Experiences of senior Māori public health practitioners working in public health units in Aotearoa New Zealand:

Success factors and barriers for Māori working in public health units

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He Mihi

Ko te pae tāwhiti, whaia kia tata

Ko te pae tata, whakamaua kia tina!

Nā Rangi Metekingi

He mihi ki a Ngāti Whātua ki Kaipara, Ngāti Whātua ki Orakei, Te Kawerau a Maki, nā rātou te whenua I whakamana I a au I tēnei haerenga hōhonu.

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Abstract

In Aotearoa (New Zealand) the underpinning document that frames the nation's response to public health is Te Tiriti o Waitangi. Te Tiriti o Waitangi has stood and still stands as the most important document for the pursuit of equity for Māori and other Indigenous groups alongside the United Nations Declaration of Indigenous Peoples (UNDRIP) (United Nations, 2007). Regardless of any ideological understanding of the purpose and execution of the Te Tiriti, there continues to be an imbalance in representation by Māori in influential, leadership and decision-making positions in the health sector, and inequity across Māori and Pacifica populations that could be addressed by transforming the systemic issues that contribute to these inequities. Public health specifically focusses on population health and, more specifically, the prevention of illness by focussing on the social determinants of heath that significantly affect outcomes for Māori. Therefore, public health units (PHUs) are major contributors to the health sector's responsibility for addressing inequities in health for Māori.

This research study is a Kaupapa Māori qualitative investigation into the experiences and observations of senior Māori public health practitioners in mainstream PHUs, particularly in relation to success factors for and barriers to successful practice. Senior Māori staff were defined as those who work or have worked in mainstream PHUs for five years or more.

This study found that restrictions on Kaupapa Māori practice and cultural freedom in the PHU workplace was being experienced and/or observed by all the participants. The lack of value placed on mātauranga Māori, Kaupapa Māori practice and te ao Māori worldview was inherent in all the kōrero. Inconsistencies in human resource practices were observed relating to hiring for capacities that required te ao Māori knowledge, where appointments

of non-Māori were commonly made based on other ‘knowledges’ and qualifications. Also observed was resourcing for professional development or for Māori projects generally not being prioritised and the existence of institutional barriers or institutional racism within these decisions. The public health sector needs to truly understand the damage that occurs by persisting in operating in a way which allows cultural erosion, seemingly with little desire to implement solutions. In the process of establishing and describing the enablers of and barriers to success for Māori working in public health units in Aotearoa, this study shows a need to actively implement solutions that mitigate the perpetuation of environments less suitable to Māori success or, better yet, create solutions that prevent damaging situations or environments from existing in the first place.

Table of Contents

List of Tables

Attestation of Authorship

I hereby declare that this submission is my own work and that, to the best of my knowledge and belief, it contains no material previously published or written by another person (except where explicitly defined in the acknowledgements), nor material which to a substantial extent has been submitted for the award of any other degree or diploma of a university or other institution of higher learning.

Signed:

Emma Waimarie Rawson

Chapter 1: Introduction

Introduction

This research takes a qualitative approach to investigating the experiences and observations of senior Māori public health practitioners in mainstream public health units (PHUs), particularly in relation to any success factors and barriers to successful practice. Senior Māori staff were defined by the research team as those who work or have worked in mainstream PHUs for five years or more. The work of PHUs includes environmental health, communicable disease control, tobacco control and health promotion programmes. Some of these programmes contain a regulatory component generally performed by Medical Officers of Health (Ministry of Health, 2017).

Beaglehole, Bonita, Horton, Adams, and McKee (2004) described 'public health' as: "Collective action for sustained population-wide health improvement" (p. 2084). The Ministry of Health described public health as:

> …about population groups rather than medical treatment of individuals and looks beyond health care services to the aspects of society, environment, culture, economy and community that shape the health status of populations. Good public health is based on creating conditions that enable people to contribute and participate and requires the input of agencies beyond the health sector agencies. (Ministry of Health, 2009, p. 3)

The World Health Organization (2016) defined public health as all organised measures (whether public or private) to prevent disease, promote health, and prolong life among a whole population. Its activities aim to provide conditions in which people can be healthy and focuses on entire populations, not on individual patients or diseases.

In Aotearoa (New Zealand) the underpinning document that frames the response to public health is Te Tiriti o Waitangi. Te Tiriti o Waitangi was and still stands as an important document for the pursuit of equity for Māori (Durie, 1998; Reid & Robson, 2007) and

other Indigenous groups, alongside the United Nations Declaration of Indigenous Peoples (UNDRIP) (United Nations, 2007). The significance of Te Tiriti is outlined in Article Three regarding ōritetanga (equity). Article Three declared something for Māori that no other colonised people or group of politically 'black' people on the planet had at that time: it gave Māori the same rights and privileges as British citizens (Came, O'Sullivan, Kidd, & McCreanor, 2020). Te Tiriti remains centrally significant because breaches of that treaty that continue to have negative effects on health outcomes for Māori. Consequences of the breaches of the Te Tiriti are well outlined in the recent Wai 2575 claim report by the Waitangi Tribunal (2019) specifically relating to health. The Waitangi Tribunal found the Crown does not recognise tino rangatiratanga (sovereignty/ self-determination) or mana motuhake (Māori political control). It affirms that the Crown has failed to commit to health equity, and that there is a consistent underfunding of Māori health.

Te Ture Whakaruruhau: Code of Ethical Principles for Public Health (Public Health Association of New Zealand [PHANZ], 2017b) sets a Māori worldview and Māori principles – manaakitanga (generosity and mutual respect), rangatiratanga (leadership and self-determination), whanaungatanga (social organisation and collectivism) and kotahitanga (unity of purpose of direction) – firmly alongside generic public health principles of solidarity/social capital, beneficence/competence, justice/equity and honesty. These principles are all underpinned by the acknowledgement of Te Tiriti o Waitangi, which sets the basis for ethical relationships and actions. The purpose of the code set out in *Te Ture Whakaruruhau* is to provide guidance for delivering public health interventions that acknowledge and honour the rights of Māori to equity in health as well as meeting generic public health goals.

Regardless of any of these frameworks and ideological understanding of the purpose and execution of Te Tiriti, there continues to be an imbalance in representation by Māori in influential, leadership and decision-making positions in the health sector. Inequity across Māori and Pacifica populations could be addressed by transforming the systemic issues such as institutional racism, insufficient numbers of Māori in the workforce and in leadership, and addressing the ineffective 'equity' policies and practices, and the lack of public health training and support for staff, that contribute to these inequities. Public health specifically focusses on population health, more specifically, the prevention of illness, by focussing on the social determinants of heath that significantly affect outcomes for Māori. Therefore, public health is clearly a major contributor to the health sector's responsibility to address inequities in health for Māori.

Te Uru Kahikatea: Public Health Workforce Development Plan 2001-2016 (Ministry of Health, 2007) highlights the needs for Māori public health workforce under "Objective 2: Strengthen the Māori public health workforce and the capability of the non-Māori workforce to improve Māori health and reduce inequalities" (p. 36) (see Table 1).

Table 1: *Te Uru Kahikatea: Public Health Workforce Development Plan* – Objective 2

Action	**Three- to five-year outcomes for this objective**
2.1 Develop a planned and strategic approach, and an implementation plan to: • strengthen the Māori public health workforce • increase the capability of the non-Māori workforce to improve Māori health and reduce inequalities. This work requires appropriate advice and the identification of strategies to support the public health workforce to more effectively address the health needs of Māori. It will include developing a sector profile, working framework and implementation plan for the public health workforce to respond more effectively to the needs of Māori.	A national Māori public health workforce development provider is providing leadership and management of: • Māori public health workforce development initiatives • workforce initiatives aimed at strengthening the responsiveness and capability of the non-Māori workforce to advance Māori health.

2.2 Maximise opportunities in all the other PH [workforce development plan] objectives to further Māori public health workforce priorities by: • encouraging Māori recruitment and retention in public health careers where Māori are under-represented • enhancing training and development opportunities for Māori in public health • reducing training and development barriers for the Māori public health workforce • increasing cultural support in the workplace for Māori • improving the responsiveness of the overall workforce to Māori health needs • implementing strategies to advance careers and leadership opportunities	• The number and proportion of Māori working in public health medicine, health protection and other areas of the workforce where Māori are underrepresented has measurably increased. • The number and capability of Māori working in senior, management and leadership roles in the public health sector have measurably increased. • Other action areas have been prioritised and are being implemented.

Source: Ministry of Health (2007).

The three- to five-year outcomes of *Te Uru Kahikatea 2007-2016* (Ministry of Health, 2007) have yet to be realised and that strategy is currently under review by the Ministry of Health. Embedded in this objective is the recognition that increasing Māori public health workforce capacity and the responsiveness of the wider public health workforce is necessary. These actions and objectives have been echoed similarly in many other Māori health and health workforce documents and frameworks including *Raranga Tupuake* (Ministry of Health, 2006), *Rauringa Raupa* (Ratima et al., 2008), *Whakapuāwaitia Ngāi Māori 2030: Thriving as Māori 2030: Māori Health Workforce Priorities* (Reanga Consultancy Ltd, 2012), *Te Rakau o te Uru Kahikatea: Public Health Nursing Knowledge and Skills Framework* (PHANZ, 2017a), *Te Iti me Te Rahi* (McClintock, Stephens, Baker, & Huriwai, 2018) and, most recently, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry, Wai 2575* (hereafter the *Wai 2575 Report*) (Waitangi Tribunal, 2019). Throughout these documents a consistent theme is the need to develop and support a skilled and valued Māori health workforce and acknowledge this as integral to improving Māori health equity. Valuing and supporting growth in the Māori

workforce sits alongside the need to continue to upskill and increase the capacity of the non-Māori health workforce in their ability to be responsive to the needs of Māori. A significant point to highlight here is that while many of these documents directly address the general Māori health workforce and health workforce development, there is little that specifically focuses on the public health workforce. *Te Uru Kahikatea* was specifically written and developed for the public health workforce. However, given the often intersecting roles within health and public health in addressing the wider determinants of health, the needs of the public health workforce also need to be defined, evaluated and reflected on alongside the available data relating to general health workforce capacity. More specific research needs to be done to gain a comprehensive understanding of specific public health workforce definitions in order to clearly identify experiences, capacity and need.

One of the issues is the lack of clarity and consistency around the definition of 'Public Health'. Public health work is done in all areas, health, social services, education and more. There needs to be clearer definitions of the work that the public health workforce does and who does it, and also of what is required of public health service providers by the Ministry of Health in commissioning processes. Public health service providers' responsibility to equity and Māori health is to ensure that the actions outlined within the *Public Health Services Tier One Service Specification* (Ministry of Health, 2014) are enacted. Further references to these actions state that they are not limited to what is outlined in that document. The current problem is that it is left to those provider organisations, with varying levels of understanding of Māori responsiveness, accompanied by various levels of responsive leadership and political impetus, to determine how to implement public health services for Māori health outcomes.

Three of the five of the expected outcomes from *Public Health Services Tier One Service Specification* (Ministry of Health, 2014) are specific to Māori and the other two are directly associated:

> The outcomes sought by Public Health Services are:
>
> - a healthier population
> - a reduction of inequity in health outcomes
> - improvements in Māori health
> - increased safeguards for the public's health
> - a reduced burden of acute and chronic disease. (p. 5)

Public Health Services Tier Level One Specifications Service Objective 3.2 Māori Health (Ministry of Health, 2014) reads:

> The public health approach to improving Māori health requires both enhancing health outcomes in general terms and attention to the particular areas where Māori have inequitable health outcomes. Health providers are expected to provide health services that will contribute to realising this aim.
>
> This may be achieved through mechanisms that use appropriate models of health and service delivery and facilitate Māori access to services. Provision of appropriate pathways of care might include, but are not limited to:
>
> - ensuring that the services are, and can demonstrate, cultural competence
> - that services are provided that meet the health needs of Māori.
>
> It is expected that, where appropriate, there will be Māori participation in the decision making around, and delivery of, services that affect Māori health outcomes. (p. 5)

Service Objective 3.3 Reducing Health Inequities (Ministry of Health, 2014), paragraph 2, reads:

> Both the Ministry and public health providers have an important role in supporting intersectoral approaches to address the social determinants of health and a critical role in ensuring health services themselves do not exacerbate inequitable disparities in health outcomes between population groups. This means that, to be effective, services must ensure they are accessible and relevant to all people and groups. (p. 5)

Both Service Objectives 3.2 and 3.3 clearly define expectations of service providers to ensure they are meeting the needs of Māori, and contributing to reducing inequities. More

importantly, there is no particular limitation to their approach in how to achieve this, with the expectation that Māori will be included in decision making. Yet, consistently, Māori health statistics remain distinctly negative in comparison to non-Māori (Waitangi Tribunal, 2019).

A significant determinant of health that is now being recognised more, with more academic research, acknowledgement by the Waitangi Tribunal and government reporting, is racism – more specifically, institutional racism – that is being highlighted as one of a number of consistent barriers to Māori health equity (Health Safety and Quality Commission, 2019; Ministry of Health, 2020; Waitangi Tribunal, 2019).

Paradies (2006) defined racism as avoidable and unfair actions that further disadvantage the disadvantaged or further advantage the advantaged. Racism can be expressed through stereotypes (racist beliefs), prejudice (racist emotions) or discrimination (racist behaviours and practices). Institutionalised racism is the systemic maintenance and reproduction of ethnic inequality (Mutu, 2013). Jones (2001), Harris et al. (2006a, 2006b) and Paradies, Harris and Anderson (2008) all highlighted that racism is a determinant of health and that it is not just interpersonal racism but structural or institutional racism that creates significant barriers to equity in health outcomes for vulnerable people.

There is a growing interest in research that looks at Māori staff workplace satisfaction and experiences in recruitment, retention and workplace development, particularly in health and education. Much of the available literature investigates the experience of Māori nurses with reference to structural racism. Huria, Cuddy, Lacey and Pitama (2014) observed that structural discrimination impacts pay parity and the efficacy of services across the health sector for and by Māori.

Haar and Brougham (2011) argued that despite the growing attention towards Māori culture in Aotearoa, and emerging within the workplace, Māori employee satisfaction

with cultural values and beliefs in the workplace has been overlooked. For many Māori working in public health and other sectors, there is a growing frustration and dissatisfaction that their contribution is undervalued and underpaid. Hooker (2015) argued that recruiting and retaining staff in sectors where disparities between Māori and non-Māori are significant could promote a more culturally centred approach to the needs of Māori while removing barriers to access and engagement to improve health, educational and social outcomes.

The purpose of this research was to examine the experiences of senior Māori who work or have worked in PHUs in Aotearoa. I sought to understand, through their experiences and observations, whether there may be racism or other barriers and identify Māori success factors that would support, more broadly, equitable outcomes in health.

Research Question

What are the success factors or barriers for Māori working in PHUs in Aotearoa?

Positioning of the Researcher

I am a Māori woman, mother, daughter, sister and wife, and I am a senior Māori public health practitioner with over 16 years' experience. Most of that experience has been in different forms of health promotion and a number of years in 'mainstream' organisations, including two District Health Boards (DHBs). I have held various roles and levels of influence.

I am of Ngāti Ranginui, Ngāi Te Rangi and Raukawa descent. I was born in West Auckland in the 1970s to a Māori man from Tauranga Moana and a Pākehā woman from a North Canterbury farming family. I was born in Tāmaki Makaurau (Auckland), but I grew up in Te Waipounamu (South Island), in Christchurch.

When I became a mother and my daughter was young, with a Bachelor of Te Reo Māori already under my belt, I decided to return to postgraduate study in public health at the University of Otago. Public health has become my chosen field to contribute to Māori development more widely and it is an area that I see as pivotal for developing thriving and successful Māori leadership, community development and engagement.

