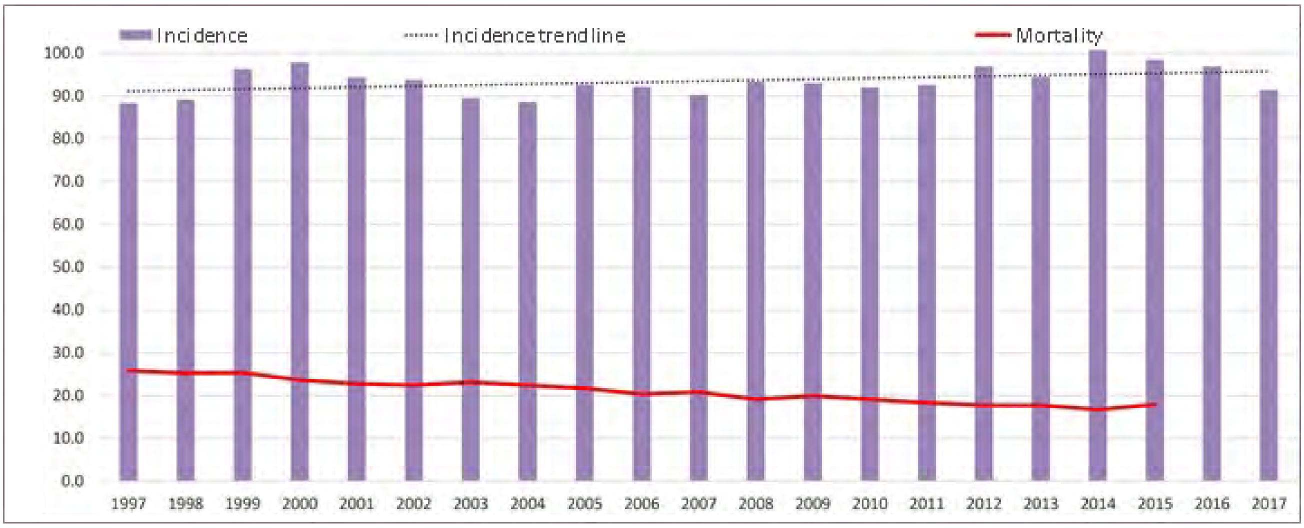

Figure 2 Incidence of and mortality from breast cancer in New Zealand 1997-2017 (age standardised rates per 100,000 women).[6] Note: mortality data is not yet available for 2016 and 2017.

Breast Cancer Disparities and Ethnicity

It is widely recognised that there are considerable disparities and inequities in health and well-being, and health outcomes between Māori and non-Māori.[10, 11, 12] The statistics on breast cancer incidence and mortality paint no better a picture for Māori women.

Figure 3 shows the ASR incidence and mortality per 100,000 women from 1997 to 2017. For incidence the trendlines show very clearly that among non-Māori there has been no increase over 20 years to 2017 (the last year for which data is available), and that all the increase in incidence evident in Figure 2 (page 5) can be attributed to an increase in incidence among Māori women. This is significant in that, internationally, increases in breast cancer incidence are attributed to a range of lifestyle and exposure risk factors (e.g. a decrease in number of children and later age at first pregnancy, reduced breast-feeding, increased exogenous hormone exposure, and detrimental dietary and lifestyle changes, including obesity and less physical activity).

Three significant factors that are major contributors to the risk of breast cancer are smoking, alcohol consumption and body weight/BMI; factors that also contribute to a range of other non-communicable diseases, including cardiovascular disease.

