Conceptualising Kawa Whakaruruhau as a Nursing Praxis: Learnings from Māori nurses

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Abstract

This thesis presents the findings of a Kaupapa Māori research project aimed at conceptualising Kawa Whakaruruhau as a nursing practice. Kawa Whakaruruhau is a Kaupapa Māori (Indigenous people of Aotearoa New Zealand) nursing theoretical framework that was gifted to nursing in Aotearoa New Zealand by tangata whenua (people of the land). Kawa Whakaruruhau was intended to be integrated into nursing practice in Aotearoa New Zealand to underpin the nursing care of whānau Māori (Māori family units) accessing health services. However, since its implementation into the nursing education curriculum in 1992, no formal evaluation of Kawa Whakaruruhau has been undertaken. Moreover, due to public and political pressure, a redefinition period resulted in Kawa Whakaruruhau, a Māori-centric theoretical framework, becoming 'cultural safety' for everyone, reflecting multiculturalism. This thesis reports the impact of Kawa Whakaruruhau on Māori nurses. Informed by Māori nurses' kōrero, this thesis further conceptualises Kawa Whakaruruhau as a Kaupapa Māori nursing praxis.

Utilising a Kaupapa Māori methodology and methods, with a decolonising approach, this thesis aimed to answer the following research questions: 1. How do Māori nurses define Kawa Whakaruruhau? 2. How has Kawa Whakaruruhau impacted Māori nurses and their practice? Twenty-one Māori registered nurses, with 2 or more years of nursing experience, participated in the research. Kanohi ki te kanohi (face to face) and online individual interviews were conducted over 8 months, utilising pūrākau as a Kaupapa Māori form of narrative inquiry. Analysis of the pūrākau was conducted using Te āta-tu Pūrākau framework. The rigour of the thesis was established using the Veracity of a Kaupapa Māori Project framework, which challenges the researcher to engage in reflexive practices to ensure that there are tangible benefits for Māori arising from the project.

The participants described Kawa Whakaruruhau as a Kaupapa Māori nursing praxis. It involves ethical and moral decision-making practices, guided by Te Tiriti o Waitangi, tikanga Māori and professional nursing knowledge that are fundamentally underpinned by Māori nurses' desire to uphold the mana of the tangata and/or whānau accessing healthcare. The foundation of Kawa Whakaruruhau, as a praxis, is whakawhanaungatanga, which Māori nurses prioritise, allowing time and space for this process. Spaces and practices they perceived to enact Kawa Whakaruruhau had a positive impact on Māori nurses. Participants reported that spaces that enact Kawa Whakaruruhau provided an increase in their confidence and practice development, including the refinement of their dual competencies. Notably,

consolidation of their soft nursing skills, such as health consumer advocacy and communication techniques, was solidified.

This thesis contributes to the conceptualisation of Kawa Whakaruruhau as a Kaupapa Māori nursing praxis. Firstly, the thesis explores Kaupapa Māori nursing practices, skills, and knowledge that constitute high-quality professional nursing practice being delivered to whānau Māori every day. Given the lack of formal evaluation of Kawa Whakaruruhau and cultural safety in nursing in Aotearoa New Zealand, this thesis provides insight into the impact it has had since its implementation into nursing education in 1992. Moreover, culturally unsafe spaces and practices have been highlighted to challenge the wider nursing workforce on current cultural safety education and practices contributing to the well-documented ongoing Māori health inequities (MOH, 2024).

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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 used artificial intelligence tools or generative artificial intelligence tools (unless it is clearly stated, and referenced, along with the purpose of use), 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: J. T. McGregor

Date: 26.08.25

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Ka hanga e te Atua te tangata, he mea rite ki a ia, i hanga ia e ia kia rite ki te Atua
God created mankind in His image, in the image of God He created them
(Genesis 1:27)

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work and professional knowledge and skill base that serves whānau Māori every day, supporting their journey to hauora.

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Ethical approval for this research was granted by Auckland University of Technology Ethics Committee on 28 August 2023, approval number is 23/213 (Appendix A).

Foreword

Ko Wharepahunga te maunga
Ko Waikato te awa
Ko Tainui te waka
Ko Ngati Raukawa te iwi
Ko Ngati Huia to hapu
Ko Aotearoa te marae
Ko Jenny Tokomauri McGregor toku ingoa

I am a 41-year-old woman born in Aotearoa NZ to a Māori (Ngāti Raukawa) father and a 6th to 7th generation Pākehā (Scottish/Irish) mother. I have always had a strong sense of being a 'Kiwi' and feel very connected to Aotearoa NZ, both the whenua and the people. I am presently on a journey of reclamation of my Māoritanga. My parents and grandparents come from very large whānau who are typically working class and experienced discrimination due to being financially 'poor'. On my father's side, the discrimination was further complicated by also being tangata whenua. Nevertheless, both sides prioritise relationships over material wealth and are humble people. We may not have had much materially, but we had what was needed. We were blessed with a large number of aunties, uncles, and cousins. I am a mum, daughter, wife, sister, niece, friend, and cousin to many. All four of my grandparents are my earthly role models in life, and I think of them daily.

Within te ao Māori, our pūrākau of creation mythology are foundational to the conduct of our day-to-day living and "remind us of the sacred relationships that have emerged from the creation of all living things and the importance for us as 'tangata' (people) to always affirm our place alongside 'atua' (sacred deities) that gave us life" (Pihama, 2020, p. 354). It is important to note that in te ao Māori there is no single creation pūrākau, it varies between iwi and hapū (Pihama, 2020). Both sides of my whānau are Christian, and many still practise their faith today. As such, I believe we are all created by one God who has created all humankind equal, in His image—this is the overarching belief that inspires me in my day-to-day life. All societal structures that advantage or disadvantage certain people have been man-made and need to be exposed, deconstructed, and reconstructed to ensure equitable access to resources for all people – guarding the inherent dignity of humankind.

As a Registered nurse, from one of the‘caring professions’, we have the privilege of walking alongside people in their most vulnerable times. Regardless of a person’s characteristics and socio-economic status, the expectation of the nursing regulatory body and the public is that each person will receive quality nursing care as part of their healthcare experience. This expectation is based on the presumption of the neutrality of the nursing and wider healthcare workforce.

The nursing workforce does not exist in a vacuum. Nurses are human, with their own biases, assumptions, values, and beliefs that filter the information they receive during their working day (I include myself). Aotearoa New Zealand (referred to as Aotearoa NZ hereafter) has systematically and intergenerationally normalised the dehumanisation and exclusion of its Indigenous people, Māori, through policy and racist discourse (Mutu, 2020; Smith, 2021). Therefore, it seems impossible that the healthcare system would be insulated from this normalised racism. From a nursing perspective, nursing education and the standards of practice are Eurocentric—nursing ethics, knowledge, codes of conduct, and legalities are all informed by Western knowledge, values, and beliefs. Therefore, nursing, both consciously and unconsciously, perpetuates Pākehā hegemony in healthcare. The advantage of accessing a health system that represents the person is evident in the intergenerational health advantages of Pākehā and the inequities in Māori health outcomes.

Registered nurses in Aotearoa NZ are confronted by the complex social and health realities of many whānau Māori in their daily practice. As leaders in the international integration of cultural safety into nursing curricula, they appear to ascribe to the idea that they are a culturally safe workforce. Yet, research consistently shows that nurses are not always culturally safe for whānau Māori accessing healthcare or for Māori nurses—the two groups Kawa Whakaruruhau intended to benefit (Hunter & Cook, 2020; Huria et al., 2014; Simon, 2006; Wilson, 2008).

This thesis was inspired by various people. Firstly, my whānau quiet humble people who taught me people are important because they are people, not because of what you have. Importantly, this thesis is an acknowledgment of the generations of Māori nursing leaders who have stood up and spoken out for Māori health equity, starting with the right of whānau Māori to quality nursing care. Their courage to challenge nursing as a ‘caring profession’ is inspirational. Whānau Māori have the right to live with dignity, aspirations, and sovereignty, including when engaging with healthcare services. It is time for nursing in Aotearoa NZ, as a professional body, to look inwards, instead of at whānau Māori and ask, ‘how can we do better?’. This thesis aims to celebrate the significant skills, knowledge base, and contributions

that Māori nurses make to hauora Māori daily, starting with the core of Kaupapa Māori nursing practice—Kawa Whakaruruhau.

Chapter One: Introduction

This chapter provides an overview of this thesis. First, the development of Kawa Whakaruruhau is discussed, including the redefinition period following its integration into nursing curricula in Aotearoa NZ. Next, an overview of the precursors that led to the development of Kawa Whakaruruhau is outlined. The precursors are Māori health, Te Tiriti o Waitangi, and an inequitable Māori nursing workforce. Following the discussion of Kawa Whakaruruhau, the research aim and questions are presented, followed by an outline of the thesis, which includes a brief overview of each chapter.

The Development of Kawa Whakaruruhau

Culture and Health

Health inequities for Māori are not a new phenomenon. However, the context in which Māori health inequities are examined has changed. A critical construct of this change has been the recognition of the impact culture has on health (Wepa, 2015). The momentum behind the social movement that challenged the state of Māori health followed the establishment of the Waitangi Tribunal in 1975. This movement emerged when civil rights were gaining momentum internationally (Ramsden, 2001). During this time, Māori leaders asserted that Māori health inequities were a breach of Te Tiriti o Waitangi (Ramsden, 2001). Māori nurses were an active part of this movement.

In 1988, Māori nursing leaders from all over Aotearoa NZ gathered at the Hui (meeting, gathering) Waimanawa. At this hui, Hinerangi Mohi (a Māori nursing student) asked an important question—"What about cultural safety?" She expressed concern that ethical, physical, clinical, and legal safety were regarded as pertinent to nursing practice, but the cultural safety of the tangata (person) and/or whānau (family unit) receiving care was not considered. A series of hui were held around the motu (nation, country) where Māori nurses deliberated and discussed the notion of cultural safety. As an outcome of the hui, Dr. Irihapeti Ramsden (1990), a nursing educationalist, authored a formal report titled *Kawa Whakaruruhau: Cultural Safety in Nursing Education*. It is important to note that this document formalised Kawa Whakaruruhau as a theoretical framework intended to underpin nursing practice in Aotearoa NZ. Before this report, Māori nurses had long been practicing in ways consistent with the Kawa Whakaruruhau framework and striving for changes that would ensure culturally safe care and nursing education for Māori.

The ingoa (name), Kawa Whakaruruhau, has always been contentious in nursing and wider society, and conceptual inconsistency remains today. In her PhD thesis, Ramsden

(2002) stated that the ingoa, Kawa Whakaruruhau, was gifted by her grandfather, To Uri o Te Pani Manawatu Te Ta, and was supported by his peers. Although Ramsden (1990) argued that it is for the tangata and/or whānau accessing care to determine whether they have felt culturally safe, Ramsden stated that by breaking down the words Kawa Whakaruruhau, the overall meaning of the concept could be grasped. *Kawa* are immutable customs and protocol, and *Whakaruruhau* is a shelter or a place to be sheltered. Together, Kawa Whakaruruhau denotes nursing practices that keep people culturally safe.

The *Kawa Whakaruruhau: Cultural Safety in Nursing Education* (Ramsden, 1990) guidelines were revolutionary and challenged the fabric of nursing and healthcare ethos in Aotearoa NZ. The guidelines asserted that healthcare and practice are embedded in a Western worldview, and thereby exclude Te Ao Māori (the Māori world). Within the context of Aotearoa NZ, the Western worldview is expressed in Pākehātanga, which is dominant, normalised, and taken for granted (Ramsden, 1990). Therefore, healthcare staff, who were predominantly Pākehā (New Zealanders of European descent), were blind to it. Kawa Whakaruruhau challenges nurses to examine the culture of nursing, the healthcare system, and their own cultural perspectives. The British-based nursing ethos of providing care to all, regardless of differences, was one of the tenets of the myth of a culture-neutral healthcare service. Kawa Whakaruruhau challenged this ethos, stating that nurses must regard people's differences when caring for them. Therefore, the two primary objectives of Kawa Whakaruruhau are the development of a culturally safe nursing workforce that could better serve whānau Māori accessing care, and culturally safe nursing education for Māori nursing students (Papps & Ramsden, 1996; Ramsden, 2015).

Kawa Whakaruruhau was incorporated into the nursing curriculum and included in the state examination in Aotearoa NZ by 1992. Unfortunately, Kawa Whakaruruhau sparked public outrage, and a heavily racist ideology fuelled a political and public backlash between the years 1992 and 1996. The backlash was sparked by the threat that Kawa Whakaruruhau posed to the national identity of Aotearoa NZ, and the endemic myth that Aotearoa NZ was a country with ‘the best race relations in the world’. Moreover, Māori nurses were seen to be challenging the Pākehā system and demanding special privileges (Ramsden, 2002). The public feared that the Kawa Whakaruruhau content would take space from ‘traditional’ clinical nursing knowledge and, in doing so, enforce political correctness.

Student nurses participated in the backlash against Kawa Whakaruruhau; for example, refusing to attend Kawa Whakaruruhau classes taught by Dr. Ramsden (Ramsden, 2002). A well-known case of opposition to Kawa Whakaruruhau and cultural safety was the

case of Anna Penn, a nursing student from Otautahi, Christchurch. In 1993, Anna Penn published a 6-page open letter outlining her experience of failing the cultural safety component of her nursing education course based on her conduct at a visit to a local marae. Anna Penn stated that her conduct was due to her opposition to being unable to speak when she wanted, due to the marae protocol, as a female. Anna Penn's case was well publicised by the media and contributed to the public backlash against cultural safety education in nursing (Fergusson, 2021).

In 1995, the government announced an inquiry by the Science Select Committee on Education and Science ('1995 Select Review Committee'), intending to review Kawa Whakaruruhau in nursing education around Aotearoa NZ. Further education reviews, an audit of Nursing Education Providers in 1997-1998, and the Nursing Council of New Zealand's (referred to as 'The Nursing Council' hereafter) Strategic Review of Undergraduate Nursing Education undertaken in 2000-2001, were instigated. In response to the 1995 Select Review Committee, and the further education reviews, Kawa Whakaruruhau underwent a period of refinement. Starting with a council committee review in 1996, it became a much broader concept, known as cultural safety (Nursing Council of New Zealand [NCNZ] 2011; Papps, 2015). However, the 1995 Select Review Committee review report did recommend that Te Tiriti o Waitangi be kept as part of cultural safety education.

Cultural safety differs from Kawa Whakaruruhau as it focuses on providing culturally safe care for everyone. Over the past 30 years, cultural safety has been the dominant discourse for nursing, and a response to the cultural competency legislated in section 118(i) of the Health Practitioners Competence Assurance Act (HPCAA) 2003, which required all health practitioners to demonstrate cultural competence (Vernon & Papps, 2015). An amendment in 2019 added the following wording to this section of the legislation: "(including competencies that will enable effective and respectful interaction with Māori)" (Parliamentary Council Office, 2021). However, Māori and Te Tiriti o Waitangi have been omitted from the most recent Nursing Council's (2011) expanded definition of cultural safety. Instead, Kawa Whakaruruhau is depicted as an extension of cultural safety, defined as "Cultural Safety in a Māori context" (NCNZ, 2011, p. 7).

Definitions of Kawa Whakaruruhau and Cultural Safety

In this section, definitions of Kawa Whakaruruhau and cultural safety are provided to clarify the differences between the two for the reader. This thesis utilises the definition of Kawa Whakaruruhau from Ramsden's (1990) *Kawa Whakaruruhau: Cultural Safety in Nursing Education.* This definition has been selected as the document describes Kawa Whakaruruhau

in its original form, before public and political backlash ensued. Cultural safety is defined using the Nursing Council's (2011) definition in *Guidelines for Cultural Safety, The Treaty of Waitangi and Māori Health*.

Ramsden (1990) stated that Kawa Whakaruruhau is hard to define, as it is for the health consumer to determine whether they have received culturally safe care. However, she explained that within the Aotearoa NZ context, Kawa Whakaruruhau affirms Te Tiriti o Waitangi as the foundational national document and recognises Māori as being the most at risk in society, culturally. Kawa Whakaruruhau requires the nurse to be self-aware of their own culture and the culture of the healthcare system, and how both can potentially impact whānau Māori accessing health services. As highlighted in the Kawa Whakaruruhau guidelines (Ramsden, 1990):

> After much consideration, work, and thought among Māori nurses and a Māori legal consultant, we have concluded that there is no rigid definition of Cultural Safety… Because Cultural Safety is based in the less measurable dimension of attitude, it cannot be defined against physical or legal safety… Like ethical safety, cultural safety must be interpreted according to each event. The degree of cultural risk or danger must be assessed by those who are able to perceive it. It follows that those people are to be found within the culture at risk. In Aotearoa, the people who are most culturally at risk are the tangata whenua, te iwi Māori (p. 8)

The Nursing Council's (2011) definition of cultural safety has been used as it remains the most current and is the practice standard expected of registered nurses (RNs) in Aotearoa NZ. This definition retains the focus of self-awareness on the nurse, but a multicultural lens is applied:

> The effective nursing practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability… The nurse delivering the nursing service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual. (NCNZ, 2011, p. 7)

Kawa Whakaruruhau, a Māori-centric theoretical framework, morphed into cultural safety, incorporating a multicultural lens and subsequently excluding Māori from its

definition. In fact, cultural safety and Te Tiriti o Waitangi are explicitly separated in the Nursing Council's (2011) *Guidelines for Cultural Safety, The Treaty of Waitangi and Māori Health*. Like contemporary politics, the move to shift the focus off Māori and onto the multicultural, diverse composition of Aotearoa NZ society was about restricting rangatiratanga Māori and relegating Māori to another 'minority' group instead of tangata whenua (the people of the land).

Thirty-four years since Kawa Whakaruruhau was integrated into the nursing curriculum in Aotearoa NZ, no formal evaluation of its effectiveness or impact has been conducted. As such, it is difficult to determine whether the original outcomes of Kawa Whakaruruhau have been achieved; although there is sufficient evidence of culturally unsafe nursing practice, suggesting that there is still work to be done to ensure Māori have access to culturally safe healthcare services and nurse education environments (Hunter & Cook, 2020; Huria et al., 2014; Simon, 2006; Wilson et al., 2022). Furthermore, the various challenges to its conceptualisation in the early years, for example, its redefinition, have likely had a lasting impact on how Kawa Whakaruruhau is understood and practised in nursing and healthcare. There is a need to understand how Kawa Whakaruruhau is conceptualised by Māori nurses and examine its impact on Māori nurses and their practice.

Background

This section discusses the precursors to the development of Kawa Whakaruruhau, providing critical information about the whakapapa (genesis) of Kawa Whakaruruhau. Kawa Whakaruruhau was developed in response to the state of Māori health and the lack of responsiveness of health services in Aotearoa NZ to Māori, and to honouring Te Tiriti o Waitangi (Liang & Pomare, 1994; Papps & Ramsden, 1996). Specifically, the objectives were to create a culturally safe nursing education environment and healthcare service for Māori (Papps & Ramsden, 1996; Ramsden, 2015). Māori health, Te Tiriti o Waitangi, and the Māori nursing workforce are discussed in detail.

Māori Health

Before British settlement began in the early 1800s, it is believed that Māori had lived relatively healthy lives. Writings from early European explorers and studies on Māori skeletal remains evidence a healthy population likely free from the diseases that burden Māori today, such as metabolic disorders (Durie, 1998a; Ministry of Health [MOH], 2020). By the mid-to-late 1800s, following an influx of British immigration, Māori health had declined at an alarming rate, which was viewed as a sign of their imminent extinction (Durie, 1999). At the

time, infectious diseases such as tuberculosis, typhoid fever, and the Spanish Flu plagued Māori communities due to a lack of previous exposure and the social conditions of the time, including the musket wars, poverty, and isolation from traditional practices (Durie, 1999; Ministry of Culture and Heritage, 2020a; MOH, 2017; Wilson & Haretuku, 2015; Wood, 1992). To illustrate the impact of infectious diseases, an excerpt from a letter written by Aperatama Rupene to the *Auckland Star* in 1918 describes the devastation of the times—"there is weeping and desolation. Boys have died across the war, whole families have been wiped out by the influenza, and there are many aching hearts because these boys are in gaol" (Ministry of Culture and Heritage, 2020a, para. 4).

Although early population estimates were likely inaccurate due to counting methods, it was estimated that the Māori population decreased from 150,000 in 1820 to 39,854 (actual count) in 1896 (Durie, 1998a; Durie, 1999; MOH, 2017). In contrast, the Pākehā population increased from 25,000 in 1830 to 625,000 in 1890. Poor Māori health was feared by Pākehā as a threat to their health and a drain on health resources, especially given the likelihood of their probable extinction (Wood, 1992). At the time, Darwinism was the dominant Eurocentric perspective utilised to explain Māori mortality (McKillop et al., 2012).

The early 1900s marked the end of the first wave of colonisation. Until this point, the focus had been the physical survival of Māori (Durie, 1999). Around this time, Māori communities began to focus on recovery and redevelopment in colonial Aotearoa NZ, where they had become the minority in their lands (McKillop et al., 2012). Public health measures initiated in Māori communities significantly improved Māori mortality and morbidity, and the population began to recover slowly (Durie, 1999). Services, such as the Native Health Nursing service, had positive results in the short term. Still, the long-term impact of Eurocentric health services and unequal funding and resource distribution on Māori health is questionable (McKillop et al., 2012).

By the 1970s and 1980s, international social and political awareness of Indigenous peoples increased, with a focus on Indigenous health and well-being (Durie, 1998b; Smith, 2017). By this time, the Māori population had recovered from the number of people who succumbed to infectious diseases between 1769 and 1890 (Ramsden, 2001). In the 1970s, urban Māori activism experienced a significant increase. Traditionally, Māori activism focused on Māori land losses, poverty, and justice. However, Māori health inequities were becoming a focus of Māori activism, including their poor health as a failure of the Aotearoa NZ government (Ramsden, 2001).

During the 1980s, Māori health professionals continued to publicly voice their concerns about the state of Māori health and offer recommendations on the direction Māori health needed to take. Significant milestones in the development of Māori health included articulating the positive impact of culture on health (Wepa, 2015). For example, at the first national hui of Māori health professionals, held at Hoani Waititi marae in Auckland in 1984, the impact of colonisation on Māori health was publicly discussed (Department of Health, 1984; Thompson, 2014). During this period, the relationship between culture and health was first highlighted in Aotearoa NZ (Ramsden, 2015; Wepa, 2015). However, Durie (1998a) argued that Māori health workers, such as Dr Pomare and Dr Rangi Hiroa, discussed the impact of culture on health in the late 1800s.

He Whakaputanga o te Rangatiratanga o Nu Tireni me Te Tiriti o Waitangi

Preceding Te Tiriti o Waitangi was He Whakaputanga o te Rangatiratanga o Nu Tireni (referred to as 'He Whakaputanga' hereafter). He Whakaputanga denoted "the emergence" of a Māori sovereign state in 1835. Prompted by the need to fly a flag on ships for international trading purposes, James Busby suggested the formation of a flag for the rangatira (chiefs and leaders) in the north of Aotearoa NZ. In response to a threat that France or the United States of America would claim Aotearoa NZ, Busby drafted He Whakaputanga to declare Aotearoa NZ as a sovereign Māori state (Healy et al., 2012; Keane, 2017). Over 4 years, 52 rangatira signed He Whakaputanga, which declared Aotearoa NZ a Māori state and asserted that full authority and sovereignty over lands and laws would be retained by Māori ("Ko te Kīngitanga ko te mana i te w[h]enua") (Archives New Zealand, 2024). He Whakaputanga was officially recognised by the British monarchy in 1836. In return for his Majesty's (William IV) protection against threats to mana and Māori authority over the lands, Māori would protect the British who resided in Aotearoa NZ (Ministry of Culture and Heritage, 2021). Importantly, it was agreed that the Te Whakaminenga (The Confederation of United Tribes) would meet (huihuinga) yearly to decide on the laws of the land (Archives New Zealand, 2024). The huihuinga did not eventuate due to the subsequent failings of the Crown to acknowledge tino rangatiratanga (absolute sovereignty) of the rangatira and their hapū (familial unit within a tribal group).

In the following years, the drastic decline in Māori health and the increasing British lawlessness in the decade 1830-1840 were all precursors to Te Tiriti o Waitangi (Durie, 1998b). According to historian Dame Claudia Orange (2023), Te Tiriti o Waitangi subsumed He Whakaputanga, although this is disputed by rangatira Māori in Te Tai Tokerau. Te Tiriti o Waitangi was first signed by representatives of the British Crown and iwi/hapū on 6 February

1840 at Waitangi in the Bay of Islands. Thus, Aotearoa NZ became a British colony (Orange, 2023). Te Tiriti o Waitangi was signed by different representatives at various locations in Aotearoa NZ over 7 months (Ramsden, 2015). Approximately 540 rangatira (leaders) signed Te Tiriti o Waitangi (Te Reo Māori version), and 39 rangatira signed the Treaty of Waitangi (English language version) (Wilson & Haretuku, 2015; Winiata & Luke, 2021). Not all iwi had representatives sign either document (Wilson & Haretuku, 2015).

The legitimacy of Te Tiriti o Waitangi has been contested since it was first signed, and its terms were dishonoured for the first 130 years after signing. Te Tiriti o Waitangi was famously declared a legal nullity in 1877 by Chief Justice Sir James Prendergast in the Wi Parata v The Bishop of Wellington court hearing. He argued that because Te Tiriti o Waitangi had not been integrated into domestic law and had been signed 'between a civilised nation and a group of savages', it was null and void (Ministry of Culture and Heritage, 2020b, para. 4). From the 1970s until recently, the English language version, known as the Treaty of Waitangi, was regarded as the official version, despite having significantly fewer Māori signatures and the international principle of Contra Proferentum. The application of the Contra Proferentum principle means that where there is an ambiguous contract (i.e., two languages with different meanings), it should be interpreted against the drafter of the contract, and the contract in the native language should take precedence (The Waitangi Tribunal, n.d; Wilson & Haretuku, 2015).

As described by the Waitangi Tribunal (n.d), Te Tiriti o Waitangi is a treaty comprising two texts, although it is considered a single document. Significant differences in the meaning (through translation) of words and concepts between the two versions are apparent (see Table 1) (The Waitangi Tribunal, n.d; Winiata & Luke, 2021). However, the meaning drawn from the third article in both versions is more precise. Therefore, the two versions are not interchangeable (The Waitangi Tribunal, n.d). The differences between the English language and Te Reo Māori versions have had significant implications for the application to the socio-political context in Aotearoa NZ (Ramsden, 2001). In recent years, preference has been given to Te Tiriti o Waitangi. However, the current National-Act-New Zealand First government has altered the political landscape, and various policies have been introduced or suggested that aim to redefine Te Tiriti o Waitangi (the Treaty Principles Bill) or remove it from policy altogether. Unfortunately, the current political rhetoric is suggesting that Te Tiriti o Waitangi is allowing for Māori to have special privileges that other citizens are not afforded (Act Party, 2022).

Table 1.

Differences in Meaning Between Te Tiriti o Waitangi and the Treaty of Waitangi

	Te Tiriti o Waitangi	The Treaty of Waitangi
Preamble	• Secure tribal rangatiratanga • Secure Māori land ownership	• Protect Māori interests from the encroaching British settlement • Provide for British settlement • Establish a government to maintain peace and order
Article One	• Māori permitted the British kāwangatanga (governance over the land)	• Māori ceded sovereignty
Article Two	• Te Tino Rangatiratanga upheld over lands and taonga • Māori gave right of Crown to purchase lands if they wished to sell it	• The crown guaranteed Māori the 'undisturbed possession' of their properties • Crown exclusive rights to purchase Māori land
Article Three	• The Crown promised Māori the benefits of royal protection and full citizenship • Emphasises equity	

Source: The Waitangi Tribunal, n.d; Ministry of Culture and Heritage, 2021.

There are debates about the context in which Te Tiriti o Waitangi was constructed, including that the differences in the meaning of words were purposefully construed to mislead Māori (Ministry for Culture and Heritage, 2021). Opposing arguments assert that Te Tiriti was carefully crafted, particularly concerning Crown land purchases (Ministry for Culture and Heritage, 2021). Nevertheless, it is agreed that the 'spirit' of Te Tiriti o Waitangi "embodied a partnership in which the Crown, chiefs, and tribes would all have a place" within a new nation-state (Ministry of Culture and Heritage, 2021, para. 15). Te Tiriti o Waitangi is the overarching document of Aotearoa NZ, which "provides a foundation of belonging for all, grounded in mutual care, respect, and the right of Tangata Whenua to exercise tino rangatiratanga" (Human Rights Commission, 2024, para 3). Of significance to Māori health and Kawa Whakaruruhau, Te Tiriti o Waitangi guarantees Māori health equity (Article 3) and rangatiratanga over taonga (Article 2), including hauora Māori (Māori health) and mātauranga Māori (Māori knowledge) (Ramsden, 1990). Moreover, Kawa Whakaruruhau was developed as a nursing response to nursing's Te Tiriti o Waitangi obligations and the Māori-Pākehā relationship (Wood & Schwass, 1993).

Unfortunately, the promises made by the British when signing Te Tiriti o Waitangi were not honoured. Instead, a campaign of domination and control by European settlers ensued to establish a Eurocentric colonial state by subjugating hapū and iwi (tribe) around the motu (Mutu, 2019). The efforts to dehumanise Māori were multi-faceted, such as the

marginalisation of mātauranga Māori and denying the negative impacts of colonisation on Māori, to legitimise the brutal behaviour of the colonists. Mutu (2019) argued that the same attitude towards Māori persists today. For example, the redefinition of Te Tiriti o Waitangi is currently a topical issue in Parliament. The Hon. Nicole McKee, an ACT Member of Parliament and Minister, proposed redefining the meaning of Te Tiriti o Waitangi to ensure that

> Every child born in New Zealand, and every legal immigrant, has the same rights. Those are the rights of a citizen. Nobody should get an extra say because of who their great-grandparents were. Nobody should have to be treated differently because of who they are. (Act New Zealand, 2022, para. 1)

This rhetoric suggests that Māori are demanding special rights and privileges over everybody else to discredit Te Tiriti o Waitangi, as opposed to Te Tiriti o Waitangi affirming Māori status and rights.

The Māori Nursing Workforce

There is a long-standing argument that Māori nurses are fundamental to achieving positive Māori health outcomes, dating back to the establishment of the health system in Aotearoa NZ. For example, the Young Māori Party petitioned Parliament in 1897 for the establishment of Māori nurses. They envisaged that Māori nurses could bridge the gap between Māori culture and Western medicine (McKillop et al., 2012). Shortly after, Māori women entered the national nursing workforce in 1898 after James Pope, the Inspector for Native Schools, advocated for Māori nursing scholarships in the form of a 1-year apprenticeship to become a ‘nurse assistant and dresser’ (Simon, 2006; Woods, 1992).

Pope discouraged providing scholarships for the nursing scheme to Māori who had become ‘Europeanised’ as he envisaged that Māori nurse assistants could take their knowledge and practices back to their communities to support improving Māori health (Woods, 1992). Pope’s objections to Europeanised Māori nursing assistants suggested that engagement with the Māori community and culture was desirable for Māori nurse assistants (Woods, 1992). However, the nursing training and practice system was heavily Eurocentric, and assimilation was encouraged. For example, Māori nurses were often encouraged to anglicise their names (McKillop et al., 2012).

Within a few years, the 1-year training programme was no longer deemed sufficient to equip Māori nurses with the necessary skills and knowledge to impact their communities (Holdaway, 1993; Wood, 1992). In 1905, Māori women who had completed the Nursing Assistant scholarship were offered a 3-year scholarship to obtain the necessary skills and

training to be eligible to sit the state examination for registration as a nurse in Aotearoa NZ (Simon, 2006). One of the first Māori RNs in Aotearoa NZ, Akenehi Hei, graduated from the programme in 1908 (MOH, 2017). I was unable to determine whether Mereana Tangata, the first Māori nurse to register in 1902, under a Europeanised name, graduated from the programme as well (Kai Tiaki, 2013).

The cultural incongruency between the mainstream nursing training programme in the early 1900s, the state hospitals, and Māori nurses was evident (Holdaway, 1993). For example, health officials argued that the state examination was complex for Māori nursing students. Dr. Te Rangihiroa (also known as Sir Peter Buck) believed that Māori nursing needed to be more practice-based than theory-heavy to achieve the best results for Māori communities and to address the urgency of Māori ill health and the dire need for Māori nurses. As such, the possibility of a culturally appropriate alternative exam was discussed, supported by Mr. Bird, the Inspector for Native Schools (Simon, 2006; Wood, 1992). Unfortunately, the scheme was discontinued in 1910 due to the inability to recruit Māori nurses and the lack of funding and resources (McKillop et al., 2012).

Once disbanded, the Māori nursing scheme was replaced by the Native Health Nursing Service (NHNS), which comprised Pākehā nurses who held a Eurocentric ideology that dominated their practice. Māori nurses were marginalised by Pākehā nurses, who publicly voiced their superiority and their ability to engage Māori health consumers (McKillop et al., 2012). As McKegg (1992) asserted, the European/Pākehā nurses were viewed as culturally superior to the Māori nurses and were able to provide a better nursing service. The Pākehā nurses employed in the NHNS identified various challenges to delivering health services to Māori, mostly the cultural incongruency between the health service and Māori culture (McKillop et al., 2012). Cultural incongruency was also evident to Akenehi Hei, who advocated for non-Māori nurses to understand ‘Māori life’ to better serve Māori people (McKillop et al., 2012).

Despite the relatively small number of graduates from the 1899 Māori Nursing Scheme, it could be argued that those graduate nurses played a significant role in the population recovery of the Māori people in the 1900s. For example, Holdaway (1993) asserted that most early nursing graduates (from the nurse assistant scheme) returned to their respective communities to work as nurse assistants after completing their course. Moreover, prominent Māori doctors, such as Dr. Pomare and Dr. Rangihiroa, strongly advocated that Māori nurses deliver accessible health and health education to Māori communities, suggesting that their work’s value was recognised (Holdaway, 1993). Dr. Rangihiroa noted

Māori objections to accessing Western-based health services. He advocated for alternative options, such as health cottages, that would be more accessible to Māori communities and staffed by Māori nurses. Again, this suggests Māori nurses' capacity to improve access to health services for Māori. However, the ideology at the time emphasised the need to impart Western-based health practice and knowledge to Māori communities to improve Māori health and to halt the drastic depopulation (Durie, 1999). While some have long recognised Māori nurses for their fundamental role in delivering equitable health services to Māori, the recruitment and retention of Māori into nursing has been a long-standing issue, spanning over 100 years (Barton, 2025).

Defining Māori Nursing

Limited literature is available that conceptualises Kaupapa Māori nursing, although it is growing (Maloney-Moni, 2006; Simon, 2006). It is important to note that Kaupapa Māori "predates any and all of us in living years and is embedded in our cultural being" (Pihama, 2010 p. 6). Due to Kaupapa Māori theory and practice developing in the field of education, it is hard to determine when or why the concept of Kaupapa Māori nursing was defined or formalised (Simon, 2006). However, the long-standing plea for Māori nurses suggests that defining what specific skills Māori nurses would contribute to improving Māori health was essential.

Various sources note that Māori nurses have unique characteristics that are critical to the improvement of health service delivery to Māori, such as the ability to understand Māori culture and an innate understanding of colonisation and its impact on health (Durie, 1998a; Holdaway, 1993; Wilson, 2018, Woods, 1992). A first of its kind, Simon's (2006) research with Māori nurses defined Māori nursing as culturally affirming and culturally aware, utilising Māori networks, employing Māori models of health, and serving as a role model for Māori accessing healthcare services. In general, Māori nursing is the synergy of Kaupapa Māori frameworks and Western nursing knowledge, which is expressed in dual competency of each nurse (Te Rau Ora, 2011).

Access to appropriate professional development pathways is essential for the development of an equitable Māori nursing workforce (Te Kaunihera o Ngā Neehi Māori (The Council of Māori Nurses), n.d.). In 2011, the Huarahi Whakatū framework was accredited by the Nursing Council as an alternative Professional Development and Recognition Programme (PDRP) for the clinical competency assessment of Māori RNs. Te Rau Ora's (2011) Huarahi Whakatū framework conceptualises Māori nurses' dual competency as the two constructs: Pukenga Haumanu (clinical competencies) and Pukenga

Māori Motuhake (Māori cultural competencies). Pukenga Haumanu is based on the Nursing Council's competencies for RNs. Pukenga Māori Motuhake was developed to "assist the Māori nurse in their delivery of care based upon Māori methods and knowledge" (Te Rau Ora, 2011, p. 10). Notably, the Huarahi Whakatū PDRP framework formalises the dual competency of Māori nurses and allows dual competency to be recognised, developed, and rewarded. Unfortunately, the PDRP was not listed on the MOH's (2021) website, which listed all the PDRP programmes available to nurses in Aotearoa NZ. Although I was unable to locate the Huarahi Whakatū PDRP on the updated Te Whatu Ora – Health New Zealand PDRP webpage (Te Whatu Ora, 2025), I did note that it is listed on the Nursing Council's list of recognised PDRP (NCNZ, 2025b).

Challenges to the Retention of Māori Nurses

For decades, nursing literature has called for an equitable Māori nurse workforce to help create a more culturally safe nursing education and healthcare environment for Māori (Holdaway, 1993; Papps & Ramsden, 1996; Wilson, 2012, 2018; Wilson et al., 2022; Woods, 1992). Long-standing challenges to the recruitment, retention, and success of Māori nurses have persisted since Māori entered the nursing workforce (Barton, 2025; Holdaway, 1993; Te Kaunihera, n.d.). Educational and workplace environments for Māori nurses continue to be culturally unsafe and, at times, hostile. As summarised in the Waitangi Tribunal's (2019) (WAI 2575) Health Services Outcomes and Kaupapa Inquiry, Māori Nurses claim (Wai 2713):

> Along with broadly supporting the submissions of the stage one claimants on the persistence of Māori health inequities as evidence of insufficient Crown action, the Māori Nurses submitted that 'building a sustainable and properly paid Māori nursing and health workforce is essential to addressing inequities and disparities in Māori health'. They argued that the institutional racism inherent in the health system is to the detriment of Māori and themselves as Māori nurses, and accordingly, they sought recommendations relating to workforce issues such as pay parity and the cultural competency of staff in mainstream health entities. (p. 14)

Current literature resonates with the Māori nurses' claim in the WAI 2575. Māori nurses highlight numerous challenges within the workplace that affect the retention and development of the Māori nursing workforce. Māori nurses are not recognised for their unique skills and contribution to Māori health (Komene, Gerrard, Pene et al., 2023; Wilson et al., 2022). Māori nurses bring a dual clinical and cultural competency to the nursing workforce, comprising specialised nursing knowledge, skills, and an understanding of te ao

Māori (the Māori world) (Barton, 2025; Huria et al., 2014; Komene, Gerrard, Pene et al., 2023; Te Rau Ora, 2011; Wilson, 2018). Māori nurses understand Māori realities, including the collective experience of colonisation, whanaungatanga (relationships), kanohi kitea (the 'seen face'), and tikanga Māori (Wilson, 2018; Wilson et al., 2022). The impact of culturally congruent care for Māori, the protection of wairua, and whakawhanaungatanga (relationship building) is identified as pivotal for healthcare services for Māori (Komene, Pene, Gerrard et al., 2023; Maloney-Moni, 2006; Wilson et al., 2022).

Māori nurses experience unique challenges in the workplace and education system. Hunter and Cook (2020) argued that Indigenous nurses' emotional labour (maintaining an appropriate demeanour in a challenging situation) is unrecognised, such as being "unable to live their cultural values at work" (Hunter, 2019, p. 3). During nursing education, Māori reported having to justify the inclusion of Māori health papers and Kawa Whakaruruhau within their nursing courses to non-Māori students (Huria et al., 2014; Walker et al., 2016; Wilson et al., 2011). Māori nurses also reported feeling excluded or singled out for being the only Māori nurse and being expected to be the source of knowledge on all things Māori (Huria et al., 2014; Robert, 2020; Simon, 2006). Māori nurses have reported extra workloads due to being assigned 'Māori issues' by colleagues, and feeling obligated to advocate for and assist Māori clients or Māori student nurses in navigating the health and education systems (Hunter & Cook, 2020; Huria et al., 2014; Wilson, 2021). Moreover, Māori nurses report the tension between westernised health practice and tikanga as a significant challenge, and their knowledge of te ao Māori and hauora Māori (Māori health), being marginalised or overtly excluded from care practices by their colleagues (Huria et al., 2014; Hunter & Cook, 2020; Walker et al., 2016).

Whether in clinical practice or education, workplace settings significantly impact Māori nurses' practice and their ability to develop as Māori nurses (not just nurses who identify as Māori) (Simon, 2006). As recognised by generations of Māori leaders, Māori nurses are essential to the development of culturally safe healthcare services for whānau Māori. Unfortunately, workplace and educational environments that do not support Māori nurse success and retention are detrimental to Māori health (Barton, 2025).

Aims and Research Question

This thesis aimed to understand how Kawa Whakaruruhau is conceptualised by Māori nurses and determine its impact on them and their nursing practice. The research questions are:

1. How do Māori nurses define Kawa Whakaruruhau?

2. How has Kawa Whakaruruhau impacted Māori nurses and their practice?

Thesis Outline

This thesis commences with a comprehensive literature review chapter. Next, the methodology and methods are discussed in detail. The findings chapters follow, including the discussion chapter located in Poutama whā. A conclusion chapter completes this thesis.

Chapter 1. Introduction: has outlined the key background information for this thesis. An overview of Kawa Whakaruruhau and cultural safety was described, and the precursors to Kawa Whakaruruhau outlined.

Chapter 2. Literature Review: presents an integrative literature review, underpinned by Kaupapa Māori methods, that examines the whakapapa (genesis) of Kawa Whakaruruhau. Notable gaps in the nursing literature are identified, providing a sound rationale for this research.

Chapter 3. Methodology and Methods: discusses Kaupapa Māori methodology as the theoretical underpinnings for the research. Justification for this methodology is discussed and supported by Māori scholarly works from the past 30 years. A methodical description of how each Kaupapa Māori method was utilised is provided.

Chapter 4. Poutama Tahi – Social Dimension: provides the findings from the social dimension of each of the research participants' pūrākau. The social analysis is concerned with the social setting of the pūrākau including the space, time, location, socio-economic, historical, and cultural considerations and sequence of events (Rogers, 2023). The social dimension of culturally safe and unsafe spaces is identified.

Chapter 5. Poutama Rua – Relational Dimension: offers the findings from the relational dimension of each of the research participants' pūrākau. The relational analysis is concerned with relationships' historical, cultural, and evolving nature (Rogers, 2023). This chapter identifies how relationships impact spaces that are perceived as culturally safe and culturally unsafe.

Chapter 6. Poutama Toru – Emotional Dimension: provides the findings from the emotional dimension of each of the research participants' pūrākau. It offers insights into how culturally safe and unsafe spaces are experienced on an emotional level, personally.

Chapter 7. Poutama Whā – Interpretive Dimension: is a reflexive interpretation where the findings are critically analysed and positioned within the relevant literature. As a discussion chapter, Poutama Whā considers how the findings align with the research aim and

questions. An integration of Kaupapa Māori theory and nursing knowledge is used to formulate a discussion that is highly relevant to nursing in Aotearoa NZ.

Chapter 8. Poutama Rima – Spiritual Dimension: provides the findings from the spiritual dimension (Wairuatanga) of the participants' pūrākau. Importantly, the spiritual dimension is not included in the researcher's analysis, as Wairuatanga is deeply personal and highly subjective. The approach taken is respect and openness to the research participants' perspectives and descriptive reporting, with interpretation limited to what is needed to understand the context (Mikahere-Hall, 2017).

Chapter 9. Conclusion: completes this thesis. The chapter circles back to the research questions and provides a clear, succinct statement answering each question. The nursing implications are discussed, including recommendations for the nursing profession in Aotearoa NZ. Finally, the study's limitations are outlined.