Early in my career I began to work in health promotion, for mainstream organisations, three times in Māori-specific roles for two different DHBs at opposite ends of the country and also in generic roles in non-government organisations (NGOs) but always with the expectation that I was the 'go-to Māori' and therefore available as a resource for everything related to Māori. I experienced this as the expectation that, as a Māori staff member, I would bring my knowledge to the table but I was not remunerated for this, nor was I seen as valuable to decision making at the macro level. In the workplace I was constantly frustrated by watching interventions and projects always fall short, and development being incomplete in terms of the advice taken on board about what would work best when addressing the health outcomes of Māori.

So, after working for several years in health promotion in mainstream DHB culture, it became really clear to me that I could not practice wholly as a public health practitioner, as Māori, completely and freely. I saw through the rhetoric that 'Māori were a priority' and how some roles were labelled 'Māori' but there were never the resources, investment or trust in the advice we gave as to how to honour our people and the needs they have. Knowing that unless something significant changed we would not reach our full potential in these environments and, more broadly, never get the outcomes our people needed was constantly disturbing. I saw half-baked attempts at tick-box interventions, programmes or position allocation. Our ways of being and doing were undervalued within systems that

were meant to be the providers of health initiatives and programmes to increase equity in health for our people.

It is my experience that there is a significant story to be told here regarding how successful we can be as Māori practitioners in public health in a system that was created by a colonial government. My story is not unlike others. These stories are valuable for us to understand what we need as Māori to support our success as practitioners in a contemporary world and largely within systems that were not created with our people in mind. My story brought me to research, utilising research as a tool to support tātou te iwi Māori in ways that honour us.

A Kaupapa Māori approach is critical for this project because I am Māori; as a Māori woman this is where I operate from the worldview of te ao Māori. It is imperative to me to honour and be part of enhancing a tūturu Māori approach that squarely puts te ao Māori, a Māori worldview, at the centre of creating evidence for transformative change in public health in Aotearoa. I will discuss this further in the methodology chapter.

Te Ao Hauora Tūmatanui

The dialogue around 'Māori public health' is an evolving one in Aotearoa. In 2002 the Ministry of Health recognised the need for stronger Māori public health leadership, which saw the establishment of a Kaupapa Māori Public Health Leadership Programme (Lovell, Tunks, & Egan, 2015). This programme plays a core function in the growth and development of Māori public health leadership, enhances sectoral collaboration and promotes the value of Kaupapa Māori approaches for positive public health outcomes. Recognising the site of struggle and redefining it, returning to traditional values and practices, strengthening identity and mātauranga for contemporary application is a 're-ordering' of the status quo (L. T. Smith, 2012, p. 41). Te ao Māori (the Māori world) has

a public health framework at its core operation socially, environmentally, spiritually and physically (Durie, 1998; Signal & Ratima, 2015). The lore of tikanga and kawa provide us with protective measures for our minds, bodies and souls that are inherent in everything we do. Practices such as kaitiakitanga, tapu and rāhui are population health, naturally and effectively, normally. Royal (2007) referred to a deep kinship between humans and the natural world. This connection is expressed through kaitiakitanga, "a way of managing the environment. … Kaitiakitanga means guardianship and protection. It is a way of managing the environment, based on the Māori world view" (Royal, 2017, para. 1).

Tapu and rāhui are protective concepts that enable the placing of a restriction over action or location, often for practical reasons of sustainability or hygiene but also in a spiritual context. Durie (2003) described tapu as "a type of public health regulation basically concerned with the avoidance of risk, protection of the environment and its resources" (p. 407).

Colonisation ultimately weakened the 'public health practices' in place in te ao Māori pre-colonisation, and the effects of that continue. We now seek to re-order, re-define and return to our mātauranga and Māori public health systems. Understanding the colonial nature of our health system in Aotearoa, we begin to see an authentic recognition in the research into the existence of institutional racism in public health systems, structures, policies and procedures (Came, 2012; Harris, Cormack, & Stanley, 2018; Harris et al., 2006a). The evidence of institutional racism in every part of the operating systems and structures, within health, education and social services, from government to procurement, policy development and implementation, is being researched and exposed. Institutional racism can be seen to be present right through recruitment, retention and remuneration, and therefore has effect on workplace satisfaction and success (Waitangi Tribunal, 2019).

There is a growing body of evidence that describes the existence of institutional racism in public health (Came, Doole, McKenna, & McCreanor, 2018; Came & Griffith, 2017). Came (2012) has shown that there are existing issues within public health policy and funding in Aotearoa that are affected by institutional racism and that this disproportionately affects Māori providers, programmes and, therefore, outcomes. Racism in its varying forms, including institutional racism, within health systems has been found to be a significant determinant of health for Indigenous People across the globe (Bastos, Harnois, & Paradies, 2018; Harris et al., 2018). If this is so for patients, why would it be different in a workplace? In the workplace it appears that Māori/Indigenous cultural knowledge is not valued or remunerated as much as generic 'learned skills' or qualifications in public health, even though Māori cultural knowledge is often called upon as a 'specialist' set of skills often for the purpose of enabling organisations to demonstrate 'cultural competence'. There is no direct literature about valuing Māori knowledge in public health and therefore a gap in the data exists. What we can see in the secondary data is that Māori are under-represented in management positions, positions in health, and in public health (Came & Tudor, 2017; Lovell et al., 2015; McClintock et al., 2019), and/or are in positions vulnerable to disestablishment. Therefore, the majority of Māori who work in public health continue to remain relegated to roles that are without influence or involvement in decision making, including the distribution of public health resources, human and/or financial, to long-term sustainable measures that could ensure the reduction of health inequalities for Māori.

Thesis Organisation

This thesis has been organised into six chapters.

Chapter one, the introduction, has set the context for the research and provided the historical background to and a description of te ao hauora tūmatanui – Māori public health

– and the continuing challenges in the experiences of Māori working in mainstream public health and continuing levels of inequity.

Chapter two is a review of the relevant international and national literature specifically relating to public health – that is, Indigenous experiences of working in public health, the Māori health workforce, institutional racism in health, barriers to success in public health, success for Māori in public health, success for Māori, and workplace satisfaction. Accompanying this is a section on the gaps in the literature and the rationale for the study.

Chapter three describes the methodology, why it was chosen, and the methods of participant recruitment, data analysis and ethical considerations.

Chapter four describes the key themes arising from the findings resulting from the semi-structured interviews with 10 selected senior Māori public health practitioners.

Chapter five is the discussion of the significance and implications of the findings for public health practice and organisational structure in the future.

Chapter six presents the conclusion and recommendations to further support Māori in the public health workplace and, more significantly, to address existing systemic barriers or factors to Māori success in public health in Aotearoa.

Summary

While there have been efforts over time through the Ministry of Health to develop and support responsiveness to Māori in public health, it is clear there are still inequities for Māori. There continues to be imbalance in representation by Māori in influential, leadership and decision-making positions in the health sector. Consequently, in my research, I was interested in investigating questions such as: What are we experiencing in terms of the systemic issues such as institutional racism? What do others have to say

about insufficient numbers of Māori in workforce and leadership? Are we addressing ineffective ‘equity’ policies and practices? Is there a lack of public health training and support for staff that contributes to these inequities and what do these things look like? The next chapter begins this investigation by reviewing international and national literature that investigates Indigenous experiences in public health and the wider health sector.

Chapter 2: Literature Review

Introduction

The available anecdotal evidence suggests that, for Māori, there are many barriers to working successfully in mainstream public health in Aotearoa. However, there is a paucity of empirical evidence that describes or investigates this situation. There is, though, a growing body of evidence investigating the Māori health workforce capacity generally, which describes a consistent systemic failure to address the needs of the Māori health workforce. This has been outlined consistently over time in reports such as *Raranga Tupuake* (Ministry of Health, 2006), *Rauringa Raupa* (Ratima et al., 2008), *Whakapuāwaitia Ngāi Māori 2030: Thriving as Māori 2030: Māori Health Workforce Priorities* (Reanga Consultancy Ltd, 2012), *Te Iti me te Rahi* (McClintock et al., 2019) and, probably most significantly, the *Wai 2575 Report* (Waitangi Tribunal, 2019).

Barriers such as pay inequity, lack of progression pathways and fewer resources for professional development persist as systemic barriers which could be defined as 'institutional racism' because the Māori public health workforce is consistently under-resourced and undervalued. This literature review highlights the experiences of the public health workforce globally, nationally and locally. It seeks to understand whether there are barriers to success for Māori working in mainstream public health and how these manifest. This review also seeks to identify the gaps or significant links in the literature, and the rationale for the study.

Search Strategy

The objective of this literature review was to search for academic publications and research between 1980 and the present which had a direct relation to the experiences of

senior Māori public health practitioners. I searched the university library databases and scholarly commons as the primary platform, and then the reference lists of the articles I identified were examined for other links to relevant literature. Firstly, a search strategy was developed to identify broad general geographical and subject areas, using the following terms: international public health, international Indigenous public health, public health New Zealand, and Indigenous/Māori public health. Secondly a more refined search was decided upon for within those geographical areas using the following themes: indigenous experiences working in health or public health OR institutional racism in public health OR success for Māori in public health OR success for Māori OR work satisfaction general OR Indigenous OR Māori OR public health workforce OR Māori health workforce.

Publications were included where they had some reference to health or public health workforce satisfaction, followed by Indigenous public health and then Māori public health. Articles were excluded when not directly containing key themes concerning the public health workforce or work satisfaction of staff, barriers to working in public health, success factors for working in public health or anything not directly relating to the satisfaction of staff who are Indigenous. Twenty-nine articles met the inclusion criteria and were reviewed for this chapter.

This chapter has been set out according to these four key literature themes:

- Indigenous experiences working in public health
- Māori health workforce
- Institutional racism in health/public health
- Success for Māori in public health / success for Māori / workplace satisfaction

The chapter ends with a summary of the gaps in the literature and the accompanying rationale for the study.

Indigenous Experiences Working in Public Health

On the face of it, most of the literature relating to Indigenous experiences in public health is less about the Indigenous practitioners and more overtly descriptive of the need for non-Indigenous workers to be better educated in working within Indigenous communities. There is also a clear theme regarding the fact that most health and public health workers are non-Indigenous (Wilson, Kelly, Magarey, Jones & Mackean, 2016). I could find little literature about the experience, capacity, capability or observations of Indigenous People working in public health. There is a focus on non-Indigenous workers and their observations of how to improve their own practice or how they can shift the locus of power to Indigenous communities by encouraging self-determination and empowerment opportunities (Chino & DeBruyn, 2006; Kowal & Paradies, 2005).

The existing literature addresses the issues of social determinants including power, ownership, material poverty and spirituality, and also recognises the need for mainstream or non-Indigenous practitioners to improve understanding and, indeed, grow a new set of understandings about how to work to support the best outcomes rather than assume they have the answers (Anderson et al., 2018; Chino & DeBruyn, 2006; Coelho & Shankland, 2011; Kowal & Paradies, 2005). However, there is also a lack of evidence that directly speaks to the public health narrative and the experiences of Indigenous public health workers in mainstream public health settings. There is little mention of the value of Indigenous knowledge as a remunerable skill or a significant knowledge system for the healing of Indigenous issues and the improvement of Indigenous population health, let alone what this knowledge system might offer the general population.

While there is a great deal to be gained by focussing on non-Indigenous practitioners and how to improve their cultural responsiveness, there is very little research that explores how Indigenous public health practitioners experience working in a mainstream

environment. This is the case even though Kowal and Paradies (2005) described non-Indigenous workers "living the contradictions, such as public health practitioners in post-colonial worlds" (p. 9). Topp, Edelman and Taylor (2018) conducted a systematic review of Aboriginal and Torres Strait Islander health workers' experiences of accountability. They described how Aboriginal health workers "straddle cultural obligations (e.g., related to gender, age and kinship) alongside the expectations of non-Indigenous colleagues and supervisors which were underpinned by 'Western' models of clinical governance and management" (p. 9). It seems that the onus in the system is on the Indigenous workers to fit into roles that often lack clarity and attribute a lesser recognition of the value of real cultural capital. The challenge, then, is for the individual to have to 'manage' their innate being within these systems without experiencing compromised wellbeing.

In the analysis of the previously described papers it was clear that the overall issue is the constant mismatch or misalignment between government systems and Indigenous needs and values. There is also a theme that although health systems globally often recognise the need to shape interventions and implementation in collaboration with Indigenous People, there is little or no mention of reforming the systems to include and value Indigenous practice in public health as business as usual.

Coelho and Shankland (2011), in their work in Brazil, found that despite improving health indicators for the general population, inequities between Indigenous People and the general population remain. Despite the acknowledgement of Indigenous needs, the ability to shift from a notion of fairness or "the necessity of ensuring continuity and universality, avoiding fragmentation of service provision" (p. 52) remains a barrier to ensuring public health approaches that adequately address Indigenous health. It appears that there continues to be very little reference to the Indigenous workforce or Indigenous workforce experience.

Māori Health Workforce

"The New Zealand Public Health and Disability Act 2000 is the primary framework for the structure and function of the health system" (Waitangi Tribunal, 2019, p. 1). Māori are affected by the policies and legislation that underpin this sector, whether they are staff of health organisations or people who need to use health services.

It was challenging to find consistent current data on the health workforce at large in Aotearoa. The summary of feedback on health and disability workforce strategic priorities and a framework for developing New Zealand's health workforce from the Ministry of Health (2019) stated that even though Māori comprise 14.9% of the total population, we account for less than 4% of the active medical workforce and less than 7% for nursing and allied health. We know that Māori are concentrated in less senior and less well-paid positions when compared to non-Māori (Ministry of Health, 2007). Only 6.2% of the whole DHB workforce is Māori, with 14.6% of that number in lower-level care and support roles as opposed to 1.4% in senior medical roles (McClintock et al., 2019).

Ratima et al. (2007) and McClintock et al. (2019) agreed that the needs of Māori working in the health sector include cultural connection and whanaungatanga, and the barriers to this way of being include the significant impact of institutional racism. The provision of mechanisms to support and grow Indigenous capacity in health needs to be a priority (Curtis & Reid, 2013; Curtis, Wikaire, Stokes, & Reid, 2012; Sheehan & Jensen, 2006).

Institutional Racism in Health/Public Health

Came (2012) described institutional racism as a pattern of differential access to material resources and power determined by race which advantages one sector of the population while disadvantaging another. Paradies (2006) said that racism can be broadly defined as avoidable and unfair actions that further disadvantage the disadvantaged or further

advantage the advantaged. Racism is expressed through stereotypes (racial beliefs and myths), prejudice (ideas and biases about particular racial groups) or discrimination (racially-based behaviours and practices) that lead to some groups being advantaged or disadvantaged compared to other population groups. Institutionalised racism is the systemic maintenance and reproduction of ethnic inequality (Mutu, 2013). Jones (2001), Harris et al. (2006a, 2006b) and Paradies et al. (2008) have all highlighted that racism is a determinant of health and that it is not just interpersonal racism but structural or institutional racism that creates significant barriers to equity in health outcomes for vulnerable or marginalised people. There is a growing interest in research that looks at Māori staff workplace satisfaction and experiences in recruitment, retention and workplace development, particularly in the health and education sectors (Haar & Brougham, 2011; Hook, Waaka & Raumati, 2007; Hooker, 2015). Much of the available literature that references structural racism regarding the health workforce investigates the experiences of Māori nurses. Huria et al. (2014) observed that structural discrimination impacts pay parity and the efficacy of services across the health sector for and by Māori.

