

## **Understanding the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa New Zealand**

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### **Abstract**

**Introduction:** There are low numbers of Pacific allied health professionals in Aotearoa, which warrants urgent prioritisation of more Pacific allied health professionals. Life expectancy differentials persist among Pacific people in Aotearoa compared to non-Pacific.

**Methods:** This qualitative study explored the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa. The research explores the perspectives of five Pacific allied health professionals utilising Talanoa methodology and thematic analysis.

**Discussion:** Four themes were identified: theme one, Cultural capability and capacity; theme two, Pacific values and responsibilities; theme three, “I struggle navigating white spaces”, and theme four, Emotional and cultural intelligence.

**Conclusion:** This study identified three meta-themes: cultural isolation, cultural intelligence, and cultural load. Pacific cultural knowledge and expertise are crucial in helping non-Pacific allied health clinicians recognise and embrace culturally responsive healthcare. This study contributes to the gap in the literature by highlighting the challenges and opportunities Pacific allied health professionals experience in Aotearoa.

**Keywords:** Pacific, allied health, culturally responsive, cultural load

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## Introduction

Pacific peoples in Aotearoa make up 382,000 (8%) of the total population. In Auckland, 15.5% of the population identify as Pacific (Stats NZ, 2018). A collective worldview is fundamental to traditional Pacific people (Ioane, 2021; Smith, 2021; Taylor et al., 2019). Secondary to a labour crisis in Aotearoa in the 1950s, Pacific people migrated until the recession in the 1970s when they were subjected to discrimination by the government and police (Anae et al., 2015; Smith, 2021). During Dawn Raids apology, the government admitted that “inequities that stem from direct and indirect discrimination continue to exist” and “lives on in the disruption of trust and faith in authorities” (Ardern, 2021, “Apology statement”, para. 2). Colonial structures continue to exclude Pacific people from tertiary education leading to disparities in the healthcare workforce (Waiari et al., 2021). Pacific people continue to be challenged by socioeconomic hardship and increasing health needs (Health Quality & Safety Commission, 2021; Ioane, 2021).

Life expectancy differentials persist among Pacific people in Aotearoa compared to non-Pacific due to health inequities (Came et al., 2019; Curtis et al., 2015; Health Quality & Safety Commission, 2021; Walsh & Grey, 2019). Pacific people are under-represented in health professions (Ministry of Health & Le Va., 2012). This study highlights the need, also identified by Harwood et al. (2022), to prioritise Pacific allied health professionals.

In Aotearoa, Pacific peoples have been identified as a priority group targeted to improve health equity (Te Whatu Ora., 2022b), but progress is not assured. Throughout the current study, healthcare was undergoing reforms which promised to achieve equity of access, and outcomes, particularly for Pacific people. The Ministry of Health published Te Mana Ola in July 2023, the first Pacific Health strategy, setting the direction and priorities for achieving equity in Pacific Health (Minister of Health, 2023). However, the coalition government passed legislation to disestablish Te Aka Whai Ora (Māori Health Authority) in July 2024. This created a shift from optimism that the health reforms would bring change, to a sense of uncertainty for what the future holds for Pacific people (Radio New Zealand [RNZ], 2024).

Pacific allied health professionals comprise only 3% of the healthcare workforce nationally despite targeted recruitment by educational providers (Technical Advisory Services [TAS], 2021). Most allied health staff providing care to Pacific populations are from non-Pacific communities. Without engagement, allied health staff including leaders may not routinely acknowledge the value of Pacific allied health clinicians, beyond helping with translation, resources or de-escalating a cultural misunderstanding (Kurtz et al., 2018).

Pacific health staff often have additional kainga (see glossary below), community and kainga lotu commitments. Familiarity with wider responsibilities mean Pacific people may be perceived as leaders

(O'Connor, 2008; O'Connor, 2018). In a Western health system, there are challenges for these individuals, where they are expected to lead in relative isolation (Harwood et al., 2022).