Conclusion

Due to ongoing Māori health inequities and breaches of Te Tiriti o Waitangi, Kawa Whakaruruhau was developed to be a nursing praxis to support the development of culturally safe nursing practice when caring for whānau Māori. However, to appease the public and political backlash against Kawa Whakaruruhau, the framework was altered to include all 'cultures' and Māori were excluded from the definition. Kawa Whakaruruhau became known as cultural safety. Research demonstrates that, despite the integration of cultural safety into nursing education and practice, nursing education and healthcare spaces remain culturally unsafe for whānau Māori and Māori nurses. With the Nursing Council (2025a) explicitly outlining Kawa Whakaruruhau as an expectation of RNs' competence in the new competency framework *Standards of Competence for Registered Nurses*, a clear conceptualisation of Kawa Whakaruruhau is essential. This thesis presents the research process that took place to conceptualise Kawa Whakaruruhau by Māori nurses, one of the groups intended to benefit from Kawa Whakaruruhau. On a broader scale, Māori nurses are identified as pivotal to achieving health equity for Māori, so understanding culturally safe spaces is crucial.

Chapter Two: Literature Review

This literature review explored the research question: What is the whakapapa (genesis) of Kawa Whakaruruhau? The focus of the review is the conceptualisation and application of Kawa Whakaruruhau and/or cultural safety to clinical nursing practice in a Māori context in Aotearoa NZ. Additionally, the international Indigenous health context was considered, given the comparable colonial histories of countries such as Australia, Canada, and the United States of America.

Utilising Kaupapa Māori Theory and methods to underpin the process, a comprehensive review of available theoretical and empirical literature on Kawa Whakaruruhau and cultural safety in nursing was conducted. The findings of this integrative literature review are presented. First, the theorisation of Kawa Whakaruruhau in nursing in Aotearoa NZ is explored, including the events that immediately preceded its development. Second, various challenges to implementing Kawa Whakaruruhau in nursing theory and practice in Aotearoa NZ are discussed, such as competing dominant discourses like Transcultural Nursing (Papps, 2015; Ramsden, 2015). The challenges resonate with those identified in recent international nursing literature. Finally, the implications for taking Kawa Whakaruruhau into the future of nursing practice in Aotearoa NZ are discussed, including the identification of notable gaps in the nursing literature that support this wider research project.

Reviewing the Literature – a Kaupapa Māori Approach

This integrative literature review was underpinned by Kaupapa Māori methodology and provided the opportunity to conduct a comprehensive review of the available literature on the topic of interest (Whittemore & Knafl, 2005). Kaupapa Māori Theory was privileged throughout this process and underpinned the review by informing the conduct of the methods. Extracted literature with Māori authors were prioritised and given greater weight during the data evaluation and analysis process, including utilising Ramsden's (1990) document as the reference for defining Kawa Whakaruruhau.

Kaupapa Māori Research – Whakapapa method

Kaupapa Māori Theory is "first a philosophy, then a strategy" (Walker et al., 2006, p. 335). It combines the epistemological, ontological, metaphysical, and ethical constructs that form Māori realities. Mātauranga Māori is knowledge developed in a Māori way, such as when using Kaupapa Māori Theory as a research methodology. Mātauranga Māori should be privileged when exploring the meaning of phenomena of relevance to Māori. In simple terms, Kaupapa Māori research is conducted in a Māori way, by Māori, and for Māori (Smith,

2015). Kaupapa Māori research is explored in greater detail Chapter 3 – Methodology. The core assumptions underpinning this literature review are:

- Te Ao Māori is a legitimate and valid worldview that has been preserved throughout the process of colonisation; and
- Mātauranga Māori is the most appropriate knowledge base to draw from for contextualising and analysing the results of the review.

Whakapapa

Whakapapa is the foundation of mātauranga Māori. Whakapapa is an epistemological and ontological system that organises the living and non-living world based on relationships with people and the spiritual realm (Taonui, 2011). Sir Apirana Ngata described whakapapa as the 'building blocks' of te ao Māori; and the foundation of Māori values, philosophy, tikanga, te reo Māori, and one's relationship to others and the whenua (land) (cited in Taonui, 2011).

Whakapapa, as a research methodology, can be utilised to make sense of phenomena through a Kaupapa Māori lens (Graham, 2009). Whakapapa examines the origins of a phenomenon within its historical and cultural contexts, enabling accurate predictions to be made about similar phenomena in the future (Graham, 2009). Graham (2009) asserted that whakapapa as a research methodology, "noticeably provides the space for Indigenous theorising, philosophical reflection and research outside of a typical colonial experience" (p. 3). Furthermore, Graham suggested that the following questions can be applied to explore the whakapapa of a phenomenon:

1. How did Kawa Whakaruruhau come about?
2. What was responsible for the presence of Kawa Whakaruruhau?
3. Looking at the past, how can we predict the future of Kawa Whakaruruhau?

Aim

This literature review explored the whakapapa of Kawa Whakaruruhau by applying Graham's (2009) research questions as the framework. The first question has been presented in the background section of the introduction chapter (the precursors to Kawa Whakaruruhau). The following two questions are answered in the findings of this literature review chapter. Precisely, this integrative literature review aimed to explore the whakapapa of Kawa Whakaruruhau within the socio-cultural context in which it was developed, and how it has evolved since its implementation into nursing in 1991. Although the term 'Kawa Whakaruruhau' was initially used interchangeably with cultural safety (the more commonly

used term), this literature review privileges Kawa Whakaruruhau (as defined in the introduction).

Integrative Literature Review

Whittemore and Knafl's (2005) methodology for conducting an integrative literature review was utilised in the current research. The integrated literature review methodology was selected because it enabled a comprehensive review of a wide range of literature on the phenomenon of interest (Whittemore & Knafl, 2005). The integrative literature review can be utilised to review, define, and analyse phenomena for various purposes, such as the conceptualisation and history of a phenomenon. Therefore, this approach enabled a thorough examination of the available literature on Kawa Whakaruruhau, cultural safety, and nursing in a Māori and broader Indigenous context. A methodical and robust exploration of the whakapapa of Kawa Whakaruruhau was conducted.

Rigour

Whittemore and Knafl (2005) identified that a literature review is essentially 'research of the research', so it should meet the same methodological rigour as a primary research project. The challenges of performing a rigorous integrative literature review stem from the diverse range of data gathered for such a review. If conducted effectively, the integrative literature review can produce a comprehensive synthesis of the literature on the topic of interest. However, without a robust methodology, there is the risk of developing a biased presentation of the literature. Therefore, Whittemore and Knafl's framework has been utilised for conducting the methods of this literature review.

In addition, Smith's (2017) criteria for establishing rigour in Kaupapa Māori research—"veracity of a Kaupapa Māori theory approach" (p. 8)—were utilised to ensure that the literature is robust from a Kaupapa Māori perspective. Smith's framework guided the development of the theoretical components of the data analysis, the findings, and discussion. The five elements underpinning the veracity of a Kaupapa Māori project are:

1. *Researcher positionality* – involves self-reflection by the researcher on their own experiences and knowledge, and the contribution both make to the research.
2. *Criticality* – requires the researcher to analyse the ongoing power imbalances between Māori and tauiwi (settlers). Kawa Whakaruruhau is the focus of this research, and a Kaupapa Māori methodology has been utilised to privilege te ao Māori and challenge the dominant discourse surrounding cultural safety in nursing.

3. *Structural and cultural considerations* – recognition of the structural and interpersonal constructs that impede the flourishing of Māori society, such as access to te reo Māori and autonomy over one's life. The whakapapa methodology situates Kawa Whakaruruhau within its appropriate socio-cultural context.
4. *Practicality* – continuous reflection by the researcher on the theorising against the practical elements of the research project is needed.
5. *Transformability* – demonstrate the potential for achieving positive outcomes for Māori, including developing Kaupapa Māori research methods. This research draws on mātauranga Māori to explore the whakapapa of Kawa Whakaruruhau in nursing practice in Aotearoa NZ. Moreover, this literature is part of a broader Kaupapa Māori research project that examines the significance and application of Kawa Whakaruruhau in Māori nursing practice.

Problem Identification Stage

Identifying the problem and defining the purpose of the review form the foundation of an integrative literature review (Whittmore & Knafl, 2005). Both determine the focus of the review and the types of literature extracted during the data extraction process. The identified problem for this research is the lack of conceptual clarity and theoretical differences between Kawa Whakaruruhau and the commonly used concept, cultural safety, in nursing practice in Aotearoa NZ. Therefore, the purpose of this literature review was to explore the conceptualisation and integration of Ramsden's (1990) document, *Kawa Whakaruruhau: Cultural Safety in Nursing Education*, into nursing education and practice in Aotearoa NZ. Moreover, the social and political contexts in which the theoretical framework was developed, evolved, and redefined are examined to align with Smith's (2017) framework. In addition to identifying the phenomenon and its purpose, the researcher should explicate the theoretical underpinnings that inform the review to focus the search appropriately and meet the objectives of the study (Whittemore & Knafl, 2005).

Literature Search Strategy

To conduct a comprehensive literature search, a robust search strategy is necessary. Without a sound literature strategy, a skewed review can result (Whittmore & Knafl, 2005). The three approaches used for this literature review included searching online databases, Google Scholar, and the AUT library. The following electronic databases were searched: Australia and New Zealand Reference Centre, CINAHL, Google Scholar, MEDLINE, and SocINDEX.

Keywords used in the search were: Kawa Whakaruruhau, cultural safety, Indigenous, Māori, health, and nursing.

Registered Nursing (RN) literature published between 1985 and 2025 that discusses Kawa Whakaruruhau or cultural safety in an Indigenous context was included. Both theoretical discussions and practical application of Kawa Whakaruruhau and/or cultural safety were included to provide a broad range of conceptualisations. National and international Indigenous health contexts were sought. Literature that discussed cultural competency, cultural awareness, or similar terms were excluded to avoid confusion of concepts. Cultural safety discussions related to other non-Indigenous contexts were also excluded as the focus of this thesis is on Indigenous people. Non-RN literature was excluded as the scope of practice varies from a RN, so the applicability of the findings is likely limited. The inclusion and exclusion criteria are outlined in Table 2.

Table 2.

Inclusion/Exclusion Criteria – Literature Review

Inclusion Criteria	Exclusion Criteria
• Years 1985 to 2025 • Focus on Kawa Whakaruruhau theory or its application to nursing practice • Focus on cultural safety theory or application to nursing practice • Indigenous health context • International indigenous nursing context • The overall focus of the article/theses is Kawa Whakaruruhau or cultural safety • Focused on RNs, including nurse educators	• Cultural sensitivity, cultural competency or other similar terms • Not focused on the Indigenous health context • Other health or social science discipline • References Kawa Whakaruruhau or cultural safety, but has a different overall focus • Literature about student nurses' experience of cultural safety • Literature about enrolled nurses' experiences of cultural safety • Literature focusing on nursing education content • Letters to the editor and opinion pieces

The initial search returned a total 9, 963 records. Google Scholar returned 8,738 of those records. The Nursing Council's website was also accessed to search for relevant literature. To determine the data's relevance, an initial review included examining the title and abstract against the inclusion/exclusion criteria. The total number of records (including reports from websites) selected (n=776) were based on their titles and abstracts. Due to the high number of records, a thorough secondary review of the selected records was conducted.

Data Extraction

After the first review of each article's title and abstract (n=776), relevant citations were exported into EndNote for secure storage, before a secondary review was conducted. The secondary review involved thoroughly reviewing abstracts (and discussions if necessary) against the inclusion and exclusion criteria to determine the literature's relevance to the aim of the literature review. Given the large amount of literature returned during the search stage, this process was essential to ensure that only pertinent literature was included. Literature that was a duplicate or did not meet the inclusion criteria was removed from Endnote to avoid confusion. From a total of 776 articles, 566 imported citations were duplicates, 133 did not meet the inclusion criteria, and 5 could not be accessed due to insufficient citation material. The most common reason for the removal of literature following the secondary review was that cultural safety, although mentioned in the abstract as an aspirational nursing outcome, was not the focus of the article. A total of 72 articles were extracted for the review. A PDF file of each article was downloaded into a storage file, and a copy was printed for reading and analysis purposes. See Figure 1 for the PRIMSA diagram of the data selection process.

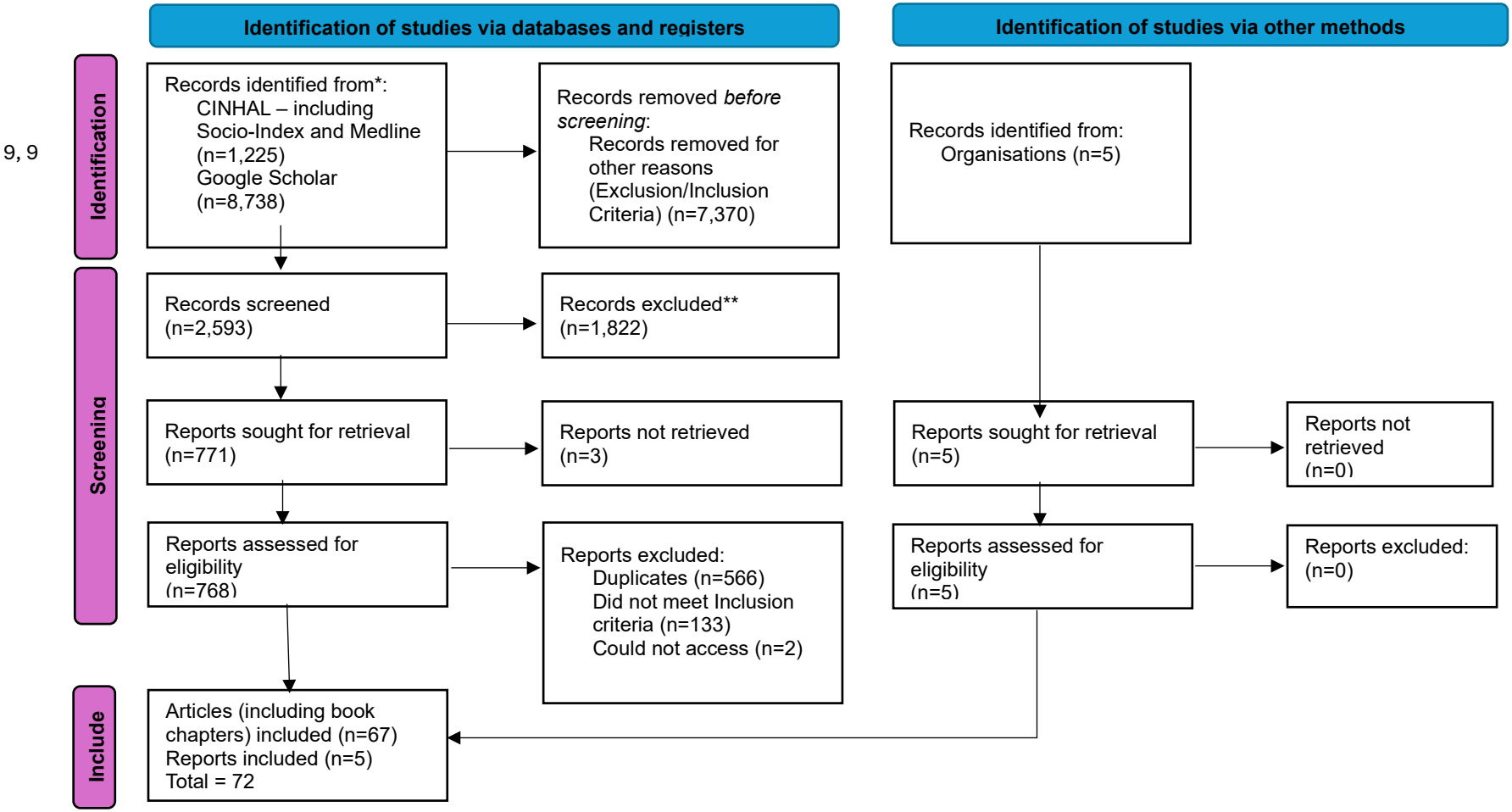
Data Evaluation

The literature selected for this review includes original qualitative research, theoretical frameworks outlining Kawa Whakaruruhau and/or cultural safety, articles outlining the application of Kawa Whakaruruhau and/or cultural safety to specific clinical areas, discussion papers, opinion pieces/letters to the editor, and a media article that discusses the implementation of Kawa Whakaruruhau into nursing training in Aotearoa NZ.

Using a 2-point coding system, the literature was reviewed and categorised based on its relevance to the aim of this review (Whittemore & Knafl, 2005). (See Appendix B for a table of the included literature.) Code 1 (highly relevant) was designated to literature that was highly pertinent to conceptualising the whakapapa of Kawa Whakaruruhau. That is, literature that Māori nurses wrote about Kawa Whakaruruhau in a Māori context. Nursing Council literature was designated code 1 as the guidelines directly impacted the conceptualisation of Kawa Whakaruruhau and cultural safety which was evident in literature written around the same time as each set of guidelines. Code 2 (relevant) was applied to literature that was less specific to the development of Kawa Whakaruruhau, but discussed cultural safety in an Indigenous concept and provided information on the socio-cultural constructs that give context to the development of the concept. Literature identified as being highly relevant was prioritised and held greater 'weight' when writing up the findings (Whittemore & Knafl, 2005).

Figure 1.

PRISMA diagram for the selection of literature



Source: Page, et al. (2021).

Findings

This section addresses the second question of Graham's (2009) Whakapapa methodology in which the 'presence' of Kawa Whakaruruhau in nursing is discussed. The findings demonstrate that Kawa Whakaruruhau underwent a refinement period due to various external factors, leading to conceptual inconsistency. Definitions from national and international nursing literature are identified, and the emergence of cultural safety in the international nursing fraternity is briefly discussed. Various challenges to the actualisation of Kawa Whakaruruhau in nursing are identified, including in nursing education.

Defining and Redefining Kawa Whakaruruhau

In 1988, the 'Hui Waimanawa' was organised so Māori nurses could discuss addressing Māori health disparities and low numbers of Māori in nursing programmes throughout Aotearoa NZ (Papps & Ramsden, 1996). Māori nurses and Māori student nurses from all over Aotearoa NZ participated. Here, Hinerangi Mohi, a first-year nursing student, raised concerns regarding the lack of safe nursing practice concerning cultural considerations. Hinerangi's question resonated with Māori nurses. Following a second hui in 1989, Hui Piri ki Nga Tangaroa in the Manawatu, the report, *Kawa Whakaruruhau: Cultural Safety in Nursing Education,* was formalised by Dr. Irihapeti Ramsden (1990). At this time, Ramsden was working as the appointed Māori nurse representative on the Nursing Council's education advisory committee (Murchie & Spoonley, 1995). The objectives included improving education spaces for Māori student nurses, increasing Māori nurse retention, and improving Māori health service users' experiences (Papps & Ramsden, 1996; Wilson et al., 2022). By 1990, the concept of Kawa Whakaruruhau had become part of the Nursing Council's competence assessment standards for nurses; and by 1992, cultural safety was included in the national nursing education programme. It accounted for 20% of the total examination questions in the state examination for registration as a nurse (NCNZ, 2011).

Ramsden (1997) emphasised that the objective of Kawa Whakaruruhau was for "nurses to be safe around" (p. 125) tangata and whānau accessing care. Cultural safety is an outcome of nursing education, an underlying theoretical and skill base for nursing that can be likened to nursing ethics and nursing knowledge (Ramsden, 1993). Ramsden (1990) stated that cultural safety could be broken down by examining each word. Culture was defined as:

> our way of living is our culture. It's our taken-for-grantedness that determines and defines our culture. The way we brush our teeth, the way we bury people, the way we express ourselves through art, religion, eating habits, humour, science, law and sport;

> the way we celebrate occasions (from 21sts, to weddings, to birthdays) is our culture. (Wepa, 2015 p. 66)

Safety can be defined as "a state in which or a place where you are safe and not in danger or at risk" (Cambridge Dictionary, 2025, para. 1).

Following the substantial public and political backlash between 1992 and 1996, pressure continued to build. As a result, the government's Select Committee of Education and Science intervened and ordered an unprecedented formal review of nursing education by the Cultural Safety Review Committee, led by then-Human Rights Commissioner, Dr. Erihapeti Murchie, and Professor Paul Spoonley. The review, *Report to the Nursing Council of New Zealand on Cultural Safety and Nursing Education in New Zealand 1995*, was a comprehensive assessment of 15 polytechnics and the cultural safety curricula content in both nursing and midwifery courses. The review considered both negative and positive feedback from the public and health professionals. Recommendations from this review influenced the development of Kawa Whakaruruhau. The eight recommendations included retaining the name 'cultural safety' (not Kawa Whakaruruhau) and that the Nursing Council take a more pragmatic role in delivering cultural safety in nursing education. The review emphasised that cultural safety was about all cultures, but Te Tiriti o Waitangi was central to understanding relationships in an Aotearoa NZ context (Murchie & Spoonley, 1995).

Following an audit of nursing education providers in 1997/98 and the Council's Strategic Review of Undergraduate Nursing Education in 2000/01, the separation of cultural safety from Te Tiriti o Waitangi and Māori Health was cemented (NCNZ, 2011) in order to "minimise confusion and variation in teaching that was identified in the above audits and reviews" (NCNZ, 2011, p. 6). These changes occurred despite early guidelines published by the Nursing Council (1992) that identified cultural safety as needing to start with tangata whenua. Moreover, Ramsden (1996) asserted that the two non-negotiables put forward to the Cultural Safety Select Review Committee in 1995 were:

1. Kawa Whakaruruhau (cultural safety) would retain its te reo Māori and English names, and
2. Te Tiriti o Waitangi would remain the foundational document for understanding power dynamics in the Aotearoa NZ context in Kawa Whakaruruhau.

The relationship between Kawa Whakaruruhau and Te Tiriti o Waitangi was explicitly outlined in the following statement from the participants of the Hui Piri Ki nga Tangaroa (1989):

- Māoritanga is a taonga.

- Institutional and individual racism persistently violates this taonga and contravenes Te Tiriti o Waitangi.
- Tino Rangatiratanga is guaranteed in Te Tiriti o Waitangi and is the birthright of every Māori person.
- Tino Rangatiratanga is guaranteed in Article II of Te Tiriti o Waitangi. The full chieftainship of everything that is held precious to Māori people. The right of Māori people to have control over our destiny is a taonga handed down by our ancestors.
- It must be maintained by ensuring that this birthright is recognised, developed and strengthened. (p. 10)

Despite these earlier assertions by key architects of cultural safety, its current definition is distinct from Kawa Whakaruruhau and Te Tiriti o Waitangi. It encapsulates the diverse populations of Aotearoa NZ society (NCNZ, 2011). Currently, Kawa Whakaruruhau has been identified as "Cultural Safety in a Māori context" (NCNZ, 2011, p. 5) and nursing's commitment to Te Tiriti o Waitangi is deemed separate to cultural safety (NCNZ, 2011). At the time of writing this thesis, Kawa Whakaruruhau is under review by the Nursing Council.

Re-definement

Ramsden's (2002) doctoral thesis described a process known as the evolution of cultural safety that occurred between 1990 and 2002. She argued that the changes made to the concept of cultural safety were influenced by various external sources, such as nursing education and select committee reviews. Unfortunately, the redefinition of cultural safety was less about the health consumer (Ramsden, 2002). Ramsden highlighted the following questions as ngā pou (pillars) of cultural safety, necessary for any redefinition of the concept as the context changes:

- How is cultural safety defined?
- What are the processes for assessment of theoretical and clinical cultural safety?
- How does the patient say that students [or nurses] are culturally safe? (p. 107)

The significant backlash against Kawa Whakaruruhau was identified as a manifestation of the Māori-Pākehā power imbalances in Aotearoa NZ (Richardson, 2004). Due to public perceptions, the conceptualisation of cultural safety moved away from a Māori-centric focus to mitigate the conflation between race and culture. There was considerable public pressure to reiterate the concept due to the assumption that cultural safety was Māori imposing their demands on the caring profession (Ramsden, 1995a, 2002). Further, Ramsden

(2001) cautioned against developing a check-box mentality of Māori culture, based on stereotypes and the nurse's assumptions about Māori from an imagined cultural-neutral position. Nevertheless, despite the shift to a diverse cultural safety framework, many Indigenous nurses and allies have continued to assert Kawa Whakaruruhau as a nursing practice that is essential for improving the health outcomes of Māori (Blackmoore-Tufi &Taylor, 2022; Hunter et al., 2021; Kidd et al., 2014).

Definitions from the Nursing Literature

Within Aotearoa NZ nursing literature, definitions and defining features of Kawa Whakaruruhau and cultural safety vary. The definitions from an Aotearoa NZ context are presented first, followed by definitions from an international nursing context.

Despite conceptual changes, nursing literature from Aotearoa NZ identified Kawa Whakaruruhau and cultural safety as a Māori-centred framework in nursing, which aligns with Ramsden's (1990) guidelines. Kawa Whakaruruhau was recognised as a criterion added by the tangata whenua of Aotearoa NZ (Bickley, 1990). Specifically, cultural safety is about growing nurturing nursing hands that meet the cultural safety of tangata whenua first, and is transferable to others second (Cooney, 1994). After the turn of the century, cultural safety was described as a taonga for nursing that requires a critical analysis of one's own culture, the power imbalances in healthcare, and the culture of nursing (De Souza, 2008; Robinson et al., 1996). Additionally, an understanding of the principles of Te Tiriti o Waitangi and a critical examination of Māori health context and needs were identified as part of culturally safe care (Blackmoore-Tufi &Taylor, 2022; De Souza, 2008; Kidd et al., 2014; Hunter et al., 2021; Pere, 1997).

The importance of challenging Pākehā hegemony was a defining feature of Kawa Whakaruruhau and cultural safety conceptualisations in Aotearoa NZ nursing literature. Early guidelines from the Nursing Council (1992) stated that Pākehātanga underpinned nursing education and practice, and recommended that the concept be taught to nursing students. Moreover, the relationship between Pākehā and Māori was identified as foundational to the cultural safety framework (Wood & Schwass, 1993). Despite literature identifying the transparency of the dominant culture as an imperative of cultural safety, the focus on Pākehātanga is no longer in the guidelines (Nairn et al., 2014).

In recent years, the focus has moved to examining the role that nursing, as a professional body, has in perpetuating Māori health inequities. For example, Barton (2018) stated that culturally safe nursing is the awareness that nursing perpetuates the power imbalances and systemic oppression that lead to health inequities for Indigenous people.

Therefore, culturally safe nursing care includes the application of an equity lens in a Māori health context. Moreover, a critical reflection on the complexity of Māori health, such as understanding the impact of racism, is important for upholding human rights and striving for social justice, identified as key to culturally safe nursing care (Barton, 2018; Blackmoore-Tufi & Taylor, 2022; Hunter & Cook, 2020).

The demonstration of Kawa Whakaruruhau in nursing is identified as relational practices underpinned by te ao Māori values and practices. Culturally safe care is identified as the demonstration of practice that reflects aroha, pono, and manaakitanga. Specific examples of culturally safe care include utilising appropriate models of care, correctly pronouncing te reo Māori names, and facilitating informed choice for tangata and/or whānau accessing care (Baker, 2012; Cook et al., 2014; Helleston & Hakiaha, 2016; Longmore et al., 2019; Wilson, 2008); as well as demonstrating advanced listening skills and a range of communication skills (Blackmoore-Tufi, 2023; Cook et al., 2014; Hughes, 2018). Nurses determine that the tangata and/or whānau feels culturally safe by their willingness to attend appointments, verbal cues, and the patient being able to verbalise personal needs (Baker, 2012).

International Perspectives

From an international nursing perspective, conceptualisations of cultural safety in an Indigenous context have similar features to Kawa Whakaruruhau. Cultural safety is identified as a post-colonial Indigenous response to Indigenous health inequities (Browne, 2003). As well as a nursing praxis, cultural safety is identified as a theoretical lens for critically examining the manifestation of politics in healthcare access and delivery for Indigenous populations (Browne, 2003; Hulko et al., 2021; McGough et al., 2022). Further, a critical reflection on the history of nursing as a ‘whiteness’ cultural institution that has marginalised, perpetuated negative stereotypes and excluded Indigenous peoples was identified as essential to cultural safety in nursing. For example, nurses have been active participants in ethnocidal practices, such as unconsented sterilisation of Aboriginal Australian women after childbirth (Best, 2014; Bryce & Foley, 2014; Carter et al., 2017; Cox, 2016; Power et al., 2021a). As such, cultural safety challenges nurses to examine the impact that colonial, economic, and socio-historical contexts have had on Indigenous health (Best, 2014; Bidinzki, 2012; Bourque Bearskin, 2011; Browne, 2003). Moreover, Western perspectives on health experiences by Indigenous people, such as pain perception, are challenged by cultural safety (Fenwick, 2006).

International Indigenous and non-Indigenous nursing scholars urge the profession of nursing to modify the ethos underpinning nursing practice in an Indigenous context. Cultural safety is described as an intercultural philosophy that can advance ethical care and relational skills in nursing toward trusting, relationship-focused nursing (Bidinzki, 2012; Bourque Bearskin, 2011; Gifford et al., 2022; McGough et al.,, 2022). Culturally safe nursing care can significantly influence the identity formation of Indigenous peoples, both negatively and positively (Carter et al., 2017). Therefore, nurses are challenged to critically reflect on their biases, assumptions, and privileges that influence their nursing care when working with Indigenous people (Cox & Best, 2022; McGough et al., 2022).

Similar to conceptualisations from Aotearoa NZ nursing literature, international literature asserts that culturally safe care for Indigenous peoples should be determined by Indigenous peoples themselves (Gifford et al., 2022; Hulko et al., 2021). Culturally safe nursing care of Indigenous peoples is care underpinned by Indigenous models for health and values; that is, the incorporation of diverse family structures; Indigenous values such as love and care; understanding that access to culture, such as cultural teachings on health, is healing; and that culturally safe care is linked to identity formation (Best, 2014; Carter et al., 2017; Gifford et al., 2022). Although the international nursing literature is growing, further research is needed on how cultural safety is applied to Indigenous health practice (McGough et al., 2022; Withall et al., 2021).

Challenges to Implementing Kawa Whakaruruhau into Nursing

Traditionally, nursing in Aotearoa has been focused on the practical skills of nurses rather than the theoretical knowledge base from which nurses work (Papps, 2015). The first bachelor's degree in nursing was introduced in 1992 (Wilkinson, 2023). Tertiary-based nursing education meant that nurses would undergo comprehensive training, enabling them to work in a variety of settings. The shift to tertiary-level education for nurses was a cultural shift that contributed to the challenge of implementing Kawa Whakaruruhau into nursing education. Ramsden (1995a) described Kawa Whakarururhau as part of the process by which nursing established itself as an independent profession in a patriarchal society. On a broader scale, Kawa Whakaruruhau contributed to the maturing of Aotearoa NZ as a society in general by defining what our values are and what our societal "baselines" were (Ramsden, 1995b. p. 2). Previously, nursing in Aotearoa NZ was underpinned by Florence Nightingale's virtues of "duty, obedience and servitude" and a universalist approach to caring for all, regardless of differences (Papps, 2015, p. 38).

The public's upset over Kawa Whakaruruhau was fuelled by an ideology that Māori were imposing ideas about a submissive female-dominated profession, and that 'political correctness' was overtaking clinical competence (Ramsden, 1997, 2000b; Stabb, 1995). Moreover, the positivist paradigm emphasises individualism and the superiority of Western biomedicine, which is also evident in nursing (Richardson, 2004). Therefore, the idea of Māori nurses challenging the appropriateness of the Pākehā nursing knowledge and education system was infuriating (Ramsden, 1995b; Robinson et al., 1996). Also, the idea that Indigenous health inequities resulted from systemic inequities and was not individuals' 'fault' was difficult to fathom (Walker, 2017). As a result, Kawa Whakarururhau and cultural safety were not prioritised in the same way as Eurocentric nursing knowledge, nor are they prioritised in practice (Bourque, 2020; Hunter & Cook, 2020). A similar backlash to the integration of cultural safety in nursing in Australia, fuelled by the media, has been described by Molloy et al. (2021).

Cultural Competence Assessment

A significant milestone in the development of Kawa Whakaruruhau in nursing was the HPCAA, 2003. Under this legislation, the Nursing Council would become the statutory body responsible for "setting and monitoring standards and competencies for registration" of a nurse. The HPCAA (2003) was designed to ensure the safety of the public and the competence of RNs (and other health professionals) practising in Aotearoa NZ (Banks & Kelly, 2015). Cultural competence was not defined in the HPCAA (2003). Therefore, each statutory body is required to set the standards for cultural competence. The broad definition of cultural safety is the framework used in nursing to assess nurses' cultural competence (Vernon & Papps, 2015).

In 2004, the Continuing Competence Framework was established by the Nursing Council in response to the HPCAA (2003) to monitor and evaluate the nurse's professional practice. In the Continuing Competence Assessment framework, the nurse must demonstrate that their practice meets the requirements of their scope through competency assessment every 3 years (NZNC, 2011; Vernon & Papps, 2015). Competencies 1.2, 1.5, 2.4, 3.1, and 3.2 (see Table 3) were designed to assess constructs of culturally safe practice, such as implementing Te Tiriti o Waitangi in practice and a commitment to facilitating positive Māori health outcomes (Banks & Kelly, 2015). However, to reiterate, the Nursing Council's (2011) cultural safety definition for nurses does not explicitly include the implementation of Te Tiriti o Waitangi to practice or a commitment to Māori health improvements, so confusion in the guidelines remains.

Table 3.

Nursing Competencies that Demonstrate Cultural Safety (2011-2025)

Competency 1.2	Demonstrates the ability to apply the principles of the Treaty of Waitangi / Te Tiriti o Waitangi to nursing practice
Competency 1.5	Practises nursing in a manner that the health consumer determines as being culturally safe
Competency 2.4	Ensures the health consumer has adequate explanation of the effects, consequences, and alternatives of proposed treatment options
Competency 3.1	Establishes, maintains, and concludes therapeutic interpersonal relationships with health consumers
Competency 3.2	Practises nursing in a negotiated partnership with the health consumer, where and when possible

Source: NCNZ. (2011)

The tangibility of measuring Kawa Whakaruruhau and cultural safety in the state examination and competence assessment has remained a contentious issue. Firstly, Te Kaunihera o Neehi Māori disputed the appropriateness of a multiple-choice state exam in measuring cultural safety in nursing practice (Ramsden & Page, 1993). The nurse's self-assessment method in the Continuing Competence Assessment framework was also seen to exacerbate the retention of power intended to be transferred during culturally safe nursing care (Ramsden, 1997). Despite competency 1.5 stating that the nurse "practices in a manner that the client determines as being culturally safe" (NCNZ, 2011, p. 6), the nurse declares themselves culturally safe by self-appraisal and peer-approval. Also, the Nursing Council's (2011) competency framework does not specifically measure Kawa Whakaruruhau in practice. However, the new competency framework, which includes Kawa Whakaruruhau as a requirement of RN competence, will be fully integrated into the Continuing Competency Framework in 2026 (NCNZ, 2025).

Competing Discourses

The conflation between culture, race, and ethnicity has been problematic for implementing Kawa Whakaruruhau into nursing education and practice in Aotearoa NZ (Ramsden, 2002). For clarity, 'race' is an outdated term used to categorise a person into a social group based solely on their physical characteristics. Ethnicity refers to a social group that one identifies with, encompassing cultural practices commonly shared by the group, such as language and ancestry (Wepa, 2015). An ethnic or social group is not usually put in a position to define itself unless it becomes an oppressed minority (Wepa, 2015).

Before Kawa Whakaruruhau, the nursing ethos in Aotearoa NZ focused on providing care for all, regardless of cultural differences. During the civil rights era, Madeleine Leininger's Cultural Care Theory informed cultural care in nursing, a field known as transcultural nursing (Leininger, 1997). Transcultural nursing is grounded in the discipline of Western anthropology, where the nurse anthropologist works in partnership with key informants of an ethnocultural group to develop culturally congruent care for that community (Leininger, 1997; Ramsden, 1995b). Ramsden (2001) challenged the idea that nurses can be neutral observers or 'experts' of an ethnocultural group differing from their own. There is concern that this approach potentially 'othered' ethnocultural groups, promotes a reductionist view of culture, and reinforced the idea that healthcare institutions were culturally neutral (Bourque, 2020; Ramsden 1995b).

The dominance of transcultural nursing led to cultural safety concepts being taught interchangeably with concepts that resonated with Culture Care Theory (Ramsden, 2001). The ideology that nurses will care for anyone, regardless of age, gender, socio-economic status, religion, culture, and ethnicity, underpinned nursing education and practice in Aotearoa NZ (Ramsden, 2001). The focus of transcultural nursing remained on the cultural differences of the health consumer, rather than on the nurse's ability to provide care that the consumer deemed safe and protective of their cultural needs (Ramsden, 2001). As such, the nurse becomes the 'cultural expert' instead of recognising the health consumer as the expert in their own life (Coup, 1996). Essentially, culturally safe nurses are defined as those who can practice 'safely' amongst the differences that all people have (Hughes, 2018). Thus, transcultural nursing theory was regarded as incompatible with cultural safety, and inappropriate for the Aotearoa NZ nursing context (Coup, 1996). Leininger (1997) disputed Ramsden and Coup's claims about transcultural nursing, stating that the concept of cultural safety is part of the broader practice of transcultural nursing. Although both theories identify culture as pertinent to client well-being, transcultural nursing does not consider the nurse's position or power dynamics in the nurse-patient relationship, and is based on the premise that nurses can 'know' other cultures.

Multiculturalism

In the formative years of Kawa Whakaruruhau, limited understanding of Te Tiriti o Waitangi and the concept of biculturalism perpetuated negative depictions and stereotypes of Māori. The stereotypes were based on the ideology that Māori were demanding special privileges, being divisive, and disregarding all other ethnocultural peoples living in Aotearoa NZ (Ramsden, 2001). Moreover, the national 'romanticisation' of the colonisation process, such

as heroic pioneers and good race relations, led to confronting feelings for many when the truths of colonisation were uncovered during cultural safety training (Ramsden, 1995b, 1997). Consequently, multiculturalism, which presents Aotearoa NZ as a diverse society, became the socially preferred concept for describing the society, including in nursing education (Richardson & Carryer, 2005). Although, it is important to note that pre-colonial indigenous populations, such as in Aotearoa NZ, were a diverse people already (Pihama et al., 2002). Colonial multiculturalism and diversity refers to the promotion of the idea that various cultural groups influence the cultural identity on a societal level where in reality Pākehātanga is the dominant culture influencing society. As such, Te Tiriti o Waitangi is not given the same importance, and Māori become another minority group within Aotearoa NZ. Further, the dominance of Pākehātanga is not acknowledged because Pākehā are treated as another group within the multicultural context.

The concept of multiculturalism perpetuates that culture is conflated with race or ethnicity. Multiculturalism promotes the examination of the 'exotic' cultural differences of minority peoples by the dominant, normative culture (Ramsden, 2001). In a nursing context, multiculturalism positions the nurse as a 'cultural voyeur' observing different cultures through the lens of the nursing culture, which was considered culture-neutral and normal (Papps, 2015; Ramsden, 2001). In the Aotearoa NZ context, this view reinforced Māori as the 'other' in which the perceived cultural differences of Māori were scrutinised and marginalised by monocultural institutions, including nursing (Power et al., 2022; Smith, 2021). Multiculturalism is the preferred lens for teaching cultural safety internationally; however, the importance of explicitly utilising cultural safety in an Indigenous context is identified as a form of validation of the atrocities associated with colonialism (Bryce et al., 2018)

As well as the 'exotic' differences being highlighted, so were the perceived deficits of the 'other' culture due to falling short of the dominant culture's standards. During this process, the nurse's own culture, values, and beliefs were overlooked and reinforced as 'normal' (Best & Cox, 2022). Comparing the cultural differences and perceived deficits of Indigenous peoples with the dominant healthcare culture can unconsciously reinforce negative stereotypes of Indigenous peoples, such as being 'non-compliant' and 'vulnerable' (Gifford et al., 2022). The lack of acknowledgement of monoculturalism in major institutions led to the socio-political contexts of Māori health inequities being ignored, and the development of the 'Māori deficit' discourse (Ramsden, 2001).

Moving Forward

Aligning with Graham's (2009) whakapapa framework, this section looks at the future of Kawa Whakaruruhau in nursing by examining its whakapapa. Conceptual clarity is highlighted in the nursing literature as pertinent to the authentic integration of Kawa Whakaruruhau in nursing education and practice.

Conceptual Clarity

Kawa Whakaruruhau is a Kaupapa Māori framework that was gifted to nursing by Māori nurses as a safety criterion. Kawa Whakaruruhau was intended to have positive implications for patient safety and the evolving nursing identity in Aotearoa NZ. However, the entrenched power dynamics in Aotearoa NZ led to the colonisation of Kawa Whakaruruhau. Less than 10 years following its development, the multicultural conceptualisation of cultural safety was privileged and became the concept guiding culturally competent nursing care in Aotearoa NZ (Richardson & Carryer, 2005). Although Kawa Whakaruruhau is currently under review by the Nursing Council (2025), it is arguable that the legacy of cultural safety and its discourses will remain in nursing in Aotearoa NZ.

Using the more socially acceptable framework of multiculturalism, the integration of Kawa Whakaruruhau into the nursing curriculum and practice varied widely in approach. Without a Te Tiriti o Waitangi lens in the cultural safety definition, the power imbalances and colonial histories of Aotearoa NZ were negated, and negative stereotypes about Māori, such as having biological inferiority, continued to be the rhetoric (Papps, 2015; Richardson & Carryer, 2005). Interestingly, critical constructs of cultural safety, such as addressing colonisation and the impact on the health and well-being of Indigenous peoples, are often omitted from nursing education courses by educators to avoid conflict (Bourque, 2020). The shift from Kawa Whakaruruhau to a diversified cultural safety framework was also to remove the focus off Māori and onto the health service and/or nurse (Ramsden, 2002). However, the non-negotiables identified by Ramsden in 1996, in response to the 1995 Select Committee review, asserted that Kawa Whakaruruhau would remain the name of the concept, and Te Tiriti o Waitangi would be the foundational document for understanding power dynamics in Aotearoa NZ.

Te Tiriti o Waitangi underpins Kawa Whakaruruhau and is foundational to conceptualising and delivering culturally safe care to whānau Māori (Barton, 2018; Blackmore-Tufi & Taylor, 2022; Doutrich et al., 2012; Ramsden, 1990). Specifically, the concepts of tino rangatiratanga and equity underpin Kawa Whakaruruhau (Hunter et al., 2021; Ramsden, 1990). Moreover, Te Tiriti o Waitangi is central to understanding ongoing

colonialism and power dynamics evident in the Aotearoa NZ health system, including in the nursing profession (Ramsden, 2002; Richardson, 2021). Therefore, how can nurses understand Kawa Whakaruruhau if Te Tiriti o Waitangi does not underpin the concept?

Conceptual clarity is identified as a significant challenge to implementing cultural safety in nursing practice and education globally (Best et al., 2022; Hulko, 2021; Lock et al., 2021). Although similarities in definitions are evident in the literature, international sources identify a range of definitions and defining features of cultural safety, which can pose a cultural risk to those it is supposed to protect (Lock et al., 2021). For example, Lock et al. (2021) found that there is limited evidence of an Aboriginal Australian 'voice' in the definitions of cultural safety theyreviewed in Australian health and social policy. Similarily, Bourque (2020) stated that the rapid influx of cultural safety guidelines by various Canadian nursing organisations has led to inconsistency in the definition of cultural safety and its delivery in nursing education. Importantly, the cultural safety of Indigenous people receiving healthcare needs to be conceptualised and led by Indigenous people (Gifford et al., 2022; Power et al., 2021a). However, it is the responsibility of the entire nursing workforce (Power et al., 2021b). In Aotearoa NZ, Kawa Whakaruruhau was a framework conceptualised by Indigenous nurses, but pressure from the dominant population led to it being changed to suit their agenda.