McCluney, Schmitz, Hicken, and Sonnega (2018) asserted that "structural racism has been linked to racial health inequalities and may operate through an unequal labor market that results in inequalities in psychosocial workplace environments" (p. 1). A growing body of literature implicates experiences at work in a range of "deleterious psychosocial hazards" (McCluney et al., 2018, p. 3). Because adults spend much of their time at work, psychosocial exposures at work may have critical implications for population health inequalities. Jones (2000, 2001) posited that "Institutionalised racism is often evident as inaction in the face of need. Institutional racism manifests itself both in material conditions and in access to power" (p. 2). Came (2012) described New Zealand health policy as being monocultural and the institutional racism in this persistent singular position as violence: "racism is not only about conspicuous acts of violence but can be

carried in the hold of mono-cultural perspectives" (p. 1). There is no room here to consider the effect of such monocultural constructs on the wider population and least of all the Indigenous population. It suffices to observe, as Came (2012) noted, that there are multiple ways in which monoculturalism might manifest negatively on outcomes for Māori as employees and, indeed, on wider public health goals for the community.

Another way to critically examine the effect of institutional racism on Māori who work in public health would be through the narrative of historical trauma and the implications of triggered stress by public reminders of that historical trauma related to colonisation. This is displayed in work by Mohatt, Thompson, Thai, and Tebes (2014) which sought to demonstrate that anyone who has experienced historical trauma through colonisation would be affected by public reminders of that trauma. An example of this is the dismissive nature of monocultural systems that, by way of their very existence, invalidate the culture of Indigenous groups and therefore re-traumatise by omission.

Whilst efforts are made to create environments that support a Māori worldview or way of being, born out of New Zealand's relationship with Te Tiriti o Waitangi as a constitutional document, they are inconsistent at best. In a telephone survey of primary health providers on the effectiveness and monitoring of their service delivery to Māori, Came, McCreanor, Doole, and Simpson (2015) found that there was an element of Māori responsiveness from most of the public health units that participated. These elements of responsiveness included Māori-specific roles, engagement with mana whenua, enhancing cultural competencies and allotting resourcing to Māori-specific programmes and interventions. The finer details of how responsiveness was executed varied between PHUs. In relation to the current health system, the *Wai 2575 Report* states clearly that the Crown has a Tiriti obligation to ensure culturally appropriate health services (Waitangi Tribunal, 2019).

Success for Māori in Public Health / Success for Māori / Workplace Satisfaction

There is little literature or research directly addressing Māori staff satisfaction in public health workplaces. However, the few quantitative studies that make up a small but growing body of research on workplace satisfaction generally within Aotearoa indicate that there are some key points to be considered when looking at what constitutes satisfaction for Māori, namely cultural satisfaction, loyalty, and environments of understanding (Haar & Brougham, 2011; Hooker, 2015). Some of the literature specifically and clearly indicates the lack of satisfaction for Māori in the workplace in regard to the value placed on culture (Hooker, 2015).

Cultural satisfaction at work is concerned with how satisfied employees are with the way their culture is portrayed and respected in their workplace (Haar & Brougham, 2011). There is a need to recognise and make allowance for the difference between innate Pākehā individualism and Māori collectivism in how to approach the way in which Māori are supported and the types of environments that encourage thriving Indigenous workers (Hook et al., 2007). Despite the growing attention to Māori culture emerging within the New Zealand workplace, Māori employee satisfaction with cultural values and beliefs in the workplace has been overlooked (Haar & Brougham, 2011). For many Māori working in public health and other sectors, there is a growing frustration and dissatisfaction with their contribution being undervalued and underpaid. Hooker (2015) argued that recruiting and retaining staff in sectors where disparities between Māori and non-Māori staff numbers are significant could promote a more culturally-centred approach to the needs of Māori while removing barriers to access and engagement to improve health, educational and social outcomes**.**

There is a clear link between Māori employee loyalty and what Haar and Brougham (2011) highlighted as "organisational citizenship behaviours" (OCBs), namely the behaviour that exceeds one's basic job, as "Māori workers are likely to respond strongly in loyalty and OCBs when their cultural beliefs are supported in their workplace" (p. 470). Further to that, there is a supporting position that specific human resources policies to support Māori cultural satisfaction or environments of understanding would be beneficial in acknowledging and appreciating the nature of the cultural capital brought by Māori, and the importance of that to workforce satisfaction and efficacy (Haar & Brougham, 2011; Hook, 2016).

There was no literature that specifically reported an investigation into the human resources practices affecting recruitment, retention and remuneration of Māori staff in PHUs or Māori senior staff roles at a governance or executive decision-making level. Came et al (2016) asserted that systems change would be a more potent pathway to ensuring embedded processes and honouring the core of public health, which is to build sustainable systems (p. 113).

It is notable that there are no Ministry of Health requirements for PHUs to self-assess based on effectiveness, only on outcomes. The employment of staff and how successful those staff can be is a major contributing factor to the success of the health system and public health approach overall.

Gaps in the Literature and Rationale for the Study

There is a paucity of literature focused on staff experiences in public health, Māori public health and the experiences of Māori and other Indigenous peoples when working in mainstream public health and in PHUs. Most of the existing literature is based in clinical health or is from the newer, growing focus within the human resources management field

which is beginning to provide important indicators on how to understand and support the needs of Māori workers generally. It is clear after this review that there is a need for more research to provide evidence on how non-Indigenous People and organisations can work more effectively with Indigenous groups to improve Indigenous health outcomes. However, more importantly, there is a glaring need to increase the amount of evidence about what works in existing systems to ensure Indigenous workers and professionals' satisfaction with working in public health. There is also a need for evidence on how to achieve the best outcomes through a 'responsive' public health practice and workforce, given the persistent inequities that still exist for our communities.

None of the published literature directly addressed the success of Māori in the public health workforce or discussed success for the Māori workforce as directly relating to health outcomes for members of the wider community. Similarly, the literature has not investigated Māori public health professionals in a mainstream public health workplace setting.

The study aimed to contribute to the literature by highlighting the experiences of Māori staff working in mainstream PHUs, identifying the barriers to successful practice and the factors that contribute to Māori success in these environments. The identification of success factors as well as barriers will provide insight into what is required to support a systemic shift towards workplace environments that support and value Indigenous 'being' and practice. Increasing equity for the Māori workforce may also result in improvements in public health outcomes for Māori that are driven by Māori staff and ways of practice that can be implemented in a system that truly reflects the nature of the people within it and whom it serves.

Chapter 3: Methodology

Methodology: Kaupapa Māori

A qualitative research design was preferred because it was more suitable for storytelling and richly capturing the experience narratives of participants. Qualitative research acknowledges and allows for the analysis of narrative (Sutton & Austin, 2015). It provides an opportunity for the participants to have a voice and greater empowerment in the sharing of experience, which fits with the use of Kaupapa Māori theory (L. T. Smith, 2012).

Kaupapa Māori theory puts the Māori worldview at the centre of any work that is aimed at transforming an inequitable Māori position. G. H. Smith (1997) stated that Kaupapa Māori acknowledges, and is underpinned by, Māori struggles for autonomy and self-determination. Adhering to the principles of Kaupapa Māori theory ensures that the work is robust in its approach, that it is adequately effective and reflective of a Māori worldview, and that it honours the Indigenous participants who work in mainstream systems. Kaupapa Māori legitimises Māori voices, narrative and worldview. Kaupapa Māori theory was used as the approach of this study to honour the mana (inherent respected status of humanity) and tino rangatiratanga (right to self-determination) of the subjects and of the kaupapa (subject matter), and to safely guide the practical aspects of the work, i.e., the interviews, handling of data and intellectual property in a culturally appropriate, tikanga-based manner (L. T. Smith & Reid, 2000).

G. H. Smith (1990) discussed Kaupapa Māori concepts of 'being Māori', by right of whakapapa (kinship, genealogy), by cultural default, as a process to define and create practice from the perspective of te ao Māori, and therefore to own a space of mana Māori motuhake and tino rangatiratanga. Practising Māori ways of knowing, doing and relating

was directly at the centre of the process of this study, following what G. H. Smith (2003) described as a rationale that centralises the issues related to the validity and revitalisation of Māori language, knowledge and culture. This process supported the aim of empowering the participants to tell their stories as openly and freely as they were able in order to gather the most honest, rich and complete picture of how they experience and observe, or had experienced and observed, their working environment to be. I was charged with ensuring a safe, culturally appropriate way to begin to clarify what the barriers to success are for Māori working in mainstream PHUs, to understand if institutional racism was part of these senior Māori public health practitioners' experiences, and then to begin to discover what an environment for successfully practising as Māori public health practitioners in a mainstream public health space looks like. It was paramount to use an approach that valued Māori process above all and actively created a re-ordering (L. T. Smith, 2012) of the research process. It was important to use a process that is shaped by the struggle to resist and survive the assault on (our) culture (Chilisa, 2012) and requires that Māori ways of knowing and value systems inform the research.

For me as the researcher, it was important to develop the recruitment process as one recognising and embodying *he kanohi kitea* (Cram, 2009; L. T. Smith, 1999), relationships of trust and knowing, of mutual understanding of people and place, whanaunga links and collegial respect, along with an intent to work on a process of utu (reciprocity) in the giving and receiving of knowledge. The emphasis was on the relationship and communicating clearly how the research intent was to support the transformation of negative outcomes for our people. This can be demonstrated in what Cram (2009) and L. T. Smith (1999) both described as the concepts and process of *aroha ki te tāngata* and *tītiro whakarongo – kōrero*. These are practical actions such as shaping the interview process to allow the participants to dictate the direction, content and flow

of the interview by giving them the driver's seat in terms of the 'how' of the interview. For example: whether the interview would be face to face, via an online platform or on the telephone; what time of day the interview would be; whether we needed to take a break halfway through and come back later; not sticking to a 45-minute window; if whānau walk in, stopping to acknowledge their presence and having a quick chat; and allowing the interview to take as long as required for the story to be told. *Manaaki ki te tāngata* means actively holding and caring for the kōrero by following lead of the participants telling their stories rather than allowing the pre-prepared semi-structured questions to dictate the direction. Allowing flexibility and change according to the kōrero is also in line with the concept *of whakarongo tītiro – kōrero*. Tipene-Matua, Phillips, Cram, Parsons, and Taupo (2009) observed that tikanga processes ensure that all those who want to have their say are given the space to do so and, whilst these processes will not suit all people or situations, these are the processes of mana Māori motuhake that provide safety and reassurance for all involved.

Method

Consultation

No formal consultation with Māori was undertaken. I am a Māori woman, a Māori researcher who has been working in the public health sector for over 16 years. Given my cultural background as the primary researcher, prior experience, and familiarity with Kaupapa Māori methodology and the focus of the study, formal consultation was not required for this study. This was stated and accepted in the ethics proposal to AUTEC. At the time the original research question was created, I was working very closely with other academics and senior public health practitioners as part of a group called Stop Institutional Racism (STIR). This group is a special interest group of PHANZ seeking to eradicate institutional racism in public health through increasing the availability of robust

academic material, increasing awareness through education and creating tools to address institutional racism. I am also a graduate of the Māori (Public) Health Leadership Programme (Ministry of Health/Digital Indigenous) which has over 600 graduates across New Zealand. This is a large group of Māori public health and other health and education leaders who are invested in increasing the capacity of Māori in those workforces and encouraging Kaupapa Māori practice in all areas to enable health equity for Māori. Through these networks, numerous informal discussions were had about the topic. It was agreed that there was a paucity of formal research in public health in New Zealand into the experiences of Māori as staff in mainstream PHUs. Along with other significant anecdotal evidence and the existing literature relating to Māori and Indigenous public health and workplace success, the findings of other New Zealand-based research on institutional racism in public health and on Māori health workforce capacity/capability, this was enough to suggest the focus of the study was relevant and timely.

Participants

The study consisted of individual interviews with ten participants. The participants were all Māori who work or have worked in mainstream PHUs in Aotearoa and have been in public health for more than five years. It did not include practitioners who do not have Māori whakapapa or those who have worked or work in PHUs for less than five years. If they no longer worked in a PHU, they had worked in one in the last 15 years. I was most interested in senior practitioners who were more likely to have deeper insights into barriers and solutions, such as institutional racism and how it manifests. It was important that participants had significant and varied experience over time that gave them an understanding not just of the practical importance but also the political importance of defining and describing their experiences and what success looks like, or could look like, for Māori working in mainstream public health.

Recruitment process

Participants were selected by purposive sampling in consultation with existing networks (Palinkas et al., 2015). The rationale for active recruitment was to ensure the selection of Māori public health practitioners who have the political and cultural capacity to recognise and describe their experience of barriers to public health practice and the effect of those barriers on adequately addressing Māori health issues. Also, the number of senior Māori public health practitioners who had the required five years of experience in a PHU was not overly large and therefore the pool for selection was already narrow, supporting an active recruitment process. This approach was also informed by existing whanaungatanga, my own knowledge and existing networks of Māori working in public health coupled with suggestions from several key people in the sector. These included Dr Heather Came, the original supervisor on the project, a health promotion and public health expert and a key ally in addressing issues of inequities for Māori. Mr Grant Berghan, Māori Public Health Champion and sector leader, and senior colleague Mrs Tania Hodges, former registered nurse, public health leader, business owner and director, were also involved and asked to put forward names of Māori public health practitioners whom they understood would make an informed contribution to the study. Tania and Grant facilitate the Māori Public Health Leadership Programme, a long-running programme funded by the Ministry of Health which mentors hundreds of Māori participants from across New Zealand. Potential participants were notified of the project through word of mouth and advertising through these existing professional networks and were asked to indicate their interest via email or telephone to either myself or my supervisor.

A number of those who indicated interest were ruled out for not fitting the criteria because either they had not worked in a PHU at all or had not worked in one for the minimum five years. A list was compiled of the 10 most likely candidates from either volunteers or names suggested by my supervisor and supervision whānau member Grant Berghan.

Participants were finally selected based on the criteria of length of time worked in a PHU, and cultural, political and professional competency. The final list was approved by both my original supervisor Dr Heather Came and supervisor mentor Professor Denise Wilson.

Along with my supervisor, mentor and research whānau member, I, as the Principal Investigator, had the combined experience of the networks and cultural competency to make the decisions on the best participants to approach by letter of invitation. There were numerous volunteers from outside the recruitment criteria who responded to the wider email invitation and offered expressions of interest, which indicates the need for future investigation on this subject in the broader health sector.

A letter or email invitation was sent to 10 possible participants along with a consent form. All 10 responded. Contact details were mostly already held through the extensive professional networks of the Principal Investigator, supervisor, and mentor and research whānau. The potential participants were given a maximum of two weeks to consider the invitation and make contact to set up an interview time. As lead researcher, I followed up with participants and set interview times and locations, either online, as they were scattered across the country, or in person, if it was possible to meet kanohi ki te kanohi. It worked out that about half of the interviews were conducted in person and the other half via online platforms, such as Skype. All interviews were recorded by digital audio device for transcription.

Data collection

Individual semi-structured interviews were carried out and audio recorded, either face to face (five interviews) or by telephone, Skype or other recordable medium (five interviews). Each interview lasted between 45 minutes and 1.5 hours. The style of the interview was relaxed and no strict time limit was imposed, to allow for the participant to have the freedom to speak authentically and fully. Developing an atmosphere of

whanaungatanga (relationship building) was important to create trust and relationship in order to encourage rich and thorough kōrero.

Interview questions (Appendix D) were developed and pre-tested with two Māori public health colleagues before interviews commenced. Questions investigated and observed the structural barriers to Māori success in mainstream workplace environments, such as organisational cultural responsiveness, professional development pathways available to staff, ease of access to stages of progression, feelings of job security, and appropriate recognition of cultural expertise.

Transcription

Audio recordings of the interviews were transcribed verbatim using an external Māori transcriber recommended by Whakauae Research Services Ltd. The transcriber has knowledge of the Māori language which was important in not only directly transcribing words but more importantly for the participants contextual use of te reo Māori and Māori concepts. During the first reading of the transcripts for the initial coding, the transcripts were read in conjunction with listening to the recordings, to allow checking for any obvious inaccuracies. There were only a few instances where words were missing due to the recording being inaudible, which was indicated by the transcriber. These were checked by listening to the recordings in those places to see if the words could indeed be made out, if it was not already obvious from the rest of the sentence. In most instances these omissions were single words or partial sentences which did not affect the overall messages from the participant data.