Institutional bias and racism are present across the healthcare system (Came et al., 2019; Steyn et al., 2021). Limited workforce ethnic diversity exacerbates the effects of racism (Health Quality & Safety Commission, 2021; Smith, 2021; Snyder & Schwartz, 2019; Taylor et al., 2019). In Aotearoa, racism is a critical determinant of the ethnic health inequities that have not narrowed in the last 20 years (Steyn et al., 2021; Te Whatu Ora., 2022a). Racism can be understood as institutionalised, personally mediated and internalised (Jones, 2000). Systemic racism is documented in the Hauora report (Ministry of Health, 2019) and Bula Sautu (Health Quality & Safety Commission, 2021). Ethnic pay disparities are documented in public sector leadership in Aotearoa (Came et al., 2020). The Human Rights Commission has conducted a Pacific Pay gap inquiry that has identified concerning disparities. Pacific peoples in healthcare experience the same pay gap as the national average. However, this does not account for the disparities in Pacific representation in allied health professions (Matada Research Group, 2022).

The first author is a physiotherapist with Tongan whakapapa and thirteen years' experience working in mainstream healthcare services. She noted the 'othering' of Pacific allied health staff as they endeavoured to uphold their Pacific values while working in a Western biomedical health model. Also identified was the issue that professional development around culture was superficial. Cultural and professional development may exacerbate 'othering' if a dominant culture is held as the norm (Curtis et al., 2019).

There is limited research in Aotearoa detailing the experiences of Pacific healthcare professionals. This study begins to address this gap. Recurring themes in the scant extant literature include the importance of building meaningful relationships with Pacific people. Literature emphasises a Pacific collective worldview and the relational nature of Pacific peoples' connections. An Aotearoa-based qualitative study was undertaken with Pacific mental health service providers and identified that Pacific mental health outreach services have not yet impacted Pacific communities. Pacific communities have inequitable access to knowledge of the available services and mistrust these services (Fa'alogo-Lilo & Cartwright, 2021). Non-Pacific providers often struggle to comprehend the importance of collective cultural values to provide equitable access and care to Pacific people. This gap impacts their ability to provide culturally responsive care (Fa'alogo-Lilo & Cartwright, 2021). To provide culturally safe care, non-Pacific healthcare professionals must have an appreciation of the significance of a collective worldview and continue to work towards a representative workforce (Fa'alogo-Lilo & Cartwright, 2021).

Other studies foreground the significance of the collective worldview where relationship-building is a priority. Mullane et al. (2022) hosted focus groups with healthcare workers to understand how they supported diabetic Pacific people to achieve equitable outcomes in Aotearoa. Included in the focus groups were three Pacific dietitians and two Pacific community health workers. Mullane et al. (2022) highlighted the importance of building good relationships as a requirement for providing equitable care. The importance of engaging the family collectively was vital for improved health outcomes (Mullane et al., 2022).

In some contexts, a Pacific-led service is recommended to ensure optimal outcomes. In a study of 21 healthcare professionals, including eight Pacific staff working in bariatric surgical care, the under-representation of Pacific staff was identified as a barrier to the inclusion and retention of Pacific patients (Taylor et al., 2019). The study found that non-Pacific clinicians needed to appreciate the collective nature of family decision-making.

Limited Pacific representation extends into academic institutions educating health professionals. Waiari et al. (2021) noted similarities between issues facing Pacific students and those experienced by the Pacific health workforce. The study identified barriers for Pacific students entering healthcare qualification pathways. For example, the collectivist approach for Pacific peoples is incompatible with the Euro-centric individualistic focus that still pervades our academic institutions. Academics must work to minimise the hierarchies limiting Pacific student interaction in the classroom, instead fostering human connections. Waiari et al. (2021) also recommend programmes such as the Tuakana-Teina network, a model for buddying systems. A Tuakana network in tertiary institutions provides a safe place for Pacific students to enrich their identities. To support Pacific student success in health qualifications, cultural identity and belonging must be fostered, with Pacific knowledge integrated into academic institutions (Waiari et al., 2021).

Pragmatic actions can make a difference to Pacific allied health professionals. Tofi's (2022) Talanoa research explored thriving as Pacific allied health professionals with 11 participants in the first two years of practice. The researcher identified four enablers of thriving: cultural support; leadership; allyship; and valuing the unique skillset of Pacific allied health professionals (Tofi, 2022). Examples of these enablers include establishing and resourcing a cultural supervision programme using a Tuakana-Teina framework; and developing Pacific career and leadership pathways into senior roles. Recommendations for allyship included mandatory training programmes, such as cultural safety and Te Tiriti o Waitangi. Fundamental enablers include appropriate remuneration and recognition of Pacific allied health professionals' cultural intelligence and skillset. These practitioners will benefit from

access to culturally aligned professional development and incentivised research opportunities (Tofi, 2022).

