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特集：健康先進国に求められる文化に即した保健医療―災害保健活動に焦点を当てて―

＜ Review ＞

Providing culturally safe nursing care in disaster: Japanese and New Zealand perspectives

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Abstract

The purpose of this review is to introduce a concept of a culturally sensitive approach to the disaster management and response by providing specific examples from two major natural disasters in Japan and New Zealand.

This review also provides a brief outline of national and local disaster management structure, drawing from extensive experience accumulated in both countries.

Consequently, this review introduces a concept of cultural safety and expands its reach in the context of providing a culturally sensitive response in Great East Japan Earthquake disaster and Christchurch earthquakes 2011.

This review also expands a link between culturally sensitive response and community resilience.

keywords: Disaster, nursing, resilience, community, cultural safety

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I. Introduction

The Asia-Pacific region is the most disaster-prone area of the world and it is also the most seriously affected one. Almost 2 million people were killed in disasters between1970 and 2011, representing 75 per cent of all disaster fatalities globally [1]. Both Japan and New Zealand situated in the Pacific ring of fire area which increases their risk and exposure to devastating earthquakes. Great East Japan earthquake disaster and Christchurch earthquakes 2011 posed unique challenges for the affected communities.

The aim of this review is to describe disaster landscapes in Japan and New Zealand and to outline disaster management approaches for both countries, focussing on cultural aspects of disaster response and recovery.

This review introduces a concept of cultural safety in nursing care and pays particular attention to the role of culturally safe nursing care, providing the examples from Japan and New Zealand experience. Addressing cultural aspects during a disaster response and recovery phases can promote community resilience and assist in building an additional capacity.

The link between culturally safety and disaster nursing response requires further research and exploration. However, it provides an important insight and learning point about the importance of integration of cultural competencies into the overall disaster response and health care system response in particular.

II. Disaster landscape and cultural implications: New Zealand

New Zealand is exposed to a range of significant hazards and threats. Natural hazards, such as earthquakes, volcanoes, or extreme weather, are only one type. New Zealand economy relies heavily on primary production and is vulnerable to adverse impacts from pests and diseases; the potential for an infectious disease pandemic has been

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highlighted in recent years through the bird and swine flu crises; heavy reliance on technology and just-in-time supply chains means we are vulnerable to disruption from a wide range of domestic and international sources; and the global geopolitical environment means threats to our security and economy are complex and often unpredictable. In New Zealand, risks are classified into five categories: natural hazard risks, biological hazard risks, technological risks, security risks, and economic risks [2].

Aotearoa New Zealand is officially a bicultural nation, and is governed by a bicultural legislative foundation. The two predominant cultural groups are Māori and New Zealand Pākehā (people of European origin). New Zealand has three official languages: Te Reo (Māori language), English, and New Zealand Sign Language. Aotearoa New Zealand is becoming increasingly multicultural so there are increasing numbers of people who identify with other cultures and use languages other than Te Reo or English as their first language. Following the Canterbury earthquakes, central and local government acknowledged that they needed to improve how they engaged with culturally and linguistically diverse (CALD) communities when carrying out emergency management [3].

The effective response and significant community support facilitated by Māori in the aftermath of the Canterbury earthquakes, as well as in other emergencies, has generated considerable interest in Māori disaster resilience. Māori moral and relational attributes applied to create community resilience promote a collaborative approach to disaster response and recovery, commitment to environmental restoration, and the extension of hospitality to others experiencing adversity. Māori also has assets and places, which often have, and will again be mobilized to secure community wellbeing in the aftermath of disasters [2].

III. Disaster landscape and cultural implications: Japan

Japan, as a part of the ring of fire, experienced uncountable tectonic activity related to natural disasters, including earthquake, tsunami, volcanic eruption, pyroclastic flow, and ashfall. Also, Japan experienced a chemical terrorist attack in 1995 and the nuclear disaster in 2011. There is no case identified in Japan with infectious diseases which the Public Health Emergency of International Concern determined its risk. Disasters equally affect people despite their nationality, race, or ethnicity.

