

Mahi Ngātahi: Culturally responsive ways of working with whānau accessing Well Child/Tamariki Ora services

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Abstract

Well child/tamariki ora (WCTO) services in Aotearoa provide child and family health services to over 90 percent of families with children under five years of age. Feedback from Māori consumers across the health sector describes experiences of institutional racism and unconscious bias. The feedback from whānau accessing WCTO services is no different. Māori as Aotearoa New Zealand's Indigenous people and partners to Te Tiriti o Waitangi are entitled to experience the same level of health and wellbeing as non-Māori. However, research and growing health disparities indicate that this is not the case. It is thought that by increasing health professional and organisational cultural responsiveness, Māori will be more likely to connect with WCTO services in meaningful ways and in turn, experience better health outcomes.

The intent of this research was to provide a theoretical explanation for health professionals working together with Māori in a WCTO context. The study was designed to identify what matters to whānau engaging with services mandated to support families with young children. The research question was, 'what are the processes involved for working together in a culturally responsive way with Māori accessing WCTO services?' A kaupapa Māori methodology and constructivist grounded theory methods research design was used to develop a theory for culturally responsive WCTO services. Eighteen whānau (35 participants) with children under five were interviewed about their experiences with WCTO services.

Mahi Ngātahi – a theory for culturally responsive well child/tamariki ora services was constructed which explained whānau experiences in their interactions with WCTO providers. *Doing 'to' whānau, diminishing whānau mana and getting what whānau need* were identified as core categories of the theory. Based upon this theory, **Mahi Ngātahi - A cultural responsiveness framework for WCTO services** was developed to depict the steps involved in providing culturally responsive WCTO services to whānau, within a whānau context. The cultural responsiveness framework outlines three stages – (1) *connected*, (2) *included* and (3) *culturally safe*, as the processes involved in providing culturally responsive WCTO services. The cultural competence progression of the practitioner is also identified as contributing to culturally responsive WCTO service delivery.

Whānau in Aotearoa want WCTO services that they see themselves in. They want a service that meets them where they are rather than one that judges them against predetermined outcomes. This research reinforces the need for a reduction in organisational silos and highlights relationship building as fundamental to the provision of services that meet whānau needs.

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Whiti ora ki te whei ao
Kia te ao mārama
Whiti ki runga, whiti ki raro.
E ngungu ki te pōhatu
E ngungu ki te rākau
Tītaha ki tēnei taha
Tītaha ki tērā taha.
Tihei mauri ora.

Prayer for the beginning

*Cross over to life in the changing world
In the world of light and understanding.
Cross upwards, cross downwards.
Turn to the rock
Turn to the tree
Leaning to this side
Leaning to that side.
Sneeze forth the breath of life.*

Life has changed for me significantly from the day I embarked upon this research and I thank everyone I have known along the way for the encouragement, the challenges, the lessons, the laughs, the conversations and the shoulders to cry on. I am in the fortunate position of having many people to acknowledge for supporting me in this journey and for the gifts offered to me throughout this process.

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The mind can go in a thousand directions, but on this beautiful path, I walk in peace. With each step, the wind blows, with each step, a flower blooms.

- Thich Nhat Hanh.

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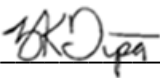
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Attestation of Authorship

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: Zoë Tipa

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Ko wai au?

Te Kohurau te mauka
Arai te Uru te waka
Arai te Uru te tai
Oraumoa te awa
Poutaiki te pā neherā
Moeraki te kaika
Kai Tahu me Kahungunu ōku iwi
Ko Zoë Tipa ahau
Tēnā koe

Culture is what makes us fundamentally different from each other. It would be very difficult to find two people who are influenced by the same collective of cultural groups, values, beliefs and practices - yet we homogenise cultural groups to either include or exclude people. Throughout my life, I have struggled to define my own culture. I thought it needed to be considered exotic to gain recognition or suppressed to avoid negative responses from others who may not agree with my decisions or way of life. Despite this, I have persisted with a slightly antagonistic worldview that refuses to 'compartmentalise' aspects of myself into categories. This includes the values and beliefs I currently hold relating to each facet of my identity, such as what it is to be Māori, what it is to be a woman and what it is to be a nurse.

What I have discovered is that not many people like to be categorised into a checklist of norms that determine membership in specific cultural groups. Yet we continue to do this to people, as if their way of being is a variance or a perspective on a standardised 'norm'. The movement towards cultural safety in nursing was inspirational. It challenged the practice of herding people into 'cultural collectives' and theoretically turned the tables on the power dynamic that underlies the 'provision' of nursing care by asking the recipient of the service to determine whether or not it was appropriate. So, with this understanding, why do people still feel 'done to' by health services? Why does it work for some and not others?

I was recently supporting a family member who had just had a baby. I noticed some different nursing approaches to supporting her with breastfeeding as she had established that this was how she wanted to feed her baby. One nurse sat down and told her to "relax" and "just enjoy every moment of being a mum". One nurse came in and forcefully rearranged pillows in an almost origami type fashion and managed to get the baby latching and feeding - but leaving the mother fearful and uncertain about how she will replicate this at every feed. Another nurse came in and took the time to listen to what was going on. She acknowledged about how hard

things were and that people would not want to sign up for this if they knew what it was really like. She then offered some practical assistance that resulted in the baby latching easily and feeding well and the mother feeling more confident to do this alone. This nurse intuitively knew that the mother needed some straightforward, practical advice and offered the use of a feeding aid. She checked in as to whether this would be something the mother might be willing to try, however was then required to complete a rigorous process of obtaining signed consent, locating the equipment and having to justify the use of the aid to her colleagues.

Culturally safe care is not a checklist of 'cultural norms', nor is it applying your own way of being in the world onto someone else. It is about metaphorically meeting someone in the space they are in and working alongside them to determine a way forward. It requires an ability to 'park' your own positioning. This is difficult when the information health professionals are asked to discuss sits in opposition to recipient's needs. If nurses are not sharing messages as intended, then from an organisational and political perspective, they are not doing their job. In contrast, when the recipients of care are confronted with information that challenges their beliefs or the way they have been doing things (that is, their cultural values), they unsurprisingly often become defensive, sometimes angry and very likely to disregard any future information shared with them.

To work in a culturally safe way with everyone, the systems that measure organisational outputs and outcomes need to reflect better the diverse realities of culturally safe practice. For the nurse to provide the practical assistance required by the mother in the example above, she needed to obtain written consent for the use of a feeding aid and justify her decision to her colleagues. The action of obtaining written consent for an intervention such as this, and the requirement to justify this intervention implied to the mother that she was somehow not capable of doing what she 'should' be doing and that the organisation is not taking responsibility for her inability to breastfeed 'normally'. This is a subtle example of organisational systems hindering the ability for nurses to provide culturally safe care. The need for systems to reflect a responsiveness to cultural difference is central to the improvement of health outcomes, the provision of culturally safe care and relational practice.

Cultural responsiveness is not about having separate services for people of different cultural identities. The complexity in being able to cater for difference in this way would be logistically difficult. Cultural responsiveness is about the flexibility of services to meet the diverse cultural needs of individuals, families, whānau and communities. Cultural safety is the way in which the service is delivered. Given this distinction, it is important to consider representation of minority

cultures within a dominant cultural discourse. The acknowledgement that difference exists is an important first step in becoming culturally responsive. The openness to difference and respectful recognition of the difference that exists within historically categorised 'cultural' or 'ethnic groups' is significant in supporting an agile approach to diversity. Moving to creating environments that celebrate the difference that exists between people will ultimately provide a platform for inclusion rather than exclusion and services that everyone can see themselves within.

In the early to mid-2000s, I worked as a Whānau Ora nurse within a Māori health provider. I remember a nursing colleague who worked at the mainstream medical centre approaching me shortly after I started and asked, "what is it you actually do?" The tone implied that my work was somehow inferior to hers, or that no one knew what use the service was that was run by Māori. Again, this was an example of how something different is perceived as threatening the dominant norm. My experience with the provider gave me insight into Māori realities and health service provision in rural communities and positioned me as to some of the strengths and limitations of kaupapa Māori health services within Aotearoa. I recall the service facilitating frequent opportunities for Kuia and Kaumātua (Elders) to provide feedback on what was working well and what could have been better. I have never again seen in my career the frequency and genuineness of stakeholder engagement that existed within this kaupapa Māori health service provider. However, I observed that often what was provided in response to the feedback did not align with what was funded and reported upon. My observation was that this was a lack of systemic agility and responsiveness to Māori needs.

My studies and employment took me to Plunket (a national provider of health and education services for families with children under five) where I worked in various roles for 11 years. As a result of this experience, I have extensive organisational knowledge and experience that informs my interpretation of Well Child/Tamariki Ora [WCTO] practice. What I believe, from both my experience and previous research (Tipa, 2013) is that overall, WCTO services did not meet the needs of many Māori whānau. What whānau signalled they wanted in terms of service providers that listened to their needs was often overridden by the provision of predetermined health education messages. I saw the widespread impact that a neoliberal business approach had over the delivery of health services alongside the continual additions to health education and screening which appeared to erode attempts to work in relational ways with families. This all detracted from the practice of being client and whānau centred and shifted the focus to output metrics - often cleverly disguised as outcomes.

There were glimmers of hope, for example, within Plunket a Whānau Āwhina Whānau Ora team was established in Kirikiriroa/Hamilton, which was developed by a group of Māori staff who wanted to be free to do 'whatever it takes' to support whānau and engage them within WCTO services. The result, although not yet formally evaluated is very positive with successful outcomes not only for whānau, but for the staff involved in providing the service feeling that what they do makes a difference. When nurses can put aside the organisational demands for 'box-ticking', whānau are supported to identify what they need and are more likely to engage with a WCTO service. However, current funding models and organisational systems create barriers to providing services in this way. The efficacy of nursing care is measured by the number of contacts in which specific health education information has been provided or the number of referrals completed. What is missing is the voice of the client in this evaluation, and, Māori voices.

This research seeks to highlight the voices of Māori whānau and their experiences of WCTO services. My current perspectives related to WCTO services are based upon what I have experienced, and how I make sense of these experiences. This outlook does inform the way that I approached this research and the way I made sense of the data. No doubt my position will evolve and adapt over time, in response to my continued thinking and the world around me. Cultural responsiveness to me is the antithesis to racism and intolerance – both interpersonal and institutional. I believe we are at a time and place in which people are no longer willing to accept judgment and discrimination at the hand of dominant cultural 'norms' and that dominant cultural norms need to shift to authentically embrace difference. I hope this research contributes to this momentum and the realisation of true cultural safety in the experience of health care in Aotearoa and that organisations realise the impact and implement this approach within care delivery.

Chapter One: Introduction

Culturally responsive nursing practice is the ability of nurses to establish and maintain meaningful relationships with recipients of care. Central to this is a genuine commitment to ensuring power and decision-making sits with the person (and family or whānau) receiving the health service (Wilson et al., 2018). Therefore, cultural responsiveness can be considered a fundamental component of person-centred care. At its core is a philosophy of caring that acknowledges and celebrates difference by catering to the diverse needs of individuals (Tipa et al., 2015; Wilson, 2017; Wilson et al., 2018). Cultural responsiveness is informed by discourses of social justice and equity. It is about creating alternative opportunities for services to connect and engage with populations that sit outside dominant cultural 'norms' (Bennett et al., 2018; Wilson et al., 2018). The provision of culturally safe and responsive care is highly dependent upon the environment (structural, cultural and fiscal) in which services are accessed and experienced.

There is currently a need for conceptual models to support nursing practice when working alongside Māori whānau, although there is very little evidence relating to relationships with Māori specifically accessing well child services. There is also increasing evidence that describes the negative impact that adverse experiences with health services, including a lack of sensitivity and acknowledgement of the realities of Indigenous peoples has on health outcomes and the ongoing engagement with health services (Bourque Bearskin, 2011; Browne & Fiske, 2001; Harris et al., 2012; Human Rights Commission, 2011; Isaacs et al., 2010; Virdun et al., 2013). The aim of this research, therefore, is to identify and develop a culturally responsive theory to support well child service delivery with Māori well child service consumers in New Zealand. This research will further define a culturally responsive approach when working with Māori families and whānau accessing well child services.

For the purpose of this thesis, I have provided some operational definitions to support an understanding of my theoretical positioning as well as provide context for the discussion. **Cultural responsiveness** is a broad concept that incorporates both cultural safety (the experience of the client and whānau) and cultural competence (the practice of the health practitioner) (Hasch, 2018; Heke et al., 2019). Cultural responsiveness is a term that encompasses all cultures and ethnic groups. However, in this thesis unless otherwise stated, I have referred to cultural responsiveness in terms of working with Māori whānau – both interpersonally and organisationally. **Cultural safety** is discussed as an outcome of care that is

determined by all consumers and whānau accessing health services with an emphasis on the experience of Māori health consumers within Aotearoa (Wepa, 2015). **Cultural competence** is defined as the qualities, skills and activities of the health practitioner in their work with others – again with an emphasis on effectively working alongside Māori to reduce inequities (Heke et al., 2019). Within this thesis, I have referred to Well Child/Tamariki Ora nurses and health workers as WCTO practitioners so as not to identify specific organisations or roles.

Background

As the largest professional group delivering health services in New Zealand, registered nurses are likely to have a significant level of contact with Māori families and whānau (Mills et al., 2012). The number of registered nurses who identify as Māori has remained relatively static over the past decade, sitting at 8% of the total registered nurse workforce in New Zealand (Nana et al., 2013; Te Kaunihera Tapuhi o Aotearoa: Nursing Council of New Zealand, 2019), 16.5% of New Zealanders identifying as Māori in the 2018 Census (Statistics New Zealand, 2018). Increasing the number of Māori nurses is thought to improve health equity by having a culturally matched health workforce with the population receiving the service (Mitchell & Wilson, 2019; Tipa et al., 2015). However, Wilson et al. (2011) discussed the challenges inherent in increasing the number of Indigenous nurses and suggested that although there is value in having a nursing workforce ethnically reflecting the population being served, the reality is that recruitment and retention of Māori into the nursing profession remains an issue. Within a health system designed by a dominant Western culture, there is a requirement for service fluidity to respond to the diverse needs of Māori as the establishment of separate Māori for Māori service delivery is unlikely to be feasible. Enhancing the cultural capabilities of all health professionals is therefore thought to have a positive impact on health outcomes for Māori in terms of increasing engagement with primary healthcare services (Makowharemahihi et al., 2014; Tipa, 2013; Wilson, 2008).

The needs of people in minority cultures and ethnic groups are not supported by the quality of nursing practice as well as the needs of people from the dominant culture (Rumball-Smith, 2009; Southwick & Polaschek, 2014). Māori in Aotearoa experience inequitable and differential access to determinants of health and to services they access or receive. (Curtis et al., 2019; Ministry of Health, 2014a). Despite numerous initiatives specifically targeting Māori health, there continues to be disproportionate representation of Māori in the rates of preventable disease, injury and death (Ministry of Health, 2014a). This overrepresentation is linked to intergenerational trauma, cultural assimilation and systemic racism within health services that have a mandate to protect Māori (Came, 2019). Bolitho and Huntington (2006) described feelings of vulnerability

experienced by Māori parents when accessing health services for their unwell children. Parents expressed uncertainty around their own assessment of their child and did not want to be seen to be overreacting or judged as not knowing what they are doing. This aligns with the importance Māori parents placed upon Plunket nurses being 'non-judgmental' in an evaluation study completed with Plunket clients in 2013. At the point of accessing well child services, Māori clients and their whānau highlighted the need for a service that is responsive to their needs and priorities as individuals in order to attempt to address health disparities for Māori tamariki (children) (Tipa, 2013).

Mahi Ngātahi refers to the Māori concept of working together or working as one. It refers to a collective responsibility and accountability of supporting and caring for each other. This thesis builds upon my Master of Philosophy research, which examined the 'Family Partnership Model' (Davis & Day, 2010) and its value and application to Plunket nurse practice in terms of working alongside Māori whānau in a culturally responsive manner (Tipa, 2013). Overall, the findings supported Family Partnership communication as a model for culturally responsive nursing practice when working with Māori, however, it highlighted limitations in terms of the application of this communication theory to practice as well as difficulties in identifying meaningful opportunities to obtain feedback from Māori clients.

An underpinning premise of this current research is that cultural responsiveness places the onus on the service provider – both individually and collectively, to ensure the experience for the consumer is culturally safe. I will examine what processes constitute a culturally responsive relationship with Māori in the context of well child health, and therefore, increase the limited body of knowledge and understanding relating to working together to achieve positive outcomes for individuals and communities. In this chapter I will discuss the context in which this research has been conducted and provide an overview of the research approach and objectives.

Colonisation and Te Tiriti o Waitangi

As a Māori researcher, it is important to firstly situate this research within the historical context of Aotearoa. Māori are the Indigenous peoples of Aotearoa, having arrived in the country approximately 650-850 years before the first European contact in 1769. Prior to colonisation in the early 1800s, Māori had established complex social and economic structures that served to support productive living. European colonialism was driven by the movement of 'imperial expansionism' which saw unprecedented overseas travel and migration (Pool, 2015). The subsequent assimilation of Māori culture and worldviews were demonstrative of settler

superiority and were underpinned by the belief that they were saving the 'Natives' from barbarity. "In justifying the subjugation of Māori, many British saw themselves as physically and morally superior to the Natives ... introducing them to higher technology and life-ways" (Pool, 2015, p. 28). Colonisation changed the Māori way of life irrevocably in terms of economy, cultural identity and the social and political landscape of Aotearoa.

Te Tiriti o Waitangi was signed by 43 Northern Māori chiefs and Lieutenant Governor Hobson (as Queen Victoria's official representative) on the 6th February 1840. The purpose of the Treaty was to formalise the arrangements for agreed co-existence between Māori and the Crown (Stenson, 2012). Treaties were commonplace at the time in the establishment of new colonies throughout the world and formal colonial rule commenced after the signing of Te Tiriti o Waitangi/The Treaty of Waitangi (Pool, 2015). Over the eight months following the signing of Te Tiriti in Waitangi, original copies and versions of the Treaty were taken to Māori communities where they were signed by over 500 chiefs (Stenson, 2012). The two texts (English and Māori) were not direct translations of each other and fundamental differences in translation, interpretation and application in the years following the signing led to negative flow-on effects in all aspects of life for the Māori population (Pool, 2015).

Critical to the examination of the differences between the versions of Te Tiriti o Waitangi ('Te Tiriti') is the exploration of Māori cessation of sovereignty versus the guarantee of Māori autonomy. Prior to the signing of Te Tiriti, He Whakaputunga (The Declaration of Independence of the United Tribes of New Zealand, 1835) was signed by 34 (and latterly 52) Northern Māori chiefs, that proclaimed sovereign power and governance would reside with Māori and that non-Māori would be unable to pass laws. The document was officially recognised by the British government and it was considered an agreement that reduced the likelihood of Māori entering into formal agreements with other colonising powers (Orange, 2015). However, five years later, the English version of the Treaty of Waitangi declared that the Māori chiefs would hand over all the rights and powers of sovereignty to the Crown (Stenson, 2012). Discrepancies in the Māori and the English versions of Te Tiriti o Waitangi led to widespread debate and 'dueling discourses' relating to the intent of the agreement which continue today. Some believe Te Tiriti gives Māori legitimate rights to self-determination and political recourse, whereas others see it as an intellectual restraint serving the Crown (O'Sullivan, 2007). Despite the debate, there is no doubt that the legislation that was passed following the signing of Te Tiriti had a devastating impact on Māori well-being.

Following the signing of Te Tiriti, a Governor of New Zealand was appointed to uphold law and order and extend Pākehā authority over the land using military threats and force. In 1853 the Constitution Act was passed that enabled settlers to form a government and create laws. The laws that followed were passed with a Pākehā majority of eligible voters as Māori were excluded from voting based on having communal ownership of land (Stenson, 2012). The ensuing loss of land due to legislation that prevented communal ownership and the Crowns' right of pre-emption resulted in social and economic impacts that forever changed the Māori way of life. Additionally, the introduction of settlers into Māori society led to high rates of Māori mortality due to warfare, starvation, and limited immunity to new diseases (Wepa, 2015). Dr Isaac Featherston's famous quote in 1856 encapsulated the future predictions for Māori as well as the perceived superiority of the settler mentality. "...[t]he Maoris are dying out, and nothing can save them. Our plain duty, as good compassionate colonists, is to smooth down their dying pillow. Then history will have nothing to reproach us with" (as cited in Easton, 2011, p. 176).

The loss of land had significant economic and environmental impacts on Māori and irrevocably damaged the social connectedness of whānau identity. Land was considered a benevolent teacher by Māori. People did not own it, but were part of it, responsible for caring for it and it providing the common connection between whānau members (Durie, 1998). Adding to the land loss were a number of assimilationist policies implemented by the Crown which were designed to eliminate Māori culture and ways of life. The Native Schools Act in 1867 and the subsequent Education Act in 1877 effectively outlawed Māori language in schools and made the Western schooling system compulsory for all Māori children (Reid et al., 2014). The Tohunga Suppression Act passed in 1907 disenfranchised Māori from accessing traditional knowledge and understandings. This invalidation of Māori worldviews resulted in intergenerational physical, psychological and spiritual trauma.

It was not until the 1980s that the increasing disparities between Māori and non-Māori evident across all socio-economic and health measures led to a change in the way successive governments approached Māori policy (Orange, 2015; Stenson, 2012). The role of the Treaty of Waitangi in influencing strategies and approaches to Māori health has fluctuated based on various political environments (Wepa, 2015). There is criticism that the principles of the Treaty, utilized throughout government policy since 1975 are simply mechanisms to dilute the threat of Te Tiriti, and reflect an attempt by the Crown to 'gloss over' the substantial differences between both versions (Mikaere, 2013). There are also increasing calls for the authentic integration of Indigenous principles and the articles of Te Tiriti throughout government and society in Aotearoa

to support restitution and social justice for Māori – in contrast to a patriarchal sovereign society where assumptions and privilege remain untested (Porter, 2006; Simon, 2016).

The Waitangi Tribunal was established under the Treaty of Waitangi Act in 1975 with a mandate to provide mediation between Māori and the Crown over contemporary Treaty issues. The scope was extended in 1985 to include Māori claims against the Crown since the signing of the Treaty in 1840 (Hayward & Wheen, 2004). The Waitangi Tribunal was essentially developed to assist with the political settlement of Māori grievances by accessing independent research and the result was the identification of broader social justice and political issues impacting on Māori. Hayward and Wheen (2004) outlined the following requirements for a claim to be made to the Waitangi Tribunal,

..a claim must relate to one or more of the following matters: an enactment, regulation or some other legislative instrument; a practice or policy of the Crown (including a proposed practice or policy); or an act or omission of the Crown (including a proposed act or omission) (p. 20).

In 2019, over 200 submissions were received by the Waitangi Tribunal in support of participating in WAI 2575 – the Health Services and Health Outcomes Inquiry relating to grievances around health services and outcomes. A combination of both Crown commissioned and Tribunal commissioned research will be completed in stage 1 of the inquiry followed by a Judicial conference to plan for stage 2 of the inquiry (Ministry of Justice, 2019).

Biculturalism and self-determination

Biculturalism relates to the outcome of experiencing two cultures simultaneously. This involves participating within a dominant cultural framework, while preserving one's own cultural heritage (Chu et al., 2017; Robertson & Hale, 2017). An issue with this perspective of biculturalism is that it places the onus on the minority culture to preserve their cultural heritage within the confines of dominant cultural norms rather than ensuring equal representation. Te Tiriti o Waitangi represents a bi-cultural agreement, yet what biculturalism means in a practical sense in terms of addressing historical grievances, defining the principles and asset management are continually debated (Levine, 2016). O'Sullivan (2007) was critical of the notion of 'bicultural distributivism' which upscales the representation of Māori in governance and decision-making positions to ensure equal representation of Māori viewpoints. The issue lies not in the commitment to Māori representation, but in the non-Māori structural environment in which decisions are made. O'Sullivan described the result as a continued lack of restoration of Māori social and political worldviews. His criticism of biculturalism is further reflected in the following statement:

Biculturalism cannot do better than to simply have a mission statement in Māori, or to adorn letterheads and buildings with Māori motifs. To do this, while maintaining institutions where Pākehā values, procedures and practices are seen as always normal and right, is insulting at best. The Treaty demands institutional change (O'Sullivan, 2007, p. 20).

Despite the limitations of biculturalism, the stance served a significant purpose for policy development in New Zealand during 1970s and 1980s in terms of increasing the visibility of Māori concerns and perspectives. Biculturalism challenged the 'one people' and 'homogenous nation' ideologies and reflected an intent to honour the partnership represented by Te Tiriti. However, the complexities of power dynamics within the partnership were underestimated and the bicultural position ultimately served to categorise Māori into a single homogenous group with a single homogenous worldview (O'Sullivan, 2007). At the heart of biculturalism in Aotearoa is the notion that there are two distinct and separate ethnic groups to which one can belong. With increasing ethnic and cultural diversity, the positioning of people within the ethnic classifications of Māori and Pākehā are less clear. There is also an emerging concept of 'ethnic mobility' in which people select their ethnicity based on context or upon a preference over time (Kukutai, 2004). Cultural and ethnic identity are becoming less static and therefore the implementation of bicultural approaches is becoming less relevant. Exploring ways in which Māori worldviews are 'normalized' into systemic structures and individual identity is catered for could be paramount in supporting credible partnerships moving into the future.

This 'normalization' of Māori worldviews would be challenged by some Māori activists who view self-determination (tino rangatiratanga) as separate from a notion of nation-state unity (Hawksley & Howson, 2011). Hawksley and Howson described the need for Māori to have autonomy over their own rights and development as a people, which includes holding the state accountable for historic injustices. O'Sullivan (2007) argued however, that the calls for a separate government with separate institutions and social mores for Māori often detract from the true nature of autonomy in terms of disregarding the tribal origins and differences that exist between Māori. Hawksley and Howson (2011) highlighted the importance of political activism in extending the positioning of the state to continually adapt and respond to a range of Māori needs and expectations. Mikaere (2013) claimed that the practice of tino rangatiratanga for Māori in Aotearoa has been sacrificed at the hand of Crown sovereignty and that absence of He Whakaputunga in policy and legislation has led to a lack of credibility in the application of Te Tiriti today. The realisation of tino rangatiratanga does not sit exclusively within bicultural partnerships, rather within Māori communities providing ways to legitimize Māori realities and identify pathways towards achieving Māori aspirations (O'Sullivan, 2007).

Hauora Māori

The concept of hauora Māori has been loosely translated into 'Māori wellbeing'. The dominant discourse of this translation however, limits the depth and contextualisation of the concept and the ways in which 'hauora' may be interpreted. Heaton (2018) provided the following definition of hauora, which illustrates the complexity of the term in providing a direct translation:

...hauora is referred to as the supernatural hau (breath) or ora (life) given to Hine-ahu-mai-i-te-one (the first feminine form). Hau (wind or vital essence of life), ha (breath), ora (to be alive, healthy, to survive) and wairua (spirit) were infused into the first feminine form, the progenitor of humanity to animate life (p 461-462).

Heaton (2018) described an issue with the use of the term 'hauora' in representing a bicultural interpretation of health in the sense that the translation oversimplified hauora to align with the World Health Organisation definition of health. She discussed the contrasting openness afforded by the experience of hauora as opposed to the narrow dominant concept of 'wellbeing' and identified the need for a close association between hauora and 'knowing the human self'. Wilson and Hickey (2017) defined health as a sociocultural construct influenced by worldviews, context and cultural realities. They discussed the concept of hauora as centred around wellness and holistic Māori worldviews. These worldviews are significantly influenced by whakapapa (genealogy), wairuatanga (spirituality) and whanaungatanga (relationships) that often sit in contrast to biomedical models of health. Jones et al. (2014) described Māori concepts of health as encompassing both an individual and collective continuum that connects generations. They highlighted the interconnectedness between the physical and spiritual dimensions of hauora Māori as well as the significance of the environment and connection with the health of the land.

Statistics related to Māori health measures in Aotearoa provide sobering reading. There is an overrepresentation of Māori experiencing preventable disease and associated hospitalisations (Jones et al., 2014; Reid et al., 2014). Māori also have higher rates of interpersonal violence and are 2.5 times more likely to die from assault and homicide than non-Māori. The suicide rates are also 2 times higher for Māori than non-Māori and Māori are more likely than non-Māori to be hospitalised for self-harm. Māori tamariki under 14 years of age have unintentional injury rates 3.5 times higher than non-Māori (Ministry of Health, 2015). While the statistics provide measures that indicate Māori experiences of health are worse than non-Māori, there is a question as to what Māori constitute as hauora and whether the comparison to non-Māori remains relevant or appropriate given the history of colonisation and assimilation of culture. Over a decade ago, Durie (2011) highlighted that due to the diversity that exists amongst Māori, health outcome measures should be identified in collaboration with Māori and considered in

terms of Māori progress over time rather than using non-Māori comparative markers. There remains little evidence of this approach to routine analysis of Māori health statistics today, which often fuels reactive strategies to improving Māori health outcomes.

There have been several theses that have examined different aspects of Māori experiences of health services. Wepa (2016) studied what happens for Māori and their whānau when accessing health services. She determined that there is a constant struggle for Māori accessing healthcare due to the level of discrimination experienced throughout the system. For this reason, she argued that current health care interventions do not contribute to reducing inequities as they do not meet the needs of Māori whānau. Graham (2018) explored the experiences of young Māori mothers following the birth of their first child. She identified that the self-reported wellbeing of young Māori mothers was influenced by the way they were empowered by other females. She also discovered that experiences within the context of te ao Māori were approached with confidence by young Māori mothers, yet the opposite was true for experiences within the health system. Graham recommended further kaupapa Māori research into the motherhood experiences of young Māori mothers with a wellness and emancipatory lens. Brown (2018) examined Māori and Pacific whānau coping strategies to overcome health system barriers. The results reflected the negative impact of racism on health outcomes and challenged the structural discrimination against traditional and cultural holistic practices. All these studies support the need for further research and advocacy to improve the healthcare experiences of whānau.

Child and family nursing services

Internationally there are various approaches to supporting maternal, child and family health and many of these programmes sit alongside family planning and contraception services. Ringheim et al. (2011) stated that “most countries that have achieved rapid economic growth have also had strong family planning programs that help women avoid unplanned pregnancies and have the smaller families they actually prefer” (p. 1). Health disparities are more prevalent in poorer countries where services do not focus on the well-being of women and children and where women are less likely to have choices relating to contraception and child rearing. Duvendack and Palmer-Jones (2017) highlighted the connection between women’s education to the level of agency they have in making decisions about their households and welfare. They suggested that structural changes in society also play a role in influencing women’s decisions to have smaller families. The focus on maternal and child health internationally often sits within the

context of poverty and any movement towards sustainable change calls for wider community development and advocacy (IMCHF, 2012).

The International Federation of Red Cross and Red Crescent Societies (IFRC, 2013) outlined alarming international rates of child deaths, reporting that around half of all child deaths occur in five countries and 65% of maternal deaths occur in 11 countries. Aotearoa has the ninth highest mortality rate for children under one year of age in the Organization for Economic Cooperation and Development [OECD]. Given these rates of mortality, the United Nations and international non-governmental aid organisations have made efforts to increase the coverage of child and maternity health services. Despite this increased focus, the inequities between the rich and poor even within countries with extensive child and maternity service coverage continue to increase (IFRC, 2013). In response, the United Nations International Children's Emergency Fund [UNICEF] the Government of India, and Partners in Population and Development have advocated for global and national leadership for maternal and child health initiatives by drafting an operational framework to implement the *Global Strategy for Women's, Children's and Adolescents' health* (Every Woman Every Child, 2015). This strategy highlights the need to target the most vulnerable and difficult to access and engage maternal and child populations and presents a roadmap to eradicating all preventable deaths of women, children and adolescents within a generation.

There are a variety of different approaches internationally to providing health services to families with young children. Health services for families in England and Australia are the most closely aligned with service provision in Aotearoa with policies and systems often shared between countries. Child and family health services in Australia align with both state and national health priorities (Guest et al., 2013). For this reason, child and family nursing systems and organisational structures vary from state to state, although they are supported by a national Maternal and Child Health Nurse Association for policy development, professional consultation and the development of legislation (Maternal Child and Family Health Nurses Australia (MCaFHNA), 2015). The intent of child and family health services is to build on family and community strengths, while identifying and responding to actual or potential issues affecting health and wellbeing (NSW Department of Health, 2011). Despite having a well-accepted maternal and child health system, Schmied et al. (2015) suggested that many children and families in Australia do not receive a universal service. Reasons for this relate to the lack of national consistency in data collection and analysis as well as limited standardised systems to support inter-professional collaboration. This criticism would be supported by a governmental publication titled, *Headline Indicators for Children's Health, Development and*

Wellbeing, which is unable to report on seven of the 19 indicators due to the lack or poor quality of data available (Australian Institute of Health and Welfare, 2011; Schmied et al., 2015).

The health visitor service specifications in England (NHS England, 2014) outline similar aims to New Zealand in terms of supporting integrated service delivery to meet the needs and improve health outcomes for young children and their families. The health visitor/public health service also provides 4 levels of service; community development, universal, universal plus and universal partnership plus (Cowley et al., 2013), which essentially mirrors the needs assessment framework used in New Zealand. The Department of Health in England devolved nationally-led commissioning and oversight of health visitor services in October 2015 with the intent of better responding and reflecting local communities' needs (Department of Health, 2011). Subsequently, funding and professional development limitations have had an impact upon growing the health visitor workforce across the United Kingdom and have hindered progress towards the 'new service vision' of providing tailored packages of care based on individual client needs (Luker et al., 2012). The new approach to health visitor services also aimed to re-define the role in the context of public health and create a sense of excitement around the profile of health visitors and opportunities to make a difference within communities (Department of Health, 2011). Given the Australian experience with the fragmentation of child and family nursing services between states, the performance of the new service structure in England, and, mechanisms for identifying client needs are of interest internationally.

Child and family nurses in Australia, WCTO nurses in New Zealand and health visitors in England are registered nurses with additional qualifications and/or training in the child and family health specialty. They work with families in a primary health context, providing services at home, clinics and other community settings and need to be able to work within diverse populations (Cowley et al., 2013; Ministry of Health, 2014b; NSW Department of Health, 2011). Additionally, community health workers in both Australia and New Zealand are employed in child and family health services to reflect the communities in which they are working, to increase the cultural acceptability of services. The community health worker reinforces health promotion and health education messages and has a pivotal role in supporting the integration of clinically focused child and family services within communities (McMurray & Clendon, 2015).

The Ministry of Health (Ministry of Health, 2013b) recognise that cultural competence is fundamental to responding and engaging populations in New Zealand with the poorest health

status and supporting health services to identify ways in which they can achieve this is paramount to improving outcomes. There are limitations in overlaying international child and family health processes and systems within unique cultural and historic contexts. For example, the mechanisms in which health outcomes are measured and the ethnocentricity surrounding output measures often sits in contrast to culturally responsive approaches. Cultural considerations within international child and family health services are not overt and do not appear to be a foundational component of service delivery. Therefore, identifying opportunities for service practitioners to adapt and respond effectively at all points of connection with whānau in Aotearoa will provide more effective insight as to where changes to services need to be made.

Well child/Tamariki ora services

Well child/Tamariki ora [WCTO] services in Aotearoa are designed to support numerous government strategies, guidelines and action plans and are developed in accordance with the WCTO National Schedule (Ministry of Health, 2013a). The design and arrangement of WCTO contracts is based on the concept of 'proportionate universalism.' Proportionate universalism provides a funding structure for health and social services to be supplied at a greater or lesser intensity for families and whānau based on assessed need. Under the universal service component of this funding model, all children under five years of age in Aotearoa are entitled to a minimum of seven well child 'core' contacts within specific developmental age-bands, with an eighth well child assessment provided via the B4School check. (Ministry of Health, 2014b). Needs assessments completed at contacts with families that identify the need for further support as part of a plan of care. The main purpose of the needs assessment is to identify the extent to which risk and protective factors may inhibit or enhance child health outcomes and promote health equity across populations (Hussey, 2011).

The WCTO clinical service is underpinned by three strands outlined in the WCTO National Schedule, namely; health and development assessments, family/whānau care and support, and health education (Ministry of Health, 2013b). It is funded by the Ministry of Health and offered (at no cost) to all families and whānau with children under five years of age. WCTO services are provided by multidisciplinary teams including lead maternity carers, registered nurses, general practitioners, community health workers, paediatricians and vision and hearing technicians (Ministry of Health, 2013b). The aim of this multidisciplinary approach is to provide a seamless transition of care between the required clinical expertise and competencies to promote optimal health outcomes for all Aotearoa children under five. Central to the achievement of positive health outcomes is the relationship between the

parent, family/whānau and the WCTO service provider (Ministry of Health, 2013b). It is these relationships that form the basis for this research and more specifically, the organisational contexts in which these relationships are developed and continually influenced by.

The Royal New Zealand Plunket Society (commonly known as Plunket) was founded by Sir Frederick Truby King in 1907. Aotearoa had a high infant mortality rate which prompted the country to join a “Western world infant welfare movement” (Bryder, 2020, p 201) to secure the survival of future citizens. This backdrop provided the impetus for Dr Truby King to apply his knowledge of medicine and animal husbandry to saving babies lives (Bryder, 2020). With the foundation of medical knowledge and management by groups of voluntary women, Plunket became Aotearoa’s most successful and by many accounts, most famous voluntary organisation. Plunket nurses were employed ‘to help the mothers and save the babies’ by providing information and education relating to child-rearing practices while monitoring infant health (Bryder, 1998; Clendon & McBride-Henry, 2014). Dr Truby King’s ideology was associated controversially with eugenics in relation to his views on selective breeding and establishing a “healthy, capable race” (Chapman, 2003, p 88). The first academic criticism of Dr Truby King’s philosophy to motherhood and child rearing came from Professor Erik Olssen in 1981 in which he described King’s approach as a mechanism for social control over women’s lives (Bryder, 2020). Bryder (2020) described the feminist movement of the 1970s and 1980s as contributing to a movement away from the ‘scientific motherhood’ prescribed by the medical profession and patriarchy, towards more women-centred approaches. Nonetheless, the establishment and influence of the Plunket service had an impact on many families with new babies in Aotearoa throughout the twentieth century.