A considerable volume of research has linked tobacco smoking with an increased risk of breast cancer for many years, and some research has found that risk is higher when smoking commences in adolescence and before a first full-term pregnancy.[14] A number of studies have also found that smoking at the time of diagnosis led to higher breast cancer mortality rates.[10]

Māori women have the highest rates of smoking in New Zealand at 37% (compared with all adult smokers at 13%)[13] and are three times more likely to smoke than non-Māori women.[15] Māori are the youngest to start smoking at only 14 years of age on average.[16]

Alcohol consumption is also causally related to increased risk of breast cancer[5] with a 50% increase in risk with daily consumption of five standard drinks. There is no safe limit for alcohol consumption[5] and risk increases with as little as one standard drink per day.[†]

A continuously updated report by the World Cancer Research Fund and the American Institute for Cancer Research, Diet, Nutrition, Physical Activity and Breast Cancer, concluded that there is a significant dose-dependent increased risk of both pre- and post-menopausal breast cancer with increasing alcohol consumption, with no safe limit of consumption.[17]

According to the Ministry of Health (MoH) information on Tatau Kahukura: Māori health statistics, Māori women are less likely than non-Māori women to drink four or more times a week, but twice as likely to drink large amounts of alcohol at least weekly.[18]

Being overweight or obese is associated with the increased risk of many cancers, including breast cancer.[16, 19] With every increase in weight of 10kg over a healthy weight (BMI of 18-24.9) post-menopausal breast cancer risk increases by 40%.[16] In addition, obesity correlates with a poorer prognosis in breast cancer and higher mortality, with a US study finding that women with a BMI of 40 or more had twice the risk of dying from breast cancer than those with a healthy BMI.[18]

While there is little difference in the percentage of overweight Māori compared with non-Māori (27.6% and 28.2% respectively) there are many more obese Māori women than non-Māori (47.2% and 24.7% respectively).[20]

These three modifiable risk factors are significant in raising the risk of breast cancer among Māori and there needs to be a significantly greater focus on addressing these issues and ensuring adequate education to reduce the incidence of smoking, excess alcohol consumption and obesity among Māori women in order to reduce the in- creasing incidence of breast cancer.

When breast cancer mortality is considered (see Figure 3), it is evident that overall mortality is declining, and while mortality for Māori is still significantly higher than for non-Māori, the decline in mortality for Māori women matches the decline in mortality for non-Māori.

However, a “disproportionate number of Māori women are diagnosed with [a] more advanced stage of cancer"[21] and a later stage at diagnosis results in poorer outcomes and higher mortality. As well as later stage at diagnosis, Lawrenson et al. found that other contributors to higher Māori mortality include that they are more likely to experience a delay in the time from diagnosis to treatment, are less likely to receive radiotherapy, and are less likely to adhere to long-term adjuvant endocrine therapy.[21]

As with many other diseases and health outcomes, equitable access to appropriate and best practice health care is essential in reducing mortality and improving outcomes for Māori. Institutionalised racism – as discussed in the AWHC article “Māori Health: Addressing Inequities and Racism in the Health System” in the August edition of this newsletter[22] – must be addressed as a matter of urgency if we are to close the current breast cancer mortality gap between Māori and non-Māori.

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† risk rises with each alcoholic drink per drinking session; one standard drink per day imposes a far smaller increase in risk than drinking seven drinks on a Saturday night.

Breast Cancer Disparities and Deprivation

Disparities between Māori and non-Māori women in the incidence of and mortality from breast cancer are as much an issue with poverty and deprivation as ethnicity. Robson and Harris found that such inequities are a consequence of the differential distribution of social, environmental, economic and political determinants of health[23] and this seen when the distribution of incidence and mortality across deprivation quintiles is considered.

Figure 3 Incidence of and mortality from breast cancer in New Zealand 1997-2017 (age standardised rates per 100,000 women) in Māori and non-Māori.4, 13 Note: mortality data is not yet available for 2016 and 2017.

Recent data show that generally among non-Māori/non-Pasifika women breast cancer incidence increases with increasing deprivation.†† The Māori deprivation data is very similar, just more extreme, reflecting the overall higher rates of breast cancer in this population (Figure 4). The pattern in both is not entirely linear, with the lowest incidence in quintile 2, while women living in the lowest deprivation quintile have a higher incidence, although still lower than the bottom three quintiles.