In the health context, institutional racism occurs alongside personally mediated racism and tokenistic inclusion of marginalised people within health advisory groups (Came et al., 2019). Pacific leaders who participated in the research by Came et al. (2019) shared their experiences of being involved in health advisory boards and steering groups. The senior leaders' participation in these fora was designed to ensure Pacific perspectives were presented to improve outcomes for priority populations (Came et al., 2019). Even though these leaders were invited to participate, they encountered negative experiences. Came et al. (2019) detailed these leaders' experiences, including tokenism, and witnessing and experiencing racism. Senior leaders battled to have their cultural intelligence recognised in an environment that prioritised Western knowledge (Came et al., 2019). Despite these negative experiences and the racism faced, the leaders were determined to remain engaged in these groups for the greater good of equitable healthcare. The level of commitment to continue to be involved illuminates the sense of cultural responsibility Pacific health professionals carry.

Covid-19 impacted Pacific communities more severely due to the pre-existing structural inequities and systemic racism. During Talanoa between one academic and two Pacific nursing leaders, the imperative for strengthening the Pacific nursing workforce in Aotearoa was highlighted (Smith et al., 2021). The Talanoa took place following the Delta outbreak in 2021 that affected Pacific communities disproportionately and informed critical recommendations concerning the Pacific nursing workforce that apply to the broader Pacific health workforce. Findings are similar to Tofi's (2022) study. The first recommendation was for career development pathways for Pacific nurses with professional and cultural development opportunities, mentoring, and access to colleagues and leaders who act as champions for Pacific nurses. The second recommendation was for Pacific approaches to be embedded in undergraduate and postgraduate pathways to promote health equity. Smith et al. (2021) conclude that Pacific health workers are essential in achieving health equity for Pacific populations because Pacific engagement is culturally nuanced and must respect Pacific worldviews. The research question guiding this study is as follows: what are the challenges and opportunities for Pacific allied health staff to provide care in a culturally aligned way?

## **Methods**

### Research design

This research utilised Talanoa, a traditional Pacific Island storytelling process to guide the conversation (Tupou, 2018). Talanoa can be an informal or formal conversation, exchanging ideas or thoughts. Talanoa

is best face-to-face. A literal translation means conversing and interacting without a rigid framework guiding the discussion (Vaioleti, 2006). Pacific researchers must demonstrate respect and understanding of Pacific ways of knowing, generating knowledge, and their diverse worldviews (Sanga & Reynolds, 2017). Research that restricts indigenous expression may silence ways of knowing and experiencing, therefore, devaluing the Pacific knowledge base (Farrelly & Nabobo-Baba, 2014).

#### Recruitment

Participants were recruited using professional networks, including advertising through Pasifika Allied Health Aotearoa New Zealand (PAHANZ). Information power was utilised to determine the sample size (Malterud et al., 2016). There were five study participants, who had worked as allied healthcare professionals for at least four years and up to a maximum of 20 years in a range of clinical settings, including community, outpatient, or hospital-based clinicians from physical and mental health environments.

#### Data collection

The insider position of the first and second authors is appropriate for research with Pacific people. Talanoa acknowledges the importance of the relationship between the researcher and participant and the benefits of the researcher being an insider to the research. The concept of relational vā is essential as it culturally connects and separates those involved in research through Pacific spirituality and hierarchies such as gender, age and social status (Vaioleti, 2006). The strength of the relationship and the first author's ability to convey empathy was crucial in maintaining the relational vā (Fa'avae et al., 2016; Farrelly & Nabobo-Baba, 2014; Vaioleti, 2006).

The importance of the relationship between the researcher and the participants flows into the data collation and analysis (Vaka et al., 2016). The researcher is reliant on the first steps within Talanoa of mihimihi and fakafehokotaki. Pacific people share Pacific-specific information, such as their parents, grandparents and kainga, making meaningful connections and strengthening relationships (Lacey et al., 2011; Vaka et al., 2016).

For this study, a blend of in-person Talanoa and e-talanoa was used. Interviews were audio recorded and transcribed by the first author. The transcription process included de identifying the data set. In recent years, the ability to e-talanoa and establish vā in an online forum, such as Zoom has been considered by Pacific researchers (Fa'avae et al., 2022; Faleolo, 2021). The context of a global pandemic requiring physical isolation has enabled a different approach. However, e-talanoa is complex and should not be solely relied upon as a Pacific research method, instead utilised alongside Talanoa to strengthen findings (Fa'avae et al., 2022; Faleolo, 2021).