Thematic Analysis Process

Thematic analysis was used to map patterns within the talk (Braun & Clarke, 2006). The transcriptions were then initially ordered into four code families, then nine themes.

Further analysis saw these key themes broken down again into four key themes with three to four sub-themes inside each theme.

Data familiarisation

For the beginning of the analysis, the individual transcripts were read as they came in from the transcriber to check for accuracy as previously mentioned. Then they were each read twice to ensure that I was familiar with each text individually as well as how they fitted (or did not fit) together.

Initial coding

Initially, the aim was to code the data roughly into the question categories, of which there were four. Due to the nature of the questions it was in many ways easier initially to sort the data into the following codes:

- Experience/History/Job Description/Position
- Human resources
- Racism
- Resilience/Thriving

Sorting codes into themes

The data from the initial coding then became nine initial themes by looking more closely at the rough groupings within the original four code families and separating them out into more specific groupings that followed the actual words of the participants. This helped to separate out themes that may have sounded like institutional racism but may not have been directly named using those words. These were subsequently included as 'Barriers'.

Themes and basic descriptions

- ***Access to resources***: Professional development, promotion and/or funding for Māori projects and people.

- ***Culturally safe as Māori in PHUs***: How do they keep themselves safe, supported, and surrounded with appropriate supervision and guidance?
- ***Barriers to success:*** Those things that make it hard to function as Māori.
- ***Undervaluing Indigenous knowledge and practice*****:** Clear discrepancies in treatment based on acknowledged skill or training versus Indigenous ways of doing and being and the lack of value placed on them.
- ***What institutional racism looks like:*** Clearly identified behaviour, action or system functions that were openly identified by the participants as institutional racism.
- ***Kaupapa Māori practice:*** Descriptions of what Kaupapa Māori practice consists of.
- ***Attributes for success as Māori in PHUs, factors for success for Māori in PHUs****:* What are the personality traits and or personal beliefs, actions and support networks participants had or suggested would be integral to surviving the system?
- ***Recommendations for change / decolonisation***: Creating thriving organisations and systems that support, make space for and/or are created for Kaupapa Māori approaches and ways of being.

Reviewing the themes

There was a lot of overlap between the original themes and it was challenging to decide where some of the kōrero fitted because of that. There was a need to think very clearly about the difference between simple barriers, challenges and defined institutional racism. I returned to the data frequently to be clearly directed and driven by the actual words of the participants, and continued to be conscious that although something sounded like it could be viewed as one thing, such as institutional racism, unless it was clearly defined by the participants as such, then it was categorised as another type of barrier. Therefore,

several sub-themes emerged. Institutional racism, as an example, became a sub-theme under the main theme of Barriers rather than a separate theme.

Distilling the themes

The data was then distilled down to three themes:

- **Valuing Indigenous Intelligence** – Organisations and systems that can demonstrate genuine understanding and recognition of the importance of cultural identity and practice among Māori public health practitioners, including the provision of environments that understand and support the existence and growth of cultural identity and responsiveness to the needs of Māori.
- **Encountering Institutional Racism** – Māori staff and Māori interventions being low priority in all aspects of procurement, delivery and contracting; human resources practices not prioritising the human or policy needs that would ensure organisational capability to address Māori public health needs.
- **Indigenising Public Health** – Organisations need to transform to include the Te Tiriti as a tool for: successful public health action; growing and supporting the leadership both of Māori and non-Māori; having expectations of competency in responsiveness to the needs of Māori staff and community; understanding staff re-appropriating their Māori-'ness'; te ao Māori practice being the norm; and the human resources lens reflecting a Māori worldview.

These three themes allowed for the variety of sub-themes that came from the codes to be sorted more clearly into more significantly definable groupings. This allowed for a more practical and coherent description of complex, layered and nuanced similarities and crossovers, and gave a coherent flow from the revelations of what works and creates environments for success, to highlighted barriers/challenges, existing elements or recommendations for change to indigenise public health. The idea was that when the

findings were written up they would form in themselves a collective narrative journey from recognising what already exists in terms of Indigenous knowledge and value, the general lack of value given to mātauranga Māori and te ao Māori worldview, the struggles and the causes of continued struggle, through to the solutions-focused kōrero depicting and describing the reclamation of Indigeneity as a legitimate and valid foundation for public health practice and system change.

Writing up

The key findings were written up according to the three main themes, with a description of each theme, why each was important and then a description of each of the sub-themes associated with each main theme. I confirmed the analysis, the nature of the themes and the validity of the analysis by using participant quotes to make direct connections between the participant data and the evolution of the themes and sub-themes, thereby directly linking the narrative of the chapter to the words and thoughts of the participants.

Ethical and Cultural Issues

Confidentially, consent and identification of participants

A standard university ethics application for a low-risk study was made to Auckland University of Technology Ethics Committee (AUTEC) and was approved (AUTEC Number 16/221) (see Appendix A).

A participant invitation and information sheet (see Appendix B) was provided to potential participants to read prior to agreeing to participate. The participant information sheet made it clear that participation in the study requires additional consent. Consent was confirmed by the participant agreeing to the interview by signing an additional consent form (see Appendix C). Verbal recorded consent was also taken.

In research outputs, participants are identified by their own name by their own choice, or by a pseudonym if they wish their names and contributions to remain confidential. An initial short conversation to recruit for participation and negotiate consent was had with each participant at the time the participation was confirmed. I asked if participants were happy to be identified or wished to remain anonymous; this question was then asked again verbally at the beginning of each interview and written on the participant consent form which had to be signed by each interviewee. Of the 10 participants, only one was uncertain about wanting to remain anonymous. That one participant was in two minds but decided in the end that they would prefer anonymity. The reason they were uncertain was due to job insecurity. Ultimately there was no need to identify anyone in the research, so I made the decision to keep all participants names anonymous. The Principal Investigator and supervisors had access to the data during the collection and analysis stages; this was made known to potential participants in the participant information sheet.

Description of the participants

Table 2: Participants

Gender	**Current area of public health practice**	**Length of time in PHU**
Female	Middle Management - DHB	20 years
Female	Middle Management - DHB	8 years
Female	Health Promoter - NGO	8 years
Female	Middle Management - NGO Māori Provider	10 years
Female	Whānau Ora	30 years off and on
Female	Mainstream NGO Māori-Specific Role	15 years
Male	Mainstream Senior Management not PH	6 years
Male	Mainstream Senior Management not PH	29 years off and on
Male	Mainstream Senior Management not PH	5 years
Male	Mainstream - Consultant	7 years

Rigour: Tika and pono

It would be inconsistent for me to use anything other than a Kaupapa Māori approach to show rigour given that, as Bishop (1996) observed, a Kaupapa Māori approach involves challenging and reframing the dominance of the Pākehā worldview in research. Therefore, for this study I adhered to the kōrero of Bishop (1996) in relation to validity and keeping the locus of power in Kaupapa Māori by demonstrating accountability, transparency and truthfulness through the concepts inherent in being Māori such as: Tika – authenticity, that which is right; and Pono – truth, honesty, transparency.

Tika and pono are some of the key elements of tikanga Māori values-driven behaviour from within a Kaupapa Māori process that inherently demands accountability to the participants and the data, not only in physical action but spiritually and emotionally by cultural default. Within this thinking is also the inherent reflexivity built into cultural processes and ways of being. Robust practice and transparency are a by-product of proper process and ensuring the ceremonial safety that adheres to the notions of tika and pono surrounding even the most mundane daily activities. The ultimate goal in this inherent practice is the survival of the collective, iwi, hapū, and whānau.

In acknowledging a need to ensure transparency and accountability during the journey, some practical examples of how tika and pono were exercised in the process of this research are the opportunities that were taken or created to test the initial thinking on the research topic, questions and initial findings, This included a workshop in 2016 at the STIR Symposium in Auckland where the initial research concept and question were discussed in a workshop with a peer group of national and international Indigenous, Māori and non-Māori public health practitioners, researchers and academics. The initial thinking, approach and methodology was critiqued, and feedback offered as to the nature and type of question and research method required for the original question. This helped form further thinking about the overall aim of the study.

After the interviews were completed and transcripts reviewed for accuracy, the initial findings were presented to an international peer group, nearly six months later, at the World Congress of the World Federation of Public Health Associations in Melbourne, Australia, in April 2017. This allowed again for reflection, discussion and an opportunity for critique. Authenticity – tika – and truthfulness (transparency) – pono – were also tested by sharing the completed findings chapter with the participants to check their thoughts and receive feedback on their recognition or otherwise of the themes that were obtained from the interviews, and to affirm the correct contextual use of participant quotes.

Perceived limitations of the study

Finding 10 senior Māori practitioners who had or were working in PHUs for five or more years was a challenge in that many Māori appear to move out of PHUs within five years. Some leave and go back later but many had moved on to other NGOs or iwi-based health initiatives or out of hauora altogether. At least two of the participants had held senior roles that had some influence and were able to frequently observe the experiences of other Māori staff in PHUs. Possible limitations are the small sample size and potential bias in the nature of the selection. The small pool of participants meeting the inclusion criteria for the study and the selection of participants made by myself or my supervisors based on our relationships or knowledge of these people could have biased the sample. I attempted to mitigate this by having open discussion about this possibility with my supervision team and other senior members of the sector about this process which enabled reflection and careful consideration. All the participants were able to opt out at any time up to thesis submission. A statement about withdrawal was included in the participant information sheet to mitigate any feeling of loyalty that may have driven participation because of relationships.

Summary

This is a qualitative research project that interviewed 10 senior Māori public health practitioners, using semi-structured interviews, face to face and over online media. Kaupapa Māori theory was used because of the intrinsic survival instinct that drives our connection to and responsibility for the mahi which demands constant thought and morally protective action. This translates into how our research and data is collected and translated, how it honours the stories of the participants and how it ultimately effects the necessary transformation for our people. The findings of these interviews are presented in the following chapter.

Chapter 4: Findings

Introduction

This chapter presents the findings from interviews with senior Māori public health practitioners. These findings highlight the participants' experiences of barriers to their success as well as the tools, thoughts and actions that helped them survive PHU environments while they were or are in them. The participants also talked about what could make the public health workplace environment one that supported Māori success.

The findings have been structured into three broad themes, with sub-themes inside them: the first theme, Valuing Indigenous Intelligence, has sub-themes of Kaupapa Māori practice, 'being' Māori, strong sense of identity, and relationships with kaumātua and community; the second theme, Encountering Institutional Racism, has sub-themes of minimal institutional support and understanding, recruitment and retention, and 'Anything Māori is pretty much illegal'; and the final theme, Indigenising/Re-ordering Public Health, has sub-themes of environments for success, re-appropriating 'Māori-ness', and Māori leadership and influence within organisations.

Valuing Indigenous Intelligence – This theme contains the most significant taonga from the kōrero. All the participants talked of experiencing or observing how Māori are undervalued. Mātauranga Māori is a commodity that Māori are expected to offer with little to no recognition of the specialist nature of those skills and knowledges. This theme touches on the need for organisations and systems that can demonstrate genuine understanding and recognition of the importance of cultural identity and practice among Māori public health practitioners and for correct remuneration and recognition of those taonga. There is a glaringly obvious need to provide workplace environments that

understand and support the existence and growth of cultural identity and the link from that to being authentically responsive to the needs of Māori.

Encountering institutional racism – This theme relates to the prioritising of Māori staff and resourcing. There is a theme throughout all aspects of procurement, delivery, contracting and research where Māori are short-changed. This includes not prioritising human resources appropriately – that is, non-Māori being employed to fulfil roles they are ill-equipped for culturally, while often overlooking Māori applicants – and a lack of organisational policies and procedures that ensure organisational capability and capacity to authentically address Māori public health needs.

Indigenising/Re-Ordering Public Health – Organisations need to transform. The participants offered many suggestions about what they knew 'successful environments' could look like, what worked and what did not work. Some of those suggestions concerned Te Tiriti and its place as a tool for successful public health action, growing and supporting leadership (both Māori and non-Māori), and having expectations at all levels of competency in responding to needs of Māori staff and community. These are environments where staff are living and working in their Māori-ness, where te ao Māori and Kaupapa Māori practice are the norm, and human resources practices reflect a Māori worldview.

Theme 1. Valuing Indigenous Intelligence

Indigenous intelligence for the purpose of this research includes: mātauranga Māori; Kaupapa Māori practice; Māori processes; ways of building relationships; knowledge transmission; understanding and practising tikanga Māori and adhering to kawa; and Māori values and ways of being. Overall, the participants spoke of the need for mainstream organisations to acknowledge and create space for this Indigenous

intelligence and increase opportunities for language acquisition and access to cultural professional development. Participants suggested organisations provide appropriate opportunities to increase and support the holding and transmission of cultural knowledge and the increase of cultural and indigenous practice capacity. Organisations would then have the cultural intelligence to be able to genuinely acknowledge the skills and attributes of Māori staff that are unique to 'being' Māori, that are "specialist" in their very nature.

> Bottom line was they expected Māori health protection officers to have all the extra competencies as well as the generic ones, but the organisation weren't prepared to pay any more for that. So, you had to have dual competencies, but you couldn't be recognised for the extra effort to attain or maintain them. (James)

Participants spoke of the struggle with the pressure on Māori staff to carry the responsibility to provide advice and support for being 'culturally responsive.' This responsibility was expected regardless of the role Māori staff were employed to undertake. Mainstream organisations were not prepared to remunerate them for the additional special skills being asked of them.

> … in actual fact, when I look around in the system I'm quite clear that actually, the intelligence that we need to make a difference for the health and wellbeing of our people is our own intelligence, so I really value it and I'm happy for it to be tested as well. I don't have any issue with anything that I say being challenged and tested. Because I'm not interested in being right, I'm interested in getting to the best possible outcome for our people. (Hone)

> There wasn't that recognition of our specialised set of skills and knowledge of our communities and what we brought. We weren't just educators, we were facilitators, we were co-ordinators, we were researchers, we were evaluators, we were a lot of things in one. There was an expectation because you're a Māori, that you would do other things within the organisation whether it be language, pōhiri, tikanga, kawa, meeting with certain people, like the expectation was on you. (Haeata)

Māori bring a their worldview into every situation and setting, as does anyone. Whilst Māori can be as diverse in personality and cultural knowledge levels as any group of people, there are practices and ways of being that are inherent in how we are. There are clear similarities in the kōrero of the participants that highlight key behaviours, ways of

practice and being, and expectations of appropriate ways to approach engagement, project development and management.

> … these key traditional activities that Māori are involved in, actually, inform the way that people work as well, you know, it's the way that we network, the way that we whanaungatanga, all those things that actually have really positive outcomes for the work that people do. So, again, you know, a lack of appreciation within the DHB environment, because they just want bums on seats at the end of the day. (David)

Being able to practise freely or, rather, 'be Māori', and being acknowledged for the specific skills of community engagement and relationship building, and for the way that we as Māori do this among our own, is clear in the shared stories. Having a clear sense of cultural identity and how that clarity of identity is formed, strengthened and even translated into improving public health practice is not only a type of 'skill', it also is a part of living mātauranga brought by Māori to public health; it is also required as a key tool of survival in an environment that is unfriendly to āhuatanga (appearance), whakatinanatanga (embodiment in practice) and wairuatanga (spirituality). Embedding concepts of manaaki (giving and caring), kaitiakitanga (guardianship, duty of care), tika (truth) and pono (honesty) into core organisational culture is part of this. Māori staff could practice karakia, make time for whanaungatanga with other Māori within the organisation and externally, and spend time seeking knowledge and guidance from kaumātua and kuia as means to maintain resilience.