The number of foreigner in Japan has increased over the years, and the record indicates 2,730,093 residents in 2018 [4] which is more than two percent of total population [5]. These people came from 195 countries or area of the globe, and more than half proportion of these come from China (28.0%), Korea (16.5%), and Vietnam (12.1%) [6]. The number of foreign visitors is 28,691,073 in 2017, and Korea, China, and Taiwan are the top three countries[7]. People living in a country where the language is not the same as their first languages are considered vulnerable population under disasters. Ito reported higher death rate in foreigners compares to Japanese at the Hanshin Awaji earthquake in 1995 and surveyed newsletter addressing foreign affected people [8]. She reported that foreigners lived in old houses, and they were overstayers afraid of deportation, besides language difficulties and no health insurance. This indicates inequity in disaster risk reduction and response for people whose first language is not Japanese.

The official language of the country is Japanese, and English has used for foreigners. The languages used by the majority of foreigner in Japan, and visitors do not match the language used for information sharing in general. Kanbara et al. identified through analysing disaster and emergency relief information at stations, sightseeing spots and educational institutions [9,10]. Information identified was in English and hard to read because of location or litter size. Although the Council of Local Authorities for International Relations developed a multilingual disaster information tool which online system translates the disaster-related term into seven languages [11], this tool needs more attention to reach more people whose first language is not Japanese.

IV. National and local disaster management approach: New Zealand

1. New Zealand National Disaster Resilience Strategy

Civil Defence Emergency Management (CDEM) in New Zealand is governed by the CDEM Act 2002 which (a) promotes the sustainable management of hazards in a way that contributes to safety and wellbeing, (b) encourages wide participation, including communities, in the process to manage risk, (c) provides for planning and preparation for emergencies, and for response and recovery (d) requires local authorities to co-ordinate reduction, readiness, response and recovery activities through regional groups, (e) provides a basis for the integration of national and local planning and activity through a national strategy and plan, (f) encourages coordination across a wide range of agencies, recognising that emergencies are multi-agency events affecting all parts of society [12]

In 2019 the Ministry of Civil Defence and Emergency Management has published a comprehensive National Civil Defence Emergency Strategy, aiming to set out goals and objectives for civil defence emergency management over the next ten years. This Strategy has been given the name

of National Disaster Resilience Strategy to reflect the fact that one of the main goals of this Strategy was a development of capabilities to respond to disaster focussing on building community resilience.

Disaster resilience is the ability of individuals, communities, organizations, and states to adapt to and recover from hazards, shocks, or stresses without compromising long-term prospects for development. According to the Hyogo Framework for Action [13], disaster resilience is determined by the degree to which individuals, communities and public and private organizations are capable of organizing themselves to learn from past disasters and reduce their risks to future ones, at international, regional, national and local levels.

Of a particular note, it should be pointed out that this National Strategy emphasizes the link between culture of communities and the resilience, by recognizing the importance of culture to resilience, including to support the continuity of cultural places, institutions, and activities, and to enable the participation of different cultures in resilience. This Strategy clearly states that how culture sustains us in times of upheaval is a key area for consideration for communities and emergency management organizations alike. Cultural life, including cultural practices and events, institutions, heritage buildings, and cultural practices are important to our wellbeing, and for maintaining a sense of normality and comfort during and following emergencies. We must do what we can to ensure the continuity of cultural life [2].

2. New Zealand National Civil Defence Emergency Management Plan

The National Civil Defence Emergency Management Plan 2015 sets out the roles and responsibilities of everyone involved in reducing risks and preparing for, responding to, and recovering from emergencies. This includes central and local government, lifeline utilities, emergency services, and non-government organizations. This plan clearly identifies four key components in the emergency management process, which are also known as 4 Rs (Table 1). The purpose of this plan is to state the guiding principles and roles and responsibilities for CDEM across the 4 Rs at the national level so that all agencies and CDEM Groups are able to (a) understand the hazards and risks; (b) work to reduce those hazards; (c) build resilience in respect of those hazards; and (d) build capability and capacity to provide coordinated, integrated, and effective responses to, and recovery from, emergencies [14].

Following guiding principles of this plan, the New Zealand Ministry of Health developed the National Health Emergency Plan. The plan builds on the experiences of preparing for, building resilience to, responding to and recovering from a range of hazards in New Zealand and elsewhere, including human disease pandemics, tsunami, terrorist incidents, earthquakes, and technological incidents over the past decade. The plan recognizes that supporting individuals, families, and communities in preparing for, responding to and recovering from emergencies requires effective planning based on an understanding of community vulnerabilities, risks, and strengths [15].