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## Ethics

Ethical approval gained from the Auckland University of Technology Ethics Committee (AUTEC). (AUTEC Reference number 22/128). The gender, role and specific Pacific identities are not reported in order to maintain confidentiality and deidentification of participants, given the overall small number of Pacific allied health practitioners in Aotearoa.

## Data analysis

The thematic analysis **used in this study** (Braun & Clarke, 2022) complements Talanoa by allowing the participants' information-rich experiences to be analysed collectively, enhancing the depth of their collective meaning (Tupou, 2018; Vaka et al., 2016; Vaka, 2014).

## Findings

The four themes identified are outlined and supported by quotes from Talanoa participants. The themes are as follows: firstly, Cultural Capability and Capacity; secondly, Pacific Values and Responsibilities; thirdly, "I struggle navigating white spaces", and finally, Emotional and Cultural Intelligence.

### **Cultural Capability and Capacity**

Participants identified that job interviews and the professional opportunities available highlighted the value of being a Pacific allied health clinician. Participants indicated advantages and drawbacks in being part of a now desirable minority. One participant described the shift from being an outsider to a commodity:

*As soon as I qualified, everybody wanted a piece of me.... they all said to me... varying degrees of this same phrase, "You would be a valuable asset to us". (Participant Five)*

Participants perceived their workplace leaders commonly had a superficial appreciation of the nuances of the cultural components of the work:

*There's a lot of work that needs to be done, in terms of management, in Pacific.... I think we've relied more on [Pacific] colleagues rather than management.... our manager at the time, a nurse... didn't know protocols for [allied health profession].... in other words, not much support. (Participant Two)*

The participants' experiences illustrate the isolation faced by Pacific practitioners, where being employed and holding their position is deemed as enough by these organisations.

Another participant expressed confidence to advocate for their patients, including having difficult conversations with their colleagues:

*I've come to realise that we're in a place to be the voices for patients and be able to speak up for them when a clinician is saying something, but you can see that actually, that person does not understand or does not grasp that and being able to say, "actually, why don't we step back and look at this a bit better and be able to approach things better?" So, it's about us calling out other colleagues as well. (Participant Four)*

There are very few Pacific people in healthcare leadership roles. Participant four reflected on their broader leadership experience developing the confidence to have these conversations and to challenge practice has strengthened with experience, as outlined in the quote above.

### ***Pacific Values and Responsibilities***

All participants' contributions reflected values and responsibilities that relate to family, church, and cultural traditions. The participants' perceptions were that the organisations these clinicians work for benefit from these values daily.

One participant outlined their experiences and expertise in what it means to be from a Pacific community and how they learned these attributes from cultural immersion:

*As we grew older, we knew how to speak [Pacific language] more because we were immersed in church... I went to school in [the Pacific] for a year. So that sort of helped me with learning cultural norms. And the language especially... we're so involved in... events and processes... your obligations and your role... we actually live it [Pacific values]. (Participant Two)*

Cultural expectations conflicted with the following participant's professional identity:

*Okay, to be a really good [allied health professional], I know, I have to do this [formal assessment and reporting process]. But at the same time, that wouldn't make me a good Pacific Island person because that's against the values of how I was raised. (Participant Three)*

The participant demonstrated tension between moral obligations and the differences in values between personal and professional identities. When working with Pacific clients Pacific allied health must know when and how to uphold Pacific values and professional requirements.

The following participant spoke about the ability to practice culturally responsive healthcare to see Pacific populations thrive:

*Understanding that from a Pacific clinician... we're actually in a really great space to be able to share knowledge from... both perspectives, being a clinician and being Pacific. And so I think, stepping up and being able to speak out when... people aren't being culturally safe when you see something happen that... doesn't look appropriate or doesn't fit with... a Pacific worldview. (Participant Four)*

Across the dataset, participants highlighted that they thrived in workplaces where they could advocate for and see Pacific populations thrive.