The mortality picture is less straight forward (Figure 5). For non-Māori/non-Pasifika women there is a strong linear association of increasing mortality with increasing deprivation. However, among Māori women, the lowest mortality is seen in quintile 3 with higher mortality seen in quintile 1 (the least deprived), declining somewhat in quintile 2, while increasing significantly in quintiles 4 and 5 (most deprived).

While non-Māori/non-Pasifika data follows the expected mortality trend across deprivation quintiles, there is no obvious explanation for what we see among Māori women with higher mortality in the two least deprived quintiles.

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†† The New Zealand Index of Deprivation (NZDep) is an area-based measure of socio-economic deprivation in New Zealand based on nine census variables, where Quintile 1 represents people living in the least deprived 20 percent of small areas and Quintile 5 represents people living in the most deprived 20 percent of small areas.

Current medical literature does not describe this pattern (the data was provided directly by the MoH in October and would not be included the most recently published papers).

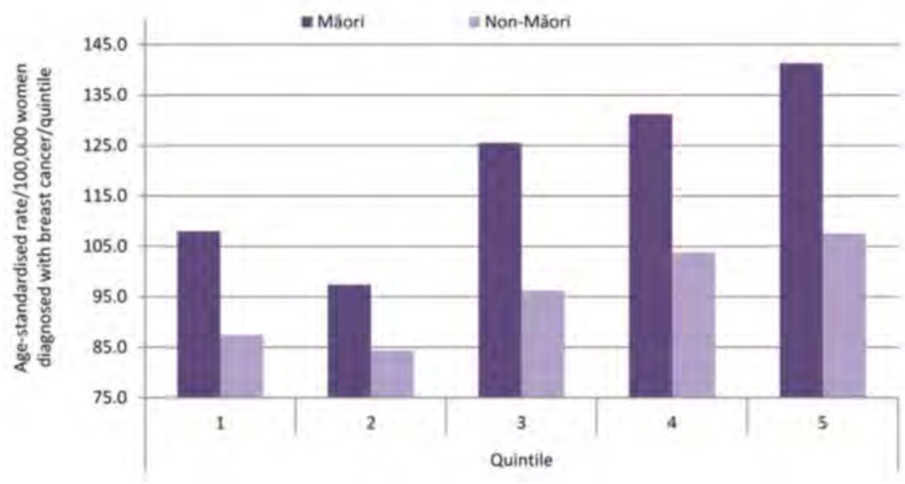

Figure 4: Breast cancer incidence in each deprivation quintile as ASR per 100,000 Māori and non-Māori/non-Pasifika for the years 2012-2016 combined.[25]

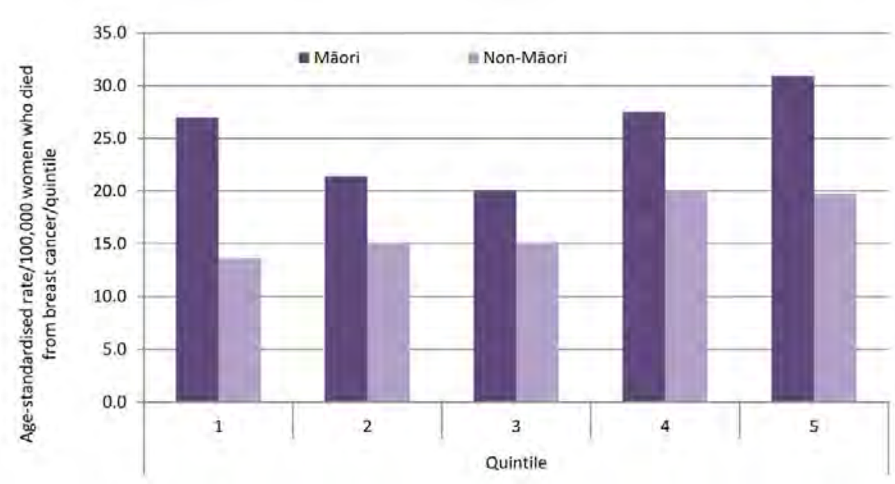

Figure 5: Breast cancer deaths in each deprivation quintile as ASR per 100,000 Māori and non-Māori/non-Pasifika for the years 2012-2016 combined.[25]