1.1 Kaupapa Māori practice

The sub-theme of Kaupapa Māori practice in public health follows on from this and is defined by the participants as ways of being that truly include Māori and Māori communities, underpinned by Māori concepts and values. This aligns with Article Two – tino rangatiratanga – and Article Three – ōritetanga – of Te Tiriti o Waitangi and the Māori right to determine who and what will be the best approach for our people. This requires authentic, functional relationships between PHUs, their Māori staff, Māori

communities and leaders at all levels. A genuine recognition and understanding of kawa and tikanga, and the ability to honour the role of kaumātua and communities and where they fit, are all part of Kaupapa Māori practice.

Haeata talked about the challenges of and restrictions on thinking from a Kaupapa Māori perspective and working in mainstream public health:

> I was already working in a, I think, in a Kaupapa Māori way, you know, values-based working in line with Te Tiriti and equalities focus, but I was just in the system, I was in, you know, a government organisation. Even though [Māori] get funding, we definitely have a different level of autonomy, being in a Māori organisation in terms of what we can do. (Haeata)

> Sometimes you're like 'Oh, it's really good that I know these things, like, that I've been in this system, and I see how it works', and sometimes you're just like 'Oh my gosh, it's kaka.' Oh, my gosh, really you're constantly navigating two worlds and you feel like you have to be a translator. And I used to sit there and think 'Far, man, if our whānau knew the level of thought that goes into some of these things, they'd probably just think it was so funny.' (Haeata)

Terina highlighted the importance of Māori staff supporting each other to deal with the challenges of being able to operate effectively as Māori in the PHU:

> So in health promotion we had quite a number of Māori working here and we were in seven different sites in health promotion and we wanted to get together often to talk about how being Māori, with Kaupapa Māori within a mainstream Public Health Unit, and being hōhā with what might have been constraints by being Māori within a mainstream Public Health Unit. So we met up once a month, all the Māori, really, so that we were in a safe environment to vent our frustrations and see how we can kind of mitigate some of the barriers to doing our work. (Terina)

Haeata also spoke of the dissonance involved in the obligation to carry out the mahi because of the bigger picture and the responsibility to be of service to the 'people', and how the work is a way of life rather than a 'job':

> It's not just a normal job, where if you actually don't like it, you feel like you can just leave once you're fed up. Even though you do have those feelings because you feel responsible to your, to your whānau and to your hapū and your iwi and your communities. And even if there isn't like a whakapapa tie there, just in terms of the communities we're working with, it's like, man I can't leave because, you know, you've already invested our own time and our own identity, you know,

> your own self in it, you're heavily invested in some of these communities … it's not your normal type of mahi and it's quite hard to, you take it personally, and it is about passion, and it is about, wanting to improve things, so you, you know, I, I think you feel quite a bit of responsibility and, like, sometimes a burden. (Haeata)

1.2 'Being' Māori – I te ao hurihuri

The participants all experienced and observed a range of complex barriers to successful practice as Māori working in PHUs. These barriers took various forms and had different levels of impact and visibility. Hera highlighted very strongly that 'being' Māori was really difficult in these mainstream spaces and that the lack of understanding about what it is to 'be Māori' contributed to feelings of lack of safety and inability to deliver services that were effective for Māori:

> In the public health unit …, there's no stuff for us to keep us culturally safe. We have to go out of the unit which is probably to go down and see our Māori services team to really be able to do that. We can't go to the manager and say to her that I'm feeling culturally unsafe here. I can't do that. (Hera)

> I don't think they really actually understand who, what we are, who we are as Māori and what we do as Māori. (Hera)

What also came through was the common experiences of being scrutinised or 'watched' more carefully. Experiencing suspicion as a regular part of environments that were less than supportive of Māori success.

> Or you weren't allowed to ferry passengers and I'll never forget when a colleague from Inland Revenue used to pick up the Tauas and take them to, you know, like we all do, take them to their hui, go back to work, park up the car. He was disciplined over having passengers in work cars. I mean, you, that wouldn't happen these days, but it was like that then. And of course, you know … Yeah, nah, we were naughty, we were naughty, very naughty workers. Māori workers are naughty. (Piki)

For some of the participants this included a feeling of being judged or feeling inferior just for being 'Māori'. David's experience highlights this:

> I mean, I'm a strong advocate nowadays. I don't put up with too much crap, so I can kind of protect myself a little bit better than, probably, what I used to be able

> to do. But on a regular basis, I always feel a little bit inferior, eh, in a whole range of ways, And, you know? It's not easy. (David)

1.3 Strong sense of identity

Almost all the participants talked about their strong sense of identity and/or connection to culture as one of the things that helped them to deal with the challenges of working in an environment that was not conducive to their practice as a Māori person. There were similarities in some of the experiences of those who are in senior management roles in other areas of the health system currently, in that they had grown up strongly influenced and surrounded by whānau, in their tribal area. They had strong sense of knowing where they came from and how they identified as Māori, particularly in relation to their iwi and hapūtanga.

> …it's like probably because for me there's the 'fuck it! factor'. I don't give a fuck about hierarchy or any of those types of roles or functions, that my focus is more about how you either add value in terms of Māori health gains or mana whenua relationships gains and how that translates from a Te Tiriti framework basis that [PHU name] has, or you're taking up space, you know, it's, that part is really the focus. And so whether you're a technical expert on surveillance or communicable disease control around your specific area is one thing, but really my focus is around how we translate a Te Tiriti response for mana whenua living here within Tāmaki and then how that applies to our efforts to mataawaka as well as part of that manaaki process. (Terina)

> I was brought up by my grandmother who was from Tūhoe and you know, she really only ever spoke Māori to me and I guess that she was very clear on what was, what was right from wrong and she also developed, I think, robust values in me about, you know, how I, how I should behave and also how I should treat other people. … I'm not saying that I'm more intelligent or less intelligent than anybody else is, it's just that I value the intelligence you bring to the table. And I think it is unique and it's unique to Māori. (Hone)

1.4 Relationships with kaumātua and community

A core relationship for Māori practitioners is with kaumātua, recognising their knowledge base of social history and place in society. Kaumātua are those who support the community and its success by being available, by duty and/or choice, to provide cultural and pastoral care to those coming after them, however that may be required. They are a

doorway, a conduit to the traditions of the past and a reflection of the impact of all that has been absorbed by our people since Te Tiriti o Waitangi and before. Kaumātua are senior and significantly important to the cultural leadership and fabric of the community for Māori. Kaumātua should be centrally involved in informing decision making and steering the direction of the work we all embark on, as much for our own cultural safety as for the safety of the work.

> So in recruitment they'd be there in your appointments, in your interviews, in your disciplinaries. If you, if I was gonna be disciplined by my manager for something, being naughty, um, they would expect to be brought in as kaumātua to me. Probably to tell me off, you know? Not just to protect me but also to say taihoa, don't get too, um, we need you. It wasn't about being uppity, it was they wanted us there to protect the taonga and resources that we could influence coming back out to the community. They didn't like me leaving. I got told off a lot that year. (Piki)

In line with the kōrero about the importance of our connection and responsibility to kaumātua, and the central role they play, is the importance of Māori workers' relationships with community and our responsibilities to them. Kath talked about the importance of taking care with these relationships and obligations

> I think just that thing around competency and recognition of, um, the amount of work that goes in from Māori staff to address some of our, you know, I said to some of our Māori staff, look I think you need to make people aware of the amount of time that you're in those Māori communities in your own time. And that there needs to be a measurement of what the realistic thing around Māori relationships is. And an understanding of when we damage, if anything goes into those settings and it's our relationship for work, and damages that, we are unable to move away from that as Māori staff. (Kath)

If staff who are Māori are not recognised for their natural assets, relationships, cultural knowledge, mana whenua status and mātauranga Māori as equal to other 'learned' qualifications, then they will always be recipients of less than what is required to address the need that is reflected in the data about Māori health and outcomes. A major part of this is understanding the processes which there are to support practice and ways of being and meeting the cultural obligations to those processes.

> We tried as, um, kaimahi group to get things happening, sort of like transform our generic box in to like a kaumātua friendly box or something, you know, to encourage the presence of kaumātua, come in and have a cup of tea, you know, do that cross pollinating stuff. Um, tried some of that, um, and I think we had a friendly enough manager, [Persons Name] was our manager, but his hands were pretty tied in much respects, he was sort of spreading himself too thin. (James)

Theme 2. Encountering Institutional Racism

The theme of 'Encountering Institutional Racism' reflects the state of the consistent disadvantage experienced by Māori in PHUs, as employees or in the development of projects that are easily sacrificed or inadequately resourced to accomplish what is required. This reflects a clear contradiction between the rhetoric of responsiveness and the actual action to ensure a properly recognised and resourced Māori workforce and enough commitment to the provision of resources for effective sustainable public health activities and initiatives targeted for Māori.

> If it's tagged to Māori it should go to what Māori determine, not what someone else determines it is that we need, you know, five percent of the medical health officer's salary will come out of Māori budgets. Twenty percent for the psych, for the epidemiologist will come out of the Māori health budget. That seems to be skimming off the top of Māori to put in other clinical people who had no training, no connection, no relationship with Māori. I know that the public health sector is under-resourced, but I didn't care, that's not my problem. (Piki)

> So the public health system didn't recognise marae as public places and so the system would not provide free water samples for marae communities whereas every other public water supply gets lots of money and attention spent on it to monitor its safety. (James)

This often appears to occur because of funding priorities and funding imbalances that seemingly disadvantage and set Māori staff and interventions up for failure.

> The reason why I left was the way they were funding, we had a budget of maybe $300,000 for the Māori health activities, $100,000 of it was going in to a psychologist who was giving good advice, you know, like you have the medical officer of health, you have psychologists and specialists and public health specialists, and they're very highly qualified, highly knowledgeable people and I didn't see why money for Māori health, $100,000 should go to one person. I didn't see the benefit of it for our people … she was a lovely woman, she used to go to a lot of Māori huis, but she wasn't doing anything [for us]. (Piki)

Kath highlighted the struggle as a manager to get funding for professional development for Māori staff:

> So, we are vying for workforce development resource along with everyone else in the DHB. It's quite difficult now because there does seem to be a lot more restriction on what we can use for developing staff. I've had to advocate at almost every opportunity that Māori staff have wanted to enter in to, I've had to advocate for them. So, it kind of shows you that there is a little bit more, there's a lot more of a struggle there. (Kath)

A commonly occurring observation was that although there appears to be a recognition of the need to address Māori health and outcomes, that recognition is not displayed in the amount of resources allocated to ensure truly responsive methods of public health practice or delivery to address those needs. The message here is that the gap between rhetoric and action is glaringly obvious.

> I think there is a tendency to rely on individuals in Māori roles to really be able to utilise what little policy that supports us and there's definitely a lot of work to do, I mean, our policies and that, we all talk about equity and reducing inequalities and inequities that exist for Māori health but, at the end of the day the programmes that we deliver are set by others, aren't necessarily, don't necessarily have that as a driving factor when it's writing up plans, annual plans and so forth. (Kath)

> But was there enough to make the sort of difference we aspired for? No. Not really. So, if you, again, you only have to look at less than 1% of vote health is allocated to Māori initiatives or Māori health initiatives in this country, that's 1% of $16 billion. And 1.49% of DHB funding, of $11 billion, is allocated to Māori led providers or Māori providers. …that's a reflection I guess of the level of value the system places on Māori health. 1.49% of the, I guess, I mean, it's how, you could, I mean, you could interpret that in a lot of different ways but, you know, if you have people standing up saying, you know, Māori health is important, Māori workforce is important, Māori led, Māori leadership is important and you see that less than 1% is going to Māori initiatives, it sort of makes those statements sound like rhetoric. (Hone)

2.1 Minimal institutional support and understanding

This sub-theme responds to the observations of tokenism, the minimal effort by non-Māori staff and for the development of non-Māori staff in improving their responsiveness to Māori. This displays a lesser regard for the importance of culturally appropriate measures and a lesser understanding of what actual capacity and supportive

work environments look like that promote public health practice that is truly responsive to the needs of Māori.

> …on the ground level the cultural awareness, cultural responsive stuff, I feel is just token. (Haeata)

How and what organisations invest in their responsiveness to Māori, through the development, recruitment and training of non-Māori staff, reflects their level of understanding and valuing of Māori. Māori outcomes can be affected by proper investment, including human resources capacity for high-level cultural competence and responsiveness.

> So, you know, there's Māori funding there so they're basically telling you well, this is the only criteria you can do is because this is why you're gonna get the funding. But yet the nurses or the non-Māori, oh, well you can do this because you've, we've got funding for you to do whatever. Well how come us as Māori can't go over there too, to do whatever? Why do we have to stick to our Māori funding? (Hera)

Frustration about tokenism in the guise of actual responsiveness was common in the responses and quite bravely and clearly described as being a very real way to 'tick' the culturally competent staff box.

> When you have mana, you do what you believe, and you want, and sometimes that means just you doing it on your own and letting the kaumātua do their thing and, you know, and the tikanga, the protocol. So, you go in and everyone is reading out the karakia and, you know, I'm like, oh, geez, can you not just ask the person who is most appropriate out of the management team to do it? To lead it? Why do you all have to do it together? It's not a bloody choir. I just think please, okay, you can sing 'Te Aroha', nice, that's really nice. [A visiting manager] had come from the DHB. And when he got up to talk to us, cos we were talking about Whānau Ora, he said okay, alright then, cos he'd done all his mihi and all that and he said "can you sing anything else except Te Aroha? or is that the only tune you've got up your sleeve?" So, he sort of joked at them and they had another song of course, they had several waiata up their sleeve and I thought oh my god, but it just felt plastic. Always has, always will because of what they've done in the past. They took [Name of Māori service] away. They got rid of kaumātua. I'm not interested in how well they can sing and do karakia. (Piki)

Participants were frustrated with organisations not doing as much as they could to transform systems into ones that are truly responsive to the needs of Māori. Further, they

observed the disassociation of the mainstream from the importance of the key foundations of Te Tiriti relationship and responsibility. As David said, "There's a real lack of appreciation of the Te Tiriti relationship." Many of the participants had observed this:

> I don't care if they put in the job description, you should be culturally competent, aware of the Te Tiriti of Waitangi, cos that's in everybody's job description, you know? And we're a bicultural organisation. That is total lip service, it's token, absolutely token and because in reality they were saying sure, you can be cultural, but you can't be Māori. It's stupid. (Piki)

The observation by Hone was not only that the disconnect and lack of responsiveness to Māori through Te Tiriti practice or otherwise was apparent but that the existing legislation supported the opposite:

> If you look at the public health and disability legislation from 2000 and 2001 it's quite explicit in there that District Health Boards have an obligation to reduce the disparity for our population, especially in Māori health. To acknowledge and respect the principles of our Te Tiriti of Waitangi. To continue to foster and develop, to continue to foster Māori development. To communicate effectively with Māori for the purposes of equity, so the legislative levers are actually in there. Even if you drop it down into the Ministry's operational policy, it's quite explicit. (Hone)

2.2 Recruitment and retention

The lack of institutional understanding and commitment to truly responsive organisational practice – that is, the kind of capacity that is required – is highlighted by work environments that continue to employ non-Māori to lead Māori-focused projects. Many of the participants talked about frustration over the decisions to employ those who lack the specific skills and expertise to work in Māori settings, often in situations where there are Māori staff with those skills and the expertise to fulfil the role but who may not have the same qualifications or 'perceived' capability, even though they are Māori.