### **“I struggle navigating white spaces”**

All participants spoke of the daily struggle to provide culturally responsive care within a biomedically-oriented healthcare system. Participant Three's comment is used to name this theme, “I struggle navigating white spaces”. This participant reflected on being isolated in their workplace and the obligation they felt to stay there due to the lack of other colleagues to champion diversity and cultural competence:

*I struggle navigating white spaces... because I'm the only Pacific Islander... I have a hard time navigating my way around, you know, the brown person in the white space, but there are no workshops on that. There's no workshop. It's always the other way around.... It was definitely just a kind of white space. I've had to learn how to navigate that space... I'm in the office of 156 people, but I'm the only [ethnicity] in this office. And I've been the only [ethnicity] for, like, the last few years.... I knew that there needed to be somebody in that space. (Participant Three)*

Participant Two shared their ideas about how non-Pacific allied health professionals could provide care to foster cultural safety:

*Building more networks in the community... I just see a lack of that... Because I know that they're [non-Pacific allied health]... so concerned with hospital and acute services. But what's lacking is they need to build more community networks to build that foundation for our referral, so when we refer, we refer to community organisations that can actually work with them [Pacific patients] long-term. (Participant Two)*

Participant One reflected on the value of establishing a culturally informed network and the importance of kai to bring people together harmoniously:

*I do a Rōpū of Pacific staff come together, and I bring them together mainly... to build their confidence, and they do the presentations to us... some of us are seniors, some of us aren't, some of them more*

*cultural... for us to ask questions... and they get confident... these are Pacific people... you can establish your own network, that we would have monthly breakfasts... no one can argue when you're eating. (Participant One)*

Participants highlighted the importance of leadership within the Pacific allied health workforce to support networking rather than external leaders.

### ***Emotional and Cultural Intelligence***

Participants noted that engaging effectively with patients and their kainga was crucial to provide high-quality healthcare interventions.

Pacific staff highlighted that they worked with an ongoing irreconcilable tension because the fast-paced turnaround in health care does not allow for culturally appropriate relationship building. Participant Five outlined the need to have emotional and cultural intelligence to engage effectively:

*There's this emotional intelligence stuff because how are you supposed to be able to understand other people's cultures if you can't even understand the way that you think about yourself and your own culture.... And engagement... being able to communicate effectively is also another skill that... to a lot of Pacific comes... naturally, there's just because we are told to communicate effectively. (Participant Five)*

Participants identified the importance of knowing the specifics of the population that they provided care to. Tailoring the approach to meet their needs was identified as crucial in achieving engagement with services:

*As allied health, we've got... to know our communities. We can't know all communities. We just need to start in our locality. Like if you know [city] got a high population of [ethnicity], and if you go to [city], you got a high population of [ethnicity]. (Participant One)*

Participant Three reflected on the need to develop relationships with colleagues and referral services:

*Connecting with them face-to-face because I know that's having that time, which I guess we haven't had time to sit down and build those networks. We've tried that with our other Pacific teams here... like the mental health team, which is great. But then sometimes you lose touch, and then you've got different people in different roles, just high turnover, and you just don't know who's who. (Participant Three)*

Participants reflected on the priority to foster professional relationships, particularly where they could connect a'u tonu.

Participants were committed to achieving a more representative workforce for the better patient care and health outcomes. In participating in Talanoa with the researcher, participants displayed tolerance, graciousness and respect for the organisations and people they work with.

## **Discussion**

### ***Cultural Isolation***

Cultural isolation was referred to throughout the data set in the context of low numbers of Pacific colleagues and Pacific allied health staff. The findings in this current study echo those by Waiari et al. (2021), who argue that the underrepresentation of Pacific allied health students is a long-standing issue for undergraduate pathways to qualification. The theme generated in this current study of working in cultural isolation, lacking culturally safe environments, is supported by Mullane et al. (2022) and Harwood et al. (2022). The lack of Pacific healthcare workers was a barrier to equitable diabetes and stroke care, respectively (Mullane et al., 2022; Harwood et al., 2022). The findings in this current study draw attention to the emotional burden of being the only Pacific person. Similarly, Taylor et al. (2019) and Fa'alogo-Lilo and Cartwright (2021) highlighted the shortage of Pacific healthcare staff acting as a barrier to trust and emotional safety for Pacific patients.

This study identified that when seeking employment, participants perceived there was a demand for a Pacific workforce, but it was often tokenistic. Participants concurred that non-Pacific leaders only held limited knowledge of the cultural attunement required to work safely. Fa'alogo-Lilo and Cartwright (2021) reported similar findings that non-Pacific people need to appreciate the importance of Pacific cultures' collective nature and values.