AWHC sought comment from Prof Diana Sarfati, a cancer epidemiologist at Otago University. She said she could not think of an obvious reason for this mortality/deprivation pattern, but pointed out that total numbers were small.[24] Across the five years of data there were a total; of 33 Māori deaths in quintile 1 and 35 in quintile 2 (compared with 511 and 551 respectively in non-Māori).[25] Prof Sarfati said with small numbers a few more or a few fewer deaths might make a significant difference to the ASR rates,[24] thus changing the picture entirely. It will be interesting to see how the picture changes over the next ten years and beyond.

Despite the unexpected association of higher mortality in quintiles 1 and 2, Māori women living in the most deprived areas of New Zealand are far more likely to be diagnosed with and die from breast cancer than their non-Māori neighbours.

Robson, Purdie and Cormack write in Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and Rural–Urban Status, 2002–2006 that “In New Zealand, as in other countries, markers of socioeconomic position (such as income, employment, living standards and deprivation) and geographical distribution of the population are patterned by ethnicity.”[26] Thus, Māori women are over represented in higher deprivation quintiles and in age-standardised rates of breast cancer.

Robson et al. go on to say that “an increased risk of overall cancer incidence and mortality has been found to be associated with lower socioeconomic status, a pattern that is particularly pronounced for some specific types of cancer”;[26] in New Zealand, our deprivation statistics show that breast cancer is one of those. In addition, among breast and other cancers, women with higher levels of deprivation are also more likely to be diagnosed at a later stage than women from areas of higher affluence.[26]

In research published in 2016, Seneviratne et al.[27] found that “Māori and Pacific women were around two and three times more likely respectively, to be diagnosed with metastatic disease compared with NZ European women.” They also found that “Significantly higher proportions of more advanced cancer, including metastatic cancer were observed in women from high deprivation compared with low deprivation groups and rural compared with urban residing women.”

The New Zealand patterns contrast with international patterns of breast cancer incidence and mortality when considered through a socio-economic lens. As a whole, New Zealand has a breast cancer incidence rate that is typical of a highly developed nation – in fact, together with Australia we have the highest breast cancer rates in the world. In Europe the highest rates of breast cancer are found in the women with the highest socio-economic status, although this was found to become insignificant when controlled for reproductive factors.[28] Conversely, mortality was lowest in women with higher socio-economic status; we see this in non-Māori women but not in Māori women.

Breast Cancer and Young Women

High profile media reports and breast cancer awareness stories might give the impression that breast cancer incidence among young or pre-menopausal women is increasing. However, that is not the case and breast cancer is still very much a post-menopausal disease.

Figure 6 shows that there is still a significant gulf between the incidence of breast cancer among pre-menopausal women compared with post-menopausal women. While there is a small increase, it is in line with population growth in this group. The significant increase in incidence in post-menopausal women appears to be greater as seen in the steeper gradient of the trendline in this group, however this increase is also inline with population growth.

Between 2001 and 2017 the premenopausal population grew by 16% while the post-menopausal population grew by 50%, in line with reports on our "aging population". Stats NZ says this is the result of both people having fewer children (sub-replacement fertility) and people living longer, accentuated by the large number of people born between 1950 and the early 1970s moving into the older age groups.[29]

Figure 7 shows that the absolute numbers of young women dying from breast cancer actually decreased between 2005 and 2016, while absolute numbers increased among post-menopausal women.*

Figure 6 Incidence of breast cancer in pre- and post-menopausal women from 2000 to 2017.[3]

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* this contrasts with the declining mortality as shown in Figure 3, because Figure 3 uses age-standardised rates while Figure 7 uses absolute numbers of deaths in each year in the age groups. It is beyond the scope of this article to compare ASR rates between pre- and post-menopausal groups.