While the first baby taken under the care of Dr Truby King was Māori, Plunket has had a relatively short history providing services to Māori and Pacific families. There was an early agreement with the Health Department at the time, for Public Health nurses to attend to the care of Māori infants and families. There was little resistance to continuing this arrangement until the 1960s in which Plunket initiated an attempt to curb the stigma of racism associated with the organization (Bryder, 1998). Despite this, Plunket’s relationships with many Māori remain fraught and the recent history of segregated services has not been forgotten. Plunket policy in the 1950s precluded Plunket nurses from going to Māori pā and marae, however Māori were able to attend Plunket clinics. Some Plunket nurses in the 1960s however still refused to see Māori mothers and Plunket nurses did not visit Māori mothers at home and relationships with Māori were therefore not as strong as they were with Pākehā (Cram et al., 2019). Plunket is often credited for reducing the infant mortality rate in the early 1900s, however, there is some

debate as to whether a combination of other influencing factors had more of an impact - such as reduced family size, increased food availability and a reduction in overcrowded living conditions (Bryder, 1998). Given the history of relationships between Plunket and Māori, it is unsurprising that a level of mistrust towards the service remains and that many WCTO services struggle to engage effectively with whānau.

Today Plunket has contact with 90 percent of newborn babies born each year across Aotearoa (Brankin, 2018). There are numerous Tamariki Ora providers (kaupapa Māori WCTO services) located throughout the country, many based within Iwi/Māori providers, however Plunket as a Western service sees the majority of all Māori whānau with newborns. This can be partially explained by the lack of whānau input into choosing a WCTO service. The WCTO Practitioner Handbook outlines the process for referrals to WCTO providers and neglects to include whānau choice as part of the referral process (Ministry of Health, 2013b). Likewise, the Lead Maternity Carer referral form to WCTO providers does not indicate that a choice of provider is made by the mother and/or whānau and is instead left to the health professional to complete.

National data across all WCTO providers indicates that in 2016, only 72 percent of infants received all their WCTO assessments in their first year of life. This was even lower for Māori, at 57 percent and Pacific at 59 percent (Ministry of Health, 2016). There is no narrative provided as to the reasons for the drop off in engagement in the WCTO programme, but what is clear is that the current structure is not fully engaging with close to half of all Māori enrolled in services. Interestingly, the statistics for B4School checks - a stand-alone assessment for 4-year-old children provided by a multitude of providers with a strong developmental and behavioural focus, were sitting at 92 percent national coverage in 2016. Māori rates of engagement in B4School checks were also a lot higher at 86 percent. This thesis will provide some insight into the systemic and interpersonal barriers that exist for Māori accessing a WCTO on an ongoing basis.

[Social services for children and families in Aotearoa](#)

While the focus of this research sits primarily within a nursing context, it is important to also acknowledge the wider social service environment that sits alongside of health. Health of an individual is continually influenced by socio-ecological, socio-economic, and socio-political determinants that are often outside the direct scope of a health care professional to change. Aotearoa has one of the highest rates of child abuse and neglect in comparison to all countries in the OECD. One child dies on average every five weeks from violence and most of these

children are under five years of age (UNICEF, n.d.). WCTO service providers are required to screen families for violence at every core contact and more often if violence is indicated (Ministry of Health, 2013a). While all WCTO nurses are provided training related to assessment for child protection issues, child protection assessment is not mandated within the WCTO framework (Ministry of Health, 2013a). The processes for acting upon concerns about child protection and family violence vary based on WCTO provider systems. Policies underpinning clinical decision making in WCTO nursing practice are driven by legislation relating to the care and protection of children.

The passing of the Children's Act (formally the Vulnerable Children's Act) in 2014 and the subsequent establishment of dedicated Ministry for Children marked the intention for a major reorientation of social services for children and families in Aotearoa. The Children, Young Persons and Their Families Act 1989 was changed to the Oranga Tamariki Act 1989. Under section 7AA of the Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act 2017, the chief executive of Oranga Tamariki must ensure that the department "recognise(s) and provide(s) a practical commitment to the principles of the Treaty of Waitangi (te Tiriti o Waitangi)" ("Children, Young Persons, and Their Families (Oranga Tamariki) Legislation Act," 2017). This commitment involves setting measurable outcomes for Māori tamariki (children), paying regard to the mana (prestige/empowerment) of tamariki and whānau and seeking to develop relationships with iwi. O'Brien (2016) discussed these changes as being centered around the concepts of investment, outcomes, and vulnerability. He contended that these concepts, while having positive connotations in society, were politically driven and ambiguous terms that provided a false sense of understanding of the work involved in reorienting social services towards client-centered practice. O'Brien asserted that the neo-liberal approaches to the way outcomes for whānau are defined and measured limit the efficacy of social work practice.

Oranga Tamariki is the Ministry for Children in Aotearoa. The primary responsibility of this Government department is the care and protection of children (under 18), which includes preventing issues from arising, providing intensive support for children and families, and organizing care for children at risk of harm when the other alternatives are unsuccessful (Oranga Tamariki, 2020). Children's Teams were established throughout the country to provide a multidisciplinary and collaborative approach in working with families and whānau to make changes to improve their well-being (Oranga Tamariki, 2019). The criticism of neo-liberal approaches to funding within Oranga Tamariki is centered around the limitations of using a reductionist model focused on individual families to address social issues (Hyslop, 2017; O'Brien, 2016). The result is a disconnect between fundamental social work theory and practice. Reactive

social strategies blaming the circumstances of individual families for social issues reduce the ability of WCTO services to engage in ways that do not reinforce that sense of 'blame'. Whānau do not always differentiate between the health and social services who are working with them (Tipa, 2013), therefore negative experiences with one service are likely to influence future engagement with all services. Hyslop and Keddell (2018) argued that the social work practice context needs to be centered around addressing social inequalities and that the emphasis on the individual within new the structure is not conducive to effective child protection social work.

At the time of writing this thesis there is heightened scrutiny in relation to the wellbeing of children and their whānau in Aotearoa, particularly Māori. Around 68% of children Oranga Tamariki work with are Māori (Oranga Tamariki, 2020). Widespread national criticism of Oranga Tamariki exists about the disproportionate and unreasonable uplifting of Māori children from their families (Kaiwai, Kipa, et al., 2020). The concern is not necessarily about the need to protect tamariki from a particular family member or environment, rather the process of decision making relating to who will care for the child, as it appears that Māori children are often placed away from extended whānau members. Rouland et al. (2019) cohort study found 42.2% of Māori children in the first 17 years of their life had a notification of concern completed about them as alleged victims of abuse or neglect. This study also reported that 20.4% of Māori children had been substantiated as victims of abuse and/or neglect. One in four children in Aotearoa have contact with child protection services in their lifetime and one in fourteen Māori children are placed in out of home care. Of those children who have been abused while in the care of the state, more than 70% are Māori (Rouland et al., 2019).

The intergenerational trauma experienced by Māori whānau as a result of years of racist social practice has culminated in an uprising of sorts, with many Māori whānau expressing frustration at having a lack of agency in decision making regarding the safety of their tamariki. Many Māori believe that the kupu Māori (Māori words), Oranga Tamariki, refer to the wellbeing of children, whereas the perception of Oranga Tamariki performance is the opposite. Māori are calling for increased whānau, hapū and iwi approaches to the care and protection of tamariki because the current system does not support Māori whānau. Kaiwai, Allport, et al. (2020) presented a summary of Māori concerns which included intergenerational trauma, discrimination and prejudice relating to the removal of children and services having little empathy or recognition of Māori culture. These events continue to highlight the requirement for services to identify ways to better respond to Māori both fairly and appropriately. Māori have experienced immeasurable loss over many generations at the hand of the Crown and the actions of Oranga Tamariki represent further violations of Māori rights to self-determination promised in Te Tiriti

o Waitangi. The lack of service responsiveness and damaging practices surrounding the uplifting of children from whānau perpetuates the disparities that exist for Māori and need to change.

Cultural competence

The foundational work of Madeleine Leininger provided the platform for the concept of cultural competence with her development of the transcultural nursing theory, amidst a backdrop of the civil rights movements in the 1960s and 1970s (Chiarenza, 2012). She described culturally congruent care as “culturally-based care knowledge, acts, and decisions used in sensitive and knowledgeable ways to appropriately and meaningfully fit the cultural values, beliefs, and lifeways of clients for their health and wellbeing, or to prevent illness, disabilities, or death” (as cited in McFarland & Wehbe-Alamah, 2014, p. 14). Cultural competence places the responsibility on the health professional to work effectively within the cultural context of the client as well as demonstrate skills in caring for diverse populations (Hart & Mareno, 2016). There has been debate relating to the positioning of cultural competence in relation to person-centred care (Campinha-Bacote, 2011). Campinha-Bacote (2011) described cultural competence as primarily focussing on improving outcomes and reducing disparities for ethnically diverse and disadvantaged populations, whereas person-centred care is about providing individualised care with an emphasis on enhancing interpersonal relationships. The ambiguity in situating the two terms lies in whether cultural competence is a subsidiary to person-centred care or whether the opposite is in fact the case. Despite this, both approaches emphasise the need for care to respond to the uniqueness of individuals (Campinha-Bacote, 2011).

Betancourt et al. (2005) discussed the importance of cultural competence in quality improvement activities to address health disparities. However, they were cautious to attribute cultural competence to the elimination of health disparities given the multitude of causes. Hamlin and Anderson (2011) described cultural competence as an enabling process whereby consumers of health services are empowered to contribute to the achievement of positive health outcomes. This includes having the opportunity to influence and potentially change aspects of services that are perceived negatively. Additionally, cultural competence is thought to be enhanced by creating opportunities to develop personal awareness through reflection. Hovland and Johannessen (2019) highlighted the value in challenging student nurses’ values, belief and attitudes in developing their cultural competence. This approach was echoed by Lowell et al. (2018) who determined that creating clinical experiences for students to increase their adaptability resulted in increased cultural competency.

All health professionals working in Aotearoa must be 'culturally competent' under the Health Practitioner's Competence Assurance Act 2003. This includes ensuring services are responsive to Māori as well as ensuring clients' rights to cultural and personal beliefs are acknowledged and respected. However, there is currently no standardised definition of cultural competence across professions (eCALD, n.d.). The Ministry of Health (2014a) recognise that cultural competence is fundamental to responding and engaging populations in Aotearoa with the poorest health status. The cultural competence training for clinicians and health care providers provides a description of what cultural competence is not and rationale as to why. They are clear that cultural competence is not "treating everybody the same ... a cultural checklist ... learning about other cultures [or] coming from the same ethnic group" (2020, para.11). Despite this, there are still several documents produced in the health sector within Aotearoa that outline strategies and information for working with specific ethnic groups, which reinforces an ethnocentric interpretation of culturally competent practice.

An amendment to the Health Practitioner's Competence Assurance Act 2003 outlined a requirement for the regulatory bodies of health professions to set standards of cultural competence that "enable effective and respectful interaction with Māori" ("Health Practitioners Competence Assurance Amendment Act 2019," 2019, p 17). The Nursing Council of New Zealand (Nursing Council) is responsible for the regulation of the nursing workforce insofar as ensuring that all nurses in Aotearoa are competent to practice (Te Kaunihera Tapuhi o Aotearoa: Nursing Council of New Zealand, n.d.-b). The Nursing Council competencies were developed to ensure nurses in Aotearoa consistently demonstrate the activities and skills within their scope of practice (Nursing Council of New Zealand, 2012). The NZNC competency 1.5 describes the requirement for nurses to "practice nursing in a manner that the health consumer determines as being culturally safe" (Nursing Council of New Zealand, 2012, p. 13). The use of the term 'cultural safety' recognises the power that is inextricably linked to a cultural context. The term 'cultural competence' used in wider nursing literature refers to the role of the nurse and has been categorised into awareness, attitudes and behaviours (Dudas, 2012). Cultural competence is a progressive process to which there is no end-point to achieve (Campinha-Bacote, 2011; Dudas, 2012; Hart & Mareno, 2016). Dudas categorised the key results of a culturally competent nursing workforce into increasing patient outcomes; effective communication and relationship building; and increased organisational satisfaction rates.

The Nursing Council approves professional development recognition programmes (PDRP) for registered nurses to demonstrate competency and further develop practice. When registered nurses submit a portfolio of practice examples to an accredited PDRP assessor and are assessed

as meeting PDRP, they are exempt from completing a recertification audit during the timeframe that the PDRP assessment applies. The employer responsible for PDRP may also incentivise progression through PDRP levels (Te Kaunihera Tapuhi o Aotearoa: Nursing Council of New Zealand, n.d.-a). Huarahi Whakatū is a professional development recognition programme that has been developed specifically for Māori nurses that reflects the existence of both clinical competencies and cultural competencies for Māori registered nurses (Te Rau Ora, n.d.). Dual competency reflects the body of knowledge drawn upon from being Māori within a practice context (Baker & Levy, 2013). Baker and Levy (2013) argued that measuring cultural competency using a series of skill acquisition classifications negates the personal values and reflexivity required to meet cultural competence. Therefore, Huarahi Whakatū was developed to ensure cultural excellence was recognised alongside clinical achievements for Māori nurses.

The Takarangi Competency Framework was developed as a kaupapa Māori tool for cultural competence. It provides a beginner to expert pathway for progressing Māori cultural fluency within competencies that already exist within professional groups (Matua Raki, n.d.). The Takarangi Competency Framework privileges Māori culture and Indigenous knowledge at a depth that is not necessarily reflected in existing professional competencies. It also ensures that culturally competent practice is demonstrated and assessed rather than relying upon articulated knowledge and/or qualifications (Matua Raki, n.d.). The framework is presented in a spiral that connects the past with the present – old knowledge with new. It is divided into 14 competencies with examples for professionals to identify and assess within their own practice (Matua Raki, 2009). An initial impact assessment of the Takarangi Competency Framework indicated that the use of the framework improves the practice of people working with Māori. However, a lack of organisational buy-in and loss of momentum following the initial training has limited the sustainability of the model (Matua Raki, 2010).

Thesis Outline

Chapter One has provided the key definitions related to cultural responsiveness. I have outlined the context in which whānau experience health and social services and the historic events leading to Māori experiences of hauora today. I provided an overview of bi-culturalism and the relationship with self-determination with reference to the partnership promised by Te Tiriti o Waitangi. I described the services designed to support children and families both within Aotearoa and internationally. Cultural competence was defined, and the issues associated with an ethnocentric interpretation of the concept were explored. Chapter One provided the aim and justification of the study and the context in which the research was conducted.

Chapter Two describes the search strategy undertaken to review the literature for this study. In Chapter Two I examine the literature related to Māori well child health and whānau health determinants. Literature describing the experiences of health for Indigenous peoples internationally is discussed. Cultural safety and cultural responsiveness are explored alongside an examination of the impact of power upon relationships within a cultural context. Institutional racism is defined and discussed in relation to the literature. An overview of Māori models of health is provided including commentary referring to the application to practice within a Western oriented health system. I also provide an examination of the literature related to the research topic and proposes the contribution this study will make to the existent body of knowledge.

Chapter Three outlines the methodological approach taken within this study. A definition of the kaupapa Māori methodology used in this research is provided, including how it has been applied throughout this research. A description of the kaupapa Māori ontological and epistemological foundations is also presented. An overview of the epistemological foundations of constructivist grounded theory is provided to establish the fit with kaupapa Māori methodologies. A discussion related to the research interface between kaupapa Māori methodology and constructivist grounded theory methods further reflects the philosophical connection between two paradigms. I provide the justification of the methodological approach taken in this study and consider how this was applied to the research design.

Chapter Four identifies the methods utilised for data collection and analysis. I demonstrate the connection between kaupapa Māori values and constructivist grounded theory methods. An overview of the role of the research advisory rōpū (group) is presented, alongside an outline of the processes used for recruitment and data collection. Examples of observations, transcriptions, coding and memo-writing are provided to explain how these processes were utilised throughout the study. Kaupapa Māori axiology is explored in relation to how the ethical principles were upheld throughout the research. The research is evaluated using Charmaz's evaluation criteria interwoven with kaupapa Māori ethical principles. A section on researcher reflexivity provides insight into the tension and opportunities for learning encountered in completing this research. Finally, I describe the way kaupapa Māori methodology and constructivist grounded theory methods were used to develop a theory of cultural responsiveness for whānau accessing WCTO services.

Chapter Five presents the findings of this study. A model depicting **Mahi Ngātahi – A Theory for Culturally Responsive WCTO Services** is explained in relation to the three theoretical categories

generated through data analysis. The categories of *doing to us*, *diminishing whānau mana* and *getting what whānau need* are presented individually with an explanation of the sub-categories and focussed codes associated with each category. Each category is further defined with an analysis of whānau experiences including direct quotes from participants within the study. I present **Mahi Ngātahi - A Cultural Responsiveness Framework for WCTO Services** that brings all theoretical categories together with an explanation as to what is required for culturally responsive WCTO services.

Chapter Six locates the findings of this study within the literature. A discussion is provided relating to Māori experiences of WCTO services in Aotearoa. Lack of partnership, reacting to statistics and positioning Māori as other are all examined as key discussion points identified within this study. **Mahi Ngātahi - A Cultural Responsiveness Framework for WCTO Services** is considered within the context of existing literature relating to Māori experiences of health services and health service design.

Chapter Seven revisits the research question and aims and provides a summary of the main points discussed throughout the thesis. I outline the limitations of the research alongside implications and recommendations for the nursing profession and the wider health sector. Finally, my future aspirations relating to this research are discussed alongside my concluding thoughts related to this study.

Summary

Cultural responsiveness is linked to the provision of person-centred care. This research will identify and develop a theory to support culturally responsive nursing practice within well child/tamariki ora services. The impact of colonisation on the well-being of Māori cannot be underestimated. In this chapter, I have outlined the context in which the research was conducted and highlighted the discourses surrounding Te Tiriti o Waitangi and He Whakaputunga and the importance of integrating Māori worldviews into mechanisms for health service delivery. The concept of hauora Māori in broader terms than Māori health was explored, with an acknowledgement of holistic and spiritual aspects of a person as fundamental to wellbeing. The impact of government driven outcome and output measures are likely to have a significant influence over the culture of the environment in which care is provided. Therefore, identifying how Māori measure hauora and success is pivotal in constructing a model for cultural responsiveness.

Cultural competence is the platform from which cultural safety has evolved and encapsulates the way cultural practice is regulated and measured across health and social professions in Aotearoa. The lack of consistency in definitions of cultural competence is problematic as the concept of power is often overridden, which reinforces a hegemonic stance. Well child/tamariki ora services are well positioned to engage and influence the well-being of children and families, however, ongoing access rates for Māori after initial contact are significantly low. There is no doubt that the environment, be it social, political, whānau, or organisational, all influence the degree to which a health worker or a service can respond to the needs of an individual and their whānau. The following chapter will explore the literature further and provide a theoretical foundation for the development of a culturally responsive theory.

Chapter Two: Literature review

Introduction

There is a paucity of conceptual models, discussion and/or frameworks for working in culturally responsive ways with Māori in a nursing context. There is also limited literature relating to working with Māori whānau accessing Well Child/Tamariki Ora (WCTO) services. However, the health disparities that exist for Māori and a desire to improve outcomes have been well documented over time (Came et al., 2017; Curtis et al., 2019; Howden-Chapman et al., 2000; Reid & Robson, 2006). In this chapter, I contextualise Māori health experiences within the literature. Previous research I have completed indicated that partnership relationships form the basis for culturally responsive practice (Tipa, 2013). This literature review further explores the literature related to ways of working together and partnership relationships.

The literature review consisted of a search for current peer-reviewed articles and was conducted via the AUT online library, EBSCOhost research databases. The following search terms were used to locate articles specific to this study: *“Māori health”* and *“Māori health disparities”*, *“Māori child health”*, *“Indigenous health”*, *“cultural safety”*, *“cultural responsiveness”*, *“partnership relationships”*, *“nursing partnerships”*, *“institutional racism”* and *“unconscious bias”*. Variations of these terms were used to ensure exhaustive search results. Where necessary, older articles and literature were accessed to support the discussion relating to the topics identified as central to this research. Priority was given to recent, peer-reviewed literature to ensure currency of sources. Due to the limited literature on Māori health and WCTO services, literature was chosen for inclusion primarily based on the association and relevance to the search terms identified. This meant that the literature was focused on defining the concepts rather than describing previous studies, as there has been no previous research into Māori experiences of WCTO services in Aotearoa.

In this chapter, I will explore the literature related to the fundamental components of cultural responsiveness and Māori well child health. I will further situate the research question within the literature and provide a platform for data collection and analysis.

International Indigenous peoples' health

It is widely recognised that Indigenous peoples experience worse health and social outcomes than non-Indigenous populations (Bailie et al., 2010; Kildea et al., 2013; Otim et al., 2014; Parker

& Jamieson, 2010; Singh et al., 2014). In Australia, data related to Indigenous child health is not routinely available, nor is it interpreted at a national level. Despite knowing issues are prevalent amongst Indigenous communities, there is little or no data to support initiatives to address health disparities (Fremantle et al., 2008). Otim et al. (2014) described “poor priority setting methods” (p 2) in Indigenous health as contributing to health disparities across Australia’s Indigenous population, with funding targeting issues causing the *least* concern across Indigenous communities. Durey and Thompson (2012) called for critical reflection upon policies and processes in Australian healthcare providers to examine the effectiveness and appropriateness of services for marginalised populations.

Lambert et al. (2014) described health literacy as having an influence over Indigenous health outcomes and suggest that systemic cultural and social barriers existing within health care institutions often exacerbate health literacy issues. Durey and Thompson (2012) discussed the “wilful blindness” (p 4) surrounding the structural and social health determinants that underpin the disproportionate losses to Indigenous people in Australia – within a neoliberal political climate. They highlighted the need for an examination of social determinants influencing the health of Indigenous Australians rather than activities focussed upon directly addressing health issues. Although there is an increased commitment to ‘close the gap’ between Indigenous and non-Indigenous health outcomes in Australia, social and structural determinants of health are the major contributing factors to poorer health outcomes (Donato & Segal, 2013). For this reason, Donato and Segal argued that key structural changes in Australia’s primary healthcare system are required to overcome fragmented funding approaches and promote increased collaboration across the primary healthcare sector.

King et al. (2009) examined the correlation between determinants affecting Indigenous health in North America. They discussed the holistic view taken to observing ‘wellness’ or ‘living the good life’ which includes a balance across physical, mental, emotional and spiritual wellbeing. King et al. discussed the involvement of the wider family or social group as part of the healing processes and note the negative impact that a loss of cultural identity has on Indigenous health. They argued that many of the measures relating to health disparity contribute to a negative self-identity amongst Indigenous populations. They suggested that there has been an ‘overpoliticisation’ of Indigenous health and there is a need for self-determination of Indigenous peoples over their own health service delivery and outcomes. This supports the rationale for using kaupapa Māori research methodology and in particular, the principle of ‘Mana Whakahaere’ (iwi authority) which relates to the process of collaboration with

participants and intellectual property belonging to and being guided by the wider Māori community (Hudson et al., 2010).

Watson et al. (2013) described the role of Aboriginal and Torres Strait Islander health workers as 'brokering' culturally appropriate and acceptable health promotion and education interventions in the field of child and family health for Indigenous communities in Queensland Australia. They discussed the importance of having evidence-based support structures in place for Indigenous health workers who have become, in many respects, the intermediary between an array of health services and the clients with whom they have relationships. In Nova Scotia, First Nations people accessing mental health services indicated the need for health professionals to reduce stigma within Indigenous communities in relation to mental health. While confidentiality was important, participants in this study indicated that if family and friends wanted to help someone who was unwell, they should be supported to do this rather than turned away (Vukic et al., 2009). Vukic et al. (2009) also highlighted the need to increase the number of Aboriginal health workers in the workforce and the importance of non-Aboriginal health workers being responsive to Aboriginal culture and history.

Māori models of health

Indigenous models of health recognise the connection between Indigenous worldviews, Indigenous development and the experience of health (Durie, 1999). Māori health models have been developed to support service delivery and design as well as health professional knowledge relating to Māori realities. McNeill (2009) reflected upon the use of symbolism within Māori models of health stating that "all of the existing models embrace the Māori penchant for the poetic use of symbolic iconic Māori metaphors as a framework" (p.2). The holistic conceptualisation of wellness is a common factor across all Māori models of health. Māori models highlight the importance of spirituality in supporting the wellbeing of individuals and whānau (Cherrington, 2009). There is often a tension between holistic Māori models and Western bio-medical models of health which has led to fundamental cultural barriers in Māori accessing health services that support different worldviews. It is thought that this may have also contributed to the paradoxical data indicating that increased access to primary health services does not equate to improved health outcomes for Māori (Russell et al., 2013).

One of the most utilised Māori models of health in New Zealand is Te Whare Tapa Whā – the four sides of the meeting house which reflect four dimensions of holistic well-being. Te Whare Tapa Whā was developed in 1982 by Mason Durie following a hui of Māori health workers at the

time, to challenge a Western biomedical reductionist view of health primarily focussed on the physical dimension (Rochford, 2004). The model of the four walls of the meeting house represents the interrelationship between the four dimensions of health - tinana (physical), family (whānau), hinengaro (mental), and wairua (spiritual) and the need for all dimensions to be in balance for the house to remain well (Cherrington, 2009). Despite the positive reception to Te Whare Tapa Whā and the widespread adoption of the symbolic representation of Māori worldviews in relation to health, there are criticisms about the over-simplification of the terms. Heaton (2015) argued that the discourses relating to Te Whare Tapa Whā are socially constructed by the dominant culture and challenges readers to consider hauora from positions that are frequently 'othered'. She argued that in reducing the model to the four dimensions of 'hauora', the complete picture of the whare (house) has been lost. This includes the entrance to the whare, who can speak within the whare, the tikanga that surrounds the whare and the whenua (land) upon which the whare is constructed.

Mason Durie developed Te Pae Mahutonga (the Southern Cross) model in 1999 which situated Te Whare Tapa Whā within a broader health promotion context. Te Pae Mahutonga is underpinned by traditional Māori celestial navigation and connection with horticulture (McNeill, 2009). The four stars of the Southern Cross represent the four goals of Māori health promotion, and the two pointer stars depict the action required to achieve the goals (Durie, 1999). The four goals of health promotion in Te Pae Mahutonga according to Durie (1999) are:

- Mauri Ora (Access to te ao Māori) – relates to having a secure cultural identity. This includes access to land, spirituality, language, knowledge, marae, and whānau.
- Waioara (Environmental protection) – having a healthy environment including air and water being free from pollutants, abundant vegetation and having access to the natural environment.
- Toiora (Healthy lifestyles) – including harm minimisation, targeted interventions and positive personal development.
- Te Oranga (Participation in society) – relates to having a role in society, including education, employment, knowledge and decision-making.

The two pointer stars reflect:

- Ngā Manukura (Leadership) - which includes community, health and tribal leadership with an emphasis upon communication and collaboration.
- Te Mana Whakahaere (Autonomy) – health initiatives must reflect community ownership and control to support community aspirations and self-governance.

The Meihana model was published in 2007 using the foundations of Te Whare Tapa Whā, incorporated Māori beliefs, values and experiences as factors that influence each of the components of health (Pitama et al., 2007). It provides a framework for the clinician working with Māori to identify and assess holistic cues, which may be contributing to the client's current state. The Meihana model was redeveloped in 2014 to reflect the diverse settings in which Māori access health services as well as increase the focus upon reducing health disparities (Pitama et al., 2014). Pitama et al. (2017) described the use of the Meihana model with a clinical psychology setting as providing an opportunity for the profession to demonstrate its commitment to the intention of Te Tiriti o Waitangi.

The model depicts a double-hulled canoe (waka hourua), illustrating the connection between the Māori patient and their whanau. The crossbeams (aku) in the canoe reflect each aspect of a clinical assessment and the need for the practitioner to ascertain the strengths and/or weaknesses of each component when planning care. Tinana relates to the physical assessment, hinengaro is the psychological and emotional wellbeing, iwi katoa is referrals and access to other services and support, wairua is connectedness and spirituality and taiao relates to the physical environment and safety (Pitama et al., 2014). The review of the Meihana model in 2014 saw the introduction of 'Ngā Hau e Whā' (the four winds) that reflect the external structural and political influences on the patient and 'Ngā Roma Moana' (the currents) which are the internal or personal influences on the patient. All of these factors affect the progression of the individual towards accessing quality health services and ultimately 'Hauora' (wellbeing). Pitama et al. (2014) described the responsibility of the health professional to sit on the canoe and navigate a course towards well-being alongside the patient and their whānau. 'Whakatere' reflects this navigation in the picture of the sail within the model.

Rangimarie (Rose) Pere developed Te Wheke (the Octopus) model in 1991 as a holistic model of Māori health and wellbeing. The intent of the model is to support development of the dimensions of health rather than 'correct' areas of dysfunction. The centre of the octopus represents whanau, hapu and iwi, reflecting the interconnectedness of individuals within the wider family context (Love, 2004). The eight tentacles of the octopus represent each individual dimension of health and overlap to demonstrate the connections to each other. The eyes of the octopus represent the 'waiora' – or the total level of wellbeing that the eight dimensions have contributed to the whole (Love, 2004). Love outlines the eight dimensions of health in Te Wheke as follows:

- **Wairua** – spirituality, language and connection with the spiritual realm through karanga, karakia and whakapapa. It also relates to the concepts of tapu in terms of what is sacred and needs to be protected and what is considered noa or cleansed of tapu.
- **Mana ātua ake** – refers to “the fire that no one can put out” (Tikao as cited in Love 2004, p. 25). Mana relates to prestige or empowerment and is closely linked to the spiritual realm. People are considered a channel rather than the source of mana. The relationship with the land is associated with mana and it can be passed through generations.
- **Mauri** – refers to life force or the link between the physical and the spiritual realms. Mauri is present within all living things and leaves a person upon death. The land has its own mauri and people can gain sustenance and healing from the mauri of other people and places.
- **Whanaungatanga** – relates to kinship and social bonds and “seeing, and defining oneself as part of a system” (Love, 2004, p. 43). Whanaungatanga encompasses the link to ancestral connections and the respect shown to kaumatua (elders) who represent the closest living link to ancestors who have gone before.
- **Tinana** – is the physical dimension and reflects the need for sustenance and development of the body. Haka and waiata are the physical expression of wairua and the process of karanga and whaikorero acknowledges the physical connection to and between Papatūānuku (the earth mother) and Ranginui (the sky father).
- **Hinengaro** – relates to the mind, intuition and emotion. The literal meaning is “hidden lady” which refers to the privacy and intimacy of thoughts and emotions. The hinengaro is often protected through metaphorical speech or non-verbal expression.
- **Whatumanawa** – relates to the emotional dimension and the ability to speak from the heart. Whatumanawa allows for reflecting upon and feeling emotions over time, which is reflected in the process of ‘un-veiling’, in allowing people to revisit the emotions involved in losing loved ones.
- **Hā ā koro mā ā kui mā** – translated means ‘the breath of life from our forebears’. This dimension reflects the connection to something bigger; that to disrespect oneself is to disrespect ancestors who have given life to following generations.

While there have been attempts to incorporate Māori models of health as the basis for assessment tools in WCTO nursing practice, the contracting models and reporting structures often prevent the authentic application of Māori models to practice contexts. The result is a retrofitting of Māori models over existing reporting requirements and assessment frameworks and further compartmentalisation of the dimensions of health. Assessment indicators may ‘fit’

across multiple dimensions, however the Western approach to assessment and reporting considers the indicator against one dimension only – negating the interconnectedness of everything which is fundamental to an holistic model of health (Lyford & Cook, 2005). What is clear is the need for services to work in ways that legitimise Māori ways of being and Māori models of health provide opportunities for increased understanding and consideration of Māori worldviews (Janssen & Nelson, 2014).

Māori well child health and whānau health determinants

The literature relating to Māori well child health in New Zealand is limited. A difficulty in the interpretation of data in well child service provision is the low level of confidence in attributing changes in trends or parenting practices to specific well child interventions with individuals and whānau (Tipa, 2013). Health literacy levels of many Māori parents of children under five appear to be relatively low (Ministry of Justice, 2010). This is further evidenced by health promotion initiatives specifically relating to Sudden Infant Death Syndrome (SIDS) prevention for Māori not appearing to make marked changes to parenting practices. Tipene-Leach et al. (2010) completed a study examining SIDS related knowledge across Māori parents. They discovered alarming rates of high-risk parenting practices such as maternal smoking, co-sleeping, and early cessation of breastfeeding as prevalent amongst Māori parents involved in the study. They highlighted the need for health promotion messages in relation to SIDS prevention to engage with Māori in meaningful ways in order to facilitate change. The identification of mechanisms to provide feedback and evaluate the success of interventions on a regular basis is pivotal to any form of continuous quality improvement and service responsiveness to Māori (Tipa, 2013; Tipa et al., 2015).

It is understood that the interplay between complex socio-economic determinants of health has an impact on long-term health prospects (Clendon & Munns, 2018). *The Addressing the Drivers of Crime* report (Ministry of Justice, 2010) and *Te Ohonga Ake* report (Craig et al., 2014) outlined a variety of factors which increase the likelihood of adverse long-term outcomes for children and families. Māori are over-represented in statistics reflecting higher rates of teenage births, higher rates of solo parenting, lower rates of parental education, lower income and 24% of Māori children under one-year-old being exposed to second-hand smoke. These reports discussed the barriers to engagement with services being around structural or organisational limitations such as cost, eligibility, judgmental attitudes, and inflexibility. They also described the way that situation-specific limitations such as stress, low literacy levels, lack of family support and domestic violence may contribute to negative outcomes for children.

Overall, both reports highlighted that Māori children are particularly likely to experience vulnerability risk factors and that services need to consider ways to engage appropriately to support Māori participation and positive outcomes.

Māori engage with WCTO [Well child/Tamariki Ora] services across multiple organisations with well child contracts. These services include Plunket, Māori/Iwi provider services, public health nursing services through District Health Boards (DHBs) and Primary Health Organisations (PHOs). Despite the diversity of WCTO providers on offer, the majority of Māori parents and whānau continue to access the Plunket WCTO service (Ministry of Justice, 2010), with Plunket statistics highlighting that over 70% of all Māori babies born are enrolled with Plunket at some stage during their first five years of life. (Royal New Zealand Plunket Society [RNZPS] 2015). This suggests that although Plunket is unequivocally a 'Western' service, there are aspects of the service or system that are already to some extent engaging with Māori communities. There may be several reasons for this engagement, including the referral processes from midwives and the branding of 'Plunket' as a national institution or 'rite of passage' for over 100 years. However, as highlighted in the background section, there is a significant drop off in contact in WCTO assessments over the first year of life. Aspects of the Plunket service working well for Māori will need to be identified as part of developing an understanding relating to culturally responsive ways of working and reasons for disconnection with the service are important to explore.

The *Growing Up in New Zealand* longitudinal study (2012) reported that over 91% of the 6846 children in the cohort had received all of their entitled WCTO assessments during the first 9 months of their lives. Ethnicity data relating to this statistic was not available. In contrast, the *Now We Are 2* report (2014) highlighted that only 33% of children in the cohort had received their 2 year assessment, with increasing numbers accessing primary health services from general practitioners, public health and Māori/Iwi providers rather than necessarily staying with their original WCTO provider or receiving any formal well child assessment. This may be due to the parental perception of vulnerability of smaller infants and uncertainty around growth and development at an early age and the impact that returning to work can have on access to services. It is important to determine the perception of well child services as the child grows and whether the engagement for Māori whānau with these services changes over time.

The *Te Ohonga Ake* report identified that Māori children (aged 0-14) were admitted to hospital with injuries arising from assault, neglect and maltreatment at over three times the rate of

non-Māori between 2007 and 2011, with the admission rate highest for Māori babies under 1 year of age (Craig et al., 2014). Despite the over-representation of Māori children in injury and mortality rates, the *Rainbow Report* published by Change for Our Children (Cowan, 2015) reported Māori infant death rates falling between 2009-2014 from 4.4 to 3.0 deaths per 1000 live births. This is a significant decrease as the deaths of Māori babies were increasing up until 2012. However, the total mortality rates of Māori are higher overall in comparison with non-Māori and non-Pacific and particularly in relation to SUDI and intentional deaths (New Zealand Mortality Review Data Group, 2018).

While data relating to Māori child mortality and morbidity rates appear to be readily and regularly available for analysis, the examination of the impact and evaluation of health interventions specifically with tamariki Māori are less visible. Jones et al. (2013) took an Indigenous approach to completing research with Māori children and their whānau living with asthma. They determined that the partnership relationships with the researcher as well as the buy-in from the local Māori community were fundamental to the ongoing engagement and retention of Māori whānau participants in the study. This suggests that the continuity and commitment to the relationship from both parties as well as a supportive context in which the relationship occurs are important factors to consider in terms of what constitutes culturally responsive care for Māori.

In 2010 the Whānau Ora initiative was adopted by the New Zealand government with the primary aim of optimising whānau wellbeing. The intention of the initiative was to minimise the fragmentation and duplication of health, education and social services working with Māori (Te Puni Kōkiri, 2015). Whānau Ora approaches recognise the whānau as a collective and identify ways to optimise the strengths and capabilities of all members. They also promote ways of working alongside whānau to address issues within the context of multiple determinants that impact upon whānau wellbeing (Boulton, 2019; Te Puni Kōkiri, 2015). At a political level, Whānau Ora was established to drive health sector behaviour to address the growing health inequities between Māori and non-Māori. While there are indications that the Whānau Ora initiative is having a positive impact on the lives of many Māori, there are criticisms that the policies have not addressed the wider structural barriers impacting on Māori wellbeing as a whole (Boulton, 2019). Boulton (2019) maintained however that Whānau Ora has created a paradigm shift whereby wider interpretations of hauora are more readily being integrated into government policy.

Institutional racism

The New Zealand Health Survey data indicated that in 2011/12 Māori had nearly twice the rates of self-reported experiences of racial discrimination than non-Māori. This is significant, as experiences of racial discrimination are linked with an increased risk for poorer health outcomes (Cormack et al., 2018; Harris et al., 2012; Jones, 2000; Williams & Mohammed, 2009). Institutional discrimination is embedded in organisational policies, processes and attitudes that disadvantage a particular racial or minority group and can therefore be relatively invisible in comparison to overt expressions of interpersonal discrimination. Sir William McPherson articulated the concept of institutional racism in his report relating to the racially motivated murder of Stephen Lawrence in London in 1993, and the way the Police handled the investigation at the time. McPherson defined institutional racism as:

The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people (Macpherson, 1999 para. 6.34).