Nursing Education and Practice

Nursing education and professional development are key to the future of Kawa Whakaruruhau. Various factors limiting the integration of Kawa Whakaruruhau and cultural safety for Indigenous peoples into nursing practice have been identified in the nursing literature. Firstly, the development of an effective and consistent curriculum is required to make an impact on cultural safety nursing education (Bourque, 2020; Cox & Best, 2022). Secondly, the ability of non-Indigenous nursing educators to teach cultural safety has been challenged by Indigenous nursing educators, including their ability to teach Indigenous perspectives (Best et al., 2022). However, Power et al. (2021b) make an important point that although Indigenous nursing educators need to lead the ongoing development of cultural safety in Indigenous contexts, cultural safety is the collective responsibility of all nurses and nurse educators. On an institutional level, the socialisation of nurses, during nursing education, into a neoliberal university and healthcare system is identified as a challenge to the development of cultural safety (De souza, 2022). The worldview underpinning tertiary and healthcare systems is manifested by nurses in interpersonal interactions (Cox & Best, 2022). The dominance of Western values, knowledge, and beliefs in nursing education and practice

restricts the authentic integration of Kawa Whakaruruhau into nursing practice (Miller et al., 2025; Smye et al., 2006). Therefore, and perhaps most importantly, the enduring myth of health care being culture-neutral and the blindness to whiteness in society limits the authentic application of cultural safety education in nursing (Best et al., 2022).

Literature has established that Māori do not always receive culturally safe nursing care despite the assumption that nursing is a culturally safe workforce (Hunter et al., 2021; Komene, Pene, Gerard et al., 2023; Wilson et al., 2022). In general, the systemic processes that prevent the authentic implementation of Kawa Whakaruruhau into nursing practice and the healthcare system need to be explored and challenged to deliver culturally safe care for Indigenous people (McGough et al., 2022; Power et al., 2021b). As such, the nursing profession needs to critically reflect on its role in perpetuating health inequities for Māori, including culturally unsafe care (Wilson et al., 2022). Nursing in Aotearoa NZ "has lost its drive, commitment and direction for the vision of Kawa Whakaruruhau" (Manson, 2017, p. 30). Nursing leadership needs to move over and authentically commit to making space for Māori nurses and their leadership for the improvement of Māori health, including in the authentic integration of Kawa Whakaruruhau into nursing practice (Hunter & Cook, 2020; Power et al., 2021b; Wilson, 2023). As asserted by Māori nurses, it is time to move forward with a genuine commitment to Kawa Whakaruruhau in nursing practice in Aotearoa NZ, starting by defining and measuring Kawa Whakaruruhau in practice by Māori nurses (Ramsden, 1997; Wilson, 2023).

Conclusion

Kawa Whakaruruhau underwent a process of colonisation driven by a multicultural agenda and, in the process, has been diluted and distorted so that its original objectives have not been achieved (Ramsden & Papps, 1996). The public backlash early in its existence was a direct result of a colonial society feeling threatened by Indigenous peoples asserting a voice in the colonial health system, including nursing education. Thirty years on, the inequity evident in the Māori nurse workforce and relevant literature highlights culturally unsafe nursing education and workplace experiences for Māori remains (Blackmore-Tufi, 2023; Huria et al., 2014; NCNZ, 2019; Simon, 2006). A gap in the literature exists regarding whether Papps and Ramsden's (1996) objectives for Kawa Whakaruruhau have been achieved for Māori nurses. Moreover, clarity around the conceptualisation of Kawa Whakaruruhau is required if it is to underpin nursing practice in the new Nursing Council's (2025) competency framework. Therefore, this research explores the influence of Kawa Whakaruruhau on Māori nurse

practice and its conceptualisation as a nursing practice. The research is essential because understanding a culturally safe work environment that supports the retention and professional development of Māori nurses is crucial for achieving an equitable workforce and, in the broader sense, improving Māori health outcomes. Nursing, as the largest health professional body, is in a position to make a significant impact in the actualisation of culturally safe health services for Indigenous people (Stout & Downey, 2006).

Chapter Three: Methodology

This chapter discusses Kaupapa Māori Theory, which underpins the research. A brief history of the formalisation of Kaupapa Māori Theory provides the context for its evolution in academia. A decolonising approach is utilised throughout the chapter to actively expose and challenge Pākehā hegemony in research involving Māori. Next, the core values, principles, and underlying assumptions underpinning the research are discussed. Māori ethics for research are outlined, and a description of how Māori ethical expectations were met in this research project is provided. The rigour of the study is established using a Kaupapa Māori framework, which challenges the researcher to engage with Kaupapa Māori literature to ensure that the researcher's ideas align with what has already been established by Māori scholars. Next, the Kaupapa Māori research methods are outlined, and a detailed explanation of how each method was used is provided.

Kaupapa Māori Research

This research used a qualitative research design with a Kaupapa Māori methodology. Kaupapa Māori Theory underpins Kaupapa Māori research. During the 1970s and 1980s, resistance to the impact of colonialism on te reo Māori, tikanga Māori, Māori culture, and mātauranga Māori grew (Smith, 2017; Walker et al., 2006). Although the philosophies underpinning Kaupapa Māori Theory are not new, the need to formalise its conceptualisation arose in response to a triad of social and political movements. First, following the formation of the Waitangi Tribunal in 1975, space for Māori grievances to be heard by Aotearoa NZ society was created. Cases heard by the Waitangi Tribunal required the articulation of grievances through a Kaupapa Māori lens. It is essential to note that the findings and recommendations made by the Waitangi Tribunal remain non-binding. Second, revitalisation programmes in Aotearoa NZ, such as kohanga reo (language nest), required theoretical frameworks to guide the Kaupapa (Durie et al., 2012; Walker et al., 2006). Third, the international reclamation of indigeneity led to identifying what is te ao Māori, what had been colonised, and what reimagining te ao Māori in colonial Aotearoa NZ looks like.

The foundational construct of Kaupapa Māori Theory is the legitimisation of te ao Māori (the Māori world). Before colonisation, te ao Māori was the normative philosophical worldview of iwi, hapū, and whānau living in Aotearoa NZ. Although Māori is a colonial term constructed to describe the native people living in Aotearoa NZ as a homogeneous group, there is a general Māori worldview that is consistent throughout iwi, hapū, and whānau histories. However, it is essential to note that Kaupapa Māori Theory asserts that

kawa and tikanga (customs and protocol) vary amongst iwi, hapū, and whānau, and to assume that one-size-fits-all for Māori aligns with colonial discourse (Pihama et al., 2002).

Further, Kaupapa Māori Theory critiques and challenges Pākehā hegemonic constructs that marginalise and oppress Māori (Pihama et al., 2002). Kaupapa Māori Theory fights for 'methodological space' to co-exist equally with Western methodologies. As Pihama et al. (2002) argued,

> Kaupapa Māori Theory is a politicising agent that acts as a counter-hegemonic force to promote the conscientisation of Māori people, through a process of critiquing Pākehā definitions and constructions of Māori people and asserting explicitly the validation and legitimation of te reo Māori and tikanga. (p. 57)

Kaupapa Māori research is research conducted by Māori, with Māori, for Māori (Smith, 2015). As this research focuses on Māori nurses and Kawa Whakaruruhau, a Kaupapa Māori research methodology has been utilised to align with the kaupapa (plan, purpose) of the research in two ways: Kawa Whakaruruhau is a legitimate Kaupapa Māori nursing theoretical framework for practice and has undergone colonisation by Western concepts such as diversity and multiculturalism; Kaupapa Māori research is the most culturally safe methodology to explore the conceptualisation and impact of Kawa Whakaruruhau on Māori nurses' practice.

Historically, research on Māori has been exploitative of Māori culture, language, and resources (Mahuika, 2008). Western research has justified socio-political constructs that led to the social exclusion and 'othering' of Māori within their land, including the national health system (Smith, 2021). Therefore, Smith's (2021) decolonising approach was central to the research process, ensuring that a Māori way is privileged at every step of this research. Each pūrākau was analysed accurately through a te ao Māori lens to produce meaningful results that aim to benefit the Māori nursing community. As such, Māori ethics, principles, and values guided the development and implementation of the research to ensure that the mana of each participant, the wider research team, Māori nursing, and Kawa Whakaruruhau were upheld and treated with the utmost respect and aroha. Kaupapa Māori methods have been used exclusively throughout this research process.

Research Principles

In addition to aligning with the ethical principles outlined by the Auckland University of Technology Ethics Committee, Smith's (2015) five Kaupapa Māori research principles underpinned the research: whakapapa, te reo Māori, tikanga Māori, rangatiratanga, and mana

wāhine-mana tāne. The principles have been constructed from five significant struggles that Māori have endured in colonial Aotearoa NZ.

Whakapapa

Whakapapa has been disrupted by colonialism; for example, the relegation of pūrākau to the realm of myths and legends (Lee, 2009; Smith, 2021). Within this research, whakapapa is applied in two different ways. The first is the assertion of the individual as an integral part of an iwi, hapū, or whānau collective; and then as part of a heterogeneous group, collectively called Māori (Mahuika, 2008). This challenges the individualism that exists in a Western worldview that misaligns with the collective reality in te ao Māori. Secondly, whakapapa is recognised as the foundation of mātauranga Māori. As such, whakapapa was applied as a methodology for exploring Kawa Whakaruruhau and Māori nursing in Aotearoa NZ (Graham, 2009).

Te Reo Māori

Referring to the Māori language, te reo Māori is a taonga and vector of transmitting mātauranga Māori (Māori knowledge systems or experiences of the world). Te reo was utilised throughout the research where appropriate. Māori concepts are often 'lost in translation' when translated to English, so loose translations are provided, but are limited by English.

Tikanga Māori

'The right way', denoting customs and practices informed by mātauranga Māori. Aligning with a decolonising approach, an exploration of the implications of colonialism on tikanga Māori reinforced the importance of privileging te ao Māori throughout the research. Ethical practice in Māori research stems from tikanga (The Pūtaiora Writing Group, 2015). By using a Kaupapa Māori methodology, it was assumed that tikanga would be incorporated into the research. According to the Pūtaiora Writing Group (2015), "Tikanga also provides a framework through which Māori can actively engage with ethical issues and consider the effect research may have on their values or relationships" (p. 2). Aligning with this concept, the focus of the research changed once it was brought to life and implemented into the Māori nursing community. As such, the feeling of accountability to participants, my supervisors, and the wider nursing community increased for me. At this point, I was able to lean on our tikanga (and my whānau) to ensure that the mana of the research whānau, including my own, and the mana of Kawa Whakaruruhau and Māori nursing were upheld. The Māori values that underpin conduct and tikanga during the research process are outlined in Table 4.

Table 4.

Māori Research Principles

Principle	Meaning
Aroha ki te tangata	Respect, care, and love for participants in this research.
Kanohi kitea	'The seen face'. A researcher who is known to and authentically engages with the research community.
Titiro, whakarongo… kōrero	Look and listen, then speak. Humility is a highly respected value in te ao Māori.
Manaaki ki te tangata	Providing hospitality and care for research participants and upholding their mana through demonstrations of gratitude, respect, manaakitanga, and care.
Kia tupato	Proceeding with caution by incorporating the principles of Kawa Whakaruruhau into research, Te Tiriti o Waitangi serves as the framework for examining the position of tangata whenua in Aotearoa NZ, including access to mātauranga Māori and Māori aspirations such as tino rangatiratanga and hauora Māori.
Kaua e takahia te mana o te tangata	Never trample on the mana of the person/whānau. Conducting research methods that uphold the mana of the research whānau. Understanding that knowledge is taonga and being imparted to oneself as a reciprocal act of generosity
Kaua e mahaki	Be humble in all of your conduct.

Source. Pipi et al. (2004)

Rangatiratanga

Rangatiratanga was preserved by tūpuna in Te Tiriti o Waitangi. Rangatira Māori knew that tino rangatiratanga was fundamental to Pae Ora (healthy futures) for mokopuna (Pihama, 2020). As explored previously, the intentional disruption of rangatiratanga was necessary to assert colonial dominance. Socio-political strategies to establish and cement the colonial agenda relied on undermining rangatiratanga. Rangatiratanga loosely translates to self-determination, access to and autonomy over resources, including hauora and mātauranga Māori, as outlined in Te Tiriti o Waitangi and He Whakaputanga. As Ramsden (1990) asserted, Kawa Whakaruruhau is underpinned by the notion of rangatiratanga over taonga, such as hauora, as a birthright of tangata whenua.

This research asserts rangatiratanga by drawing on mātauranga Māori by accessing the work of Māori theorists and scholars, Māori supervisors, Māori participants, and previous Kaupapa Māori research and research methods. The use of Kaupapa Māori methods increases

the validity of findings as the data are gathered and analysed through a culturally congruent lens. Beneficial and tangible research outcomes are both an ethical expectation and fundamental to Kaupapa Māori methodology (Smith, 2017; The Pūtaiora Writing Group, 2015). By using Kaupapa Māori methodology, it is assumed that the findings will provide an accurate portrayal of how Kawa Whakaruruhau has impacted Māori nurses' practice, aligning with rangatiratanga. On an interpersonal level, I strived to be flexible and adaptable during participant interviews and when contacting them. Additionally, I considered the participants' preferences for location and mode of interview. In both examples, the aim was not to impose on participants and to let them choose the time and spaces that worked best for them.

Mana Wāhine-Mana Tāne

This principle asserts that research methodologies and conduct need to uphold mana of wāhine Māori (Māori women) and tāne Māori (Māori men). Central to this concept is understanding the impact of previous research on wāhine and tāne, including the colonisation of gender and gender roles in te ao Māori. As Simmonds (2011) noted, "Historically, our difference(s) have been defined for us, usually by non-Māori men but also by others, and have been defined predominantly in negative terms. That is, that Māori were/are different, and therefore somehow lacking, because they were/are 'not white'" (p. 11). Mana Wāhine-Mana Tāne became the fundamental concept underpinning how I conducted the research as it unfolded. First, I quickly realised how 'small' the Māori nursing community is, so humble and respectful conduct is essential as a researcher to meet ethical expectations from both Western and te ao Māori perspectives. I have discussed this further in the participant recruitment section. Second, mana has been the theoretical basis for understanding the objective of Kawa Whakaruruhau in nursing practice (discussed Chapter 6; Poutama Whā). In terms of the research process, the relational aspect of this research became the foundation of my ethics and conduct as a researcher. The relationships between me, the participants, and the wider Māori nursing community were the overarching construct that determined my conduct and research practice.

Exploring the whakapapa of Kawa Whakaruruhau led to a deeper understanding of the concept, which is currently limited by the definitions of cultural safety. Kawa Whakaruruhau is embedded in the ontological realities of te ao Māori, which includes, but is not limited to, living with and making sense of the socio-political and historical contexts of colonialism (Ramsden, 1997); as well as examining the concept of mana, specifically what it is and how one comes to obtain it. Kawa Whakaruruhau upholds the mana of tangata whenua by asserting Māori rights to rangatiratanga over one's health, as equal partners in Te Tiriti o

Waitangi, and holds tangata Tiriti to account in the context of Māori health and building an equitable Māori nursing workforce (Ramsden, 1990). On a systemic level, Kawa Whakaruruhau challenges the nursing profession to lead the way in exploring and exposing the power imbalances in the current health system (Wilson, 2023). On an interpersonal level, Kawa Whakaruruhau requires nurses to engage in regular self-reflection to unpack their own biases and assumptions and to explore how these may impact the nurse-whānau relationship, thereby upholding the mana of the individual and whānau.

Reflective Practice

The following reflective questions are identified by Smith (2015) as fundamental when constructing research using a Kaupapa Māori methodology:

1. What research do we want to carry out?
2. Who is that research for?
3. What difference will it make?
4. Who will carry out this research?
5. How do we want the research to be done?
6. How will we know it is a valuable piece of research?
7. Who will own the research?
8. Who will benefit? (pg. 48)

Smith's eight questions guided my reflections made during the development and completion of the research. Most significant to me, or most often reflected on, was the question 'Who is the research for?' Upon listening to the pūrākau of the participants, I saw my research proposal 'come to life'. I experienced a shift in the purpose of the research, from being about myself and my 'research proposal' to being about a broader movement among Māori nurses; that is, equitable healthcare for whānau Māori embedded in Kawa Whakaruruhau. During the completion of this research, I have made many new connections with Māori nurses, and it is clear that there is a drive to authentically establish Kawa Whakaruruhau in nursing so that whānau Māori can access safe and quality healthcare.

Ethics

Historically, research with Indigenous people has had a devastating effect on the portrayal of Indigenous peoples by society in general, including the decimation of Indigenous knowledge systems. As Smith (2006) asserted,

> For Indigenous and other marginalised communities, research ethics is, at a very basic level, about establishing, maintaining, nurturing reciprocal and respectful

> relationships, not just among people as individuals, but with people as collectives, as members of communities and with humans who live in and with other entities in the environment. (p. 10)

Ethics for research with Māori needs to be centred around establishing a connection that is pono (true) and tika (done the right way), as well as considering the socio-historical context of the research, including ensuring beneficial outcomes for the community that participated. Te Ara Tika (Ethical Guidelines for Research with Māori), developed by the Pūtaiora Writing Group (2015), were implemented to ensure that the research aligned with Māori ethics. The key Māori concepts highlighted in the guidelines for best practice for Kaupapa Māori research with Māori are:

- *Tika (design)* – The tika of this research is a Kaupapa Māori design. Kaupapa Māori research is highlighted in Te Ara Tika as the 'gold standard' for Māori-focused research, primarily to ensure the validity of the study and the relevance of the findings to the community of interest.
- *Kaitiaki (guardianship)* – Māori are the kaitiaki of this research. Both supervisors and I are Māori.
- *Māhaki (extending beyond cultural safety)* – This principle is about the humble and respectful conduct of the research team, and ensuring that mātauranga Māori is the lens and knowledge base for developing and conducting research. A decolonisation approach during reflection and revision on this work ensured that te ao Māori remained the lens through which all decision-making, analysis, and writing took place.
- *Mana Whakahaere (sharing of power and control)* – This research is by Māori, with Māori, for Māori. The research methodology utilised Māori principles, values, and methods.

Essentially, this is 'by Māori, for Māori, with Māori' in which Māori are the kaitiaki (guardians) of the research. I, the researcher, and both of my supervisors are Māori. The outcomes of this research are intended to primarily benefit Māori nurses, with the overarching objective being to contribute to Pae Ora (healthy futures for whānau), which upholds the ethical principles of māhaki and mana whakahaere (MOH, 2020).

Pūrākau - A Kaupapa Māori Narrative Inquiry

Lee's (2009) pūrākau as a Kaupapa Māori narrative inquiry in qualitative research was the method used in this research. Pūrākau is one form of Māori narrative or storytelling that is

"an expression of Māori experiences" (Lee, 2009, p. 4), and a vector for mātauranga Māori (Māori knowledge systems) to be imparted from generation to generation, providing guidance (Mikahere-Hall, 2017). Pūrākau has two components: *Pū*, meaning root; and *Rākau*, meaning tree (Waretini-Karena, 2014). The literal translation of pūrākau is described by Lee (2005) as an appropriate representation for characterising whānau relationships in te ao Māori. Grounded by the roots in the whenua, the rākau depicts the interdependence of whānau relationships.

Pūrākau derives meaning from historical and contemporary realities of whānau, where "relationships and connections to our social circumstances are shared" (Mikahere-Hall, 2015, p. 152). Traditionally, pūrākau are used to relay histories, experiences, and convey subtle meanings and wisdom for iwi, hapū, and whānau to draw upon (Waretini-Karena, 2014). Pūrākau is increasingly used in educational and social services practice as a research methodology. Within a research context, pūrākau is a Kaupapa Māori approach to capturing participants' narratives in a "culturally relevant" way (Mikahere-Hall, 2015, p. 155).

Historically, pūrākau have been colonised by Western ideologies, which have altered their meaning for Māori (Waretini-Karena, 2014). Pūrākau have been relayed in Western institutions, such as schools, to depict the Pākehā view of Māori, such as Māori as a homogenous group with one pūrākau for all iwi and pūrākau as mere mythology (Lee, 2009). As asserted by Lee (2009), "Kaupapa Māori can be viewed as a Māori expression of a decolonising methodology and central in reclaiming pūrākau as a narrative inquiry that is not only appropriate but is a legitimate way to represent and research our stories" (p. 5). As this study aimed to capture the narratives of Māori nurses' conceptualisation of Kawa Whakaruruhau and personal nursing practice, Pūrākau is an appropriate method for capturing the realities of Māori nurses in a culturally congruent way (Lee, 2009).

Methods

Participants

Eligibility to participate in this research included RNs who identify as Māori, who have 2 or more years of experience working as a RN in Aotearoa NZ, and who received their nursing education in Aotearoa NZ. The eligibility criteria were designed to recruit participants who had received Kawa Whakaruruhau or cultural safety education during their nursing education, ensuring they were aware of the concept. Moreover, the participants needed to have at least 2 years of clinical experience as an RN to have the necessary expertise to draw upon when exploring the impact of Kawa Whakaruruhau or cultural safety on their clinical

practice. RNs were recruited due to the scope of practice that explicitly requires culturally safe nursing care as a standard of competence. For ethical reasons, exclusion criteria to participate in this research included no:

- immediate whānau or current students of the primary researcher,
- person who was unable to give their informed consent due to a medical reason (e.g., severe disability)
- person who completed their nursing education at an overseas institution
- RN who had not held an Annual Practising Certificate in the past 5 years
- enrolled nurses

The majority of participants had been practicing between 6 and 20 years. Nineteen participants held a Bachelor of Nursing qualification and the majority had either cultural safety or Kawa Whakaruruhau and cultural safety training. Only one participant was from the South Island, the remainder spread across the North Island. Participants were practicing across a range of specialities. A summary of the 21 research participants is shown in Table 5.

Participant Recruitment and Data Collection

Rewi's (2014) article outlined whanaungatanga as a method for participant recruitment in Kaupapa Māori research and was utilised as the framework for participant recruitment in my study. Whanaungatanga aligns with Kaupapa Māori theory. At the centre of Kaupapa Māori philosophical approaches is whānau (Smith, 2015), the foundation of Māori society. Traditionally, whānau referred to "extended family, family group, a familiar term of address to several people - the primary economic unit of traditional Māori society" (Te Aka Māori Dictionary, 2025, para. 2). Modern application includes people (unrelated) who share a common interest or purpose. Within the research context, whānau refers to a "metaphoric whānau" (Rewi, 2014, p. 4) who are connected by kaupapa (the research).

Using a whanaungatanga approach to participant recruitment privileges te ao Māori societal structures (the whānau) as the foundation of this research. Referring to the research team (including participants) as a research whānau holds the researcher accountable for upholding Māori ethical standards and tikanga. The concept or value of kanohi kitea (the seen face) highlights the importance of the researcher being known to the research whānau. Participants were recruited through word-of-mouth and pānui via my networks within the Māori nurse and health community, including non-Māori contacts. Ngā Pae o Te Māramatanga (NPM) also advertised the research on their platform. Various participants stated who our connection was when we made contact. During the first phase of the

interview, some participants discussed nurses we both knew, who were held in high regard and identified as allies to Māori, demonstrating a reciprocal and trusting relationship with our mutual contact.

Table 5.

Demographic Data of the Research Participants

Years registered as a nurse	Number (n)	Type of nursing education in Aotearoa New Zealand	Number (n)
1-5 years	3	Hospital-based	0
6-10 years	6	Diploma of Nursing (Polytech)	1
10-20 years	7	Bachelor of Nursing (Polytech or University)	19
20-30 years	1	Bridged from enrolled to registered nursing	1
30 years +	2		
unsure	2		
Nursing Education Type	**Number (N)**		
Kawa Whakaruruhau	0		
Cultural Safety	7		
Both – Kawa Whakaruruhau and Cultural Safety	9		
None	3		
unsure	2		
Practice Location	**Number (n)**	**Current Practice Speciality**	**Number (n)**
Northland	6		
Auckland	6	Adult health-acute	1
Waikato	2	Community (Western-based)	6
Bay of Plenty	1	Community (Kaupapa Māori)	5
Wellington Region	2	Mental health (Western-based)	1
Otago	1	Nursing Leadership	3
Hawkes Bay	2	Nursing Education	4
Whanganui	1	Nursing Research	1

The sense of whanaungatanga was strengthened by the familiarity of Māori nurses with my supervisors (whose names were stated on the Information for Participants Sheet and the Consent Form). Some participants had personally met my supervisors throughout their career, and others had 'heard the names' through the nurses' grapevine or within te ao Māori. This familiarity or *kanohi kitea* (the seen face) is a core value of Kaupapa Māori research. Although I was unknown to most of the participants, the connection we had was built on the relationships they had with our mutual nursing connections. As such, *kaua e takahia te mana*

o te tangata (don't trample on the mana of the people) underpinned my conduct during this process. I was aware of the relationship between the participants and our mutual contacts, which increased my sense of accountability to multiple parties. These values do not require deep thought or active application during the research process; they are inherent to Māori conduct, and I had the privilege of watching such behaviour my whole life through my father and whānau.

Expressions of interest from Māori RNs started the day the research pānui was advertised. Primarily, I was contacted by potential participants via email, and I received one phone call. Potential participants were sent a reply email with a copy of the Information Sheet for Participants (Appendix C) attached. I stated that I was happy to answer any queries they may have and to contact me again if they wished to proceed. If they expressed a desire to proceed as a participant, I forwarded an email with a consent form (Appendix D) to them and asked what their preferred location, dates, and times for an interview were. I suggested kanohi-ki-te-kanohi for interviews and advised each participant that I would travel to their area if they wished. Virtual interviews were offered if requested by the participant due to logistical reasons, such as work timetables and work travel.

For those who initially expressed interest but did not reply to my first email, I sent a follow-up email to 'check in' and see if they had any queries or comments regarding the research. If there was no further response, I did not contact them again. I ended up with a total of 23 participants. All participants completed their interviews, except two, whom I was unable to contact again as initially organised. In both cases, I emailed the participants to confirm days and times for their interviews, but I received no response.

Whanaungatanga (the establishment of relationships) is built by a reciprocal demonstration of pono (truth, honesty, integrity); aroha (care, love, respect); and manaakitanga (generosity, care for others, hospitality) as the researcher and the participants work together for a common goal (Rewi, 2014). Whakawhanaungatanga is "the process of establishing relationships, relating well to others" (Te Aka Māori Dictionary, 2025, para.1) and in the research space, it is required that appropriate consultation and transparency with the community about the aims, outcomes, and intended actions of the research is undertaken.

Data Collection

I travelled to the location of 16 participants. The locations included Whangārei, Auckland, Wellington, Hamilton, Whangānui, and Tauranga. All the kanohi-ki-te-kanohi interviews were done at the participants' workplaces in boardrooms or interview rooms organised by the participants. Kanohi-ki-te-kanohi interviews were the preferred method for the interview, as

they align with the concept of whakawhanaungatanga and Māori relational practices (Mikahere-Hall, 2017). However, virtual interviews were completed via Microsoft Teams for five participants due to logistical reasons, such as working hours or childcare requirements.

Data collection started with whakawhanaungatanga. Karakia was offered before the beginning of all interviews. Research participants engaged differently with karakia, with half taking up the offer. Others expressed that their day had already begun in this way and had therefore accepted the blessing bestowed by the earlier karakia. I spent 30-60 minutes talking with participants before the interview started. I was mindful that participants were taking time out of their day, including a workday, to participate in this research, so I started by asking if there was a specific time limit. Next, the conversation turned to their nursing careers, their interest in this research, and their experiences as Māori nurses.

Various participants expressed their desire to have 'Māori nurses' voices heard' by the wider nursing body in Aotearoa NZ regarding Kawa Whakaruruhau and the unfair conditions still disadvantaging whānau using the health system. Time was taken to discuss the service that each nurse was working in, so there was an appropriate context for the interviews. I did not record this period of engagement as it is not tika to jump straight to the purpose of the encounter without establishing a connection first, nor was it pertinent to the aim of this research. See Appendix E for examples of the research questions. I was often introduced to other team members (who were not participants) as well as a couple of team leaders and managers. I expressed gratitude to various team members for allowing me into their space during their busy workdays. If interviews were in a participant's break time, I offered to bring in kai (food). Some of the participants humbly accepted. At other times, interviews were scheduled for early in the morning, so participants declined the kai as they had recently eaten.

All the interviews were recorded on a dictaphone and transcribed verbatim by me and a transcriber (see Appendix F for the confidentiality agreement). Once the transcription of each interview was completed, I emailed a copy to the research participant for their approval of the accuracy. Identifying factors, such as workplace details and names were removed during the transcription process. All transcripts were forwarded for secure storage at AUT (as per protocol). All audio recordings were deleted as soon as the transcripts were prepared and checked for accuracy. One participant requested a large amount of her pūrākau be removed because the case she discussed was a rare occurrence in her workplace. I deleted any reference to that case from her transcript.

During the data collection phase, the idea of mutual benefit sharing solidified for me, and I stopped referring to this research as 'my' research. I would instead thank the

participants for their participation in ‘this’ research. Referring to research generically instead of individually was an acknowledgement of the collective effort Māori nurses undertake daily to improve the health outcomes for whānau Māori, and acknowledging the significant contribution each participant's pūrākau made to the overall research project. Additionally, I wanted to acknowledge that Kawa Whakaruruhau is a Māori nursing theoretical framework, intended for Māori nurses collectively. As stated by one of the participants, “*We are all on the same waka*”. This thesis is another piece of evidence to add to Māori nursing research kete, supporting the cause for re-establishing Kawa Whakaruruhau in nursing practice. Therefore, it is one project that is part of the larger movement in Māori nursing at present.

Using a Kaupapa Māori methodology implies that tikanga Māori will be incorporated into the research process (Rewi, 2014). Rewi (2014) stated that tika or tikanga “means using the correct, right or most suitable way applicable to any given situation, often dictated by an inner knowing or gut feeling” (p. 244). Whakawhanaungatanga was essential for upholding tikanga. I was guided on how to uphold tikanga through my understanding, checking with my whānau members, reflecting on the conduct of our kaumātua, and consulting with my research supervisors.

Koha

Koha is a noun and denotes a “gift, present, offering, donation, contribution - especially one maintaining social relationships and has connotations of reciprocity” (Te Aka Māori Dictionary, 2025, para. 1). Turei (2024) described koha as part of the visual language that transmits and communicates Māori customary protocols and lore, based on tikanga and values such as reciprocity. Within the context of research, koha is given to symbolise gratitude for the participant’s time and willingness to share their pūrākau; and I also wanted to express my gratitude for allowing me into their workspace and taking the time to accommodate me. Due to research ethics, large amounts cannot be given to avoid coercive practices; as such, NZ$60.00, the form of a Pressie Card (voucher), per participant was gifted. I presented this during whanaungatanga at the start of the interview. To denote that each participant's pūrākau was appreciated and valuable even before hearing it. The koha was accepted graciously by all the participants, except one, who felt she could not due to her employer’s policies around accepting gifts.

Data Analysis

The pūrākau were analysed using Mikahere-Hall’s (2015) Te Āta-tu Pūrākau Kaupapa Māori method for data analysis of Pūrākau. Te Āta-tu Pūrākau is aligned with the methodology and

allows for an in-depth exploration of the multidimensional aspects contained within pūrākau. A robust analysis of each research participant's pūrākau was completed. Te Āta-tu Pūrākau analysis method appreciates the subtle "shifts that occur through the telling and unfolding of one's Pūrākau; that in telling and sharing, inspiration and understanding are found" (Mikahere-Hall, 2015, p. 163). Mikahere-Hall has developed a 5-step poutama (stepped pattern) analysis method, designed to be accessible and structured for Māori researchers using pūrākau as a narrative inquiry method. "The differing dimensions of each poutama are spatial, relational and time dependent, such as *i te wā* (in time), capturing the philosophical fundamentals of an interconnected Te Ao Māori worldview" (Mikahere-Hall, 2024, slide 42). As identified in the findings chapters, the themes sometimes interlink and overlap, denoting that the 'Te Āta-tu Pūrākau' is not always linear but a dynamic process for uncovering the meaning within a pūrākau (Mikahere-Hall, 2017).

The five poutama consist of:

1. *Poutama tahi*: structural – the 'sequential nature' of the story. This layer is concerned with the context, setting, time period and place to which the pūrākau refers. It explores the social layer of the pūrākau.
2. *Poutama rua*: explores the relational layer of the pūrākau. The position of the storyteller in various dimensions or contexts is examined, including in relation to other people or organisations.
3. *Poutama toru*: explores the feelings connected to the various dimensions/parts of the pūrākau. This layer analyses the emotional content of each pūrākau.
4. *Poutama whā*: the researcher provides an interpretive illustration and thus 'adds a layer of meaning' received from the pūrākau. This poutama is presented as the discussion chapter in this thesis.

   Poutama rima: the spiritual content within the pūrākau is identified and acknowledged. Wairua (spiritual) content reflects the participant's beliefs as expressed in the pūrākau, highlighting the significance of the holistic nature of hauora (health) for the participant.

Data Analysis Process

To utilise Te Āta-tu Pūrākau data analysis framework, each pūrākau was read and re-read and coded into colours to represent each of the differing poutama dimensions. Then, the excerpts describing the context of each poutama were copied and pasted into the data analysis table (see Table 6 as an example). A data analysis table was completed for each of the participant's pūrākau. Following the completion of the individual data analysis, an overall analysis was

performed, examining the themes from each poutama across all of the tables. Themes were grouped into main themes and then sub-themes.

Table 6.

Data Analysis Table Using Te-Āta-tu Pūrākau

Participant Pūrākau	Poutama tahi: Social analysis	Poutama rua: Relational analysis	Poutama toru: Emotional analysis	Poutama whā: Interpretive analysis	Poutama rima: Wairua hauora
Participant 8 Pūrākau	"I've been to non-Māori general practices too… the comparison is scary [compared to Kaupapa Māori practices]"	"As in you feel safe to use the language and the faces are familiar when you're within a Māori health provider and culturally you're taken care of".	"Especially Māori nurses they, they, they are happy or they're settled because their culture, their wairua is settled in those spaces. Do you know what I mean?"	Kaupapa Māori health practice - Te ao Māori space is safe and promotes a settled trusting feeling for Māori nurses' Identity protected	"Because that takes care of our wairua, our taha tinana, our taha whānau, everything to do with our identity"

Rigour

Study rigour was established using Smith's (2017) five elements for measuring the "veracity of a Kaupapa Māori Project approach" (p. 8). In the 1980s, Kaupapa Māori philosophy emerged out of a self-development revolution through the conscientisation of the Māori people. At that time, Smith argued that the Māori mindset shifted from a reactive state to a proactive one, and asserted that utilising a Kaupapa Māori approach means that the research can be translated into transformative practice. As such, it is essential to move from achieving self-determination as an outcome to becoming self-determining. Smith's approach is underpinned by principles that position tino rangatiratanga (self-determination) and Māori aspirations as the objective when applying a Kaupapa Māori approach to research or practice, ensuring that it is transformative and beneficial to Māori. Therefore, the veracity of a Kaupapa Māori project is fundamental to the rigour of a Kaupapa Māori study. A more comprehensive description of the five criteria of the framework follows, including an outline of how each criterion was integrated into this thesis.

Positionality

Researcher reflexivity is paramount to the rigour of the project and increases the researcher's accountability to the community (Marquez, 2022). Smith (2017) challenged the researcher to reflect on their location in time and space concerning the project, including how the

researcher's prior experiences and knowledge base contributed to this research area. Therefore, the explication of the researcher's positionality is foundational to research that is pono and tika and grounded in an Indigenous context.

Ko Wai Au? – An Insider's Pūrākau

I am from Ngati Raukawa and I am a descendant of Irish and Scottish immigrants to Aotearoa NZ. Walking in both Māori and Pākehā worlds is both a challenge and a source of strength and aroha. Within te ao Māori, I used to feel like I was on the periphery. The same could be said about the Pākehā world—never Māori enough and never fully Pākehā. In my Pākehā whānau, we were the 'part-Māori' cousins. In my Māori whānau, I was a Pākehā-like cousin. I could not speak te reo Māori, was not confident with tikanga, and have fair skin. While these characteristics do not mean that I am not Māori, the inability to kōrero Māori or look Māori resulted in me being labelled and categorised as 'not a real Māori' by the Pākehā world (Smith et al., 2021). That label stuck with me, and I found it easier to fit into society if I did not challenge this assumption. This was difficult as a young woman and caused me significant distress, but now I am a lot more comfortable in my skin and tend to view racism as coming from ignorance. I love my Māori and Pākehā whānau, and am proud of the type of people that they are.

I carried the pain associated with the stories of the experiences of my tūpuna. The stories were told to us as a reminder of the reality of the world we walk in as Māori. The pūrākau date back generations, and have remained in my heart. These pūrākau have given me the strength to stand up and speak when needed, while reminding me of the struggles Māori have been through. I have already passed these pūrākau on to my daughter and son. They also remind me that I have not faced the challenge of being judged by the colour of my skin. At times, I would be almost apologetic for standing up to racism against Māori and questioning the status quo rhetoric about Māori. Consequently, my Māori-ness was often called into question by the perpetrator, "Just how Māori are you?", "Really! Are you Māori? How much?" This behaviour exhibits biological determinism and socially assigned identity concepts that categorise Māori based on Pākehā ideals of what it means to be Māori, asserting power and delegitimising Māori grievances (Tinirau et al., 2021). At times, it was easier to say nothing and try to blend into the Pākehā world, while feeling like an outsider and an imposter as I walked around with the secret of being Māori.

I have reflected on my sites of privilege, which include my parents both being registered mental health nurses. I have never experienced being pulled over by the police or followed around in a shop by an assistant because of the colour of my skin, which are two

examples of all-too-common experiences for Māori (Tinirau et al., 2021). Although literature highlights that light-skinned privilege exists among Māori, it also presents its challenges (Tinirau et al., 2021). My challenges came when my 'Māori identity' was revealed to non-Māori, usually by someone else asking perpetrators of racism to stop as "Jenny is part Māori, you know". Not to mention times I have been called "Rangi" (a derogatory name for Māori) or friends' parents have said to them, "Oh, you better watch out for her then" because of my Māori ancestry. The problem with non-Māori categorising fair-skinned Māori as "not a real Māori" is that they assume you will hold similar opinions and the normalised racist views about Māori as they do. Furthermore, no matter how many times you tell them, "But I am Māori", they do not seem to understand that you and your whānau are the same as the Māori they ridicule on the television programme Police 10/7 or make jokes about (Tinirau et al., 2021).

One significant event for me that demonstrates the normalisation of racism I have experienced in Aotearoa NZ happened in 2014. My husband and I were at dinner at a restaurant, north of Auckland, on our honeymoon. When I was in the bathroom, David (my husband) heard people sitting next to us laughing about a joke someone just told. The joke was "how do you drown a Māori? Throw $5 in a river". Children were sitting at the table with these people. When I came back to our table, I noticed my husband was leaning over and saying something to the man who had just said this 'joke'. The man started swearing at David. David told him to stop being so disgusting with what he was saying, especially in front of kids! Nevertheless, the restaurant staff asked what had happened, and then we were asked to leave without any apology from the table. We were so shocked and upset, and all we could think about was my aunties and uncles who had been at our wedding, celebrating with us the day before.

After a few years away from school, I commenced my Bachelor of Nursing in 2007 and graduated in 2010. I am a RN and have worked in acute and community services in Christchurch, as well as West and South Auckland. Currently, I work as a nurse educator with nursing students, teaching Kawa Whakaruruhau and Hauora Māori in Wellington. I have seen, firsthand, the challenges facing Māori in obtaining health today and for healthy futures for their mokopuna. Although there is some improvement, such as the establishment of Kaupapa Māori services, a multi-layered, complex system continues to make access to health attainment challenging for Māori. I believe nursing, as a professional body, can make a significant impact in disrupting the system that limits equitable access to the resources

required for Pae Ora. I pursued postgraduate study in Māori health due to the racism I experienced or witnessed during my career as a nurse.

My experiences of living in constant hypervigilance for racism were every day for me. I experienced it throughout nursing education and my nursing career. I started to wonder how whānau must feel accessing health services riddled with racism, especially when they are vulnerable, physically or mentally, and need aroha. How can nurses and doctors show aroha to people whom they belittle and hold such negative opinions of?

As I reflect on the racism that I encountered from non-Māori as a child and young woman, including the early years as a RN, I realise that it is very much a deficit position to take, as I have centred on the racism experienced by Māori. It is essential to highlight that the racism was when I was out in the Pākehā world and was in stark contrast to my home life and experience of being Māori with whānau. As a middle-aged woman, I am confident in who I am now, so it is hard to fathom how much racism impacted my day-to-day life. Back in those days, I was often brought to tears by the hurtful dehumanisation of my father, grandmother, wider whānau, and myself.

I thank my Pākehā mother, who always said, "You are so lucky to be tangata whenua" and said other positive things about being Māori, such as "Māori are the best-looking race in the world". These comments were more powerful than the day-to-day racism that I experienced and had an overall bigger impact. My mother started working in Kaupapa Māori iwi-led services and would always share stories about the positive impact that these services were having for whānau. Her conclusion was "they have a healthier worldview"—referring to te ao Māori. I saw this worldview in action with my whānau. My father and my uncles are gentlemen—humble, modest, generous—and demonstrate Māori values in everything they do. The contrast between what I was told and witnessed at home and what society told me about being Māori was staggering. The stereotypes and negative portrayals of Māori, of me, were simply a falsehood. As I grew older, I became increasingly flabbergasted by the falsehoods about Māori normalised by society and the apparent impact they were having on whānau in need of professional, culturally safe healthcare. It was challenging to witness those who are most in need of quality health services being unable to access services that uphold their mana and their right to rangatiratanga over their health and the health of their whānau.

Given the above, I humbly state that my positionality in this research is as an 'insider', as identified by Smith (2006). Insider research is essentially research conducted with and for those who have been forced into the margins of society, including Indigenous

populations in colonial societies. The researcher is classed as a potential insider if they are from the community or population being researched. The 'margins' can be multi-layered and consist of various constructs of marginalisation, as described in intersectionality, such as for wāhine Māori (Smith, 2006). Therefore, it is essential to acknowledge the multifaceted nature of marginalisation for Māori nurses, and their intersections, particularly wāhine Māori. Researching in the margins validates the lived experiences of the various people who have been marginalised by white ideals of what it means to be human, including but not limited to people with disabilities, people with mental distress, LGBTQIA+ identities, non-nuclear families etc… An examination of the histories of people who do not conform to white ideals reveals multilayered oppression, especially for those who are indigenous.

Although nursing is a colonial institution, it is important to note that nursing, as a profession and as a body of knowledge, also has its history of "patriarchal oppression" (Matheson & Bobay, 2007, p. 232). Firstly, the female-majority workforce in nursing is one layer of oppression by the historically male-dominated medical profession (Van Herk et al., 2011). Secondly, nurses are typically viewed by the public as subordinates to the medical profession. As such, nurses have been viewed as doctors' assistants and practical, as opposed to theoretical, which was highlighted by Ramsden (1996) as one reason for the backlash against Kawa Whakaruruhau. Literature highlights that nursing has exhibited elements of Freire's (1970) theory of oppressed group behaviours, such as submissiveness, low self-esteem, horizontal violence, and possibly burnout (Daiski, 2004; Matheson & Bombay, 2007). However, it is important to acknowledge that there is a lack of research on Freire's oppressed group behaviour model in nursing (Matheson & Bobay, 2007). Nevertheless, the domination of the medical profession over nursing has led, in some situations, to the oppression being transferred by nurses onto patients, among themselves, and healthcare assistants (Daiski, 2004; Rooddehghan et al., 2015). Therefore, this research is conducted within the margins of a multi-layered and complex system of colonial constructs related to health, healthcare, women, and indigeneity. As asserted by Smith (2006), "when Māori researchers research 'with', 'for' and 'as' Māori, we are working within this multi-layered, multi-dimensional dynamic" (p. 5).

An "insider is a person who is in a position of privilege by way of a kinship relationship, immediate or extended. In this vein, being classified as an insider infers access to deeper levels of information. Or does it?" (Rewi, 2014, p. 246). Although insider research can "facilitate the expression of marginalised voices and that attempt to re-present the experience of marginalisation in genuine and authentic ways" (Smith, 2006, p. 5), there are

perceived limitations. The perceived limitations include lack of distance, lack of objectivity, mistaking the researcher role with an advocate's role, the possibility that participants give less detail in their responses as they assume that the researcher already knows the answer, and the possibility that the researcher's personal connection to the data can "retract" focus from the research processes (Rewi, 2014 p. 347). Therefore, robust theoretical underpinnings and methods are essential to conducting a rigorous research project from this insider position (Smith, 2006).