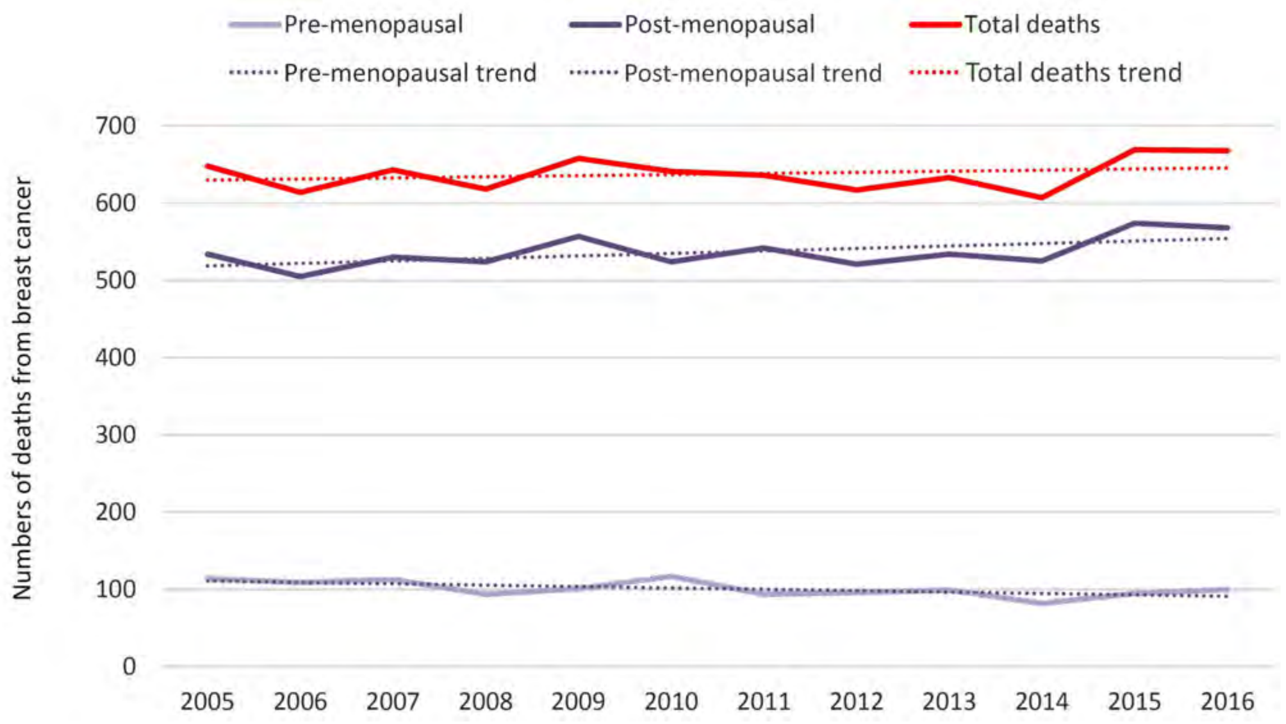


Figure 7 Breast cancer mortality in pre- and post-menopausal women from 2005 to 2016.[3]

Conclusion

Breast cancer is the most significant cancer affecting New Zealand women and is the fifth most common cause of death. Thus, breast cancer imposes a significant burden on our population. However, the burden is not borne equitably, with Māori women and those living in areas of greatest deprivation bearing a disproportionate burden of both breast cancer incidence and mortality.

One in nine New Zealand women will develop breast cancer in their lifetime[30] – the risk increases with age, but women as young as 15 have been diagnosed with breast cancer in the last 20 years. Fortunately, the incidence of breast cancer in young women is not increasing, but it is in Māori women.

As a significant cause of morbidity and mortality in this country more must be done to address our breast cancer statistics, in particular among Māori. While better and more timely treatment, and earlier diagnosis among Māori to ensure that more women are diagnosed with early breast cancer are critical to reducing deaths and addressing inequities in outcomes, what is essential is that the incidence of breast cancer is addressed. Even for those who survive breast cancer the burden of this disease is significant for individuals, families and our communities, and it imposes an enormous financial burden on our health system. Incidence can only be addressed through risk reduction and prevention strategies and these must be addressed at a policy level as a matter of urgency.