Came and Humphries (2014) described a generalised reluctance in discussing institutional racism despite interpersonal racism being 'frowned upon' in privileged societies. They defined institutional racism as both action and inaction that provides an advantage to a specific sector of the population while disadvantaging another and suggested that the pervasive nature of institutional racism makes it difficult to identify and even more difficult to address. Came and Humphries highlighted the need for managers of health services to have a high level of 'moral integrity' to create a shift in strong social and institutional mores that disadvantage those who do not belong to the dominant group. In 2014, Came called for urgent action to address institutional racism within New Zealand health sector leadership and policy making and suggested that inaction from the public health sector would exacerbate a potentially 'modifiable racist system'. Despite this, there has been little indication of improvements in health indicators for Māori, suggesting that aspects of the current health system remain inaccessible for many Māori health consumers and their whānau.

Oda and Rameka (2012) discussed the difficulties in addressing institutional racism as it gains strength and traction in being part of organisational culture. They argued that New Zealand policies that focus on equality of service rather than equity of access provide a platform for institutional racism to evolve. Māori health outcomes have suffered as a result of a health system

designed to cater for the health perspectives and needs of the dominant culture in New Zealand (Jansen et al., 2009; Theunissen, 2011). 'Unconscious' or 'implicit' bias are terms increasingly discussed in reference to race relations and gender equity issues in New Zealand (Human Rights Commission, 2012; Ministry of Women's Affairs, 2013; Revell, 2012). Unconscious bias relates to a combination of knowledge and experience at a subconscious level and the way this is processed into thoughts and actions towards others. It has been proposed that by lifting the lens of cultural safety from individual interventions to achieve institutional cultural congruence, the behaviour of health practitioners will reflect more culturally adaptive, diverse and responsive principles (Oda & Rameka, 2012; Walker et al., 2010).

Marmot (2016) commented that the process of colonisation transfers the 'basic necessities' in terms of access to power, money and resources from Indigenous people to colonisers, resulting in inequities in health outcomes. Came et al. (2017) highlighted the perpetual nature of inequities in the health system for Māori in stating that "[t]he consistent production of inequitable health outcomes between Māori and other New Zealanders now seems an enduring feature of the health sector" (p.106). They commented that there is a need for non-governmental organisations (NGOs) providing health services, to transition from projects targeting Māori towards normalising everyday engagement with Māori by creating environments in which Māori worldviews are at the centre of practice. There is an argument that the long-standing health inequities between Māori and non-Māori reflect a breach of Te Tiriti o Waitangi, as outlined in the WAI 2575 claim (Ministry of Justice, 2019). Came et al. (2018) were critical of the mono-cultural approach to contracting and monitoring of Māori public health providers in contrast to generic providers. They highlighted the calls for measures that place the gaze on Crown behaviour towards addressing Māori health inequities and the discrepancies that exist in the operationalisation of the rhetoric that all providers are treated equitably.

Power

Central to nursing and therapeutic relationships are the concepts of 'power' and 'empowerment'. Potter (2012) suggested that nursing education and textbooks provide ambiguous information surrounding the concept of power in relationships between nurses and patients. Potter argued that the negative connotations surrounding power in nursing have led to nurses abdicating their own power, which deems them often unable to contribute and participate fully in partnerships. This uncertainty around participating in relationships with shared power and decision-making was observed in a study of Plunket nurses in terms of their relationships with Māori clients. Many Plunket nurses in the study feared challenging aspects of

parenting practice with Māori clients due to the perceived damage to the relationship. The negative impact of this approach ranged from a general mistrust in the nurse providing the service, to clients feeling judged by the nurse, through to nurses feeling uncertain whether what they do makes any difference to client outcomes (Tipa, 2013). Therefore, the interplay between people in terms of power attached to environments, interventions, relationships and information needs to be explored and understood in order to work together in authentic partnerships.

Ramsden (2015) connected the concept of power with cultural stereotyping. She described “smorgasbord nursing” or “cultural tourism” (p 78) as the practice of a nurse sitting comfortably within a nursing culture and assessing the cultural needs of patients from their own standpoint. This practice ostensibly positioned the patients in deficit (in comparison to the dominant nursing culture) and contributed to an imbalance in power. Altman et al. (2019) published a study that examined the experiences of women of colour in their interactions with health providers during pregnancy and birth. They developed a framework depicting the influence of power at both interpersonal and structural levels over the degree of autonomy and self-determination experienced by women. They identified the negative impact that biased or discriminatory care has on the ability for women to make informed choices for themselves and their children. Altman et al. (2019) linked the way power is understood within health services to the delivery of equitable care. They argued that racial discrimination within health services leads women to have to present themselves in a particular way to receive respectful care. This situates the power with the provider of services rather than ensuring that services adapt and respond respectfully to the needs of each woman and family accessing their service.

Empowerment is generally defined as the way in which people make decisions and control their actions (Ayme et al., 2008; Suárez Vázquez et al., 2017). In a health care setting, this refers to the improvement of wellbeing and quality of life. Suárez Vázquez et al. (2017) determined that the higher the level of trust patients with long term conditions had in a health professional, the lower the level of self-reported empowerment. This was explained as being due to the illness focus of the participants within the cluster being studied. In patients with less severe conditions, the level of self-reported empowerment increased alongside the trust in health professionals. When patients experienced a severe or acute illness, they appeared less likely to cope with decision making relating to the condition. This study is of interest due to the potential correlation of whānau experiencing varying degrees of empowerment when accessing WCTO services. The emphasis on ‘well child’ within WCTO assessments may equate to the need for whānau to experience self-reported empowerment in order to have high trust in WCTO

providers. McLaughlin (2016) described the way empowerment positions people into those being empowered and those doing the empowering and can therefore in effect further disempower populations who are already marginalised. This critique of empowerment is a reminder that power is often determined by the service or provider rather than the patient themselves.

Working together – partnership relationships

Partnership relationships are considered the 'relational core' of nursing with the foundational work of nursing theorist Hildegard Peplau defining the nurse-client roles and the phases of the relationship that result in personal and professional growth and positive experiences for both parties. In the early 1900s Peplau was controversial in her thinking, as at the time, nursing was controlled by medicine and there was a culture of transactional and custodial nursing care - particularly in psychiatry (Chinn & Kraemer, 2011). Peplau (2004) defined nursing as "a human relationship between an individual who is sick or in need of health services, and a nurse especially educated to recognise and respond to the need for help" (p. 6). The notion of working together in a partnership relationship in response to the needs expressed by the patient becomes increasingly important in health promotion, disease prevention and mental health nursing in which the lens is shifted away from physical interventions, towards the communication around often competing health and social priorities.

Christensen (1998) examined nursing partnerships as progressive processes in which nurses support patients to pass through a health-related experience. She placed the nurse in the 'giving' role and the patient in the 'receiving' role, with both parties working towards an optimal experience and outcome. Christensen acknowledged the context that exists for patients that affect the partnership relationship and described these as internal and external 'conditions'. She discussed the other 'passages' that exist for patients alongside the health-related experience and the way they continually impact and influence each other. The effect of change upon this matrix of interrelated activity is complex as it may involve challenging patient's constructs that have and continue to provide meaning to life events. The active role of the patient in receiving care is also described in Christensen's nursing partnership model. Although not always recognised, patients are actively working with the nurse towards a common goal rather than passively receiving care (Christensen, 1998). This notion and the extent to which clients are actively involved in WCTO partnerships will be important to establish within this research in order to increase understanding relating to cultural responsiveness.

The Family Partnership Model was developed in the 1980s by Professor Hilton Davis – a Child Psychologist in the United Kingdom, in response to parent feedback that they were not listened to, treated with respect, or recognised for their own expertise by health professionals (Davis et al., 2002). The Family Partnership Model provides a framework to address the frequent ‘mismatches’ between what parents expect from health professionals and the services that are offered and provided (Davis & Day, 2009). Underpinning this framework is the importance of health professionals gaining a clear understanding of the issue(s) presented by the parents rather than providing advice from an ‘expert’ standpoint. The rationale for this approach is that even though the advice may be valid, parents are less likely to implement change unless they have buy-in into the process.

A limitation around embedding the Family Partnership Model within Aotearoa has been the costs associated with the training as well as ongoing supervision to support continuous learning and application of the framework to practice (Wilson & Huntington, 2009). Family Partnership principles are fundamental to effective WCTO clinical practice in Aotearoa, however in its current format, the model is unsustainable in a not-for-profit environment. Additionally, the lack of emphasis on the cultural environment when using the Family Partnership model in practice limits its effectiveness when working within Māori realities (Tipa et al., 2015). This highlights the need for a Māori led framework to support engagement with whānau in WCTO practice.

Family centred care or patient and family centred care is the provision of healthcare that is oriented around the needs of the patient and family. It is reliant upon patient and families being partners in the care that is provided to them (Kuo et al., 2012). Family centred care within a paediatric setting ensures that all family members are viewed as recipients of care, not just the child (Shaul, 2014). There is an emphasis upon working with families in ways that are culturally supportive and encourage family input into decision making processes (Matziou et al., 2018). A lack of consistent definitions and different interpretations of actions that constitute family centred care are the key criticisms of this approach (Kuo et al., 2012). Matziou et al. (2018) determined that nurses often lacked specialist knowledge and information to effectively provide family centred care in their practice. Furthermore, they identified that nurses’ abilities to involve family effectively in the provision of care were enhanced by post graduate education. They suggested that this was due to the increased ability of nurses with higher levels of education to apply theory to practice.

Family centred care is a term that describes an approach primarily in a tertiary setting, despite being used in many primary healthcare contexts. Ridgway et al. (2020) completed a systematic

review of family centred care in child and family nursing in community settings across Australia, England and New Zealand. They determined that aspects of family centred care were being used within child and family nursing in the community rather than family centred care itself. They identified relationships as pivotal to meeting the needs of families and highlighted the impact of organisational structures and individual belief systems on the implementation of family centred care in practice. Dennis et al. (2017) determined that working in partnership using a family centred care approach required practitioners to work in relational ways with families to gain an understanding of their culture and environment. Many Māori whānau experience discrimination and coldness from health professionals and systems that leads them to feel alienated when receiving healthcare (Graham & Masters-Awatere, 2020; Tipa et al., 2015).

Graham and Masters-Awatere (2020) highlighted that whānau are often required to provide care for their family members as their needs are not being met by the health service. They described the health system in Aotearoa as “unwittingly continu(ing) to perpetuate historical trauma against Māori” (p 199). The term ‘partnership’ has been highly politicised in reference to te Tiriti o Waitangi and working with Māori. ‘Partnership’ is one of the principles designed by Crown agencies to summarise the intent of te Tiriti o Waitangi. Many Māori do not agree with using these Crown-defined principles and instead focus on what was promised within the articles (Came et al., 2017). O’Sullivan (2019) described the Treaty settlement process as supporting a move from ‘partnership’ to independence. He discussed the emphasis on creating partnerships as detracting from Māori aspirations for self-government. Mikaere (2013) described the principle of partnership as “lofty rhetoric” (p 171) which leads to Māori being portrayed as unreasonable if they question the intention of the Crown. She believed the use of the Treaty principles created another “layer of deceit” (p 172) in the relationship between the Crown and Māori. The notion of partnership and what it means to Māori must be closely examined when considering how WCTO services can more effectively with whānau.

Cultural safety

Cultural safety extends beyond cultural competence by acknowledging the social and political power structures that exist within the provision and experience of care (Kurtz et al., 2018). The practice of cultural safety negates the need to ‘know’ about different cultural practices and instead emphasises the need for self-awareness on the part of the health practitioner (Curtis et al., 2019). Cultural safety provides an opportunity for nurses to transcend assumptions or generalisations in relationships and respond to the varied and unique cultural needs of the individual receiving care (Richardson, 2010).

The original concept of cultural safety emerged from concerns by Māori student nurses that their learning environment was 'culturally unsafe' and was contributing to the low rate of Māori entering and remaining in the nursing profession (Wilson, 2014). The history of cultural safety is grounded in the socio-political context of activism and social change that occurred in Aotearoa in the 1980s and 1990s as outlined in the previous chapter (Richardson & MacGibbon, 2010). It is therefore no coincidence that the development of cultural safety occurred within a climate of increasing calls from Māori for the Government to uphold the promises inherent within Te Tiriti o Waitangi. According to Richardson (2010), Ramsden was unapologetic in her view that cultural safety needed to privilege Māori worldviews against the backdrop of a dominant Pākehā health system.

The original *Guidelines for Cultural Safety* for nursing in Aotearoa were written by Irihapeti Ramsden in 1991 and approved by the Nursing Council of New Zealand in 1992. Since then, it has been a requirement for all registered nurses in Aotearoa to practice in a manner that the consumer perceives as culturally safe. Today, there is an abundance of literature examining cultural safety within nursing education (Kurtz et al., 2018). However, there is significantly less literature relating to the practical application of cultural safety and the assessment of culturally safe nursing practice. This may reflect a theory-practice gap, although it also highlights the juxtaposition that exists between nurses' requirements to reflect upon cultural safety as a core competency in practice and the necessity for the recipients of care to assess whether the service was culturally safe (Tipa, 2013; Wilson, 2008). There is also some confusion relating to the difference between cultural competence and cultural safety with both terms often being used interchangeably in practice and education environments (Curtis et al., 2019). Recognising the implications of power dynamics both within and upon relationships is the fundamental difference between cultural safety and cultural competence (Kurtz et al., 2018).

Irihapeti Ramsden (2002), often referred to as the 'pioneer' of cultural safety, described the concept as relating directly to the feedback provided by the client and whānau. She stated, "Cultural Safety is simply a mechanism which allows the consumer to say whether or not our service is safe for them to approach and use. Safety is a subjective word deliberately chosen to give the power to the consumer" (p. 181). The need to create opportunities and appropriate mechanisms for feedback is therefore fundamental to the practical application of cultural safety. Davis et al. (2002) discussed the importance of building relationships to support open and honest communication. They highlighted the risk of people in 'helping' roles distorting their own perceptions of their effectiveness if the relationship is not established in such a way

that invites honest and regular feedback. Ramsden (2002) described the same phenomena in terms of the attitudes of health professionals directly affecting the wellbeing of people in their care. She observed that health professionals are often not aware or alerted to their own attitudes that have an impact upon the acceptability of a service.

The need for nurses to understand themselves as bearers of culture – not only personally but as nurses within an environment of practice, is fundamental to the demonstration of cultural safety (Jones, 2017). Nurses' willingness to reflect upon themselves and to see themselves as positioned by culture brings a degree of humility and authenticity that underpins culturally safe practice with diverse populations (Jones, 2017; Ramsden, 2002). Ramsden (2002) maintained that cultural safety is about the attitudes and behaviours of the nurse rather than what is different about the patient. This differs to Leininger's (1970) foundational work in transcultural theory that focuses on the nurse demonstrating 'culturally based care' that adapts to the patient's values and beliefs, because the assessment and judgment of cultural differences in patients primarily sits with the nurse.

The difference between transcultural nursing and cultural safety is reflected in the way power difference is considered between the nurse and the client and/or whānau. In transcultural nursing, the power of decision making, while informed by the patient, remains with the nurse whereas culturally safe practice is the demonstration of a shift of power from the nurse to the patient and whānau. Cultural safety requires nurses to provide care that reflects an understanding of the self as a bearer of culture and adapts to what is wanted and needed by the consumer. In 2019 the Medical Council of New Zealand issued a statement outlining a shift in focus from cultural competence to cultural safety and health equity (Medical Council of New Zealand, 2019). These guidelines support an increase in the self-reflection of medical professionals however do not outline the importance of creating environments in which patients can provide feedback on the care they receive. This change demonstrates a willingness for the medical profession to shift however the extent to which it is understood and creates a shift in culture will be assessed over time.

Cultural responsiveness

'Cultural responsiveness' is a term originally described in education environments relating to approaches towards teaching children from diverse ethnic backgrounds. This definition has reduced the concept to requiring teachers to demonstrate an understanding of a vast array of cultures without an emphasis on power and the environment in which culturally responsive

practice occurs (Tuncel, 2017). Unsurprisingly, there has been a movement away from cultural responsiveness in education settings towards culturally sustaining pedagogies that position cultural identity, experiences and the knowledge of students as mechanisms to enhance rather than hinder learning (Kidwell & Pentón Herrera, 2019). In this thesis however, the term cultural responsiveness refers to a broader socio-political approach that encapsulates the practice of culturally safe care within a wider environment of practice. It is considered at an individual level, however, requires organisations to critically reflect upon the environment in which relationships are developed and maintained.

Cultural responsiveness extends the reach of cultural safety by incorporating an awareness and sensitivity to difference into a broader socio-ecological context in which culture and determinants of health are multidimensional and interwoven (Werkmeister-Rozas & Klein, 2009). This description shifts the lens from individual nurse-client relationships to organisational and governmental approaches in responding to needs. There are challenges at both individual and organisational levels to ensure services are culturally responsive while being delivered universally across populations (Wilson, 2014). Bowen (2008) described cultural responsiveness from an organisational perspective as appropriate and effective service responses to the diverse needs of populations. Bowen discussed access to services and cultural competence as essential factors in responding to population diversity. Despite this, strategies to improve access to health services within Aotearoa for Māori have predominantly focussed upon location and transport rather than system structures and organisational culture and have therefore had limited impact upon rates of engagement.

The process of ethnic categorisation hinders the ability for nurses and organisations to respond to the unique and diverse needs of individuals. An example of this is the Constitutional classifications of the First Nations people of Canada who have been classified into three large groups rather than the 618 First Nations in existence. The resulting communication and provision of services does not necessarily encapsulate the differences that exist within the groups themselves (Nelson & Wilson, 2018). Cultural responsiveness is grounded in suspending judgments and approaching all people as individuals with a commitment to gaining an understanding around what matters to them (Wriedt et al., 2014). This involves the development of service delivery models and organisational philosophies that cater for and support diversity. Organisational structure, contractual requirements and service design are key elements that influence the provision of a culturally safe and responsive service at an individual level.

Wriedt et al. (2014) discussed the requirement for cultural responsiveness to be embedded systemically throughout organisations, within education, policy and service delivery design with the objective of increasing equity of outcomes across populations. Education institutions have highlighted the necessity of cultural responsiveness to prevent culture being cited as a reason for educational failure (Sullivan & A'Vant, 2009). They reinforced the need for organisations to be cognizant of the culture created within the work environment that guides professionals to be open to making changes or improvements based on feedback. Richardson and MacGibbon (2010) described the requirement for nurses to navigate through 'opposing discourses' in providing culturally safe care within a hospital setting. They highlighted the importance of nurses to be aware of organisational power dynamics and the negative impact these can have on interactions with clients. Given the recent structural changes to many primary healthcare services in New Zealand, it is imperative to consider the environment in which well child professionals provide culturally safe and responsive care and the influence of the environment on nurses' ability to work alongside Māori whānau (Mitchell & Wilson, 2019).

Summary

This chapter outlined the search strategy undertaken to review the literature. The literature related to whānau experiences of WCTO services is limited. There are also few conceptual frameworks designed specifically to support working alongside whānau in culturally responsive ways. Many Māori children are born into complex socio-economic environments which influence the degree to which adverse long-term health outcomes are experienced. WCTO services within Aotearoa are well-positioned to have regular contact and provide support to whānau, however, the contact appears to lessen after the first year of life. Partnership relationships have been identified as an optimal way of working to ensure engagement and contribution from both parties towards mutual outcomes. In WCTO services, Family Partnership appeared to be a communication framework that supported health professionals to work with families in this way, but the costs related to professional development and the time taken to practice using this framework proved unsustainable due to funding.

Cultural safety remains an essential component of the nursing curriculum and standards of practice, however, there remains confusion in application between cultural safety and cultural competence. The shift of power from the nurse to the client/whānau is the factor that fundamentally differentiates cultural safety from cultural competence and transcultural nursing. The concept of power is complex and requires constant consideration as to who holds it and what the impact is upon the other party. Cultural responsiveness extends the gaze to the

environment in which culturally safe care is provided. This links to the concept of institutional racism whereby policies focussing on equality of service, potentially negate the inequities that exist within and across populations. Māori models of health have been positioned to integrate Māori worldviews into a Western health system, however funding and reporting contracts often limit the ability of these models to be authentically applied to practice. Overall, the literature positions a study which develops a theory from the experiences of whānau accessing WCTO services as essential in raising the awareness of approaches that can improve outcomes for Māori.

The following chapter will outline the kaupapa Māori methodological approach taken in this study. It will describe the tenets of my interpretation of kaupapa Māori methodology and the connection with constructivist grounded theory methods. It will provide an explanation of why this approach was taken and examples of how the principles were applied.

Chapter Three: Methodology

Tukua taku wairua kia rere ki ngā taumata
Hei arahi i āku mahi
Me taku whai i te reo Māori
Kia mau, kia ita
Kia kore ai e ngaro
Kia akoina, kia pupurihia
Kia whakamaui kia tina!
Haumi e! Hui e!
Taiki e!

Let my spirit ascend to the topmost summits
As a guide for all that I do
And in my aspirations for Te Reo Māori
So that it can be retained
And not lost
Taught and preserved
So that it can be maintained
To forever energise in sustainability
In security!

Introduction

I have opened this chapter with a karakia (blessing/incantation) which acknowledges the significance of the use of te reo Māori (the Māori language) throughout the whole thesis, but specifically this methodology chapter. The kupu (words) in te reo often represent much more than a direct English translation allows and provide both traditional and contemporary insights into te ao Māori (the Māori world).

In designing this research, I sought to develop an understanding of cultural responsiveness as defined by whānau with tamariki under five years of age. Therefore, the need to identify an appropriate methodology that would privilege the views of whānau eligible for WCTO services within a wider context of te ao Māori (the Māori world) was important. The methodology also needed to demonstrate a recognition of Māori rights to self-determination and showcase mātauranga Māori (Māori knowledge). There has been criticism of non-Māori methodological approaches historically failing to recognise and legitimise Māori realities (Cram, 2017; Pringle et al., 2010; Smith, 2012; Wilson, 2017). For this reason, along with my own whakapapa Māori, I wanted to explore kaupapa Māori as a research methodology.

I focussed on identifying the Indigenous views of Māori relating to WCTO services to construct a theory for culturally responsive service delivery. The methods I selected needed to align with the process of obtaining the 'voice' and insights of Māori as well as contribute to a kaupapa Māori methodology. I chose to use Charmaz's (2014) constructivist grounded theory methods to collect and analyse data as these allowed for the recognition of my own position and influence (further explored in the reflexivity section of the methods chapter) in constructing a theory within the context of well child/tamariki ora services.

This chapter will begin with an overview of my theoretical position and define the kaupapa Māori research paradigm that provided the foundation for this research. The whakapapa of this study and key belief systems underpinning Māori realities will be discussed in relation to the ontology of the research. I will then describe the epistemology of the study and re-present my research question and aims followed by an exploration of the four values central to my interpretation of a kaupapa Māori research design. Constructivist grounded theory will be described, including the four tenets that inform the methodology. Finally, I will discuss the connection between kaupapa Māori methodology and constructivist grounded theory methods.

Kaupapa Māori Research Paradigm

Kaupapa Māori research is driven by the need to emancipate Māori worldviews¹ and values from Western research processes. It was developed as a decolonising approach by Māori to address the shift in which Māori worldviews, once seen as ordinary, became an exotic variation on what is 'normal' (Cram, 2017; Smith, 2012). Understanding the role of research in the colonisation of Māori reinforces the significance of kaupapa Māori research today. Historically, Māori ways of being were simplified and generalised based on brief encounters with Western researchers and these representations of Māori were then presented back to Māori through Western eyes (Smith, 2012). This resulted in Māori being viewed from a deficit base, with research being interpreted using generalisations that blamed Māori for poor outcomes – without consideration of the socio-political, historical and cultural realities of whānau (Wilson, 2017). Kaupapa Māori research is primarily about self-determination (tino rangatiratanga). This means that Māori need to determine whether research will contribute to the greater good of Māori and have full control over the research process.

Nepe (1991) described kaupapa Māori research as a body of knowledge with epistemological and metaphysical foundations that have existed since the beginning of creation. He described this knowledge as the way Māori worldviews are validated and are not only owned by Māori but also controlled by Māori. Mahuika (2015) explained that kaupapa Māori research is not about rejecting other ways of knowing, but about providing a platform for Māori to articulate their experiences. She described the need “to challenge and disrupt the commonly accepted forms of research in order to privilege our own unique approaches and perspectives, our own ways of knowing and being” (p. 38). There are some concerns with a kaupapa Māori approach

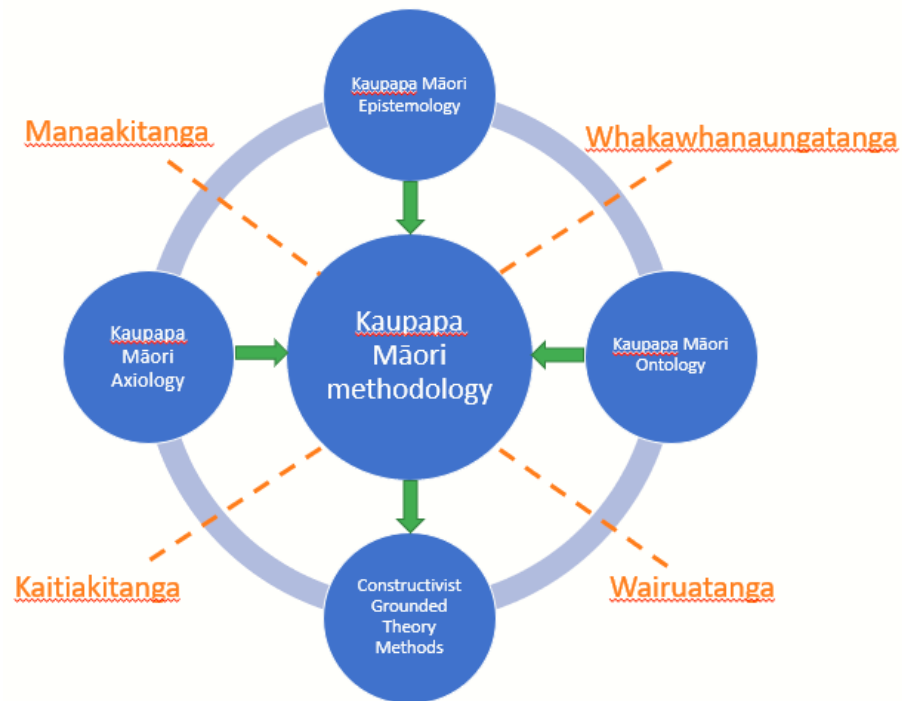
¹ Māori worldviews situate Māori ways of knowing and being at the centre of reality which is the embodiment of tino rangatiratanga (absolute cultural integrity) as promised in Te Tiriti o Waitangi. Pohatu, T. (2003). Māori world-views: Source of innovative social work choices. http://www.rangahau.co.nz/assets/Pohatu/Pohatu%20T_maori_worldviews.pdf.

homogenising or romanticising Māori values and ways of being and creating a dichotomy which classifies people as either 'insiders' or 'outsiders' (Mahuika, 2015). Therefore, recognising the post-colonial fluidity that exists for Māori and the impact that our own institutionalisation as Māori researchers have on conducting kaupapa Māori research is essential in ensuring the validity of kaupapa Māori research (Waitere-Ang, 1998).

The tenets of kaupapa Māori research are immersed in multiple Māori worldviews and are consequently difficult to define or reduce to a selection of concepts. Guidelines for research with Māori were developed to address Māori ethical issues in order to prevent harm or adverse experiences for participants. 'Te Ara Tika' (Hudson et al., 2010) is a framework used to consider kaupapa Māori ethical principles needed for research involving Māori, that clearly differentiates kaupapa Māori research from Māori centred and mainstream research designs. It is widely accepted that tikanga provides an appropriate pathway to access Māori knowledge and ensure the preservation of mana (justice and equity, reflected through power and authority) throughout the research process (Hudson et al., 2010; Jones et al., 2006; Walker et al., 2006).

The connection between a kaupapa Māori methodology and constructivist grounded theory methods is central to this research design. In order to adhere to tikanga Māori, it was important to identify the underpinning concepts that defined my approach to kaupapa Māori research. I developed a diagram (Figure 3.1) to demonstrate my theoretical position based on my interpretation of a kaupapa Māori methodology. This interpretation is closely based on Cram's (2017) definitions of the components of a Kaupapa Māori Inquiry paradigm. The diagram outlines a kaupapa Māori methodology at the centre of the research process, with an emancipatory and decolonising intent. The outer circles represent the components of the philosophical inquiry of this study that are connected to each other and contribute to the kaupapa Māori research paradigm. The constructivist grounded theory methods are connected to the kaupapa Māori research paradigm as they are informed by kaupapa Māori methodology. The four 'values' are linked through to the centre of the study with dotted lines and depict 'Ngā Hau e Whā' or the four winds that connect people. These values provided the philosophical basis for my kaupapa Māori methodological approach, which is illustrated by the dotted lines. The values were identified and agreed upon with the research advisory rūpū. Each component of this model will be explored and extrapolated further in the following sections.

Figure 3.1
The Kaupapa Māori Research Paradigm



Kaupapa Māori Ontology

Ontology can be defined as “a formal, explicit specification of a shared conceptualisation” (Studer et al., 1998, p. 184). Put simply, ontology is the way in which the world is experienced within a specific research paradigm. Kaupapa Māori ontology refers to ‘what is real for Māori’ (Henry & Pene, 2001). Henry and Pene (2001) described a kaupapa Māori research paradigm as a philosophical belief system entwined with a set of social practices. A consideration relating to ‘what is real for Māori’ is that many Māori do not necessarily feel comfortable claiming a Māori identity as they believe they do not fit a pre-determined set of criteria (Te Huia, 2015). While it is acknowledged that Māori worldviews differ from iwi to iwi, hapū to hapū, whānau to whānau and person to person, there are some commonly recognised beliefs which imbue many Māori realities. In the following section, pūrākau (traditional Māori narratives) will be described as fundamental to Māori history and identity. Whakapapa (genealogy) will be discussed in terms of the interconnectedness of all things and whānau as the social context in which cultural identity is shared and developed.

Pūrākau

Pūrākau is a term that has been historically used to describe Māori ‘myths and legends’. However, there are increasing calls for pūrākau to be re-acknowledged as traditional Māori narratives containing “philosophical thought, epistemological constructs, cultural codes and worldviews fundamental to our identity as Māori” (Lee, 2009, p. 1). The reclaiming of pūrākau and their use in research, contributes to the wider decolonisation movement and cultural regeneration for Māori (Smith, 2012). Lee (2009) described the early documentation of Māori narratives by Eurocentric anthropologists as ‘dangerous’ due to their inaccurate representations and fantasy portrayals which essentially destabilised Māori social and religious structures. She explored the impact Christianity had in redefining pūrākau to align with Christian stories to reflect Pākehā worldviews, as well as their use in a covert destruction of traditional Māori belief systems. The use of a kaupapa Māori methodology provides an opportunity to position pūrākau within a contemporary research context.

Central to the guidance of pūrākau is the practice of storytelling. Storytelling allows for the exploration and understanding of cultural identity as well as the preservation of history. Stories evolve over time and are influenced by contemporary contexts, interpretations and applications to specific situations (Lee, 2009). Cram (2017) outlined ‘ako’ (culturally preferred pedagogy) as a key principle within kaupapa Māori research ontology which represents the learner and the teacher both sharing and learning. In kaupapa Māori research, this can be applied in the use of pūrākau and storytelling for both participants and the researcher to contextualise the experiences described throughout the research process. While there is an emphasis upon identifying codes that capture the essence of what is described by participants, the use of pūrākau in sharing participants stories to support mutual learning and interpretation is important. This extends to the metaphysical realm in terms of exploring spiritual frameworks for engagement with whānau.

Whakapapa

All things in te ao Māori are considered to have whakapapa (genealogy). Historically, whakapapa was the way the world was ordered and understood. Roberts (2013) described the role of whakapapa as a framework upon which reality can be examined. In Māori cosmology, there is one set of original primal parents from which all people and things are descendants. The children of Ranginui (the sky father) and Papatūānuku (the earth mother) are often referred to as ‘environmental atua’ (gods) and are each responsible for a different part of nature. People are

not separate from this complex environmental lineage as it forms the basis for kinship ties between people and between people and the wider environment (Roberts, 2013). Cram (2017) further highlighted the link between whakapapa and creation in terms of the spiritual ties that connect people and the environment together. She described the process of Māori honouring these ties using reciprocity as an 'economy of affection' in contrast to a historical colonial economy of transaction or even exploitation.

Gillet (2009) described the understanding of non-human whakapapa as requiring a person to look subjectively at their experiences in the world – rather than looking objectively at the world itself. The original idea for this research topic evolved from the experiences of Māori whānau as participants in my master's research that evaluated the extent to which a communication programme called 'Family Partnership' could be considered a model for cultural responsiveness (Tipa, 2013; Tipa et al., 2015). Whānau involved in the research indicated that Plunket nurses did not always acknowledge their culture in terms of what it meant for them (the whānau). Whānau felt that questions relating to who they are, and their cultural realities were an 'add on' and they were concerned about being 'judged' because of their culture and ethnicity. The research also highlighted organisational limitations in providing culturally safe and responsive practice as a direct result of funding structures and the organisation of teams (Tipa, 2013). It was clear that the experience of receiving WCTO services did not always align with the values and beliefs of Māori whānau.

Whānau

Despite many Māori social and religious structures being decimated at the hand of colonisation, whānau [extended family network] has remained a constant concept in the organisation of Māori society (Smith, 2012). Traditionally, whānau reflected ties to a common ancestor and provided a location for teaching and learning, developing social connectedness and contributing to communal responsibilities (Durie, 1998). Whānau provides a context to establish cultural identity which is both individual and collective and consists of both physical and spiritual realms (Durie, 1997). The connection between physical and spiritual realms is echoed in the telling and re-telling of whakapapa, highlighting the interconnectedness between the living and those who have passed on (Durie, 1997). The literal meaning of 'whānau' is to give birth, however it is a word that has evolved alongside Māori society and is frequently used in reference to groups with a common purpose, including community groups, workplaces and households (Durie, 2003).

A common framework that binds whānau together is 'kaupapa' (collective vision and aspirations) (Cram, 2017). The connections that link Māori together are fundamental to understanding the realities for Māori whānau. Metge (1995) observed that a Māori understanding of whānau from within whānau is often 'taken for granted' and therefore there is often confusion when others interpret what whānau is differently. Central to this was considering the different whānau connections that exist as part of this study. The whānau as participants, myself and my whānau, the collective research whānau, and the whānau who are not participants but will be impacted upon by findings, were all perspectives I needed to incorporate into the construction of theory.

Pūrākau house the whakapapa of all creation from which whānau are connected through lineage. Pūrākau, whakapapa and whānau remind us of the interconnectedness between all things and provide the foundation for the metaphorical and metaphysical interpretation of phenomena. They provide an opportunity for both Māori and non-Māori to gain insight into ways that Māori experience the world.

Kaupapa Māori Epistemology

Within kaupapa Māori research, ontological and epistemological assumptions are often interwoven because of the connection between the concepts through whakapapa (Marsden & Royal, 2003; Stevenson, 2018). Roberts (2013) stated that "mātauranga and wānanga comprise a body of knowledge situated within a cognitive genealogical framework called whakapapa ... this provides the theoretical or epistemological basis for a Maori [sic] 'way of knowing' about the world" (p.93). Mātauranga Māori provides a mechanism for exploring and understanding the Māori world and is commonly translated as 'Māori knowledge'. Mātauranga Māori is demonstrated in te reo (Māori language) and tikanga (customs and protocol) and is generated through the use of whakapapa (Pihama, 2015).

Smith (2015) explained that mātauranga allows for increased insight or clarification relating to a specific issue. She added that kaupapa Māori approaches place mātauranga at the centre of reclaiming a space for Māori knowledge and ways of being within research. This includes engaging Māori back into research after years of viewing research as inextricably linked to European imperialism and colonialism (Smith, 2012) as well as increasing Māori involvement in conducting research. Reclaiming a space in research with Māori also requires the development of new research strategies and approaches that search for meaning within Māori worldviews (Jones et al., 2006).

I was interested in what cultural responsiveness looked like as a concept constructed by Māori whānau in relation to WCTO services. I began by considering research questions relating to ‘ways of working together’ to support a research process with less bias and industrial terminology than the concept of ‘partnership’ (Mondahl & Frederiksen, 2020). In developing the research question and aims, I was conscious of the emergent research and voice relating to Māori experiences of implicit bias and institutional racism (Came & Humphries, 2014; Houkamau & Clarke, 2016). I was also cognizant of the silence surrounding cultural safety which seemed to reflect a ‘lull’ following the upheaval and turmoil of integrating the concept into nursing school curricula and the Nursing Council of New Zealand standards of practice in the early 1990s (Wilson, 2012). This was further reflected in the dilution of the term within Nursing Council competencies which reinforced the institutionalised practice of nurses within Aotearoa rather than supporting a critique of power within the practice context. Subsequently, I developed the following research question with the advice and support of my supervisors and my research advisory group:

‘What are the processes involved for working together in a culturally responsive way with Māori accessing well child/tamariki ora services?’

This study was designed to explore what Māori whānau believed constituted both culturally responsive practice and service design when accessing well child/tamariki ora services. My previous research as well as the literature highlighting accounts of experiences of institutional racism led me to believe that the current approach was conducive to environments in which cultural safety was practiced by nurses and experienced by whānau. Therefore, there was a need for Māori knowledge to inform the development of culturally responsive WCTO services. The objectives of the study were developed alongside my research advisory group, and further elaborated upon the research question with aims to:

- identify Māori knowledge about WCTO service delivery and outcomes
- define cultural responsiveness from Māori worldviews in accessing WCTO services
- explain a theory for culturally responsive ways of working together with Māori
- increase the understanding of culturally responsive relationships in WCTO service delivery

Gaining insight as to how Māori experience WCTO services and the connection to what was currently known about cultural responsiveness was important in fulfilling the research objectives. Marsden and Royal (2003) describe the term ‘Te Whe’ (sound) which when traced back through whakapapa lines is associated with the process of ‘wānanga’ (discussion, debating,

imparting knowledge). The outcome of wānanga is 'wisdom' related to the kaupapa being discussed. This increases the impetus to ensure Māori voices are heard and ideas are explored within the wisdom of the collective.