This study demonstrated the need for a culturally centered moral responsibility requiring Pacific healthcare professionals to take up mentoring, teaching, and leadership roles. Participants perceived they added value, and experienced additional pressures, requirements, and expectations, including mentoring other younger students. Participants recalled stepping into mentoring roles earlier than their tauivi peers when they were students. This was referred to as the Tuakana network by Waiari et al. (2021) and is further supported by research undertaken by Tofi (2021), who noted a key recommendation for a Tuakana-Teina framework to act as a cultural supervision model to support Pacific allied health workers.

Across the dataset, it was evident that as Pacific allied health professionals developed experience and confidence, they were comfortable with challenging difficult situations and their colleagues. These results are similar to those highlighted in Jackson et al.'s (2020)

study, which noted that experienced Pacific allied health professionals had expertise that allowed them to express themselves effectively. Participants in this study noted the need for improvement in undergraduate training contexts and workplaces. Similarly, Waiari et al. (2021) described a 'disconnect' between university culture and Pacific culture. The culture of academia focuses on individualism and self-reliance, whereas Pacific cultures are interdependent and reflect the collective nature of kainga. The disconnect can potentially negatively impact Pacific students by demanding they live and study in two worlds (Waiari et al., 2021).

Participants in this study expressed the strong sense of service felt to advocate for patients and kainga by calling out behaviours not aligned with Pacific values. Experience gained through leadership in roles at home, with kainga, and in the church was relied upon when expressing confidence in their ability. The lived experiences of participants reflected those reported by Came et al. (2019) of Pacific leaders working alongside government advisory groups. The researchers noted the high level of commitment, determination, and reliance on Pacific values required to remain engaged due to their experiences of tokenism and racism (Came et al., 2019).

### ***Cultural Intelligence***

In this study, early and multiple cultural responsibilities were expected of participants. Their place within the family structure impacted their interactions with colleagues and patients outside the home. The eldest children in Tongan families, particularly, are raised with cultural expectations and responsibilities, including additional responsibilities for younger siblings (Oranga Tamariki, 2015). These results are similar to O'Connor (2008) and O'Connor (2018) who refer to a strong sense of responsibility that comes with being Pacific, especially concerning leadership and representation. Pacific identity and values impact how Pacific individuals view themselves and interact professionally. Came et al. (2019), note the challenge for Pacific leaders to firmly establish and share their academic and cultural credentials to be respected, as often they are a lone representative on boards and committees. In these contexts there is typically the privileging of Western biomedical approaches over indigenous knowledge.

The participants in this current study considered their ability to express cultural values that sometimes clashed with leadership and professional identities. Hughes (2018) suggested that emotional intelligence and cultural safety lead to culturally intelligent healthcare providers being able to understand social and cultural cues.

Participants in this current study reflected that thriving was the goal for clinicians, patients, and kainga, including utilising their Pacific scope to

inform equitable care and enable thriving for all Pacific people. Similarly, Tofi (2022) explored Māori and Pacific allied health professionals thriving and found that culturally informed support was essential. If the organisations that Pacific allied health work for placed greater value on the cultural knowledge that they bring, this would enable thriving too (Tofi, 2022).

In this current study, participants relied on cultural values of reciprocity and commitment to the greater good to function effectively as healthcare practitioners. Similarly, Ioane et al. (2021) and Waiari et al. (2021) reported the need to utilise Pacific knowledge and protocols to engage with Pacific people effectively. Despite the differences between Pacific cultures, similarities in relational values, reciprocity, a collective worldview, and shared Pacific protocols, mean there are benefits to planning Pacific healthcare that incorporates Pacific knowledge with the Western system (Ioane et al., 2021).

Participants in this current study discussed occasions where they strategically allowed their interactions with Pacific kainga and clients to extend beyond allocated times, despite the feeling that they were being judged by their colleagues. These findings concur with other studies that identified that culturally safe practice requires time. Mullane et al. (2022) reported on the need for 'time for equity' as a key theme of their study by allowing appointments to go as long as necessary. Fa'alogo-Lilo and Cartwright (2021) agreed that integrating Pacific values to take one's time and to treat the person with respect and dignity is fundamental to achieving equitable health outcomes.

### **Cultural Load**

In this current study, cultural safety was reflected on, and participants referred to the need to have safe places to be Pacific and to seek support in culturally relevant environments. Similarly, Waiari et al. (2021) described the need for Pacific allied health students to have a safe place to be Pacific without being judged.