> What happens is you get so many applications that it goes through a, um, HR process and I mean DHBs are such a big, it's such a big machine and I mean, you know, these HR people, they don't know anything about, community, community development or health promotion. I mean, you know, who are they to sort of assess who goes through to be short listed and who doesn't? So yeah, I thought that process was, it could have been better. (Liz)

> …there's no real value placed on the recruitment and development of the Māori workforce and I know that because if you look at the evidence, 93% of District Health Board staff is non-Māori, 7% is Māori. And yet as a population we make up 15 to 16% of this country's population. One Māori CEO in the country. So, we know that the way the health system recruits staff favours non-Māori. I'm not saying its bias [against] Māori but it, the evidence shows that it definitely favours non-Māori. I mean, you only have to look at the statistics. (Hone)

Other ways that participants observed that Māori roles were not valued was when positions became vacant and were left unfilled, as Kath highlights:

> So we've had, recently we've had that, we did employ for specific Māori work so yeah, there were, but we've had some changes too so we've lost a couple of positions and they've just not been filled so, for Māori positions, we've got one. One filled position. (Kath)

Hera and Liz both talked about being passed over for jobs or promotions for roles given to non-Māori staff even though their own qualifications matched or were higher than the other applicants:

> A secondment opportunity came up just recently to lead the health promoting team. A secondment position I applied for along with someone else who had applied, and I didn't get the position. The other person, the successful person that got it was in training to be doing the health promotion certificate at this moment. Has a teaching degree but never taught, and less than three years within the organisation at Public Health and got the position. White. Pākehā. (Hera)

> *Liz*: I applied, I applied for roles. I can recall at one particular time I applied for a role I had believed I had the qualifications and what not, the same as others that had only just been in the service maybe for six months or had been shoulder tapped who got the role. And I didn't.
>
> *Interviewer*: Non-Māori people?
>
> *Liz*: Yep. Yep. So that was quite a common occurrence really. (Liz)

Te Atarau spoke of his preference for applying for and working in non-Māori roles as he felt he could be more influential from those positions, but that it was still very hard as Māori to get those non-Māori roles. He described how easy it is to get pigeonholed into Māori roles because you are Māori and that those Māori roles often do not have the influence you would want:

> I think, you know, if organisations, if their recruitment approaches were different and not kind of, I don't know if I'm going off track here, but, if recruitment processes in this country still kind of label and what's the word I'm looking for? You know, corral people into these different, you know what I mean? If we're still seen as, you know, 'Māori who would be great in a Māori role', then those processes kind of immediately take us out of consideration for these non-Māori roles. … I think I'm the exception as one of those who has been, who has managed to be in, like the role I'm in now, to be in non-Māori roles but I'm a Māori. (Te Atarau)

The lack of opportunities for Māori staff progression was evident in the stories. Māori are clearly the minority in senior management roles and less likely to be in positions of influence over decision making on the distribution of funding or human resources capacity.

> I mean you get some people are appointed into positions and they openly declare they don't know anything about how to work with the Māori community. And I just wondered how the hell did you get the job? You know? Because if you don't have that important part, you know, important capability, what is the criteria we are using to appoint people in to positions and they don't have the capability to do that? Fascinating … it shows that it really values non-Māori intelligence. And non-Māori workforces … are we treated differently? Absolutely. I mean, the statistics provide evidence to show that. (Hone)

> So it's about, if, if we're looking at better things, more of that kind of work to go on and that means more Māori FTE, cos, I currently only sit in that [alone], in the public health service and, yeah, those kind of approaches need to be had more often. More workforce development for staff, better recognition, like I said before, of cultural competencies that come with individual staff members, because they're recognised. … So you might have one individual [Māori] worker who sits alongside four [non-Māori] health promoters in their roles, and, so it's, I think we definitely need more Māori FTE in all public health services, all public health units. Yeah. (Kath)

2.3 'Anything Māori is pretty much illegal'

Institutional racism in the workplace appears to exist at all levels in the health system and manifests in multiple forms. Institutional racism is a clear barrier throughout the participant narratives, particularly when it comes to freedom of expression of culture and cultural practice.

> I didn't really wanna go there [the public health unit] cos I was community based, I don't believe in community development, I believe in iwi development, I didn't

> want to go in there because I knew it was racist, before I even got there, as an institution. Some of them weren't even nice people, you know. (Piki)

The convenient ignorance of what constitutes culturally appropriate and culturally responsive practice in PHUs was displayed in actions like the assimilation of Māori into other teams, the isolating of Māori staff from one another, and the consciousness of a need to alter behaviour to appear to be less 'Māori' to reach positions of influence.

> I've always felt that Māori health workers are advocates, they're agitators, they're change agents maybe is a better word these days. They're innovators, they're creators. That's what Māori health, public health should be. Instead we're assimilated, mainstreamed, you know, we're integrated. I haven't seen the amazing results of, you know, how that's affected immunisation rates, quit smoking rates, cervical screening rates, oh my god. (Piki)

> I've tried to sell myself in the DHB as not being Māori. [Of] course, anyone that knows me knows I'm Māori. But you know, again, the way that you try and promote yourself in a DHB election process, you know, promoting yourself as Māori isn't necessarily gonna be a successful outcome for anyone. Which, again, just reinforces the racism that happens in our little, small communities. So, I mean, I feel pretty passionate about it and I think we need more people, probably, to be able to try and take some strong governance roles and hold DHBs to account. But, of course, then there's the Ministry [of Health]. You know, the Ministry's as dysfunctional as anyone. (David)

Institutional racism manifests when organisations require Māori staff to justify their use of organisational resources or time at a much more highly scrutinised level than non-Māori. This demonstrates a pre-conception that Māori staff are more likely to be under-performing than non-Māori staff and therefore should be monitored more closely. Māori staff can end up feeling that they are characterised as problematic or taking advantage or not as valuable.

> …put it this way, I mean, the system is, you know, ingrained in our New Zealand society is institutional racism and I guess the way that, that Māori people are treated differently on a daily basis is that they're not valued in the same way. Our people are not valued in the same way. The capability that our people bring to the table is not valued in the same way. You only have to look at the performance of the system to see that. Performance of the system for non-Māori is awesome so it shows that the system really values the health and wellbeing of non-Māori. Cos it performs really well for non-Māori. It doesn't value the health and wellbeing of Māori in the same way. (Hone)

> So, I definitely believe that as a Māori health worker, most of what we were doing, because it wasn't recognised, because it was under the radar, anything Indigenous or Māori is pretty much, really, when it comes down to it, "illegal". Because you could be punished for it. You could be warned and threatened with losing your job over it, I mean, please. (Piki)

> An example, I recruited a, a young Māori woman at one point who had a bachelor's degree and was studying post grad dip in something or other and the question I got from this manager was, um, does she have a qualification? And it was clear in the advertising, throughout the whole process that he had signed off on, that the person had to have an undergrad degree. So, you know, I felt like saying nah, nah, I just ignored all of that, hired one of my cousins, you know? (Te Atarau)

Haeata, Kath and Hera all talk about the existence of workplace culture that consciously or unconsciously leaves space for interpersonal racism and the unchecked attitudes that influence choices that disadvantage Māori institutionally because of personal judgement based on race:

> It was really hard dealing with, um, you see a lot of the attitudes that you hear about, you know, the, the racism, institutionalised racism. Um, the redneck beliefs that a lot of staff hold. And it's really insidious and it's really, um, under the radar, like, it's not in-your-face racism. It's the side comments, it's the little microaggressions, it's the, um, little comments like 'Oh, you've been working here and they're still the same.' You know, total disregard of where whānau are at and the trauma that they've been through. So, it's all that, those little things that kinda get at you. (Haeata)

> There's all the privilege, white privilege that goes on in the public, goes on in society, as a whole. And it's something you don't get away from in the Public Health Unit so, you know, when Māori have hui, there's a different response to, to when it's not, when it's a mainstream hui. So, people will ask how long is it gonna be, you know, how much are you gonna spend on food, that sort of stuff. So that's, yeah, that's different treatment. (Kath)

> What I have to do in my own mind is continue to do my mahi because I love what I do, be professional with how I can do what I can do, and just suck it up when I don't, you know, or walk away. And that will happen eventually. But in the meantime, I still want to be there. To pay my bills, mmmm, yeah. Um, yeah. It's racism, man. Just racist. I just felt it was like, yeah, I think cos I'm Māori. And I know our Māori director that sits underneath us, I know that she wants more Māori staff to be moving up the chain, moving up the ladder but we, that's never gonna happen in Public Health with the leadership that's there now. It will never happen. And we haven't got a leader up the top who thinks like how we think. They're baldhead. Sorry, sorry. (Hera)

Something Māori do very well is create resources out of nothing. In these interviews there were numerous statements from the participants about how there were no monetary resources but there were always ways found to make things happen when needed. Part of the challenge here is that Māori are so good at making things work that when it comes to resource distribution, it can make it look like we cope with the very little amount we do get.

> I think because South Island has always been the poorer cousin, monetarily, we've always had to do things with a bit of edge and try make it fit, what the community and have it driven from the community. So if you work at a Public Health Unit you can do a lot of that. You can-do cutting-edge stuff, but don't be too Māori. (Piki)

> What is it like being Māori? Pretty challenging, especially in a mainstream generic Public Health Unit. Um, uh, because you're having, for me anyway coming from a Māori worldview sort of framework or base in terms of what I do, in terms of public health, there wasn't really much in terms of tools or frameworks within the unit so you sort of had to, uh, use the generic frameworks or tools and then tailor them relevant to, uh, Māori communities in terms of being able to engage Māori communities. (Liz)

Theme 3. Indigenising / Re-Ordering Public Health

With readily identified barriers to working well in mainstream organisations came recommendations, observations and ideas about how these environments could be transformed to work better for Māori staff. Re-ordering refers to the rebalancing of power and influence to allow Māori perspectives and worldview to be fully appreciated and utilised in genuine ways in a public health setting. Indigenising refers to making space for those perspectives and worldview to be the at the centre, as the norm.

3.1 Environments for success

Hone identified that being deliberate and intentional about how we deliver, and who we listen to in terms of what we deliver, is key to successful public health practice and delivery.

> If that Public Health Unit was going to make the biggest amount of difference for our Māori community then we needed to adopt a more deliberate and intentional approach around getting more of the right intelligence in to our workforce and more people with the right values and more people with the right capability to work within the [named] community. Now, from my perspective a lot of those, uh, those values, that capability and that sort of intelligence we were after were actually from the Māori community. (Hone)

Hone and Liz also highlighted that consideration more broadly within systems such as attention to how capacity is grown and what kind of human resources are employed and that means intentional human resources practice relating to the growth of Māori capacity and competence:

> The other thing I did is that I changed the composition panel so even though I was Māori I always, uh, felt it was important to have a Māori community representative or Māori leader participating on our recruitment panels. (Hone)

> What happens is you get so many applications that it goes through a, um, HR process and I mean DHBs are such a big, it's such a big machine and I mean, you know, these HR people, they don't know anything about, community, community development or health promotion. I mean, you know, who are they to sort of assess who goes through to be short listed and who doesn't? So yeah, I thought that process was, it could have been better. (Liz)

A number of the participants were also clear that the focus needed to be not just about how Māori capacity and competence was understood and catered for but also on ensuring the right kind of competence in non-Māori staff to deliver for our people, given the percentage of non-Māori staff versus Māori staff in the sector.

> If you are working in a place with a high Māori population then you need to make sure that the criteria that you use to recruit is reflective of that … [and] I've got another view, if you're clinically competent, you cannot be clinically competent unless you're culturally competent. It just doesn't make sense. … If you wanna work with our people you have to earn the privilege to work with our people. …Our health workforce needs to, in the same way that I've had to earn the privilege of sitting at the management table, they have to earn the privilege of working with our Māori people in our Māori communities. And that means that they need to develop that capability to do so. But because that hasn't been valued in the past, that criteria isn't, uh, weighted and or really fully explored when people apply. And I know that because when you look across this country at the CEOs of District Health Boards, 19 of the CEOs in this country, of the 20 District Health Boards are non-Māori. We've got one Māori. Uh, when you look at the

> directors of nursing in this country, 19 directors of nursing in this country are non-Māori and we've got one Māori. (Hone)

3.2 Re-appropriating 'Māori-ness'

Steps can be taken to ensure organisations and public health practice are authentic and truly responsive to the needs of Māori by shifting from a position that values only 'mainstream' ideas. This sub-theme is about Māori reassertion to regain space and place in being able to 'be' Māori and insert mātauranga Māori and Kaupapa Māori practice as the norm to strengthen, give balance and provide accountability to the mahi, our way. Piki honours the way her mother, a highly respected kuia in public health in Aotearoa, consistently supported and reminded her to keep in her 'ness':

> I suppose we've just gotta get back to basics and tell it our way cos it's unique. My story is unique, mum's story was unique but hopefully there is a theme that runs through. I mean, it's that Māori, you know, we've got our own whare, you know, I just think it's so important to have them. We've got our own whenua, we've got our own whare, why aren't they there, you know? We don't all have to be nurses and doctors. … Probably why I did survive my mahi is because mum is such a, she was such an action-oriented person and I could be inclined to be a bit more intense and writing reports and then doing research but she would make, no, you can't do that, you're here for the people and you get out there and I was like oh my god. … So, um, yeah, was lucky to be like that, like to get back to the basics. (Piki)

James' kōrero highlighted the need to return to having mātauranga Māori processes in place to ensure the accountability and strengthening of Māori in leadership in public health management:

> Definitely more Māori in management. Having said that we need our own tikanga in place to ensure that we don't have more of the wrong Māori in management. (James)

3.3 Māori leadership and influence within organisations

Participants spoke of the need to be visible in their community, allowing the community to have a say in who best represents them, and the accountability inherent in being in roles that are never about the individual and the 'job' but about the collective success of Māori.

Hone talked about how institutionalised some of our people have become within systems and that we need to shift the levels of influence by inserting more Māori into leadership and other levels:

> I have a philosophical issue with the way that general Māori have really convoluted to a system that privileges the status quo and so we need to challenge ourselves and that's what we'll be doing at our next meeting and, think through what's a better approach, more effective approach and it can't be about the general Māori, it needs to be about what's gonna benefit for the health and wellbeing of our community, you know? How can we make the biggest amount of difference? And to be honest I think that is having more Māori and or people with the right value bases CEO and leadership positions outside of general Māori, to be honest. (Hone)

David spoke of the need to have shared leadership and decision making, and stronger representation in governance:

> Um, so, you know, strengthening governance and ensuring mana whenua, um, structures and accountabilities are in place, I think would be part of the answer, eh? (David)

And Hone identified the need to look at new relevant ways of integrating effective Māori leadership into current systems:

> I think that the Māori GMs are past their use-by date, to be frank. I mean, I think what we really need is to get more effective, uh, senior leadership in place with the right value base. (Hone)

Solid, values-based, accountable Māori leadership was identified as a key component of re-ordering the current system and most of the participants agreed that more Māori in these types of roles of real influence were needed.

Summary

In summary, there were some particularly strong themes that emerged across the participant data. Most especially, the themes highlighted that Indigenous intelligence, mātauranga, being Māori, and operating from the paradigm of te ao Māori are not valued in mainstream public health. For Māori outcomes to improve in this area, there needs to

be a shift in what knowledge is valued. Māori must be able to practice as Māori. A re-ordering of the way public health organisations function, where power sits and how it is used, the levels and places of influence and decision making, and the kinds of knowledge used to define and determine these things need to be imbued with mātauranga Māori in order for environments and service delivery to be functioning in a way that accounts for the pluralistic nature of Aotearoa. These matters will be discussed further in the next chapter.

Chapter 5: Discussion

Introduction

Māori have a unique way of being, behaving and believing that is informed by cultural concepts, protocols and practices; and it is in the conscious creation and normalisation of environments where this freedom to 'be' Māori, as we define it, individually and collectively, that we will see success for Māori in public health and Māori public health outcomes. To do this, we must understand the barriers faced by Māori working in PHUs which prevent the realisation of a fully capable and recognised 'expert' Māori workforce and a truly responsive public health practice.