Smith (2012) attributed Māori researchers being able to study Indigenous knowledge to the activism that has occurred within a Māori research space. She believed the levels and types of activism have varied over generations, however posited that activism has been fundamental in regenerating mātauranga Māori. George (2012) described the Māori cultural renaissance of the 1970s and 1980s as having inadvertently homogenised the perceptions of Māori ways of being. She described the practice of non-Māori defining Māori knowledge as limiting Māori self-determination. Activism that places Māori issues in the spotlight, therefore needs to consider the multiplicity of Māori perspectives and initiatives designed to address Māori issues need to be driven by Māori. Came (2012) stated that the apologies for historic racism at government levels in both Australia and New Zealand were an outcome of sustained activism. She added that activism has led to the advancing of Māori aspirations, particularly in relation to te reo, the establishment of the Waitangi tribunal and the development of Māori service providers. Despite this, the apologies have not brought about change. Māori continue to experience racial discrimination recurrently throughout their lives (Cormack et al., 2020). Honouring the efforts of those who have created and continue to create a space for mātauranga Māori was therefore an important premise of the epistemological fabric of this research.

A kaupapa Māori paradigm was used with the intention to showcase the development of Māori knowledge that enhanced the wellbeing and self-determination of whānau, hapū and iwi accessing WCTO services. Māori are calling for health and social services to better respond to Māori realities without judgment or blame (Houkamau et al., 2016; Tipa, 2013). This research was designed with the intention of identifying what services need to do to respond to these issues. Cram (2017) highlighted the need for holistic models of health to be emphasised when considering mātauranga Māori. Central to this approach is challenging the illness focus within research in the health sector. Privileging a holistic view of health also aligns with the metaphysical connections between the self, others, nature and the universe – which speaks to the ontological assumptions of a kaupapa Māori paradigm.

Kaupapa Māori research is political and reflects Māori driven aspirations as well as numerous struggles for power and recognition. A fundamental premise of kaupapa Māori methodology is ensuring the drive for research lies in improving Māori health outcomes (Smith, 1999). This involves a shift away from blaming Māori for the disparities that exist and instead looking to the

structural and systemic influences on health and wellbeing (Cram, 2017). Cram (2006) discussed the important role of kaupapa Māori researchers as both validating and affirming Māori identity and critiquing non-Māori (and colonial) constructs of Māori realities. What is known is that WCTO services are not always working for Māori and this research sought to identify what matters to Māori and only Māori can determine what needs to happen to reorient services to respond to Māori realities in the future.

Kaupapa Māori Methodology

Kaupapa Māori methodology sits within the principle of 'tika' which encapsulates 'what is right' within a situation and is considered 'best practice' in research design involving Māori (Hudson et al., 2010). Hudson et al. (2010) link the concept of tika to the validity of research and whether the research design reflects a process of obtaining the data and achieving the outcomes as intended. Kaupapa Māori methodology is about research design that ensures proposed outcomes are realised within Māori communities. Cram (2017) discussed the influence that situating Māori knowledge outside of Māori communities had on the implementation of 'assimilationist policies'. She argued that a kaupapa Māori approach needs to promote a process of decolonisation by creating space for a Māori world to be understood as 'normal' or 'ordinary'. There was a need to define kaupapa Māori methodology within the context of this research. As Moewaka Barnes (2000) explained, there is a need to embrace diversity within approaches to kaupapa Māori research as there is no one way of exploring phenomena. Moyle (2014) discussed the shift from kaupapa Māori methodology being viewed as a form of critical theory that focused on Western constraints oppressing mātauranga Māori, towards a constructivist theory which supports the development of research practices that respond to what Māori view as 'fit for purpose'. This view aligns closely with my approach to developing a kaupapa Māori methodology – particularly with the inclusion of constructivist grounded theory methods.

Smith and Reid (2000) undertook a literature review that examined kaupapa Māori principles and practices. They agreed that there is no 'formula' for conducting kaupapa Māori research as this would contradict the underlying premise of Māori communities owning and driving the process. Commentators on kaupapa Māori methodologies are clear that multiple methods may be appropriate to use as a means to obtain and analyse data, however the values inherent within Māori worldviews must underpin the use of different approaches (Jones et al., 2006; Smith, 2012). The complexity in defining kaupapa Māori principles and the need to challenge constructs that sit at the centre of kaupapa Māori research design is reflected in the following statement:

Who controls the definition of Kaupapa Māori principles? Let us rephrase the question – what are the principles, practices and procedures of Kaupapa Pākehā? By doing this we see the ethnocentricity of the question. This question rarely presents itself because Pākehā do not analyse or question their own culture; it is considered the ‘norm’. Historically Māori have been positioned as the Other to Pākehā. The questions are about naming, claiming and controlling. This is the story of Colonisation (Smith & Reid, 2000, p. 2).

When I selected kaupapa Māori methodology to underpin this research, I needed to recognise the emancipatory intent of kaupapa Māori research while adapting to what Māori needed and wanted from the research. The national WCTO Tier Level Two Service Specifications (Ministry of Health, 2014b) outline the mandatory requirements in service provision for all WCTO providers, including what constitutes a ‘core’ and ‘additional’ contact and the process for families entering and exiting a WCTO service. The relative rigidity of these specifications (currently under review) and the translation into experiences of service delivery needed to sit in contrast to the approach taken to exploring mātauranga Māori regarding WCTO services. Likewise, the voice of Māori needed to be authentically privileged within a Western dominated health system. Alongside my research advisory group, I identified the following four values (Ngā Hau e Whā) illustrated within the Kaupapa Māori Inquiry diagram (Figure 3.1) that informed my approach to kaupapa Māori methodology.

Whakawhanaungatanga

Whakawhanaungatanga is the process of connection through whakapapa. It is about linking the past to the future and is essential in building relationships throughout the research process. This involved seeing the research as having its own whakapapa and making this connection with the whakapapa of whānau experiences with WCTO services. Smith (2015) linked the principle of whakapapa to Māori identity and the process of whakawhanaungatanga involves Māori locating ourselves within whānau, hapu and iwi. This contradicts a ‘pan-Māori’ approach in which identity is externally imposed; instead acknowledging the unique identities of individuals. Bishop (1995) provided the following comprehensive definition of whakawhanaungatanga:

Whanau means extended family. Whanaunga are relatives/relations, those members of your whanau with whom who have an inextricable, bodily link. Whakapapa is the mechanism used by Maori people to establish familial relationships, with whom one has these inescapable, bodily links. Whanaungatanga literally means relationship by whakapapa, that is blood-linked relationships (the suffix ‘tanga’ has a naming function). Whakawhanaungatanga is the process of establishing relationships, literally by means of identifying, through culturally appropriate means, your bodily linkage, your engagement, your connectedness and therefore (unspoken) commitment to other people (p. 215).

He described three stages of whakawhanaungatanga within a Kaupapa Māori research process. The first stage involved establishing and maintaining relationships. The second stage related to the researcher seeing themselves as inextricably woven into all aspects of the research. The third stage ensured that relationships developed as part of the research contributed to the emancipatory intent of a kaupapa Māori research paradigm. Ruwhiu (2008) highlighted the importance of establishing a 'research whānau' to support the collaborative approach to kaupapa Māori methodology in terms of identifying the mechanisms to inform research practice. This had an additional benefit of helping to address tensions associated with the power differential between the researcher and participants.

Manaakitanga

Manaakitanga represents the values of kindness, respect and humility (Kuntz et al., 2014). Manaaki sits within the principle of 'manaakitanga' which relates to upholding the mana of all parties involved in the research process. Mana is a Māori term that encapsulates the movement of spiritual energy between people and the environment.

Mana may be defined as spiritual authority. It's a relational concept. Mana is the authority that has been given to you by the wairua (spiritual realm), or by the divine authority; by your tīpuna (ancestors), and by your people. It gives you authority over your circumstances. Traumatic experiences, abuse, loss of land, loss of language, poverty and other adverse circumstances can diminish a person's mana. (NiaNia et al., 2019, p. 335)

Within this research context, mana informed the process of relationship building between myself and participants and supported an openness to establishing and maintaining relationships. The concept is also linked to the recognition of support provided by Kaumātua in terms of ensuring that research processes were guided and realigned as necessary to meet specific needs. Manaakitanga links to the quality of respect and recognition of spirituality and the need to be guided by participants as to the protocols and processes they wished to follow.

Wairuatanga

The direct translation of 'wairuatanga' is 'spirituality'. The spiritual dimension in Māoridom is considered just as real as the physical and emotional dimensions. For many Māori, spirituality does not necessarily equate to religion, however it does relate to specific values, beliefs and practices as well as an intrinsic connection with Mother Earth (Kennedy et al., 2015). Pere (n.d.) described wairua as a term that can be looked at by translating the words 'wai' meaning 'water' and 'rua' meaning 'two'. She described the connection to the Divine as one 'water' and the

mechanism of recording activity as the second ‘water’. Essentially, this refers to two entities working both together and in opposition – with the aim of achieving a ‘balanced wholeness’. Marsden and Royal (2003) summarised the significance of wairua for Māori in stating that the “...ultimate reality is for Māori the reality of the spirit” (p. 47). This has implications for ensuring researchers meet Māori participants both within the physical and spiritual space and are guided by participants as to what is required to connect with them in a spiritual capacity.

Despite the positioning of ‘wairua’ as necessary for existence, there is limited understanding of wairua within many Western contexts, leading to a devaluing of Māori identity and beliefs (Valentine et al., 2017). Adding to this complexity, Māori are not homogenous, and while some people may be strongly connected to te ao Māori, others may be more disconnected or have different understandings as to what wairua means for them. Wairua becomes particularly significant in a research context when entering into conversations around what is needed to ensure wairua is not defined using a reductionist or limiting approach (Barnes et al., 2017). Valentine et al. (2017) experienced the need for similar considerations in their study exploring the dimensions of wairua with Māori individuals.

Aware of ... the diverse ways wairua has and continues to manifest in our own lives, we did not wish to privilege any views of wairua over others, nor did we intend to misappropriate knowledge relating to wairua, lest we whakaiti (belittle) the mana (spiritual integrity) of other Māori, as well as the construct of wairua (p. 66).

Kaitiakitanga

Marsden and Royal (2003) define kaitiakitanga as the act of guarding, protecting, fostering or sheltering something. Smith (2012) highlighted the link between protecting a way of life to the survival of Indigenous populations. This sentiment was echoed by Boulton et al. (2014) who commented that the emphasis of kaitiakitanga is not on ownership, but on individual and collective safeguarding of the ‘mauri’ (intrinsic life essence) of research information and knowledge. This is reflected in the ethical guidelines for research involving Māori, whereby the responsibility of Māori members on ethics committees is one of ‘kaitiaki’ (guardians/protectors) to protect and advocate for Māori interests (Hudson et al., 2010).

Kaitiakitanga relates to the level of meaningful Māori input that is established and maintained within research. Paul-Burke and Rameka (2015) stated that, “[k]aitiakitanga is about relationships and is as much spiritual and intellectual as it is physical and political” (p.8). Hudson et al. (2010) outlined ‘best practice’ within the whakapapa (relationship) domain of *Te Ara Tika*

ethical guidelines as 'Kaitiaki'. This is about ensuring that Māori communities are the recipients of tangible and identifiable outcomes as a result of research that is conducted with them. Central to attaining outcomes is the transparency and authenticity of relationships that are established as part of the research process and beyond. Māori need to have governance over all stages of the research and as such, this was a fundamental responsibility of the research advisory group.

Constructivist Grounded Theory

Glaser and Strauss (2012) developed grounded theory methodology in the early 1960s as an attempt to 'bridge the gap' between theoretical and empirical research. The development of grounded theory methods for qualitative research happened at a time when quantitative methods had gained dominance in defining research (Charmaz, 2014). The purpose of grounded theory is to provide an explanation of what is important to the population participating in the research by developing a theory which is grounded in the context in which the study occurs. It is a research method that generates theory from rigorous coding, categorisation and comparison of data. Charmaz (2014) described grounded theory methods as systematic but flexible processes used to view data in new and different ways. Strauss and Corbin (1998) described the process of grounded theory in three phases: 'basic description', 'conceptual ordering' or categorisation of data and finally 'theorising' and organisation of ideas into a mode of presentation.

Patton (2002) believed one of the reasons for the popularity of grounded theory is due to its foundation in qualitative inquiry and the emphasis on subjective experiences throughout the research process. While there are a number of 'versions' of grounded theory, Breckenridge et al. (2012) maintained that there are two main versions – 'constructivist' and 'classic' grounded theory. The key difference between classic and constructivist grounded theory is that classic grounded theory requires the researcher to look for patterns in the data that provide a conceptual explanation of behaviour whereas constructivist grounded theory approaches focus on interpreting the meaning of participants to generate understanding (Breckenridge et al., 2012).

Constructivist grounded theory was presented by Charmaz in 2003 as a 'post-modern' alternative to classic grounded theory. It contests the notion that 'meaning' lies static within data until discovered, and instead proffers the view that 'meaning' is interpreted by the way individuals interact with and construe the data (Breckenridge et al., 2012). Constructivist grounded theory is underpinned by a philosophy that denies the existence of an objective reality

(Gibbs, 2013). Charmaz (2014) added that her approach to grounded theory assumed the process of offering an interpretation of the studied phenomenon rather than establishing an 'exact picture' of the concept. The four epistemological standpoints that inform constructivist grounded theory methods are explored in the following section.

Constructivism

Constructivism is a foundational epistemology and ontology of constructivist grounded theory that positions reality as based on an individuals' subjective standpoint. It has underpinnings in an interpretive theoretical paradigm. Constructivists view the world as model that is built by the way it is understood by individuals. This perspective sits in opposition to objectivism which contends that there is an absolute truth which sits outside subjective interpretation (Fosnot, 2005). Constructivist epistemology sits well within a kaupapa Māori methodology in terms of recognising and respecting the differences between whānau. As indicated in the literature review, historically, whānau have felt categorised or judged by Plunket services (Tipa, 2013) and the emergent literature relating to Māori experiences of unconscious bias or institutional racism suggests that Māori are being viewed by many health services through a stereotypical lens with a homogenous voice.

Pragmatism

Pragmatism refers to a mechanism of settling philosophical and metaphysical disputes by considering the practical consequences of something considered to be true (James & Sheffield, 2019). The pragmatist tradition that assumes meaning is generated through practical action in response to an issue (Charmaz, 2014). While rationalists claim that reality is already made, pragmatists argue that it is constantly under construction and therefore evolving based on action and the process of making sense of the action. A pragmatist view of reality consists of the environment in which people participate and interact (Bryant & Charmaz, 2007). In this research, whānau were invited to voice their experiences of WCTO services that were informed by the wider context of being Māori within Aotearoa. The process of developing a theory in response to the issues experienced by Māori accessing WCTO services supports a pragmatic approach in identifying potential solutions while contemporaneously gaining a different understanding of what the WCTO context provides for Māori who access these services.

Symbolic interactionism

Symbolic interactionism was developed from pragmatism and provides another epistemological and ontological foundation of constructivist grounded theory. Blumer (1969) described a key facet of symbolic interactionism as the 'meaning' that humans place on 'something' and the influence that has on how people act towards it. Blumer claimed that meaning is not static and that it is constantly able to be tested and changed based on ideas, experiences, feelings, attitudes and motives. Action and interaction is another component of symbolic interactionism which relates to the social response to another person's gestures or actions (Chamberlain-Salaun et al., 2013). Charmaz (2014) described temporality as an important component of symbolic interactionism. She highlighted the process of analysing the way the present evolves and how present knowledge and experiences inform interpretations of the past. This was evident throughout the interviews I completed particularly with whānau who were recalling numerous experiences with WCTO providers with different children. What they needed when they were visited initially was different to what they see that they needed at that time from their current perspectives.

Interpretivism

Interpretivism is an epistemological position that sits in contrast to positivism as an approach to understanding human and social phenomena (Crotty, 2007). Interpretivism overarches a number of methodological approaches such as constructivism, hermeneutics and phenomenology that offer an interpretation of meaning that sits outside a fixed reality. Charmaz (2014) described the way that interpretive theories position the 'actors' as having subjective viewpoints and recognised the subjectivity of the researcher. This recognition of subjectivity allows for researchers to interpret the actions and meanings of participants and for participants to interpret the meanings and actions of researchers. This is particularly significant when integrating constructivist methods into kaupapa Māori methodology. Ensuring that Māori worldviews are not overridden in favour of interpretations of data that 'fit' a Western reality was a fundamental consideration as a researcher. As an example, Smith (2012) challenged the validity of research involving Māori in relation to the non-Indigenous social settings in which Māori were moved as a result of colonisation.

Essentially, this has been crisis research directed at explaining the causes of Māori failure and supposedly solving Māori problems ... researchers sometimes made huge inferential leaps and generalisations about how the rest of Māori society functioned and which elements of this society were inhibiting successful development (p. 176).

Constructivist Grounded Theory and Kaupapa Māori Design

The validity of indigenous research and knowledge and the use of scientific criteria to test this validity has created historic debate (Durie, 2004). Durie (2004) proposed a framework to bridge the gap between the methodological principles inherent within indigenous knowledge and Western science. He outlined mātauranga Māori research as locating people within the natural world and scientific research as withstanding scientific enquiry and proposed that ‘research at the interface’ provides an opportunity to combine both approaches. The aspiration of conducting research at the interface is to enhance outcomes for Indigenous people by utilising a combination of values and methods to optimise the research process (Durie, 2004). Durie (2004) outlined four principles as foundational to a research at the interface approach (Table 3.1). These principles, in conjunction with the four values presented in (Figure 3.1) have guided the way this research has been conducted and have supported the process surrounding this research at the interface.

Table 3.1 – Research at the interface principles

| Mutual Respect | Shared Benefits | Human Dignity | Discovery |
|--|--|--|---|
| Recognition of the validity of each system of knowledge. | Indigenous communities share benefits of research including intellectual property and commercialisation. | Cultural and spiritual beliefs and practices are reinforced by research. Indigenous world views are not compromised. | Innovation and exploration using Indigenous methodologies and scientific methods. |

(Durie, 2004, p 10)

Kaupapa Māori methodology is about identifying collective aspirations for the greater good of whānau, hapū and iwi. An underlying premise of kaupapa Māori research is that Māori worldviews and ways of being are “normal” (Smith, 2008). Grounded theory sits in contrast to positivist methodologies that position the researcher as passive, unbiased, and separate from participants (Charmaz, 2014). This aligns with kaupapa Māori methodology in recognising the influence the worldviews of the researcher have on the process. Moewaka Barnes argued that

denying the existence of kaupapa Māori research can be seen as a lack of understanding that the worldview of a researcher is integral to the research and how it is carried out, including the way in which methodologies and methods are developed (2000, p.4).

The use of kaupapa Māori methodology in this research began with the identification of an issue (WCTO services not always meeting the needs of whānau) from the responses of whānau who had participated in my master's research. The establishment of a research advisory group of Māori health professionals, whānau and kaumatua supported the development of a research question and objectives for the study. This process supported a collective vision for the research and identified the collective aspirations for whānau receiving WCTO services. The ongoing input from the research advisory group members during the research process ensured my safety in applying Māori values and tikanga [protocols] throughout the study. Data was analysed and constructed within the context of 'Ngā Hau e Whā' identified within the kaupapa Māori research paradigm (Figure 3.1). Once the initial findings were identified, multiple stakeholders were invited to provide feedback and input into the sub-categories and the theoretical categories. This supported Māori ownership and engagement throughout the analysis and interpretation of data.

Constructivist grounded theory methods are able to uphold kaupapa Māori methodology by situating Māori at the core of data analysis by taking an inductive approach to data collection. Charmaz (2014) described the process of inductive data collection as completing purposive sampling before moving into taking a wider view of the data. In this research, the wider picture was the context of Māori whānau with tamariki under five. Initial purposive sampling ensured that participants all identified as Māori which meant that the resulting theory was informed by Māori views. Using the initial data to develop abstract analytical categories supported the theory to be constructed rather than emerge from the data. This process allowed for a flexible and adaptable approach to data collection and analysis by building upon what had been said rather than attempting to 'fit' data into predetermined categories. I believe that approaching data collection in this way increased my ability to respond to the input from whānau and advisors throughout the process.

Kaupapa Māori approaches and grounded theory methods have been used together in several other studies. Wepa (2016) explored Māori whānau engagement in health services and designed a research approach based on constructivist grounded theory methodology that was informed by kaupapa Māori theory. The integration of kaupapa Māori informed tikanga and processes followed in data collection supported whānau engagement in the research. This led to the co-construction of data in collaboration with participants and ultimately a theory grounded in the experiences of whānau accessing of health services. Hayes Edwards (2014) used kaupapa Māori methodology and constructivist grounded theory method to develop a theory related to ūkaipōtanga (nurturing) and Māori women's breastfeeding experiences. Utilising a kaupapa

Māori methodology ensured that Māori values underpinned the research process. Levack Jones et al. (2016) completed a constructivist grounded theory study nested within kaupapa Māori methodology which identified factors which influence Māori uptake of pulmonary rehabilitation programmes. The study demonstrated the integration of Māori leadership and decision-making throughout data collection and analysis processes.

Smith (2012) described how many Western research approaches draw on Western cultural norms to interpret and contextualise data. The inference is that a Western defined reality reflects a higher standard or more refined ways of knowing and a lack of contextualisation within cultural mores, creation narratives and the location of power. It was important to ensure that power was situated with Māori throughout the research process and this meant that a constructivist approach towards data analysis appeared to be more able to cater for ongoing guidance and input from participants. The process of constructivist grounded theory involves the researcher attempting to understand how participants make sense of their situations and then analyse the collective meaning (Charmaz, 2014). Charmaz believed that taking a constructivist approach highlighted the flexibility of the grounded theory method and stressed the importance of the researcher positioning their analyses as one construction of the phenomenon being studied rather than an 'accurate rendering'.

Sbaraini et al. (2011) highlighted that a key difference in grounded theory as opposed to other methodologies is that the data analysis occurs in parallel to data collection. They discussed the emphasis of inductive analysis in grounded theory methods and the need for the researcher to be able to shift the focus of the research onto what is important to participants. This is enhanced by theoretical sampling and asking more questions about the data to ensure categories are saturated (Charmaz, 2014). The ability of the researcher to shift perspectives in order to be open to categories identified through the data collection process is important. This is dependent upon maintaining a sceptical stance towards assumptions and having ideas "...earn their way into your analysis through their theoretical power..." (Charmaz, 2014, p. 201). Therefore, categories do not need to fit the literature nor does the literature create categories (Calman, 2006). Within this study, my assumptions were tested through the process of memo-writing and further questioning to test potential categories with whānau participants. It was a challenge to avoid the use of pre-existing categories from the literature and the use of terminology used by whānau supported an interpretation of data that was grounded in their understandings.

Summary

This chapter has outlined my interpretation of a kaupapa Māori research methodology. I have presented a model demonstrating the connection between kaupapa Māori methodology and constructivist grounded theory. The ontological and epistemological foundations of kaupapa Māori methodology have been explored. The research question and associated aims have been discussed. I have provided an overview of the epistemological background of constructivist grounded theory. The points of connection between kaupapa Māori methodology and constructivist grounded theory methods further justify the decision to conduct research at the interface.

I have concluded this chapter with a karakia to close the spiritual opening and protection offered by the karakia at the beginning of the chapter. The following chapter will outline the methods utilised within the study for data collection and analysis and contextualise these within the values framework described in this chapter. It will provide ethical assurances, and a description of the research rigour and approach to evaluation as well as a section on researcher reflexivity.

Kia tau ngā manaakitanga a te mea ngaro
ki runga ki tēnā, ki tēnā o tātou
Kia mahea te hua mākihikihi
kia toi te kupu, toi te mana, toi te aroha,
toi te Reo Māori
kia tūturu,
ka whakamaua kia tīna! Tīna!
Hui e, Tāiki e!

Let the strength and life force of our ancestors
Be with each and every one of us
Freeing our path from obstruction
So that our words, spiritual power, love, and
language are upheld;
Permanently fixed,
established and understood!
Forward together!

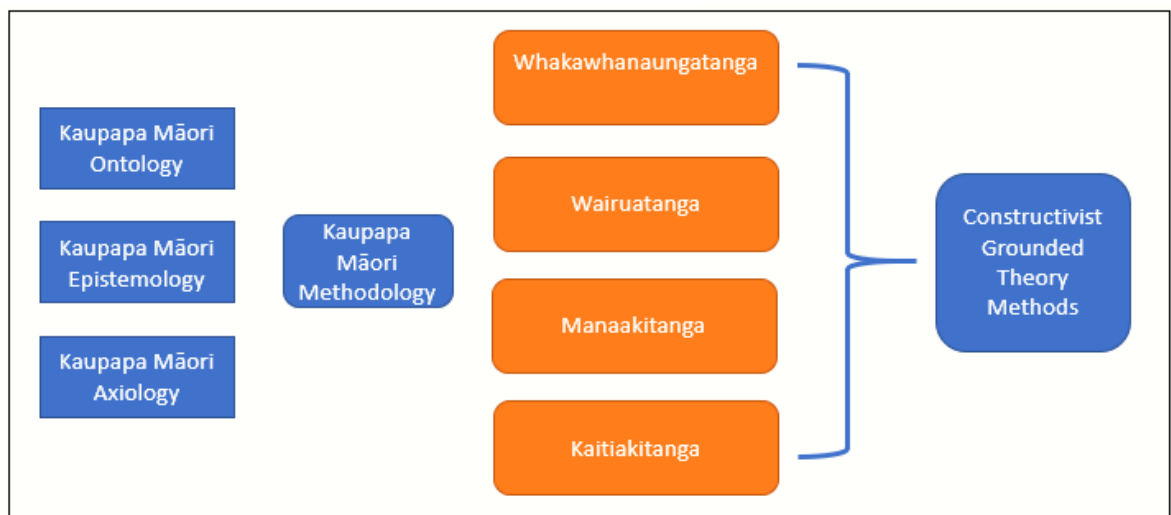
Chapter Four: Methods

Introduction

This chapter will describe the data collection and analysis methods used in this study. Firstly, I will provide an overview of the way kaupapa Māori methodology and constructivist grounded theory methods informed my approach to data collection. I will outline the role and actions of the research advisory group which have been fundamental to upholding the principles of kaupapa Māori methodology. The recruitment strategy and participant selection criteria will be explained with reference to the values underpinning my application of kaupapa Māori methodology. I will discuss the process of data analysis and provide specific examples of the process undertaken. I will also outline the ethical and cultural considerations which informed my approach to data collection and analysis. The criteria used to evaluate the research will be described, alongside a reflexive analysis of my approach to the research.

The integration of constructivist grounded theory methods and kaupapa Māori methodology was an important consideration throughout the process of data collection and analysis. The four values identified in the methodology within the previous chapter provided the foundation from which the research methods were conducted. The connections between kaupapa Māori methodology, the four values (Ngā Hau e Whā) and constructivist grounded theory are illustrated in Figure 4.1. The specific integration of these values within the research methods will be explored throughout this chapter. The emphasis is not on constructivist grounded theory methods as part of kaupapa Māori methodology, rather kaupapa Māori methodology and values informing constructivist grounded theory methods.

Figure 4.1
Ngā Hau e Whā



Research Advisory Rōpū (Group)

The research advisory rōpū was established before the research commenced, with the purpose of ensuring the study was conducted in a manner consistent with Te Tiriti o Waitangi, was culturally responsive and informed by service perspectives and/or political developments. The primary responsibility of the research advisory rōpū was as kaitiaki (guardians) of the research. The aim of the rōpū was to work collaboratively to inform the development of the research. Other responsibilities of the rōpū included:

- The provision of cultural support and guidance for the study
- The identification of approaches to collecting data with Māori participants
- Creating a space to talk safely about the research and its associated challenges

The rōpū contributed to the development of the research through:

- Critiquing the research and methods
- Sharing their knowledge and expertise on Well Child/Tamariki Ora systems and processes
- Advising on the process of obtaining consents for data collection
- Providing advice to ensure relevant audiences/stakeholders were engaged in the research
- Identifying and discussing strategies to address emerging issues which were encountered as the research progressed

The research advisory rōpū members met face to face on 4 occasions over the first 18 months of the study. Following the initial development of the research question and aims and ethical requirements, meetings were held with individual members of the rōpū on a regular basis. Membership changed over the course of the research due to changes in roles, workloads and accessibility of individuals. The membership of the research advisory rōpū was predominantly Māori. At all stages of the research there was representation from WCTO nurses, Kaiawhina, managers and tikanga/reo experts. Meetings commenced and closed with karakia and kai was provided at face to face meetings. As the research progressed, there was less need for formal face to face meetings and more discussion with individuals about specific topics or issues. The support and expertise of the research advisory rōpū contributed to ensuring the values of Ngā Hau e Whā (Figure 4.1) were upheld throughout the study.

Recruitment Strategy

I purposively recruited 15 Māori whānau who were eligible to receive Well Child/Tamariki Ora services. There were 35 people who participated in this research in total. The recruitment criteria were as follows:

- Participants identified as Māori
- Participants were located within the greater Auckland and Waikato areas
- Participants had one or more tamariki under five years of age
- Participants (inclusive of whānau) were willing and able to participate in the interview and/or focus group process

Given the increased focus on supporting vulnerable children and the recently established Ministry for Children (Oranga Tamariki), there was an emphasis on recruiting Māori whānau who had minimal engagement or those who had disengaged with WCTO services. This was to ensure that there was an integration of the standpoints of people who would not have routinely had opportunities to provide feedback in shaping the understanding of what constitutes cultural responsiveness in a WCTO setting. The research advisory rūpū members provided input relating to culturally acceptable recruitment methods and processes. I advertised for participants using flyers [refer Appendix I] and word of mouth via Plunket and Tamariki Ora clinics, GP clinics, Plunket and Tamariki Ora internal and community networks and social media platforms such as Facebook and Twitter. I also used whānau networks to approach potential participants with information regarding my research. I provided a link to my website (www.mahingatahi.com) for the research for participants to gain more information about me and read the information sheets and consent forms about the research.

Following the initial sampling of 15 whānau, I conducted three focus groups and three further interviews for theoretical sampling to explore the concept of WCTO cultural responsiveness within te ao Māori. It was important to include whānau in the interview process wherever possible as tamariki Māori often exist within a wider context than a nuclear family unit. Despite this, many of the interviews were conducted with mothers either alone or with their tamariki. Two interviews were with fathers and two interviews were with both mothers and fathers. The focus groups consisted of mothers only. Kaupapa Māori research is underpinned by the principle of 'whānau' (Smith, 2012) and Figure 4.1 outlines whakawhanaungatanga as a core value within this research. This was about recognising the connections between myself and the participants as well as the participants with others. Whānau were always invited and welcomed as part of the recruitment process and within interviews, however for many participants, whānau were

unavailable during the times that suited participants or participants preferred to speak with me alone. The inclusion of whānau was just as much about inviting and including whānau in the interview process, as remaining cognizant that each participant represents and reflects a wider whānau group even when not physically present.

Data collection

Data was collected via a combination of individual and whānau interviews, as well as focus groups to support the process of exploring ideas generated in the interviews within a group context. The concept of manaakitanga (sharing and being generous) is important, not only in terms of acknowledging the mana of whānau, but in upholding my mana as a Māori researcher by looking after participants. Therefore, I endeavoured to create environments in which participants felt at ease and valued for their time and input into the research process. Kai (food) was shared in each of the interviews and focus groups and when it was not eaten, it was left for the whānau to share at a later stage. All participants were invited to select where they would feel most comfortable being interviewed. Many participants wished to complete the interview at home, and some met with me in a public location.

The interviews often commenced with karakia (as indicated by whānau), to open the space for the discussion and another karakia to bless the kai that was shared throughout the interviews. There was often an extended process of whakawhanaungatanga in which we made connections relating to whānau, friends, places and experiences. The information sheets (refer Appendix II) were read and explained to the whānau and an opportunity was provided to ask any questions and clarify any aspects of the research and/or process. The consent forms were then explained and read through by participants before signing (refer Appendix III). Prezzie cards as koha (gifts/acknowledgment) were given at the beginning of the interviews, as I wanted participants to feel acknowledged for participating, rather than for their degree of contribution. The length of the interviews ranged between 1 to 1.5 hours and concluded with karakia. Participants were invited to review the transcripts of their interviews and to follow the research progress on my website.

Charmaz (2014) described the need to develop a few broad open-ended questions to invite participants to lead the process in constructivist interviewing. Further questions evolved throughout the interview by focussing on significant statements made by participants. The initial interview questions were discussed at a research advisory rōpū meeting and it was thought that there needed to be a differentiation in the interview questions between ‘partnerships’ and

‘relationships’. I then developed a series of ‘second-level’ interview questions as prompts to further explore the concepts introduced by the higher-level questions (refer Appendix IV). The four open-ended interview questions I initially developed were:

- What have been your experiences with (well child/tamariki ora) services?
- What matters to you in a (well child/tamariki ora) service?
- How would relationships look if they were working well between yourself, your whānau and your well child provider?
- What does partnership look like to you when working with a well child/tamariki ora service provider?

Charmaz (2014) outlined that the researcher needed to take an active role in the interview process by clarifying, summarising, and showing interest in responses by asking questions to find out more. As part of the data collection process, I documented the observations I made throughout my interactions with participants - particularly in relation to the first meeting, relationship building and body language. Charmaz (2014) described the impact that the choice of methods has on what is ‘seen’ in the research process. Part of this involved picking up on what was *actually* said by participants and responding in real time. As participants indicated what was important to them, research ‘leads’ were defined and evaluated against data that had been constructed into theory. Charmaz argued that grounded theory research methods need to be flexible enough to promote a sense of trust and contribution amongst participants in order to provide a context and richness to the data. Linking back regularly with research advisory rōpū members was important throughout the data collection and analysis stages to challenge my thinking and contextualise my initial interpretations within te ao Māori perspectives.

Table 4.1

Example of Identifying and Reflecting Upon Observations

| Interview questions and responses | Observations | Reflections |
|--|--|--|
| Tell me a bit about your experiences with well child services? (High level) | | |
| Yeah they’ve been pretty good. I had a lot when they were younger and then it kind of gets real spaced out, but I guess for me I haven’t need all the support. But they’ve been pretty good – I like that because I’ve got twins they kind of help out by holding one when they’re doing the weighs and stuff, I haven’t had any problems or concerns. The only thing that’s hard is that a lot of references they give me are based on how old they are and they were prem. So you always feel like they’re behind because you’re not going the | Telling me that the service has been pretty good – but it feels like there is a “but” or something that is underlying. Something about the service is making the whānau feel bad for their babies not | There appeared to be a disconnect between information and assessments provided by the WCTO service and recognition of the impact of that assessment in a wider societal context. There are feelings of judgment and information that |

corrected age, you're going by what their age is. So that's been a bit, well you've just got to kind of expect that they're not quite tracking as they're supposed to.

meeting expected developmental milestones.

does not necessarily 'fit' the realities of all whānau.

So in terms of the babies not meeting the expected age-related milestones, do you feel like you had to defend your babies' progress? (Second level)

I paraphrased what I had heard before ultimately asking a closed question!

Yeah, I think you just feel a bit like, when people say at this stage they should be doing this and this, you feel like they should kind of base everything around the corrected because you're always going to feel delayed with milestones. And I see it a lot but with prems, everyone's worried about their babies reaching milestones because there's always the ages that they're supposed to be doing this and eating this but every baby's different. I guess every baby reaches milestones at different ages anyway even when they're not prem. But I guess for me, the only thing I would have wanted more of is them to have adapted the information to what I should expect, not what everyone else with a "normal" 9 month old would be doing. So I could get an idea of what I could expect them to be doing in my situation.

This whānau is impacted by social pressure around babies doing things at 'expected' times and the service has not recognised the impact of that for them. They do not appear to be getting information they need. The tone implies they could take or leave the service. Mum wants things to be different.

I need to be aware of reframing closed questions, but fortunately this participant kept talking. This clarified that the information was causing her to worry about her babies' developmental progress and needing to reassure herself. This connects with whānau wanting the service to give them what they need.

When they didn't offer that advice, what was the impact on you? (Impact)

I guess I felt like I had to kind of ask, instead of the information being provided and tailored to my situation. So because they were prem, would I start doing solids when people normally start or do I wait until they're corrected age. But it is good they do the charts kind of adjusted so you can see their corrected age. But I guess yeah, you just always feel behind because you know they are behind to what other babies their age are. It would be nice if they did more kind of stuff like that. Because quite a lot people have prem babies and I think it would be good to have... I guess because you just feel, kind of more unprepared because you had your baby so early, so you are kind of thrown off in terms of where you're supposed to start things.

The whānau felt like they were in the dark and there were parts of the service that didn't give them what they were expecting. I get a sense that they feel let down by a service they thought was going to help them more than what they did. There is a lot of pressure. Mum is on the verge of tears. She is starting to trust that I am here to listen to her.

Questions relating to impact are useful as it supports participants to explore both their thoughts and feelings about a situation. This reinforced the importance of a service giving whānau what they need and not making assumptions. Part of finding out what people need is including them in the service. This whānau felt left out because they didn't fit the "norm".

Charmaz (2014) described one of the benefits of utilising grounded theory methods for data collection as having the flexibility to follow up on leads almost simultaneously with the effect of efficient refining and reshaping of key ideas. However, Charmaz was cautious to note that the decision to select any method used to collect data has consequences and needs to be considered in relation to the research question being asked. She discussed constructivist grounded theory methods as placing the emphasis on the influence and participation of the researcher in terms of what they 'see' in the process of data analysis. Charmaz highlighted the need for data collection methods in grounded theory research to evolve as the research progresses to drive the ongoing development of ideas.