The plan clearly states that communities should be actively involved in all aspects of resilience-building and preparedness planning, implementation, and review. It is important to: understand that communities are made up of dynamic and networked groups of people engage with communities proactively and meaningfully support and build on networks and activities that already exist within communities. Ensure that emergency health and welfare services address the specific needs of communities enhance self-reliance for all individuals, families, and groups in communities [15].

V. National and local disaster management approach: Japan

Three laws, Disaster Measures Basic Act, Disaster Relief Law, and Act Concerning Support for Reconstructing Livelihoods of Disaster Victims aim to protect people in all phases of disaster. The Disaster Measures Basic Act focuses on prevention, mitigation, and disaster risk reduction. The Disaster Relief Law aims to protect affect population and social orders by providing 12 areas of relief work during the early phases of disaster; removing road blockage, res-

Table 1 4Rs

Reduction	Identifying and analysing risks to life and property from hazards, taking steps to eliminate those risks if practicable, and, if not, reducing the magnitude of their impact and the likelihood of their occurrence to an acceptable level.
Readiness	Developing operational systems and capabilities before an emergency happens, including self-help and response programmes for the general public and specific programmes for emergency services, lifeline utilities, and other agencies.
Response	Actions taken immediately before, during, or directly after an emergency to save lives and property, and to help communities recover.
Recovery	The co-ordinated efforts and processes used to bring about the immediate, medium-term, and long-term holistic regeneration and enhancement of a community following an emergency.

cue, missing body searching, burial, medical care, shelter and temporary housing, food, water, non-food items, temporary housing repair, financial support, and school supplies. The Act Concerning Support for Reconstructing Livelihoods of Disaster Victims provides affected people grants to reconstruct livelihoods.

Regarding medical relief, the Red Cross has been a humanitarian worker under the Japanese Red Cross Law enacted in 1952 [16]. The Disaster Medical Assistance Team was established in 2005 by the Ministry of Health, Labor, and Welfare from the lessons learned from the Hanshin-Awaji earthquake in 1995 [17]. Since then, the Disaster Psychiatric Assistance Team and the Disaster Health Emergency Assistance Team have established in 2013 and 2016, respectively [18, 19]. The Japan Medical Association formed the Japan Medical Association Team in 2011 soon after the Great East Japan Earthquake disaster onset [20]. Besides these relatively formal organizations, there are numbers of Non-Governmental Organizations and Non-Profit Organizations being a part of disaster medical relief, and the numbers are growing.

After the Kumamoto earthquake disaster in 2016, coordination among medical assistance teams has been a focus to be strengthened to provide more comprehensive health services for people, including vulnerable population [21]. However, linguistical and culturally competent care for foreigners is challenging even during the non-disaster phase. Namikawa and colleagues investigated 327 cities, townships, and villages about preparedness of disaster response manuals in 2013 [22]. The study reports 80% of participants need the manuals whereas less than 1% has created manuals. This study indicates a need for disaster risk reduction strategies and practice suitable for people whose first language is not Japanese.

VI. Cultural safety and nursing practice in New Zealand

Nursing Council of New Zealand defines cultural safety as the effective nursing practice of a person or family from another culture and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability. The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well- being of an individual.

Cultural safety relates to the experience of the recipient of nursing service and extends beyond cultural awareness and cultural sensitivity. It provides consumers of nursing services with the power to comment on practices and contribute to the achievement of positive health outcomes and experiences. It also enables them to participate in changing any negatively perceived or experienced service [23]. A key concept of cultural safety implies that to be culturally safe in any situation you first need to understand your own culture and feel connected to it.