Criticality

A critical analysis of the context in which the project is conducted is necessary to support the veracity of a Kaupapa Māori project. Smith (2017) asserted that an in-depth understanding of colonisation, past and present, and the unequal power imbalances at play in Aotearoa NZ is crucial to the veracity of a project. Therefore, this research utilises Kaupapa Māori Theory, which legitimises te ao Māori while challenging the ongoing colonial power that dominates the significant institutions in Aotearoa NZ, including healthcare settings. By examining the influence of a Kaupapa Māori nursing theoretical framework on Māori nursing practice, the inherent power imbalances in nursing become apparent. Legitimising Kawa Whakaruruhau (in its original form) in nursing challenges the dominant discourse surrounding culturally safe care for Māori health consumers and Māori nurses (Wilson, 2023).

Structural and Cultural Considerations

There is a need to identify the cultural and structural factors that limit the freedom of Māori culture and language (Smith, 2017). Cultural considerations encompass both human-level and structural, institutional, and systemic factors. Using Smith's (1992) ideas, this research affirms that the culture of nursing in Aotearoa NZ originated from British models of health and nursing services (McKegg, 1992). As such, Māori were marginalised and expected to conform to participate in nursing (McKillop et al., 2012). Institutional, interpersonal, and intrapersonal factors have contributed to the nursing workforce's inability to establish an equitable Māori workforce. Therefore, mātauranga Māori, including Kawa Whakaruruhau, is the most appropriate knowledge base to draw upon in creating solutions to the Māori nursing recruitment and retention challenges in Aotearoa NZ.

Practicality

Kaupapa Māori researchers must ensure that the research outcomes have equal benefits for the researcher and the participants, including the applicability of the research outcomes to nursing practice. As described in the methodology section, critical reflection was undertaken

throughout this research project using Smith's (2015) research questions. Journaling was conducted to support the reflection process. I accepted opportunities to share elements of this project that would support the overall kaupapa, such as guest presentations in related nursing classes.

Transformability

Smith (2017) stated that the project needs to demonstrate the potential for achieving positive outcomes for Māori. The research challenges the 'status quo' on cultural safety rhetoric in nursing practice in Aotearoa NZ and contributes to improving social outcomes for Māori. As such, this research draws upon mātauranga Māori to explore the Kawa Whakaruruhau in Māori nursing practice. The aim is to achieve tangible results that contribute to developing culturally safe practice environments for Māori nurses and whānau Māori.

Conclusion

Using Kaupapa Māori methodology and methods aligned well with the aim of the research. Māori values, beliefs, and practices heavily informed my conduct. As such, the recruitment, data collection, and analysis flowed well. Ensuring that my research aligned with ethical and rigour expectations articulated by Māori scholars increased my accountability as a researcher to produce a robust and meaningful thesis that is intended to benefit Māori nurses and whānau Māori, primarily. By transcribing at least half of the transcripts myself and by using the Te-Āta-tu Pūrākau method, a deep analysis of the multi-dimensions of each pūrākau was conducted, allowing adequate time and attention to be given to each pūrākau. Engaging in reflective practices, especially reviewing Kaupapa Māori theoretical literature and the history of oppression in nursing, supported the development of a deeper understanding of the intersectional nature of the systematic oppression of Kaupapa Māori nursing, including Kawa Whakaruruhau.

Chapter Four: Findings – Poutama Tahi: Social Dimension

The findings of this research are presented in five chapters to mirror the Te-Āta-tu Pūrākau analysis framework. Chapters 4, 5, and 6, outline the findings from the social (poutama tahi), relational (poutama rua), and emotional (poutama toru) dimensions of the participants' pūrākau. Chapter 7 (poutama whā), is a reflexive interpretation of the first three dimensions. Using relevant Kaupapa Māori and nursing literature, a thorough exploration of the findings is presented as a discussion chapter. The final poutama of the framework, the spiritual dimension, is presented in Chapter 8. The spiritual dimension is acknowledged in this framework but treated with the utmost respect by avoiding interpretation of the participants' Wairuatanga (spirituality). As argued by Pihama (2020), creation stories vary greatly between hapū and iwi. The intention of presenting each dimension in a separate chapter is to define the participants' perspectives and experiences of culturally safe and culturally unsafe spaces and practices. However, there is notable overlap between each dimension, reflecting the interconnectedness of the dimensions of human experiences and the non-linear progression to deeper understandings from a te ao Māori perspective (Mikahere-Hall, 2017).

This chapter presents the social analysis of the participants' pūrākau and includes themes related to the setting, time, space, and socio-political contexts. The emerging themes highlight how the social settings impact the perception of Kawa Whakaruruhau or culturally unsafe spaces. All the participants' pūrākau identified the following social settings as relevant to the enactment of Kawa Whakaruruhau: Kaupapa Māori spaces, Western-based spaces, and te ao Māori-Western interface. As such, these three spaces were identified as the predominant themes within Poutama Tahi. Within each theme, the sub-themes describe the various constructs of each clinical space and the impact and influence of each construct on Kawa Whakaruruhau. The themes are set out below in Table 7, which includes a sample of direct quotes from participants' pūrākau to illustrate the theme.

Table 7.

Poutama Tahi - Social Analysis Themes and Sub-Themes

Social Analysis Theme	Sub-themes	Pūrākau – Examples of Participants' Quotes
Theme 1: Kaupapa Māori Spaces	➢ Nursing practice ➢ Visibility of Māori **1. Defining Kawa Whakaruruhau** • Inservice delivery • A koha from tangata whenua to nursing	*"It was just a way to help us kind of validate the way that we thought and the way we lived our lives".* (P10) *"Kawa whakaruruhau that's what it means for me… there's an acknowledgement of one's culture when working with them. Well, not even acknowledgement like an understanding".* (P8)
Theme 2: Western-Based Services	**1. Normalisation of Racism** • Western knowledge dominance **2. Hierarchy in Healthcare** • Margination of mātauranga Māori and tikanga Māori • Clinician-centric care **3. The Colonisation of Kawa Whakaruruhau** • Conceptual clarity • Tokenism	*"Culturally unsafe* [within a mainstream service] *my whole career".* (P7) *"We were talking about the stats… Māori being at the top* [of population] *unvaccinated …the lecturer asked, 'Oh why is that?' and this Pākehā woman sitting at the front, immediately without no hesitation said, "Oh because they're lazy" referring to Māori".* (P11) *"and I had a doctor from (place) straight into our clean area… where it was sterile and demanding that he talk to someone in charge".* (P2)
Theme 3: Te Ao Māori-Western World Interface	➢ Biomedical model vs. Hauora Māori **1. Mana Motuhake** • Walking in two worlds	*"To be honest, when I started, I didn't understand how much culture could impact health… I think that's partially because of how I was educated into nursing by a biomedical model… so you look at their physical health, you do the assessments… that's the problem… you know".* (P1) *"Yeah, I get shoulder tapped a lot and I have, I have a lot of difficulty saying no because I know the negative impact it will have if we don't have a voice in that space or we don't have someone sitting at the table. And I'm quite a young nurse in terms of my nursing career".* (P10)

Theme One: Kaupapa Māori Spaces

This section outlines the social settings of spaces perceived to be culturally safe. Kaupapa Māori spaces were identified within nearly all the pūrākau as culturally safe. Specifically, Kaupapa Māori services were identified as supportive of the development and practice of Kaupapa Māori nursing, and Kawa Whakaruruhau was identified as an integral part of Kaupapa Māori nursing practice. Kaupapa Māori spaces were identified as actual institutions, such as Kaupapa Māori health services, or a space created by a Kaupapa Māori initiative within a Western-based service. The participants identified institutional and

interpersonal practices that allow Kawa Whakaruruhau to flourish within clinical settings. As highlighted in the following quote, Kaupapa Māori spaces normalise 'the normal' for the participants:

> *It was just a way to help us kind of validate the way that we thought and the way we lived our lives.* (P10)

> *I'm very fortunate that I work for an iwi provider, so when I walk through the door, this is who I am.* (P16)

On an institutional level, Kaupapa Māori services were identified as spaces where mātauranga Māori is normalised and utilised to guide health and service delivery, thus developing Kawa Whakaruruhau on a systemic level. For example, the integration of tikanga Māori and Maramataka was described as examples of practice delivery models based on te ao Māori concepts. The authentic application of Kaupapa Māori policies to clinical practice was identified as key to the enactment of Kawa Whakaruruhau in clinical spaces. Furthermore, the importance of strong leaders to lead and implement culturally congruent policies and clinical practices that challenged the status quo were highlighted as essential to Kawa Whakaruruhau flourishing in practice. Robust clinical guidelines and Māori-centric policies in health were also identified as key to the enactment of Kawa Whakaruruhau on a service level. For example, practice delivery models that supported the development of whanaungatanga were identified as supportive of the development of Kawa Whakaruruhau. The following excerpts provide evidence of the importance of institutional conditions that support Kawa Whakaruruhau:

> *A lot of the things that we do are done differently from what you'd find in mainstream. Our hui and things are based on the Maramataka (Māori lunar calendar), so we take into consideration what the weather is like, what the signs of the times are like according to our wisdom that's been passed on to us.* (P10)

> *But I do think because there were some policies in place and you had a charge nurse who was like, "We are doing it this way". This man was Māori, she put her foot down, "This is it". She took over.* (P6)

> *I know our people, I know what they need. You know when you've got the backup from where you come from, because they give us all the tools we need to get our job done – time, vehicles, you know, our equipment, and we are not pressured to be keeping time limits or restraints on our time. And, the feedback is always good. Well, they let me come back.* (P11)

> *And then once the patient has been accepted to the service, they will go and do that whakawhanaungatanga with them. So that could even be one or two visits. For our organisation, there are no time constraints on how long that process would take.* (P9)

Nursing Practice

Kawa Whakaruruhau was identified as being distinct from cultural safety in that it is naturally integrated and an expectation of Kaupapa Māori health practice, including nursing. There is an expectation that Kawa Whakaruruhau was enacted in nursing practice in Kaupapa Māori services. Kawa Whakaruruhau was identified as practising in a way that demonstrates understanding of the intergenerational impact of colonisation, such as including constructs of Māori health in nursing assessments and applying an equity-focused service delivery and practice. For example:

> *I think we have an expectation that we already practice that in our own nursing profession, just being Māori nurses in general.* (P10)

> *Kawa Whakaruruhau is more known within Māori nursing. No, we're going to stick with Kawa Whakaruruhau, because that's where our understanding sits.* (P15)

> *Everything that is happening for that whānau is a flow-on effect to what happened all those years ago— alcohol, drugs, mental illnesses, family violence, everything. I think practising with all of that in mind, thinking about what's happening for that whānau and what happened before that, and it's intergenerational.* (P5)

> *So, I don't think there is that understanding of colonisation and how violent it was and how it's created intergenerational trauma with our whānau. I hope that they would be challenging their service specifications from an equity focus.* (P7)

Visibility of Māori

The visibility of Māori staff was identified as one of the most important factors in creating culturally safe spaces. Having Māori physically present in education and clinical spaces was centred around a by Māori, for Māori approach being brought into clinical practice by Māori health professionals and as a korowai (cloak) for Māori in culturally unsafe spaces. Participants emphasised the acknowledgement of Māori diversity, noting that all Māori nurses are included, whatever their Māoritanga journey stage, to develop Kawa Whakaruruhau in practice. On a similar note, the presence of even a single Māori nurse in a Western-based organisation was identified as necessary for whānau accessing healthcare

services. Participants stated that the visibility of Māori nurses represented the opportunity for Māori patients to express their needs whilst accessing care. For example:

> *I'm going to be honest, probably seeing, firstly, other Māori in the workplace. That's always a good sign.* (P8)

> *Even if they weren't brought up with their koro and kuia. It doesn't matter, way more Māori nurses.* (P5)

> *I think it provides a safety net for having difficult conversations. Also, I don't know how to describe it any other way, but I call it eye-lingual, so like the nonverbal communication where you're like, "What the hell is going on?" And you look at your Māori colleagues, and you know they know, so!* (P17)

> *I think I was like, one of three Māori nurses there, they just, "Girl, girl, have you got any more of those? Whereas they'll probably get turned down by somebody else. It's as simple as just a dressing or a Tubigrip.* (P4)

Sub-theme One: Defining Kawa Whakaruruhau

The overall social context in which Kawa Whakaruruhau is enacted was defined by various participants. Kawa Whakaruruhau was described as an innate way of being that is embedded firmly within te ao Māori. While some participants identified that it was impossible to define Kawa Whakaruruhau in a blanket statement, as doing so would contradict the purpose of the practice, various participants identified foundational constructs of Kawa Whakaruruhau. Participants identified inherent ways of knowing and understanding, and personalised and dignified care as foundational to Kawa Whakaruruhau; as well as displaying actions and values that are centred around upholding the mana of the tangata and/or whānau being cared for, or colleagues being worked alongside. Some of the pūrākau demonstrated that Kawa Whakaruruhau aligns with Māori values passed down from whānau and learnt during childhood as opposed to nursing education. Importantly, the generational differences and lived experiences of Māori were noted as contributing to the diversity of Māori; particularly, the experiences of older Māori growing up in Aotearoa NZ were identified as requiring special consideration. For instance, sensitivity is required around the use of te reo Māori for those who had experienced punitive treatment at school for speaking it. Overall, from the perspective of the social dimension, the enactment of Kawa Whakaruruhau was perceived in clinical spaces and healthcare practices that valued te ao Māori.

The diversity of the social experiences of Māori was identified by various participants as an important consideration for culturally safe practice. For example:

> *Because if you're going to have a Māori nurse who was brought up and in te ao Māori. I think definitely they're going to have a different version of Kawa Whakaruruhau to someone who wasn't brought up in that space, didn't have the language.* (P17)

> *Appropriate* [care] *to their culturally safe needs and wants because not every Māori is built the same and they all have different ideals on what they want to feel valued and culturally safe!* (P20)

Despite the diversity of Māori, the innate Māori values possessed by Māori were identified as fundamental to the enactment of Kawa Whakaruruhau by the participants. For example:

> *It would look like everybody holding everybody up, rather than everybody trying to push each other down to get up. It's really about awhi and aroha, and encouraging and uplifting. It means respect, protection, understanding, encouragement, and empowerment.* (P14)

> *It's innate within us as to how we engage with our whānau and people that, almost like it can't be taught, it's like it exists. We see the world through our own lens and our own view. You'll be told when things aren't tika.* (P9)

In Service Delivery

In clinical spaces that are perceived as culturally safe, Māori can practice nursing in an authentic way that aligns with Māori values and tikanga Māori. Participants who identified times they felt culturally safe in a Western-based organisation attributed this to feeling valued by the staff who were genuinely invested in providing culturally safe spaces for Māori. For example:

> *Māoritanga, that we don't have to be justifying why we react to colonisation, and we know that Māori nurses flourish when they are supported in an environment that values their culture and supports them in their practice, and our practice is different.* (P7)

> *Karakia every day, waiata sung freely. It's us, it's here, we are predominantly female, but we hold space. We follow tikanga here. We don't have male speakers, but we get up and do mihi, karakia, and waiata.* (P11)

> *It's so bizarre, but in my current employment in the tauiwi* [Western-based] *organisation, I feel more culturally safe because they ask me, and it's genuine asking me if this is okay.* (P14)

> *I've felt culturally safe* [in Western-based health services] *because they've been like really supportive and empowering me to advocate for my patients.* (P20)

A Koha from Tangata Whenua to Nursing

Aligning with early Kawa Whakaruruhau conceptualisations, participants identified examples of Kawa Whakaruruhau practice that extended to their non-Māori patients. Incorporation of Kawa Whakaruruhau into nursing practice for whānau was identified as having a flow-on effect to everybody, including the need to balance safe spaces for all. For example:

> *We have one multicultural representative from* [place] *on that. So, we sat down and we were discussing how we go about blending the need for indigeneity and making sure that's in place and diversity.* (P10)

> *So, it's like you're Pākehā – awesome. "So, you came from this background, cool. So how do you feel safe? What do you do to feel safe?"* (P13)

Theme Two: Western-based Health Services

This section of social analysis focuses on the social constructs of spaces perceived as culturally unsafe. Western-based health services, including primary and secondary care providers, were identified as culturally unsafe environments a lot of the time. Culturally unsafe environments were spaces where Māori nurses and tangata and/or whānau experienced racism and marginalisation of Kaupapa Māori knowledge and practice. For some participants, the unsafe space was continuous and experienced over a variety of settings; for others, it was experienced in certain circumstances. The normalisation of racism and deficit framing in Western-based services was highlighted by nearly all the participants as limiting Kawa Whakaruruhau in practice. The hierarchical nature of Western-based health services and the impact of that structure on Kaupapa Māori nursing practices are also outlined.

Sub-theme One: Normalisation of Racism

The widespread normalisation of racism toward Māori, including deficit-framing rhetoric, was identified by participants as the fundamental construct of culturally unsafe spaces in Western-based organisations. Deficit-framing rhetoric refers to a victim-blaming mentality by health professionals toward Māori and their health outcomes. Both clinical and professional

development settings were identified by participants as having the normalisation of racism. Racism and rhetoric were experienced by the participants in the way colleagues and leadership spoke about Māori, and in some of their practices, which occurred on repeated occasions for some participants. Comments made by participants' colleagues were sometimes irrelevant to the setting and shared during break times or personal time. The racism towards Māori was so normalised that it was said despite the presence of Māori colleagues. The following excerpts provide evidence of the generalised racism and rhetoric that contribute to the participants' perception of culturally unsafe spaces.

> *Coming into the job, you hear a lot of nurses saying, "Oh they're so useless. Why have kids if you're not going to look after them?"* (P3)

> *We were talking about the stats of vaccines and the populations and the differences. And yes, Māori being at the top unvaccinated. The lecturer asked "Oh why is that?" And this Pākehā woman, immediately, without no hesitation said, "Oh because they're lazy", referring to Māori.* (P11)

> *We had students talking about why Māori get scholarships, why Māori get special treatment when it comes to their grades and their courses. It was not a safe space to have a discussion like that, particularly being Māori. It wasn't a discussion, it was a blame fest.* (P17)

> *Last week, when they were talking about trick or treaters in the staffroom and I was sitting at a table with predominantly non-Māori, there was one other Māori. But she said "Oh I had these horis* [derogatory reference to Māori] *come up to my door the other day and they weren't wearing any outfits.* (P5)

Sub-theme Two: Western Knowledge Dominance

The dominance of the Western worldview was identified by participants as the foundation of all major institutions, including healthcare and nursing. The dominance of the Western worldview was identified as a limiting factor preventing Kawa Whakaruruhau from flourishing and as a major contributor to creating culturally unsafe spaces. The entrenchment of the Western worldview manifests in various layers: institutional, interpersonal, intrapersonal, and systemic, through policies, procedures, practices, relationships, and the physical space. In turn, Kaupapa Māori practices are marginalised.

On an institutional level, cost was identified as the priority of the health system. As such, a healthcare system that runs on time and cost was noted to have many downfalls in

terms of delivering quality patient care, including Kawa Whakaruruhau. On an interpersonal level, the entrenched Western healthcare delivery model was noted to produce a system in which participants noted whānau often felt marginalised. The following excerpts provide evidence of the dominance of the Western worldview in health and the impact that has on Māori.

> *Within the healthcare system, the systems are very similar with the same whakaaro. But it's how systems are. See you can't get away from it no matter how much you try.* (P2)

> *A lot of them say it's that they're not listened to. They feel like just a cog in the wheel of the system.* (P12)

> *When I was there, handovers took 5 to 10 minutes, and you barely really talked to your colleagues, and really ask for help or anything, or being able to have those conversations with your patients and their families, of how are you even doing? I don't really see many people doing social assessments on their patients. It's meet that medical need and then discharge out the door.* (P12)

Hierarchy in Healthcare

Hierarchical gradients in healthcare that promote the power being held by few, harm staff relationships and, ultimately, patient outcomes. Participants identified the hierarchical structure in healthcare as a social construct that influenced Kawa Whakaruruhau in practice. Of relevance, the power dynamics between medical doctors and nurses, leadership and front-line workers, and tangata and/or whānau accessing healthcare and the system were identified as the prominent relationships influencing and being influenced by clinical spaces. Of note, the distance between leadership and front-line workers was highlighted by various participants as a construct of culturally unsafe spaces. Similarly, the hierarchical structure of Western-based services was noted to be restrictive in terms of Māori voices being heard and delivering policies that were supposed to be of benefit to Māori. The dominance of the medical profession had implications for the actual physical space and the sequential flow of the clinical environment. The following excerpts provide evidence of the impact of the hierarchical gradient in Western-based health services.

> *I had a team of about 12, and a student nurse with me. And I had a doctor from* [place] *straight into our clean area, where it was sterile, and demanding that he talk to someone in charge. And one of the Kaiawhina said, "Oh* [name] *just up there*

talking with some of the whānau. And then he shouted, "Which one is she, the black one or the white one?" (P2)

So, you have the executives thinking that they have set a policy and that's been enacted, but it's not. And then you've got to fight your way through middle management to the top to say it's not working. (P7)

You will have that token Māori voice, but our voices aren't necessarily heard and acted on. So, in mainstream, everything may be written down, and policies enacted. But sometimes things aren't carried out how they say that they're going to carry them out, the policies written don't align with what happens, quite often. (P9)

Marginalisation of Mātauranga Māori and Tikanga Māori

The participants noted that the dominance of Western knowledge in Western-based services left little space for mātauranga Māori, including Kawa Whakaruruhau. As such, learning and practice were heavily based on Western epistemologies. In turn, mātauranga Māori was marginalised. The marginalisation of mātauranga Māori manifests in various ways, including lack of access to Kaupapa Māori nursing models and knowledge, and a disregard for Māori nurses' knowledge and experience in practice. The participants identified various examples of when tikanga Māori was marginalised at both interpersonal and institutional levels. The interpersonal marginalisation of tikanga Māori resulted from non-Māori nurses' decision-making around how and when tikanga would be applied in the clinical setting, without consultation with Māori. On a systemic level, the marginalisation of tikanga Māori was evident in policy and procedures in Western-based health organisations, such as the dominance of Western ethics in nursing practice. For example:

When I was studying, I couldn't find one Kaupapa Māori nursing course where you learn with Kawa Whakaruruhau, cause my underlying learning was with the competencies set out. (P1)

I'd told everyone that we were going to do a shared lunch, so I had to go back and retract all my comments about it. I said, "No, no, no, management said we're not doing it anymore". And then, sure enough, the speakers show up from [location] *and morning tea rolls around and who scarpers out of the room? Management, because the speakers are looking around for their kai, expecting to be fed, cause they've come all the way from* [location]. (P5)

Sometimes with mainstream practice and the Nursing Council code of conduct, it will say that we cannot give gifts or cannot do anything that might imbalance that power that the nurse has with the patient. So, that might be perceived as an imbalance of power by giving a kai package or food parcel or giving clothing. (P9)

Clinician-Centric Care

Healthcare service delivery was described as a clinician-centric model, similar to a doctor-centred care model. Within this section, nurses were also identified as holding the power in health service delivery, so the concept was widened to clinician-centric. Healthcare services were noted to run on clinicians' time. Moreover, time constraints were noted as a major challenge to Kawa Whakaruruhau in practice. The time challenges ranged from the allocated time of appointments and the opening hours of services. The power imbalances and clinician-centric model are described in the following excerpts.

We don't make the sandwiches, we don't buy the sandwiches, we don't pay for the sandwiches. Yet we [nurses] *have some sort of ownership over who gets a sandwich.* (P21)

But on this system you've got half hour slots, that's all you get. So whatever you can get in half an hour. I can't do that and I won't. (P2)

Historically, we've been a service that goes from like 8 till 4:30. That's outside of their working hours, so I spoke with our manager, and I just said, "Hey, look like this is what's happening. For the sake of this person getting their Bicillin injection, I'm happy to start earlier. I'll do it before work or after work". Initially, I was told, "no, you've got to send them to the GP". (P3)

Sub-Theme Three: The Colonisation of Kawa Whakaruruhau

Within the social dimension, the dominance of cultural safety in nursing was identified as a limiting factor for the actualisation of Kawa Whakaruruhau in the wider nursing workforce. The imposition of Western ideas or values on Kawa Whakaruruhau was described as a colonisation process. Kawa Whakaruruhau was characterised as a large-scale practice that is not limited to nursing but needs a multifaceted approach for its implementation to protect it from a re-colonisation process that has restricted it over the last 30 years. Importantly, the resistance to Kawa Whakaruruhau by the professional body of nursing was identified as a limitation to the flourishing of Kawa Whakaruruhau. Moreover, the current rhetoric surrounding cultural safety and Kawa Whakaruruhau was identified as reflecting the value

that the body of nursing places upon it as a nursing practice in Aotearoa NZ. For example, the ongoing debates about Kawa Whakaruruhau and cultural safety in nursing were identified as evidence of the lack of authentic integration into nursing. In comparison, the nursing code of conduct and code of ethics are accepted foundational documents for nursing practice in Aotearoa NZ, and there is no debate about it. For example:

> *I think nursing has a real space to be able to change this, but we just haven't collectivised, and it's really concerning because we're the largest workforce, why can't we make the changes that we want to?* (P17)

> *Where it sits in nursing? In all honesty, it has no standing in nursing, because it's been so watered down and then each institution chooses how they interpret it. So it lost its essence. How do you change that? If they see value in Kawa Whakaruruhau, then they will put that at the forefront. If they don't see value in it, then it's just another paper that gets another tick.* (P16)

> [Kawa Whakaruruhau] *needs to be normalised cause at the moment it's something that people want to argue about or don't think that it should be included. But, if it were 30 years ago, it would just be normalised now. Or if it's not a core paper, then every paper has it integrated into every paper. You have got to do something that pertains to Māori health.* (P7)

Conceptual Clarity

Conceptual inconsistency of Kawa Whakaruruhau and cultural safety in nursing and nursing education was noted to be an ongoing challenge to Kawa Whakaruruhau flourishing in the wider nursing workforce. Specifically, the interchangeability of the terms cultural safety, Kawa Whakaruruhau, and cultural competency in nursing education was identified as problematic. Also, the variation in the conceptualisation and the limited educational content on Kawa Whakaruruhau between each learning institution was highlighted by participants as a limitation to Kawa Whakaruruhau. For example:

> *Most of so it was an introduction if I could describe our learning or our lessons around Kawa Whakaruruhau and cultural safety. The terms were used, one and the same.* (P15)

> *Kawa Whakaruruhau, which is for Māori and cultural safety, which is for everyone else, but your average nurse can't tell the difference. And, most of the ones I've come across can't say the word Kawa Whakaruruhau.* (P6)

Then we know about the variation between schools and that it doesn't even touch on what it is. Some of it's come out of some nurses resisting it. (P18)

Tokenism

The tokenistic approach to Kawa Whakarururhau and cultural safety in nursing was identified as a limitation to Kawa Whakaruruhau. Notably, the time dedicated to teaching each topic in nursing education, as well as the frequency with which it was taught or available as a professional development option, were identified as problematic. Participants described their education in Kawa Whakaruruhau as being limited to a specific time frame, such as a one-semester paper. Moreover, the perceived tokenistic positioning of cultural safety in nursing practice was reinforced by the limited ongoing professional development available to nurses upon registration. Comparisons were made between Kawa Whakaruruhau and the mandatory yearly updates on core training modules, such as CPR updates and cultural safety updates, in which it was noted that there were very limited options for Kawa Whakaruruhau in Western-based services. Related topics, such as Te Tiriti o Waitangi workshops, were identified as being available for professional development days at Western-based health services. However, the mode of delivery of the workshops was noted to be inappropriate for topics related to Māori health, suggesting it would be better delivered in a culturally congruent way. The tokenistic cultural safety rhetoric and limitations on Kawa Whakaruruhau were highlighted as contributing factors to it becoming a tick-box exercise for registration as a nurse in Aotearoa NZ, rather than a tangible measurement of nursing competency. For example:

As nurses, we've got to do our APC [Annual Practising Certificate] *every year, and we've got to do our PDRP* [Professional Development and Recognition Programme]. *Other than the two questions in our PDRP. Our cultural competency, we kind of just get taught it at the start or like a briefing of it in our degree but there's no like continuity.* (P3)

The Treaty of Waitangi workshops, they have those at the hospital. It needs to be a wānanga kind of situation, opposed to going to the hospital for this 1-hour session and then you're finally competent to practice safely under the Treaty, but I think more of like a wānanga." (P5)

I mean clinical safety has always held a higher presence than cultural safety, regardless of the fact that they should be working in partnership and be held in the exact same regard. (P6)

Theme Three: Te Ao Māori-Western World Interface

Participants identified the interface of Māori and Western knowledge as a space where significant tensions arose in their practice. For example, integrating Kaupapa Māori practice into Western-based health services proved to be challenging for various participants. The tensions described by participants related to the power struggle between people and systems fighting to maintain the dominance of Western knowledge or those who were striving to validate and apply mātauranga Māori to nursing education and practice. In the process, mātauranga Māori was marginalised or invalidated as a knowledge base for professional nursing practice. As such, pay inequities, tokenistic Māori representation in leadership, and a lack of recognition and remuneration for Kaupapa Māori practice and mātauranga Māori were noted in nursing. For example, a participant highlighted a Māori leadership role she held that did not have any power in the decision-making regarding Māori health by non-Māori leadership. On an organisational level, the funding requirements by Te Whatu Ora (The Aotearoa NZ national health service), such as reporting, were identified as a struggle due to the frequency with which it was required, as well as the cultural incongruency of key performance indicators set by the health service for Kaupapa Māori providers. For example:

> *He called me 'philosophical', and I was like that's not philosophical. What it is, is Kaupapa Māori, mātauranga Māori.* (P1)

> *Yeah, they're not compensating for that* [Indigenous knowledge]*. There's pay inequities between organisations such as ourselves, Māori health organisations and the mainstream.* (P9)

> *If we were to put a programme up to Te Whatu Ora* [district]*, there's a lot of hoops to go through just to practice the way we always practice. For them to say we need to check that it's a valid way of doing things. Oh, we need a 3-year evaluation programme to make sure the way you're working fits with what the Ministry of Health has given us. So, we have to try to prove our methods, constantly, and that this is the way that whānau want to work.* (P9)

> *It's because we weren't part of the decision making processes. So, the role I had at* [Name] *and the PHO* [Primary Health Organisation] *was as Māori health manager, but actually it sat down underneath so it didn't sit at the leadership table where they were making all the decisions in the PHO.* (P18)

Biomedical Model vs. Hauora Māori

The dominance of the biomedical model in nursing education and practice was identified as a barrier to learning and/or applying Kawa Whakaruruhau in practice. Participants stated that the biomedical model's central focus is on the individual's physical health and disease process, and the impact of culture on health and health outcomes can seem incompatible or irrelevant to a practice based on the absence or management of a disease. Challenges arose when participants practiced whānau-centred care, which includes a holistic approach to well-being, opposed to the absence of disease. The incompatibility of whānau-centred care with a model that is designed for individual care can be challenging. Moreover, the compartmentalisation of health, lack of holistic health assessments, and use of medications as a primary intervention were noted to be inconsistent with hauora and Kawa Whakaruruhau. For example:

> *Just going to a school and seeing a kid for school sores, and then the nana's sick, and then helping the nana. And, it's like "That's not your job." And well, it kind of is*. (P3)

> *It should be around well-being, health, not mental health. So if it's around well-being, and we all know that there are days when you wake up and go, I just don't want to go to work today. Well, maybe you should just go and have a mirimiri. Maybe you should go down to the water. There are those sorts of things that we need to be normalising, as opposed to, "Oh, you don't feel well, go and see a doctor". And they'll give you some antidepressants.* (P16)

> *And I believe they must be very much more holistic in terms of, housing, mental health and hauora because if we're not looking at mental health and what's causing the anxiety, which could be the housing or the finances, if you're not receiving your full entitlements from Work and Income, then how are you going to access your medicines or get anywhere, to get to appointments?* (P9)

Sub-Theme Two: Mana Motuhake

Participants identified the te ao Māori-Western world interface as an opportunity to assert one's autonomy as a Māori nurse by integrating mātauranga Māori into their professional practice. The process of weaving mātauranga Māori into practice was a conscious effort that for some participants required a decolonisation and indigenisation process. Mana motuhake (autonomy, self-determination) was expressed by participants actively seeking out and

integrating mātauranga Māori, Māori values, and tikanga Māori into practice, and asserting themselves as Māori first in the workplace. For example:

> *For me personally, it is being allowed to work freely in a space that allows me to be me ethically, morally, from the way I talk, learn, and understand. I know me, I know how to keep myself safe, and I know how to provide a safe space, whether I'm with the community or educating our DHB nurses or iwi provider nurses.* (P2)

> *A culturally safe place for Māori nurses is that when they walk through the door they are identified as Māori. Not that they walk through the door and they're a nurse. In so many of our roles, we have to leave being Māori at the door.* (P16)

> *Definitely it's about being safe, feeling safe in my own space. I'm Māori first, and then I'm a nurse.* (P18)

The importance of having Māori nurses present in Western-based health services was identified as important to the development and enactment of Kawa Whakaruruhau in practice. Some participants chose to work in Western-based services for periods of time to support and advocate for whānau Māori accessing care.

> *I think over the years, I developed the sense that actually I think I'm needed in mainstream.* (P18)

> *Yeah, I get shoulder tapped a lot, and I have a lot of difficulty saying no because I know the negative impact it will have if we don't have a voice in that space or we don't have someone sitting at the table. And I'm quite a young nurse in terms of my nursing career.* (P10)

Walking in Two Worlds

The participants described challenges of walking in both te ao Māori and the Western world. The challenges include representing the Western-based health service in te ao Māori space, bringing non-Māori into te ao Māori spaces, and being the Māori representation in a Western-based organisation. The participants identified working with culturally unsafe non-Māori nurses in a te ao Māori space as a challenge to maintaining the culturally safe space they had created with their whānau through whanaungatanga. As such, bringing non-Māori nurses into a te ao Māori space prompted the nurse to be protective of the whānau and their space by attempting to manage the behaviour of the non-Māori nurses or by challenging the thinking behind the nurses' behaviour. For example:

We need two nurses to vaccinate. I am very picky with who I take, especially to particular houses. If I've got no choice and I take someone with me, I'd just debrief them. (P4)

There was a bowl of kina on the table, and the non-Māori colleague was like, "Oh, you don't see that in a staff room very often". And then [name] *said, "Oh, what would you expect to see, some scones or something?" And this was in a staff room in front of everyone. Obviously, their uptake in the school for non-Māori nurses is not very good, and just little comments like that, you know that's normal for us to have kina and kaimoana in general on a staff table.* (P5)

The challenges of being the lone Māori in a Western-based health service were identified by participants as resulting in tokenistic behaviour by non-Māori staff. The tokenistic integration of tikanga Māori was perceived as culturally unsafe and limiting of Kawa Whakaruruhau. For example:

All the time, like teaching sessions, te reo classes, all sorts of things. Or if they need a karakia for something, they're like "Do you know a karakia for blah blah blah?" They always come to the Māori nurses first. (P5)

I can feel uncomfortable if there's a particular meeting or a space, they always go to you to do karakia. There is plenty of space for everyone else to do the same thing. That's where it goes back to that whole cultural safety thing. Is that we're all culturally safe, so why is there just one specific person that you go to, to ensure that cultural safety is met? (P13)

Conclusion

The social analysis of participants' pūrākau identified Kaupapa Māori services as culturally safe spaces that inherently practised Kawa Whakaruruhau on various levels. Kawa Whakaruruhau was recognised as a culturally congruent practice that is normalised in Kaupapa Māori spaces as it aligns with a Māori worldview and is enacted through the integration of Māori values and tikanga Māori into practice. Kawa Whakaruruhau is identified as a strength-based practice that centralises whānau and rangatiratanga for both nurses and whānau receiving healthcare; as well as tangibly celebrating and valuing te ao Māori. It also includes practising from a foundation of understanding and knowing regarding colonisation and the profound intergenerational impacts of power imbalances, social exclusion, disenfranchisement, and marginalisation experienced by whānau to various

degrees. Therefore, Kawa Whakaruruhau is expressed in practice as manaakitanga—upholding the mana of the whānau receiving healthcare. As well as an equity-focused practice.

In contrast, the social analysis of Western-based organisations identified various constraints to the development of Kawa Whakaruruhau in nursing practice in Aotearoa NZ. The normalisation of deficit-framing rhetoric regarding Māori health was tangible in Western-based health services and expressed in interpersonal interactions towards Māori nurses and tangata and/or whānau receiving healthcare. The dominance of Western knowledge and values was identified as a constraint to Kawa Whakaruruhau and manifests in a hierarchical gradient in which power sits firmly with those at the top, including medical doctors and leadership. As such, the hierarchical gradient is evident in the clinician-centric model of care utilised by Western-based health services. The dominance of Western knowledge in Western-based services limited the applicability of Kawa Whakaruruhau to nursing practice as mātauranga Māori and tikanga Māori were marginalised at the institutional and interpersonal levels.

Not only was the cultural safety rhetoric in nursing identified as a challenge to Kawa Whakaruruhau in nursing practice, but the actual lack of knowledge surrounding Kawa Whakaruruhau and its colonisation in nursing doctrine was identified as problematic. The assertion was made that Kawa Whakaruruhau is a collective responsibility of nursing as a professional body, and currently the resistance towards Kawa Whakaruruhau by nurses is tangible.

Lastly, the intersection of te ao Māori and the Western World was identified as both a challenge and an opportunity to create culturally safe spaces for tangata and/or whānau accessing healthcare. Again, the dominance of the Western knowledge system was identified as a constraint to Kawa Whakaruruhau in practice and an obstacle that Māori nurses had to navigate carefully to ensure that the relationships created with whānau were kept intact. Often, Māori nurses had to attempt to manage the behaviour of non-Māori staff members when entering a Kaupapa Māori space. However, aligning with Smith's (1992) model of Māori resistance, the tensions at the intersection of te Ao Māori and the Western world led to an assertion of one's mana motuhake as Māori, and as an advocate for whānau accessing health services.

Chapter Five: Findings - Poutama Rua: Relational Analysis

Poutama rua analyses the relational constructs of the participants' pūrākau. It identified the relationships discussed as being between participants and tangata and/or whānau accessing health services, institutions, colleagues, and leadership and management. This relational analysis revealed three main themes: Culturally Safe Nursing Practice, Culturally Unsafe Health Practice, and Kaupapa Māori Nursing and Western Healthcare Practice Interface. The sub-themes analyse the dimensions of the interpersonal relationships within each theme and how the relationships interplay with Kawa Whakaruruhau and healthcare delivery. Moreover, the relational analysis identifies how nursing practice is impacted by relationships, specifically practice perceived as culturally unsafe and practice that embodies Kawa Whakaruruhau. The themes and sub-themes are laid out in Table 8.

Table 8.

Poutama Rua: Relational Analysis Themes and Sub-themes

Social Analysis Theme	Sub-themes	Pūrākau – Examples of Participant Quotes
Theme 1: Culturally Safe Nursing Practice	***1. Kaupapa Māori Nursing Practice*** • Professional Nursing Standards • Whakawhanaungatanga • Trust • Titiro…whakarongo…kōrero ***2. Shared Whakapapa*** • Aroha ki te tangata	*"When I am culturally safe at work, it's usually when I'm by myself and I'm in a client's house and I know that they're going to be cared for, because I trust that I am culturally safe when I practice nursing".* (P4)
Theme 2: Culturally Unsafe Health Practice	***1. Racism*** • Deficit-framing rhetoric • Infantilisation • Racial profiling • Clinical outcomes • Non-Māori fragility ***2. Dominance of the Western worldview*** • Hierarchical gradient • Conformity	*"that accusatory attitude, "You're not doing this… You can't be doing this". It's immediately there's a preconceived idea that if you are Māori, you're not taking your medications. You're not doing as you're told".* (P7)

Social Analysis Theme	Sub-themes	Pūrākau – Examples of Participant Quotes
Theme 3: Kaupapa Māori Nursing and Western Healthcare Practice Interface	1. ***Rangatiratanga*** • Practice re-alignment • Nursing professionalism 2. ***Practice Development*** • Reflective practice • Collegial relationships • Dual competency	*"Then the nurse who looks after all the educators fully jumped down my throat. I said, 'why can't we do something like that'…it's just as important if not more important to be able to engage with whānau Māori because there's so many people out there who aren't engaged with our health services".* (P4)

Theme One: Culturally Safe Nursing Practice

The relational constructs of Kawa Whakaruruhau are based on practices under the sub-themes of Quality Nursing Care and Shared Whakapapa. Kawa Whakaruruhau is developed within relationships that embody manaakitanga, aroha, pono, and tika, alongside robust nursing knowledge and practice. Essentially, whanaungatanga is at the centre of practice that enables Kawa Whakaruruhau to flourish—the foundation of effective and therapeutic nursing care. Most importantly, it was identified as the professional responsibility of the nurse to enact practices that enable Kawa Whakaruruhau. Kaupapa Māori spaces were identified as spaces that allow the development of Kawa Whakaruruhau with ease, as the Kaupapa supports it.