Theoretical Sampling

Theoretical sampling is integral to a grounded theory approach as it provides direction for data collection in order to refine the theory being developed (Khan, 2014). Charmaz described theoretical sampling as a process of tightening the hermeneutic spiral (Charmaz, 2014) as this ensures that the resultant theory matches the data collected. Khan discusses the data collection process as beginning with initial 'purposive' sampling before moving into targeted theoretical sampling based on identified leads. I commenced data collection with semi-structured interviews exploring the notion of cultural responsiveness in relation to ways of working together.

The focus of the semi-structured interviews evolved as the data collection progressed in order to respond to theoretical leads that had developed from the data. An important role of theoretical sampling involves clarifying the relationships between categories rather than examining them only in isolation. Charmaz (2014) discussed theoretical sampling as the targeted collection of data required to saturate the initial categories identified which strengthens and defines an emerging theory. Following the identification of categories during the initial sampling process, and discussion with research advisory rōpū members, theoretical sampling determined the pattern for the construction of a theory of cultural responsiveness.

Constructivist Interviewing

Constructivist interviewing differs from a traditional approach to interviewing in that the relationship between the interviewer and interviewee informs the social constructions that build both what is said and understood. This contrasts with viewing interview responses as a direct account of the reality of what was experienced. Therefore, the need to invest time in

building relationships with participants supports the notion of mutuality throughout the interview process (Charmaz, 2014). Berryman et al. (2018) discussed the way many Iwi viewed the relational intent of the Treaty of Waitangi as 'mana ōrite'. This term refers to both parties recognising the spiritual power or significance of the other.

The importance of recognising and protecting the mana of participants within interviews was fundamental in building relationships and therefore interviewing using a constructivist interviewing technique. Upholding the mana of participants involved checking in as to a time and location that participants felt most comfortable to be interviewed. It also involved being led by participants in terms of the processes to follow for karakia and kai. Furthermore, the process of clarifying and paraphrasing to ascertain my level of understanding as to what was being said in response to the questions posed, supported the co-construction of understanding phenomena.

Memo-writing

Memo-writing is an important activity in completing grounded theory research as it supports the analysis of codes by facilitating an internal conversation as to the researcher's own thoughts, assumptions and standpoints. It also enables the identification of connections and comparisons between concepts (Charmaz, 2014). The process of memo-writing is pivotal in developing categories and identifying areas of variation or further development. Memo-writing becomes important in the theoretical sampling phase of the research process as it supports researchers to identify and predict where and how to find data to saturate categories (Charmaz, 2014). Charmaz highlighted an important function of memo-writing as a mechanism to prevent 'pre-conceiving' the data. The ability to consider data as it is in the present moment allows for researcher reflexivity in challenging assumptions that may have been previously unknown or not acknowledged.

Stocker and Close (2013) presented a way to supplement traditional memo-writing practice with voice memo recording. They believed this method captured nuances in emotion and language which may have otherwise been missed in written memos. I found myself making more immediate use of voice-memoing following interviews with participants and writing memos related to that idea once I listened to the playback of my initial thoughts and feelings. Stocker and Close (2013) argued that using the process of voice-memoing supports the researcher to 'transport' themselves back to an event so to remain as grounded as possible within the data during the process of analysis. Table 4.2 provides an example of a voice memo related to whakapapa which was then transcribed. When listening to the memo, I was transported back to

moment I made the connection between whakapapa and service history and regained a sense of an inescapable link between historic relationships and events and future outcomes.

Table 4.2

Example of a Voice Memo Transcribed

Memo – Whakapapa

There is something in what whānau are saying about identity. Having a baby seems to challenge people in terms of who they are and what they once held as important. The stories attached to whānau take on more meaning with a new life. Parents become the caretakers of their children's stories and services seem to be unaware of their role in these stories. People's interpretation of the present is informed by the past and the future can change that interpretation. I had always thought whakapapa referred to genealogy but if everything is interconnected, whakapapa could refer to experiences whānau have had. Whakapapa appears to provide the record of events which is added to over time. Temporality suggests that meaning associated with these events often changes over time. What does that mean in terms of the way WCTO services work with whānau? Is there enough acknowledgement of the journey bringing the whānau and WCTO services together?

The process of memo-writing helped to lift the data from a description of experiences to an explanation of what appeared to be happening for whānau.

Table 4.3

Example of a Voice Memo Transcribed

Memo – Manaakitanga

I have been amazed at the hospitality extended by whānau across the interviews I have conducted. People with little to no extra income have welcomed me into their homes, provided kai, created a space for me to kōrero with them. They don't expect anything from me and are excited to tell me their stories. It's not just the food, it's the willingness to engage and interest in what I am doing. I feel like I can't give them enough in return for what they have given me. I wonder, does this look and feel the same in non-Māori research settings? Participants have described the concept of manaakitanga. It almost doesn't do it justice to put it into words. It is about the feeling you get when you sit alongside someone who wants you to be there. It is about feeling fully accepted into some else's space. When it is not there, I can't work effectively in that space, no matter how much I might want to. But they want me here and I want to be here, so to me that seems like the ideal environment to be working within.

Data Analysis

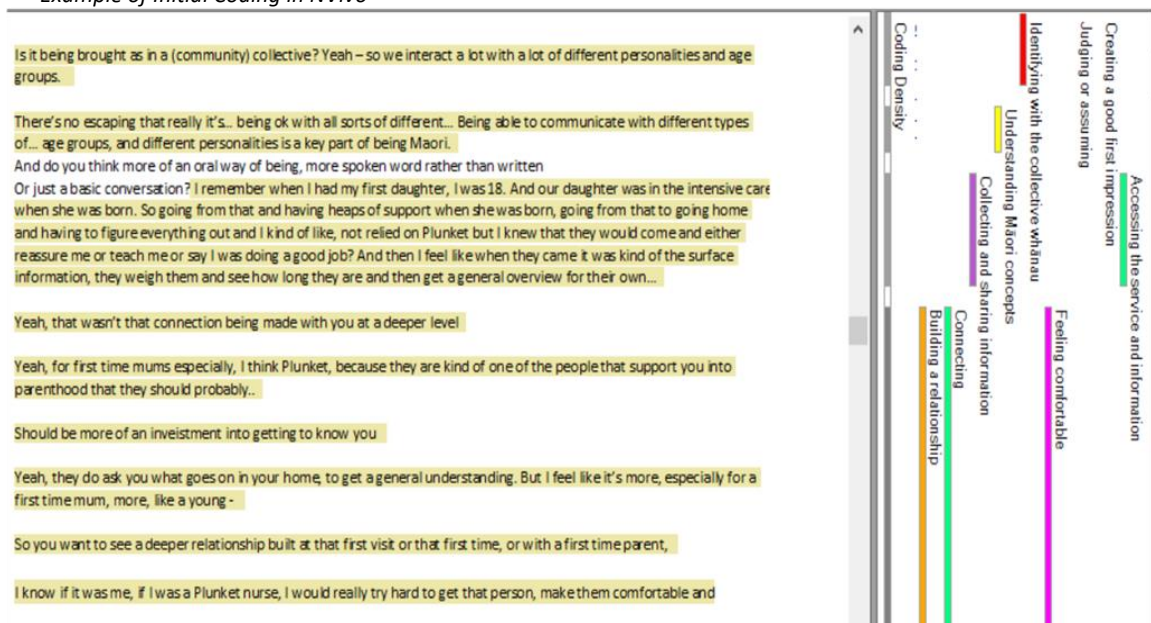
Grounded theory research methods are unique in the sense that data collection and analysis take place concurrently. Interview data was transcribed and uploaded to NVivo software for data analysis in which initial 'coding' was completed. Charmaz (2014) described coding as a process of asking analytical questions of the data. Coding involves examining the data in fragments and assessing and categorising them with a label. The purpose of coding is to connect the collection of data with the development of an emergent theory. Coding is a process of identifying generalised themes that are encapsulated within various actions and events, times and contexts (Charmaz, 2014). In the abstract process of data analysis, codes provide the connection between data and interpretation and reinforce what has been learnt so far. Charmaz described coding as providing 'the analytic frame' from which an understanding is built.

The interview transcripts were coded line by line as part of the initial coding process. Initial coding involves a process of searching for analytic concepts that can be further investigated. Charmaz highlighted the importance of being open to all possible threads or interpretations of the data within the initial coding phase. This involved considering data within the context of people's lives, their standpoints and their actions. One of the benefits of completing careful initial coding is that the process 'forces' the researcher to look at the data in ways that may differ from participants' interpretations. This increases the visibility of assumptions and generates new insights (Charmaz, 2014). Initial coding involves asking analytic questions of the data. Charmaz provided the following four key questions based on Glaser and Strauss' Grounded Theory methods that I used to inform the process of coding:

- "What is this a study of?"
- "What do the data suggest?"
- "From whose point of view?"
- "What theoretical category does this specific datum indicate?" (Charmaz, 2014, p 116)

Figure 4.2

Example of Initial Coding in NVivo



The process of initial coding supported the identification of 87 initial codes. Asking questions of the initial codes and further interviews led to the generation of 31 focussed codes and three theoretical categories outlined in Table 4.2. The theoretical categories **doing to whānau**, **diminishing whānau mana** and **getting what whānau need** were identified as processes that influence the cultural responsiveness of a WCTO service.

Table 4.4
Focussed Coding Mapped to Theoretical Categories

| Focussed codes | Sub-categories | Theoretical categories |
|--|---|--|
| <ul style="list-style-type: none"> Disregarding our values Taking ownership of us Making assumptions Relying on tools Ticking the boxes Withholding information Re-telling our stories Not knowing Feeling uncomfortable Isolating us Feeling powerless Feeling judged | <p>Coming into our space</p> <p>Being left out of the loop</p> <p>Shutting down</p> | <p>Doing to whānau</p> <p>Doing to whānau</p> <p>Doing to whānau</p> |
| <ul style="list-style-type: none"> Knowing who we are Having a history with health services Making sense of parenting Understanding Role-modelling Struggling Protecting our space Being self-reliant | <p>Defending who we are</p> <p>Mistrusting the service</p> <p>Avoiding contact</p> | <p>Diminishing whānau mana</p> <p>Diminishing whānau mana</p> |

| | | |
|--|-------------------|--------------------------|
| <ul style="list-style-type: none"> • Finding other help | | Diminishing whānau mana |
| <ul style="list-style-type: none"> • Whakawhanaungatanga • Non-judgmental engagement • Supporting whānau strengths • Service flexibility | Feeling connected | Getting what whānau need |
| <ul style="list-style-type: none"> • Find out what whānau want • Responding to what whānau need • Supporting culturally safe practice | Being included | Getting what whānau need |
| <ul style="list-style-type: none"> • Service humility • Understanding power • Creating opportunities for feedback and change | Feeling safe | Getting what whānau need |

The analysis of the data within the context of te ao Māori changed the questions I was asking of the data in the initial coding phase. The question posed by Charmaz “from who’s point of view” is the data being interpreted challenged me to consider the codes within a whānau context as well as a service delivery context. It also changed the language I used to construct the categories. Originally, I wanted to use terminology almost exclusively in te reo (Māori language) to reflect what I believed whānau were saying – although whānau were not using te reo to describe their experiences. The use of te reo for some of the coding challenged me to consider the constructs and meaning I held in relation to the terms. These constructs were explored further throughout the process of memo-writing (Tables 4.2 & 4.3). However, it became clear that by using common terms in te reo, I was applying pre-existent understanding and definitions of the concepts. To minimise the categorisation into pre-existent theories or concepts, Charmaz recommended following a process of coding for ‘action’. This process requires the researcher to look describe segments of data using words that denote actions and allows for new ideas to develop.

During the initial coding phase of data analysis, the researcher is required to remain open to various possibilities and identify areas in which data are lacking. On many occasions, I identified leads within the data which needed to be explored further and these informed my line of

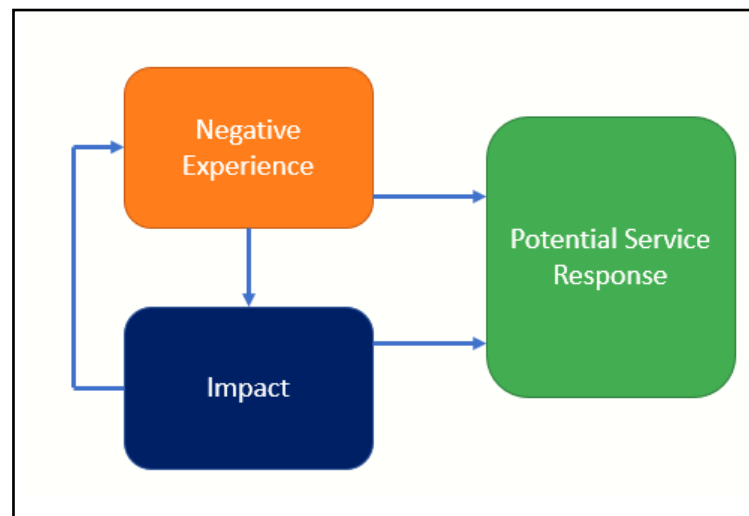
questioning in subsequent interviews and focus groups. This was particularly useful following the identification of the three theoretical categories. Charmaz described this process as inevitable in completing emergent research as it demonstrates an ability to reflect upon what you are learning from the data and delve deeper into the problem being explored.

Focussed coding is the second phase in analysing the data. It involves identifying the most significant and/or frequent codes that capture the complete essence of the data. Following the focussed coding phase is theoretical coding which examines the relationships between categories and moves the focus from analysis to theory generation (Charmaz, 2014). Once no new 'theoretical insights' are gathered from the data, the categories determined in the theoretical sampling phase are considered saturated – or as Dey (1999) argued, 'theoretically sufficient'. Charmaz described a risk inherent in grounded theory research as a researcher claiming data saturation when the categories may not be. Her advice to researchers using grounded theory methods was to "use grounded theory guidelines to give *you* a handle on the material, not a machine that does the work for you" (2014, p 115; Gibbs, 2013).

Constant comparison helps to establish similarities and differences within data at each stage of analysis (Charmaz, 2014). This process helps to make analytic sense of the data and challenge any interpretation that might be informed by 'taken-for-granted' understandings while continually testing ideas (Charmaz, 2014). This involved suspending the urge to disregard some of the initial categories identified when it became apparent they were no longer surfacing within the data. It also involved identifying opportunities for them to be explored further or surface within a re-interpretation of a category later in the analysis. Boeije (2002) described the process of constant comparison as supporting the researcher to determine what data will be gathered next as well as answer questions by analysing and reflecting on previous data.

The first two theoretical categories generated from the focussed codes and sub-categories reflected the negative **experiences** whānau were describing relating to WCTO services and the **impact** of these experiences. The third category (getting what whānau need) outlined what is required for whānau to experience a culturally responsive WCTO service. This meant that the first and second categories were constantly informing the third category in terms of highlighting what is going wrong and therefore ways in which the WCTO service might respond more effectively to whānau needs. The connection between the theoretical categories is outlined in Figure 4.3.

Figure 4.3
Relationships Between Theoretical Categories



There was a need to continuously consider the connections between the focussed codes which led to the construction of the sub-categories. This supported the process of identifying and defining the theoretical categories. The relationships between the theoretical categories formed the basis for the development of a model outlining the processes involved in culturally responsive WCTO service delivery.

[Kaupapa Māori Axiology](#)

Māori ethical principles are integral to the fabric of kaupapa Māori research and Māori society as a whole. Mead (2016) described Māori ethics [tikanga] as a way of reclaiming Māori knowledge and ways of being that have been lost. He described tikanga as an ethical framework which outlines how people should conduct themselves in society.

Tikanga Māori is a normative system ... A normative system deals with the norms of society, with what is considered to be normal and right. Tikanga Māori was an essential part of the traditional Māori normative system since it dealt with moral behaviour, with correct ways of behaving and with processes for correcting and compensating for bad behaviour (Mead, 2016, p.14).

There are several overarching principles that describe the tikanga to be followed when conducting research in Māori settings (Jones et al., 2006; Mead, 2016; Moyle, 2014). These

principles will be discussed with examples relating to how they were upheld throughout this study.

- **Aroha ki te tangata (Respect for the people you are working with)**

This principle refers to the diversity that exists between people and the recognition of multiple and varied worldviews that underpin different realities. In a practical sense, this principle was reflected in my approach to meeting whānau and adapting to their environment. This included being invited into their homes or other environments and checking in as to the processes they wished to follow throughout the interviews. It also involved adapting or reframing the questions based upon what had been shared previously, reflecting my commitment to listening and understanding their viewpoints.

- **Kanohi kitea (The seen face)**

This principle is about the transparency of the researcher and the openness afforded by face to face interactions. Whānau participants within this research were provided with information about me, my whakapapa and my profession and work history prior to agreeing to participate (refer Appendix II). Throughout the face to face interviews, I took opportunities with whānau to further connect with them and share aspects about myself and my life to assist with building a relationship and optimizing their engagement with myself and the topic. When I made heart connections with whānau, they were able to feel my genuine intentions for the research and how seriously I took my obligations to them and all whānau accessing WCTO services.

- **Titiro whakarongo kōrero (Look and listen first, then speak)**

This principle refers to the art of listening and being present before constructing another question or interrupting with information. Learning to fully be present is a continuous journey, even for the most accomplished of communicators. I discovered I was continually reflecting on how to pace my questioning and revisiting techniques to suspend the urge to think about the next question I wanted to ask. This improved as the number of interviews increased and as I felt more comfortable with the interview process.

- **Manaaki ki te tangata (Be generous in sharing with and hosting people)**

Manaakitanga was a key principle identified as underpinning and influencing the entire research process. It was demonstrated in both tangible and intangible ways

throughout the study. I have previously discussed the provision of kai and koha for both participants and the research advisory rūpū. I have also shared information relating to the methods and the results of the research with colleagues, peers, and interprofessional networks. This reflected my commitment to ensuring that the information gathered in this research is accessible to anyone who is interested. This was further supported by publishing initial findings on my website (www.mahingatahi.com) with a view to publishing the official findings upon successful examination. Whānau were given transcripts of interviews and an opportunity to clarify, amend or withdraw what was transcribed.

- **Kaua e takahia te mana o te tangata (Take care not to trample on the mana of people)**

This principle connects with the previous principle of manaakitanga in terms of ensuring that researchers work in ways that uphold the dignity and rights of the people involved. Upholding the mana of participants in this study involved ensuring they were able to make decisions relating to their participation in the research, at all stages of the research. Having had the opportunity to read through and discuss the information sheet (refer Appendix II), whānau completed consent forms prior to participating in interviews (refer Appendix III). Whānau were given copies of both the consent form and the information sheet for their reference. This is also about my commitment as a researcher to completing the research, having integrity and following through on what I said I would do with the information shared with me.

- **Kia tūpato (Be cautious)**

Kia tūpato refers to the processes put in place to protect the safety of participants involved in the research. Within this study, kia tūpato encapsulates the way data was protected once collected. I transcribed the interviews in a private location and saved each file under a pseudonym to protect confidentiality of participants. I also ensured that no identifiable data was transcribed such as addresses or the names of other people. These were again replaced with pseudonyms. Once transcribed, the audio files were permanently deleted from the recording device. The transcriptions were stored electronically and kept in a password protected folder on my personal computer. All transcripts and consent forms are stored on an electronic hard drive which will be stored in a locked filing cabinet on AUT premises for ten years following the completion of the research before being securely destroyed. Kia tūpato also relates to

the way kaupapa Māori research is conducted and the authentic integration of Māori worldviews throughout the research process.

- **Kaua e māhaki (Do not flaunt your knowledge)**

This principle is about the demonstration of humility in conducting research with Māori. An important premise of kaupapa Māori research is recognising that everyone involved in the whakapapa of the research has ownership of the research. This extends from the authors whose ideas and research contribute to my understanding as a researcher, to the expertise of the research advisory rūpū, through to the invaluable information offered by whānau participants. Whenever I discuss this study with others, I am aware of the collective ownership of the information and acknowledge the different roles everyone has played in contributing to a final theory. This principle also reflects the way my thinking has evolved over the course of the research and my openness to change and adapt based upon new ideas and different perspectives. This means that different opinions are equally valid, based on different views of the world. Therefore, my knowledge in completing this research is something that is offered that reflects a particular space and time and is not the only way of interpreting phenomena.

Te Ara Tika: Guidelines for Māori Research Ethics (Hudson et al., 2010) were also used to support the development of the ethical approach to this study. This research was designed to place participant decision-making and consultation with Māori at the forefront of all processes, in order to promote self-determination and mutual ownership of the research process. This involved supporting participants to take the lead in the research by firstly determining whether they would be interested in participating and indicating their interest to me through word of mouth, email, texting or phone calls. Participants then decided on the mode and structure of interviews they felt most comfortable with, and whether they wanted wider whānau participation in the process. This included the use of te reo and whether the whānau felt more comfortable completing interview in te reo. No participants elected to have the information sheets or interviews in te reo, however this was offered with a genuine intent of supporting the request. The semi-structured questioning facilitated a process of clarification in what was said, which supported a mutual understanding. Guidance from the research advisory rūpū was important in ensuring the questions and approach sat comfortably with how they would like to see whānau engaged in terms of upholding the mana of all involved in the process.

Ethics approval

Ethical approval was granted from the Auckland University of Technology Ethics Committee (AUTEK 17/355, refer Appendix V). One of the concerns raised by the committee was my (then) employment as a National Advisor for Plunket and the potential for a conflict of interest with prospective participants. At the time, I had no direct contact with WCTO clients in over five years, however, I needed to ensure that I did not recruit participants that I had worked with in a professional capacity. Participants were reassured that their involvement in this research would have no impact on the service they received from their WCTO provider and that the provider would not be informed that they were involved in the research. Another consideration highlighted by the committee was ensuring that I did not give clinical advice or suggestions to participants and instead referred people on to their WCTO provider or to Plunketline (A WCTO telephony service). The way the interviews were conducted and the type of information I was gathering appeared to minimise this from occurring, however it was useful to have a planned approach in the event of being asked for clinical advice.

Research Evaluation

Charmaz (2014) considered the audience of any research as the ultimate judges of the quality of the study. The methods are examined in relation to the contribution they have made to the final product. She presented four criteria for evaluating the quality of grounded theory studies and I used the following criteria, interwoven with kaupapa Māori research principles to consider the quality of this study:

Credibility – ensuring there was enough data to warrant the claims and that there were strong links between what the data said and how it was analysed. The process of purposive sampling, coding and analysis through to theoretical sampling supported the credibility of this research. Regular discussions, emails and meetings with the research advisory rūpū was important in ensuring that I consistently had different perspectives considering the extent to which the data connected with the analysis. This was also about the respect I held (aroha ki te tangata) for the information and advice provided by both the advisory rūpū and the research participants and the need to act upon their guidance to enhance the quality of the research. Being known in Well Child/Tamariki Ora nursing environment enhanced my credibility with Māori whānau accessing WCTO services. For this reason, WCTO nurses also promoted the study to prospective participants.

Originality – ensuring the categories offered new insight and significance to existing social realities and theoretical ideas. Regular academic supervision, connecting with the research advisory rūpū and discussing the research with a cross-section of interested parties (including Māori Women’s Welfare League (a national Māori women’s organisation) , Kohanga Reo Trust (a national governance group for Māori immersion preschools), Mana Ririki (a national advocacy group to reduce child abuse in Māori communities), Te Puni Kōkiri (The ministry for Māori development), Whārangī Ruamano (the national Māori nurse educator group) and Plunket) assisted me to gauge the originality and theoretical significance of the results. Comparing the major categories identified in the final stages of analysis with relevant literature also supported me to identify ways in which this research challenges and/or refines current ideas. It was important to be cautious (kia tūpato) with the claims or promises I made with the process and the results of the research. The extent to which recommendations will be implemented or changes made in the future are unknown and it was better to be humble with participants in relation to the level of influence the results will have on organisations rather than trample on the mana of people involved by not following through on promises.

Resonance – ensuring the theory made sense and offered participants some insight into their world by linking ideas to the bigger social and political context. The process of constant comparison allowed for the exploration of different meanings in interpreting the data. The interview and focus group process in data collection supported both individual interpretation and collective consciousness and therefore opportunities to identify ways in which the theory might be interpreted by Māori whānau across different forums. As a researcher it was important to have whakaiti (humility) and be open to different perspectives and worldviews by not approaching the interviews or focus groups from an ‘expert’ position. This supported engagement with participants and the quality of information and insights shared. Once findings were identified, I spoke with numerous Māori individuals and groups to determine whether the findings resonated with them. Everyone I spoke with could relate to what whānau were saying and could share examples of their own similar experiences with other health services. This suggested that the findings resonated with Māori across a wider health context.

Usefulness – ensuring this study contributed towards a better world and highlighted areas for further research. This research has the potential to inform WCTO sector education and service design and I anticipate evaluative research being completed in the future to examine the outcomes from applying the theory that is constructed in this research in a more practical sense. Despite the usefulness of the findings, Māori do not generally place value upon people who parade their knowledge (kaua e māhaki) so it is important to continually attribute the insight

and learnings from this research to the whānau involved. This will enhance the usefulness and applicability of the findings in the future.

Researcher reflexivity

Researcher reflexivity refers to the position of the researcher within what is being studied and consequently, the values informing the interpretation of data (Lumsden, 2019). Lumsden (2019) described a reflexive approach as having a consciousness of the context in which the interpretation of data exists and the power dynamics that impact upon those being 'researched'. Charmaz (2014) described the process of reflexivity in data analysis as identifying assumptions that inform the interpretations of participant meanings and actions. By identifying these assumptions, Charmaz suggested that researchers can connect subjective viewpoints with the wider social environment and therefore minimise the replication of rhetoric or popular discourse to construct meaning. Therefore, a reflexive stance recognises the need to raise the lens of data analysis to consider meaning that sits outside a collective understanding.

'Insider status' refers to a researcher conducting research within a group of which they are a member (Fleming, 2018). There are criticisms of researchers with insider status having potential biases or lack objectivity when researching within a group they identify with (Fleming, 2018; Moyle, 2014). Identifying as a Māori researcher, theoretically placed me within the category of an insider. However as McIntosh (2011) explained, focussing only upon the similarities between the researcher and participants negates the socio-political power differences and privilege afforded to researchers through tertiary education. Charmaz (2014) argued that it is the goal of ethnography to gain an 'insider's' view of the world. The challenge for me as a Māori researcher was to ensure that the meaning for participants was not lost through my own interpretation of experiences and concepts. This was addressed by regular connection and clarification with members of the research advisory rūpū, as well as the process of theoretical sampling which supported further exploration of theoretical leads.

A significant reflexive moment for me occurred when I was writing the methodology chapter. My knowledge of kaupapa Māori methodologies felt increasingly superficial the more I read about the underlying philosophy. I realised that I had developed my research question and aims from a dominant service perspective – trying to 'fit' whānau realities into a service context. My 'insider' status aligned more closely to being a nurse who had worked in WCTO service provision rather than as part of a whānau experiencing services. I was concerned that the orientation of the research undermined the intent of kaupapa Māori methodologies. Once I was aware of this

tension, I was able to work through it by reframing my interview questions and data analysis. Debriefing with members of my research advisory rōpū also supported me to consider the different implications of ideas that were generated through analysis of the data. Constructivist methods assist researchers to continually test and build their ideas. These methods also guided my analysis to be situated within the experiences of whānau rather than the process of service delivery.

Throughout the data collection and analysis process there was the temptation to use commonly understood Māori terms that encapsulated what was being said by participants. I identified my own assumptions about the use of the terms, which increased following consideration of the terms when writing the methodology chapter. For example, the use of the term 'whakapapa' referring to genealogy and within this research, being interpreted to reflect whānau encounters with health and social services over time. The use of the term in this way, led to a description of whānau rather than the identification of the experience of whānau. This positioned me as an outsider looking in upon whānau rather than sitting alongside whānau hearing what they were saying about their experiences, which in this example related to whānau 'protecting their space'. Another consideration regarding the use of Māori concepts is ultimately who this research is designed to support in practice. Many non-Māori will not have the depth of understanding that I am beginning to appreciate in relation to Māori terms, and the reduction of the terms to a simple English translation is not consistent with the emancipatory intent of kaupapa Māori methodology. This led me to carefully consider the terminology of the theoretical categories to reflect the experience and aspirations of whānau rather than a description of whānau values.

Summary

This chapter has outlined the methods and processes undertaken for data collection and analysis in this research. The integration of kaupapa Māori methodology and constructivist grounded theory methods was explored, including the four values central to kaupapa Māori methodology informing the methods. The influential role of the research advisory rōpū was described, alongside my strategy for participant recruitment. The approach to data collection was outlined with examples of reflections and memo writing. The process of data analysis and coding was described which culminated in an overview of the relationships between the theoretical categories. Kaupapa Māori axiology was discussed in relation to the processes undertaken within this research to uphold ethical principles. Finally, researcher reflexivity was explored with specific examples which influenced the trajectory of the data analysis and discussion. In Chapter Five I provide an explanation of the findings generated through utilising these methods.

Chapter Five: Findings - Mahi Ngātahi A theory for culturally responsive WCTO services

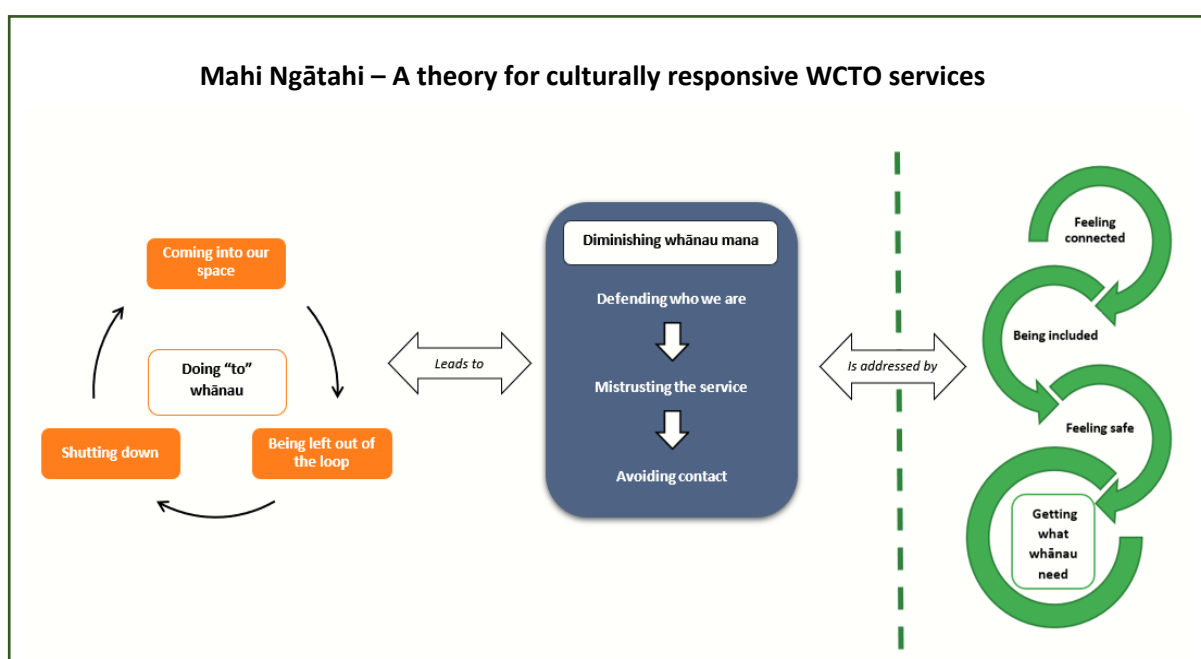
Introduction

In this chapter, I will present the model outlining the theory **Mahi Ngātahi – A theory for culturally responsive WCTO services** (Figure 5.1). The findings will be presented in three sections which reflect the theoretical categories constructed from the focussed codes. The three theoretical categories, *doing to whānau*, *diminishing whānau mana* and *getting what whānau need* represent the experience of WCTO services from whānau perspectives, the impact of these experiences and what services need to do to address the impact of these experiences. The properties of the categories and the processes within the categories will be discussed with quotes from whānau participants. In the final section of this chapter, I will present a framework for culturally responsive WCTO services.

Mahi Ngātahi – A theory for culturally responsive WCTO services

Figure 5.1

Mahi Ngātahi – A Theory for Culturally Responsive WCTO Services



The Mahi Ngātahi model (Figure 5.1) explains the impact that the cycle of negative experiences of WCTO services has on whānau. The theoretical category **doing to whānau** consists of a cycle of WCTO services *coming into the space* of whānau, with subsequent interactions leading to whānau *being left out of the loop* in terms of decision making, which leads to *shutting down* to

multiple aspects (if not all) of the service. The impact of this cycle is reflected in the theoretical category **diminishing whānau mana** which begins with whānau feeling they need to *defend who they are* which leads to increased level of *mistrust in the service* and finally to *avoiding contact*. This section of the model illustrates a process of cause and effect which builds as the cycle of 'being done to' repeats. The green section to the right of the model represents another process leading to the third theoretical category **getting what whānau need**. Each step in this process reflects a way to mitigate the experience outlined in the left side of the model.

Doing 'to' whānau

The category **doing to whānau** was constructed from the focussed codes *coming into our space*, *being left out of the loop* and *shutting down*. This cycle reflecting the experiences of WCTO services is represented in Figure 5.2. Each sub-category was generated from a group of focussed codes which are also illustrated in Figure 5.2. **Doing to whānau** begins with the experience of services coming into the physical and metaphorical 'space' of whānau. *Coming into our space* represents the whānau space being forcefully entered into rather than held as a separate mutual space created by the relationship of whānau with the WCTO practitioner. The associated responses from whānau leads to a sense of *being left out of the loop*. This relates to the actions of services effectively distancing whānau from the process of engaging with a WCTO service. This leads to whānau *shutting down* or closing off to a WCTO service. Whānau internalise this disconnection and the cycle continues until whānau disengage completely from WCTO services. A detailed discussion relating to each of the sub-categories of the cycle **doing to whānau** will follow with an outline of the properties that have contributed to each experience.

Figure 5.2
Process Overview – Doing to Whānau



Coming into our space

The sub-category *coming into our space* represents the perception of WCTO services coming into whānau homes and treading upon existing support structures surrounding the whānau. This sub-category was generated by whānau indicating that their realities and values were not important to the service and were perceived as a variation from a dominant cultural 'norm'. In attempts to bring whānau into the service, there was an adoption of health professional appointed decision-making responsibility which led to services taking ownership over the whānau. This was interpreted by whānau as services making assumptions about their lives and 'taking over'. The use of tools (graphs, developmental assessment tools, computers) perpetuated the disconnect between what whānau wanted services to hear about what matters to them and what was informing the service assessment of their realities.

The values of whakawhanaungatanga and manaakitanga were highlighted by whānau as fundamental to their worldviews and were often disregarded by WCTO services. Whakawhanaungatanga was defined by whānau as the connections that exist between people and the level of influence and input people have into other people's lives. It extends beyond initial introductions and is referred to as an ongoing process of relationship building. Whānau described services as lacking a commitment to whakawhanaungatanga, even if the service was governed by Māori.

A lot of Māori want to go straight for the Māori service, because you expect the whole whānau environment, you expect to feel more comfortable. You expect to be able to do the whole whakawhanaungatanga thing and it didn't happen (Focus Group 2).

Whānau explained that there is often a lack of recognition by WCTO services of the relational structures that surround their lives. This ranged from the mother being the only person to receive information through to the provision of health promotion messaging that contradicted the advice provided by extended whānau. There was a lack of recognition that whānau receiving the service and whānau members supporting other whānau with babies are one and the same. The impact of this dislocation and reduction of whānau influence was depicted in the following quote:

So my sister – she's like a really open person – and she doesn't take no from anyone. her and her Plunket nurse clashed a bit, I mean a lot. So my sister, she has a way of persuading my other whānau members – so they were like iffy about the Plunket nurse and then it's when they met their ones - we all had a – just had a bad thought – about Plunket ... And I think

that can be with a lot of Māori families, they can be headstrong, and the nurses don't realise why (Focus Group 3).

Manaakitanga refers to the way whānau regard each other as well as the demonstration of the value of relationships. It is considered by many whānau, to be a guiding principle that underpins a Māori way of life. Whānau are acutely aware that everyone demonstrates their values differently, however understanding what manaakitanga looks like within each whānau provides an opportunity for connection that is often overlooked. Information sharing between whānau is considered manaakitanga as it represents the knowledge and expertise that exists within the collective whānau. When WCTO services provide information without recognising the knowledge that has been shared by other whānau members, they are stepping into the relational currency system of whānau without invitation. The result is service providers trampling on the mana (power and/or prestige) of whānau by positioning their information as superior.

...that bedsharing thing. So this Pākehā Plunket nurse, she came out and said 'you can't sleep with your baby, do not put baby in your bed, rarara.'... I'm like, shut up, not that I was going to anyway. But traditionally, you know - I'm surprised I'm here! And my grandmother, she had us in bed with her. I'm like, oh my god, what would we have done without you! Like shut up... (Whānau M).

'Taking ownership of us' was another property of *coming into our space*. This began with the way appointments were negotiated and arrangements were made to go into whānau homes. Some whānau experienced a process that was not negotiated, and they were effectively forced into receiving a service. The level of resistance created by an experience of having choice taken away reflects the impact of disempowering processes upon whānau.

They made the appointment to meet at my house, but it felt forced upon me to actually have them around to examine my child. I didn't have a choice. Yeah. I didn't get a chance to actually say much (Focus Group 2).

Whānau felt that WCTO service practitioners would come in and 'take over' with the baby. The perception of WCTO services taking ownership within whānau appeared to be exacerbated by the emphasis on the physical assessment of the baby. There was also a sense of grieving the loss of a relationship with the midwife who was perceived to be more interested in the whānau – and women as mothers, rather than having a sole focus on the baby. The positioning of the service provider as 'experts' on the growth and development of children appears to disconnect the tasks of assessment with the building of relationships. This leads to relationships with

whānau being built that do not necessarily engage with the needs of the māmā (mother) and/or whānau, as the focus is primarily on the child.

Because you know when you're with your midwife they are solely focused on you as the mama... And then when you have your baby and six weeks later you go to Plunket and it's all about baby (Whānau J).

Like a lot of attention is kinda for the baby, not for the parents. You don't have someone really saying "you're doing a good job" or "have you eaten?", it's kinda like "has the baby been fed?" or "how's the baby growing?" but like you could be not eating or not sleeping and not in a good way ... I just think there should be more kind of support and understanding that we are trying our best (Whānau L).