Four main principles are central to cultural safety. Principle one focuses on improving the health status of New Zealanders and emphasizes health gains and positive health outcomes. In addition, it requires that nurses acknowledge the beliefs and practices of those who differ from them through age or generation, gender, sexual orientation, occupation and socioeconomic status, ethnic origin or migrant experience, religious or spiritual belief and disability. Principle two focuses on a culturally safe nursing workforce by emphasizing the significance of power relationships and the need for nurses to undertake a careful process of institutional and personal analysis of power relationships. Principle three requires a broad application of cultural safety to encompass recognizing inequalities within health care interactions that are reflective of historical and social inequalities in health. Finally, principle four states that cultural safety has a close focus on the nurse as a bearer of his/her own culture, history, attitudes, and life experiences and the response other people make to these factors. It challenges nurses to examine their practice carefully; recognizing that the power relationship in nursing is biased toward service providers and that there is a need to balance power relationships in practice, so consumers receive an effective service. Cultural safety also includes an emphasis on preparing nurses to resolve any tension between the cultures of nursing and the people using services so as to provide equitable, effective, efficient and acceptable service delivery, which minimizes risk to people [23].

VII. Cultural safety and nursing practice in Japan

Cultural safety has not been widely recognized in Japan despite increasing numbers of foreign residents and visitors. In nursing education, cultural considerations utilizing theories proposed by McFarland and Wehbe-Alamah[24], Giger and Davidhizar and Giger[25], and Purnell [26] are discussed in global health and context which may imply nurses should be aware of importance of cultural competency when they work in foreign countries or for international non-governmental organizations rather than caring foreign

people seeking help in Japan. However, literature indicates substantial gaps to be filled for health services for people whose first language is not Japanese. Several articles indicate that difficulty in communication is a major barrier accessing to health services for people whose first language is not Japanese [27-31]. This type of report persistently appears over and over and this implies insufficient health service system still exist in Japan.

VIII. Cultural aspects of community resilience

Community resilience can be defined as the capability to anticipate risk, limit impact, and bounce back rapidly through survival, adaptability, evolution, and growth in the face of turbulent change [32]. A cultural turn has been identified within disaster research in recent years due to the increased attention to how culture mediates disasters and exacerbates or mitigates their impact [33]. By shifting the focus from short-term disaster management to longer-term disaster risk management in the Sendai Framework for Disaster Risk Reduction (DRR) 2015–2030 greater space is provided for wider structural determinants of vulnerability, including cultural considerations [34].

Culture is an ever-changing process, as the adaptation practices, both visible and intangible, conducted for millennia by populations prone to disasters have proved [35]. People tend to adapt actively and creatively to contain risks affecting the areas in which they are accustomed to live because of the repetitiveness and the predictability of certain hazards. The recurrence of risk can be an important driver of both destructive and positively transformative cultural change in the areas of politics, economics and society [36]. Supporting cultural values and addressing social and economic factors during a recovery phase could promote self -efficacy and contribute to the development of the resilient communities.

IX. Cultural aspects of nursing care in disasters

1. Christchurch, New Zealand Earthquakes

In 2010 and 2011, the Canterbury region of New Zealand was hit by a number of significant earthquakes. The first earthquake, on September 4, 2010, was of Magnitude (Mw) 7.1 and resulted in numerous injuries and significant infrastructure, land, and building impact. There was no loss of life, but many people were displaced from their homes, and a local State of Emergency was declared. A second major earthquake which hit the city of Christchurch, on February 22, 2011, was of the lower magnitude of Mw 6.3 but resulted in significant loss of life: one hundred and eighty-five people died as a direct result of the earthquake and thousands were injured . This was the second deadliest natural disaster in New Zealand history. A national State of Emergency was declared and remained in effect until April 30, 2011 [37]. By March 2016, greater Christchurch had experienced almost 18,000 aftershocks; over 35 of these were of magnitude 5 Mw or greater [38].

The loss of lives and impact on communities and livelihoods had severe implications for the health and wellbeing of individuals in the affected areas and required collaborative action to support psychosocial recovery [37]. The eastern side of Christchurch, an area that was primarily comprised of communities with limited socioeconomic resources, was the region most significantly impacted by the earthquakes. The geospatial concentration of Māori in the severely impacted areas suggested that in comparison with the wider community, Māori were disproportionately affected in terms of reduced financial resources, access to basic necessities, sanitation, power, transport, and support from frontline responders [39].

It is expected that nurses, like other health professionals, will play a significant role following a disaster. Indeed, nurses have been active participants in response and recovery efforts during and following disasters [40]. The nursing response following the February 22 earthquake has not differed from described in the previous research. Nurses on duty cared for patients in whatever way they could, and this included working in the hospital emergency department, evacuating wards, assessing conditions in residential homes and working in the community.