Participants in this study noted that they did not receive support that acknowledged the cultural complexities of their role. Tofi (2022) reported that allied health professionals often felt frustrated at the expectation to provide cultural leadership regardless of the cultural appropriateness for the individual. Specific examples that participants in this study referred to as creating further difficulties and disconnection were the lack of culturally appropriate supervision opportunities, cultural support and allyship within their allied health professions. As Tofi (2022) discussed, it was challenging to participate in culturally appropriate reflective supervision practice as these cross-cultural approaches could not accurately address key cultural concepts of collectivism, connection, and reciprocity.

Across the dataset, there were tensions between being ‘put on a pedestal’ and not being adequately resourced. The weight of expectation as the only Pacific person was felt by participants in terms of the expectations for them as individuals to be an expert to teach and support new Pacific colleagues. Mullane et al. (2022) discussed the importance of enabling a culturally responsive healthcare workforce as a key strategy to better meet Pacific peoples’ needs. Cultural safety training must be supported across all levels of institutional leadership by providing time, resources, policy, and community engagement through partnerships with indigenous populations (Kurtz et al., 2018).

There are merit and disadvantages in referring to diverse cultural groups under the umbrella term of Pacific people. There are varied approaches to cultural professional development and cultural competency training for healthcare staff (Kurtz et al., 2018; Curtis et al., 2019; Waiari et al., 2021). Very few professional development interventions allow non-Pacific individuals to fully understand the colonial and historical contexts and the reason for mistrust in the systems. Pacific allied health professionals need to extend Pacific values strategically in their work. This supports the work of related studies reflecting the need to address systemic mistrust early by healthcare professionals’ first understanding and acknowledging the historical context (Ioane et al., 2021; Mullane et al., 2022). Health professionals must demonstrate fakafehokotaki to help remove barriers for patients and kainga as a collective. This ongoing process requires maintaining safe boundaries while building connections (Mullane et al., 2022).

Participants reflected on their awareness of health inequities, which drove the need for a representative workforce. This issue was fundamental to taking up an allied health career and continuing to work in environments of Pacific underrepresentation. To achieve health equity, cultural safety as perceived by the recipients of care needs to be a key driver (Curtis et al., 2019). Cultural safety initiatives must target individuals and organisations to review and challenge their culture, biases, and privilege (Curtis et al., 2019).

## **Conclusion**

Culturally responsive care is crucial for equitable outcomes. Empowering Pacific allied health clinicians who offer significant cultural expertise is critical. This cultural expertise is fundamental in helping non-Pacific allied health clinicians to embrace culturally informed healthcare. Three meta-themes of cultural isolation, cultural intelligence, and cultural load were identified. This study has demonstrated examples of identified cultural isolation Pacific allied health professionals felt. Participants perceived their cultural intelligence was paradoxically relied on and minimised by their colleagues and organisations. Participants experienced the cultural load of working in a healthcare system where they are a professional ethnic minority. Culturally responsive healthcare

enables relevant connections to be made between staff and patients early, empowering patients throughout their healthcare journey. The research provides visibility that allows colleagues to build further research exploring Pacific allied health professionals' experiences in providing culturally responsive care across Aotearoa.

## Glossary

<b>A'u tonu (Tongan):</b>	face to face
<b>Bula Sautu (Fijian):</b>	a Fijian saying expressing an aspirational goal for 'good health that is lived to its full potential; a life of abundance'.
<b>Fakafehokotaki (Tongan):</b>	engagement
<b>Hauora (Māori):</b>	health
<b>Hui (Māori):</b>	meeting
<b>Kainga (Tongan):</b>	extended family
<b>Kainga Lotu (Tongan):</b>	church family
<b>Mihimihi (Māori):</b>	acknowledgements
<b>Pākehā (Māori):</b>	New Zealander of European descent
<b>Tauivi (Māori):</b>	foreigner, European, non-Māori, colonist
<b>Teina (Māori):</b>	younger/less experienced sibling
<b>Tuakana (Māori):</b>	older/most experienced sibling
<b>Vā:</b>	a relational space that connects social, physical, spiritual, cultural, and environmental elements, people, places, and objects
<b>Wānanga (Māori):</b>	indigenous seminar, conference, forum
<b>Whakapapa (Māori):</b>	ancestry

<b>Whānau (Māori):</b>	extended family
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