It's like they're just there because they've gotta do their job and that's to assess your baby. (Focus Group 3).

The questions that were asked in relation to the care of the baby were more likely to make whānau feel like the WCTO provider was taking ownership of them than questions relating to the wider whānau. Direct questioning about the care of the baby often put whānau on the defensive and without the wider relationships with whānau, gave them the impression that WCTO services were only concerned about the welfare of the baby. There was an implied judgment that whānau by themselves were not capable of looking after their babies. At times, the assumptions by the WCTO providers were more overt and led to whānau feeling uncomfortable in their own homes. As described by Whānau A, the WCTO nurse made an assumption about them that led to a breakdown in the relationship from the beginning.

So anyway baby was asleep... I had him on the couch – anyway, the Plunket nurse came in and was like, "Oh, he's a bit pale" and then my husband came out from the shower and she was like, 'Oh... it's just his colouring'... What the ... ?! (Whānau A).

Another property of *coming into our space* was 'relying on tools'. At times this was related to whānau receiving a service from multiple people and the observation that there was an overreliance on tools to inform the relationship. There was a general lack of relational practice with whānau that was needed for them to positively engage with the service. Instead whānau described transactional practice which focussed on the 'tasks' associated with the tools for data collection and a separate process from building the relationship.

I always got someone different. I felt the person didn't know me and they were always expecting me to have my well child book. Then I lost it and

so they were like oh ok now what? Umm, I can tell you about my baby? (Whānau D).

I don't think I knew anything about my nurses, like they would tell me their names but you know, nothing else. Whereas especially with Māori, we like to get to know the person and where they're from and have that conversation. But no, it's just "Hi I'm dadada and I'm here to do this and they pull out their computer." I'm like you're in my house – I wanna know who you are (Focus Group 2).

Plunket or Tamariki Ora is not about my baby – it's just about, "What's his weight?" It wasn't about my baby in general (Whānau B).

This practice led to whānau closing off to the relationship with the service as they felt that their perspectives of their children were left out of the assessment process. There appeared to be a use of tools within whānau spaces without the invitation of whānau to participate in the assessment. Growth charting within the WCTO book was seen by some whānau as another tool that 'judged' them and their babies against non-Māori families from the moment they were born. The use of tools was closely linked to the process of *being left out of the loop* whereby whānau felt disconnected from the information being obtained during the assessment process. The information collected by using the tools did not appear to resonate with the realities of whānau which led to further confusion about their use.

Those graphs are based on ... not our babies. Maybe if you compared them with other Māori babies then maybe they would be more useful. But no, my baby is too big. Already being judged before he gets old enough to know what that is (Whānau J).

They need less focus on the graphs and more focus on our lives, because our lives don't revolve around the graphs. Maybe they could explain why they do those types of things and why it is beneficial for the baby and the mum (Focus Group 2).

Being left out of the loop

Being left out of the loop was the subcategory that continued on from *coming into our space*. Once whānau had experienced WCTO services within the physical space of their homes or within the metaphorical space of their whānau, they felt that they were not always included in the decision-making related to planning for interventions. They felt as if they were one of a number of people the service needed to see on a particular day, that they had to repeat information to multiple service practitioners, and that they did not understand aspects of the service that had been provided. *Being left out of the loop* described the way whānau were further disconnected

from the service they had experienced, which made them feel that they had experienced something they were not fully part of.

The first property of *being left out of the loop* is 'ticking the boxes'. Some whānau felt that the WCTO service was just 'ticking the boxes' with the nurses working off a checklist of actions to complete with everyone enrolled in the service. The practice of whanaungatanga was neglected in favour of completing tasks. Whanaungatanga was referred to by participants as the connections that exist between people and the level of influence and input people have into other people's lives. This extended beyond initial introductions and referred to an ongoing process of relationship building. It involved accessing the knowledge and expertise of the whānau with an understanding of this sitting within the relational network of the collective whānau. When nurses were perceived as 'ticking the boxes', they were focussed on completing the tasks required in the WCTO assessment at the expense of acknowledging the relational network in which whānau exist.

I just wish they'd make you feel more than just a statistic or just filling out your worksheet, that type of behaviour makes mums not want to be a part of whatever you've got going on they just feel like another number (Whānau A).

The process of whanaungatanga explains the roles of people within whānau. This process was missing from some participants' experiences with WCTO services. These whānau expected that WCTO services would build relationships with them that went beyond the collection of data; however, the emphasis instead was on obtaining information from the whānau to meet the requirements of the service.

I kind of like, not relied on Plunket but I thought that they would come and either reassure me or teach me or say I was doing a good job? And then I feel like when they came it was kind of the surface information, they weigh them and see how long they are and then get a general overview for their own records... (Whānau T).

'Withholding information' was another property of the sub-category *being left out of the loop*. At times whānau felt that they were not told information that they should have been told, or that WCTO services were purposefully keeping the relationship 'superficial' in order to avoid having to respond to their actual needs. This was related to the both the social needs of whānau and the physical or developmental concerns about their children.

Yeah they probably just do the surface stuff only, not really getting any deeper than that – with my son I've had a few concerns like with his speech? But they kind of just said wait till he's four to go to the doctor and have his B4 School Check (Whānau X).

When whānau believed WCTO services were withholding information, they looked to other whānau for support. There was a sense of collective whānau who felt ostracised by WCTO services and tried to support each other with the struggles they faced. Often this support was informed by the previous experiences rather than information offered by WCTO providers.

Whānau need a lot more support for them and their families and those Plunket services just don't do that. Just help with whatever they need, like if parents are struggling, helping them out with like clothes or whatever they need (Whānau A).

When effective support was provided by WCTO services, the relationship with the service improved significantly. This support ranged from having people listen to what is happening for them and being able to relate to them, to asking what type of support might be needed. When the support was wanted and was appropriate for the situation, whānau saw it as an act of love and kindness.

My sister was there when I truly needed a friend and was so amazing amongst the chaos and helping me navigate some of the scariest days of my life. I thought I'd made the biggest mistake having a baby but now I wouldn't be without him (Whānau Z).

She (the WCTO nurse) noticed from the time I've had my first child till now, she noticed different things. And she was like, so do you need help with this – because she knew I wasn't going to ask. So, she asked herself. So yeah, she knew that I'm struggling with this, so you need help with this. She really cared about me (Whānau A).

Being left out of the loop was also connected to examples of struggling within whānau and the need to retell their stories. This related to retelling their stories to multiple health professionals as well as needing to retell their stories to whānau or friends as a result of not getting what they needed from the health professional. Many of these stories were centred around maternal mental health issues. There were several whānau who described their journey with post-natal depression and anxiety. The way these experiences were interpreted was closely linked to descriptions of how a sense of connection was facilitated by friends, whānau and health services. When the relationship with a WCTO service was positive, whānau were open to

sharing about their mental health history. However, when whānau perceived there were barriers, they would identify other people to discuss their issues with.

Because I suffered post-natal depression with my first two because they were exactly 13 months apart, born on the same day but different months. The Plunket nurse didn't really help with any suggestions, I don't even know if she knew. I ended up talking with my family instead (Whānau C).

Things were really tough, I couldn't even tell my partner I was needing to go on anti-depressants so I was lucky I had family and friends I could talk to that helped me through that time (Whānau M).

And my Plunket nurse who I had then was really helpful, like she'd come to me and go beyond probably what she had to, 'cause then I was on medication when I was already in a shitty place, um and because I suffer quite badly with anxiety and stuff, and I'm better now, but she helped me a lot with that as well. Yeah, she was just in particular like a really nice person. Helped me get what I needed. She made me feel more human again" (Focus Group 1).

The experience of 'not knowing' was the final property of the sub-category *being left out of the loop*. Not knowing what the service was, what to expect or why led to whānau disregarding the WCTO service and being unable to identify what the benefits were of having a WCTO service visiting them. There was a sense that these experiences fuelled whānau suspicions that they were intentionally being excluded from knowing about the service. Some whānau felt that they were giving information to WCTO providers without understanding what it would be used for. They felt that the WCTO service was more about collection data rather than building a relationship and as a result, gave minimal responses to questions that were asked.

Shutting down

The final sub-category of the theoretical category *doing to whānau* was 'shutting down'. This sub-category referred to the next stage in the process of *doing to whānau*, following on from 'coming into our space' and being 'left out of the loop'. Shutting down refers to the ways whānau internalise the negative experiences of a WCTO service. Shutting down included the property of 'feeling uncomfortable'. Feeling uncomfortable was a common description used by whānau to explain the lack of connection with the WCTO provider and/or service. When accessing the service, whānau felt that they did not fit in with the expectations of the service or that the service did not fit in with their values and ways of being. This was related to a lack of

understanding of different worldviews and a lack of openness to include aspects of care that were important to whānau into their practice.

I wish my nurse would have more of an open, you know when you like meet someone - open minded, be just – have a good aura – you feel like ‘good person’ – like the conversation flows easier with people who are open themselves (Whānau A).

Feeling uncomfortable was connected to a lack of acknowledgment of wairuatanga. Whānau described wairuatanga as providing a connection to all things and people (both living and deceased) throughout their journey with WCTO services. Wairuatanga was expressed differently for each whānau, however, the majority of whānau acknowledged spirituality as an important part of who they are. Whānau talked about spirituality in terms of having their own ‘space’ and creating space for engagement with services. Wairuatanga was considered by some whānau as more important to Māori than non-Māori and therefore it was not expected to be acknowledged or understood in non-Māori environments. The stories related to wairuatanga and communication with tupuna (ancestors) were often discussed within whānau, however, were less likely to be shared with non-Māori due to the potential discomfort of being misunderstood.

I think it [karakia] is one of those tapu subjects. Like people, especially if they’re not Māori, they’re talking it. And it becomes that thing where if you don’t understand it then you shouldn’t be doing it (Whānau I).

Well it’s something I don’t expect Pākehā people to understand. Because I have tried having these conversations with Pākehā and it’s just like a whole other world for them, having that type of kōrero (Focus Group 1).

When whānau were disconnected with their wairuatanga, they experienced isolation from each other and from themselves as spiritual beings. The level of isolation that whānau experienced determined the degree to which they shut down towards a WCTO service. The connection to tupuna and wairuatanga and this relationship to ‘being Māori’ was underacknowledged by WCTO providers. Whānau located themselves within a network of ancestors that have provided the foundations of life. However, WCTO service approaches essentially truncated whānau from this network. The wisdom passed on from ancestors was described by the following participants as being found within waiata (songs), whakataukī (proverbs) and speeches.

What the nurses don’t see is that our tupuna have left us templates, and we’ve just got to find them and actually like, even in our waiata, our

whaikorero, everything, the templates are already there for us to follow (Whānau T).

Another property of 'shutting down' related to whānau feeling powerless. At times whānau had difficulty expressing what they needed or identifying what they were entitled to. This extended beyond receiving services, to how whānau choose to live their lives and what they choose to share with others. Being able to trust people to respect the decision-making authority of whānau was an outcome of whānau feeling that others trusted their opinions and decisions. This aligned with people outside the whānau taking the time to understand the significance of values and practices within each whānau and each situation. When whānau felt they were powerless in receiving a health service, they were positioned to feel powerless in subsequent interactions with other services. Whānau K provided an example of this during an emergency caesarean section.

When my daughter was born, I wanted to be there. And the surgeon goes "wait over there". Sort of up in the corner and away from everything. And I sat away from it. And I said, "When my daughter's born, I've got a process, and I'd like to cut the cord with some pounamu and I've got a little bit of harakeke." And he goes "Oh no no no, we'll see what happens because we just need to get this baby out." And he was a bit agitated at the time, a bit hostile. He was hostile (Whānau K).

Whānau K acknowledged the acuity of the situation, however the insinuation by the medical team was that their priorities and values were unimportant led to a feeling of powerlessness. When the baby was born, the father had to remind the team of his intention to karakia and cut the cord. He was not allowed to hold the baby and instead the baby was placed on the mother who was unconscious. There was also a sense that the age and experience of the whānau had an impact on the level of power they were afforded in the situation.

I didn't feel like it was a warm process. The birth of your child should be the most celebrated thing. Everything that occurs in that space, in that time, should be one of those things that will never leave you. But I was young. So that was my first experience, but it made me question what I might be in for each time someone comes over (Whānau K).

Whānau felt that there were assumptions made about them when they access WCTO services which led to them shutting down. These assumptions were aligned to feeling 'judged' or 'stereotyped' as Māori. Participants want to be acknowledged as being Māori, but they do not want to be prematurely aligned with predetermined categories depicting Māori 'norms'. Likewise, they did not want people to not acknowledge their culture out of a fear of getting it

wrong. The issue with non-acknowledgement was that the default positioning of the interaction returned to the dominant culture which did not necessarily meet the needs of whānau.

There's an ignorance to seeing that others might have a different way of doing something. Or knowing about something and assuming that that's how people are going to do things, so none of that negotiating in the space between and actually finding out. And I don't know what's more damaging to relationships. Either not offering or assuming. It's kind of neglect or assume (Whānau M).

The judgements and assumptions surrounding whānau by health services have an impact upon how whānau see themselves as Māori. Some felt that they are not 'Māori enough', or that they should be doing things a certain way in order to fulfil the expectations of people looking in.

Another assumption and what I just realised recently – you know how my big girl gave birth a couple of weeks ago? And automatically the midwife thought that because she's Māori/Cook island there's – let's just tie it up with one of those things that they tie it up with? The cord...? (Whānau T).

Just how they speak to you. The way you're looked at. "Do you have a community services card?" I bet they don't ask others that. I just smile and nod and think to myself I am not going to spend my time with you again (Focus group 1).

The experience of being disregarded by people outside of whānau was common across whānau participants. The resulting lack of trust in others saw whānau shut down to attempts to engage in relationships. When whānau felt 'let down' by an interaction or an event, it jeopardised the likelihood of them allowing others in.

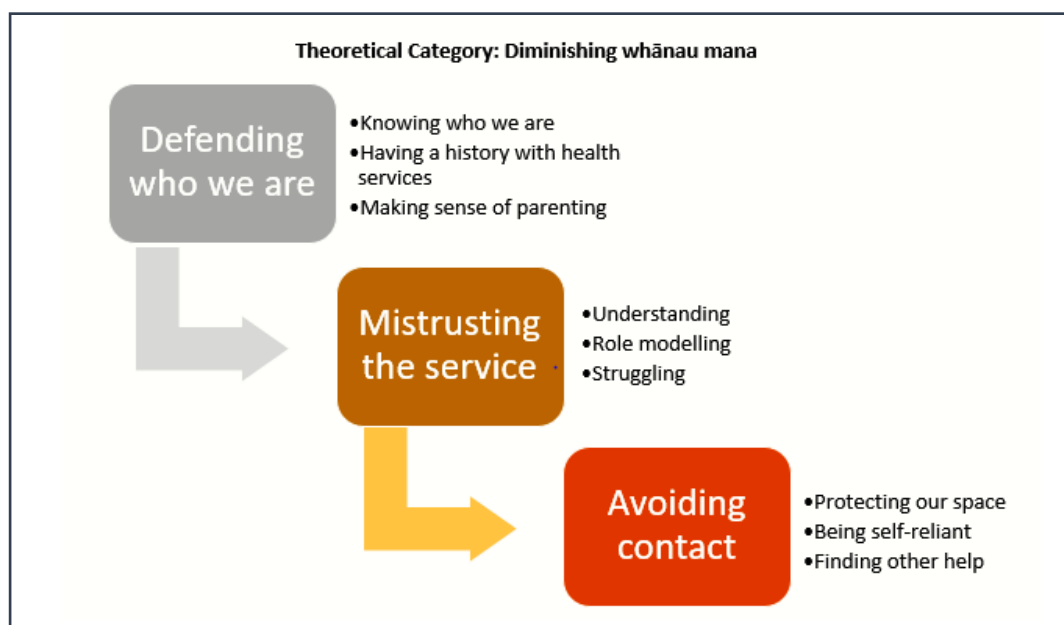
... like when you go to triage at the hospital, you've got to tell the triage nurse, the reception, another nurse, the house surgeon and the registrar ... and if someone is ugly to you and then the next person is like, 'what's going on for you' – I'm like shut up, it's 'cause I don't want to talk to you.. (Whānau J).

Diminishing whānau mana

Diminishing whānau mana is the second theoretical category constructed from the data. This category reflected the impact that **doing to whānau** had upon the mana of whānau and the way WCTO services were perceived by Māori. 'Mana' is term that has been defined in previous

chapters as a relational concept which provides people with spiritual authority over their lives (NiaNia et al., 2019). **Diminishing whānau mana** was constructed from the sub-categories *defending who we are*, *mistrusting the service* and *avoiding contact*. Figure 5.3 illustrates the relationships between sub-categories and the process involved in diminishing whānau mana. The sub-categories are expanded to illustrate their construction from the properties identified in the data. These subcategories will be further described in the following section with excerpts from participants.

Figure 5.3
Process Overview – Diminishing Whānau Mana



Defending who we are

Defending who we are is a sub-category constructed from the properties ‘knowing who we are’, ‘having a history with health services’ and ‘making sense of parenting’. *Defending who we are* describes a position taken by whānau who feel that that the service is ‘doing to them’ instead of working with them. This positioning is both defensive in terms of reacting to judgments and protective against the perceived threat of the WCTO service. It is based in negative experiences of health and social services and reflects the way experiences inform the response of both existing whānau and generations to come accessing WCTO services. When whānau feel defensive, they are less likely to engage with the messaging of the service related to health education and promotion as it is seen as attacking their way of life and parenting choices.

‘Knowing who we are’ as Māori was a property that depicted a need to provide a definition of

what it is to be Māori for non-Māori. There were whānau that described having to defend their 'Māori-ness' to WCTO practitioners. Some were apologetic for not being 'Māori enough'. This was reinforced by a homogenous interpretation of Māori values and beliefs by service practitioners. There were also whānau that felt if they were too Māori, they made non-Māori uncomfortable. Whānau described different values that were viewed as fundamental to their understanding of 'being Māori' that had been handed down through generations. There was also the connection to how these beliefs influence whānau approaches to parenting. When parenting practices were challenged by health promotion messaging without acknowledgement of the whakapapa of the practice or value base driving them, whānau felt the need to defend their whakapapa.

I was one of those kids who was raised by a village. I, you may not have noticed yet, but I still have only child syndrome? (Laughs) And that's because of the way I was brought up... but at a young age I was heavily immersed in te ao Māori and with the tikanga and manaaki and all that sort of stuff, and awhi and all that. And I like to think I am bringing some of that, ALL of, what I have learned from my grandparents and all that passed on knowledge (Whānau T).

The values, I mean, what my parents taught us, they're just normal. That's just how we were brought up. I mean it's not like we went to school and learnt it. It was what it was. It is who we are. I don't know if those nurses understand that (Whānau J).

Many whānau contextualised their WCTO journey in relation to their healthcare experiences with services from pregnancy and birth through to the present day. Others discussed the influence that previous experiences with older children had over their current experiences of WCTO services. When these previous experiences were negative, whānau automatically approached subsequent service providers with heightened level of uncertainty and defensiveness. Some whānau did not clearly differentiate WCTO services from the collection of other agencies involved in their lives and their history associated with those agencies. There were also whānau who relied on extended whānau experiences and perceptions to inform their decisions relating to WCTO service access. When services were considered unreliable, whānau felt they needed to defend themselves to protect against being let down again. This defence often took the form of disengaging or declining services altogether.

With my oldest boy he was with Plunket I think (I didn't know the difference), with child number 4... it must have been Tamariki ora because she was Māori, I assumed she was Tamariki ora... She was really good. My

midwife failed to tell me that my baby was tongue tied ... With my number two, the lady - she was a Māori lady – actually she was Tamariki Ora and she was really cool. We built a really good connection within the first two visits, and that was really cool, and then all of a sudden she left, and no follow up with us... And then, with my last baby, I don't think I had anyone, I don't think I even had a phone call... So if someone else comes along, I'm like F off! (Whānau T).

For some whānau, having children has increased their awareness of the ways they were parented, and they indicated a desire to change the way they parent their children. This process of making sense of parenting creates a vulnerability for whānau which is not often acknowledged by WCTO services. As a result, whānau put either conscious or unconscious barriers up to prevent WCTO services from engaging in that level of dialogue to prevent them from being judged.

Something I haven't told them [WCTO service] is that I want to try and change the cycle with me and my kids because I was getting hidings every day with leather belts and all that sort of stuff so I want that to change with my kids (Whānau A).

I think I've had to consider ways of saying or doing things. Now I think, how does saying or doing this for [child's name] impact positively or negatively on him based on my own experiences as a kid ... but I don't really talk about that with Plunket, they are just here to check his weight (Whānau Z).

Mistrusting the service

The *mistrusting the service* sub-category consisted of the properties, 'understanding', 'role-modelling' and 'struggling'. The level of mistrust whānau had towards a WCTO service correlated with the perception of previous negative experiences. However, levels of trust were also related to how these experiences were understood over time. The way the service was understood contributed to the trust whānau had in the service. Likewise, the way health promotion and health education information were shared by practitioners and understood by whānau had an impact on the trust that whānau had in the service. When the service was seen to support the role-modelling aspirations of whānau, there was more likely to be engagement and trust in the service. Whānau also needed to trust that the service would help them with aspects of their lives they were struggling with, rather than be perceived as adding pressure or judgment.

Understanding what a WCTO service was and why they should engage with it was an important aspect that influenced the degree of trust whānau had in the service. When whānau felt they

were excluded from knowing about the service, or that there was an assumption they knew what the service was, they felt there was a hidden agenda to the data being collected about them.

They could explain why they do the types of things they do and why it's beneficial for the baby and the mum. Why did they need to do that?
There's no explanation (Whānau B).

There was also a lack of understanding about the role of the different WCTO providers. Tamariki Ora providers were seen to have better relationships with whānau and being able to understand Māori realities more than Plunket. However, Tamariki Ora providers were also viewed as being unreliable and inconsistent in their contact with whānau and Plunket were considered a more professional (and therefore a more trustworthy) option. A lack of continuity of care also contributed to the mistrust and uncertainty surrounding WCTO services.

How is Tamariki Ora even different to Family Start? You don't even know who's coming to see you. For all you know it could be someone lying about who they are. Especially when you get someone different each time (Focus Group 1).

The link between understanding and health literacy was also identified by some whānau who described the ways nurses spoke to them as confusing. There was also an assumption that English was the first language for the whānau and therefore they knew what was being spoken about. This practice of cultural dominance undermined the mana of whānau in terms of the service not creating a space for te reo to be valued as informing whānau worldviews.

My family, our first language isn't English – so then it was like, I would like, have a look at my phone and see what that word means, just to keep on top of it (Whānau R).

Role-modelling was another focussed code that led to the sub-category of mistrusting the service. Māori whānau were rarely acknowledged for the role-modelling they do within Māori communities. There are activities that whānau are consciously undertaking to demonstrate their love for each other and pass knowledge on to their tamariki. For some whānau this is about role-modelling cultural and spiritual beliefs and for others, it extended to role-modelling how to fit in with society. Whānau felt that they were judged as unable to provide or role model support to other whānau by services that provided the help for them. There appears to be a cycle in which whānau are continually positioned as 'service recipients' needing help rather than acknowledged for the support and role-modelling they do with extended whānau. Whānau

needed to feel that health professionals trusted their opinions and decisions as role models and people contributing to the wellbeing of society, for them to trust others. This involved health professionals taking the time to understand the significance of values and practices within each whānau and take opportunities to learn from whānau.

‘Struggling’ was another property that led to the construction of the sub-category of *mistrusting the service*. Whānau often mentioned their own struggles but emphasised their observations of others who have had limited finances or involvement with statutory child protection agencies. There was a sense of empathy for other whānau who faced similar situations and a willingness to provide support, even if it was only to be able to relate to their situation. Whānau did not feel that they could always trust WCTO services to provide the support needed to alleviate the experience of struggling.

I meet with young mums and they talk about the financial struggle and I’m like yeah yeah I totally agree – we’ve got five and me and my husband both work and you know.. and then they’re telling me how they’re broke... poverty’s a huge thing here and those services don’t do much to change that (Whānau M).

Whānau described the reality of having children as coming with struggles which often required them to look for additional support for themselves. Struggles related to parenting were often perpetuated by experiences of financial poverty, relationship instability, and/or mental health issues. When whānau did not receive the support, they anticipated from WCTO services, they looked to other trusted people within their lives to help them. This support ranged from having people listen to what is happening for them and being able to relate to them, to asking what type of help might be needed.

Avoiding contact

Avoiding contact was the third sub-category involved in the construction of the theoretical category **diminishing whānau mana**. *Avoiding contact* consisted of the properties ‘protecting our space’, ‘being self-reliant’ and ‘finding other help’. Whānau attempts to reclaim or protect their ‘space’ involved putting either physical or emotional distance between them and the WCTO service. Being self-reliant saw whānau relying upon their own strengths and resources which rendered the WCTO service redundant. Finding other help reflected the need for whānau to find something different to what they had experienced before. Avoiding contact in whatever form it took, seemed the only option for whānau to prevent WCTO services from diminishing their mana.

When whānau felt they needed to protect their space, it was due to the discomfort they experienced when receiving WCTO services. This sustained frustration often led them to avoid contact with the services altogether.

They talk to us like, “You’re over here”, “Māori is over here”. They make assumptions, like my mum is tall, fair, green eyes and they can be talking to me and my mum walks in and they change and act all professional. That makes me angry and it makes her even angrier (Focus Group 2).

I’d like to feel comfortable with that person coming to see us. Maybe more visits? Because I think you’re gonna get a few mums that would tell them to get stuffed because they don’t feel comfortable with them (Whānau B).

Feeling uncomfortable with the WCTO service led whānau to become protective of the space surrounding them. This protection of the physical space included avoiding appointments by not being at home or not attending clinic appointments or avoiding phone calls. However, protecting their emotional and spiritual space involved shutting down the questions or giving minimal responses. Some whānau resorted to lying to the nurse to avoid any further discussion when they felt uncomfortable. It was clear that when whānau felt the need to protect their space, there had been a significant breakdown in the relationship – or a relationship had not been established in a way that could sustain the requirements of each party.

It was like, be there on this date. We need to come and do this this and this. I just avoided answering their texts, their phone calls. It’s like “I’m ok, if I needed you I would reach out for you”. But I didn’t need to. And that’s coz I didn’t want to (Focus Group 3).

Historic experiences with health and social services also had an impact on the degree to which whānau felt the need to protect their space. When these experiences were negative, whānau were automatically anxious and on alert regarding contact with any subsequent service. This cumulative history added to the whakapapa of service experiences for each whānau and were shared with wider whānau as required, influencing the degree of engagement even prior to enrolment with a WCTO service.

My sister’s pregnant now, she’s in her third trimester and she’s been asking me these questions, like who should she go to and I’m like well just so you know, I would recommend [service name] because they keep to their appointments, but in saying that I’ve heard bad things about them too... (Focus Group 2).

Being self-reliant was another property of *avoiding contact*. When whānau expressed a need or desire to take of themselves rather than engage with a WCTO service, they were responding to historic negative experiences of services and protecting themselves. This response reflected a desire to physically avoid contact, however, it also highlighted the mana they were holding for themselves and their whānau. The notion of accessing a WCTO service was akin to handing over their mana to a service who was not able to be trusted with it. Self-reliance was not necessarily a negative concept, as it demonstrated a level of self-determination, but it often reflected more of an avoidance of the service rather than a shift in responsibility to the whānau unit.

...because the type of person I am, if I feel like I don't want to see them, I'm all good, I can take care of myself, I don't need you, I think I know everything – yeah I'm one of those (Whānau T).

Finding other help was linked to the property of being self-reliant. Whānau identified other people or services that they believed could provide what they needed from a WCTO service. Whether it was suggesting that the GP would see them from now on, or directly asking for a different service, whānau were able to identify who they would trust to give them information when the WCTO service was not fulfilling expectations. Often this identification of alternative service providers provided an option for whānau to avoid maintaining contact with a WCTO service.

I just said to her I would take baby to the GP for a weigh. I didn't want them coming in here with their judgments, making me feel like a bad mother. I'll just weigh her when I get her jabs (Focus group 1).

Getting what whānau need

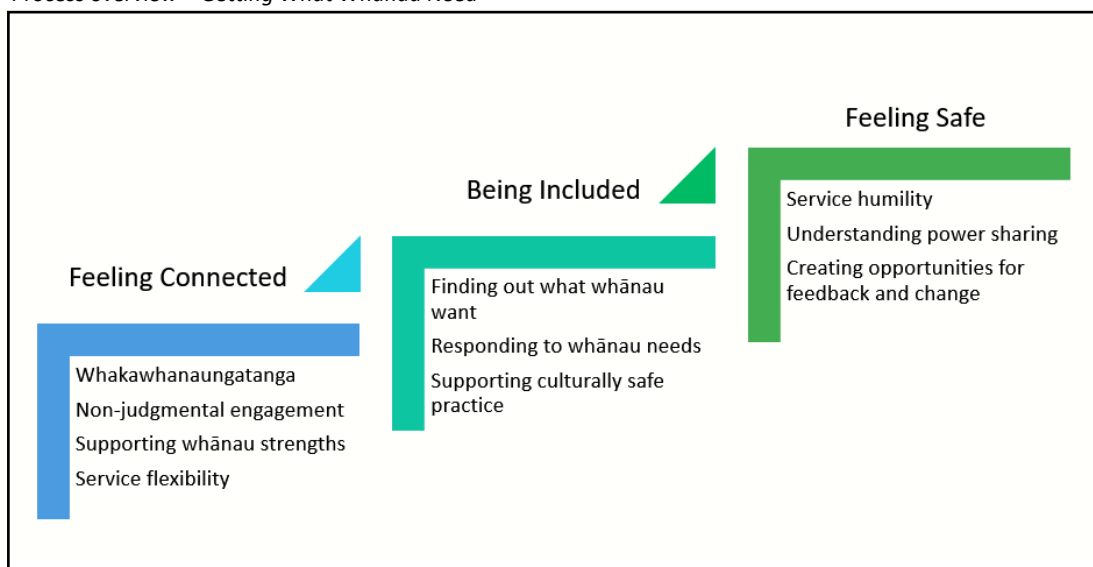
Getting what whānau need is the third theoretical category in **Mahi Ngātahi - a theory for culturally responsive WCTO services**. This category refers to the steps needed to address the cycle of being 'done to' by WCTO services and the impact of diminishing whānau mana. It presents three sub-categories reflecting the stages of culturally responsive engagement with whānau and an ultimate outcome of whānau **getting what they need** from a WCTO service. The steps are illustrated in Figure 5.4 as a staircase with each step predicating the next. If there is a negative experience for whānau as outlined in the previous sections, service practitioners need to return to the bottom of the staircase in order to begin the process of rebuilding the relationship with whānau. This section will explore each of the steps involved in **getting what whānau need** with narratives from participants. The first step *feeling connected* relates to the

relationships established between service practitioners and whānau. The second step *being included* reflects an organisational responsibility to authentically include Māori in all areas of WCTO organisational decision making. The third step is *feeling safe* which represents the space for diversity and difference created by service providers, systems and structures.

Feeling Connected

Feeling connected is the first step towards **whānau getting what they need** from WCTO services [refer Figure 5.4]. This sub-category represents the relationships required for culturally responsive ways of working with whānau. Whakawhanaungatanga is required to form the foundation of any relationship with whānau. Having a non-judgmental approach is a fundamental to connecting with whānau beyond a superficial engagement and lowers the defensiveness of whānau, which in turn promotes connection. Another property of *feeling connected* relates to the identification and promotion of whānau strengths. This supports a reframing of whānau within the eyes of the WCTO service provider(s) which enhances the likelihood of whānau seeing themselves engaging with a WCTO service. The ability for the WCTO practitioner to adapt and adjust to the needs of whānau is another pivotal property informing the level of service connection with whānau.

Figure 5.4
Process overview – Getting What Whānau Need



As discussed in the methodology chapter, whakawhanaungatanga refers to relationships established through identifying common areas of connection. This includes an exploration of the relationships whānau have had with health and social services, what they want services to know about them and what they want to know about services. Once initial relationships and points of

connection are established, the process of whakawhanaungatanga needs to continue throughout all contact with WCTO services. Whānau described the importance of WCTO services connecting with them at a heart level before getting into the business of the service. This heart connection involves whānau wanting WCTO practitioners to see them as individuals with unique perspectives and for whānau to feel an authenticity and genuine regard for them held by WCTO practitioners.

... speak to me from your heart before you tell me what you know
(Whānau G).

The importance of investing time in building connections with whānau cannot be underestimated. When whānau felt that they connected with the WCTO practitioner, they were more likely to trust them and feel comfortable to share more information with them. Whānau spoke of wanting someone to work with them who was 'friendly and supportive'. This was not as a friend but as a professional who engages with them in ways that a friend might. This involved getting to know the whānau and the experiences and needs of the adults caring for the baby.

When they took the time out to actually have those conversations about me and what I think. That just tells me that they are interested in getting to know who I am as a parent (Whānau J).

I really like her, she's really warm and friendly. I trust her, we can talk about anything (Focus group 1).

Having a non-judgmental approach was a quality that many participants described as essential to connecting well with them. When whānau felt that WCTO practitioners were open to who they were, even if they did not always understand their choices or ways of life, the relationship was built on a solid foundation of respect. The feeling of being respected by healthcare providers serves to enhance the mana of whānau by recognising the self-determination required for whānau to make choices that work for them. When whānau felt respected, they demonstrated their value of the WCTO service practitioner, as expressed in the following quote;

We had a really packed house at the time, and like we had a long driveway and we had five cars at our house, and whenever we'd see her come, all my brothers would just move their cars out because that's how good she was as well, and our baby loved her. Yeah, and she just acknowledged all of us and respected how we did things (Focus group 3).

The identification and promotion of whānau strengths was another property of *feeling connected*. Whānau expressed a need for services to support them in identifying what they are doing well rather than focus on what is not going well. This positive reinforcement strengthened the relationships with whānau and strengthened the way whānau saw themselves and their parenting practice.

Instead of criticizing us, maybe tell us what we are doing right. That gives us something to feel good about. But instead we are just left feeling stink about everything we do wrong (Focus group 2).

She (WCTO provider) was really friendly, she always told me I was doing well and was really encouraging. I felt like I could be honest with her about what was going on for us (Whānau R).

The level of flexibility of the WCTO service also had an impact on the connection with whānau. This was related to the physical flexibility of home visiting versus clinic appointments, communication such as instant messaging, text messages or phone calls as well as flexibility as to what support could be offered by the WCTO service. Whānau challenged the 'rigidity' of services that did not adjust to their needs. They wanted a variety of approaches offered in order to maintain a sense of choice over how they engage with services. Some whānau appreciated the home visits and face to face contact with WCTO providers. Others preferred to be contacted over the phone and to self-initiate any additional support. Some whānau preferred contact via instant messaging service as they rarely had credit on their phones for text messages. All whānau wanted a choice as to the mode in which WCTO service providers communicate with them.

Being Included

Being included is the next step in the process of **getting what whānau need**. Being included refers to the ways whānau see themselves within a service and are involved in the decision-making processes surrounding them. Finding out what whānau need from a WCTO service promotes a sense of inclusion whereby whānau take the lead as to how the service is provided to them. The WCTO service environment needs to support culturally safe practice by including whānau in all aspects of service delivery and finding out what is needed to optimise whānau engagement. The inclusion of whānau in this step relates to both individual interactions with whānau, and organisational decision making and relationship building with whānau, hapū and iwi.

Checking in with whānau as to what they wanted from a WCTO service allowed for transparency and boundary setting within the relationship. When WCTO practitioners worked in this way, whānau felt they had control over their space and were able to voice their needs more freely. When whānau were given choices about the care they received, they were more likely to trust the WCTO service.

I felt like she could understand my views, asked me what I wanted and gave me steps, and like my concerns, were heard and not like oh ok we'll just leave that, she was like 'ok, we'll just do this and this, how does that sound?' gave me directions and into the right direction and I really liked her (Focus group 1).

The ability of a WCTO service to respond to whānau identified needs was often reflected in the level of variety of the types of services provided. WCTO service providers need to be able to offer support in different ways for different whānau. One whānau described the way a WCTO nurse took her to the supermarket for food when she had no alternative transport. She recognised that was not the purpose of the service, but the difference it made to her life at that time supported her future engagement with WCTO services. Other whānau felt guilty that additional the support they received was not offered to others (i.e. non-Māori). At times, the perceived disparities in service delivery presented a barrier to whether whānau would accept any additional service. Whānau wanted to see inclusion for everyone accessing WCTO services.

Well I had no car and they came and picked me up to take me shopping and that sort of stuff... It makes my life a little bit easier because I'm not stressing about how I'm going to get my groceries or get my son to the hospital or whatever he needs (Whānau A).

...providing extra support for Māori families, that's great. But in a way I feel like that is racist because I do know people that would benefit from having someone helping them, like they have no car. They have two kids, they've got a baby, one's in day care but they're not Māori so it kinda could benefit more people if they just put criteria around need instead of race (Whānau L).

The majority of whānau interviewed indicated that WCTO services as they are currently offered do not meet their needs or could be improved. They felt that services had remained unchanged for many years and did not reflect the needs of whānau today and did not recognise the traditional Māori parenting practices that have transcended time. This suggests that there needs to be authentic input and inclusion of whānau, hapū and iwi into WCTO service design. An example of a change needed within WCTO service approaches relates to spirituality as an

integration of spiritual and holistic practices as part of a WCTO approach can create space for inclusion and connection. Most whānau considered karakia as an important spiritual practice related to their holistic well-being and spirituality. Karakia is also seen as a way of clearing the energy within an environment and allowing for attention on the present.

People go into people's houses all the time and say a prayer, make sure there's no bad energy, clear the energy out. I believe in this and it's good to make sure we are in a good space. For me being Christian, that is really powerful to us (Whānau J).

This is what being Māori is based on. We say karakia[s] for everything".
(Whānau I)

Recognising the connection of whānau within the wider environment supports a sense of inclusion within WCTO services. The importance of being grounded by returning the placenta to the land and therefore being able to connect with the wider spiritual realm is something that is rarely discussed by WCTO providers. Acknowledgment of the land where clinics are situated, or assessments are conducted would support the inclusion of whānau within WCTO service delivery. The link to pūrākau (creation narratives) and the notion of grounding tamariki by connecting to Papatūānuku (the Earth Mother) was expressed in the following description of burying the whenua (placenta).