Disaster professionals, health care providers, and persons affected and impacted by disasters all bring individual learned patterns of language and culture to any experience. These unique patterns must be transcended in order to achieve equal access, reduce the loss of lives and property, and improve the quality of health care provided. Disaster professionals do not have to be students of sociology or anthropology in order to understand and appreciate cultural differences and better relate to the varied neighborhoods within which they work. Relief during a disaster, by its very nature, is more immediate, and the principal responsibility of a first responder is to take action, not change beliefs. In either case, it is important to know the culture of the community affected, for you cannot change long-held beliefs if you do not understand those beliefs, and you cannot expect people to take action contrary to their common sense if you do not understand what motivates them [41].

In the immediate response and more prolonged recovery phases, following the Christchurch earthquakes, nursing teams in both acute care settings and the community have

based their care on main principles of culturally safe nursing as outlined in the previous section of this review. There were mindful and aware of their own culture and beliefs while providing care to patients in hospitals and community. Interactions with patients took into account multiple factors to ensure patients and their families felt supported, listened to and empowered. In many cases patients and people impacted by the earthquake had an opportunity to express what felt right to them in all concerning nursing care. It assisted in building their sense of power and independence and also helped to cope with ongoing stress and anxiety during many months of ongoing aftershocks which followed the February 22 earthquake.

The link between culturally safety and disaster nursing response requires further research and exploration. However, it provides an important insight and learning point about the importance of integration of cultural competencies into the overall disaster response and health care system response in particular.

2. Japan: Great East Japan Earthquake Disaster

On March 11, 2011, the Great East Japan Earthquake disaster occurred and resulted in 19,689 death toll and 2563 missing as of 2019 March. Literature search with key wards including disaster, culture, nursing, and care in English and Japanese was attempted with the search system named "Ichushi-Web". None article addressing cultural safety at the time of disasters was identified. However, Foster and Hirata reported results from questioner survey for 154 foreigners who resided in Tohoku area; Iwate, Miyagi and Fukushima and were affected by the Great East Japan Earthquake Disaster [42]. The participants reported less stress-related symptoms if they had many Japanese friends and felt sense of belonging to the society, however this study did not mention whether these residents received culturally safe support or care. There was a positive correlation between sense of belonging and the number of friends which may suggest these participants held high fluency in Japanese or friends spoke fluent English. The paucity of culturally competent care urgently calls for knowledge, good practices, as well as research in this area in Japan where more inbound and immigrant and/or migrant population is expected because of the Olympic and Paralympic games in 2020 and Economic Partnership Agreement. Nurses are expected to cope and adapt to rapidly changing society even or certainly in disaster context [43].

X. Conclusion

This article addressed differences and similarities of disaster risk reduction and response mechanisms in two Pacific rim countries. Both countries have developed structured and organized national and local systems. However, New Zealand have thrived to incorporate Maori's culture into disaster risk reduction and response mechanisms whereas systems of Japan seem to be built on homogeneous culture and its language, Japanese. Two earthquake disasters occurred in 2011 in each country depict there are gaps about sufficient and culturally competent support for venerable population. This paper also introduced cultural safety which is now required training for all nursing professions in New Zealand. Providing culturally safe care would be achieved through self-awareness of own culture and whether it is achieved will be judged by clients not care providers. Evaluation research for cultural safe training would be a foundation for sound disaster risk reduction as well as good practices and further evidence for disaster response.

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＜総説＞

文化的に安全な災害看護の提供：日本とニュージーランドの視点から

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抄録

本稿の目的は，災害対策と対応に関して文化的な方法の概念を，日本とニュージーランドの２大自然災害を例示して，紹介することである．

また，本稿では，両国で積み重ねられてきた経験から，全国的または地方の災害対策の構造の概要を提供する．

つづいて，文化的に安全なことの概念を，2011年の日本およびニュージーランドの地震での文化に即した災害対応の展開において紹介する．

本稿はまた，文化に即した災害対応とコミュニティレジリエンスの関連を展開する．

キーワード：災害, 看護, レジリエンス, 地域, 文化的安全