The research questions for this study were structured to investigate the experiences of senior Māori public health practitioners with a view to understanding the barriers to practice for Māori in mainstream public health institutions/organisations. The rationale was that anecdotal evidence clearly highlighted that barriers are experienced by a large proportion of the Māori in the current public health workforce who work in PHUs. In setting up the study it became clearer through the participant selection process that many of the Māori public health practitioners who volunteered for the study initially had left mainstream PHU services and had not remained in them for five years. The research criteria required participants who had worked in a mainstream organisation for five years or more.

There are clear themes that arose in the analysis of the experiences and observations of Māori employees and the review of the available literature. This chapter focuses on some key points that were generated from the findings of the study. The chapter is formulated into two main themes, 'Valuing Indigenous Intelligence' and 'Health of the Māori Public Health Workforce'. It finishes with a section of recommendations to address the questions

about what can and must be done going forward to support transformative action within the public health sector.

Many of the findings described in the previous chapter are not new to those in the public health sector, but it is important to highlight and discuss them. The aim is to ensure that these experiences are on the record, as they are significant to the overall success of public health service delivery in Aotearoa and, more importantly, the reduction in health inequities for Māori. As discussed in earlier chapters, it is clear that overall the issue of the mismatch or mis-alignment between government systems and Indigenous needs and values is a constant theme (Came, 2012; Came et al., 2015; Coelho & Shankland, 2011). The findings and recommendations emerging from this research can assist Māori public health staff to feel safe and confident in the fact that we are able to do the best work for our people without being personally, culturally and professionally compromised. There is a clear and significant need to investigate and emphasise many of the issues, particularly the experiences of Indigenous public health workers in current mainstream public health settings.

The evidence in this study strongly shows that we must be looking towards creating environments which encourage thriving Indigenous workers. Māori come to work in public health in several ways. Many find themselves there by default, often acting on values inherent to being Māori such as manaaki, caring, helping others without expectation of return, collectivism, and service for the greater good are concepts and values embedded in te ao Māori, whānau, hapū and iwi, be they urban or rural, traditional or contemporary manifestations. This ‘drive to serve’ is demonstrated often through action and engagement (Durie, 2018; Ratima et al., 2007). Public health is an area that Māori people find themselves working in because we want to help our people thrive – it is about whole populations, hauora-a-iwi. Most of the participants spoke of not having

had the intention to work in public health but that they had a duty or role to play in supporting our people to be self-determining and living healthier, longer lives and therefore came to work in the public health sector as a natural fit.

Giving serious attention to identifying and addressing barriers to practice, including the "deleterious psychosocial hazards" (McCluney et al., 2018, p. 3) of current mainstream PHU operations, is the key. To do this requires continuing to hold a microscope over these persistent systemic failures. The kōrero of the participants has clearly affirmed the existence of institutional racism in PHUs at multiple sites. Institutional racism has been defined as pattern of differential access to material resources and power determined by race which advantages one sector of the population while disadvantaging another (Came 2012). So, although some participants specifically named racism as they described some of the barriers and challenges, others described patterns of behaviour and systemic bias that clearly meet the definition of institutional racism (Jones, 2003). The findings revealed an opportunity to positively acknowledge, highlight and promote the strengths of te ao Māori as beneficial not only to Māori working in PHUs but to public health practice in Aotearoa. This study has identified some key learnings for the sector, including understanding how to best demonstrate the valuing of mātauranga, having authentically responsive recruitment and retention practices, and having workforce development and capacity building which reflect the population and its actual needs.

The continued failures of our colonial system of health to create and support equity for Māori are contrary to article three of Te Tiriti o Waitangi awarding the 'same rights and privileges of British citizens' to Māori. Any truly responsive public health practice and service provision must be underpinned by Te Tiriti o Waitangi as the defining blueprint for equity in Aotearoa, and the obvious framework for practice which it provides, to give structure and depth culturally, spiritually and physically to that practice (Berghan et al.,

2017; Came et al., 2015), It is obvious that Māori are not experiencing the equity afforded by that document, and there are still many problems to be solved in our health system before we get to a place of genuine equality (Came, McCreanor, Doole, & Rawson, 2016; Came, McCreanor, Manson, & Nuku, 2019; Waitangi Tribunal, 2019).

Valuing Indigenous Intelligence

This section puts the focus on what is illustrated by the narratives of the participants. What is clear from the kōrero is the importance of valuing Indigenous intelligence to authentically ensure that Māori public health and public health practitioners can practice in a culturally safe work environment that recognises that intelligence as best practice (Dumont, 2002). Hudson (2004) highlighted the lack of value placed on Māori/Indigenous intelligence:

> Despite increasing acknowledgement of the Te Tiriti of Waitangi and Māori rights to fully participate within the structures of society, Māori expertise and Māori Knowledge have not yet been recognised as having the same validity and legitimacy as western knowledge. (p. 131)

This study shows that in the 15 years since Hudson wrote this, little has changed. The very recent *Wai 2575 Report* (Waitangi Tribunal, 2019) also supports claims that not enough value has been placed on Māori health initiatives or services that truly support or operate from a Māori worldview.

The stories of the participants highlighted that they feel undervalued, that their Indigenous intelligence and practices are not recognised in public health as valid mātauranga or skill, even though it is rhetorically understood to be ‘specialist’. I would argue that this study shows that Māori must be remunerated accordingly, that Indigenous/Māori intelligence be acknowledged as an equally valid approach to service development and provision, and that the skills that come from te ao Māori are specialist and therefore valuable. This study found the current practice in the sector, as observed by the participants, does not align

with this view. Within the kōrero around 'value' there arise themes of lack of representation, such as the size of the Māori population not being reflected in workforce numbers, leadership positions being few and far between, feeling like the 'poor cousin,' and not having equitable access to resources and professional development. Even though equity rhetoric flows through government reports and frameworks year after year, it is not reflected in practice within the system (Health Safety and Quality Commission, 2019). Every participant in this study had experienced challenges in practice or in access to resources either for themselves or for other Māori staff in their charge. Overall, they also spoke of understanding from experience and knowledge of the sector that funding for Māori initiatives, workforce capacity and workforce development were plainly not at the level required to address the need. Truly Māori ways of being and thinking are not present in mainstream services; the current workforce experiences a continued lack of resourcing, and this is evidently low on the priority list of the current PHU system and those who make the decisions within it (Jeffreys & Zoucha, 2018; Leininger, 1991).

A solution to the issue of undervaluing Indigenous intelligence is to create a shift in the practice environment of PHUs. An environment that supports Māori staff and aims to meet Māori health aspirations would elevate Indigenous worldviews and practice to a higher level of importance, at least to the same level as any other paradigm or theory of practice, if not beyond that. It is clear from this study and through the literature that broader Indigenous health outcomes are affected by colonisation, particularly its systemic deculturation of Māori. I would suggest that the participants' stories and the literature have painted a picture of PHUs that continue to minimise – not prioritise, resource or remunerate – the skills and mātauranga of Māori in line with their importance, and portray a system of operation that is based on western frameworks and ways of thinking that do not authentically honour the Te Tiriti or properly address Māori inequities.

I would argue that recognising and re-engaging with Te Tiriti as a framework for working in true partnership is an essential part of improving the overt valuing of Indigenous intelligence in Aotearoa. Both the literature and the participants highlighted the importance of increasing the capacity of non-Māori to discern how to make space accepting of the reality that there is more than just one worldview that is valid (Came, 2012; Came et al., 2015). I would argue that this is about creating space for the emergence of an understanding that it is not necessary to behave and act from within a western paradigm to achieve the best outcomes, particularly where Māori are concerned. Along with that is the importance of non-Māori understanding where they should position themselves to best contribute to success for Māori.

How financial and human resources are prioritised in ways that affect the recruitment and retention of Māori staff is another key area to address. Human resources procedures that lack the appreciation of the importance of Indigenous intelligence, culture and identity in current services was a key theme in the kōrero from the participants. This is supported by Durie (2003) and Haar and Brougham's (2011) research on Māori workplace satisfaction. Improving human resources practice provides another opportunity to address a significant layer in the under-representation of Māori in PHUs. Addressing how people are hired, how roles are defined, who is doing the hiring and what the job descriptions look like are all areas that can begin to shift the currently problematic practices of PHUs. The findings clearly show that Māori feel undervalued, yet they know the area of public health work addressing Māori health inequities is under-resourced and lacks capacity, particularly in relation to sector leadership and influence in decision making. The participants noted that there is some ability to be involved in recruitment, particularly at candidate interviews, but there is little real influence over decisions about which positions are required to be created or permanently funded. Limited funding streams often mean Māori roles are left unfilled or defunct after they have been vacated, seemingly without good reason when

the consistent kōrero is that there are not enough staff or positions to address the needs of the community. Therefore, questions need to be asked about who is making the decisions and given the data on burden of disease, and who is really making the calls about resourcing in the sector. The answer, apparently, is not Māori.

The available literature regarding Indigenous and Māori public health is currently sparse. There is little that mentions or directs attention to the idea that Indigenous knowledge is a valid, remunerable capital and a significant primary knowledge system for addressing the needs of Indigenous people. The idea that Indigenous knowledges provide an offering to the broader population has not yet found proper purchase.

There is a space here where there needs to be significantly more research and evidence to highlight the value of Indigenous knowledge to public health approaches. The focus needs to be on increased workforce capacity and all-round system efficacy to improve equitable Māori health outcomes.

Health of the Māori Public Health Workforce

The mismatch between current government systems and Indigenous needs and values is consistent in this research and in the literature (Came, 2012; Came et al., 2015; Coelho & Shankland, 2011). This observation is further strengthened by the most recent official reports, *Te iti me te Rahi* (McClintock et al., 2018) and the *Wai 2575 Report* (Waitangi Tribunal, 2019). Both reports have identified the obvious need for growth in Māori leadership in the health sector and increased Māori workforce development. Building leadership capacity by growing the number of Māori who hold executive power and increasing the types of senior leadership roles that have actual influence within organisations was identified as a priority by the participants. This is a strategy that will begin to shift the prevailing theory underpinning practice by increasing te ao Māori

approaches. In turn, the sector will be able to understand its place more easily in addressing inequity for Māori through firstly addressing its own inequitable set-up. Institutional racism, as discussed above, is interwoven into the issue of the inequitable distribution of leadership positions for Māori and must be simultaneously addressed.

The participants described an unreasonable expectation placed on Māori PHU workers who are often forced to wear multiple hats and all the while make their cultural identity fit into the framework of the organisations they work in (Wilson & Baker, 2012). The expectation that we must 'break out the brown' when and where it suits the organisation, just because we are Māori, completely compromises cultural integrity and authentic practice. Furthermore, dissonance was experienced when, on one level, the participants were asked to perform a ritual or ceremony on request but were not afforded financial recognition for those attributes nor offered access to cultural support to maintain those skills. This is also associated with the finding that the recognition of culture and identity is key to Māori workplace satisfaction and success (Haar & Brougham, 2011). Thus, the presence and performance of culture and identity are interwoven with the health, wellbeing and sustainability of Māori staff. Durie (2003) referred to the need for the understanding that "meaningful employment requires a coming together of aptitude, preparedness, opportunity, and cultural identity" (p. 514).

The need for social and cultural support in the workplace was affirmed by the participants. I would argue that this need is consistent across the significant workplace areas Māori inhabit, that is healthcare and social assistance, education and training, manufacturing, utilities and construction, wholesale and retail (Ministry of Business, Innovation & Employment, 2019). The literature suggests that Māori are best employed in areas that support a collectivist culture of success (Durie, 2003; Haar & Brougham, 2011). The participants in this research spoke about actions such as the removal of kaumātua from

the PHU ecosystem, thereby reducing access to an essential part of the social accountability, responsibility, and cultural and emotional support fabric of te ao Māori for Māori staff who value and respond to these supervisory roles as a necessity. PHUs that have a lesser understanding or regard for understanding how Māori capacity is successfully grown, nurtured and promoted can end up isolating Māori staff and making whanaungatanga and peer support challenging to find. This can be addressed by ensuring PHUs have numbers of Māori in decision-making, leadership, and other roles of support for Māori staff that reflect the cultural and population make-up of the communities they serve. This research suggests that low numbers of Māori at the decision-making table equates to an environment where Māori are less likely to receive the cultural and social supports that are necessary to thrive in PHUs. It is a major challenge to manage one's own innate being within these mainstream public health systems. The idea of being Māori not 'doing' Māori and the massive chasm between the two needs to be unpacked further in this context of workplace success and wellness. The words in Māori 'He Māori ahau' ('I **am** Māori') refer to a state of being, not doing. Māori might also say 'we are who we are', meaning that the Māori identity is not a cloak we put on and take off. Rather, it is a holistic approach to living and being that requires inclusivity, collectivism and a connectedness to environments that cannot be separated and upon which, traditionally and even in contemporary contexts, survival is highly reliant (Durie, 2006; Durie, Fitzgerald, Kingi, McKinley, & Stevenson, 2002; G. H. Smith, 1990, 2003). 'Doing' Māori, as alluded to by the participants, is the state of being generally expected to function in the workplace without the freedom to practice in a Kaupapa Māori way, but being expected to pull out the 'brown' bits when the PHU requires it. Examples the participants gave included leading karakia, doing the karanga or teaching all the staff te reo Māori. Hand in hand with this is the notion that one will be responsible for these 'Māori' actions, but the understanding and valuing of these cultural skills is not recognised. As discussed

above, accessing funding for maintaining or furthering mātauranga as professional development is often challenged or not prioritised. The experiences of the study participants were that Māori staff are expected to 'perform' Māori ritual and protocol but not allowed to 'be' Māori. Research by Haar and Brougham (2011) has clearly demonstrated the connection between greater workplace satisfaction and commitment to the workplace which occurs when Māori feel culturally supported. Therefore, it would be simple to conclude that when Māori feel valued and culturally empowered, they would be more likely to remain in workplaces like PHUs.

Recognising, Mitigating and Eliminating Damage, and Platforms for Success: Recommendations

The recommendations from this study include short-, medium- and long-term approaches that could effect sustainable change in PHUs and the wider public health sector. They reflect the need to ensure that organisations recognise and rise to the challenge of acknowledging and addressing the institutional racism that affects the authentic function, responsiveness and support of Māori staff and outcomes. It is important to understand the damage that occurs by persisting in operating in a way that allows cultural erosion, seemingly with little desire to implement solutions. This research illustrates the enablers and barriers to success for Māori working in PHUs in Aotearoa. In response to these findings, it is necessary to actively implement solutions that mitigate the situation or, better yet, create solutions that prevent those damaging situations or environments from existing in the first place.

Table 3: Short-, medium- and long-term recommendations for change

Timeframe	Recommendation
Short term – working within the current system	• Immediate growth in the number of Māori in executive or senior leadership roles • Increase research on Māori public health workforce satisfaction, Māori public health models of practice, Te Tiriti o Waitangi (TOW) as a framework for practice • Implement TOW as a compulsory framework for public health practice in Aotearoa • Expansion of mātauranga professional development for Māori workforce • Expansion of TOW and anti-racism training for non-Māori workforce • Cultural supervision/professional development as a normal lifelong practice requirement for non-Māori • Professional development for Māori staff that includes cultural development, supervision, access to kaumātua and other sources of mātauranga • Acknowledge and address institutional racism as a barrier to Māori equity
Medium term – working with the current system	• Recognition of Māori intelligence/cultural capital as a legitimate and specialist skill-set that is appropriately remunerated • Human resources practices, policies and procedures equipped, educated and designed to o understand how to recruit effectively o ensure roles are filled by people with skill-sets truly responsive to the needs of Māori, and o manage and promote Māori staff development • Devolving funding to Māori public health providers/ creation of Māori public health providers or Māori PHUs to be reinstated and equitably funded to reflect the need of the community they serve, i.e., more than other populations whose needs are less • Specific accountability measures on the requirements for procurement and contracting, i.e., current public health tier one service specifications and *Te Uru Kahikatea* (Ministry of Health, 2007) public health strategy for workforce development

Long term – total system change	• Systems that recognise Māori intelligence/cultural capital as legitimate and credible knowledge systems as a base for best public health practice
	• Organisations that ensure Māori and non-Māori staff
	  ○ actively maintain strong ties to the Māori community
	  ○ are actively involved in relationships that support and inform our Māori public health workforce, and
	  ○ are actually recognised as a vital part of the support and information ecosystem of public health system and community
	• TOW framework-driven health system

Much more research needs to be undertaken to add to the growing body of evidence of the manifestation of institutional racism, and the impact of institutional racism on Māori staff, in all health service work environments, expanding into human resources practices affecting Māori working in the health system.