We put the greenstone down, did the karakia, put the placenta on, a little bit of earth, a plant. That connection to Papatuanuku is really important for grounding. The nutrients from the placenta are from the mum too, so you are honouring the mum and the baby ... The purpose was to connect to the whenua. This is our whenua. The mana whenua. So to me that makes it even more special. The connection to Waikato (Whānau K).

This whānau also talked about the significance of a tree planted over the whenua and the connection of their son with the land and the whakapapa of the whānau. When whānau experience a culturally safe WCTO service, they are referring to a service they can see themselves within – in which their values are acknowledged and celebrated as part of their identity and informing who they are as parents.

The tree that I chose is a purple ake ake. When it grows, it grows to six metres. When it is fully matured, ake ake is a hard wood. So the placenta forms the heart of the rākau (tree) – essentially part of him. So when he makes the taiaha from this tree, and it becomes something he can hand

on, you know there's a real genuine narrative about it. We should be more conscientious about how we connect our children to the land (Whānau K).

Feeling safe

The final step in the sub-category **getting what whānau need** is *feeling safe*. Whānau need to feel safe when they engage with a WCTO service and the service needs to provide an environment that is safe for whānau to engage with. Feeling safe consists of the properties of *service humility, understanding power sharing and creating opportunities for feedback and change*. Service humility refers to the service practitioners adapting to difference by positioning themselves as 'other' rather than expecting whānau to conform with rigid processes and systems. Understanding power involves WCTO organisations and staff recognising the impact that power imbalances have upon whānau and taking action to address these imbalances. In order to address power imbalances and make adaptations to service delivery, services need to create opportunities to gain feedback from whānau and have a willingness to make changes as necessary.

The ultimate environment in which whānau feel safe is their own cultural environment. An important aspect of service humility is not assuming that whānau will or need to 'fit in' with the cultural norms of the service. Whānau need WCTO services to adapt and flex to connect with their realities for them to feel safe with the information they are sharing.

She did ask heaps of questions. There was one in the initial stages, I know that they have to do it about like making sure that I'm not suffering from post-natal depression. But I did feel like that was, the way it was done it was just like real blatant. It was like, "Are you ok? Do you need someone to talk to?" The mental health component was a bit of a surprise because she was just cooing over baby. We just don't mix the two things in our whānau (Whānau W).

The degree to which WCTO providers understand power sharing is closely connected to the demonstration of service humility. Whānau described experiences with WCTO staff who conducted themselves as if they were entitled to come into whānau spaces because of the service they were providing. This positioning was detrimental to relational ways of working. Whānau felt safer when they were invited to connect with WCTO services and when the decision-making authority and power surrounding engagement sat with them.

I don't even really know what they are supposed to do, I'm not really even sure what their service is apart from weighing and measuring my child... but I feel like if I don't have them come in, I'll get in trouble (Whānau P).

If they were a bit more relaxed about it, it would make us want to connect a bit more. You know "we are here if you need us" instead of "do we really need this?" (Focus Group 2)

The messaging relating to health promotion and health education also generated a power dynamic between the WCTO service provider and the whānau. When health education messaging contradicted whānau practices or beliefs, many whānau felt the need to avoid the topics or lie about their experiences to prevent judgment by the WCTO service provider. Information was provided 'at' whānau who had not established a problem with what they were currently doing, so engagement with WCTO services felt like an attack rather than a place of safety. Understanding the power of words and information as an intervention is essential to redressing the power imbalance between services and whānau.

I think if you want to glean as much information in terms of baby's progress and development and what whānau are doing then you need to have a really good relationship with the wahine that you're working with so they can speak freely and they're not restricted ... not hiding stuff (Whānau B).

Central to building relationships with whānau is creating opportunities for whānau to provide feedback which informs change at all levels of the organisation. When whānau feel that their voice is heard and their needs are accommodated within services, they will feel safe to continue to engage with and utilise the service. This process enhances relationships at all levels of whānau, hapū and iwi with WCTO service practitioners.

Well with the European Pākehā nurses they would try, and they would greet you, "Kia ora..." I appreciate that, they asked about what words they could use with us, but they weren't all know it all about it? Like tokenism you know. You can tell... they just asked us and that was cool (Whānau I).

Being engaged is really important like I've had with people where they're distracted, like their mind is on the next person. It's one of those instinct things. just feeling like "you're not present today". Yeah so being present is really important and they need to know that we pick up on those things (Whānau B).

Mahi Ngātahi – A cultural responsiveness framework for WCTO services

Mahi Ngātahi – a theory for culturally responsive WCTO services (Figure 5.1) is based upon three theoretical categories which outlined the experiences of whānau, the impact of those experiences and ways for whānau to get what they need. The results of this research provide an explanation of whānau experiences and highlight what needs to be done by WCTO services and funders to fulfil their responsibilities to Māori. Based on these findings, **Mahi Ngātahi - A cultural responsiveness framework for WCTO services** (Figure 5.5) was developed to illustrate the three steps towards *whānau getting what they need*. This framework illustrates the progression of WCTO services towards cultural responsiveness within the whānau context and supported by the cultural competence of the WCTO practitioner. The framework is presented using a poutama pattern. A poutama pattern is a Māori design often found adorning tukutuku panels in marae that represents a stair cased acquisition of knowledge. It symbolises the power of Tāne Mahuta (god of the forest) and his ascension to the heavens to bring knowledge back to the earth. The poutama is often used as a metaphor for gaining knowledge in a staged way before moving on to a higher level (Te Puni Kōkiri, 2014).

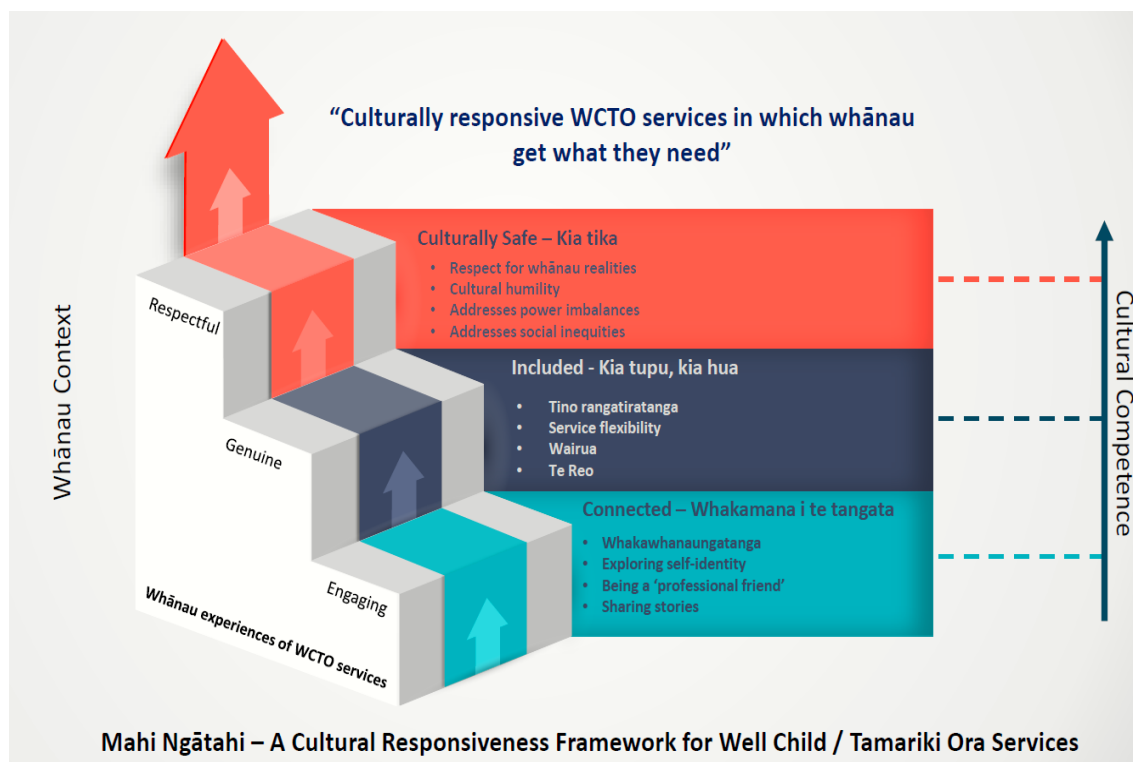
The **Mahi Ngātahi framework** sits within the whānau context. The findings of this research indicated that whānau felt they had to adapt and adjust to ‘fit in’ with the WCTO service, which meant they were often not sharing parts of themselves that were important to them and their parenting. The findings highlighted a lack of openness from WCTO providers to the variety of approaches and beliefs whānau had. Often the communication relating to parenting practices that did not align with ‘best practice’ left whānau feeling judged and excluded from the WCTO service. Therefore, any initiatives designed to support whānau, need to firstly consider the setting in which support is provided and for WCTO services, that is within the whānau context.

The right side of the **Mahi Ngātahi Framework** (Figure 5.5) depicts the continuum of cultural competence which reflects the knowledge and skills needed to work authentically through the steps in the middle towards cultural responsiveness. **Mahi Ngātahi** is a framework that provides an indication of what whānau need from a WCTO service. The intention of **Mahi Ngātahi** is to situate culturally responsive progression within the whānau context while supporting practitioner development of cultural competence. The individual steps will be explored further within the discussion chapter. Cultural competence within **Mahi Ngātahi** ensures that WCTO service practitioners are equipped with the ability to work in a way that identifies and supports whānau to fulfil their needs. However, it cannot be assumed that specific activities related to cultural competency are appropriate for every whānau accessing WCTO services. Instead

cultural competencies are identified in this model as ways of supporting culturally safe and responsive practice. It is recognised that in many instances this knowledge will already exist within whānau, WCTO providers and communities of practice.

Figure 5.5

Mahi Ngātahi – A Cultural Responsiveness Framework for WCTO Services



Summary

In this chapter, I have presented the construction of **Mahi Ngātahi – A theory for culturally responsive WCTO services**. Three theoretical categories were identified which contextualise the experiences of WCTO services for Māori whānau with tamariki under five, the impact of these experiences and a proposed service response. **Doing to whānau** was the first theoretical category explored which outlined the ways whānau received WCTO services. Whānau felt excluded in terms of decision making and data collection and existing resources within whānau were often disregarded. The subsequent isolation of whānau even in receiving a WCTO service led them to internalise their experiences and shut down engagement.

The second theoretical category identified was **diminishing whānau mana** which outlined the impact *that doing to whānau* had on the way whānau interacted with WCTO services. Whānau felt defensive in their interactions with WCTO services and that they needed to justify their way of life. There was a general mistrust of WCTO services, and this was partly in response to services

not appearing to trust whānau. Avoiding contact with WCTO services served to put physical or emotional distance in place to protect the mana of whānau.

The final theoretical category **getting what whānau need** proposed three steps to address the issues outlined in the previous categories. Feeling connected involved a deepening of the process of whakawhanaungatanga which included the identification and promotion of whānau strengths. Being included relates to whānau seeing themselves authentically within a WCTO service. Finally, feeling safe reflects the adaptability and flexibility of service practitioners to respond to difference in ways that respect the mana of whānau.

Mahi Ngātahi - A cultural responsiveness framework for WCTO services was presented which represents the integration and analysis of the research findings within the three theoretical categories. In Chapter Six, I will provide a discussion related to the theory constructed from the findings. I will contextualise the process of culturally responsive WCTO services within the literature and each step towards culturally responsive WCTO practice.

Chapter Six: Discussion

E tau hikoi i runga i ōku whariki
E tau noho i tōku whare
E hau kina ai tōku tātau tōku matapihi

*Your steps on my whariki (mat), your respect for my home,
Opens my doors and windows*

The whakataukī above captures the essence of whānau voices within this research. Within this study, I sought to identify the processes involved in culturally responsive service delivery for Māori accessing WCTO services. The findings suggest that the degree to which whānau perceive WCTO services being respectful of their realities has a direct influence over engagement with services and any interventions. The findings also indicate that current WCTO practitioners are not always working in respectful ways and that whānau are protecting their mana by shutting service providers out of their lives.

In this chapter I will present a discussion related to the findings which detailed whānau experiences of WCTO services and ways to optimise cultural responsiveness. I will examine the positioning of Māori as ‘other’ in relation to the disregard for Māori values and ways of being. I will describe the impact of reactive strategies to address Māori health needs on relationship with whānau. The lack of partnership between WCTO service providers and whānau will also be explored. Finally, I will discuss the literature related to the processes and concepts identified within **Mahi Ngātahi – a cultural responsiveness framework for WCTO services**.

Positioning Māori as ‘other’

The negative perceptions of healthcare services provided to Māori identified within this study are congruent with the results of several recent theses which explored Māori experiences with healthcare providers (Baker, 2017; Brown, 2018; Graham, 2018; Wepa, 2016). The theoretical category **doing to whānau** within Mahi Ngātahi reflected the actions of WCTO services that whānau felt were imposed upon them. It represented the dynamic of whānau having to adapt and conform to a different culture within their own space. Came and Humphries (2014) argued that the pervasive impacts of colonisation, including the loss of Māori legal, health and education systems as well as the homogenisation of the health industry have resulted in the inequities evident in Māori health today. Activities designed to address these inequities within WCTO services appear to further marginalise whānau, reinforcing the power of the dominant culture.

Structural racism and intergenerational poverty experienced by Māori have contributed to the health inequities that prevail for whānau (Cram et al., 2019). The stage one report on the Health Services and Outcomes Kaupapa Inquiry (WAI2575) outlined the following Treaty principle to be implemented across primary health care services:

The principle of options, which requires the Crown to provide for and properly resource kaupapa Māori primary health services. Furthermore, the Crown is obliged to ensure that all primary health care services are provided in a culturally appropriate way that recognises and supports the expression of hauora Māori models of care (Waitangi Tribunal, 2019, p 163).

This principle has been identified to address issues within a primary health system that does not view Māori ways of being as legitimate or required in receiving healthcare. The stage one report was also critical of the positioning of 'Māori Advisory Groups' in reference to a Crown comment that they were supported by a Māori Advisory Group in completing a Health and Disability review. The Tribunal argued that engagement and consultation with Māori as partners must be more robust in order to fulfil their obligations to Te Tiriti o Waitangi (Waitangi Tribunal, 2019). The separation of Māori advisory groups from groups making policy decisions, reinforces the lack of power and influence Māori have at all levels within the health system. This power imbalance is echoed within the WAI2915 claim into Oranga Tamariki in which whānau have expressed concerns about social workers lack of respect for tikanga Māori (Māori protocols) (Office of the Children's Commissioner, 2020). The report from the Children's Commissioner also highlighted the negative impact that child protection services isolating tamariki (children) and whānau from te ao Māori has on their wellbeing.

The disregard for Māori values and practices articulated by whānau in this study, highlights the level of institutional racism that prevails undetected within the health system. Came and Humphries (2014) described this as inaction by privileged people who believe that what they are doing is fair and just. They suggested that senior managers in health services perpetuate 'master narratives' which are the stories that reflect the way institutions do things without question, to uphold the status quo. They described the way that master narratives manifest privilege and serve to maintain inequitable outcomes between populations. These inequities are evident in the statistics representing admissions of Māori children to hospital for non-accidental injuries and neglect being three times the rate of non-Māori (Craig et al., 2014).

Whānau feeling like they were being 'done to' is the result of a master narrative being operationalised. The orientation of the WCTO service with a focus on the child and the mother

negates the relational networks in which whānau receive support. This corresponds with a study completed by Vukic et al. (2009) who determined that First Nations people who had family that were unwell wanted to be supported with skills to help their family rather than excluded from the process. Disregarding the support and expertise provided by whānau members disrespects the relational currency and equilibrium that exists within whānau. This increases the likelihood of whānau shutting down any further attempts engage. Murphy (2019) described the difficulty in Indigenous people claiming self-determination within the current “international legal architecture” (p 69) that promotes assimilation as a way of maintaining peace. He highlighted the need for increased relational strategy and Indigenous political power to ensure services are tailored to meet the aspirations of Indigenous people worldwide.

A lack of recognition of whānau strengths or ability to make connections was evident throughout this research. This is despite several Māori models of health, all regularly referred to within the health sector, outlining whānau or whanaungatanga as fundamental to an holistic assessment of health (Durie, 1998; Love, 2004; Pitama et al., 2007). Whānau did not experience the process of whakawhanaungatanga as they expected to with WCTO service practitioners. This finding echoed that found by Wepa and Wilson (2019) who determined that health practitioners talk about whānau involvement but lack the skills to engage effectively with Māori. Without whakawhanaungatanga, WCTO providers do not always identify the way knowledge and information is shared within whānau. This leads to the information provided by the WCTO service being portrayed as superior to the expertise within whānau and the mana of whānau being insulted.

Within this study, whānau perceived that the WCTO nurses’ main priority is to weigh and measure the baby and plot this information on the graphs. This led to whānau feeling compared against others or defensive about the potential judgments that were being made about the size of their baby. The lack of transparency relating to what was happening and why, further disconnected whānau from the service and left them feeling vulnerable as to what the service was doing to them. Wepa and Wilson (2019) also described the way health services silence Māori by creating environments in which whānau do not know what information they need or what questions to ask.

Health literacy can be defined as the tasks and skills required to make decisions related to health. People with higher levels of health literacy are more able to adjust and respond to situations that are unfamiliar to them (Nutbeam et al., 2018). The health literacy levels of Māori parents of children under five years of age have been reported as ‘poor’ in comparison to other ethnic

groups (Ministry of Health, 2010; Ministry of Justice, 2010). The correlation between health literacy and health and social outcomes is well documented (Nutbeam et al., 2018). However, measurements of health literacy sit within individuals and populations rather than with the systems and services providing care. This positions many Māori in deficit ways compared to non-Māori and places the service provider in a powerful position of determining which populations are 'health literate' according to their criteria. It also places blame on Māori for not knowing about or understanding aspects of their care (Wepa & Wilson, 2019).

Identifying ways to improve the health literacy of populations detracts from the responsibility of service practitioners to ensure that they deliver services in a way that people understand. This includes knowing what a service does and ensuring that people have the information and skills they need to make informed decisions about their own health and that of their family. This criticism has been documented within the literature with calls for health literacy to be considered within the context and agency held by parties interacting in the delivery and receipt of healthcare (Carlson, 2019; Papen, 2009). Positioning whānau as having low levels of health literacy perpetuates the disconnect between service delivery and whānau experience and blames Māori for not understanding what the service is designed to do. WCTO services approach whānau with an expectation for them to 'fit in' to their service context. This reinforces the cultural and contextual power held by service practitioners and the experience of being 'done to' expressed by whānau.

The Aboriginal and Torres Strait Islander people in Australia also experience widespread health and social inequities compared with the non-Indigenous population of Australia (Australian Government, 2017). Expectations for Indigenous Australians to develop health services in partnership with non-Indigenous organisations are hindered by the mistrust generated from a "legacy of historical paternalism and ongoing neocolonial practices" (Hickey et al., 2019, p 8) and the time taken to build trust is often underestimated. Likewise, Indigenous mothers in Canada cited historic experiences of racism as a reason for mistrusting health providers (Wright et al., 2019). They also expressed a desire for more holistic health care for themselves and their babies that sat outside the Western biomedical approaches on offer. Wotherspoon and Williams (2019) maintained that many cultural barriers faced by Aboriginal and Torres Strait Islanders when accessing health services are systemic rather than interpersonal. They called for health providers to identify issues facing Indigenous Australians and make system changes to support culturally responsive service delivery.

Reacting to the statistics

The statistics and commentary relating to persistent inequities in Māori health outcomes are prevalent throughout the literature (Craig et al., 2014; Curtis et al., 2019; Ministry of Health, 2014a; Ministry of Justice, 2010; New Zealand Mortality Review Data Group, 2018; Tipene-Leach et al., 2010). WCTO services appear to be delivering care that reflects a reaction rather than a proactive response to these statistics. The commitment to improving health outcomes for Māori at a population level is often lost in translation at individual and whānau levels. Health promotion and health education messaging leaves whānau feeling that they have been judged by the WCTO service and with a sense that their views are not respected. Whānau felt that they were categorised into 'being Māori' and were therefore a reflection of the negative statistics associated with Māori health and social outcomes. Whānau wanted to be seen and known by WCTO services in the way they see themselves, rather than in relation to assumed pre-determined criteria. This correlates with the literature describing Māori experiences of health services (Bolitho & Huntington, 2006; Brown, 2018; Graham, 2018; Tipa, 2013; Wepa & Wilson, 2019) and highlights the need to contextualise and adapt the generic messaging within WCTO service delivery.

The way that information is gathered by WCTO services makes whānau feel like a 'statistic'. The questions asked by WCTO providers situates whānau as having to defend their decision making. These questions that form the basis of a WCTO assessment may be appropriate to ask if a strong connection between the whānau and the WCTO service provider has been established. When whānau do not feel connected to the WCTO service provider however, many of the questions appear threatening and are often perceived as reducing them and their experiences to a series of statistical values. Wilson et al. (2019) identified the "systemic entrapment" (p 65) that prevents wāhine Māori (Māori women) from engaging with health and social services when experiencing intimate partner violence. They described a fear of encountering racism and/or deficit discourses - informed by statistics that position Māori as the problem, as contributing to the barriers preventing wāhine from disclosing violence. Durie (2011) outlined the need for Māori to be involved in identifying the measures of hauora that are meaningful to them. There is a need for WCTO services to reorient outcome measures to meaningfully engage with whānau realities. The adjustment of assessment questions to align with whānau identified outcomes may support whānau engagement and service responsiveness to whānau needs.

Māori health statistics reflect the whakapapa of health services in Aotearoa and service delivery to whānau today is a continuation of negative experiences and unmet needs for many whānau.

Whakapapa is a concept that is fundamental to Māori creation narratives and represents points of connection between people and the environment (Brannelly et al., 2013; Graham, 2009). Whakapapa is the organisation of knowledge in a way that provides a blueprint for the creation and development of all things (Graham, 2009). If Māori health statistics and experiences are considered knowledge, then the health service today has been created from what has happened for Māori in the past. The reliance upon statistics rather than experiences has led to a lack of understanding about the influence of whakapapa over whānau engagement with WCTO services. WCTO service delivery to Māori today is driven by past events that have happened for Māori at a population health level. The statistics alone do not reflect the contextual realities for whānau. Therefore, identifying ways for Māori to authentically contribute to the whakapapa of a WCTO service is critical to developing a service that better supports hauora into the future.

A lack of partnership

Working in partnership is promoted as a way of working that supports a balance of power between the nurse and the patient (Davis & Day, 2010; Si-Yan & Joan, 2019; Tipa, 2013; Tipa et al., 2015). In the mid 2000's services within communities across Aotearoa identified the Family Partnership model (Davis et al., 2002) as providing a framework for an optimal way of working with families. Family Partnership training supported health professionals with skills to suspend the urge to provide solutions to the problems presented. This involved facilitating a process in which families identified strategies they believed would work for them. Despite having organisational buy-in, it became apparent that working in this way created a tension with funding models and required an unsustainable investment in the training of health professionals (Huntington & Wilson, 2009; Tipa, 2013).

Whānau within this research described experiences with WCTO services that lacked partnership. They were left out of decision-making processes and did not always understand information that was about them. Whānau felt that WCTO service practitioners were not interested in their 'real' problems and as a result, did not receive the support they needed. Davis and Day (2010) described the need for health professionals to assist parents to analyse their own problems in order to enable them to manage them. Therefore, if problems are not being addressed at all, whānau are being deprived of an opportunity to build their own self-efficacy. Graham and Masters-Awatere (2020) also identified the uncertainty whānau faced when accessing health services. They described the alienation whānau experienced when having to build relationships with multiple service providers as well as navigate through a health system and decipher health information that did not make sense to them.

Whānau descriptions of WCTO services highlighted transactional ways of working in which providers were perceived as working against whānau. When whānau were assessed as parenting in a way that contradicted ‘best practice’, information was provided by the WCTO provider with the intent to challenge their actions. This demonstrates a reactive approach to WCTO assessment which generates a defensive response from whānau. A partnership approach to working with families fundamentally negates this expert model of practice (Davis & Day, 2010). The Family Partnership model was developed to recognise the expertise of parents in relation to decisions they make for themselves and their children (Davis et al., 2002). Davis and Day (2010) discussed the importance of identifying the constructs that surround the interpretations people make of their situations and decisions. The results of this study suggest that WCTO practitioners often relay information without understanding how whānau are interpreting what is being said. Additionally, Graham and Masters-Awatere (2020) described the way whānau “self-silence” (p 197) in order to preserve their relationship with health professionals. This highlights the need for WCTO services to consider how they are perceived by Māori and identify mechanisms to identify barriers to engagement.

Mahi Ngātahi highlighted the difference in goals between whānau and the WCTO providers. Whānau did not see themselves within the WCTO service, they instead saw themselves adapting to fit in with a Pākehā service with Pākehā measures of health. This experience is echoed by academics who have commented on the inequities within the partnership represented by Te Tiriti o Waitangi (Bell et al., 2017; O'Sullivan, 2007; Ramsden, 2002). The delivery of WCTO services funded by the Crown to Māori theoretically reflects this partnership. Kawharu asked of the Treaty partners “what do we know and understand about one another, and who are we to each other?” (Bell et al., 2017, p.136). The findings from this research suggest that whānau do not always understand about WCTO services, and their experiences would suggest that WCTO services do not always understand whānau. Kawharu added that when there is an acknowledgement that there are gaps in our understandings of each other, conversations can begin to build on our ability to work together. She cautioned however that these conversations are dependent upon both parties having the equal capacity to participate (Bell et al., 2017).

As mentioned previously, ‘partnership’ is a principle that was used to translate the intent of The Treaty of Waitangi and Te Tiriti o Waitangi into government policy. These principles have now been classified as outdated and in need of review (Came et al., 2020; Waitangi Tribunal, 2019). One of the main issues is that Māori are promised ‘partnership’ but in reality, are not given authority over fundamental decision-making processes in health service design and delivery

(Came et al., 2020). Simon (2016) described the belief among some hapū and iwi that mana motuhake (independent authority) was never given away and in particular, the iwi and hapū who did not sign He Whakaputunga and Te Tiriti o Waitangi. He described mana motuhake as an “ancestory vehicle” (p 71) which is reflected in the use of ancient tikanga (protocols) for decision-making. Whānau experiences of WCTO services do not reflect Māori aspirations or ways of being and instead continue to measure whānau against western realities. Reclaiming a service whereby partnerships reflect equal power on both sides is critical to responding to whānau needs.

The realisation of tino rangatiratanga (self-determination) for Māori is predicated upon the legitimisation of Māori ways of being within Māori communities. In order for bicultural partnerships to be successful, there needs to be an understanding of and respect for the different realities of whānau, hapū and iwi (O'Sullivan, 2007). This can be applied to working with whānau within a WCTO context. Tino rangatiratanga is not something provided by a WCTO service, rather it reflects the legitimisation of being Māori within whānau, hapū and iwi. The process of colonisation has seen many whānau disconnect from iwi and hapū which has resulted in uncertainty about what ‘being Māori’ means. WCTO service practitioners need to work with whānau to understand how they see themselves rather than make generalised assumptions about what ‘being Māori’ is according to their own criteria.

Whānau responses to WCTO services

The substantive theory generated from the findings of this study reflect a negative cycle of action and reaction in terms of the way services are delivering healthcare to whānau (Figure 5.1). The findings from Wepa’s (2016) research examining the experiences of Māori whānau when engaging with health services, while not specifically related to WCTO services, highlighted that whānau struggled to be involved in their healthcare experience. Wepa explained that whānau had to ‘survive the experience’ of healthcare. This reflects a similar sense of the attack and defence process depicted within the cycle of **doing to whānau** and **diminishing whānau mana** within Mahi Ngātahi. Many whānau felt they needed to defend who they are to WCTO service practitioners in order to uphold the mana of themselves and their whānau. Baker (2017) also highlighted the struggles Māori face as consumers of mental health services. She described the collective failure of mental health services towards Māori and the lack of resources for Māori mental health as perpetuating the disparities that exist for Māori.

The negative experiences of whānau with health and social services have an impact on the level of trust they have towards services in the future. Against a backdrop of intergenerational trauma surrounding child protection practices affecting Māori in Aotearoa, it is not surprising that there is a lack of trust in agencies working with whānau (Wilson et al., 2019). As outlined in the background chapter, over 40% of Māori children under 18 had a notification of concern sent to Oranga Tamariki - the statutory agency for child protection. Approximately half of these notifications were substantiated with evidence of child abuse or neglect (Rouland et al., 2019). These statistics are indicative of the reasons for whānau suspicion of WCTO services, particularly when they are reinforced by the practice of WCTO service practitioners who are perceived as judging the lives of whānau. The current enquiries into Oranga Tamariki also highlight concerns relating to racism, discrimination and a workforce lacking in cultural competence (Kaiwai, Kipa, et al., 2020). WCTO services need to be working in ways that support whānau aspirations rather than reinforcing negative discourses surrounding Māori parents.

Whānau interviewed in a study by Boulton et al. (2018) who had been involved with child protection services, described the process as humiliating and culturally alienating. They also expressed their discomfort with having multiple social workers assigned to their cases who did not have the knowledge about the positive progress they had made. The stories of whānau within the Family Court system further highlights the cultural alienation experienced by Māori. Boulton et al. (2020) described the lack of empathy and interest from people within the legal system as instrumental to undermining the confidence of whānau involved in Family Court processes. This correlates with the experience of whānau within this study who had received a WCTO service from multiple nurses. The change in nurses led whānau to believe the service was unreliable and they grew tired of re-telling their stories to different people. Whānau expressed a need for stability in their relationships with health services and when this was not offered, they would look to seek support from within their network of whānau and friends.

Whānau felt that WCTO service practitioners did not trust them to be role models for other parents in the community. They wanted opportunities to manaaki (care for) others but were positioned by services to be people that required the support rather than those who provide it. Whānau perceived themselves and others as 'struggling' however often found it easier to consider ways to support others than to receive the support themselves. Manaakitanga was defined by Thompson et al. (2017) as the unconditional giving to others without judgement. They explained that manaakitanga is epitomised by giving to others even when you have nothing left for yourself. It is understood that the act of giving provides more to the mana of the person who is giving than it does to the person receiving the help. It was important for whānau within

this study to have opportunities to increase their mana by giving manaaki to others, particularly if they were struggling themselves.

When whānau had negative experiences with WCTO services, they would avoid connecting with the provider to protect themselves and their whānau from any future assault to their mana. Avoiding connection with WCTO service providers included not being present when the service visited and avoiding phone calls and text messages. This was similar to the findings identified in my masters research in which Plunket nurses measured the acceptability of their service by whether the whānau were home for the next visit (Tipa, 2013). The result is a relationship based upon assumptions rather than clear communication. However in Mahi Ngātahi, whānau also indicated that they minimised their responses to questions that were asked and limited what they shared openly with the WCTO service provider. Jansen et al. (2009) identified similar results within research exploring Māori experiences of healthcare. They determined that health providers have a high level of responsibility for Māori access to health services and information. The racist attitudes of some health professionals towards Māori and a general lack of understanding of Māori worldviews contributed to the mistrust of a non-Māori healthcare system.

The Mahi Ngātahi Framework

Mahi Ngātahi – A Cultural Responsiveness Framework for WCTO Services (Figure 5.5) was developed to represent the WCTO service experience that whānau accessing WCTO services consider as ‘culturally responsive’. Whānau being able to **get what they need** from WCTO services reflects the degree to which the service is culturally responsive. The steps towards identifying what whānau need and ways of working effectively with whānau are also reflected within this framework. The steps within the Mahi Ngātahi framework are also considered within a whānau context. This study has highlighted the importance of WCTO services meeting whānau within the context of their realities, not pulling whānau into a service context and expecting them to adapt.

Te Puni Kōkiri (2015) described the Whānau Ora approach as working in a culturally responsive way within the context of whānau. Whānau Ora initiatives are an attempt to address the structural and institutional racism Māori face when accessing health, education and social services. They are also designed to ensure a holistic approach to health is accepted and recognised as part of a whānau values base (Te Puni Kōkiri, 2015). Came et al. (2020) argued that Indigenous-owned and facilitated health services that align with Māori values both clinically

and culturally provide an opportunity for rangatiratanga (self-determination) to be realised in health service provision. Heke et al. (2019) highlighted that “socio-cultural constructions of health vary depending on people’s cultural orientation and are informed by their values, beliefs and traditions” (p 610). The findings in Mahi Ngātahi reinforced the importance of reclaiming an authentic and legitimate space for Māori to be Māori when accessing WCTO services.

The cultural competence of individual WCTO practitioners must also be considered within a framework for culturally responsive WCTO practice. Dudas (2012) defined cultural competence as the awareness, attitudes and behaviours of a nurse working with people of different cultures. Whānau within Mahi Ngātahi described varying degrees of cultural competence in their encounters with different health professionals providing WCTO services. The cultural competence of individuals must sit alongside service approaches to providing culturally responsive WCTO services. One challenge identified within the impact assessment of the Takarangi Competency Framework was the lack of cross-over between the Takarangi framework and other frameworks requiring cultural competence (Matua Raki, 2010). Heke et al. (2019) called for standardised definitions and competencies surrounding cultural competence across the health workforce which could then be applied to specific contexts of practice. They suggested that increased consistency surrounding culturally competent practice will better support people with “culturally-determined understandings of health and well-being” (p 611). The following sections will further explore the three stages of cultural responsiveness within the Mahi Ngātahi framework [Figure 5.5], with links to the literature. The connection between the steps and the values identified that enhance whānau experiences of WCTO services will also be discussed.

Connected – Whakamana i te tangata

The first step of the Mahi Ngātahi framework is about making connections. Whānau expressed a desire for WCTO service practitioners to get to know them and they want to know more about the people providing the service. Whānau found it difficult to trust WCTO providers that they did not have a connection with. Whakawhanaungatanga forms the platform for relationships to build upon as it recognises the environmental, emotional, spiritual and whānau connections between people. Love (2004) explained that whanaungatanga reflects the way people define themselves within society. Whakawhanaungatanga is the process of making connections based upon these definitions. It is a practice that has been identified in several other studies as being essential in improving relationships between Māori and health service providers (Cook et al., 2014; Levack Jones et al., 2016; Staps et al., 2019). Staps et al. (2019) determined that

relationships and culture were more important than a clinical diagnosis for Māori with Bipolar Disorder. This can be difficult for health service practitioners to prioritise when the reason for engagement is reduced to an event, problem or diagnosis. In WCTO service delivery, investing in a process of whakawhanaungatanga has the potential to increase the effectiveness of the way providers engage with whānau.

Whānau participants within this study were situated across a continuum of strongly identifying as Māori though to not feeling Māori – or feeling like an imposter. Sibley and Houkamau (2013) identified that the concept of self for many Māori sits within a collective network of identity that does not exist in the same way for Westerners. They argued that due to the range of socially and biologically constructed cultural variables relating to the way Māori self-identify, recognising these variables is important to engage more effectively with Māori populations. Within Mahi Ngātahi, relationship building and gaining an understanding of how whānau see themselves in the world is fundamental to providing a culturally responsive service. This stage of cultural responsiveness requires WCTO service practitioners to engage with whānau with an openness as to who they are and what is important to them. It leaves no space for cultural or ethnic stereotyping or making assumptions about whānau realities.

When whānau felt that a WCTO service provider was engaging with them, they identified the attributes of a ‘professional friend’ as central to their engagement. This was described by whānau as someone who was friendly and supportive of them and took the time to get to know them before offering advice. Hemberg and Wiklund Gustin (2020) defined professional friends as nurses with the knowledge of their profession, who demonstrate compassion in response to a fellow human going through experiences of illness, grief and/or loss. Strandås and Bondas (2018) outlined the benefits of a professional friendship as generating trust and respect between the nurse and the patient by the creation of common story together. They described professional friendships as promoting trust so that both parties can speak freely, however patients can also expect to get the help they require. Whānau form more successful connections with WCTO service practitioners they feel they know and trust.

Māori engagement with health services involves identifying ways for whānau to tell their stories (Wepa, 2016). Every whānau within this research had a story to tell about their experiences with health services. WCTO service practitioners need to create space for whānau to talk about their history with services outside of the initial assessments. The process of storytelling allows for reflection upon past experiences. It also supports the relationship to build on a platform of understanding each other rather than inadvertently triggering reactions from negative

experiences in the past. Wepa (2016) determined that supporting whānau to tell their stories helped them heal from trauma. She suggested that health professionals have an opportunity to demonstrate empathy and compassion in their response to storytelling by whānau. Mahi Ngātahi provides a framework that is underpinned by the relationship between the WCTO service provider and the whānau. Creating space for storytelling is likely to enhance the trust and respect for each other within this relationship.

Included – Kia tupu, kia hua

Being included is the second step in the Mahi Ngātahi framework. Being included relates to the level of whānau involvement within WCTO service delivery. With a relationship based upon a platform of connection, being included refers to the ways that whānau retain control over what the WCTO service looks like for them. This relates to the concept of tino rangatiratanga [self-determination] in health care service provision. In order for WCTO services to support the realisation of Māori aspirations (O'Sullivan, 2007), they must incorporate Māori realities and ways of being into WCTO clinical practice. Tino rangatiratanga needs to drive the WCTO framework, service design and service delivery. Whānau currently do not trust WCTO service practitioners to work with them in ways that are inclusive of their values and beliefs. Therefore, WCTO services need to find ways to support whānau to feel they belong and are accepted – both as parents and as Māori.

Masters-Awatere et al. (2019) examined the value of indigenous health providers to the health and wellbeing of Māori. When whānau felt they were genuinely cared for by a health provider and the staff, they were more likely to make more autonomous health related decisions. This led to increased involvement and engagement with their own health. Similarly, within Mahi Ngātahi, whānau experienced higher levels of trust in a WCTO service provider who did not judge them and appeared to genuinely understand their views. When whānau feel included within the WCTO service, they are more likely to accept and/or adopt health promotion and health education information. This is due to information being more readily accepted when it is seen to support whānau aspirations. The use of te reo was another practice that supported relationships between whānau and WCTO service practitioners. When names were pronounced correctly and Māori terms were used in genuine ways, whānau could better see themselves within the WCTO service.