Sub-Theme One: Kaupapa Māori Nursing Practice

Professional Standards and Nursing Knowledge

The importance of nurses providing professional and high-quality nursing care in response to the tangata and/or whānau patient inviting the nurse into their personal space was identified by the participants as a construct of Kawa Whakaruruhau. Specifically, a collaborative partnership where the nurse shares their nursing skills and knowledge to support the tangata and/or whānau in their hauora journey was identified. For example:

> *When I am culturally safe at work, it's usually when I'm by myself and I'm in a client's house and I know that they're going to be cared for, because I trust that I am culturally safe when I practise nursing.* (P4)

> *Invite you into their body essentially cause you're helping. They've come to you for that. If you're doing that and you've given them the space to be them and you're giving them the tools to fix them, to help them, to aid in their recovery or to treat the symptoms because sometimes we can't fix things.* (P6)

Whakawhanaungatanga

Whakawhanaungatanga with tangata and/or whānau was identified as fundamental to effective nursing practice and Kawa Whakaruruhau. Whakawhanaungatanga refers to forming connections and getting to know one another (Komene, Gerrad, Pene et al., 2023). Establishment of a connection between the nurse and the tangata and/ or whānau was identified as the first step to building a therapeutic relationship with tangata and/or whānau. Second, the importance of time, both in the duration of the consultation and the long-term relationship, was highlighted as key to positive outcomes for tangata and/or whānau, including management of health conditions and re-engagement with health services. However, the participants did note that there are significant time constraints in certain health services. For example:

> *Whanaungatanga, connection is really important.* (P21)

> *Just getting to know and understand each other before we get down to any nitty gritty stuff, encouraging people to see me for who I am, just like they expect me to see them. And care for them, it's reciprocated. It's a relationship, it's not meant to be just one-sided.* (P14)

> *It's allowing that time, so it's a safe space in their own homes to have this education brought to them. So we'll bring out the big models and the packages and sit down with them in a space that they're comfortable with, and over an hour or up to 2 to 3 hours, and they don't have time to do that at a GP's clinic.* (P9)

> *In 8 months, I got to a place, a therapeutic relationship with him, and a trusting relationship with his treatment team, to get the treatment team to approve that I can escort leave for him.* (P15)

Unfortunately, the inability of colleagues to establish an effective nurse-client relationship with tangata and/or whānau was highlighted as a significant challenge to culturally safe care by participants. Specifically, the inability of nurses to make an initial engagement with the tangata and/or whānau referred to health services resulted in either the referrals being dismissed or delayed, or reliance on less experienced Māori nurses to take over the referral. This also led to various participants taking on larger workloads than their peers so that they could engage whānau Māori. For example:

There are heaps of other nurses who knew a lot more than I did, but they couldn't get into certain referrals. They couldn't get in with whānau. I build that rapport, that whanaungatanga. (P3)

Trust

The concept of trust was an essential aspect of the relational dynamics in relationships grounded in Kawa Whakaruruhau. Trust was identified as the key to tangata and/or whānau engaging with healthcare providers in a meaningful way and an outcome of whakawhanaungatanga. Importantly, Kawa Whakaruruhau was identified as crucial for restoring tangata and/or whānau trust with health services, given the background of broken trust with Western-based health services for many whānau. Similarly, in Western-based services, the presence of Māori nurses was highlighted as essential to promoting trust in the service for tangata and/or whānau. For example:

Because actually we're talking about gaining trust, you know, because there's such a big mistrust, particularly for Māori because of the what's happened over the years. (P18)

Because we know with our whānau that when we have their trust, we have it forever you know sort of thing, they keep coming back to us. (P16)

People in the community feel more comfortable approaching Māori nurses than non-Māori. It's because there's that automatic trust because we're the same as them, there's not that mistrust of anything else. (P5)

The ability to trust colleagues to provide culturally safe nursing care for whānau Māori was highlighted by participants as an essential component of Kawa Whakaruruhau in practice. Trust in one's colleagues manifested as having the confidence to share referrals and delegate the care of tangata and/or whānau to their colleagues. Non-Māori colleagues who were perceived to treat whānau Māori with care and dignity were identified as having good character and as demonstrating professional nursing standards. Moreover, colleagues who displayed similar cultural values and practices to Māori, such as family concepts, were identified as culturally safe. The participants felt confident and at ease working with whānau Māori while supported by non-Māori nurses perceived as culturally safe. For example:

I think (1) underneath all the training that you could possibly do, [displaying Kawa Whakaruruhau] *they're a good person, and (2) they truly want to build that therapeutic relationship with their patient.* (P8)

There are some amazing non-Māori nurses who are completely culturally competent who I would send in a heartbeat. We've got our Filipino nurses who I'd much rather send than a Pākehā nurse, because I was worried about how they were going to offend them. (P5)

I know that there are a lot of non-Māori out there that are very culturally safe, particularly like our other people of tangata whenua elsewhere, so our Filipino. They've got those basics, what they've been brought up with through the generations. (P4)

Titiro, Whakarongo… Kōrero

The value 'titiro, whakarongo…. kōrero' (listen, look…. then speak) was identified by participants as fundamental to whanaungatanga and Kawa Whakaruruhau. They noted that whanaungatanga in the nurse-client relationship is built upon the nurse's ability to genuinely listen to tangata and/or whānau. Kawa Whakaruruhau in practice is created when tangata and/or whānau are listened to and heard by the health professionals. Being 'heard' refers to the nurse understanding the message that the tangata and/or whānau is telling them. For example:

Listen to them and hear them out, because I feel like nobody is listening to our whānau and if it's a problem for them, it's a problem for me and I'm going to help them. (P4)

And it's those things that make it safe because you're actually listening to what they want. (P21)

After hearing the tangata and/or whānau, the nurse's kōrero (speaking/talking) can relay the information provided by the tangata and/or whānau accurately to the necessary recipients to support the development of effective care. The ability of the nurse to communicate the health wants or needs of the tangata and/or whānau to the health service effectively is identified as a nursing skill that develops with experience:

I'm always apologising for working for a system that is still hindering them because I can talk to them on a level that they can understand. I'm listening to their real kōrero, and I have to be a master of putting it into terminology and professionalism for this side but still get my point across. (P2)

Sub-theme 2: Shared Whakapapa

The concept of shared whakapapa refers to the inherent understanding between Māori of the contemporary realities of whānau Māori and how those realities directly link to historical trauma events. Participants mainly described historical trauma using possessive pronouns denoting 'ownership' of the subject being discussed. They described the many hardships endured by Māori as something they relate to or have experienced. Kawa Whakaruruhau in nursing practice was identified as care that demonstrates an awareness of historical trauma and the intergenerational impacts of colonisation on health and social outcomes. The shared whakapapa of Māori is always central to the participants' nursing practice as a key consideration when engaging with and caring for tangata and/or whānau Māori. The lack of understanding of historical trauma, including the significance of Te Tiriti o Waitangi to health, power dynamics, and social outcomes for Māori, by some non-Māori, was noted to be a block to creating Kawa Whakaruruhau in clinical practice for tangata and/or whānau accessing healthcare. The shared whakapapa was identified as a motivation to advocate for tangata and/or whānau to receive a high standard of care when accessing health services. For example:

> *I still think that there are plenty of nurses that don't understand, and they don't understand that it wasn't a direct translation, and that's the whole entire issue of why our people still are struggling.* (P5)

> *I don't want them to be competent in my culture, but I want them to be aware of the impacts of colonisation and the inequities and, you know, that plays out in their workspace.* (P7)

> *Some people probably refer to me as difficult! But kei te pai because the fight is for my people. And, if it means having to challenge my people, I will do that too.* (P15)

Participants considered practising Kawa Whakaruruhau includes aroha for the older generations who have experienced extreme forced cultural disconnections, especially to te reo Māori. Therefore, it was about using the most appropriate tikanga for the tangata and/or whānau, which can only be determined through building trusting relationships between the nurse and client. Younger generations of Māori were highlighted as potentially not having the same struggles that older generations have had. The generational differences identified by participants are described in the following excerpts.

There have been Māori nurses who have been marginalised their whole life, not being able to have the privilege of learning their language. The privilege of practising in a Māori way. (P17)

It's brought up a lot of hurt for some of us within this age group. It's totally different for our kura kaupapa Māori children. But you now have this strong, young, vibrant Māori coming through who are strong in their whakapapa and who they are and where they're going. And stand equally in te ao Māori and Pākehā. (P16)

Aroha ki te Tangata

Practising from a place that demonstrates an understanding of the historical trauma and realities of whānau Māori contributes to building therapeutic relationships with tangata and/or whanau. As such, aroha ki te tangata (expression of love, compassion, empathy to people) was identified within the professional relationship between the nurse and the tangata and/or whānau which, in turn, contributes to sustained relationships in which the tangata and/or whānau engage with the health service. Consequently, the nurse can grow in their practice. Therefore, the lack of understanding and exposure to the realities of many whānau Māori was highlighted as a barrier to culturally safe care. For example:

And to know that we will make mistakes, often, and that's okay because part of the learning process and our whānau are very forgiving in that sense, and they know that we've got kind of trauma in our joint whakapapa, so we have a lot of grace for each other. (P10)

You know everything that is happening for that whānau has a flow-on effect to what happened all those years ago. I think practising with all of that in mind, not just going in and seeing this kid, and you know, he looks like he's a bit rough around the edges, and his parents aren't looking after him. What are we going to do about that? (P5)

Aroha ki te tangata was described in various ways by the participants, such as the nurse acting in a protective role for the tangata and/or whānau and the nurse being flexible and understanding in terms of the reality for whānau of committing to long-term interventions from a nursing service. For example:

I'll probably get into a lot of trouble for wrapping my clients in cotton wool, but… I've got to do it to keep engaged. (P4)

> *Please don't think you're disappointing me if you're not there. If I turn up and you're gone, that's okay. I'll contact you another day. I don't want me to be another pressure that they have to commit to, or another thing that they have to show up for.* (P11)

Moreover, the effectiveness of Kaupapa Māori nursing practices was evaluated (informally) by nurses based on feedback given directly from the tangata and/or whānau who had received care. Further, ongoing engagement with the health service was identified as a key indicator of effective nursing practice, including whanaungatanga. Care that is perceived as pono or genuine by the tangata and/or whānau receiving it was noted to be of particular importance to Kawa Whakaruruhau. For example:

> *We have feedback that supports* [our work] *from our whānau, the way they text and send letters to our CEO, saying that they've never received that kind of what they perceive as genuine care and genuine response to their needs. But it's not just nursing. We have nursing, social, and lifestyle, so it's like a wraparound service.* (P9)

Theme Two: Culturally Unsafe Healthcare Practice

This section discusses culturally unsafe practices that contribute to the perception that a space is culturally unsafe for Māori nurses. Like the social dimension, racist practices (e.g., deficit framing), are freely expressed by health professionals in practice, leading to the development of spaces that are not conducive to well-being for tangata and/or whānau or Māori nurses. Moreover, the entrenchment of Western values, knowledge, and health practices leads to overt and covert marginalisation of Kaupapa Māori nursing practice, including Kawa Whakaruruhau.

Sub-Theme One: Racism

Deficit-Framing

Participants identified deficit-framing rhetoric as speech that is freely used within the clinical environment by healthcare professionals, including nurses. This section focuses on the interpersonal interactions that occur due to the normalisation of deficit-framing language in healthcare practice. The clear power imbalances between nurses and tangata and/or whānau accessing care were manifested in the way some nurses chose to speak about tangata and/or whānau who had been referred to their service. A lack of insight displayed by non-Māori nurses about the impact of colonialism on Māori and a lack of self-awareness about personal biases were also noted to be a common occurrence by the participants. Similarly, the participants identified the widespread perception that it is a Māori cultural issue as to why

Māori health is inequitable. Therefore, Māori need to fix the problem rather than examine the culture of the healthcare system and nursing. As such, the responsibility for Māori health gets relegated to Māori nurses by colleagues. For example:

> *Oh, look at them, they don't even care about their health. They're not even answering their phone. They're running away from me. Not to think why? What are they feeling from you? What are they seeing from you that you're not making them feel comfortable? Or providing a safe place for them to be able to tell you this is how they're feeling? And they feel a bit whakamā. You're the nurse, aren't you?* (P2)

> *So, it's kind of like they put the responsibility of being culturally competent on the Māori and Pacific nurses because obviously that's us, that's our lived experience.* (P5)

> *To fix all the Māori problems, dial a Māori. And I joke all the time. Like I was on the clinical side. We don't want to be the ones that have to do this, we can't fix the system that you broke.* (P6)

> *When you come in and impose your views over us, then this is the result, and it's not our fault. You know that lack of understanding leads to a deficit mindset that Māori have always been violent, unhealthy.* (P7)

Infantilisation

Infantilisation and condescending treatment of tangata and/or whānau accessing care were highlighted as a culturally unsafe practice by participants. The process of infantilising a person denotes a derogatory and belittling set of behaviours towards a population based on a set of beliefs held about them. The participants identified infantilising behaviours such as imposing instructions on tangata and/or whānau without any conversation, and suggesting that they have not followed medical prescriptions despite evidence that they have. The normalisation of this behaviour was thought to be from a deficit-framing mentality surrounding Māori health. Infantilising behaviours are described in the following excerpts:

> *And the messages were just like 'you need to do this, you need to do this – we will call her Amelia. This is happening to Amelia, you need to do this to her toe.* (P4)

> *And he looks at him like he's a piece of shit and says, "So are you taking your medications?" And I said to him, "I've told you, he's using blister packs, and you can see from his echo that his heart function has improved. So, you can see that he is taking his medications". He looked at him again like he was a piece of shit and said, "Are you sure you're taking your medications?* (P7)

In a similar vein, participants noted a blatant double standard between the treatment of Māori and non-Māori by their colleagues. They reported that there appeared to be different 'rules' for Māori and non-Māori accessing health services, as described in the following excerpt:

> *Ah it's just a punishment... well they weren't the official rules 'cause there were rules for some and rules for others… like if you were Māori and you missed an appointment you were a 'DNA' and often you would be 'that's it, you're out' but other people would get 2 or 3 times.* (P7)

Racial Profiling

Racial profiling is most discussed within the field of justice, specifically regarding policing. In health, racial profiling manifests in the healthcare professional applying personal assumptions, stereotypes, and biases to Māori to place them in a category that they perceive to be correct. The participants stated that they resonated with the tangata and/or whānau that the non-Māori nurses were talking poorly about, either by relating to their lived experience or being directly related. This highlights the lack of insight of non-Māori nurses into the realities of Māori. Categorisation of people based on stereotypes and biases was highlighted as directly contradicting Kawa Whakaruruhau. For example:

> *It's like cultural safety needs to be held in the exact same regard as your clinical safety. If you are discriminatory, judging someone, putting them into a box because they're difficult Māori, you're just treating the appendicitis, not Mr. Tipene that's in that bed.* (P6)

In the following excerpts, Participant 5 describes a nursing colleague categorising Māori, applying racial slurs to people whom she stereotyped. Similarly, Participant 17 described being categorised by her non-Māori colleagues who deemed her 'different' from the Māori her colleague had ridiculed. This behaviour demonstrates the acceptability of non-Māori colleagues expressing their personal views within the clinical space.

> *"Wow, look at that well-functioning Māori". But then you can't be too well functioning because people don't want, non-Māori don't want you to succeed in the same social construct as them. Pretty much they're worried about the success of Māori, but then also don't want you to be a hindrance to society.* (P5)

> *Because I think there's this idea that when you're Māori, and you're a nurse or you're academically successful, non-Māori think you're the exception. And so they think that they can say these things in your face and act like you are you're not part of that group. You're not a Māori like that.* (P17)

The participants asserted that they are willing to defend and fight for fair and just healthcare for whānau Māori who are accessing care, despite the risk of social consequences for themselves. One participant described her experience of being perceived as the 'angry Māori' by non-Māori colleagues for asserting the rights of tangata and/or whānau receiving healthcare:

> *"That could be my son and friends one day, and you're profiling them like that? You know that's still someone's baby", and she just looked a bit shocked, but you know this is my standard practice, I guess I'm always perceived as an angry Māori, I guess.* (P5)

Clinical Outcomes

Culturally unsafe practice, such as racial profiling, was identified by participants as impacting clinical outcomes for whānau Māori accessing health services. Racism and racial profiling lead to nursing practice driven by biases, assumptions, and deficit explanations that undermine equity and create a punitive approach to allocations of care. The following pūrākau identify how culturally unsafe practice impacts tangata and/or whānau health outcomes. Moreover, participants' pūrākau identify this as well-known to Māori nursing staff.

> *This happened to my uncle recently. They ignored him for 4 days and he had acute kidney injury, he developed a DVT* [Deep Vein Thrombosis]*, which travelled into a PE* [pulmonary embolus] *and this is all within 4 days of being admitted for a dementia assessment. So, that culturally unsafe leads to clinical unsafety.* (P7)

> *Yeah, they've experienced racism in the past. Discrimination, simple things like going to a GP or medical centre requesting something for, say, a kidney problem. You know lab bloods that haven't been checked or a trend of lab bloods going up or down, and nothing has been actioned.* (P9)

Some participants stated that their colleagues were blatantly making substandard clinical decisions because the health consumer was Māori. Moreover, in some scenarios, their colleagues were willing to openly admit that they were making racially-biased decisions to Māori staff. The following pūrākau identifies a clinical situation where a senior nursing colleague openly shared her bias against Māori accessing a Western-based health service. This pūrākau identifies her bias against Māori that directly influenced her clinical decision-making when triaging patients (prioritising) for an appointment with the service:

So yep, her actual sentence that she said out loud was, "I don't really know how to deal with Māori, so I leave them to last". (P6)

Kawa Whakaruruhau was identified as a fundamental component of high-quality healthcare for Māori whānau. The participants recognised that the trust placed in health professionals by tangata and/or whānau Māori to support them in their journey to hauora was a privilege. The participants identified real consequences for whānau Māori when health professionals break that trust; for example, a participant linked culturally unsafe care and the long-term impact on the client's health management.

And then he had an appointment with his heart specialist, and the next time we saw him, he'd stopped taking his meds. "My heart specialist says I'm done for". He passed within 3 months. So that's why cultural safety is a huge-ish thing. It's like I've seen how it affects someone when they're treated in a culturally unsafe way. (P12)

Non-Māori Fragility

Within the context of this relational analysis,DiAngelo's (2015) white fragility was been renamed non-Māori fragility to fit the Aotearoa NZ context. White Fragility refers to the defensivesss and hostility displayed by white people when challenged about racism (DiAngeo, 2015). In many of the participants' pūrākau, the participants did not identify the ethnicity of the non-Māori nurse, so it would be inappropriate to assume the ethnicity of the person they are discussing. Unless they explicitly stated their ethnicity, non-Māori is the term applied. Defensiveness, denial, and rationalising were noted to be responses of colleagues who were challenged by Māori for their racist behaviours in healthcare settings. The fragility was identified as being centred on fear of Māori taking something from non-Māori by participants. For example:

I think it's also fear-based, you know their own insecurities. You know around something that they might lose. (P18)

The participants identified differential treatment towards them by colleagues which they perceived to be because they are Māori. Participants recalled situations at work where colleagues made overt and covert acts of racism in front of or towards them. When challenged on their behaviour, colleagues responded by denying racism or acting flippantly towards the participants' concerns. For example:

I think she wanted validation that she wasn't racist because she had talked to another Māori, instead of coming to the Māori that she had actually offended. (P5)

Like I shouldn't have to beg for help, and I think because I'm Māori, you just turn your head the other way and carry on with whatever you're doing and then just expect me to get on with it. (P19)

If a Kaupapa Māori practice or initiative challenged non-Māori colleagues' practices or knowledge base, defensiveness and belittlement towards the participants were noted. Although the following pūrākau does not explicitly challenge racism, the marginalisation of Kaupapa Māori is evident. In response to the participant explaining how a Kaupapa Māori model could be integrated into the care facility, the manager appeared to marginalise the participant's knowledge base in response to his lack of understanding:

If someone wants to understand something, they'll say, "I don't understand". If they are intent on misunderstanding, they will make statements such as "That's philosophical" to start a conversation about something that isn't actually what you're trying to talk about anymore. (P1)

Sub-Theme 2: Dominance of the Western Worldview

The dominance of the Western worldview was evident in various participants' pūrākau. It manifested as the marginalisation of tikanga and mātauranga Māori, and the pressure to conform to the norms of the health service. The relational analysis of these themes demonstrated how each played out within the relationships between the participants and colleagues, as well as leadership and management.

Firstly, the dominance of the Western worldview was noted to permeate throughout interpersonal, institutional, and systemic processes, so it was evident in relationships within those constructs. Participant 7 described "*Through people's own mindset, and it is a mindset, there's the individual, the organisational, the systemic and the individual that we are fighting, you know*".

The dominance of the Western worldview also manifested in the marginalisation of Kaupapa Māori health practices, including Tikanga Māori. The marginalisation of Kaupapa Māori practices was either due to a lack of knowledge or understanding about its significance, the separation and prioritisation of clinical needs over cultural needs, and the scrutiny of Kaupapa Māori by health leadership. For example:

It's understanding when you go to someone's house, you take your shoes off and if you're there for like a social gathering you bring kai. And they just don't understand. (P5)

With the we're all equal, we're all the same it's that attitude is quite dismissive of our difference. Actually, we were the owners! We were the owners and now we're at the bottom of the heap. (P18)

Hierarchical Gradient

The participants' pūrākau describe the lack of connection between the decisions being made at the top of the hierarchical gradient and the enactment of those decisions on the front line. The disconnection between policy, leadership, and healthcare delivery was highlighted by participants as a constraint to Kawa Whakaruruhau. Specifically, the lack of accountability for policy delivery and the universal healthcare approach were noted to be inconsistent with the professional accountability theorised in Kawa Whakaruruhau. The disconnection between front-line staff, need-based prioritisation, and leadership was discussed.

The lack of consultation with front-line workers and clients about the essential aspects of service delivery was identified as contributing to the ongoing health inequities facing whānau Māori. Front-line workers, who were working with tangata and/or whānau daily, were identified as being well informed on some of the social and health needs of the communities they served. Instead, leadership is deciding what is important, despite the front-line workers' lived experience. For example:

Just a lack of communication. A lack of actually listening because they are being told by those in power that this is more important. Don't worry about those, we've got to deal with this now. Leave that. So, it's never picked back up or looked at again until something happens, that is triggered it to be resurfaced again. (P2)

They meet with the mana whenua board, but it just doesn't filter through. And they think it's happening, a bit like the Nursing Council. They set these policies, they think it's happening, but it's not. (P7)

There were a whole lot of other people making these decisions about what they're going to prioritise. Those are all universal programmes that are rolled out to everyone where we treat everybody the same. But actually, not everybody who needs it comes to that service or gets that service, you know. (P18)

Conformity

Within the relational analysis, conformity to the Western-based health system included expectations from leadership to conform to their desired perception of the health system, and tokenistic Māori representation at the leadership table. The participants' pūrākau demonstrate

the dominance of the Western worldview, the marginalisation of te ao Māori, and the pressure for Māori to conform to the system. Conformity was identified as culturally unsafe for Māori nurses. Moreover, the participants identified the pressure to conform as a major limitation to the enactment of Kawa Whakaruruhau in clinical spaces. For example:

> *But for our other Māori nurses who work for mainstream, they are employed by a Pākehā provider, and the expectation is they are a nurse first, not a Māori nurse, not a Māori.* (P16)

> *Can I say that their perception has somehow been lost, their identity and their voice have been lost, and they, for some reason, conform.* (P2)

In a similar vein, the expectation of conformity on tangata and/or whānau receiving care was highlighted by participants as a culturally unsafe practice. The conformity was described as the imposition of the Western worldview on tangata and/or whānau, and the expectation of conformity to the role of the 'patient' in the health service was identified:

> *And no one wants to decolonise their way of thinking of, "I'm the doctor. I hold authority". We are going to touch and manipulate and cut things out of and help heal because they've come in here and they've trusted us, but now we've institutionalised them*. (P6)

Theme Three: Kaupapa Māori Nursing and Western Healthcare Practice Interface

This section highlights the challenges that arise when Kaupapa Māori nursing and Western-based healthcare practices collide. Although challenging, at times, various Kaupapa Māori practices were identified that essentially lead to personal practice development and a higher quality of care for tangata and/or whānau accessing healthcare.

Sub-Theme One: Rangatiratanga

Within the relational dimension, the assertion of rangatiratanga in nursing practice was identified by the participants as fundamental to challenging the status quo in healthcare practice and integrating culturally safe care into nursing. Challenging racist behaviours and practices, and asserting their right to practice in a culturally congruent manner, were identified as two practices the participants engaged in regularly.

For example, in response to known racial discriminatory practices happening during clinical triage in a specialty clinic, Participant 7 described having to search ward lists for Māori patients to ensure that they would be offered her nursing expertise, like non-Māori patients were. There were negative consequences for speaking out against sub-standard care

for Māori in the service the participant was working in. These included the breakdown of collegial relationships, bullying, and job loss:

> *Well, any referral coming in is pushing them out, so I'm having to double-check and look through the hospital list, daily ward list to see if there were any Māori with* [health condition]. *So, like a safety net, and I know my* [service] *nursing practitioner mate down there, same thing. … I lost my job over it. A lot of bullying, and that was because we challenged them on their racism, bias, and everything.* (P7)

Similarly, within the healthcare context, participants stated that Māori need to assert their right to freely practice Kaupapa Māori nursing despite the perceived discrimination from colleagues. Participant 11 described the need to be unapologetically Māori in all situations to challenge the status quo and assert Māori people's rights to participate freely in society, on an equal playing field:

> *I just like being brown. Yeah, you can see me, you probably don't like it, and my money is the same as your money. Yeah, they can turn away or not acknowledge, I know you've seen me, I'll stand in line, and I'll be amongst it and I'll participate.* (P11)

> *Because that's all about you know practising tika and pono, having that integrity and transparency and honesty and all of those kinds of values that we hold there, we need to walk it out and practice it.* (P10)

At a broader level, participants identified challenging the status quo in Western-based health services as essential for progressing rangatiratanga. Participant 1 described the importance of challenging the status quo to grow in our practice:

> *Make people uncomfortable, essentially, that's what whaea* [Name] *said. That really stuck with me – if you're making someone uncomfortable, you're doing something right. Because we should all be a little bit uncomfortable because we live in a world where we try to aim for comfort rather than step out of our comfort zone.*

Practice Realignment

Despite the analysis revealing that Kaupapa Māori nursing practices were often marginalised in healthcare settings and unavailable during nursing education, the participants' pūrākau described examples of how they integrated Kaupapa Māori values and tikanga into their daily nursing practice. Also, the participants challenged their colleagues to realign their practice to one that enacted Kawa Whakaruruhau, starting with taking professional responsibility for

engaging with tangata and/or whānau accessing care. For example, in the following pūrākau, Participant 2 challenges her colleagues and the service she works for to put the people first and take responsibility for being unable to establish relationships with clients:

> *So, how do you do that? Ask them. Communicating and not assuming that because they're not engaged, they're not interested. You haven't connected to be able to provide that safe space. That's your job to do that, you're the professional. And 'people first' – people first.* (P2)

Culturally safe care for tangata and/or whānau Māori was identified by participants as being the responsibility of the whole nursing workforce, not just Māori nurses. Moreover, various participants identified culturally safe practice as a minimum competence requirement and identified those nurses who are not meeting that standard in breach of baseline nursing competence. Participant 13 asserted that cultural safety is a collective effort, not just that of Māori, "*Why aren't we all doing it together? And why is it just an individual thing when it should be a whole workplace cultural behavioural thing*".

The marginalisation of Kaupapa Māori nursing practices was identified as a limitation on Kawa Whakaruruhau in the wider nursing workforce. However, various participants stated that they were integrating Tikanga Māori into their practice naturally. Participant 9 identified how tikanga Māori was essential to providing Kawa Whakarururhau in a clinical scenario for Māori accessing health services. Furthermore, she identified the challenges of integrating practices, such as harirū, that are essential for whakawhanaungatanga, due to the Western values placed on nurses, including the use of therapeutic touch with clients.

> *But for our client base, it's crucial to establish those genuine relationships and that, as Māori, there is a therapeutic touch in the form of harirū when you greet someone. So, it could be perceived as safe practice, but from those who are non-Māori, that could be seen as unsafe.* (P9)

The realignment of nursing practice to integrate Kaupapa Māori values was identified as sparking fragility in some of the participants' nursing colleagues. However, the realignment of nursing practice was regarded by participants as essential to the enactment of Kawa Whakaruruhau. The following pūrākau gave specific practice examples of how the participant realigned clinical practice in a Western-based service to enact Kawa Whakaruruhau to their Māori clients. In the example, the realignment of the service norms was not well received by their nursing colleagues. However, the clinical outcome was that the

client continued to engage with the nurse and receive the medication that he needed to prevent complications of his medical condition:

> *I wrote a proposal and said, "Look, I'm happy to do it". They were like, "Oh no, we don't want people thinking this is the normal, like if we make an allowance now, then it's kind of expected". I ended up being able to do so, he continued his bicillins. Then in the office, they were like, "Oh, why is he doing that?"* (P3)

In another participant's pūrākau, she identified how one Māori nurse realigned practice in a Western-based health service to incorporate tikanga Māori into the processes for patients who had passed away while in the care of the ward. Her pūrākau identified the dynamic nature of Kawa Whakaruruhau in practice, demonstrating that other areas of practice decided to integrate the policy into their wards as well. "*She just got the resources and made it, "This is happening here". And it slowly trickled down to the other wards as well*" (RP 6).

From a health service delivery perspective, the realignment of practice to Kaupapa Māori model of practice was regarded as fundamental to tangata and/or whānau health outcomes. Participants further noted that the services generally flowed better under a Kaupapa Māori service delivery model. For example:

> *We find that when we're using the Maramataka calendar for whānau visits or for big hui that we have coming up, it does end up feeling right. It just re solidifies for us anyway that we are doing things right and it's okay to do it this way.* (P10)

> *Because the medical model is so constrained, around regulations, sickness, and those sorts of things, whereas if we're looking at a wellness model, we can be touching base with these whānau at any given time when they're well and support them on their journey.* (P16)

Nursing Professionalism

Within the participants' pūrākau, professionalism was discussed in two distinct ways: first, participants maintained their professionalism in the face of unprofessional behaviour from colleagues; and second, they queried colleagues about their responsibility to maintain professionalism. Of importance, high-quality professional conduct of registered nurses is an expectation outlined in the Nursing Council's (2012) Code of Conduct and the HPCAA (2003). One participant identified an example of open racism against her by a medical colleague. The participant describes her response as one that maintained her professional conduct in front of a team of kaimahi (colleagues):

> [the doctor said] *"Which one is she, the black one or the white one?" I said, "Excuse me, how can I help you?" And he was just condescending, saying, "Are you really in charge?" And I said, "Yes, I am".* [I chose] *to respect him, listen to what he was asking for and then decline him. Because what makes him any more special, just because he's a doctor and thinks he can come and talk to anyone that way? Let alone put me in a box by the colour of my skin.* (P2)

Similarly, the need to assert the professional standards of the nursing profession in Aotearoa NZ was discussed by participants. For example, the following pūrākau describes a situation where a senior nursing colleague disregarded tikanga to gain a bedspace in which a patient had recently passed away. In this situation, the participant had to assert that professional standards were adhered to as set in the hospital policy. "*No, follow the process – do it properly". And because I'm so vocal about culture anyway, it's not hard for me to do that*" (P6). Furthermore, the same participant described how she referred directly to the specific nursing competencies that should be adhered to in practice:

> *I've opened up a world that I didn't know existed because I'm strong enough to be like "That's not right, I don't like that – you're doing this wrong and you're not meeting your minimums. Let's not do that". So, Kawa Whakaruruhau influences a lot.* (P6)

Sub-Theme Two: Practice Development

The relational analysis of the participants' pūrākau revealed how relationships between the participants and colleagues, leadership and management, and tangata and/or whānau accessing health services impact their professional development. The participants discussed three areas related to practice development: reflective practice, collegial relationships, and dual competency.

Reflective Practice

Within this analysis, reflective practice was discussed in the context of building the necessary skill set to enact Kawa Whakaruruhau within practice and respond to culturally unsafe experiences appropriately while in a clinical setting. Developing the skills to enact Kawa Whakaruruhau was described as a continuous reflective process requiring individual commitment, as well as a sound recognition of clinical safety. The development of professional skills and knowledge in nursing includes the skill of patient advocacy, recognition of unprofessional behaviour, and being attuned to social cues to whānau Māori and colleagues. It also involves self-reflection on how clinical scenarios and Kawa

Whakaruruhau could be improved within a situation in a clinical setting. The reflection centred around the nurse-tangata relationship.

The following excerpts demonstrate the continuous reflective and intuitive processes necessary for the development of Kawa Whakaruruhau in nursing practice.

> *It's a process of reflection. You're never going to get it perfect. Like everyone's got their own preferences. Everyone's got their own things, but for me it's' very much reflection and "How did I do well?", "How did I not do so well?", "Where can I improve?"* (P1)

> *I think cultural safety isn't just about those protocols, those policies, those procedures. It's about just having the ability to read what's in front of you as well.* (P13)

> *Kawa Whakaruruhau requires commitment to learning about self so that we can be better prepared for the uncertain. So I think Kawa Whakaruruhau requires that of the individual* [commitment]. *I also feel that Kawa Whakaruruhau includes knowing when perhaps I'm out of my depth and seeking support elsewhere.* (P15)

Similarly, one participant stated that the nursing knowledge and skills associated with Kawa Whakaruruhau were not prioritised by student nurses, demonstrating that the focus is on what might be perceived as core nursing skills and knowledge, excluding cultural safety.

> *Because, as an undergrad, all you're doing is trying to learn and pass exams and get qualified. You could not care about how your practice is going to look or what it's going to look like, let's be honest*. (P13)

Collegial Relationships

The impact of collegial relationships on the professional development of Māori nurses was highlighted in the relational analysis. Firstly, reciprocal relationships that supported the mutual growth of all parties were discussed in the context of a Tuakana-teina (leader-learner) dynamic. Secondly, peer relationships underpinned by the same kaupapa were described as conducive to advancing rangatiratanga in the workplace. Moreover, relationships that demonstrated respect for Māori staff, no matter how small the gesture, were identified as representative of a deeper valuation of the Māori people and their place in society.

Tuakana-teina is a fundamental relationship in te ao Māori. Within the context of nursing, tuakana-teina was identified as integral to the development of Kawa Whakaruruhau for early career nurses and beneficial to the ongoing practice development of more experienced nurses. Within this context, tuakana refers to the more experienced nurses and

teina, early career nurses. The following participant's pūrākau identified the potential benefits of a tuakana-teina relationship within nursing for early career Māori nurses:

> *I think for our newer nurses and very junior nurses, particularly our Māori and Pasifika, I feel that their practice would benefit if they had senior nurses like me, who supported them to reflexive practices compared to holding on to the rere and having a bit of a vent but trying to continue when there's cultural safety lacking. Because all my Māori nurses experience it.* (P15)

The importance of growing the next generation of nurses to flourish professionally was identified as key to the ongoing development of Kawa Whakaruruhau and improvement of the health service for whānau Māori. In the following excerpt, the participant describes sharing communicative skills with early-career nurses, including student nurses. As such, skills to maintain professionalism in culturally unsafe situations are shared within the tuakana-teina dynamic in Māori nursing circles. The following excerpts identify the importance of collegial support to support the professional development of early career Māori nurses, particularly experienced Māori nurses:

> *And it's a good cause, that's a place where we all share what happened to us and how we handle it, and how we can reply. Not negatively, but how we can handle those situations.* (P11)

> *I'm in their spot right now in trying to be that change in that system but having a key couple of people. One person is enough to make some kind of change or to get something stimulated to change. But, we need people coming through to carry it and that's where it stops. It's that there's nobody is coming, carrying that guts of it all.* (P2)

Tuakana-teina dynamics also played a role in the continuation of positive role-modelling as nurses progressed in their careers. In the following participants' pūrākau, the participants identified nursing leaders' skills and communication styles that positively impacted their professional development, including the desire to be similar to nursing leaders once they had reached a senior nurse level:

> *I think that stems back to my first charge nurse. Yes, she did have her own office and had a Charge Nurse on it. But she'd come out and make a bed with us.* (P14)

Her kind of leadership style is to make sure that people are growing and we need to be growing our people into these spaces. I'll be all into making sure our newbies who have just gone on are taking on these leadership roles. (P10)

The importance of positive strength-based relationships between Māori nurses and nursing peers was identified as essential to transforming culturally unsafe spaces into safe ones by the participants. For example, the following excerpt identifies how a gesture of respect by colleagues demonstrated welcoming behaviour for the participant and transformed a space that had previously been unsafe.

I genuinely walked in, "Mōrena". And I got, "Mōrena", with the majority of non-Māori replying. And that really made me feel like "cool", like they weren't discriminating against me. I was welcomed. They accepted my greeting in my language. It was accepted in that space that was horrible the day before by that one person. (P11)

Dual Competency

The development of dual competency can happen at different times for nurses whereby, a Māori nurse may be advancing in generic nursing skills and knowledge, but in the earlier stages of development in their taha Māori, or vice versa. From a relational perspective, dual competency was discussed in a variety of dynamics, including the development of dual competency in culturally safe and culturally unsafe spaces, the lack of formal recognition of Māori nurses' skill and knowledge base by colleagues, and the impact of dual competency on client care. The complexity of dual competency development is described in the following participant's pūrākau:

As Māori we've got two things to learn. We've got clinical [knowledge] *and then we've got to make sure we're culturally* [prepared]*. But how do you do that as a new grad in a place who doesn't have as much care for Māori or Māori health or culture.* (P8)

Environments that do not support the development of dual competency are identified as a hindrance to Māori nurses' ability to develop Kawa Whakarururhau in clinical settings for tangata and/or whānau accessing services. However, the professional development of both dual competencies is highlighted as a protective factor for advancing Hauora Māori in the health services:

When we are thinking about whanaungatanga and manaakitanga and using that in our practice, then that environment doesn't really support that. It's about supporting

nurses with their taha Māori to be able to strengthen their resilience, because Māori nurses need to be politically staunch these days and to be politically staunch to stand up for their whānau, but not all can. (P7)

Within the relational analysis, the lack of formal recognition of Māori nurses' dual competency manifested in colleagues expecting Māori nurses to share their skills and knowledge in a tokenistic fashion, as well as an expectation from colleagues that participants would establish relationships with Māori organisations that some non-Māori nurses were unable to do for themselves:

Like teaching sessions, te reo classes, or if they need a karakia for something they're like, "Do you know a karakia for blah?" And just even like reaching out with like iwi providers or working in predominantly Māori schools. They always come to the Māori nurses first. (P5)

In the following pūrākau, the lack of recognition of the participants' dual competency was described as her nursing colleague's inability to name her skill set specifically and, instead, minimise her ability to whakawhanaungatanga whānau Māori accessing their services:

I was always allocated [Māori patients] *with the dumb reason of, "Oh I'll just think you'll understand them more". You're either painting me with the same brush as the difficult Māori who's sitting in front of them, or perhaps you have some little inkling in the back of your mind that culturally* [name] *is probably going to look after them better.* (P6)

Conclusion

The relational constructs of Kawa Whakaruruhau centre around whanaungatanga—the relationship between the nurse and tangata and/or whānau. Of utmost importance to culturally safe nursing practice, giving the time and effort to whakawhanaungatanga is paramount to effective nursing practice and the development of a therapeutic nurse-tangata and/or whānau relationships. Whanaungatanga is a natural part of Kaupapa Māori nursing practice and incorporates Māori values and adhering to tikanga Māori, such as the use of therapeutic touch, harirū. Therefore, Kaupapa Māori spaces are more likely to provide the room for whanaungatanga in nursing practice.

Within a nursing context, aroha ki te tangata denotes care that is pono, tika, and is protective of the mana of tangata and/or whānau accessing health services. Nursing care underpinned by aroha holds the needs of the tangata and/or whānau central. Therefore, it is

only by the nurse's ability to effectively listen to and hear whānau that whānau-centred care can be genuinely enacted. Gaining the trust of the tangata and/or whānau is both a privilege and a necessity for whanaungatanga and, in turn, effective nursing care. Once the tangata and/or whānau have developed trust in the nurse/health service, the nurse works hard to protect the trust that has been built. The genuine aroha felt by Māori for Māori is, in part, due to the shared whakapapa of being Māori, and also colonisation and the intergenerational impacts experienced by whānau Māori, which manifests in health and social outcomes. Māori nurses are at the forefront of experiencing those intergenerational impacts, including witnessing the daily marginalisation of Māori experiences by colonial society. Therefore, Kawa Whakaruruhau is created by whanaungatanga grounded in aroha and pono for tangata and/or whānau Māori accessing health services.

The relational dimension of culturally unsafe spaces focused on relationships between health leadership, front-line workers, and tangata and/or whānau Māori accessing health services that manifested both racism and the dominance of Western knowledge. As such, the relational dynamics between non-Māori health professionals and the tangata and/or whānau Māori were often disconnected and centred on a deficit-framing mindset from the health professional that had real-life implications for Māori clients accessing health services, such as infantilisation, racial profiling, and being relegated to the bottom of waiting lists to see health professionals. The dominance of the Western knowledge system led to a steep hierarchical gradient in which power is concentrated among a small number of people at the top of the gradient. The hierarchical gradient resulted in a disconnection between leadership and front-line workers, which impacted real-life health outcomes for whānau Māori through the implementation of policies in nursing practice. Moreover, the dominance of the Western worldview led to the marginalisation of Kaupapa Māori nursing practice, including Kawa Whakaruruhau. As such, conformity to the institution of health was required to maintain a position in the Western-based health service. Non-conformity is discouraged by health leadership and management.

The intersection of Kaupapa Māori nursing and Western healthcare practice impacts Māori nurses, leading to the assertion of rangatiratanga. The participants identified their nursing practice as a method for asserting the legitimacy of te ao Māori, as well as challenging the status quo of healthcare delivery in Western-based services around Aotearoa NZ. Asserting rangatiratanga is identified as vital to the development of space for Kaupapa Māori health practice in clinical practice and Aotearoa NZ, in general. Asserting rangatiratanga also includes challenging the normalisation of racism as a necessity to the

improvement of healthcare delivery and health outcomes for whānau Māori. In doing so, the power imbalances in the institution of health, including nurse-tangata and/or whānau relationships, are challenged, manifesting in non-Māori fragility. Thus, standing up and speaking out against racism in the clinical setting can have serious consequences for Māori nurses, such as bullying. Nevertheless, Māori nurses are willing to face those consequences for the betterment of the health services that whānau Māori receive.

The realignment of nursing practice to Kaupapa Māori practice is a fundamental construct of rangatiratanga in nursing. The realignment of practice to Kaupapa Māori includes the professional development associated with the dual competency that Māori nurses possess. As one's nursing skills and knowledge develop, so does the awareness and expectation of collegial professionalism for tangata and/or whānau Māori. Therefore, Māori nurses challenge colleagues to maintain a professional standard of nursing practice when caring for Māori clients, while also developing their skills. The skills and knowledge of dual competency are mastered and mainly refined through a process of reflective practice. Reflective practice skills develop with experience and knowledge consolidation, and can be taught to and developed by early career nurses within a tuakana-teina relationship, a reciprocal relationship that also supports reflective practices of the more experienced nurse, aiding in the mastery of a range of nursing skills.

Chapter Six: Findings - Poutama Toru: Emotional Analysis

In Poutama toru, analysis moves out of the social and relational dynamics to unfold the emotional experience of the person or people within those dimensions. In this poutama, connections between the social context, the relational context, and the impact of both on the participants' emotional experience become clear. Although the participants' pūrākau were heavily concentrated in the relational dimension of Kawa Whakaruruhau in practice, the emotional dimension adds a deeper layer of understanding of the impact of Kawa Whakaruruhau on Māori nurses and their practice, in its totality. Therefore, although this chapter is shorter, it adds a depth of understanding to defining Kawa Whakaruruhau and its importance as a fundamental philosophical approach, way of being, and practice for nursing in Aotearoa NZ. Importantly, the participants identified their emotional response as a core construct of their gauge for determining spaces and practices to be culturally safe or unsafe.

Like the social and relational analysis, the findings are divided into three themes: Kawa Whakaruruhau, Culturally Unsafe Spaces, and Transformational Action. Within each theme, the emotional response to each context is discussed. The themes and sub-themes are outlined in Table 9.

Table 9.

Poutama Toru: Emotional Analysis Themes and Sub-themes

Social Analysis Theme	Sub-themes	Pūrākau – Examples of Participant Quotes
Theme 1: Kawa Whakaruruhau	**1. Whakamana** • Strength • Feeling safe and secure	*"I've felt culturally safe is because they've been like really supportive and empowering me to advocate for my patients".* (P20)
Theme 2: Culturally Unsafe Spaces	**2. Isolation and Exclusion** • Feeling unheard • Feeling cautious • Matekiri	*"There'll be others where you feel uncomfortable because they're, you know, you could feel it. They didn't have to say, but you could feel that non-Māori who they didn't like you".* (P18)
Theme 3: Transformational Action	**3. Shared Whakapapa** • Strengthening • Practice Development	*"Ke te pai, great we appreciate you, we value you, absolutely we do. But we can't keep doing things the same way and expect different outcomes".* (P15)

Theme One: Kawa Whakaruruhau

Clinical spaces where Kawa Whakaruruhau is tangible, through the enactment of Māori values, tikanga, and the authentic valuing of te ao Māori, were described as positively affecting the participants emotionally. Specifically, feelings of empowerment and whakamana

were discussed by participants as an outcome of Kawa Whakaruruhau in practice. This first theme is named Kawa Whakaruruhau because it was the emotional gauge of the participants that determined whether a space or practice was culturally safe or unsafe. As such, the participants' emotional dimension of spaces that are perceived to enact Kawa Whakaruruhau is described.

Sub-Theme One: Whakamana

Whakamana was described by participants using various constructs, including feeling strong and secure in oneself. Whakamana was noted to have a positive flow-on effect for tangata and/or whānau receiving healthcare services, such as increasing the nurse's confidence to advocate in the workplace for tangata and/or whānau, consulting with senior health professionals regarding care plans, and addressing issues relevant to Māori with management.