References

1 Torre, L.A. et al. (2017): Global Cancer in Women: Burden and Trends, CEBP Focus: Global Cancer in Women, *Cancer Epidemiol Biomarkers Prev; 26(4); 444–57.*

2 MoH, 2019: *Mortality 2016: Data Tables*, Ministry of Health, Wellington, accessed at https://www.health.govt.nz/publication/mortality-2016-data-tables

3 New Zealand Health Information Service (various years): *Cancer: New Registrations and Deaths* (various years), Ministry of Health NZ, accessed at https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/cancer-new-registrations-and-deaths-series.

4 IARC, 2018: All Cancers Fact Sheet, Globocan 2018 accessed at http://gco.iarc.fr/today/data/factsheets/cancers/39-All-cancers-fact-sheet.pdf

5 Bray F, *et al.*, 2018: Global cancer statistics 2018: GLOBOCAN estimates of incidence and mortality worldwide for 36 cancers in 185 countries, *CA A Cancer Journal for Clinicians*, 2018 Nov;68(6):394-424.

6 New Zealand Health Information Service (various years): *Cancer: New Registrations and Deaths* (various years), Ministry of Health NZ, accessed at https://www.health.govt.nz/nz-health-statistics/health-statistics-and-data-sets/cancer-new-registrations-and-deaths-series.

7 Farmer R & Fenton A, 2016: Time trends in breast cancer and menopause hormone therapy use in New Zealand, *Climacteric*, 19:1, 42-48.

8 Stewart, BW and Wild, CP (eds), 2014: *World Cancer Report*, IARC WHO Press, accessed at http://publications.iarc.fr/Non-Series-Publications/World-Cancer-Reports/World-Cancer-Report-2014

9 Parkin DM and Fernández LM, 2006: Use of statistics to assess the global burden of breast cancer, *The Breast Journal*, 2006 Jan-Feb;12 Suppl 1:S70-80.

10 HQSC, 2019: *A Window on the Quality of Aotearoa New Zealand's Health Care 2019 – a view on Māori health equity*, Health Quality & Safety Commission, 29 July 2019, accessed at https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Window_2019_web_final.pdf

11 Came H, *et al*., 2019: Upholding Te Tiriti, ending institutional racism and Crown inaction on health equity, *New Zealand Medical Journal*, 29 March 2019, Vol 132, No 1492 accessed at https://openrepository.aut.ac.nz/bitstream/handle/10292/12402/Inaction%20NZMJ.pdf?sequence=2&isAllowed=y

12 Waitangi Tribunal, 2019: Report on stage one of health services and outcomes released, *Waitangi Tribunal News* accessed at https://www.waitangitribunal.govt.nz/news/report-on-stage-one-of-health-services-and-outcomes-released/

13 Pers. Comm. 2 October 2019: Chris Lewis, Information Analyst, Analytical Services, Ministry of Health: Māori and non-Māori incidence and mortality tables for breast cancer from 1996 to 2015.

14 Gray J, *et al.*, 2017: State of the evidence 2017: an update on the connection between breast cancer and the environ-ment, *Environmental Health* (2017) 16:94.

15 MoH, 2018: Tobacco smoking, Tatau Kahukura: Māori health statistics, Ministry of Health, accessed at https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-tauwehe-tupono-me-te-marumaru-risk-and-protective-factors/alcohol-use

16 HPA, 2019: Facts and Figures, Smokefree, The Health Promotion Agency accessed at https://www.smokefree.org.nz/smoking-its-effects/facts-figures.

17 World Cancer Research Fund/America Institute for Cancer Research, 2018: *Diet, Nutrition, Physical Activity and Breast Cancer,* accessed at https://www.wcrf.org/sites/default/files/Breast-cancer-report.pdf

18 MoH, 2018: Alcohol use, Tatau Kahukura: Māori health statistics, Ministry of Health, accessed at https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-tauwehe-tupono-me-te-marumaru-risk-and-protective-factors/alcohol-use

19 Picon-Ruiz M, et al., 2017: Obesity and adverse breast cancer risk and outcome: Mechanistic insights and strategies for intervention, CA A Cancer Journal for Clinicians, 2017 Sep;67(5):378-397.