When WCTO service delivery is driven by whānau aspirations, whānau are less likely to feel threatened or judged by the information shared by WCTO service practitioners. Anderson et al.

(2019) described a disconnect between health service delivery and community expectations related to rheumatic fever prevention and treatment. Māori and Pasifika peoples are highly affected by rheumatic fever in Aotearoa. They determined that service flexibility and rapport between the Health Promotion worker and families were two factors that improved both patient experience and treatment adherence. WCTO service practitioners need to have the flexibility to involve whānau in planning what the service needs to look like for them.

Recognition of spirituality outside of asking whether whānau 'go to church' was often non-existent within WCTO service delivery. Whānau recognised that wairua is omnipresent and needed to be respected when WCTO service practitioners came into their space. They also wanted to acknowledge their tipuna (ancestors) and the wisdom that has been passed through generations. The spiritual dimension of health is not new knowledge to non-Māori with Māori models of health being well socialised throughout the health sector (Durie, 1998; Pere, n.d.; Pitama et al., 2007). Despite this, there is a lack of recognition of the importance of incorporating discussions about spirituality when engaging with whānau accessing WCTO services. The result is a lack of inclusiveness of Māori values and beliefs within WCTO services which is not uncommon within Western models of practice (Valentine et al., 2017). Wilson and Hickey (2017) also acknowledged that a holistic view of hauora often creates a tension with a Western view of health.

WCTO service practitioners need to prioritise spiritual wellbeing for whānau to feel included within assessments. This included being open to traditional spiritual practices which connect whānau to the wider environment and protect whakapapa for future generations. It also included an openness to commencing and concluding visits with karakia to clear and protect the energy of the assessment and discussion. Wilson et al. (2018) described the way health services often ignore Māori spiritual beliefs and practices which increases the negative perceptions of health providers. They highlighted that nurses need to work in way that builds trust with whānau and stated that to do this "they should display attitudes that are genuine, empathetic and compassionate [and] actively assist patients and family participation in decision-making about their health care" (p. 3816).

Culturally safe – Kia tika

Culturally safe is the third step in the Mahi Ngātahi framework. Cultural safety is the degree to which a consumer perceives a health service as safe to approach and utilise (Ramsden, 2002). Once WCTO services have connected with whānau and provided opportunities for inclusion, the

cultural safety of the service can be optimised. Arguably, the activities within the previous two steps of the framework and the cultural competence continuum all contribute to the cultural safety of a WCTO service. Cultural safety is determined by the whānau during each interaction with a WCTO service provider. WCTO services are evaluated by whānau, hapū and iwi as to whether they are culturally safe for whānau to engage with. The level of respect that WCTO services demonstrate for different Māori realities will influence both whānau and iwi perceptions of WCTO service providers. This respect will also determine how safe whānau are in providing feedback relating to the service received.

Central to the concept of cultural safety is the notion of power and the extent to which it resides with recipients of health services. For power to be examined at a service provider level, there needs to be a demonstration of cultural humility. Cultural humility requires WCTO service providers to move away from an expert model of practice towards learning about what is important for each whānau they work with. The practice of cultural humility is ongoing and requires the constant self-evaluation on behalf of the health professional to address power-imbalances inherent within health service provision (Peralta et al., 2019). Foronda (2020) explained that at the core of cultural humility is a commitment to understanding each other. Foronda discussed the increasing need for service flexibility and openness to adapt in order to truly value diversity.

The power held by dominant cultural groups who provide the benchmark from which all differences are determined, perpetuates the unsafe service experiences of cultural minorities. Whānau within this study experienced being in the minority culture in at least two ways. Whānau accessing WCTO services are in the minority culture as consumers versus the dominant nursing and health workforce culture, and Māori are in the minority culture versus the dominant Pākehā culture within Aotearoa. The findings from Mahi Ngātahi highlighted the impact that judgements made against people from a minority culture have on future engagement with health services. However, the positioning of WCTO service practitioners by organisational policies and/or position statements are also contributing to the power imbalances experienced by whānau. Curtis et al. (2019) highlighted the importance of healthcare organisations challenging their own culture in order to operationalise steps towards health equity in populations.

WCTO providers, to a certain extent, are at the mercy of national directives relating to what constitutes WCTO service provision and how this is funded. The requirements for WCTO service delivery in Aotearoa are outlined within the Tier 2 Service Specifications (Ministry of Health,

2014b). These specifications outline that WCTO providers are required to provide culturally competent care and contribute to reducing inequalities for Māori. Often, as whānau within this study indicated, the measurements for a reduction in inequality reflect a neo-liberalist view of cause and effect (Hyslop, 2017; O'Brien, 2016). This detracts from the wider context in which whānau exist and places blame on individuals for not 'complying' with evidence-based information related to parenting practice. WCTO services cannot exist separate from the social inequities that decimate whānau security and wellbeing. They need to be funded in a way that supports a focus on the whole picture of hauora to prevent reactive practice in response to funding measures. Cultural safety requires a systemic approach to ensuring that the WCTO service enhances the social environment whānau are parenting within.

Cultural responsiveness in WCTO services

Culturally responsive WCTO services ensure that whānau get what they need within the context of their lives. This is in contrast to 'fitting' whānau within the existent structure of WCTO services. The Mahi Ngātahi theory has informed the development of a framework for culturally responsive WCTO services that is grounded in the experiences of Māori. The framework depicts the steps required by WCTO services and practitioners to engage with whānau in ways that are meaningful to them. The poutama metaphor represents the journey of the WCTO service provider working through each stage with whānau to truly identify what matters to them. Each step is informed by the previous one and connects with the growing cultural competence of the WCTO service provider. When whānau receive a culturally responsive WCTO service, they experience relationships that are engaging, genuine and respectful. These relationships form the basis for whānau to ascertain what they need from a WCTO service and have their needs met.

Miller et al. (2019) described the alignment of cultural responsiveness with the principles of social justice, specifically in relation to the intention to reduce inequities within marginalised populations. They highlighted the tension between culturally responsive and evidence-based practice. This tension has been uncovered within this study, with the wants and needs of whānau often coming second to service driven priorities of health education and health promotion. A social justice model of service delivery is required if WCTO services are to truly make a difference to the live of whānau. However, any model developed needs to respond to the individual needs of whānau without judgement or categorisation. Whānau wanted WCTO service practitioners to see the abilities and strengths they identified for themselves rather than

what was classified by the service. Similarly, they wanted assistance with issues they prioritised themselves rather than what was assessed as a priority by the service.

Wilson et al. (2018) called for healthcare environments to embrace cultural difference. They identified the nurse's ability to examine the impact of their own worldviews as pivotal to addressing inequities in populations. Cultural responsiveness within Mahi Ngātahi is dependent upon nurses' self-awareness and the identification of judgments and/or implicit bias. It also involves nurses simultaneously being aware of their impact on others while gaining an understanding of how whānau self-identify. WCTO service providers cannot be culturally safe if there is no relationship to work within. Therefore, the extent to which WCTO services build strong relationships with wider whānau, hapū and iwi will determine the capacity for relationship building and positive outcomes for individual whānau. Wilson et al. (2018) described the importance of understanding the worldviews of culturally diverse populations as they often sit in opposition to the worldviews informing the dominant healthcare system. The Mahi Ngātahi framework requires the service delivery to sit within the whānau context and privilege whānau worldviews relating to the care of their tamariki.

Summary

In this chapter I have presented a discussion related to the findings within Mahi Ngātahi. I have highlighted the impact that positioning Māori as 'other' has upon engagement with WCTO services and the historic grievances Māori carry that are reinforced by this positioning. I have described the structural racism within systems theoretically designed to support and protect whānau and highlighted the disregard for Māori values and ways of being. The categorisation of Māori based on negative statistics reinforces the blaming discourses surrounding whānau. When whānau access WCTO services they are often left out of decision-making processes leaving them uncertain and silenced about what is happening to them. The overall lack of trust between whānau and WCTO providers leads to whānau avoiding contact with services and services excluding whānau from opportunities to manaaki others.

I have discussed the development of the Mahi Ngātahi framework as an approach that supports the cultural responsiveness of WCTO services. Progression through the steps identified within this framework is thought to support whānau to get what they need from WCTO services. The cultural competence of individual WCTO practitioners is supported separately but alongside the steps towards culturally responsive WCTO services. The provision of WCTO services to Māori

needs to sit within the whānau context and services need to be open to adapting to meet the culturally diverse needs of whānau.

The final chapter will provide a conclusion to this thesis. I will review the research question and aims of the research in relation to the findings. I will provide an overview of the limitations of this study and outline the implications and recommendations I have identified.

Chapter Seven: Conclusion

Irihapeti Ramsden (2002) was critical of terms that appeared to dilute the power of cultural safety such as cultural “sensitivity, awareness, competence or appropriateness” (p 170). She believed that de-politicising the term would transfer the power from the patient and whānau receiving the care, back to the nurse. This research has indicated that culturally safe practice remains fundamental to the provision of safe and effective WCTO services to Māori. It has however, highlighted the limits of cultural safety when nurses are working within environments that do not respond to whānau realities. The intention of this study was not to undermine the ongoing importance of cultural safety within nursing practice and education, rather to progress the embedding of cultural safety into the fabric of practice environments.

In this chapter I will review the research question and aims and consider the ways in which these were explored. I will discuss the limitations of the study and the ways these were or might be addressed. I will provide an overview of the implications and recommendations I identified throughout the research process. The thesis will end with some of my concluding thoughts relating to my observations throughout the research process and my aspirations for this work going forward.

Review of research question and aims

The idea for Mahi Ngātahi was generated following the completion of my master’s research which considered Family Partnership as a model for cultural responsiveness in WCTO practice. In consultation with my research advisory rūpū, I developed the following research question to drive the research design:

‘What are the processes involved for working together in a culturally responsive way with Māori accessing well child/tamariki ora services?’

Mahi Ngātahi - A cultural responsiveness framework for WCTO Services (Figure 5.5) presents the analysed findings of this research. It illustrates the processes required to work in culturally responsive ways with whānau accessing WCTO services. This framework was developed from the substantive theory outlining the impact that doing ‘to’ whānau has upon whānau mana. The theory generated by this research indicated that this negative cycle can be addressed or mitigated by whānau getting what they need. Mahi Ngātahi encapsulates a process of connecting with whānau including mutual sharing, understanding and self-exploration. It moves into identifying ways of working together to promote self-determination and reliance while

incorporating language and values that underpin Māori worldviews. Finally, the process supports a culturally safe environment for whānau to access. WCTO services in this context are aware of addressing power imbalances and are committed to providing services that reduce social inequities for Māori. The process of cultural responsiveness sits within a whānau context and is supported by the cultural competence of individual practitioners.

The aims of this research were also identified by the research advisory rōpū were to:

- identify Māori knowledge about WCTO service delivery and outcomes
- define cultural responsiveness from Māori worldviews in accessing well child services
- explain a theory for culturally responsive ways of working together with Māori
- increase the understanding of culturally responsive relationships in WCTO service delivery

The semi-structured questions asked in the interviews and focus groups supported the identification of Māori knowledge about WCTO service delivery. At times this merged with midwifery service delivery which highlighted a lack of distinction between services. However, all participants contributed their knowledge and experiences surrounding WCTO services and the extent to which the service met their expectations was explored.

Cultural responsiveness was explored relating to how it was defined and measured for each whānau. Māori are not a homogenous group with standardised worldviews, however there was clear agreement about what met whānau needs and what hindered whānau engagement with WCTO services. Whānau **getting what they need** reflects the aspirations and expectations whānau had for culturally responsive WCTO services. What this looks like in reality for individual whānau is defined by whānau themselves. How this feedback might be obtained in a safe way is something for WCTO providers to consider connecting with whānau to discuss.

The discussion surrounding **Mahi Ngātahi - A cultural responsiveness framework for WCTO services** (Figure 5.5) explains a culturally responsive theory for working together with Māori. The findings and the discussion relating to this framework have contributed to the body of literature defining cultural responsiveness for Māori. Perhaps more significantly, it has provided a theory for WCTO to structure their services to better engage with whānau and address some of the systemic issues facing Māori accessing health services in Aotearoa.

Limitations

There are several limitations of this study which should be noted. The sample size of 18 whānau and three focus groups was small - with a total of 35 participants in whānau interviews and focus groups combined. Whānau were located within in the wider Auckland and Waikato regions, therefore the ability to generalise the findings to whānau, hapū and iwi outside of these regions needs to be considered. There was no differentiation between Plunket and WCTO providers within this study. Participants were not asked who their WCTO providers were, although many shared this within the interview process. Further research into these differences would extend the usefulness of these findings in informing service structures. Additionally, the connection between health, social service and education providers was not explored with whānau. Additional research relating to WCTO services within the wider context of whānau ora would further support a holistic understanding of WCTO service delivery. My experiences as a registered nurse working within WCTO health services and education have influenced my construction and analysis of the data. This influence has been mitigated however, with a process of reflexivity and connecting with members of the research advisory rūpū to discuss my interpretation of the data.

Implications and recommendations

Throughout the research process, I identified several implications and recommendations for further research, policy and practice. The following section will provide an overview of what this study has indicated both within nursing and the wider health and social sectors.

Cultural responsiveness

Ways of optimising cultural responsiveness to Māori within health and social services need to be considered to reduce organisational silos in addressing inequity. It is not acceptable for services to 'blame' each other for the systemic and intergenerational disadvantage Māori experience that leads to poor health outcomes. Culturally responsive ways of working are designed to meet whānau where they are and do whatever it takes to get them what they need. This is dependent upon services working collaboratively in ways that place whānau needs at the centre of decision-making processes. Culturally responsive environments optimise the experience and provision of culturally safe practice. Cultural responsiveness, cultural safety and cultural competence have different definitions; however, they all contribute to whānau engagement with services on their terms. WCTO services need to operate in ways that adapt and respond to the needs of whānau in order to make tangible differences to health outcomes.

This involves investing in authentic relationships with whānau, hapū and iwi – not unlike a Whānau Ora approach.

Kaupapa Māori research

There are few examples of kaupapa Māori research design within nursing research in Aotearoa. This may be partly due to the low number of Māori nurses (Nana et al., 2013) and as a consequence, the low number of Māori nurse researchers. Kaupapa Māori ontology and epistemology supported and legitimised my role as a Māori nurse researcher. The values that underpin Māori worldviews are easily silenced within academia, as they are within Western nursing practice environments (Hunter, 2019). In order to be culturally responsive to Māori, nursing research involving and impacting Māori needs to employ kaupapa Māori methodologies. Māori nurse researchers are in a prime position to promote culturally safe research approaches for Māori. Doing so has the potential to increase the confidence of whānau participating in research and increase the volume of Māori voices relating to experiences of healthcare.

Health literacy

The assessment of Māori as having low health literacy diverts attention from the role of health services working in ways that whānau understand. Many Māori may score poorly on health literacy assessments that have been developed from Western worldviews and within a Western health system. It could be argued that many non-Māori would score poorly on a health literacy assessment designed by Māori within a health system dominated by Māori health practices. Wepa (2016) identified a need for the development of cultural literacy tools using a ‘whānau-up’ approach. This approach ensures that the development of the resource is driven by Māori and places the onus upon health professionals to adapt and modify their practice. Health professionals need to reflect upon their own practice, particularly if they deem consumers and patients ‘non-compliant’ in adhering to proposed treatment plans. Shifting the responsibility of health literacy to the health professional within the context of whānau moves the service into a more culturally responsive space.

Cultural safety and cultural competence

The guidelines for cultural safety in nursing, education and practice (Nursing Council of New Zealand, 2011) need to be revised to consider the organisational responsibilities and environments nurses are working within. The current registered nurse competency related to cultural safety requires nurses to work in way that is considered ‘culturally safe’ by the person receiving the service (Nursing Council of New Zealand, 2012). This competency is currently

measured through self and peer assessment which contradicts the definition of cultural safety. Many clinical examples provided against cultural safety competency are reduced to an observed task being completed in a way that the assessor believes is culturally safe. Self and peer assessment indicators relating to cultural safety need to capture the way nurses obtain feedback about the experience of their practice from the client's perspective. They could then support nurses to consider how this feedback informed a process of self-reflection and how any learnings were applied to practice.

Indicators of culturally specific practice and knowledge sit within cultural competency frameworks. These frameworks need to be integrated into nursing council competencies and guidelines to ensure nurses are equipped with the knowledge and skills required to work in culturally safe ways in all areas of practice. The Takarangi Competency Framework (Matua Raki, 2009) specifically, could provide guidelines for the practical tools required to work alongside Māori in a WCTO setting - alongside clinical competencies. Within this study, whānau felt they could engage better with WCTO practitioners who pronounced their names correctly or used basic Māori terminology. The Takarangi Competency Framework could support all WCTO nurses to demonstrate a range of competencies that would improve the process of relationship building with whānau.

Relationships with whānau

Further research would support the identification of the types of relationships that WCTO practitioners should aspire to work in with whānau accessing WCTO services. Whānau within this study indicated that they wanted a WCTO practitioner to work with them as a 'professional friend'. This was someone who did not judge them, was interested in them and supported them with information when they needed it. This description aligns with a Family Partnership model (FPM) of practice (Davis & Day, 2010). Previous research indicates that the FPM training develops some of the qualities and skills necessary to support culturally responsive practice with whānau (Tipa et al., 2015). What is less clear is how partnership relationships are established and maintained with Māori against a backdrop of colonisation, marginalisation and institutional racism. WCTO services have access to over 90 percent of Māori whānau with babies and children under five. Therefore, they have a responsibility to advocate for what whānau, hapū and iwi say they need, not what services think they need. Funding models need to support innovation and creativity for WCTO practitioners to work more effectively in this way with whānau.

WCTO best-practice

WCTO clinical practice reflects a large body of knowledge relating to child assessment, social determinants of health and health promotion (Ministry of Health, 2013a). Within the WCTO schedule there are numerous priorities for health promotion and health education. Many of these priorities are in response to increasing evidence that the first three years of life lay the foundation for positive outcomes as an adult (O'Neill, 2019). Many Māori whānau face disproportionate health and social issues compared with non-Māori. This means that some of the health education and health promotion messages are simply not a priority and are often detrimental to relationships as they position whānau in opposition to the service. Classifying something as 'best-practice' polarises people into those that are following the 'rules' and those who are not. This leads to whānau feeling they will be judged if they are not doing what the WCTO service recommends. WCTO services and funders need to consider how to support WCTO practitioners to build relationships with whānau that respects the space they are in. This includes creating opportunities for them to tell their stories and progress forward in ways that whānau identify as useful for them.

Concluding thoughts

Māori as the indigenous people of Aotearoa experience poorer health outcomes than non-Māori. The effects of colonisation are still felt 180 years following the signing of Te Tiriti o Waitangi. Māori experience structural and institutional racism throughout their engagement with health services. There is an expectation for Māori accessing health services to conform with mono-cultural worldviews despite their status as 'treaty partners'. The continued assimilation of cultural values and knowledge perpetuates the uncertainty many Māori experience when accessing healthcare. The current literature related to WCTO service delivery in Aotearoa is limited and there is even less literature relating to Māori experiences of WCTO services. However, it is clear that healthy relationships within whānau are critical to the wellbeing of tamariki. Mahi Ngātahi sought to identify the processes involved for working together in a culturally responsive way with Māori accessing WCTO services. It aimed to increase the understanding of cultural responsiveness for Māori within WCTO services.

Previous research I completed with whānau and Plunket nurses indicated that working in partnership relationships supported the cultural responsiveness of WCTO services (Tipa, 2013). However, I was unclear what cultural responsiveness was, based upon the worldviews of whānau receiving the service. A kaupapa Māori methodology design with constructivist grounded theory methods within Mahi Ngātahi privileged Māori understandings of cultural

responsiveness. Three theoretical categories were identified; **doing to whānau**, **diminishing whānau mana** and **getting what whānau need**. These three categories formed the basis of the substantive theory. The Mahi Ngātahi theory reflects a cycle of whānau experiencing WCTO service delivery that overrides their values and disregards their knowledge. This leads to the mana of whānau being diminished and negatively influences any subsequent interactions with services. Mahi Ngātahi provides evidence that this cycle can be addressed by following processes to ensure that whānau get what they need from WCTO services.

The pervasive effects of structural racism and its connection with health service design that focuses upon equality of service rather than equity of outcomes is well documented within the literature (Came, 2012; Oda & Rameka, 2012; Wilson et al., 2018). Mahi Ngātahi is research that comments on the impact a universal WCTO health service has upon Māori. It provides evidence that the current WCTO service approaches do not always work for Māori. The WCTO framework, funding models and service structures require whānau to fit within boxes that are not reflective of their realities. Whānau lack connections with WCTO services and the formation of positive relationships are a fortunate by-product of individuals within services rather than a requirement of practice.

The theory and findings in Mahi Ngātahi provide WCTO services and practitioners with insight as to what is currently happening and direction as to what could enhance culturally responsive service delivery to Māori. The Mahi Ngātahi framework for cultural responsiveness outlines the steps involved for WCTO services to connect with whānau in culturally responsive ways. It is proposed that the provision of WCTO services within whānau contexts, delivered in ways they feel connected, included and culturally safe will ultimately strengthen hauora within Māori communities. WCTO practitioners are in a privileged position working alongside whānau and have an opportunity to make tangible differences to lives. What WCTO practitioners need to be supported to work in this way will require further consideration and research. What is clear is that professions, funders, organisations, education providers and individual practitioners will all need to contribute to the re-orientation of WCTO services in Aotearoa. Authentic engagement with whānau, hapū and iwi will be pivotal to the effectiveness of this change for Māori.

On a personal note, my experiences and decisions working as a Clinical Leader for a WCTO service in South Auckland were challenged in the writing up of this thesis. In the role I held, I was not immune from adopting and enforcing processes relating to the completion of notifications of concern about whānau to statutory agencies. At times this felt punitive – however, I was frightened of the potential repercussions personally and professionally if I did not follow the

process. Within a wider social and political context and with distance from the responsibilities of the role, I can see the limitations of the policies that surrounded some of my clinical decision making. It reminded me how easy it is to fall into a system that reinforces the disparities that exist for whānau. Instead of trying to change the system, we attempted to 'change' whānau - with minimal success. My hope is for more research that showcases the views of whānau to be integrated within WCTO service design.

This thesis brings together the worlds I have belonged to for some time. My experience identifying as Māori and Pākehā, however for many years feeling that I did not really fit in to either world meant I could resonate with many of the participants within this study about feeling like an 'imposter'. Likewise, completing research within an academic setting and feeling again like an 'imposter', wondering at times if I could really do it and if it would make a difference. Working within WCTO services as a nurse, an educator, a manager and an advisor gave me a passion for the potential of WCTO services and an appreciation for the knowledge base that supports clinical practice. My personal experiences watching whānau and friends with their children, listening to their challenges and sharing in their joy has given me the impetus to continue in this work.

One of the reviewers of my research proposal commenced her feedback by saying it is a shame that we need a model to teach Pākehā how to work with Māori. She was right. The findings of Mahi Ngātahi reflect a system that has not listened to the needs of Māori, a system that has attempted to do more in response to poor health outcomes and in doing so, made it worse. The **Mahi Ngātahi Framework** is about going back to basics. The way people relate to each other will determine the effectiveness of any health service, even more so when the service is in the business of 'wellness'. Whānau accessing WCTO services want the opportunity to tell their stories and share of themselves. WCTO practitioners need to invest in relationships with whānau. They need to understand the socio-political backdrop for Māori within Aotearoa and challenge policies and processes that are not conducive to whānau success. WCTO funders and service providers need to demonstrate their commitment to Māori by creating environments that support culturally responsive experiences.

The next step for this research is to disseminate the findings to Māori communities and to WCTO service providers. Publications will be written about the kaupapa Māori methodological approach used within this research and the findings within the substantive theory. A post-doctoral research proposal will be developed to evaluate the use of the Mahi Ngātahi framework within WCTO education and practice. The transferability of the framework across other nursing

specialties will also be explored. It is hoped that following further refinement of the framework, it could potentially be considered within nursing council policy and nursing education curricula. This research is my offering to improving the way nursing care in Aotearoa responds to Māori. To all whānau with tamariki under five, past and present, this research is for you – thank you for everything you do for our future generations.

"Poipoia te kakano, kia puawai - Nurture the seed and it will blossom".

Karakia Whakamutunga

Kia tau ngā manaakitanga a te mea ngaro
Ki runga ki tēnā, ki tēnā o tatou
Kia māhea te hua mākihikihi
Kia toi te kupu, kia toi te mana
Kia toi te aroha, kia toi te reo Māori
Tūturu, whakamaui kia tina
Haumie Hui e
Taiki e

Prayer to conclude

*Let the blessings of the unseen past
Bestow upon each one of us
So that all evils pass us by
So that the permanence of the word
of the authority, the love and te reo Māori remain
So that it has certainty
And is maintained
And it will be secure*

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Appendix I: Research flyer



MAHI NGĀTAHI NAU MAI, HAERE MAI

You and your whānau are invited to come and kōrero with me about Well Child and Tamariki Ora services across Aotearoa.

My name is Zoë Tipa (no Kai Tahu, Kahungunu). I am a registered nurse with an interest in how Well Child/Tamariki Ora staff and organisations respond to the needs of Māori.

I want to know what matters to you when accessing health services for Tamariki under 5 years of age. These interviews (audio recorded only) will inform my research called "Mahi Ngātahi – culturally responsive ways of working together" to complete a PhD in nursing.

Interviews or focus groups will take place in the greater Auckland and Waikato areas at a time and place that suits you. This would take approximately an hour of your time.

Do you or your whānau identify as Māori and have a child or children under 5 years of age?

Do you want to contribute to some research about Well Child/Tamariki Ora services for Māori?

Please contact me if you are interested to find out more (*you don't have to be currently seeing any Well Child/Tamariki Ora provider to take part*)

\$30 Prezzie card provided per interview

Website:

www.mahingatahi.com

Email:

mahi.ngatahi@outlook.com

Phone/text: 0221985833

AUT Ethics Approval Number: 17/355

AUT

TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

Appendix II: Information sheets

AUT

TE WĀNANGA ARONUI
O TĀMAKI MAKAU RAU

PARTICIPANT INFORMATION SHEET

INDIVIDUAL AND WHĀNAU INTERVIEWS

January 2019

Mahi Ngātahi – Culturally Responsive Ways of Working Together

Tēnā koe,

My name is Zoe Tipa. I am a registered nurse who has worked in Plunket for the past 10 years. I am completing a research project towards a PhD qualification at Auckland University of Technology and currently hold the position of Principal Academic Staff member at WINTEC. I was also fortunate to receive a Health Research Council scholarship at the beginning of last year to assist with funding my studies.

This information is provided to support you and your whānau to decide whether you would be interested in participating in the research I am completing. Please feel free to contact me with any further questions at any stage. This most important thing is that you feel comfortable and well informed to decide whether you would like to take part.

What is the reason for this study?

Over 70% of all Māori tamariki under 5 in New Zealand receive some well-child services from Plunket. There are also numerous other Tamariki Ora providers offering services throughout the country, but there are still many whānau who do not receive any support relating to the health and wellbeing of their tamariki and whānau.

Feedback and previous research suggests that this could be due to well-child health professionals sometimes "lacking the skills" for working in ways that are meaningful and valuable for Māori. This study is looking to explore what matters to whānau Māori when having contact with well-child services and develop a theory to support health professionals to improve the work they do.

Who can participate?

Any individual or whānau who identifies as Māori with a child or children currently under 5 and lives in the wider Auckland or Waikato regions (please note there is no requirement for you to be enrolled in or seeing a well-child or tamariki ora service currently to take part).

What is the process if I wanted to take part?

You can contact me directly via email: mahi.ngatahi@outlook.com or via phone or text: 0221985833 or fill in your contact details on my website: www.mahingatahi.com. This information sheet and more information relating to the study can be found on this website also. If you email or text me, I will contact you and if you are interested in taking part, we can arrange a time and location that you feel most comfortable for a discussion relating to well-child services (I can travel to you). There will be different stages of data collection as the research progresses and I would let you know if I was currently unable to interview any more participants and the approximate timeframes for further interviews. You would be welcome to meet me either individually or include your partner and/or wider whānau in the discussion. The discussion would take approximately one hour and I would also ask whether you are happy for the interview to be audio-recorded.

What are the risks in taking part?

While it is not intended that you or your whānau would experience any significant discomfort, psychologically or emotionally from participating in this research, if there was an issue you needed support with, we would work through if there is someone for example a kaumatua, a whānau member or a health professional or counsellor that you would feel comfortable in talking to. Any access to support of this nature would be free of charge. Everything you and your whānau say would be kept confidential and non-identifiable – only myself, my supervisors and an official transcriber would have access to any recordings or transcripts of interviews. No

information, including whether or not you participate would be shared with your well-child/tamariki ora provider if you are currently enrolled in a service. Audio-recordings and transcripts of interviews would be kept in a password protected computer and stored securely for 10 years following the completion of the study before being securely destroyed.

What are the benefits in taking part?

By taking part in this research, you (and your whānau) will be helping to identify ways that nurses and health services in New Zealand can respond better to Māori whānau. You will have the opportunity to discuss things that have gone well for you and things that could have been better in terms of your experiences with health services. You will also be invited to share what matters to you when you access health services and in particular what you think about accessing health services for tamariki in your whānau. A \$30 prezzie card will also be provided for each interview completed as recognition of your time and input into this study.

What happens with the results?

Once the study is completed, the research results will be published on my website (www.mahingatahi.com). I will ask you if you would like me to email or post you a 1-2 page overview of the results – or alternatively you will be able to download the full thesis from my website. Some of the results will be published in academic papers and presented at conferences. I will be running half day workshops about the research with tamariki ora and well-child service providers and I will facilitate 2 regional hui in Auckland and Hamilton to discuss the findings with whānau and wider communities.

Do I have to participate in this study?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

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 Denise Wilson, deniselwilson@aut.ac.nz, 0274070022.

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

Contact details for the research:

| Name | Role in Research | Contact Details (phone and email) |
|--------------------|----------------------|--|
| Zoe Tīpa | Student Researcher | 0221985833 mahi.ngatahi@outlook.com |
| Prof Denise Wilson | Primary Supervisor | 0274070022 denisel.wilson@aut.ac.nz |
| Dr Tineke Water | Secondary Supervisor | 09 921 9999 ext 7335 tineke.water@aut.ac.nz |

Approved by the Auckland University of Technology Ethics Committee on 12th February 2018, AUTEK Reference number 17/355.

Thank you for your time in reading this information, I look forward to meeting with you should you choose to take part in this study.

Ngā mihi,

Zoe Tīpa (Kai Tahu, Kahungunu)

PARTICIPANT INFORMATION SHEET

FOCUS GROUPS

June 2019

Mahi Ngātahi – Culturally Responsive Ways of Working Together

Tēnā koe,

My name is Zoe Tipa. I am a registered nurse who has worked in Plunket for the past 10 years. I am completing a research project towards a PhD qualification at Auckland University of Technology and currently hold the position of Principal Academic Staff Member at Wintec in Hamilton. I was also fortunate to receive a Health Research Council scholarship at the beginning of last year to assist with funding my studies.

This information is provided to support you and your whānau to decide whether you would be interested in participating in the research I am completing. Please feel free to contact me with any further questions at any stage. This most important thing is that you feel comfortable and well informed to decide whether you would like to take part.

What is the reason for this study?

Over 70% of all Māori tamariki under 5 in New Zealand receive some well-child services from Plunket. There are also numerous other Tamariki Ora providers offering services throughout the country, but there are still many whānau who do not receive any support relating to the health and wellbeing of their tamariki and whānau.

Feedback and previous research suggests that this could be due to well-child health professionals sometimes “lacking the skills” for working in ways that are meaningful and valuable for Māori. This study is looking to explore what matters to whānau Māori when having contact with well-child services and develop a theory to support health professionals to improve the work they do.

Who can participate?

Any individual or whānau who identifies as Māori with a child or children currently under 5 and lives in the wider Auckland or Waikato regions (please note there is no requirement for you to be enrolled in or seeing a well-child or tamariki ora service currently to take part).

What is the process if I wanted to take part?

You can contact me directly via email: mahi.ngatahi@outlook.com or via phone or text: 0221985833 or fill in your contact details on my website: www.mahingatahi.com. This information sheet and more information relating to the study can be found on this website also. If you email or text me, I will contact you and if you are interested in taking part, we will organise a time and location for a focus group discussion with other people who have tamariki under 5. There will be different stages of data collection as the research progresses and I would let you know if I was currently unable to interview any more participants and the approximate timeframes for further interviews or focus groups. The focus group would take approximately one hour and I would also ask the group whether they are happy for the discussion to be audio-recorded.

What are the risks in taking part?

While it is not intended that you would experience any significant discomfort, psychologically or emotionally from participating in this research, if there was an issue you needed support with, we would work through it if there is someone for example a kaumatua, a whānau member or a health professional or counsellor through AUT counselling services that you would feel comfortable in talking to. Any access to support of this nature would be free of charge.

Everything you and the group say would be kept confidential and non-identifiable – only myself, my supervisors and an official transcriber would have access to any recordings or transcripts of discussions. All

focus group participants will be reminded to ensure any information shared remains confidential to the group. No information, including whether or not you participate would be shared with your well-child/tamariki ora provider if you are currently enrolled in a service. Audio-recordings and transcripts of discussions would be kept in a password protected computer and stored securely for 10 years following the completion of the study before being securely destroyed.

What are the benefits in taking part?

By taking part in this research, you will be helping to identify ways that nurses and health services in New Zealand can respond better to Māori whānau. You will have the opportunity to discuss things that have gone well for you and things that could have been better in terms of your experiences with health services. You will also be invited to share what matters to you when you access health services and in particular what you think about accessing health services for tamariki in your whānau. A \$30 prezzie card will also be provided for each participant as recognition of your time and input into this study.

What happens with the results?

Once the study is completed, the research results will be published on my website (www.mahingatahi.com). I will ask you if you would like me to email or post you a 1-2 page overview of the results – or alternatively you will be able to download the full thesis from my website. Some of the results will be published in academic papers and presented at conferences. I will be running half day workshops about the research with tamariki ora and well-child service providers and I will facilitate 2 regional hui in Auckland and Hamilton to discuss the findings with whānau and wider communities.

Do I have to participate in this study?

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

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 Denise Wilson, deniselwilson@aut.ac.nz, 0274070022.

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

Contact details for the research:

| Name | Role in Research | Contact Details (phone and email) |
|------------------|----------------------|--|
| Zoe Tipa | Student Researcher | 0221985833 mahi.ngatahi@outlook.com |
| Dr Denise Wilson | Primary Supervisor | 0274070022 denisel.wilson@aut.ac.nz |
| Dr Tineke Water | Secondary Supervisor | 09 921 9999 ext 7335 tineke.water@aut.ac.nz |

Approved by the Auckland University of Technology Ethics Committee on 12th February 2018, AUTC Reference number 17/355.

Thank you for your time in reading this information, I look forward to meeting with you should you choose to take part in this study.

Ngā mihi,

Zoe Tipa (Kai Tahu, Kahungunu)

Appendix III: Consent form



PARTICIPANT CONSENT FORM

Project title: *Mahi Ngātahi - Culturally Responsive Ways of Working Together*

Project Supervisor: *Prof Denise Wilson*

Researcher: *Zoe Tipa*

- ☐ I have read and understood the information provided about this research project in the Information Sheet dated:
- ☐ 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 taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ☐ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ☐ I agree to take part in this research.
- ☐ I wish to receive a summary of the research findings (please tick one): Yes ☐ No ☐

Participant's signature:

Participant's name:

Participant's Contact Details (if appropriate):

.....
.....
.....
.....

Date:

**Approved by the Auckland University of Technology Ethics Committee on 12th February 2018, AUTEK
Reference Number 17/155**

Note: The Participant should retain a copy of this form.

Appendix IV: Semi-structured interview questions

MAHI NGĀTAHI

SEMI-STRUCTURED INTERVIEW QUESTIONS

1) What are your thoughts generally about well-child/Plunket services...

Optional second level questions:

- What are some examples of good things about the service?
- What do you think are the most useful parts for families?
- What are some of the not so good parts of well child services?
- What do you think the impact of these/this is on whānau?

2) What matters to Māori whānau accessing a well child service?

Optional second level questions:

- What would/could the service do for whānau?
- How would they speak with whānau/clients?
- When would the service contact families?
- What would be the most effective way for the service to contact families?
- Who else would they involve in making sure whānau get what they need?
- What do they need to know (about child health, about communities, about individual whānau)?
- What sort of service would whānau like to see?

3) What does working well together with someone look like?

Optional second level questions:

- How do whānau know if someone is working together with them?
- What would a positive relationship look like with the a) well child nurse and b) the well child service
- How much of what the nurse or health worker do whānau need to understand?

4) When we talk about culture – what do you think it means?

Optional second level questions:

- In what ways is culture discussed when people access health services?
- How would people know that someone respects or acknowledges their culture?
- How would people know that a service respects or acknowledges their culture?

5) What do you think is needed for tamariki Māori to thrive?

Optional second level questions:

What do thriving (happy/healthy) tamariki look like?

Who's responsibility is it?

What does a nurturing whānau look like?

What do you think organisations could do to support whānau to achieve this?

Appendix V: Ethical approval



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

12 February 2018

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

Re Ethics Application: **17/355 Mahi Ngatahi - Culturally responsive ways of working together**

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 12 February 2021.

Standard Conditions of Approval

1. A progress report is due annually on the anniversary of the approval date, using form EA2, which is available online through <http://www.aut.ac.nz/researchethics>.
2. A final report is due at the expiration of the approval period, or, upon completion of project, using form EA3, which is available online through <http://www.aut.ac.nz/researchethics>.
3. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form: <http://www.aut.ac.nz/researchethics>.
4. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
5. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.

Please quote the application number and title on all future correspondence related to this project.

AUTEC grants ethical approval only. If you require management approval for access for your research from another institution or organisation then you are responsible for obtaining it. You are reminded that it is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard.

For any enquiries, please contact ethics@aut.ac.nz

Yours sincerely,

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

Cc: zoe.tipa@wintec.ac.nz; Tineke Water