Strength

The perception that Kawa Whakaruruhau was enacted in a clinical space led to participants feeling a sense of inner strength and contentment. Participants reported being able to speak freely about topics that may be deemed controversial or even restricted from speaking on, as well as increasing their confidence to communicate with peers and senior colleagues about the care of tangata and/or whānau, or concerns that the participants may have had. Communicating with colleagues effectively was noted to have a positive effect on practice development. For example:

> *It's comfort in understanding that they know that things might not be right and going to them and feeling like you can challenge but also feel safe to speak loudly on things that haven't been spoken about in the past.* (P17)

> [At a professional development day] *it was a really good experience and has taught me lots. But I think, too, it was because she made the space safe for us to be able to interact and communicate right at the beginning.* (P19)

It was noted that the feeling of cultural safety stems from a strong sense of self and security in one's identity. Feeling respected as a whole person who is part of a whānau, hapū, and iwi, and the wider community, as well as a nurse, was also identified as important. This point was like the social and relational analysis findings that found compartmentalisation of one's identity at work is associated with the perception of culturally unsafe spaces. For example:

> *I think the respect factor is huge like knowing that yes, I'm* [name] *and I'm Māori and I'm a nurse, but also that I have got a wife at home, I've got a daughter, I come from here and we're here and we're all on the same page around what's going to be the right thing and the right benefits for the* [clients]. (P13)

The importance of being free to be Māori at work was described as key to culturally safe spaces and practice by various participants. The strength that builds inside oneself when grounded in one's whakapapa was identified as being transferable to nursing practice. Also, the ability to authentically connect with te ao Māori while practising as a nurse was noted to be a source of strength for some of the participants. Moreover, participants stated that freedom from the imposition of the Pākehā worldview was part of the foundation of Kawa Whakaruruhau in practice. The following excerpts demonstrate the strength and contentment felt by being in spaces where Kawa whakaruruhau is enacted:

> *I've always felt culturally safe in a Kaupapa Māori environment. We all feel comfortable being Māori and can be Māori, without having something imposed on us, that's not ours.* (P7)

> *For those Māori who are on that journey, whakapapa is so important to connect to, to strengthen you in that, and it will transfer into how you do as a nurse.* (P18)

Strength and confidence in oneself were identified by participants as being important for nursing practice development. The feeling of increasing inner strength was identified as being necessary for participants to take on advocacy roles for tangata and/or whānau accessing health services and Māori colleagues. One participant identified their inner strength as transferable to tangata and/or whānau and Māori colleagues through practices that promote the palpable valuing of te ao Māori. In turn, a collective strength can be built.

> *Then you've got ones like myself who are like, I'm going to try as hard as I can to make you proud of yourself as a Māori, as a Pacific to fight this crusade alongside me, because it's lonely out here.* (P6)

Participant 20 identified the importance of collegial support when advocating for high-quality care for tangata and/or whānau receiving work. The support she received from colleagues at a Western-based health service to be empowered to take on the role of advocate was identified as a culturally safe practice. "*I've felt culturally safe because they've been like really supportive and empowering me to advocate for my patients*" (P20).

Kawa Whakaruruhau in nursing practice was identified as care that upholds the rangatiratanga and mana of tangata and/or whānau accessing care. A sense of individual and collective inner strength was identified as fundamental to rangatiratanga. Furthermore, rangatiratanga in one's life was recognised as essential to the ability of tangata and/or whānau to make life decisions by various participants. For example:

> *It can make a huge difference to their lives or their ability to make decisions and have a bit of power, and not feel like they're powerless to their whānau. To have to support them. Things that we might take for granted.* (P9)

> *One, it's going to give them back their freedom. Two, it's going to get them involved in what they're doing, and it's not going to be just an added drill-in thing that they have to do, and then they hate it, and they don't do it. They don't stick to it because they were told to do it rather than let's stick this into your life, because we want your life to be longer, and that's mana enhancing.* (P6)

Feeling Safe and Secure

Behaviour and practices that were perceived as pono were identified as being culturally safe. The perception that behaviour and practices were pono was primarily based on a feeling of internal safety and security experienced by the participants. Furthermore, the authentic and appropriate use of tikanga Māori, even at a beginner level, during nurse-tangata and/or whānau interactions was identified by participants as creating feelings of safety, security, and the perception of interactions that are pono for the tangata and/or whānau accessing health services, as well as for themselves. For example:

> *When we greet our clients, we will harirū, and it gives that opportunity for the client to feel safe and that it's a genuine engagement when we meet them.* (P10)

> *An understanding of the basic tikanga, just like the basics. Like you don't have to be fluent in reo Māori. You have to understand, you have to be polite, you have to go and harirū everyone. You take kai, like all that basic stuff, that's when I feel my safest.* (P5)

The enactment of Kawa Whakaruruhau in practice was identified as having the potential to increase feelings of satisfaction for the tangata and/or whānau accessing health services. In doing so, whanaungatanga developed within a relationship where the nurse's actions were perceived as pono and tika:

> *That they do feel all of those things, that they are listened to, that they are not judged, that everything that you are doing, exceeds what they expect of you.* (P10)

They were so thankful. It was lovely, like the whānau welcomed me in, you know, to stay for dinner. It just felt right. (P3)

Theme Two: Culturally Unsafe Spaces

Similar to the participants' internal measurement of Kawa Whakaruruhau, culturally unsafe spaces are measured by one's feelings. Culturally unsafe spaces led to feelings of isolation, exclusion, mistrust, anger, and disbelief for the participants.

Sub-Theme One: Isolation and Exclusion

Feeling uncomfortable in culturally unsafe spaces was linked to the participants' perception of being excluded by non-Māori. This was not always associated with a particular behaviour or language, but a feeling that participants perceived as dislike or disdain from their colleagues:

There'll be others where you feel uncomfortable because you could feel it, they didn't have to say, but you could feel that non-Māori that they didn't like you. (P18)

I felt quite isolated, very like, "Wow, don't come stirring us". Like, "You're only a new public health nurse and you're trying to change it already". (P3)

Feeling unheard

The imposition of the Western worldview on tangata and/or whānau was identified as a culturally unsafe practice. Moreover, the lack of listening to whānau was identified as creating feelings of pressure and mistrust in the healthcare system. Unfortunately, the compounding negative experiences of the health system led to participants and tangata and/or whānau fearing Western-based health services. Participants noted that tangata and/or whānau might start to disengage or avoid health services, leading to the development of mistrust in the system, a possible response to traumatic experiences in the mainstream health service. Similarly, the palpable disrespect felt by participants in response to the perception that they were not listened to caused feelings of anger and frustration. Importantly, participants identified their colleagues' and health professionals' deliberate lack of willingness to listen as a trigger for anger. The following excerpts identify the lack of trust and emotional responses to health professionals' ineffective communication with tangata and/or whānau who have accessed health services;

And they start to feel pressured, and the first thing is they start to step back and go "Whoa, what's going on here?" (P16)

Because I'm really scared about sending anyone into the hospital, and I've got that fear myself now, cause it so unsafe. (P7)

And I was so wild, because I was so angry that this person was telling me what to do, not willing to listen to me, talk to me, understand why I wanted a home birth. (P6)

Feeling Cautious

The perception of culturally unsafe practices led to a feeling of caution and a desire among participants to protect whānau Māori. The flippantness of colleagues' deficit-framing rhetoric directed at Māori health led to the participants feeling fear. As such, collegial relationships were negatively impacted, and participants were cautious around certain people and services. For example:

I immediately put up a guard around myself regarding my culture, being Māori around this woman. Because of what she said so comfortably in front of me, and there wasn't any care about her conversation. (P8)

I was like, I can't in good faith put one of my fragile Māori nurses, when we've got so few, into your unsafe space where you're not going to treat them well. You're going to use and abuse them for a service that's inundated with Māori. (P6)

The participants described being willing to act on those feelings of protectiveness experienced in response to culturally unsafe spaces. However, it was acknowledged that colleagues may label them in response to standing up and being protective. For example:

I'm more than willing and more than happy to fight for our people and uphold the mana that we have as Māori. But it's just hard constantly being perceived as an angry Māori, because I'm constantly calling people out, I guess. (P5)

Sub-Theme Two: Shared Whakapapa

Shared whakapapa was identified in the relational analysis as a form of connection that supports the development of whanaungatanga. Many emotions are experienced in response to the shared whakapapa Māori have. The concept of mamae (hurt, pain, ache) was applied as the general concept of hurt and emotional connection that is attached to shared whakapapa. Mamae was felt in reaction to participants resonating with the lived experiences of whānau accessing healthcare services. However, the mamae was also connected to the shared lived experiences of tūpuna and the mistreatment of whānau Māori witnessed by the participants in their practice. The shared mamae was identified as collectively felt, and extended beyond the

hours of work. Participants described that processing the mamae experienced in culturally unsafe spaces was a skill that developed with experience as a nurse. For example:

> *When you're Māori, you're going to feel that. It's not just their circumstances. We feel it and we don't stop feeling it because I clock out. We're likely going to feel it and remember it and think about it when I'm cooking tea for my kids at home, you know?* (P15)

> *But that comes with experience in the nursing profession, and that's not how I was when I was a new graduate, for example. I would probably, you know, my heart would bleed for the experience, you know, with the experiences, and perhaps I carried them for much longer than I should have.* (P8)

Moreover, the following excerpts demonstrate the connection the participants described to the experiences of their whānau and the experiences of the tangata and/or whānau they care for:

> *The people went to Māori news and made a complaint, so I was proud of them, but it hurt me a lot because the woman and her kids reminded me of my mum.* (P17)

> *It didn't even happen to me, but we are still feeling the effects of it. It still hurts and we are still here, we still have our language, and I'm going to learn it one day and speak it everywhere.* (P11)

The flippantness and disregard displayed by colleagues towards Māori lived experiences led to participants feeling a level of disbelief at their colleagues' behaviour and attitude. Moreover, Participant 5 added that the lack of shared lived experience between Māori and non-Māori nurses was a point of tension. She felt more sensitised to the impact of racism on rangatahi since she had become a mother:

> *I think it's just that they don't have the same lived experiences as we do. They've never had to worry about their kids or how their kids are going to be perceived growing up, and I think, I'm definitely a lot more sensitive to that kind of stuff now, especially having my own baby.* (P5)

Matekiri

The tokenism identified in both the social and relational analysis created feelings of frustration and disillusionment within the healthcare setting. Moreover, tokenism was felt as disrespectful and insulting by participants. The feelings in response to the perceived tokenism and lack of respect for the mana of the Māori people within culturally unsafe spaces were

expressed as matekiri (frustration, disillusionment, disenchanted). The lack of transformational change for Māori despite ongoing Pākehā interference, the lack of authentic power for Māori in leadership roles, the tokenistic use of tikanga Māori in clinical settings, and the ongoing ignorance to the plight of Māori were points of frustration for participants. The following excerpts highlight these points:

> *We are one of the most researched people on the friggin earth!! And what has it done for us?* (P16)

> *So, I sit with leadership. Side by side. But I'm at a point now where I'm like why can't you do the karakia? We have them on little cards, you know*. (P15)

> *And it's usually around that accreditation tick boxing exercise, which is frustrating and disheartening, and a little bit insulting.* (P14)

> *Frustrated and actually I get to a point where I'm like, "I'm not explaining it to you". You know it's not my job to teach you when you've been a nurse for 30 years, you know.* (P7)

The frustration felt in response to the culturally safe spaces was identified as enough to question one's future nursing career for various participants. However, the desire to improve health services for whānau Māori accessing them is enough motivation to stay.

> *Frustrated. Makes me want to cry, walk out, and leave the job. But I know that there are so many, so many whānau Māori out there that need someone or any Māori nurse to help them. And it's frustrating and I don't want to even think about what's happening when they're going into their home.* (P4)

Theme Three: Transformational Action

Culturally unsafe spaces were identified by all the participants as ones that tokenised and belittled Māori, essentially trampling on the mana of tangata whenua. Although a variety of negative emotions were experienced in response to culturally unsafe spaces, participants also identified positive emotions that led to transformative actions and practices, namely the assertion of rangatiratanga. As such, the intersection of culturally unsafe spaces and nursing practice that embraces Kawa Whakaruruhau led to the participants' personal and professional growth of Kaupapa Māori nursing practice.

Although the conformity of Māori to Western-based health services was identified by various participants as a reality of culturally unsafe health services, there is also a conscientisation that unfolds for many in response to the emotions that are felt in culturally

unsafe spaces. In response to strong emotional reactions, the participants identified a desire to develop a pragmatic response to the culturally unsafe space and/or situation—participants noted that they were willing to stand up and be an advocate for Māori within the healthcare setting because they knew how essential it was to have a Māori voice at the table while striving for health equity. For example:

> *How do I maintain the mana of this whānau because, at the minute this doctor is just tramping all over it?* (P17)

> *Because you feel like when they or those kinds of things happen, then if you react, it's like, "Oh they've got your power". So, it's kind of holding your power.* (P11)

> *From the get go I wanted to make sure that I was saying yes to these things, because the opportunity will be lost and our people will lose out if no one's there.* (P10)

Strengthening

Although culturally unsafe spaces led to negative emotions, positive emotional responses, such as a feeling of an increase in one's inner strength, were also identified. These positive responses enabled participants to grow stronger in their own identity as Māori, including setting boundaries for how people would treat them in the workplace. Developing inner strength was also associated with the advancement of one's nursing skills and knowledge base. Ultimately, the development of dual competency as a Māori nurse was essential to increasing one's confidence to provide a useful and meaningful health engagement with whānau accessing services. The following excerpts highlight the boundaries being set in response to culturally unsafe spaces by Participant 18 who recognised the importance of Kaupapa Māori nursing as an important part of dual competency development:

> *So, it taught me how I wanted to be treated and it taught me to be stronger in who I am… I use that to my advantage I think and once you learn that actually you have something unique to offer, you know you have something that's relevant to someone else and that you can make a difference for that person because of who you are.* (P18)

Practice Development

The importance of rangatiratanga in the consolidation of nursing knowledge to practice, and the development of Māori nurses' dual competency, was highlighted as two essential constructs of practice development for Māori nurses. The emotional analysis identified the impact that one's feelings have on nursing practice development and/or how practice development affects one's emotions. Kawa Whakaruruhau in practice was identified as a

collective effort, one where nurses feel nurtured and supported to develop their practice. For example:

> *I feel like it's culturally safe place is that each person is allowed the space to grow as they need to. Each person is supported and we recognise each other's strengths and we're able to value each other and support each other.* (P12)

Similar to the relational analysis, clinical scenarios were the core focus of reflective practice. Relating to desirable and undesirable practice traits, Participant 13 used their emotional reaction as a gauge for measuring practice effectiveness:

> *It's sort of learning like, oh yeah, he made me feel, she made me feel comfortable in that situation by doing this and this. And then I think about that in my own self. And that's kind of like where I draw that from, too, as well.*

The ability to enact Kawa Whakaruruhau in practice is fundamental to Māori nurses' job satisfaction. Working from an authentic place, protective of the mana of tangata and/or whānau, and building a genuine connection with whānau, was identified as a high nursing priority by the participants that provided job satisfaction as a nurse, as described by Participants 17 and 12:

> *I was so happy because then I knew that whakawhanaungatanga was there, and that's all you need. It doesn't matter if their health gets better or not, they feel safe, and that's what matters.* (P17)

> *I feel like I'm making a really positive impact in improving their health literacy and keeping them out of hospital. You know guiding them through the process of wherever they are in their waka life and for the time that they're with us.* (P12)

Conclusion

Spaces that were perceived as enacting Kawa Whakaruruhau by colleagues created feelings of inner strength, security, and safety for those who experience them, encapsulated as whakamana, which is transformed into nursing practice that is centred in tangata and/or whānau and Māori advocacy. Practice that is protective of wairua, upholds the mana of both the tangata and/or whānau and the nurse. In turn, one's rangatiratanga is enabled, which is beneficial to tangata and/or whānau engagement in health services, health decision-making, and the development of a nurse-client relationship that is therapeutic to the client, as well as beneficial to the refinement of nursing knowledge and skills for the nurse. Being pono and tika are integral to whanaungatanga, as well as upholding the integrity of nursing as a

profession. As such, the perception of authentic care and consideration of the tangata and/or whānau by the nurse was identified as essential to building trust with tangata and/or whānau, which can contribute to beneficial outcomes, including positive engagement with health services.

Spaces that are perceived as culturally unsafe create a significant emotional response. Feelings of anger, frustration, sadness, and disbelief are common reactions to environments that are perceived to be hostile, exclusionary, and isolating for Māori nurses. These strong negative emotions can lead to cautious and vigilant behaviours around colleagues who are perceived as culturally unsafe, as well as avoidant behaviours and compounding mistrust of whānau in health services. Moreover, the commonly discussed tokenistic behaviours of colleagues that trample on the mana of Māori, can lead to feelings of matekiri. Ultimately, the decision to continue working in Western-based services as a RN comes into question. There is evidence that culturally unsafe spaces create feelings that negatively affect the development of equitable health services, including the Māori nursing workforce, in Aotearoa NZ.

The intersection of culturally unsafe spaces and Kaupapa Māori nursing contributed to transformational action. Participants utilised an array of emotions to produce pragmatic responses to the culturally unsafe practices for colleagues and whānau, positioning Kawa Whakaruruhau as a transformative practice—a cornerstone of authenticity in Kaupapa Māori practices and Kaupapa Māori praxis, in which rangatiratanga is fundamental. Throughout this emotional analysis, the strengthening of Māori has been identified as an emotional response, both to culturally safe and unsafe spaces. Although the participants highlighted an array of negative emotions in response to culturally unsafe spaces, the individual and collective strength of Māori was highlighted as a reality in all spaces discussed. However, the real impact of culturally unsafe spaces on access to and engagement in health services is not to be underestimated. It is highlighted as a motivator for Māori nurses to engage in Western-based services, for the betterment of whānau Māori health and well-being. The emotional response is described as an internal gauge for assessing the effectiveness of nursing practice.

Chapter Seven: Discussion Chapter – Poutama Whā: Interpretative Analysis

This study explored Māori nurses' understanding of Kawa Whakaruruhau and how the perception of culturally safe spaces impacts them and their practice. Through an analysis of participants' pūrākau and a reflexive approach informed by relevant literature, a deep understanding of Kawa Whakaruruhau as a Kaupapa Māori nursing praxis emerged. The findings demonstrate that participants' understandings of Kawa Whakaruruhau align with Ramsden's (1990) conceptualisation as outlined in *Kawa Whakaruruhau: Cultural Safety in Nursing Education.* Additionally, it seems that Kawa Whakaruruhau is deeply embedded in Kaupapa Māori nursing practices. Ultimately, by practising in a culturally safe manner (underpinned by Māori values and tikanga), the nurse shelters and protects the wairua of the tangata and/or whānau accessing health services. Moreover, Māori nurses experience various benefits to their practice development in response to spaces perceived as culturally safe. The key discussion points are Kawa Whakaruruhau and culturally unsafe spaces. Two key conclusions have been drawn from this research. Firstly, Kawa Whakaruruhau is naturally integrated into Kaupapa Māori nursing practices as a praxis; and secondly, Kawa Whakaruruhau positively impacts Māori nurses' job satisfaction and practice development.

This chapter discusses Kawa Whakaruruhau as a nursing praxis grounded in a te ao Māori perspective. Professional nursing practices that enact Kawa Whakaruruhau are considered from a Te Ao Māori perspective, supported by nursing practice examples from the findings. The broader implications for nursing as a professional body in Aotearoa NZ are briefly identified, including the reality of culturally unsafe health practices and spaces for Māori nurses. The emphasis on culturally unsafe practices challenges the cultural safety rhetoric that is prolific in nursing in Aotearoa NZ. This point is crucial given that the upcoming implementation of the new nursing competency framework explicitly identifies Kawa Whakaruruhau as part of nursing competence (NCNZ, 2025a).

Kawa Whakaruruhau

This section of Poutama Whā conceptualises Kawa Whakaruruhau as a Kaupapa Māori nursing praxis. Importantly, despite conceptual inconsistencies and the predominance of cultural safety rhetoric in nursing, Kawa Whakaruruhau is integrated into Kaupapa Māori nursing practices. Exposure to Kawa Whakaruruhau and cultural safety theory in nursing education varied widely among the participants. However, the participants' understandings of Kawa Whakaruruhau consistently align with Ramsden's (1990) conceptualisation. This point

suggests that the theoretical underpinnings of Kawa Whakaruruhau are well known in te ao Māori. As Ramsden (1996) argued, the realities of the colonial and colonised populations in Aotearoa NZ are very different—this is what Kawa Whakaruruhau affirms.

This section outlines key concepts related to the discussion, including Smith's (2005) Kaupapa Māori praxis principles. Utilising practice examples from the findings, nursing knowledge and skills that inform nursing practices that enact Kawa Whakarurhau are discussed. At its core, Kawa Whakaruruhau is embedded in humanising nursing practices that are informed by te ao Māori concepts, knowledge, and values. Fundamentally, when Kawa Whakaruruhau is enacted, carefully considered approaches to nursing care, underpinned by the principle of āta, are taken in response to the recognition of the intrinsic tapu and mana of the tangata and/or whānau accessing care (Pohatu, 2013). The impact on Māori nurses' holistic practice development and refinement is discussed at the end of this section.

Praxis vs. Practice

Praxis is an ancient concept originating in ancient Greece (Mayo, 2022). A social science terminology, praxis describes "the process of using a theory or something that you have learned in a practical way" (Cambridge Dictionary, 2025, para. 1). Recent interpretations centralise social justice as the key outcome of praxis (Holmes & Warelow, 2001). Freire (1972) argued that praxis was achieved through reflection and action that results in dialogue. Moreover, he argued that dialogue without action without theory is empty (cited by Raja, 2022). Therefore, praxis is the integration of theory into action, using reflection, to be transformational for an individual and society in general (Raja, 2022).

From a nursing perspective, Rafii et al. (2021) defined nursing praxis as the application of nursing theory, knowledge, and skill to advance health equity and remove barriers to health attainment for all. The integration of theory into nursing practice is facilitated by a synergy of nursing 'ways of knowing' that underpin caring: ethical, aesthetic, empirical, and personal knowing (Rafii et al., 2021). For Chinn and Falk-Rafael (2018), "choosing… advocacy for social justice is an expression of caring" (p. 3). They describe advocacy as a construct of critical caring. Contrary to praxis is the ongoing repetition of nursing practices that lack self-reflection and thought (Rafii et al., 2021). To elaborate, Mayo (2022) clearly differentiated praxis from practice, arguing that practices, "in themselves are just actions. Unless a thinking, reflective component is wedded to them, as part of a value-driven pro-cess (e.g., in Freire's "social justice" sense) for better action (transformative action), the activity falls well short of praxis" (p. 1).

For cultural congruency, Smith's (2005) *Crucial Change Factors in Kaupapa Māori Praxis* serve as the framework for conceptualising Kaupapa Māori praxis, which I have applied to Kawa Whakaruruhau in nursing. Smith identified the process of praxis as conscientisation, resistance, and transformative action. He added that this process is not always linear. Using the kohanga reo movement in the 1990s as an example of Kaupapa Māori praxis, Smith demonstrated the active resistance of Māori to Pākehā hegemony and language loss as the catalyst for transformative action in Māori education and communities. Similarly, Kawa Whakaruruhau intended to awaken the nursing profession to the social injustices plaguing Māori and manifesting in ongoing health inequities (Ramsden, 1990). Moreover, through engaging in self-reflection and applying Te Tiriti o Waitangi as the lens for understanding the societal dynamics in Aotearoa NZ, collective transformational action was intended to be the outcome (Ramsden, 1995b; Ramsden, 2002). Smith's Kaupapa Māori praxis principles have been used as a framework to demonstrate Kawa Whakaruruhau as a Kaupapa Māori nursing praxis. Collective philosophy and whānau-centred practice have been merged into one principle as they were discussed as intertwined by the participants. Key theoretical components of Kawa Whakaruruhau are defined under each of Smith's principles, and the relevant findings are highlighted to demonstrate the principle in action.

The Principle of Self-Determination or Relative Autonomy

Rangatiratanga is affirmed as a birthright of all Māori, guaranteed in Te Tiriti o Waitangi and foundational to the theoretical framework of Kawa Whakaruruhau (Ramsden, 1990). The profound impact of Pākehā hegemony on rangatiratanga is a cornerstone of Kawa Whakaruruhau and key to understanding the power relations in Aotearoa NZ (Ramsden, 1990). The principle of rangatiratanga is explicitly highlighted in the findings within the context of Kawa Whakaruruhau and culturally unsafe spaces. Nursing care that was protective of the mana of the tangata and/or whānau or the Māori nurse was highlighted within the multidimensional aspects of the participants' pūrākau and linked to the delivery of equitable and high-quality nursing care. Relevant nursing literature has been utilised to support the nursing standards aspects of the findings.

Tapu and Mana – Humanising Healthcare

Health consumer safety is topical in healthcare practice (Health Quality and Safety Commission, 2019). Creating a safety culture is "a multifactorial framework that aims at promoting a system approach to preventing and reducing harm to patients" (Ammouri et al., 2014, p. 2). Although the idea of humanising care in nursing is not new, the shift to

patient/family-centred focused care and patient autonomy internationally signals a desire to move away from the traditional steep hierarchical order in healthcare (Allande-Cusso et al., 2025). Humanising care is crucial to improved patient health outcomes and, importantly, patient safety in healthcare (Allande-Cusso et al., 2025). From a nursing perspective, patient safety and harm reduction are regarded as "imperative" for nursing care internationally (Ammouri et al., 2014, p. 23). Harm includes adverse outcomes, such as prolonged hospital stays, readmissions to the hospital, medication errors, and preventable mortality.

The perception of a client as 'fully human' is an imperative to quality nursing care and underpins the shift to patient-centred care (Allande-Cusso et al., 2025; Capozza et al., 2016). Ethical decision-making in nursing is largely influenced by the moral worth assigned to a client accessing healthcare, emphasising the importance of humanisation in healthcare (Capozza et al., 2016). Therefore, it makes sense that humanising practices and patient safety are interrelated. To specify, humanising care refers to the demonstration of the nurse's respect for a client's humanity by empowering and enhancing the person's autonomy, agency, and decision-making in their health journey (Menenses-La-Riva et al., 2021). As such, collaboration and shared responsibility between the nurse and client develop, facilitating trust in the nurse-client relationship (Menenses-La-Riva et al., 2021). Key to humanisation is the nurse's belief that the patient has the ability and right to make decisions for themselves and has lived experiences (Capozza et al., 2016; Rafii et al., 2021).

Humanising care was evident in the findings of this research project. The findings demonstrate nursing care by Māori nurses that acknowledges and is protective of a person's mana. Participants further identified their ability to resonate with the lived experience of whānau Māori accessing healthcare as a source of aroha and motivation to provide high-quality, equitable nursing care. The following section discusses mana as fundamental to nursing care and clinical spaces that enact Kawa Whakaruruhau. Tapu is discussed first as the ultimate source of mana (Tate, 2012).

Tapu

Tapu is a spiritual concept. For Ruakere (2016), tapu is concerned with the "Why am I?" (p. 2). Similarly, Mead (2003) argued that understanding a person's position in the realm of tapu is "assuming that a person is far more than the biological self" (p. 33). Therefore, te ao Māori conceptualisations of what it means to be human incorporate the spiritual immortal dimension of a tangata, wairua (Marsden, 2003).

In a te ao Māori worldview, the material dimension originates from and is rooted in the spiritual realm. Moreover, spiritual laws supersede natural law and order (Marsden,

2003). Fundamentally, te tapu i te tangata (intrinsic tapu) is received from the divine creator. Therefore, since tangata are a creation of the divine, they are an image of the divine (Tate, 2006). Tapu is the state of being, "the most important spiritual attribute" (Mead, 2003, p. 45) and the source of all life that permeates all attributes of the person and supports a person's mauri (the spark of life). Tapu has various dimensions, including sanctity, attributes, and characteristics received as a birthright; importantly, defining who we are (Mead, 2003). Tapu is the essence of being, and, therefore, the totality of tapu is the fundamental purpose and meaning of life (Tate, 2012). Restrictions are sometimes put in place to maintain, sustain, or restore the tapu of an object or person (Tate, 2012).

One conceptualisation of tapu is tapu as a birthright. A birthright can be described as "everything a child can expect by being born Māori" (Mead, 2003, p. 39). In the past, determining one's birthright was based on a complex array of factors such as birth order, parents, and the position in one's hapū based on the position of the chiefly descendants. However, Mead (2003) asserted that the

> Social distinctions of the past no longer exist. An important consequence is that all Māori now belong to the Rangatira class. All are related to the chiefs and have nobility at birth… it also follows that every Māori child is born with spiritual attributes and every child has personal tapu. (p. 45)

Tapu is the most important spiritual attribute and a birthright that all Māori children possess (Tate, 2012). In a state of wellness, the whole person is safe, and personal tapu is safe and free from threats of transgressions (Mead, 2003). Tapu can be understood as the foundation of holistic Māori well-being; and mana, as the authority, autonomy, and control to restore and sustain it (Mead, 2003; Tate, 2012). In the contemporary world, all Māori children are born as descendants of the Rangatira (Mead, 2003). Mead's (2003) assertion gives context to a key tenet of Kawa Whakaruruhau outlined by Ramsden (1990), that positions rangatiratanga as a Māori birthright.

Mana

Rangatiratanga is intricately linked with mana. *Mana kawe i te rangatiratanga o te iwi Māori* is the "foundational form of mana o te tangata in which the rangatiratanga o te iwi Māori (Chieftainship of the Māori people) is maintained or restored" (Tate, 2012, p. 84). Tate (2012) argued that the totality of tapu and mana lies within rangatiratanga. Exercising this mana requires access and control over taonga, such as mātauranga Māori. Ramsden (1990) argued that health is also a taonga and positions this assertion as a pillar of Kawa Whakaruruhau. Therefore, Māori need to possess the ability to exercise mana whakahaere (governance,

management, jurisdiction) over their well-being and health on an individual and collective level for the restoration of hauora (health and well-being). Mana whakahaere is exercised when there is an authentic "ability to control and manage resources and people to sustain, restore and possess tapu in its fullness" (Tate, 2012, p. 85).

Context determines which aspect of mana is relevant to a set of circumstances. According to Mead (2003), mana is "the dynamic and creative force that motivates the individual to do better than others" and "a social quality that requires other people to recognise one's achievements and accord respect" (p. 51). For Tate (2012) Mana has 10 identifiable aspects—power, spiritual power, authority, influence, psychic force, control, prestige and status, manaaki, charisma and rangatiratanga (chieftainship). Tate (2012) defined the relationship between mana and tapu as, "Mana is tapu-centred. In every case, the mana deriving from tapu acts to manifest, address, enhance, sustain, and restore its tapu and the tapu of other beings until the goal of possessing tapu in its fullness is reached" (p. 78).

Mana has many usages and aspects, so it is hard to limit mana to a single definition. Mana is exercised in its many forms, with the prime objective being to reach the totality of tapu (Tate, 2012). Ultimately, mana encompasses the control, power, autonomy, sovereignty, and self-determination of tangata and/or whānau in matters that directly affect them, such as health decisions (Tate, 2012).

The recognition of the mana of tangata and/or whānau accessing health services was identified as foundational to Kawa Whakaruruhau. On an interpersonal level, the mana over one's tinana was identified as a key understanding of culturally safe care. As such, nurses responded to that recognition with high-quality professional nursing practice. Practice that centred on collaborative relationships and whakamana was discussed as a desired outcome of Kawa Whakaruruhau. The participants stated that they were willing to 'fight' on behalf of the tangata and/or whānau they were caring for, and argued for just care for them such as the authentic utilisation of tikanga Māori in practice.

The Principle of Incorporating Culturally Preferred Methods

This principle affirms the importance of culturally congruent methods in practice as praxis (Smith, 2005). From a theoretical perspective, Kawa Whakaruruhau affirms the cultural and ontological differences of Māori as valid (Ramsden, 1990; Ramsden, 1993). As such, nurses should be respectful of those differences and accommodate them in practice. The findings of this research demonstrate that Māori nurses incorporate Kaupapa Māori values and tikanga Māori both naturally and intentionally into their practice for the benefit of tangata and/or whānau in their care. Pohatu's (2013) Āta framework has been used to conceptualise the

relational practices that were described by the participants for the development of sustainable, respectful relationships in practice.

Respectful Relationships – Āta

The recognition of mana informs the basis of nursing decision-making and care prioritisation in nursing practice that enacts Kawa Whakaruruhau. Participants considered the complexity of the socio-cultural context of hauora Māori in all nursing care decisions; thus, careful and considered nursing care, centred on whanaungatanga and underpinned by the principles of Āta (Pohatu, 2013). Pohatu (2013) described Āta as "a cultural tool, shaped to inform and guide understandings of respectfulness in relationships towards wellbeing" (p. 15). Āta is further described by as "gently, slowly, carefully, clearly, deliberately, purposefully, intentionally, openly, thoroughly, cautiously, intently, quiet - stands before verbs to indicate care, deliberation, or thoroughness in carrying out the activity" (Te Aka Māori Dictionary, 2025, para 1). Participants embodied the principle of Āta in their nursing care to ensure their care was conducive to whanaungatanga, protective of the mana of everyone involved, and upheld both tikanga Māori and professional nursing practice standards. Fundamentally, the relationship is underpinned by the perception of whānau Māori as sovereign units with aspirations and mana, and the acknowledgment that well-being is achieved through respectful relationships (Pohatu, 2013).

In practice, underpinned by the principle of Āta, whanaungatanga is acknowledged as the basis of wellness (Pohatu, 2013). Within relationships, Āta, as an applied principle, aims to create a safe space for all involved (Pohatu, 2014). This sentiment was consistently demonstrated in the findings through actions consistent with āta-haere (a careful, considered approach to the establishment of whanaungatanga) (Pohatu, 2013). The participants identified whanaungatanga as the foundation of therapeutic nursing care within a culturally safe space, emphasising the importance of giving both appropriate time and space for whanaungatanga. Importantly, Kaupapa Māori health services were noted to support whakawhanaungatanga by allowing the nursing staff time and resources to engage in connecting with tangata and/or whānau accessing their service. In comparison, Western-based services were identified as promoting clinician-focused care services, with time was centred around the clinician, which created barriers to engaging in whanaungatanga. Despite this challenge, participants continued to prioritise whanaungatanga in their practice.

The importance of listening to and truly hearing whānau was highlighted as essential for whanaungatanga. Through engaging in āta-whakarongo (careful listening, hearing, and deliberation of the kōrero) (Pohatu, 2013), the participants identified various positive

outcomes conducive to the relationship between the nurse and tangata and/or whānau. Positive outcomes included the development of collaborative and trusting relationships, reported improved symptom management, an increased understanding of one's medical condition by the tangata and/or whānau, and increased engagement with the health service. From a practice perspective, professional nursing practice development was noted to be an outcome for some of the participants. Notably, the inter-professional communication development of participants was identified as an outcome of āta-whakarongo, such as increased tangata and/or whānau advocacy by the nurse. Importantly, listening, hearing, and advocacy skills were noted to develop with experience.

A careful and intentional approach to nursing care planning, reflecting āta-mahi, was identified as a construct of culturally safe care (Pohatu, 2013). Participants identified nursing care planning that was underpinned by the intention of building and/or repairing relationships between whānau Māori and the health services. Some nursing care examples included: arranging appointment times and clinic opening hours that suited their working hours, conducting health education sessions in the whānau home, and transporting tangata and/or whānau to appointments to ensure they were able to attend. Similarly, participants reported strategising for equitable care for tangata and/or whānau through advocacy interventions, including: advocacy for tikanga to be integrated into care when tangata and/or whānau were unable to, and directly challenging management and leadership about racist practices and policies contributing to inequitable care for tangata and/or whānau.

The sense that a space enacted Kawa Whakaruruhau was guided by the perception that Māori values and tikanga Māori were valued and upheld. Colleagues and service delivery models that expressed an authentic desire to whakawhanaungatanga with whānau Māori and Māori nurses created feelings of safety for the participants. Examples of actions that were perceived as demonstrating a genuine desire for whanaungatanga included collaborating with Māori colleagues to provide culturally congruent care practices to tangata and/or whānau, and services that showed an authentic commitment to professional development on te ao Māori. On an interpersonal level, demonstrating respect for tikanga Māori, such as removing shoes in whare and demonstrating reverence towards karakia, was identified as conduct of good character and reflected a genuine desire to build a connection with Māori staff and whānau accessing care. Essentially, challenging the dominance of Pākehātanga in healthcare and validating te ao Māori was a significant construct of Kawa Whakarururhau.

Tikanga Māori and Nursing Ethics

Tikanga Māori provides a te ao Māori perspective in ethical decision-making (Hudson, 2005). Kawa and tikanga are informed by the relationships embedded in whakapapa and are enacted for the "preservation of mana" within relationships (The Pūtaiora Writing Group, 2015, p. 2). To be tika, the recognition of the intrinsic mana and tapu of tangata/whānau/hapū is required (Tate, 2012). Tate (2012) stated that recognising one's mana as being pono, is when one's perception is congruent with reality. Tika is the response to pono (Tate, 2012). Therefore, kawa and tikanga provide a Māori ethical perspective of conduct that is fair and just in relationships, primarily for the preservation of mana (Tate, 2012).

The participants stated that their planned nursing interventions were based on Kaupapa Māori values and tikanga Māori, as well as Western nursing knowledge (ethical framework), primarily to appropriately manaaki the tangata and/or whānau. Manaaki is exercising practical steps to "address and enhance" the tapu of manuhiri (Tate, 2012, p. 86). Careful and considered nursing approaches underpinned by tikanga Māori and nursing standards were noted to have a positive effect on whanaungatanga, particularly in the development of a trusting nurse-tangata and/or whānau relationship. The participants stated that positive outcomes of their practice were measured by the continuing engagement of whānau with their health service, and by direct feedback from whānau.

Navigating the interface of te ao Māori and Western-based nursing practices can be challenging, especially when trying to adhere to both te ao Māori ethics (tikanga) and nursing ethics. Participants provided examples of clashes between Western (nursing) and Kaupapa Māori ethics and values, such as the use of harirū (therapeutic touch) during whakawhanaungatanga between nurse and tangata and/or whānau, adjusting office hours to accommodate a client's work hours, or helping a client with transport to an appointment. These examples were identified as potentially breaching 'professional boundaries' between nurse-tangata and/or whānau, common examples Māori nurse researchers have also noted (Komene Pene, Gerrad et al., 2023; Wilson & Baker 2012).

White fragility, called non-Māori fragility in this research, denotes emotional and psychological response of some white people who are challenged on issues of racism, white privilege, and disadvantage (D'Angleo, 2015). At times, the participants' actions fuelled fragility in their colleagues, sparking anger or 'labelling' of the participant and/or the tangata and/or whānau involved. However, participants stated they were willing to wear these labels to stand up and advocate for the benefit of tangata and/or whānau. Challenging nursing practice can be difficult as it strongly contradicts the profession's reputation of integrity, care,

and trustworthiness (Hantke, 2022). The findings of this research demonstrate that when Māori nurses challenge health inequities and racism in the system, they can be subjected to bullying-type behaviour, hostility, and, at its worst, job loss. These findings resonate with similar nursing research from Aotearoa NZ (Huria et al., 2014).

The Principle of Mediating Social and Economic Difficulties

This principle states that Kaupapa Māori praxis acknowledges and addresses the profound socio-economic struggles of many whānau Māori (Smith, 2005). From a theoretical perspective, Kawa Whakaruruhau affirmed that the challenges Māori faced in contemporary Aotearoa NZ were directly related to colonisation and colonialism. It was an expectation that nurses would acknowledge that in their practice (Ramsden, 1990). As the findings demonstrate, the collective experience of colonisation and colonialism was a key driver of equity-focused nursing practice. Essentially, the aroha felt by these nurses as people with a shared experience of colonisation was deep. Pohatu's (2013) conceptualisation of Āta provides a te ao Māori perspective on how "practitioners engage with people who have been marginalised and disempowered in their relationships" (p. 12) and navigate challenging social contexts that have disempowered whānau Māori in their journey to well-being. As praxis, Kawa Whakaruruhau is the collective effort of Māori nursing to mitigate some of the profound barriers to hauora Māori by striving for equitable and quality healthcare for tangata and/or whānau accessing care.

Acknowledging the lived experiences of tangata and/or whānau is identified as the second construct of humanising care practices (Capozza et al., 2016). The shared collective experience of colonialism was a source of strength and aroha for the tangata and/or whānau accessing healthcare. Various participants shared their experiences of tangata and/or whānau, which enabled empathy and understanding of the intergenerational impacts of colonialism and how they manifest in health and social outcomes. Participants recognised the historical and social challenges restricting whānau Māori from exercising their mana for the attainment of total well-being, such as entrenched racism in the healthcare system and profound socio-economic deprivation. As such, many participants tried to mitigate the impacts by taking on extra workloads and actively seeking out referrals of whānau Māori to ensure that Māori would receive a high standard of care.

Many participants identified themselves as a vehicle for justice in a fundamentally unjust health system. Drawing on their lived experience and dual competency as Māori nurses, participants drew from their nursing knowledge, mātauranga, and tikanga Māori to select the most ethical course of action for tangata and/or whānau accessing healthcare. For

example, advocating for tikanga Māori to be integrated into nursing care plans, such as the care of tupāpāku, and providing kai and clothing for whānau when required. In an interprofessional setting, various participants described advocating to manaaki visiting speakers at professional development days, despite push-back from nursing management.

The Principle of Validating and Legitimating Cultural Aspirations and Identity

This principle positions Te Ao Māori as the normative worldview and collective aspirations as the central kaupapa of Kaupapa Māori praxis (Smith, 2005). Key to the theoretical framework, Kawa Whakaruruhau affirms rangatiratanga over taonga as a birthright and a guarantee in Te Tiriti o Waitangi (Ramsden, 1990). Being 'free to be Māori' was a central theme in the findings—freedom to be Māori was important to both the participants, as Māori who are nurses, and the tangata and/or whānau in their care. The findings demonstrate that the participants integrate tikanga and mātauranga Māori into their practice to support whānau Māori, and for their development and integrity.

The ability to freely practice Kaupapa Māori nursing practice is dependent on the clinical environment. Notably, Kaupapa Māori health services were identified by the participants as spaces where mana motuhake (separate identity, self-determination) was enabled. This was expressed by participants as the notion of being 'free to be Māori', including the ability to integrate tikanga Māori in their daily practice. Being free from immediate racism and Pākehātanga dominance was evident in Kaupapa Māori services. Participants' dual competencies were developed, supported by colleagues and senior staff members, enabling the development of culturally congruent ethical decision-making with tikanga Māori and professional nursing standards. However, some Western healthcare organisations were identified as posing various challenges to enacting Kawa Whakaruruhau, such as overcoming the attitudes of colleagues, increased and heavy workloads, and the marginalisation of te ao Māori by colleagues and policies and procedures. These challenges resonate with findings from Māori nursing research by Huria et al. (2014) and Komene, Pene, Gerrard et al. (2023). Despite these challenges, the participants strived to provide care that enacted Kawa Whakaruruhau for tangata and/or whānau accessing health services.

The Principle of a Shared and Collective Vision/Philosophy and Collectivism in Te Ao Māori

This principle identifies the importance of a collective vision to inform the development of praxis (Smith, 2005). Collectivism in te ao Māori is the acknowledgement of whānau as the foundation of society and is essential to well-being, as depicted in Te Whare Tapa Whā

(MOH, 2023). Kawa Whakaruruhau was identified as a collective philosophy that is the responsibility of the individual nurse and the nursing profession in general to enact (Ramsden, 1990).

From a Māori nursing perspective, Kawa Whakarurhau was described as a korowai, 'wrapping' in a cloak and cotton wool, and being on the same waka and journey. 'Our people' were often referred to in terms of health inequities, denoting the collectivism and collective experience in te ao Māori. Moreover, the focus on whānau-centred care was identified numerous times. Whānau-centred care provided the opportunity to provide support around tangata for the attainment of well-being.

The conceptualisation of Kawa Whakaruruhau as a praxis was identified as a key concern for advancing Kawa Whakaruruhau in nursing. The conceptual inconsistency amongst the wider nursing body, including in nursing education, and the cultural safety rhetoric were two concepts of concern. Moreover, the lack of personal and collective responsibility of the wider nursing workforce for culturally safe care was identified as a barrier to Kawa Whakaruruhau.

Kawa Whakaruruhau and Practice Development

As a Kaupapa Māori nursing praxis, Kawa Whakaruruhau is positive for tangata and/or whānau accessing healthcare, and for Māori nurses. Notably, positive nursing practice development was highlighted as an outcome of Kawa Whakaruruhau. The positive outcomes reported by participants in response to clinical spaces that fostered and enacted Kawa Whakarururhau included the inner confidence and strength to develop nursing skills through tuakana-teina relationships in the workplace, increased tangata and/or whānau advocacy, and the freedom to be Māori in the workplace, leading to dual competency consolidation.