20 MoH, 2018: Body size, Tatau Kahukura: Māori health statistics, Ministry of Health, accessed at https://www.health.govt.nz/our-work/populations/maori-health/tatau-kahukura-maori-health-statistics/nga-tauwehe-tupono-me-te-marumaru-risk-and-protective-factors/body-size

21 Lawrenson R, et al., 2016: Breast cancer inequities between Māori and non-Māori women in Aotearoa/New Zealand, European Journal of Cancer Care, 25, 225–230.

22 Claridge S, 2019: Māori Health: Addressing Inequities and Racism in the Health System, Auckland Women’s Health Council Newsletter, August 2019 edition.

23 Robson B & Harris R, 2007: Hauora: Maori Standards of Health IV. A Study of the Years 2000–2005, Te Ropu Rangahau Hauora a Eru Pomare, Wellington, New Zealand.

24 Pers. Comm. 29 October 2019: Prof. Diana Sarfati.

25 Pers. Comm. 25 October 2019: Chris Lewis, Information Analyst, Analytical Services, Ministry of Health: Māori and non-Māori deprivation data for incidence and mortality tables for breast cancer from 2012 to 2016.

26 Robson B, et al., 2010: Unequal Impact II: Māori and Non-Māori Cancer Statistics by Deprivation and Rural–Urban Status, 2002–2006. Wellington: Ministry of Health.

27 Seneviratne S, et al., 2016: Stage of breast cancer at diagnosis in New Zealand: impacts of socio-demographic factors, breast cancer screening and biology, BMC Cancer. 2016; 16: 129.

28 Lundqvist A, et al., 2016: Socioeconomic inequalities in breast cancer incidence and mortality in Europe—a systematic review and meta-analysis, European Journal of Public Health, Volume 26, Issue 5, October 2016, Pages 804–813.

29 Stats NZ, 2017: Population projections overview, Stats NZ accessed at http://archive.stats.govt.nz/browse_for_stats/population/estimates_and_projections/projections-overview/nat-pop-proj.aspx

30 NZBCF: Breast Cancer In NZ, accessed at https://www.breastcancerfoundation.org.nz/breast-awareness/breast-cancer-facts/breast-cancer-in-nz

Workshop on Self-Employment for Nurses

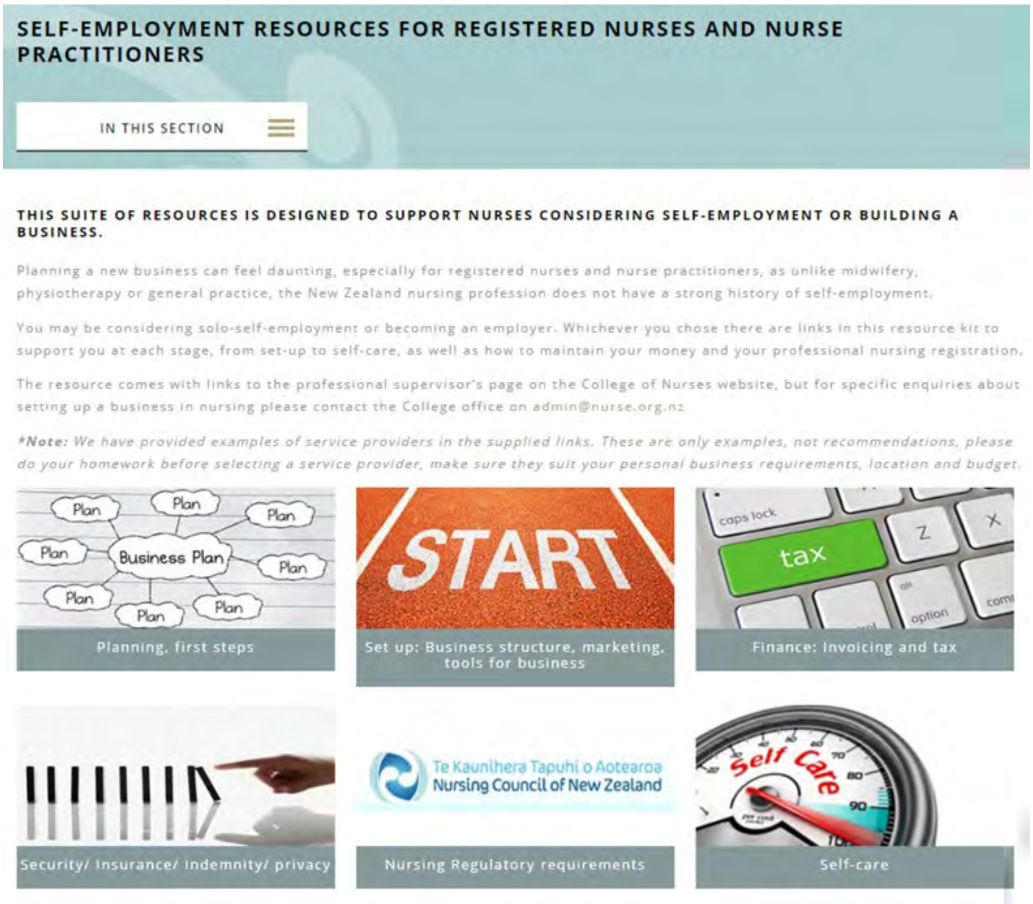
Article by Liz Manning RN BN MPhil FCNA(NZ)