This research indicates a need for professional development support in areas such as mātauranga Māori, knowledge of te ao Māori, both historical and contemporary, and te reo Māori, as equal to other 'knowledges'. Many of the participants spoke about the challenge of having these things acknowledged as important to their work. I would argue that alongside this is a need for more relevant and specific accountability measures in the requirements for procurement and contracting, such as current public health tier one service specifications and *Te Uru Kahikatea* public health strategy for workforce development (Ministry of Health, 2007). This would encourage more in-depth engagement by non-Māori in upskilling and capacity building regarding Te Tiriti o Waitangi, anti-racism training and other te ao Māori professional development as a requirement for individual practitioners and organisations.

These changes would then lead to the implementation of systems change approaches. This would start with increasing the amount of evidence that supports systemic transformation

and scoping to investigate such a transformation; and/or the devolving of funding to Māori public health funding providers; and/or the creation of Māori public health funding providers consistent with the most recent findings regarding primary health care in the *Wai 2575 Report* (Waitangi Tribunal, 2019).

Conclusion

The data from this study is clear: there is a paucity of studies directly on Indigenous/Māori public health staff experiences in mainstream organisations – that is, PHUs. The emerging work on workplace satisfaction, linked with literature and participant experiences and observations of barriers, such as the undervaluing of te ao Māori, Kaupapa Māori approaches and Te Tiriti o Waitangi that can be defined as institutional racism, exposes the need to call for serious action to address those issues. This study serves to demonstrate that a meaningful and sustainable approach to removing these barriers to workforce success for Māori needs to occur, in a way that brings Indigenous intelligence to the front. Through this significant action, we may begin to address the inequities that, shamefully, continue to exist in New Zealand through a strengthened and authentically responsive public health workforce and improved approach to public health service provision. Research is needed to fill the knowledge gaps about strategies to mitigate damage to Māori public health staff and to transform service delivery. The ultimate goal for research like this is to positively reduce the public health inequities that have been consistently experienced by Māori whānau by expanding and supporting a thriving, culturally strong, expert Indigenous workforce in a system that understands its responsibilities to, and the value of, Indigenous intelligence. The re-ordering and Indigenising of public health spaces will be for the benefit of Māori within the system and beyond it.

Chapter 6: Conclusion

The impetus for this study was to contribute to the small yet growing body of evidence in Aotearoa that shows the systemic barriers to health equity for Māori. The aim was to look at the experiences and observations of senior Māori practitioners of working in PHUs in Aotearoa in order to identify the barriers to successful practice and the factors that contribute to Māori success in these environments. The seed for this study was originally planted by my own experiences and observations of working in a PHU, and conversations with my contemporaries about their experiences and observations that supported my own.

The evidence of ongoing Māori health inequities is well documented, and the history of these inequities and their relationship to continued breaches of Te Tiriti o Waitangi has been clearly outlined in the Waitangi Tribunal's (2019) *Wai 2575 Report* focusing on primary health care provision. Establishing the links between institutional racism and barriers in public health (Came, 2012) and the link between cultural validity and workplace satisfaction (Haar & Brougham, 2011) in Aotearoa are an important starting point for this present study, but there is a need for much more.

In the first instance in this study, four main areas were investigated through a literature review:

- Indigenous experiences working in public health,
- Māori health workforce,
- Institutional racism in health/public health as barriers to success in public health, and
- Success for Māori in public health / success for Māori / workplace satisfaction.

It was clear from the review that there is a paucity of international or national writing about the experiences of Indigenous/Māori staff working in mainstream public health and

even less when looking specifically at PHUs here in Aotearoa. Identifying the gaps here supported the need for this and much more research to be conducted in this area.

The research took a Kaupapa Māori approach, driven by the values of tika and pono. It followed a qualitative process of data collection that consisted of 10 face-to-face or online audio-recorded interviews. Participants were asked a series of semi-structured questions and all the interviews were approximately 1 to 1.5 hours in duration. A thematic analysis was used to analyse the data.

As the data from the interviews was analysed, three main themes were distilled:

- Valuing Indigenous Intelligence,
- Encountering Institutional Racism, and
- Indigenising/Re-Ordering Public Health.

The findings clearly showed that restrictions on Kaupapa Māori practice and cultural freedom in the workplace were being experienced and/or observed by all the participants. Further, the dismissiveness towards or lack of value placed on mātauranga Māori, Kaupapa Māori practice and te ao Māori worldview was inherent in all the kōrero. So, too, were observations of inconsistencies in human resources practices involving hiring for capacities that required te ao Māori knowledge but not prioritising or valuing those skills. Indeed, other types of knowledge and mainstream qualifications were preferred, and non-Māori staff appointments were often made for roles that largely affected Māori. Observations of imbalances in resourcing for professional development or for Māori projects generally sat alongside a general observation that things Māori were not being valued. The existence of institutional racism within these environments was explicit and implicit in the korero. Often, the barriers that were described could be defined as institutional racism even if they were not clearly identified as such; this is supported by the literature that is coming out of Aotearoa and is an area that needs further research and

anti-racism training. Leadership was a significant area for consideration, with participants and the literature both highlighting the need to grow the capacity of the senior Māori workforce as well as the whole Māori workforce. This has been an ongoing issue over many years and is of concern when non-Māori lacking cultural competence take on Māori leadership roles in these organisations and someone Māori who has the skill-set would be more appropriate. Such approaches reflect a level of continued 'tokenism' by organisations when they do not ensure they understand cultural competency. There is a frustration in Māori staff at the continued lack of progress within these organisations toward actively understanding and becoming truly responsive to the needs of Māori staff in PHUs and Māori health outcomes. The observation is that Te Tiriti o Waitangi continues to be held in low regard and that it should be authentically used to increase competency and responsiveness as a framework for practice, as described in the literature.

In summary, these findings illustrate a public health sector that could do much more to ensure it is addressing its Tiriti responsibilities, addressing Māori health inequities and supporting environments for Māori staff to contribute from a place of tino rangatiratanga and mana Māori motuhake. The data and the findings from this thesis will be utilised to write further papers for publication.

The study was limited in scope by the focus being only on PHUs. It would be useful to include a wider view of the health sector at large and a larger sample size to investigate the transferability of these findings. More in-depth views on human resources practices and on policies and procedures would also have added value to these findings.

Māori have had and continue to have greater political influence than any of our Indigenous cousins globally because we have a Tiriti that remains in place and, under Article Three, gives us the 'same rights and privileges as British citizens'. It is from this foundation that we claim tino rangatiratanga and mana Māori motuhake, to point out the

hypocrisy of and inconsistency in the continued dismissal and undervaluing of Indigenous knowledge systems. Institutional racism is woven throughout this entire picture of the public health sector. How it affects practice and outcomes for Māori needs to be a significant focus for any future changes for the Māori public health workforce.

We must openly continue to stoke the fires of this conversation, ask questions and provide evidence, seek and find solutions and not stop requiring the current systems of governance and decision making to value Indigenous intelligence and practice in public health. Make it ‘business as usual’ and, most importantly, ensure the success of Māori.

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Appendices

Appendix A: Ethics approval letter

AUTEC Secretariat

Auckland University of Technology
D-88, WU406 Level 4 WU Building City Campus
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

11 July 2016

Heather Came
Faculty of Health and Environmental Sciences

Dear Heather

Re Ethics Application: **16/221 Sites of institutional racism in human resources in mainstream public health in Aotearoa New Zealand.**

Thank you for providing evidence as requested, which satisfies the points raised by the Auckland University of Technology Ethics Committee (AUTEC).

Your ethics application has been approved for three years until 11 July 2019.

As part of the ethics approval process, you are required to submit the following to AUTEC:

- A brief annual progress report using form EA2, which is available online through http://www.aut.ac.nz/researchethics. When necessary this form may also be used to request an extension of the approval at least one month prior to its expiry on 11 July 2019;
- A brief report on the status of the project using form EA3, which is available online through http://www.aut.ac.nz/researchethics. This report is to be submitted either when the approval expires on 11 July 2019 or on completion of the project.

It is a condition of approval that AUTEC is notified of any adverse events or if the research does not commence. AUTEC approval needs to be sought for any alteration to the research, including any alteration of or addition to any documents that are provided to participants. You are responsible for ensuring that research undertaken under this approval occurs within the parameters outlined in the approved application.

AUTEC grants ethical approval only. If you require management approval from an institution or organisation for your research, then you will need to obtain this.

To enable us to provide you with efficient service, please use the application number and study title in all correspondence with us. If you have any enquiries about this application, or anything else, please do contact us at ethics@aut.ac.nz.

All the very best with your research,

Kate O'Connor
Executive Secretary
Auckland University of Technology Ethics Committee

Cc: Emma Rawson, manukahuassociates@gmail.com

Appendix B: Participant information sheet

Participant Information Sheet

Date Information Sheet Produced:

24 May 2016

Project Title

Sites of institutional racism in human resource practices in public health units in New Zealand.

An Invitation

We would like to invite you to participate in this study which investigates how institutional racism manifests in human resources practices in public health units in New Zealand. If you accept this invitation your participation is voluntary, and you may withdraw at any time prior to the completion of data collection. There are no foreseeable conflicts of interest. However, if at any time during the study you feel uncomfortable or have concern please feel free to notify the researchers. Please note, that whether you choose to participate or not will neither advantage nor disadvantage you. This research will not be contributing to the completion of a qualification.

What is the purpose of this research?

The purpose of this study is to identify how institutional racism manifests in human resources practices in public health units in Aotearoa by investigating the experiences and observations of senior Māori public health practitioners who work or have worked public health units for five years or more. This is information will inform a Masters of Philosophy Thesis that will critically examine and highlight the sites of institutional racism and how it manifests in human resources practices in public health units.

How was I identified and why am I being invited to participate in this research?

The study is open to senior Māori public health practitioners' male and female, who work or have worked in public health units for five years or more. The researcher, supervisor and research whanau have identified people and networks who may who may have this experience and sent a general invitation to those people and networks with the explicit understanding that participation will be voluntary.

What will happen in this research?

This study is a voluntary interview with key informants who work or have worked in public health units for 5 or more years. The questions focus broadly on practitioners' experiences of institutional racism in PHU, How institutional racism manifests in human resources practices, Which of these practices are most affected, how Māori staff access professional development and other resources, and how does this affect Māori staff employment and retention.

This interview will be carried out by Emma Rawson from Auckland University of Technology as a Master of Philosophy Thesis only research project.

The interview is a likely to take around 45 minutes. Interviews will be recorded and transcribed then sent to participants to review and confirm.

What are the discomforts and risks?

The subject matter is challenging and may be evocative of strong feeling within the interview. The participants are encouraged to seek advice through workplace or peer supervision before agreeing to participate if discomfort or risk is anticipated or if this raises issues during or after the interview.

How will these discomforts and risks be alleviated?

Participants are welcome to speak with the research supervisor to discuss and issues that arise. The option of confidentiality is in place to mitigate any risk of the participants or their contributions being known by their workplace. Participants will have the choice of being identified or choosing a pseudonym if they wish there details and contributions to remain confidential

What are the benefits?

This research is being conducted as a Masters of Philosophy project.

How will my privacy be protected?

To maintain participants' privacy and confidentiality throughout the study participant anonymity will be preserved unless the participant chooses to be identified. The research team will have access to the data during the collection and analysis stages. The data will be kept securely for the time stipulated by AUTEC. Security includes the double locking of data (locked office and file cabinet) in University storage. Data will be stored up to seven years and then destroyed according to AUTEC protocol.

What are the costs of participating in this research?

There are no probable costs to the participant (tangible/psychological) while participating in this research. The time cost will be 45mins -1hour for the interview.

What opportunity do I have to consider this invitation?

Participants will have a two week window to consider participation in the study. Participants can opt in to the research through completion of the interview and opt out of the research process until the end of August 2016 by notifying the principle investigator. If participants opt out their transcripts and other documentation will be returned

How do I agree to participate in this research?

After reading the participant information sheet and you feel as though you would like to participate in the study, please contact the research team. Written and Oral consent will be taken for this study at the time of the interview.

Will I receive feedback on the results of this research?

When the research is complete a summary of findings will be distributed to the participants.

What do I do if I have concerns about this research?

Any concerns regarding the nature of this project should be notified in the first instance to the

Project supervisor: Dr. Alayne Hall : **Phone:** +64 9 921 9999 or **Email**: alayne.hall@aut.ac.nz

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Kate O'Connor, *ethics@aut.ac.nz* , 921 9999 ext 6038.

Whom do I contact for further information about this research?

Please keep this Information Sheet and a copy of the Consent Form for your future reference. You are also able to contact the research team as follows:

Researcher Contact Details:

Principle investigator: Emma Rawson: Phone: 027 6325 763 or Email: manukahuassociates@gmail.com

Project supervisor: Dr. Alayne Hall : Phone: +64 9 921 9999 ext 7115 or Email: alayne.hall@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 11 July 2016 , AUTEC Reference number. 16/221

Appendix C: Consent form

Consent Form

Project title: ***Sites of institutional racism in human resources practices in public health units in New Zealand.***

Project Supervisor: ***Dr Alayne Hall and Professor Denise Wilson***

Researcher: ***Emma Rawson***

- I have read and understood the information provided about this research project in the Information Sheet dated 01 June 2016.
- I have had an opportunity to ask questions and to have them answered.
- I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- I understand that I may withdraw myself or any information that I have provided for this project at any time prior to completion of data collection, without being disadvantaged in any way.
- If I withdraw, I understand that all relevant information including tapes and transcripts, or parts thereof, will be destroyed.
- I understand that if I do agree to participate any notes , recordings and transcriptions will be kept for a maximum seven years as per the AUTEC guidelines and could be used to inform the writing of further papers, presentations or journal articles.
- I agree to take part in this research.
- I wish to receive a copy of the report from the research (please tick one): Yes○ No○
- I wish to be named / not named as a participant in the research

Please sign if you understand and agree with the above.

Participant's signature: ……

Participant's name: ……

Participant's Contact Details (if appropriate):

……..

……..

……..

……..

Date:

Approved by the Auckland University of Technology Ethics Committee on 11 July 2016

AUTEC Reference number 16/221

Note: The Participant should retain a copy of this form

Appendix D: Research questions

Research Questions

Where? / How Long? / Where? / What kind of organisation are you in now?

- What is it like being Māori in a PHU?
- Why did you choose to work at a PHU and what keeps you there or made you leave?
- To what extent can you influence things within your work environment?

Tell me more about that

Human resources

What have been your experiences of…?

a) Accessing professional development opportunities
b) Promotion opportunities
c) Recruitment practices
d) Performance management and disciplinary procedures

To what extend do the DHB policies and procedures enable Kaupapa Māori practice?

Racism

Tell me about a time when you were working in a PHU when Māori were treated differently?

Can you think of time while you have been in the PHU where you have experienced?

a) abuse of power
b) disadvantage
c) levels of discomfort and/or violence
d) racism

Tell me more about that?

Resilience/ Thriving

To what extent are you able to access the resources need to deliver quality programmes to Māori communities?

How do you keep yourself culturally safe in a PHU?

What sorts of things are in place or would you like to see in place?

What cultural support is available for you in your workplace?