Practice development is defined as:

> A continuous process of improvement towards increased effectiveness in person-centred care, through the enabling of nurses and healthcare teams to transform the culture and context of care. It is enabled and supported by facilitators committed to a systematic, rigorous, continuous process of emancipatory change. (McCormack et al., 1999, p. 256)

Practice development is a process in which RNs continue to develop and integrate their nursing knowledge and skills required to achieve effective health outcomes for the ever-changing health needs of the public (King et al., 2021). As a nurse progresses, they move from baseline competency to proficiency (King et al., 2021). The consolidation of nursing

knowledge and practice in the early career nurse (defined as less than 5 years of professional practice) is an integral part of nursing professional practice (Llyod et al., 2023).

The significance of tuakana-teina relationships in practice development was described by various participants as being a reciprocal, beneficial relationship for nurses of all levels. For experienced nurses, sharing wisdom and knowledge with early-career Māori nurses (and student nurses) was identified as part of the role of experienced nurses and a source of job satisfaction. Imparting wisdom in dealing with the widespread racism in healthcare was perceived as an obligation of more experienced nurses. Sharing wisdom and knowledge was identified as being beneficial for the experienced nurse as it allowed for sound reflection on their practice. Teina (learners) identified the significance of having an approachable team of experienced nurses to consult with when formulating care plans for whānau Māori. As such, Kaupapa Māori nursing skills (as conceptualised in the dual competency framework) were noted to develop well within culturally safe spaces. The dual competency of Māori nurses has been discussed by Māori nurse scholars and Te Kaunihera o Nga Neehi Māori o Aotearoa, and the benefits of dual competency for hauora Māori are noted (Te Rau Ora, 2011; Walker et al., 2016; Wilson, 2018).

Relating to Kawa Whakaruruhau, continuous and ongoing engagement with reflective practice was identified as key to growing in critical caring activities, such as tangata and/or whānau advocacy; developing sound communication skills with whānau; and challenging culturally unsafe practices in clinical settings. Reflective practice is "the deliberate process of thinking through and interpreting one's thoughts, memories, actions, and activities to make sense of them, learn from them, and make changes if required" (NZNO, 2021, p. 1). Ramsden (1990) envisaged self-reflection as a core practice for developing culturally safe care in nursing. Moreover, reflective practice is identified as a tenet of Kaupapa Māori praxis (Smith, 2005). Reflective practice distinguishes praxis from repeated practice.

The enactment of Kawa Whakaruruhau in practice provides holistic safety for the tangata and/or whānau receiving care, as well as for the nurses providing the care, which has a positive impact on nursing practice development. Māori nurses naturally provide care that aligns with Kawa Whakaruruhau. Moreover, the participants' descriptions of Kaupapa Māori practice align with Wilson and Barton's (2008) *Te Kapunga Putohe (the restless hands): A Māori-Centred Nursing Practice Model,* which conceptualises the synergy of professional nursing practice and Kaupapa Māori practices for the benefit of whānau Māori receiving care. Kawa Whakaruruhau is essential to nursing in Aotearoa NZ. Indigenous nurses hold great value and are key to improving health accessibility and culturally responsive health services

for Indigenous peoples, including the integration of Kawa Whakaruruhau as a nursing praxis (Vukic et al., 2012).

Culturally Unsafe Spaces

This section discusses culturally unsafe spaces and practices based on the findings and relevant literature. The research findings demonstrate various systemic 'harms' towards tangata and/or whānau Māori receiving care, as well as to Māori nurses. Nearly all participants in this research identified the significance of Māori nurses in improving a health system that is failing Māori. However, racism underpinned culturally unsafe practices and created significant stressors for both participants and whānau Māori accessing care, including high workloads for nurses and substandard nursing care for whānau Māori. Racism towards Māori nurses, reported by the participants, resonates with the national and international literature on the challenges Indigenous nurses and nurses of colour report in their clinical environments (Cuccia et al., 2024; Huria et al., 2014; Vukic et al., 2012). For example, research by Cuccia et al. (2024) demonstrated that up to 70% of nurses of colour reported racism in their environment. Research from Aotearoa NZ, with Māori nurses, reported similar findings (Huria et al., 2014). The following section examines the processes that limit the practice of Kawa Whakaruruhau, contributing to it remaining marginalised by the general nursing workforce. The limiting constructs are racism, dehumanisation, and Eurocentrism in nursing.

Racism

Racism underpins the unequal distribution of the goods and services needed to sustain, enhance, and flourish in life, including access to quality healthcare and health services (Harris et al., 2024; Talamaivao et al., 2020). Hamed et al. (2022) added that racism "is embedded within a network of social, economic, and political entities in which groups of people are categorized and hierarchically ordered through a historical process of racialization" (p. 1). The health system, embedded with racism and steeped in a paternalistic hierarchy of knowledge, is designed to advantage one group, while disadvantaging others (Green et al., 2017; Talamaivao et al., 2020). Contemporary literature states that racism affects client healthcare engagement, the perceived quality of primary care services received, and is associated with poorer health outcomes, including mental and physical well-being (Ben et al., 2017; Hamed et al., 2022; Selak et al., 2020; Talamaivao et al., 2020).

People most affected by racism are those who have been categorised into racial or ethnic minority groups, a process called minoritisation (Hamed et al., 2022). Unsurprisingly,

people who fall into the category of a ‘minority’ are more likely to experience health inequities than the majority populations (Hamed et al., 2022). Within Aotearoa NZ, tangata whenua, Asian, and Pasifika were more likely to report racial discrimination than European-descent populations (Cormack et al., 2020; Talamaivao et al., 2020). Like international literature, perceived racism is associated with poorer satisfaction with healthcare providers in Aotearoa NZ (Harris et al., 2024).

Racism manifests at three levels: institutional, interpersonal (personally mediated), and intrapersonal, and is expressed in various socio-cultural forms (Hamed et al., 2022). Of note, racist practices continue to evolve and take on different forms, with contemporary racism being less overt but firmly embedded in institutions (Hamed et al., 2022). Dr Camera Jones’ (2000) *A Gardeners Tale* has been used to conceptualise institutional and interpersonal racism within this discussion.

Institutional and Systemic Racism

Institutional racism is defined as “the differential access to the goods, services, and opportunities of society by race. Institutionalised racism is normative, sometimes legalised, and often manifests as inherited disadvantage”, such as health inequities (Jones, 2000, p. 1212). Jones (2000) asserted that scientific research that focuses on ‘race’ only captures the effects of the racialised societal categorisation of a group of people. Therefore, it is not ‘race’ that is the variable in the disease processes, but the social conditions that have been created by racism. From an Indigenous health perspective, Hokowhitu et al. (2022) asserted that “the logic of [health] disparity helps to define the problem, the issue is that this logic simultaneously defines Indigenous peoples as the problem to be fixed and, consequently, falls into the trap of a deficit model framing” (p. 108). The myth of a culture-neutral health system perpetuates the idea that it is the ‘minorities’ that need to be fixed (Ramsden, 2015).

Institutional and systemic racism was identified in the findings as a barrier to Kawa Whakaruruhau for whānau Māori. The dominance of the Western (Pākehā) worldview in all major institutions in Aotearoa NZ was regarded as the foundation of culturally unsafe health practice. Participants noted that the dominance of Western values, ethics, and knowledge was foundational to the ongoing marginalisation of Kaupapa Māori health practices. The dominance of the Western worldview ensured that power continues to sit with Western-based health services, while participants working for Kaupapa Māori services described having to go through excessive auditing of their services and continual cessation of funding and contracts, leading to a lack of sustainable services for whānau Māori.

Interpersonal Racism and Deficit-framing Rhetoric

Personally mediated racism (interpersonal racism) is the "prejudice and discrimination, where prejudice means differential assumptions about the abilities, motives, and intentions of others according to their race, and discrimination means differential actions toward others according to their race" (Jones, 2000, p. 1213). The identification of belief systems that inform racialised thinking, such as the deficit-framing rhetoric, is important to understand. Hunt et al. (2013) argued that racialised healthcare perpetuates the risk that individuals will not receive the care they deserve but, instead, will receive care that is based on the clinician's presumptions about the tangata and/or whānau.

Interpersonal racism was experienced by nearly all the participants, particularly the normalisation of the deficit-framing rhetoric caused by sustained health inequities. The rhetoric was so embedded in the cultural norms of the various healthcare settings that it became normalised and was, therefore, acceptable 'office talk' by the participants' colleagues. Many participants identified that the rhetoric contained falsehoods about Māori and demonstrated a lack of knowledge of the socio-historical contexts of Māori health. The various 'myths' and/or beliefs that underpin Māori deficit framing are evident in the literature (Selak et al., 2020). The beliefs identified by Selak et al. (2020) resonated with the participants' pūrākau, including a denial that Māori are the Indigenous peoples of Aotearoa NZ; that colonisation was progressive for society; and that Māori health disparities are because of Māori deficits, not inequities in access, use, and quality of services.

The normalisation of deficit framing in the workplace is an example of social norms that permit the continuation of racism throughout generations (Jones, 2000). The normalisation of deficit framing led to obvious discriminatory practices such as triaging clients last at services due to the belief that Māori were challenging to deal with; colleagues making accusatory statements towards clients and their health status; refusing care to clients calling a service because it was nearly finishing time; calling Māori clients 'lazy' and 'useless' in clinic offices in front of Māori colleagues; and refusing to follow well-known tikanga (removing shoes) when visiting a whānau home because 'it's dirty'. These are typical racist behaviours (Jones, 2000).

Similarly, participants identified infantilising behaviours as racist behaviours demonstrated by colleagues towards whānau Māori. For example, accusatory attitudes from clinicians towards tangata and/or whānau regarding whether medical prescriptions were being complied with were noted by participants. Infantilising refers to people being treated in a child-like way so that the perpetrator asserts their control and dominance over the 'infant'.

Infantilisation of Indigenous people is reported in the literature as a justification for their poor treatment (Tesar et al., 2021).

Racial Profiling

Racial profiling in health has been documented as an influence on clinician judgment and decision-making for a few decades (Bowser, 2001). Racism and racial profiling in nursing are documented internationally (Cuccia et al., 2024; Iheduru-Anderson et al., 2020). Empirical evidence demonstrates that 'minority' populations are more likely to be 'homogenised' by healthcare workers. Homogenising people includes assigning a set of beliefs to a client based on one's prejudice, bias, and stereotypes about a minority group (Hamed et al., 2022). Some examples include beliefs and assumptions about attitudes, emotional regulation, and cultural practices of minority groups (Hamed et al., 2022).

Racial profiling and homogenisation of Māori were identified as culturally unsafe practices in the findings. Firstly, participants identified the clinicians' assumptions about the 'race' of a client used to explain their adherence to a medical prescription. For example, one participant reported that a colleague cited Māori being lazy as the reason for a lower immunisation uptake than the non-Māori population. Secondly, participants identified a categorisation process whereby they were placed in a different category than the whānau Māori and clients seen by their colleagues. Being assigned to this category of Māori was based on their colleagues' perceptions about the participants' socio-economic factors, including education status. Therefore, they were a different kind of 'Māori', so it was acceptable to air racist views in front of these participants. Finally, various stereotypes and assumptions about Māori were aired in the clinical environment, including perceptions that Māori were recipients of 'special treatment' such as scholarships and grants, and health services.

Dehumanisation

Dehumanisation is a racist practice driven by an ideology of inferiority of a racialised group. It manifests by restricting access to a population's history, knowledge, and cultural system through social and political methods (Hokowhitu et al., 2022). The dehumanisation of Indigenous peoples is central to colonialism (Smith, 2021). Dehumanisation processes aim to secure power and control of socio-political structures for the humanised group while dismantling the world of the dehumanised people (Smith, 2021). Hokowhitu et al. (2022) argued that the pervasive process of colonialism produces "Indigenous bodies and Indigenous

peoples as a recognisable category of the Indigenous health statistic" to reproduce the political power structures in Aotearoa NZ generation after generation" (p. 108).

Within the Aotearoa NZ context, the dehumanisation of Māori portrays them as biologically and intellectually inferior, and whānau as second-class to Pākehā families (Hokowhitu et al., 2022). These ideologies became public discourse in the decades following the start of colonisation and resulted in the stigmatisation and social and political discrimination of Māori. These dehumanising ideologies are still present in socio-political spheres today (Hokowhitu et al., 2022; Selak et al., 2020). The findings of this research demonstrate practices by nurses and other clinicians that align with dehumanising ideologies, such as Māori being unwilling or incapable of managing their health and well-being.

During the process of dehumanisation, a person and/or people lose their full humanity, identity, and autonomy in the eyes of the perpetrator, whereby the individual is disregarded and is instead classified "as part of a less human herd" (Dawson, 2021, p. 224). This dehumanisation process is theorised to be prevalent within healthcare, although limited research or evidence exists (Capozza et al., 2016; Dawson, 2021). The findings in the current research demonstrate that various behaviours and attitudes of people within the healthcare services align with the description of dehumanisation found in the literature. First, identifying the clinician and system-centric focus of the healthcare service that focuses on time, resources, and budgets over people was highlighted as a barrier to culturally safe care. Second, all participants described interactions between healthcare workers and whānau Māori that were perceived as dehumanising.

The connection between dehumanising practices and sub-optimal clinical care has been reported in the literature. Denying a client's experiences (spiritual and emotional responses) essentially denies their ability to think and feel and, therefore, denies their agency or rangatiratanga (Dawson, 2021). As such, a collaborative clinician-client relationship is unlikely to develop. Capozza et al. (2016) added that the denial of clients' experiences leads to clinicians 'overlooking clients' concerns that they have perceived to be in response to the clinician's assumptions and bias. For example, clinicians make assumptions that clinical prescriptions have not been followed by the client, resulting in repeated questions about compliance. Clinicians not listening to or hearing whānau Māori was a recurring theme in the participants' pūrākau. Again, not listening to clients can lead to inaccurate assessment due to missing subjective data (Trueman, 2017). Assumptions also lead to the clinician imposing medical interventions and prescriptions on a client instead of with a client, ignoring critical contextual factors that impact compliance (Trueman, 2017).

Language

The processes of dehumanisation are accelerated by the language that nurses use in their communication. Dahkle and Hunter (2020) identified nurses' language as "a social means of rational action that is connected to power; language reflects power existing in relationships and the meaning that nurses hold regarding healthcare users and their practice" (p. 1). Labelling patients with dehumanising language, such as referring to a client who missed an appointment as a 'DNA' (did not attend), is a practice that contributes to the dehumanisation of people accessing healthcare. Moreover, using stigmatising language, including in clinical notes, can lead to one clinician's bias against clients being transmitted throughout the healthcare service, stigmatising the client, potentially for many years to come, as health records are kept for decades (Himmelstein et al., 2022). Essentially, people who are denied agency in their health experience, such as by labelling, are not treated by clinicians to the same standard (Capozza et al., 2016). Therefore, the use of stigmatising language "may represent a value judgment of the intrinsic worth assigned to a patient" (Barcelona et al., 2024, p. 11).

The findings demonstrated the participants' discontent with the labels assigned to whānau Māori within the clinical environment. Language such as "difficult", "lazy", and "non-compliant" was highlighted as standard labels placed by clinicians based on their perceptions of Māori as a homogenised group. Many of the clinical scenarios described within the participants' pūrākau mirror what the literature identifies as dehumanisation within health (Capozza et al., 2016; Dawson, 2021). The findings emphasised how whānau Māori were not authentically listened to or were treated with flippancy in their health interactions with nurses and other clinicians, which led to whānau Māori developing an aversion to healthcare services.

Inability to Establish Rapport

The aversion whānau Māori have to health services was often described by nurses as the client being "lazy" or "hard to reach". Dawson (2021) argued that the language healthcare use workers is an essential part of practising in a way that maintains the dignity of the person accessing healthcare. It is theorised that the social expectations of the roles of the nurse and the client are deeply embedded in the culture of the health system. When a client deviates from the expected behaviour or pathway, such as expressing gratitude to a nurse, the nurse can feel undermined. The inability of a nurse to establish a relationship with a client can lead to a feeling of loss of control; whereby the nurse attempts to regain control of the situation by placing a label on the client (Copeland 2022). Furthermore, Copeland (2022) argued that

once a client and/or whānau has been labelled, it is impossible to establish a therapeutic nurse-client relationship and the focus becomes solely on the physical care of the client.

The findings of this research demonstrate that many non-Māori nurses cannot engage in whakawhanaungatanga with whānau Māori. Individual colleagues or organisations often seek out Māori nurses to attempt to engage Māori clients whom they have been unable to (Komene, Gerrard, Pene et al., 2023; Komene, Pene, Gerrard et al., 2023). Aligning with Copeland's (2022) writing, the participants identified that the inability to establish a nurse-client relationship was mostly met with resentment by their colleagues, and then labels were used. Moreover, the findings highlight that there appears to be a lack of accountability on the nurse's behalf for being unable to establish a relationship with tangata and/or whānau.

Eurocentrism in Nursing

Addressing racism in nursing is challenging as it contradicts the notion of a caring profession. Nursing literature identifies racism in nursing being centred around the supremacy of 'whiteness' (Hantke, 2022; Moore & Drake, 2021; Tobell & D'Antonio, 2022; Vukic et al., 2012). Non-European-descent nurses are 'othered' or excluded unless they assimilate into the cultural norms and values of nursing (Hantke, 2022). Vukic et al. (2012) asserted that examining the history of nursing reveals the foundations for understanding the development of racism in nursing. As a Eurocentric institution, nursing has been complicit in propagating ideology that promotes the superiority of Eurocentric knowledge and values throughout the world for generations (Tobell & D'Antonio, 2022). For example, Moore and Drake (2021) highlighted the complete lack of recognition in American nursing history literature of the African American women who were practising their traditional midwifery practice in their communities during the time of the slave trade.

In Aotearoa NZ, when the national health service was established, English nursing ideals were imported from Britain and introduced as the basis for nursing practices (McKegg, 1992; Wilson et al., 2022). Not surprisingly, the Eurocentric British-based ideals for nurses were reinforced, which led to the inclusion of women who were deemed to possess these ideals; thereby excluding many wāhine Māori (McKegg, 1992). There is a history of Pākehā nurses marginalising Māori nurses that dates to the early 1900s (McKillop et al., 2012). As such, the inequity of Māori nurses in the health system has been sustained throughout the decades (Wilson et al., 2022).

Participants discussed the privileging of the Western worldview (Eurocentrism) and the marginalisation of te ao Māori and Māori nurses throughout the professional body of

nursing and healthcare. This aligns with the nursing literature from Aotearoa NZ (Hunter & Cook, 2020; Huria et al., 2014; Walker et al., 2016). Importantly, the lack of value placed on Māori nurses' unique and essential skill set and knowledge base by the nursing profession in Aotearoa NZ has been highlighted (Wilson, 2018; Wilson et al., 2020).

The participants discussed the lack of access to Māori nursing knowledge, such as health models and Kaupapa Māori practices, during nursing education. For example, the concept of cultural safety was well known by all the participants, but Kawa Whakaruruhau, as a Kaupapa Māori nursing practice, was less known. Further, many of the participants did not remember Kawa Whakaruruhau being taught during their nursing education or as a professional development topic after registration. However, Kawa Whakaruruhau, based on their knowledge of each kupu (word), was known to many participants through their learning from whānau and community. Māori values and tikanga that were instilled in them from a young age were highlighted as the foundation of Kawa Whakaruruhau: manaaki, aroha, whanaungatanga, pono, and tika.

Relinquishment of Non-Māori Responsibility

The relinquishment of 'white' nurses' responsibility to address racism in nursing maintains the status quo and continues to marginalise those nurses who have been excluded from nursing (Iheduru et al., 2020). As described by Danquah and Elton (2021), accepting that the health system is a major contributor to health disparities "is anathema to medical ethics, professional codes of conduct, professional identities, and the reasons why we went into the caring professions in the first place" (p. 1). Therefore, accepting that health professionals are a part of the system that perpetuates health inequities for Māori can be confronting and overwhelming when posed with developing solutions (Danquah & Elton, 2021).

Kawa Whakaruruhau was intended to be a praxis for nursing in Aotearoa NZ. However, participants stated that deficit-framing positioned Māori as the problem and, subsequently, placed the onus on Māori, including Māori nurses, to rectify the problem. The lack of acknowledgement of Aotearoa NZ's colonial history, resulting in blaming Māori, was a source of incredible frustration for the participants. The expectations placed on Māori nurses by their colleagues to be the 'culturally safe' team member in their workplace led to what some of the participants perceived as the relinquishment of the responsibility for culturally safe nursing practice as a service or nursing team effort. Therefore, the expectation was placed on the Māori nurse to take charge of the 'cultural safety activities' in the workplace, such as a tokenistic karakia. These points resonate with the Māori nursing literature in Aotearoa NZ (Hunter & Cook, 2020; Huria et al., 2014).

Conclusion

Kawa Whakaruruhau is a Kaupapa Māori nursing praxis. Despite the irregularities in educational approaches in nursing training, Māori nurses inherently know about Kawa Whakaruruhau. Their understandings align with the work of Ramsden (1990) and other relevant Māori nursing literature. Their understandings offer insights into how Kawa Whakaruruhau theory can be integrated into nursing practice. Aligning with Wilson and Barton's (2008) Kaupapa Māori nursing model, *Te Kapunga Putohe*, Kawa Whakaruruhau as a nursing praxis encompasses care of the holistic dimensions of the tangata and/or whānau utilising a synergy of tikanga Māori and nursing professional standards to offer the highest standard of nursing care to tangata and/or whānau accessing healthcare. Kawa Whakaruruhau is a te ao Māori perspective of humanising nursing care. Humanising nursing care centralises the tangata and/or whānau as a person with inherent dignity—tapu and mana from a te ao Māori perspective—and having autonomy and agency.

The findings demonstrate evidence that Kawa Whakaruruhau, as a nursing praxis, creates a metaphoric shelter in which Māori nurses feel safe. Their practice can flourish, and tangata and/or whānau can receive equitable and just healthcare. It is a form of resistance to Pākehā hegemony in healthcare and transformational as Māori nurses bring a unique skill and practice to nursing in Aotearoa NZ. Kawa Whakaruruhau is underpinned by the assertion that rangatiratanga and the ability to exercise mana are fundamental to hauora Māori, which is a birthright of Māori. At its core, whanaungatanga is the priority of nursing care that enacts Kawa Whakaruruhau. The tangata and/or whānau are given time and listened to, necessary for a respectful and trusting relationship. The broader socio-political context of hauora Māori is understood on a personal and collective level, as equity (as guaranteed in te Tiriti o Waitangi) and justice that underpin Kawa Whakaruruhau as a Kaupapa Māori nursing praxis.

As a Kaupapa Māori nursing praxis, Kawa Whakaruruhau is naturally part of the practice ethos utilised by Māori nurses. However, since the implementation of cultural safety education in nursing education, an evaluation has not been conducted to assess the effectiveness of cultural safety in nursing as a professional body. With the upcoming implementation of the new NCNZ (2025) competency framework, the upskilling and development of Kawa Whakaruruhau knowledge among nursing leadership, educators, and clinical nurses is strongly recommended. This aims to promote a consistent and conceptually accurate approach to Kawa Whakaruruhau education to avoid the repetition of tokenistic and ill-informed cultural safety education in the nursing workforce. Using Kawa Whakaruruhau as a framework, the power imbalances that are perpetuated through social discourse,

including the deficit-framing rhetoric surrounding Māori health, and the Eurocentrism of nursing, need to be challenged in nursing education. Importantly, the distinction between Kawa Whakaruruhau and cultural safety is strongly recommended, given the lack of clarity in nursing that the findings have demonstrated.

Hudson (2005) asserted that ethical decision-making processes have a "constant filtering of information through these value sets" (p. 58)—personal, professional, cultural, and ethical. The findings of this research provide evidence of a professional nursing culture that normalises racism, deficit-framing thinking, biases, and Eurocentrism—essentially dehumanising Māori. Therefore, the ability of clinicians who hold racist values to make ethical decisions regarding Māori health is questionable. Within the context of nursing, understanding gained through reflection on personal bias, prejudices, and privileges is regarded as an essential component of building one's moral and ethical competence as a nurse (Wocial, 2010). It is hard to imagine that ethical and moral decisions can be made for tangata and/or whānau accessing healthcare when dehumanising practices are prolific within nursing in Aotearoa NZ.

Chapter Eight: Poutama Rima: Spiritual Dimension

Poutama rima identifies the spiritual dimension of the participants' pūrākau. Wairuatanga denotes spirituality and is concerned with the unseen divine realm. Wairuatanga is a highly personal experience; therefore, it is inappropriate to attempt to interpret one's spirituality, and it is outside the scope of this research project. However, it is essential to reassert the significance of wairuatanga in te ao Māori. For tohunga and Christian minister, Rev. Māori Marsden, it is most important to understand that the spiritual realm supersedes the physical in the order of reality in te ao Māori. While the physical passes, the spiritual is infinite (Marsden, 2003). As Tate (2012) asserted, although a magnitude of dispossession occurred during colonisation, wairuatanga can never be dispossessed. Tate's assertion supports the argument that an interpretation of one's wairuatanga is inappropriate.

Wairuatanga is not separate from taha hinengaro, taha tinana, taha whenua, or taha whānau. Instead, wairua is the essence of life and is embedded in all dimensions of the human experience (Marsden, 2003). As Tate (2012) explained, wairuatanga is embedded in the ontological reality of te ao Māori that addresses the very nature of 'being'. All that has been created, including human beings, is a creation of Atua or Ātua (inclusive of monotheism or polytheism belief systems). Atua or Ātua is the source of all being and is, therefore, tapu (set apart). Importantly, harmony between Atua or Ātua, tangata, and whenua is vital to the fundamental life goal; the totality of tapu. A complex system, expressed in tikanga and kawa, designed to protect tangata from transgressions (whakanoa) exists (Tate, 2012). Concepts such as mana and mauri proceed from tapu, and their primary purpose is for tangata and whenua to reach the totality of tapu (Tate, 2012).

The participants identified and discussed these various concepts within their pūrākau in response to their experiences of Kawa Whakaruruhau or culturally unsafe spaces. Similar to poutama tahi, rua, and toru, each poutama of the pūrākau analysis builds upon the others to unfold the depth of Kawa Whakaruruhau and its significance in hauora Māori. This chapter is not divided explicitly into themes; instead, is presented as a series of excerpts that have been divided by kupu or concepts highlighted by the participants. The purpose is to maintain the flow for the reader, while leaving interpretation of the pūrākau at a minimum. Excerpts that identify or discuss concepts of the 'unseen' energies were regarded as wairuatanga-themed and added to poutama rima. Participants discussed the following concepts: Kawa Whakaruruhau, wairua, mana, mana whenua, power, ko wai au, and pono and tika.

Kawa Whakaruruhau

All the participants discussed the impact of culturally safe spaces on one's wairua. Kawa Whakaruruhau was described using metaphoric language that denoted a safe and secure korowai, as well as cotton wool, wrapping around whānau accessing health services. Participant 9 added that the metaphoric korowai did not just protect the physical well-being of the whānau, but extended to the wairua of the whānau as well:

> *[Safe practice] it's like a korowai that wraps around them safely.* (P9)

> *I guess keeping our culture, because we were getting taught in New Zealand, keeping the Māori culture safe from harm, and just wrapping them in a cloak, in cotton wool.* (P4)

> [Kawa Whakaruruhau is] *not just the physical space but also, spiritually, their wairua.* (P9)

Wairua

Kawa Whakaruruhau was identified as having a positive effect on one's wairua. The holistic nature of the human experience, and how one construct of a person affects the others, was identified. For example, Participant 8 described sensing her settled wairua positively affecting her engagement during nursing practice. She also identified her Māori identity as intrinsically linked to her wairua. Similarly, Participant 15 identified wairua as interconnected with the physical, emotional, mental, and whānau dimensions.

> *Especially Māori nurses, they are happy or they're settled because their culture, their wairua, is settled in those spaces.* (P8)

> *I think emotion and wairua sit so closely together, and that of course impacts our tinana and our whānau. I think you can't separate any of the components from one or the other. So that's why I feel we feel it so strongly because our emotions are so entwined with our wairua. And, when, when it's unbalanced, then it spills over into those other spaces as well.* (P15)

The following pūrākau describes the participant's process for re-centring his practice when a clinical or workplace scenario may not have gone to plan:

> *And you know navigating certain situations is different like I need to respect my mana my mental, my wairua, and my hinengaro, those types of things are changed, and then it will come out in your own practice as well and that's when you need to identify it and go. Take a minute and get back to zero. I need to reset.* (P13)

Similarly, culturally unsafe spaces were identified as having a significant impact on one's wairua. Specifically, perceived tokenism was identified as an action that was experienced in a spiritual sense. For example:

> *My experience is that when I'm taking care of wairua, I do a better job. Well, my engagement with the people is better because I feel good. But if I'm in a racist place, I'm still going to do everything based on evidence clinically. And I'm going to try my darnedest. But in my puku, I'm a bit sore. So I'm a bit empty, my wairua because it's a racist environment.* (P8)

> [Culturally unsafe clinical spaces] *well, it impacted my wairua. Constantly, you know. I mean that whole (service) thing.* (P7)

> [Tokenistic accreditation at work] *With 100% of my soul, I know it is.* (P14)

Moreover, Participant 8 identifies the impact that racism can have on one's wairua if they have not acquired coping strategies to deal with it: "*Because you know, if we look at Te Whare Tapa Wha. If you're unwell, wairua, which being culturally unsafe, can make you a bit unwell. Wairua, if you don't know how to deal with it, right?*".

Mana

The concept of mana was discussed by nearly every participant at least once. There are various forms of mana; however, all mana is derived from tapu that has been endowed to tangata by Atua or Ātua (Marsden, 2003). In the following excerpt, Participant 6 described a clinical scenario that she perceived to be culturally safe for the various people and whānau that were involved. Of significant importance, she described the culturally safe care of a client who had passed, and his whānau, as being mana-enhancing. Following the death of the well-known Māori client on the ward, the appropriate policy was initiated by the staff, which tikanga Māori underpinned. "*That was the most culturally safe that I have ever felt because every part of what that man needed was respected, and done in a way that was mana-enhancing*" (P6).

Participants identified culturally unsafe care and practices as a violation of one's mana. As such, some participants described striving to uphold the mana of the whānau involved. Culturally unsafe care and services are identified as significant challenges to health attainment for Māori. Two participants talked about the concept of 'fighting for' acceptable care that ultimately upheld the mana of the client and whānau Māori.

I'm more than willing and more than happy to go and fight for our people and uphold the mana that we have being Māori. But it's just hard constantly being perceived as an angry Māori. (P5)

And we understand why they need to be there because that gives strength, you know. But it's not always supported, so then you're having to fight for the whānau on their behalf to have to do that. (P7)

As a client, the power of being truly heard by health professionals was identified as mana-enhancing by Participant 6. Moreover, an authentic collaboration between the health professional and the client and whānau was identified as essential to positive health outcomes; as well as care that upholds and, even, enhances the mana of the recipient of care:

It was really cute, really nice. It was all I needed, because with mana-enhancing. But, that obstetrician wouldn't listen to me. Both midwives would listen to me, but the medical staff didn't want to listen to me. (P6)

It's going to give them back their freedom too. It's going to get them involved in what they're doing, and it's not going to be just an added drill-in thing that they have to do, and then they hate it and they don't do it. They don't stick to it because they were told to do it rather than. "Let's stick this into your life, cause we want your life to be longer". That's mana enhancing. (P6)

Mana Whenua

Mana whenua is the authority held by iwi and hapū who have customary authority over the land (Henwood & Henwood, 2011; Te Aho, 2006). The concept of tapu and mana is derived ultimately from Atua or Ātua and also from whenua (Tate, 2012). Culturally unsafe practices, including the undermining and marginalising of Māori as tangata whenua, were identified as a constraint on the enactment of mana. The right to live freely as Māori with rangatiratanga over taonga was identified by participants, as demonstrated in the following excerpts:

We are in our own country, we are tangata whenua. We should have the power to live our lives the way that we want to. We don't want to be seen as the other. We want to be seen as mainstream. (P10)

It all comes back to that understanding and acceptance of different cultures, particularly our own in Aotearoa, because we are mana whenua. Recognising that we have our own system and knowledge and that we should be able to use them. (P7)

The previous pūrākau identified the importance of both possessing and utilising mātauranga Māori freely. A similar sentiment was expressed by Participant 10, "*We're clever people! We have strategy and different techniques we can use, so let's use our collective wisdom in the right place*".

Power

The concept of power was discussed in terms of maintaining one's power in culturally unsafe spaces as well as the identification of power in one's life, particularly for clients and whānau accessing healthcare services. Importantly, participants noted that thoughtful reactions during inappropriate interactions can retain power and mana. For example:

> *Yeah, before reacting, it changes the kind of whole power because you feel like when they or those kinds of things happen, then if you react, it's like, "Oh they've got your power". So it's holding your power, just not answering.* (P11)

> *There was no time for reaction, or even to give him any of my power because he tried to take it by putting me in a box and calling me a black person.* (P2)

> *And keep my mana, but I don't also need to make a big thing out of either. You know, like yesterday, I could have gone, "Oh, you're just getting the token Māori to stand up and do karakia". But, it was like, "No, here's a cool opportunity to introduce myself to people that I didn't know".* (P13)

From the perspective of tangata and/or whānau care, one participant noted the importance of discussing power and control in one's life in terms of well-health and holistic health service models:

> *And that mind shift is around that control. Who has control of your life? Oh, I do really. Control is where you make those decisions based on what's in front of you and what may be down the road. You make the decisions on you know, to an extent, what kai you will buy based on what you know.* (P16)

Mana Tūpuna

Tūpuna and whakapapa were identified by participants as a source of strength and hope, both in past and present tense:

> *Because we have to keep going, and we are here you know. And then you look back, and what our people did to get us here, I always reflect back to that.* (P11)

You go back to a white space, and you think, "I've got my girls behind me, I've got my tūpuna behind me, I'm good". (P1)

I respect their culture, you know, because at the end of the day, my culture's in me, it's with the people behind me, my whakapapa, my ancestors, it's like they're all there with me. (P13)

Ko Wai Au?

Tate (2012) asserted that the fundamental question central to wairuatanga is 'Ko wai au?' (Who am I?). The following excerpts describe the importance of recognising and respecting Māori identity in clinical spaces. Moreover, identity was described as intrinsic to wairua.

Because that takes care of our wairua, our taha tinana, our taha whānau, everything to do with our identity... My wairua, as in my Māori-ness, my indigeneity, was taken care of because of the place that I was at. (P8)

Māori practitioners who have been brought up in this space, we live it, we breathe it, this is our whānau and community. We automatically understand. And that is a generalisation, but you know most of us automatically understand because that's been our life. (P10)

Pono and Tika

Pono is often translated as being truthful. Relating to spoken words and actions,

> As a principle governing action, pono calls for actions that promote and acknowledge integrity, faithfulness, loyalty, reliability, and consistency… By pointing out the integrity or otherwise of a person or a set of relationships, pono opens up the way for change. (Tate, 2012, p. 109)

In following pūrākau, Participant 13 describes a situation that was deemed as being unauthentic by the participant. As such, tika could not have been implemented appropriately, thus affecting one's wairua. In contrast, Participant 14 describes a professional development day in which the participant perceived the presenter's actions as pono and, therefore, tika to the kaupapa of the day. This, in turn, had a positive effect spiritually.

Because why do I have to do it in te reo Māori? If, you know, like yes it, it represents me and my cultural whakapapa, but not everyone here is Māori, most of them are Pākehā, so why don't we have, why don't we do a karakia that everyone can understand and everyone can relate to and has good energy and good spiritual energy? (P13)

> *I think it was received a lot better than the predecessor! Yeah, it was great ideas and good graphics, and you know their energy and their knowledge, it was amazing. And their mana and their wairua was in it, you could feel it.* (P14)

Finally, within the context of nursing practice, Kawa Whakaruruhau was acknowledged as fundamental to improving health services responses for whānau Māori. Unfortunately, the implementation of Kawa Whakaruruhau into nursing and health has fallen short of its original potential. One participant described it as being in a state of potential and needing mauri to reignite its life so it can develop further:

> *I think if we were able to tie it to our environment, then it will start to gain life and wairua again. If we were able to, we could bring it over into our education, which would bring some life and mauri to that, to grow it again. So it's not just in its own little corner.* (P16)

Conclusion

Poutama rima identified the references made to wairuatanga within the pūrākau. No interpretation has been made about the participant's references to wairuatanga, as one's spirituality is personal and not open for interpretation. However, references to wairuatanga do offer contextual information. Therefore, the various concepts were grouped based on the kupu used by participants. Without imposing my interpretation on the participants' wairuatanga, from their pūrākau alone Kawa Whakaruruhau has implications for the participants' spiritual well-being. This poutama demonstrates the depth of the impact of culturally safe and unsafe spaces in practice. Although poutama whā discusses spiritual concepts, mana and tapu, this was in acknowledgement of the spiritual dimension discussed by nearly all of the participants. Further, wairuatanga is fundamental to the ontological reality of te ao Māori, so it would weaken the discussion chapter to negate these concepts.

Chapter Nine: Conclusion

He aha te me nui o te ao?

He tangata, he tangata, he tangata.

The well-known whakataukī above speaks to a te ao Māori ontological position—he tangata (the people) are the most important thing in this world. A complex epistemological system of relationships that has a divine origin, whakapapa (genealogical system), is the basis of mātauranga Māori (Māori knowledge system) and informs kawa and tikanga Māori (Taonui, 2011). Therefore, Kawa, the immutable ancient customs handed down through the generations, have been formulated in response to whakapapa (Tibble, 2021). Tikanga Māori upholds kawa and can be adapted to the context through a process, but kawa are unchangeable (Te Punaha Matatini, 2022). Importantly, to be tika (right and just) is to be responding in the 'right way' to any given situation, which Tate (2012) asserted is underpinned by just relationships in te ao Māori. Therefore, tikanga is a Māori ethical (what is right) view and response to a situation that centralises he tangata. Although it is for the recipient of care to determine whether the care they received was culturally safe, the name Kawa Whakaruruhau refers to a metaphorical 'shelter', depicting safety, over the immutable kawa (customs) of whānau and hapū; that is, the customs that preserve mana (The Pūtaiora Writing Group, 2015).

At the heart of Kawa Whakaruruhau is he tangata, the people. Dr. Irihapeti Ramsden, Māori nurse leader and key architect of Kawa Whakaruruhau, cited the beautiful whakataukī in the original guidelines document in 1990. Therefore, Kawa Whakaruruhau, as a nursing practice, intended to improve healthcare services and nursing education for Māori by creating a culturally safe nursing workforce through self-reflection and balancing the power in healthcare services (Papps & Ramsden, 1996; Ramsden, 2001). When Kawa Whakaruruhau was formulated, the idea that culture impacted health was still controversial (Ramsden, 2001; Wepa, 2015). Moreover, challenging the perceived neutrality of the healthcare system contradicted the Eurocentric nursing ethos of providing care to all *regardless* of status like race, sex, and religion, for instance. Ramsden (2001) challenged the cultural blindness in nursing and asserted that nurses must provide care *with regard* to the cultural background of the person receiving care.

The implications of Pākehā hegemony in healthcare and nursing education are challenged by Kawa Whakaruruhau, including racist attitudes, Eurocentrism in nursing, and the power dynamics in the nurse-client and nurse-student nurse relationship for Māori

(Ramsden, 1990). Moreover, Kawa Whakaruruhau confronted the normalisation of Western healthcare ideas and the 'othering' of people who sit outside these 'norms' (Ramsden, 1993). Unfortunately, Kawa Whakaruruhau, a revolutionary idea in healthcare practice, was met with fragility, sparking outrage and public condemnation by the dominant population. As such, Kawa Whakaruruhau morphed into cultural safety, which is embedded with Westernised ideas of multiculturalism and nursing theory, transcultural nursing, which perpetuates the entrenchment of cultural blindness and Western dominance in nursing (Allen, 2006; Ramsden, 2001).

On a personal level, Kawa Whakaruruhau challenges the nurse to undertake deep self-reflection about their own culture, values, and beliefs to (a) understand all people are culture bearers and (b) bring to consciousness any bias or belief that could impact nursing care delivery towards clients. As demonstrated by this research, Kawa Whakaruruhau is a nursing practice that aims to transfer power back to the client while simultaneously unpacking the culture of the Western-based health and education system and the impact of that on healthcare access and nursing education for Māori.

Conceptualising Kawa Whakaruruhau

A te ao Māori perspective of humanising care practices that includes the prioritisation of whanaungatanga and the protection and preservation of mana of clients, whānau, and nurses has been discussed as foundational to Kawa Whakaruruhau. The collective experience and reality of the effects of colonisation and colonialism on Māori is utilised as a source of aroha for clients and whānau by Māori nurses. Moreover, Māori nurses strive to provide just care, drawing on both tikanga Māori and professional nursing standards (including dual competencies). Fundamental to Kawa Whakaruruhau is that nurses' decision-making and actions are centred on the preservation of mana for everyone within the relationships. Therefore, the outcome of Kawa Whakaruruhau is equitable Kaupapa Māori nursing praxis that upholds and protects the wairua of the tangata and/or whānau, regarded as key to effective nursing care in a Māori context (Maloney-Moni, 2006).

Summary of the Research

Using a Kaupapa Māori methodology and entirely Kaupapa Māori methods, this research sought to answer the following questions:

1. How do Māori nurses define Kawa Whakaruruhau?
2. How has Kawa Whakaruruhau impacted Māori nurses and their practice?

These questions were developed in response to an integrative literature review that sought out theoretical, empirical, and grey literature to examine the whakapapa of Kawa Whakaruruhau. As Graham's (2009) Whakapapa Framework suggests, it is essential to look at the past to predict the future of a phenomenon. The literature review findings revealed two overarching challenges to the actualisation of Kawa Whakaruruhau in nursing education and practice: 1) the conceptualisation of Kawa Whakaruruhau, and 2) the implementation of Kawa Whakaruruhau into nursing curricula and practice.

Rewi's (2014) whanaungatanga method was used for participant recruitment. Twenty-one Māori RNs who trained in Aotearoa NZ and have worked clinically for 2 or more years were interviewed, using Lee's (2009) pūrākau method for narrative inquiry. Individual interviews were conducted kanohi-ki-te-kanohi and online. A deep analysis of each pūrākau was conducted using Mikahere-Hall's (2017) Te Āta-tu Pūrākau method. A multidimensional analysis of each pūrākau and then the collective pūrākau was conducted. The findings demonstrate that the social, relational, and emotional dimensions of Kawa Whakaruruhau have a significant impact on both its experience and practice. The spiritual dimension, while highly personal, gives context to the depth of the experience of Kawa whakaruruhau and culturally unsafe spaces. Using Smith's (2005) six principles for Kaupapa Māori praxis, a discussion was provided that positioned the findings within the relevant Kaupapa Māori and nursing literature.

Key Findings – Question One

How do Māori nurses define Kawa Whakaruruhau? Although Kawa Whakaruruhau sits within the Kaupapa Māori nursing kete of knowledge and skill, there are implications for the wider nursing profession, both nationally and internationally. The conceptualisation of Kawa Whakaruruhau as a practice by Māori nurses is essential to support the practice development of the nursing workforce relating to the new competency framework. Specifically, Pou one: Māori health requires nurses to practice Kawa Whakaruruhau (NCNZ, 2025). Anecdotally, student nurses are often perplexed about how to apply Kaupapa Māori concepts to nursing practice. As such, this conceptualisation is vital to the transformative impact that the new competency framework can have for Māori healthcare access and, ultimately, equitable health outcomes.

1. Kawa Whakaruruhau is a Kaupapa Māori Nursing Praxis

The integration of Kawa Whakaruruhau is naturally enacted in Kaupapa Māori nursing practices. Kawa Whakaruruhau as nursing practice is underpinned by Māori values,

mātauranga Māori, tikanga Māori, and belief systems. The enactment of Kawa Whakaruruhau in nursing practice is based on the nurse's perception of the humanity of the tangata and/or whānau accessing care. The perception of the intrinsic tapu and mana of the tangata and/or whānau needing nursing support underpins nursing decision-making—tikanga Māori is the first response while also meeting nursing professional standards.