Next year, 2020 the Year of the Nurse and Midwife, we will be launching a new workshop for nurses who are currently or are thinking about becoming self-employed or starting a business. This will be a one-day event, and we are endeavouring to link with some established expert resource in this area.

Developed by Liz Manning, who is currently working towards completion of a PhD focused on self - employed nurses, this will be a practical and nursing relevant workshop.

The College recognises and supports nurses who are self-employed in clinical and non-clinical roles, with established resources on the College website.

Keep a look out for dates and locations for this new initiative.



SELF-EMPLOYMENT RESOURCES FOR REGISTERED NURSES AND NURSE PRACTITIONERS

THIS SUITE OF RESOURCES IS DESIGNED TO SUPPORT NURSES CONSIDERING SELF-EMPLOYMENT OR BUILDING A BUSINESS.

Planning a new business can feel daunting, especially for registered nurses and nurse practitioners, as unlike midwifery, physiotherapy or general practice, the New Zealand nursing profession does not have a strong history of self-employment.

You may be considering solo-self-employment or becoming an employer. Whichever you chose there are links in this resource kit to support you at each stage, from set-up to self-care, as well as how to maintain your money and your professional nursing registration.

The resource comes with links to the professional supervisor's page on the College of Nurses website, but for specific enquiries about setting up a business in nursing please contact the College office on admin@nurse.org.nz

**Note: We have provided examples of service providers in the supplied links. These are only examples, not recommendations, please do your homework before selecting a service provider, make sure they suit your personal business requirements, location and budget.*

Personal Resilience and Positive Colleagueship Workshop

What does next year hold for you?

Globally, the World Health Organization has declared 2020 as the international Year of the Nurse and Midwife, but whatever will be happening in your world, consider taking time for your own professional wellbeing as the first thing you can do.

Shelley Jones has designed a day-long workshop on personal resilience and positive colleagueship as a self-care experience in a supportive environment with 10-12 people. Shelley's long career in healthcare means she understands the unique stressors for those working at the frontline, and she says this is an opportunity to reflect on the rewards in nursing work without losing sight of the difficulties.

If you'd like to host this workshop, please email shelley@learn-ability.co.nz for more information.

Or if you'd like to attend a workshop please register your interest with shelley@learn-ability.co.nz. We'll get back to you, and make plans to run the workshop in your area when we know a few people nearby are interested.

Click here to view the workshop programme.

Click here for a printable workshop programme.

Please contact shelley@learn-ability.co.nz directly *not the College office*

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