Drawing on the shared whakapapa of collective trauma resulting from colonisation and colonialism, aroha drives a desire to authentically support and help the tangata and/or whānau accessing care. As such, whanaungatanga is prioritised as the foundation of therapeutic care. Using Kaupapa Māori nursing skills and mātauranga Māori, including tikanga Māori, Kawa Whakaruruhau ensures that safe and equitable nursing care responses are formulated. Authentic Kawa Whakaruruhau removes bias and the victim-blaming rhetoric that contributes to the inequities evident in Māori health.

2. Whanaungatanga is the Foundation of Kawa Whakaruruhau in Practice

The basis of care that enacts Kawa Whakaruruhau is whanaungatanga. Therefore, Kawa Whakaruruhau is grounded in relationships. The desire to whakawhanaungatanga with tangata and/or whānau accessing care is driven by te ao Māori ontological understandings of tikanga. As such, establishing a relationship (whakawhanaungatanga) with tangata and/or whānau accessing care is the normal, taken-for-granted first step within a Kaupapa Māori practice framework. Again, the humanising and equalising aspect arises—the acknowledgement of a tangata as part of a wider whānau, hapū, and iwi situates the tangata and/or whānau as a person within a collective first, and a health consumer second. Similarly, the enactment of Kawa Whakaruruhau in clinical spaces allows for Māori nurses to be positioned as a wāhine/tāne Māori first, and a nurse second—denoting the importance of Māori identity.

3. Kawa Whakaruruhau Shelters All Things Māori

Within the 'shelter' created by spaces where Kawa Whakaruruhau is enacted, all things Māori are protected and treated with dignity and respect. Te reo Māori is freely used, tikanga Māori is implemented appropriately, and mātauranga Māori is authentically accessed and implemented into service delivery and practice, demonstrating that it is being held up as a taonga. Kaupapa Māori nursing practice is normalised, developed, and refined within tuakana-teina relationships. There is a safe space for mistakes to be made and ideas to be tested and modified as needed without the scrutiny of the Western magnifying glass. Freedom

from the Western worldview is experienced and a feeling of being ‘free to be Māori’ is experienced.

Key Findings – Question Two

The second question, *What impact has Kawa Whakaruruhau had on Māori nurses and their practice?* is answered using the first three Poutama in Te Āta-tu-Pūrākau.

Social

The social setting can support the development of Kawa Whakaruruhau in practice. For instance, rangatiratanga was identified as an outcome of spaces that enacted in itself, or supported the enactment of Kawa Whakaruruhau. Kaupapa Māori services were identified as spaces where Kawa Whakaruruhau was naturally integrated into the Kaupapa of the service and practice expectations of clinicians. The services did not explicitly identify Kawa Whakaruruhau as a practice underpinning health service delivery. Instead, the values, practices, policies, and procedures of the service allowed for Kaupapa Māori nursing to be freely practised which created a whakaruruhau. More importantly, Kaupapa Māori services were identified as ‘shelters’ for all things Māori, such as tikanga Māori, te reo Māori. As such, threats to Māori identity within these spaces were low, and the imposition of Western-based whakaaro was limited to interactions with outside organisations. As expected, the holistic development of dual competencies as a Māori nurse was identified as an outcome of spaces that enact Kawa Whakaruruhau, largely through tuakana-teina relationships in the clinical space.

Within Western-based health services, various racist ideologies and practices were identified. Unfortunately, racism was identified as being widespread and manifesting in systemic, institutional, and interpersonal practices, which created the perception of being culturally unsafe. Although racism restricted Kaupapa Māori practices through Western dominance and marginalisation of Kaupapa Māori nursing, Māori nurses asserted mana motuhake either directly or indirectly, such as in confrontation or quietly navigating these challenges, mainly with the support of other Māori staff and/or allies. As such, the development of dual competency was still happening, but within the confines of the restrictions imposed by Western-based whakaaro health practice.

Relational

Kawa Whakaruruhau is expressed and measured within the relational dimension. The expression of Māori values, as demonstrated in whanaungatanga, was identified as key to Kawa Whakaruruhau in practice. For instance, the findings show that a nurse’s genuine desire

to connect with tangata and/or whānau accessing care is measured through their actions and attitude. Therefore, approaching the care of tangata and/or whānau accessing care with an attitude perceived as pono and actions underpinned by aroha were identified as attributes of culturally safe nurses. Non-Māori colleagues who treated both Māori nurses and whānau Māori with dignity and authentically respected tikanga Māori (e.g., actively engaging in and supporting karakia), were identified as part of a system that creates Kawa Whakaruruhau within a clinical space.

Ethnically diverse nurses with cultural similarities to Māori were identified as allies to Māori nurses and culturally safe practitioners to whānau Māori as they can draw on 'similar' cultural backgrounds to whakawhanaungatanga. Moreover, nurses' actions that demonstrate humility when engaging with Māori, such as listening attentively and working collaboratively and in partnership, were identified as culturally safe. Overall, a genuine expression of respect for Māori through actions and words that are perceived as pono and tika, protecting mana of all involved, was identified as relational practices that demonstrate Kawa Whakaruruhau.

Emotional

Feelings are the gauge for determining whether practice and space are culturally safe. Strength, whakamana (empowerment), and a feeling of security and personal safety were identified as the feelings experienced in response to Kawa Whakaruruhau in practice. These positive emotions were identified as essential to the ongoing development of Kaupapa Māori nursing skills and knowledge consolidation, including advocacy for whānau Māori accessing healthcare. Importantly, these feelings were transferable to practice and supported the ongoing professional development of Māori nurses' dual competency in an environment perceived to be safe. From the perspective of tangata and/or whānau safety, high whānau engagement and re-engagement with health services was identified as the primary measure of the services and nurses' cultural safety practice. Moreover, whānau engagement with the participant and service in general was identified as leading to an increase in feelings of job satisfaction.

In spaces with culturally unsafe practices, the negative emotions experienced in response to racism and marginalisation, including exclusion and isolation, sometimes served as motivation for strength and to develop pragmatic responses to ensure whānau Māori received culturally safe care. As such, the intersection of te ao Māori and the Western world could be an opportunity to assert mana motuhake in Western-based settings and disrupt the perpetuation of Western-dominated practices. However, it was noted that the low numbers of Māori nurses in the general health workforce affected Kawa Whakarururhau flourishing as a

nursing praxis, as reflected in recent literature (Sewell, 2017). Although Kawa Whakaruruhau was identified as a personal and collective nursing responsibility, the findings demonstrate that Māori nurses' unique practice approach offers unique insights into the 'what' and 'how' of Kawa Whakaruruhau. However, the dominance of the Western worldview limits Kawa Whakaruruhau significantly as a nursing practice in the general nursing workforce.

Recommendations and Contributions to Nursing Knowledge and Practice

The recommendations have been formulated using the findings from both the integrative literature review and this research. In that way, the findings from this research sit within the Whakapapa of Kawa Whakaruruhau, adding Kaupapa Māori praxis conceptualisation of Kawa Whakaruruhau in practice, including the profound impact it has on Māori nurses' practice development. The findings align with Māori nursing literature that highlights the various challenges Māori nurses face in clinical practice, and emphasises the critical contribution Māori nurses make towards the aim of improving Māori health equity. Again, this finding reiterates the fundamental role Māori nurses play in the achievement of Pae Ora (healthy futures) for whānau Māori (Holdaway, 1993; MOH, 1998; Papps & Ramsden, 1996; Wilson, 2012, 2018; Wilson et al., 2022; Woods, 1992).

There has been a long-standing call for an equitable Māori nursing workforce, dating back to shortly after the establishment of the national health service (Holdaway, 1993; Te Kaunihera, n.d., Wilson et al., 2022; Woods, 1992). Therefore, a genuine commitment to Kawa Whakaruruhau in nursing education and practice is required for transformative change, including the recruitment and retention of Māori into the nursing workforce. The power imbalances in nursing education and the health system that limit Kawa Whakaruruhau as a Kaupapa Māori practice that can inform culturally safe care for tangata whenua for the large non-Māori nursing population cannot be ignored. The spotlight needs to be turned onto nursing, and off Māori—taking responsibility and accountability for the role the non-Māori nursing workforce plays in the actualisation of Kawa Whakaruruhau.

Eurocentrism in Nursing in Aotearoa NZ

Ramsden (1990) and the *Guidelines for Cultural Safety* published by the Nursing Council in 1992 asserted that Pākehātanga needs to be taught in nursing schools. Pākehātanga refers to the values, beliefs, and knowledge that underpin the cultural identity 'Pākehā'—a 'New Zealander of European descent' (Te Aka Māori Dictionary, 2025). Examining Pākehātanga is examining the Western epistemology, ontology, and philosophies that underpin the Pākehā worldview that is deeply embedded in institutions. The purpose is to examine the dominance

of Pākehātanga in nursing and healthcare delivery by the nursing workforce to demonstrate the marginalisation of te ao Māori within institutions, promoting the conscientisation of the non-Māori workforce (Papps & Ramsden, 1996; Ramsden, 1990). The Kawa Whakaruruhau lens opens possibilities for other people who have felt excluded from healthcare institutions, demonstrating how Kawa Whakaruruhau is for tangata whenua first and then extended to all through cultural safety.

The discourse of multiculturalism has been identified as a hindrance to the authentic integration of Kawa Whakaruruhau in nursing education and nursing (Bourque, 2020; Papps, 2015). Ramsden argued that multiculturalism became the dominant discourse in cultural safety education due to the backlash nursing educators received from students. Moreover, the blindness to the Western dominance in the health and education system from the white majority of nurses and nursing students perpetuated the 'othering' of Māori and the normalisation of poor Māori health outcomes. As such, deficit-framing became normalised, situating health inequities as a Māori problem (Hokowhitu et al., 2022). Moreover, a Te Tiriti o Waitangi lens was conflated with the ideology that Māori were receiving special privileges or demanding too much. This rhetoric still exists, as demonstrated in the findings of the current research. Therefore, it is recommended that a reflexive review of multiculturalism in nursing education is undertaken to understand the impact it can have on Kawa Whakaruruhau education.

Finally, with the upcoming roll out of the new nursing competence framework, it is recommended that Kawa Whakaruruhau is elevated to a 'foundational' subject of nursing knowledge and practice in Aotearoa NZ to prepare the new nursing workforce to meet the competencies. Kawa Whakaruruhau was constructed to sit alongside ethical, legal, and physical safety knowledge in nursing (Ramsden, 1993). However, the significant impact of culturally unsafe practices, such as implicit bias, has come to light in recent years, demonstrating how Kawa Whakaruruhau in practice is the foundation of other forms of safety knowledge. Primarily, Ramsden (1990) viewed 'attitude change' as the catalyst for practice change. As shown by the findings of this research, evidence of an attitude change is demonstrated in the actions of the nurse, primarily in a humble and pono attitude and in the desire to whakawhanaungatanga with Māori nurses and tangata and/or whānau accessing healthcare. In response to an attitude change, positive feelings are experienced by the recipient of those interactions, which can have a profoundly positive impact on their practice.

Within the new competence framework, Kawa Whakaruruhau sits within Pou Tahi: Māori health, which states, "Nurses are also required to demonstrate kawa whakaruruhau by

addressing power imbalances and working collaboratively with Māori" (NZNC, 2025a, p. 6). The explicit inclusion of Kawa Whakaruruhau as a requirement for competence is new. However, to achieve a nursing workforce that 'addresses power imbalances and works collaboratively with Māori', Māori nurses need to lead upcoming practice change to determine the actions that are required to achieve this outcome. Fundamentally, Kawa Whakaruruhau is a Kaupapa Māori nursing praxis embedded in te ao Māori, and is, therefore, underpinned by Māori values, beliefs, and culture. As such, the non-Māori nursing workforce is invited to support Kawa Whakaruruhau as a nursing practice by focusing on anti-racism praxis (Wiapo et al., 2024) and unpacking whiteness in nursing. Working collaboratively with Māori means supporting the development of Kaupapa Māori practice in Māori nurses and nursing students, while striving for equitable nursing practice with whānau Māori accessing health services.

Methodological Contribution

This research has contributed to the ongoing development of Kaupapa Māori research in nursing. Using entirely Kaupapa Māori methods, this research demonstrates the depth of understanding of a topic that can be achieved using Indigenous inquiry methods. Mikahere-Hall's (2017) Te Āta-tu-Pūrākau data analysis method offered a framework for data analysis firmly positioned in a te ao Māori epistemology. Moreover, this research was underpinned by Kawa Whakaruruhau and conducted in a way that upholds the values and beliefs that underpin Kawa Whakaruruhau. From the supervisory relationship to the recruitment process, using the whanaungatanga method, this research was supported and 'sheltered' within te ao Māori as its kaupapa aligned with the greater movement happening in Māori communities, nationally.

Limitations

Two limitations were identified in this study which provide avenues for future research. Firstly, a limitation of this study was the low representation of tāne Māori (n=2). This is likely due to nursing being a female-dominated profession and, thus, was demonstrated in the participant ratio of wāhine: tāne. The principle of mana tāne asserts that tāne Māori are adequately represented in research and that the impact colonialism has had on tāne Māori and their place in society is recognised. Tāne Māori perspectives on culturally safe care are vital to the actualisation of Kawa Whakaruruhau in nursing due to the knowledge and skill tāne Māori bring to relationships. Further research into tāne Māori perspectives on Kawa Whakaruruhau is recommended. Secondly, whānau Māori voice is essential to the

actualisation of Kawa Whakaruruhau in nursing education and practice. Therefore, future research which explores Kawa Whakaruruhau from a whānau perspective is recommended. Although it is important to note that the participants also provided experience from a consumer perspective too.

Conclusion

Kawa Whakaruruhau, a Kaupapa Māori nursing praxis, is being practiced every day by Māori nurses. This thesis intends to highlight and celebrate the unique and essential contribution Māori nurses make to hauora Māori. Although some non-Māori nurses provide culturally safe nursing care, the impact of widespread racism and marginalisation has a profound impact on the accessibility of quality healthcare services for whānau Māori.

Kawa Whakaruruhau is underpinned by te ao Māori values and concepts, and enacted through a synergy of tikanga Māori and high-quality nursing practices. This very much positions Kawa Whakaruruhau as a by Māori, for Māori approach—emphasising that Māori nurses need to lead the authentic integration of Kawa Whakaruruhau as outlined in Pou tahi (NCNZ, 2025a). Nevertheless, Kawa Whakaruruhau was intended to transform the entire profession of nursing into a culturally safe workforce. Non-Māori nurses have a significant role in the enactment of Kawa Whakaruruhau, which first requires an open and honest exploration of the entrenchment and impact of Eurocentrism in nursing. The role nursing education and continuing competence initiatives have in perpetuating the 'othering' of mātauranga Māori, including the significant tokenising of tikanga Māori, must also be considered.

What mātauranga Māori have been authentically integrated into nursing knowledge and practice in Aotearoa NZ? Embedded with mātauranga Māori, Kawa Whakaruruhau presented nursing in Aotearoa NZ with an opportunity for excellence in professional development in terms of the 'maturing' of the nursing identity and praxis. A koha denotes reciprocity. Kawa Whakaruruhau was a koha gifted to the wider body of nursing by tangata whenua. It is time for the non-Māori nursing workforce to honour this koha.

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Glossary of Terms

Aotearoa – traditionally refers to the North Island of New Zealand. Now refers to New Zealand

Aroha – love, compassion, empathy, care, sympathy

Āta – applied before verbs to denote careful, deliberated, and thoughtful action

Iwi – tribe or nation of people descending from a common ancestor

He Whakaputanga o te Rangatiratanga o Nu Tireni, 1835 – The Declaration of Independence of New Zealand

Hauora – well-being and health

Hauora Māori – Māori health and well-being

Hapū – Sub-tribal group comprised of several whanau descending from a common ancestor

Huarahi Whakatū – Māori nursing dual competency Professional Development and Recognition Programme

Huihuinga – gathering, meeting.

Kanohi Kitea – the seen face, denoting the importance of being known to a community

Karakia – ritual prayer, chant

Kaupapa Māori – a philosophical approach or practice underpinned by Māori beliefs, knowledge, and values.

Kawa – Marae protocol. Immutable customs

Kāwanatanga – governing authority

Kawa Whakaruruhau – Kaupapa Māori nursing praxis, denoting cultural safety

Koha – offering, gift or donation given as a social custom

Mana – spiritual power that gives authority and prestige and has many forms

Mana Motuhake – Mana by autonomy and the assertion of self-determination

Mana Whakahaere – governance, control, authority over services and assets

Manaaki – to support, care for and show hospitality for another

Manaakitanga – showing respect and care for others

Manuhiri – visitors, guests

Māori – an Indigenous person from Aotearoa New Zealand

Mauri – vitality and life force

Maramataka – traditional lunar calendar

Mātauranga Māori – the Māori body of knowledge

Ōritetanga – to be equal, same as, equity

Pākehā – New Zealander of European descent

Pākehātanga – qualities derived from Pākehā culture and social norms

Pono – to be true, congruent with reality, and honest

Poutama – a step pattern traditionally representing whakapapa and the acquisition of higher knowledge

Pukenga Māori Motuhake – Māori nursing competencies in the Huarahi Whakatū

Māori nursing Professional Development and Recognition Programme

Pūrākau – story and legend

Rangatira – high ranking, leader and held in high esteem

Rangatiratanga – chieftainship, sovereign power and authority

Tāne – man

Tangata – human, person, individual

Tangata Whenua – Indigenous people of the whenua

Taonga – treasure that can be physical or cultural

Tapu – denotes sacred, set apart, forbidden, spiritual attributes, and restricted access. Sourced from deity

Te Ao Marama – the world of light

Te Ao Māori – The Māori world

Te Po – the darkness

Te Reo Māori – The Māori language

Te Tiriti o Waitangi, 1840 – The founding document of Aotearoa New Zealand

The Waitangi Tribunal – hears claims brought by Māori about potential breaches of Te Tiriti o Waitangi

*Tika – t*o be congruent, upright, fair, and just

Tino Rangatiratanga – full authority and self-determination

Tuakana-Teina – traditionally, a relationship of mentoring between older and younger relatives

Tupāpāku – the body of a deceased person

Tūpuna – ancestors

Wāhine – woman

Wairua – the immortal spirit of a person

Whakamana – to validate, legitimise, confirm, empower

Whakapapa – genealogy, descent

Whakatauki – intergenerational proverb, saying

Whānau – family group, including extended family

Whanaungatanga – relationship and sense of belonging

Whakawhanaungatanga – establishing relationships.

Whakaaro – thought, opinion, plan

Whare – building, residence, house

Whenua – land, state

Appendices

Appendix A: Ethics Approval Letter from AUTEC

28 August 2023
Alayne Mikahere-Hall
Faculty of Health and Environmental Sciences

Dear Alayne

Re Ethics Application: **23/213 Kawa Whakaruruhau: The impact on Māori nurses and their practice**

Thank you for your responses to AUTEC's conditions.

Your ethics application has been approved for three years until 28 August 2026.

Non-Standard Conditions of Approval

1. Please revise the Executive Secretary's phone number in the Information sheet to extn 6038.

Non-standard conditions do not need to be submitted to or reviewed by AUTEC unless requested but must be completed before commencing your study.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC.
2. All public facing documents must have the AUTEC approval number and be of a high standard of spelling and grammar. Dates on the Information Sheet(s) and Consent Form(s) must be consistent.
3. Any amendments to the project must be approved by AUTEC prior to being implemented.
4. A progress report is due annually on the anniversary of the approval date.
5. A final report is due at the expiration of the approval period, or, upon completion of project.
6. Any serious or adverse events must be reported to AUTEC, this includes unforeseen issues that might affect continued ethical acceptability of the project.
7. AUTEC grants ethical approval only. You are responsible for obtaining management permission for access from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

The application number and title need to be referenced on all correspondence related to this project.

All forms are available online http://www.aut.ac.nz/research/researchethics

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

(This is a computer-generated letter for which no signature is required)

The AUTEC Secretariat

Auckland University of Technology Ethics Committee

Cc: Jmcg1225@gmail.com; denise.wilson@aut.ac.nz

Appendix B: Table of the Literature included in the Integrative Literature Review

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Baker (2012)	Aotearoa New Zealand	Master's thesis - qualitative research Semi-structured interviews 22 participants – Māori and non-Māori	• Culturally safe practice: listening, aroha, manaaki, appropriate models of care, sound communication, supporting informed choices, giving options, tino rangatiratanga • Nurses determine whether patients are culturally safe by their willingness to attend appointments, verbal cues, and ability to verbalise needs to nurses	Code 1 Highly relevant to the conceptualisation of Kawa Whakaruruhau
Banks & Kelly (2015)	Aotearoa New Zealand	Book chapter	• Discusses the role of Nursing Council in regulating nursing practice, including cultural safety	Code 1 Highly relevant to the whakapapa of Kawa Whakaruruhau
Barton (2018)	Aotearoa New Zealand	Discussion paper	• Nurses need to re-examine our contribution to the entrenched health disparities of Māori • Examine power relations and unconscious biases • Explore cultural safety again – examine the rhetoric of it	Code 1 Relevant opinion paper that contributes to the Māori nursing voice of Kawa Whakaruruhau and cultural safety
Best (2014)	Australia	Book chapter	• Colonial and racist history examination in Australia, including nursing • Aboriginal people are excluded from the nursing profession despite recommendations for an equitable Aboriginal nursing workforce • Recommends a history of nursing as essential to understand the context	Code 2 International perspective of cultural safety in an Indigenous context
Bickley (1990)	Aotearoa New Zealand	Discussion paper	• Discusses Kawa Whakaruruhau guidelines 1990 • Identifies te tangata whenua as adding another criterion for nursing; Kawa Whakaruruhau	Code 2 Brief but relevant to understanding the early

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
				conceptualisation of Kawa Whakaruruhau
Bidzinski et al. (2021)	Australia	Discussion paper	• Understanding what underpins Indigenous health; health determinants, colonial and historical contexts of health • Cultural safety as relational skills in nursing	Code 2 Short paper with general overview of cultural safety in the Aboriginal Australian context
Blackmoore-Tufi (2022)	Aotearoa New Zealand	Discussion paper - Offers applied cultural safety to the perioperative context	• Cultural safety includes: understanding equity, bias, one's own culture and the impact on the patient's care, awareness of Māori beliefs and practices, and incorporating them into nursing practice, incorporating Te Tiriti o Waitangi (TOW) into practice. • Discusses the utilisation of TOW as a framework for Māori development, health, and well-being and as the basis of the relationship between the nurse and patient	Code 1 Relevant to understanding the application of cultural safety to contemporary clinical nursing
Blackmore-Tufi (2023)	Aotearoa New Zealand	Personal narrative	• The author has experienced zero recognition for the contribution she makes culturally to her workplace • As a result of various experiences, the author began to question nursing as a career choice • Reports an observation that overseas-trained nurses need further education on the relevance of cultural safety to nursing	Code 1 Māori nurse author personal narrative of culturally unsafe practices
Browne (2003)	Canada	PhD - ethnographic study. 35 participants – First Nations women, nurses, and three other health professionals	• Safety is a theoretical lens to examine how politics manifests in healthcare, promoting critical consciousness in nursing professionals • Identifies economic, political, and social oppression of Indigenous people as influencing nurses' thoughts and behaviour towards Indigenous patients • The author asks how does nursing contribute to the long-standing patterns of marginalisation of Indigenous people in health?	Code 2 Canadian context of conceptualisation of cultural safety
Bourque Bearskin (2011)	Canada	Case review – discussion paper	• Cultural safety advances ethical care in nursing practice • Moving away from cultural competence towards cultural safety	Code 2

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Relational ethics between nurse and client need to be viewed through the cultural safety lens • Cultural safety traces Indigenous health disparities to structural, political, and historical causes	Adds to the conceptualisation of cultural safety in an international Indigenous context
Bourque (2020)	Canada	Master's thesis - Indigenous qualitative research methodology Interviews with 15 nursing educators on the experiences of integrating cultural safety into practice	• Conceptual clarification is needed as definitions vary widely, which has led to poor/fragmented delivery • Cultural competence is the preferred and dominant discourse utilised by the nursing profession • Western discourse utilised to appraise cultural safety (e.g., case studies used to perpetuate negative stereotypes of Indigenous people) • Exposure to Indigenous narratives is important for openness to cultural safety	Code 2 Relevant to understanding the international challenges to implementing cultural safety – very similar to the challenges highlighted in New Zealand literature 20 years ago
Bryce & Foley (2014)	Australia	Discussion paper	• Cultural safety is linked to respect and understanding whiteness in nursing • Understanding that there are privileges and entitlements expected based on whiteness	Code 2 Looks at racism and privilege as a construct of cultural safety
Bryce et al. (2018)	Australia	Discussion paper	• Defends cultural safety being included in the new nursing code of conduct 2018 • Commitment to cultural safety is a validation of the cultural devastation of colonialism on Indigenous peoples' well-being	Code: 2 International perspective of cultural safety in nursing. Mirrors push back experienced in New Zealand
Carter et al. (2017)	Canada	Original research - Two-eyed seeing approach Narrative enquiry Three First Nations men describe living a balanced life, for the purpose of relating findings to nursing practice and the development of culturally safe nursing practice	• Nursing practice can be affected by negative stereotypes of Indigenous people • Implications include using narrative-based interventions for clients to describe their health journey to promote identity formation • Culturally safe care is linked to the protection of identity • Recommends decolonisation and strength-based Indigenous content in nursing education	Code: 2 International perspective of cultural safety in nursing informed by Indigenous men

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Cook et al. (2014)	Aotearoa New Zealand	Original research - Part of a larger study exploring gynaecological care of women 10 Māori participants Māori-centred approach using semi-structured interviews Explores facilitators to positive gynaecological examinations for wāhine Māori	• Cultural safety acknowledges the holistic composition of a person • Cultural safety places the person in the appropriate socio-historical context • Culturally safe care is described as: mihi, whakawhanaungatanga, Kaupapa, tapu, embodied memories, and mana wāhine. • Cultural safety is the demonstration of trustworthiness, compassion, and hospitality—the ability to connect as humans • Culturally unsafe practice was the nurse disconnecting from the embodied experience of the wāhine	Code 1 Highly relevant to understanding culturally safe care from a Māori perspective
Cooney (1994)	Aotearoa New Zealand	Discussion paper – comparing transcultural nursing and cultural safety	• Comparison between transcultural nursing and cultural safety described • Cultural safety is for tangata whenua first, transferrable to other cultures second • Tangata whenua and nursing education to work in partnership • Caution not to describe Māori as a homogenous group of people	Code 2 Relevant to cultural safety in its original framework and challenges with competing discourses in nursing
Coup (1996)	Aotearoa New Zealand	Discussion paper – comparing cultural care theory and kawa whakaruruhau	• Culture Care Theory developed by a nurse from the dominant culture whereas Kawa Whakaruruhau was developed by Indigenous nurses • Cultural Care Theory encourages mastery of another 'culture', whereas Kawa Whakaruruhau demands cultural exploration of self	Code 2 Relevant to Kawa Whakaruruhau and Cultural Safety in its original framework and challenges with competing discourses in nursing
Cox & Best (2022)	Australia	Discussion paper	• Discusses the implementation of cultural safety into the Nurses Code of Conduct and registered nurse accreditation standards in 2018 • People of colour viewed as cultural – everything else 'normal' • Conceptual clarity needed – interchangeable terms problematic and reinforce stereotypes • Emphasis on institutional factors manifested in interpersonal interactions	Code 2 Relevancy to conceptualising the challenges to implementing authentic cultural safety in nursing care in a modern context

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Cox (2016)	Australia	Conference proceedings	• "Racist ghettoizing" (p. 2) of cultural safety – culture and diversity need to be clarified • The white nursing profession needs to hand over power • Cultural safety puts accountability on those with the power • Culture has been reduced to ethnicity instead of legitimising the cultural norms of individuals.	Code 2 Relevancy to conceptualising the challenges to implementing authentic cultural safety in nursing care in a modern context
Desouza (2008)	Aotearoa New Zealand	Discussion paper. Provides background on Māori, Pasifika and Asian health. Discusses cultural safety within the broader context, as well as Māori	• Four principles of cultural safety: improve health status, produce a culturally safe environment, client empowerment, and move towards relationship-focused nursing • TOW is important to nursing; it requires the nurse to practice as a "treaty partner" (p. 130) • Sites how multiculturalism is impossible if unable to have relationships with one 'other'	Code 2: Discusses cultural safety in the broader sense. Has a focus on Māori health but also discusses the wider community context. Provides definitions of cultural safety
Doutrich et al. (2012)	Aotearoa New Zealand	Original research - interpretive hermeneutic approach 12 NZ registered nurses who taught cultural safety or in clinical practice (no Māori) Investigated cultural safety from a nurse's perspective for the implications for nursing in the U.S.	• Key themes included reflection, knowing where you come from, walking alongside • Integrated the 3 principles into the findings • Gives a perspective of biculturalism – the health system as a culture of its own and the client interacts with it • Positions the culture of the patient as the norm	Code 2 Relevant to understanding a non-Indigenous nurse perspective of cultural safety
Fenwick (2006)	Australia	Discussion article	• Cultural norms affect expressions of pain • Trust is the key to effective pain management • Validation of Indigenous pain experienced intergenerationally is essential to culturally safe nursing care in pain assessment	Code 2 Relevant to understanding how cultural safety can underpin specialty nursing skills and knowledge bases

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Fergusson (2021)	Aotearoa New Zealand	PhD - a mixed methods approach. Closed and open-ended survey questions used to determine registered nurses' understandings of cultural safety and how their practice aligns to the current guidelines	• Concludes that cultural safety is better kept in Indigenous context • Differences in understanding of cultural safety and meeting the guidelines noted between Internationally Qualified Nurses and New Zealand trained registered nurses • Diversified approach to cultural safety is not appropriate – recommends a different framework for meeting the needs of the diverse society in New Zealand • Recommends keeping cultural safety as a by Māori, for Māori approach • Nurses identified cultural knowledge of a perceived cultural group necessary to culturally safe care	Code 2 Relevant to understanding the conceptual challenges to cultural safety. Focussed on cultural safety more than Kawa Whakaruruhau

Helleston & Hakiaha (2016)	Australia	Book chapter	• Whānau are the enablers of whanau ora
			• Concepts of culturally safe care:
			  • Whakawhanaungatanga – connection
			  • Whakaratarata – calming the soul (integrity of the nurse)
			  • Whakanoa – balance (sharing of knowledge)
			  • Awhi Mai Awhi Atu – reciprocity
			  • Poroporoaki – farewell
				Code 1
				
				Relevant to the conceptualisation of Kawa Whakaruruhau from a Māori lens. Nursing focussed

Hulko et al. (2021)	Canada	Original research - Community-based research. Purposive sampling Mixed methods: pre- and post-intervention questionnaires with 38 registered nurses Focused on culturally safe dementia nursing care	• Misunderstanding of culturally safety – conceptual clarity needed • Current best practice for dementia care clashes with culturally safe care for First Nations patients • Culturally safe dementia care for Indigenous people requires knowledge of what Indigenous people perceive culturally safe care to be • Indigenous-led nursing education is essential to embedding culturally safe frameworks	Code 2: Relevant to the international conceptualisation of cultural safety in an Indigenous health context
Hughes (2018)	Aotearoa New Zealand	Discussion paper	• Cultural safety can be measured as cultural intelligence • Healthcare and the health system are described as 'social institutions' comprising a wide range of people from various cultural backgrounds	Code 2 Focuses mainly on cultural safety as a generic term opposed to within the Indigenous health context

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Range of skills identified to be culturally safe – advanced listening skills, range of communication skills	
Hunter & Cook (2020)	Aotearoa New Zealand	Original qualitative - research using Indigenous narrative inquiry Interviews with 12 Māori nurses and nurse practitioners. Research focuses on Māori nurses' narratives about cultural safety concepts.	• "Universalist" models of care are dominant over socio-cultural understandings of health, particularly Indigenous health (p. 1481) • Findings suggest that clinical care is prioritised over cultural care • Non-Māori nurses can practice ethically by reflecting critically constructs of Māori health through an equity lens, Māori nurses essential to improving health of Māori, healthcare leadership needs to be authentically committed to improving Māori health	Code 1 Highly relevant to the conceptualisation of Kawa Whakaruruhau and cultural safety in an Indigenous context
Hunter et al. (2021)	Aotearoa New Zealand.	Discussion paper - centred on speech delivered by Irihapeti Ramsden	• Tino rangatiratanga – autonomy and control over most precious taonga "one's health" – guaranteed in TOW • Both tangata whenua and tauiwi to co-exist and have equitable access to resources that promote hauora • Despite cultural safety rhetoric, little improvement has been made to health and education services for Māori	Code: 1 New Zealand context and focussed on Kawa Whakaruruhau
Huria et al. (2014)	Aotearoa New Zealand	Original research - Kaupapa Māori qualitative research 15 Māori registered nurse participants Research on the effects of racism on Māori nurses Secondary source of data used to look at experiences of wider Indigenous health workforce	• Reports regular racism experienced on institutional, interpersonal, and intrapersonal levels • Leading to feeling overworked and marginalised • Dual competencies often overlooked by colleagues and workplace. Expertise in te ao Māori is often not recognised at all	Code: 1 Highly relevant to understanding culturally unsafe spaces for Māori nurses – reinforcing the importance of Kawa Whakaruruhau
Gifford et al. (2022)	Canada	Literature review	• Conscious and unconscious perpetuation of Indigenous disadvantages by nurses • We must understand cultural safety from the perspective of Indigenous people as per Ramsden's original work • First Nation Algoriquins of Piwakarugn perspective: ➢ Access to culture is essential	Code 2: Conceptualisation of cultural safety in a Indigenous context

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			➢ Family involvement is essential ➢ Nurses need to challenge the socio-political context of health	
Kidd et al. (2014)	Aotearoa New Zealand and Australia	Book chapter	• Contemporary definitions of Māori are not confined to physical appearance or lifestyle. Therefore, assumptions should not be made about culture • Kawa Whakaruruhau is defined as understanding one's own culture and how it shapes behaviour, the principles of TOW, and Māori health needs	Code 1 Relevant to nursing but specifically focuses on mental health. Written by Māori nurses and Kawa Whakaruruhau referenced
Leininger (1997)	Aotearoa New Zealand	Response article to Offers rebuttal of Coup's critique and Ramsden	• Discusses ethno-nursing as a distinct practice that supports cultural care • Article states Culture Care is misinterpreted by Coup	Code 2 Relevant to the whakapapa of Kawa Whakaruruhau – including the dominant discourse in nursing cultural considerations
Lock et al. (2021)	Australia	Analysis of 42 cultural safety definitions in public policy in Australia conducted using structuration theory and indigenist methodology	• Questions whether definitions of cultural safety are, in fact, culturally safe • Cultural risk associated with culturally unsafe definitions • Offers a structure for cultural safety definitions in the future	Code 2 Adds depth to the conceptual clarity issue identified in cultural safety literature. Limited reference to nursing
Longmore et al. (2019)	Aotearoa New Zealand	Discussion paper with interview	Focussed on the work of Tina Konia, Māori emergency department nurse. Examples of Māori nurses culturally safe practice include: • Correct pronunciation of Māori names • Accessing the Māori health team • Establishing gaps in care and developing strategies to ensure gaps are addressed • Knowing health disparities for Māori and viewing them through an equity lens	Code 1 Māori nurse perspective of cultural safety in practice

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Murchie & Spoonley (1995)	Aotearoa New Zealand	Cultural safety review committee for the NCNZ A comprehensive assessment of 15 polytechnic cultural safety curricula in both nursing and midwifery courses	• Recommended that cultural safety retain its name • Cultural safety is about all cultures but TOW is central to understanding relationships in a New Zealand context • Advised that NCNZ take a pragmatic approach in the development of cultural safety education in nursing	Code 1 Highly relevant to the whakapapa of Kawa Whakaruruhau
Molloy et al. (2021)	Australia	Original research - qualitative research using a social analysis framework to understand the impact the new code has on the culture of nursing 8 mental health nurses' perspectives via interviews, sought on the new standards for nursing practice and the impact they have had on nurses practice	• Discusses the new code of conduct 2018 outlining cultural safety as a requirement for nurses in Australia • Discusses media promoting a narrative that nurses are required to apologise for being white before interactions with Indigenous people • Found that either nurses were not aware of the changes in the code or that the changes were perceived as having little impact on nursing practice	Code 2 Relevant to understanding the international perspective on cultural safety and the challenges to implementation

McGough et al. (2022)	Australia	Discussion paper	• Research is needed on how cultural safety is applied to practice
			  • Cultura safety is not an endpoint; it is an ongoing journey created by ongoing education and self-reflection
			  • There is a lack of conceptual clarity among nurses
			  • Institutional and systemic processes inhibit the implementation of cultural safety
				Code 2
				
				Discusses cultural safety within the context of Aboriginal Australians. Gives an overview of cultural safety in nursing in Australia

Miller et al. (2025)	Australia	Original research - interpretive qualitative design 8 mental health nurses interviewed – all with experience in caring for Aboriginal clients to explore the preparedness of nurses in	Little evidence that the inclusion of Aboriginal/Torres strait islander education content has led to culturally safe nursing care
			  • Limited knowledge of cultural safety
			  • Dominance of bio-medical model noted to restrict cultural safety in practice
			  • Lack of support in professional development of cultural safety noted
				Code 2
				
				Relevant to understanding the international context of cultural safety development in nursing, including the limitations

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
		providing are to Indigenous Australians		
Nairn et al. (2014)	Aotearoa New Zealand	Discussion paper	• Implications of media on cultural safety discussed – dominant culture normalised • Reinforcing normalisation of poor health • Transparency of Pākehā culture needed • Developing critical assessment skills – perspectives etc.	Code 2 Relevant to understanding the socio-cultural contexts of health, nursing and cultural safety
NCNZ (1992)	Aotearoa New Zealand	Professional body guidelines	• Cultural safety must start with tangata whenua due to the real cultural threat of colonial power • Māori control over Māori matters is serious • Cultural risk is highest for Māori • Racism, Pākehātanga, and history are deemed important in nursing education	Code 1 Guidelines for nursing praxis in New Zealand about cultural safety and Kawa Whakaruruhau
NCNZ (2011)	Aotearoa New Zealand	Professional body guidelines	• Documents, discusses, and defines cultural safety; nurses' commitment to TOW, and Māori health improvement • Kawa Whakaruruhau is depicted as a subset of cultural safety and defined as cultural safety in a Māori context • First published in 2005, revised in 2011	Code 1 Guidelines for nursing praxis in New Zealand about cultural safety and Kawa Whakaruruhau
NCNZ (2025)	Aotearoa New Zealand	Professional body guidelines	• Identifies TOW as the foundation for nursing practice in a Māori context • States cultural safety is a professional expectation for safe and effective nursing care • Pou one: Māori health lays out the expectation that nurses demonstrate their commitment to Māori health through enacting Kawa Whakaruruhau	Code 1 Highly relevant to the whakapapa of Kawa Whakaruruhau
Papps (2015)	Aotearoa New Zealand	Book chapter	• Examines the history of New Zealand nursing – paradigms by what is shaped	Code 1 Relevant to understanding the whakapapa of Kawa Whakaruruhau and cultural safety

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Presents challenges to cultural safety implementation based on dominant discourses (i.e., multiculturalism and transcultural nursing) • Challenges to implementing changes due to lack of training for nursing education and lack of conceptual clarity	in New Zealand – particularly the social and historical context of nursing in New Zealand
Papps & Ramsden (1996)	Aotearoa New Zealand	Discussion paper	• Unsafe practice leads to avoidance of health services • Developed as a response to social and political disadvantages • Is not cultural sensitivity or cultural awareness (both require knowledge of cultural practices) • The improvement of all through the relationship of Māori and the crown, underpinned by TOW	Code 1 Highly relevant to the whakapapa and conceptualisation of Kawa Whakaruruhau
Pere (1997)	Aotearoa New Zealand.	Master's thesis - qualitative research Kaupapa Māori methodology Interviews with Māori and non-Māori nurses with 2 years' experience who had received cultural safety training at a polytechnic	• Nurses reported negative experiences of cultural safety training • Nurses reported that they agreed with cultural safety as a topic but it is a highly emotional topic that sparks heat on both sides • Cultural safety is about tangata whenua first – establishment of biculturalism as a prerequisite for multicultural	Code 1 Highly relevant to the whakapapa of Kawa Whakaruruhau
Power et al. (2021a)	Australian	Written by Indigenous nurses Based on various Indigenous focussed documents	Four key points underpinning cultural safety education: • Every nurse and midwife have a role to improve health outcomes for Aboriginal Australians • Indigenous nurses must lead the reforms of nursing curricula – a solid evidence base is required • Institutional and systemic racism need to be addressed to deliver culturally safe care • The need to move past the 'Indigenous and non-Indigenous' binaries and move forward cohesively	Code 2 Indigenous nurse perspective on cultural safety
Power et al. (2021b)	International collaboration	Discussion paper – expert panel	• Indigenous authority is required to ensure authentic application of cultural safety into nursing practice	Code: 1

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Cultural safety is being mandated through professional bodies regulating nursing practice • Cultural safety challenges ongoing – staff are not confident to teach it, and Indigenous staff are expected to produce a culturally safe workforce • Cultural safety needs to be a collective effort in nursing, not just among the Indigenous staff	Highly relevant to the whakapapa of Kawa Whakaruruhau
Power et al. (2022)	International collaboration	Editorial	• Cultural safety of the nursing workforce is still in question despite professional bodies including it in guiding documents • A massive barrier to cultural safety is the misunderstanding of it and how it is taught in nursing • Focus on ethnicity instead of the healthcare system • Need to return to Kawa Whakaruruhau	Code 1 Highly relevant to the whakapapa of Kawa Whakaruruhau – contemporary context
Ramsden (1990)	Aotearoa New Zealand	Guidelines for nursing education	• Original guidelines for Kawa Whakaruruhau • Outlines the conceptualisation of Kawa Whakaruruhau and its translation into nursing education	Code 1 Original guidelines. Used as the gold standard for the conceptualisation of Kawa Whakaruruhau in this thesis
Ramsden (1993)	Aotearoa New Zealand	Conference proceedings	• Cultural safety as an outcome of nursing education • An underlying theoretical and skill base for nursing, like ethics and nursing knowledge • Established in a time when the reassertion of Māori culture was happening • The inability to secure Māori nurse educators reinforced Māori stereotypes, and underqualified staff were often pushed into roles too fast	Code: 1 Highly relevant to the whakapapa of Kawa Whakaruruhau
Ramsden (1995a)	Aotearoa New Zealand	Discussion/reflection paper	• Nursing leading the way in cultural safety	Code 1

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Cultural safety is a concept that belongs to New Zealand and was developed out of the relationship between tangata whenua and Pākehā • Identifies it as "part of the maturing identity" of New Zealand (p. 2) • Cultural safety is part of excellence in nursing and healthcare delivery in general	Highly relevant to understanding the whakapapa of Kawa Whakaruruhau
Ramsden (1995b)	Aotearoa New Zealand	Conference proceedings	• Female-dominated nursing is more open to public scrutiny • Perceived as Māori demanding non-relevant content and "a Māori take over" (p. 3) • Public is not willing to let nursing set its professionalism • Romanticised version of Māori, race relations, and colonial history fuelling emotions • Regional opposed to national implementation resulted in variations of content	Code 1 Highly relevant to understanding the whakapapa of Kawa Whakaruruhau
Ramsden (1996)	Aotearoa New Zealand	Newspaper article	• Discusses select committee experience • Government is unable to move past the idea that cultural safety is about teaching Māori culture at the expense of other ethnicities • Cultural safety is about "diversity rather than stereotypes" (p. 9) • The experiences of the coloniser and the colonised are very different • Identifies the non-negotiable as; 1. TOW as the foundation and 2. both Kawa Whakaruruhau and cultural safety names remain	Code 1 Highly relevant to understanding the whakapapa of Kawa Whakaruruhau
Ramsden (1997)	Aotearoa New Zealand	Book chapter	The public upset because of the perception that Māori are imposing ideas on the caring profession • Fears that clinical skills would be compromised in favour of Māori stuff that no one understood • Threats to Pākehā dominance by Māori who were creating change in 'their' system • Power is retracted from the whānau/person when the word safety is replaced with other words, such as responsive	Code 1 Highly relevant to the conceptualisation of Kawa Whakaruruhau and exploring the whakapapa of the same

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• "Formal qualitative research should seek to record a broad range of service indicators including subjective response" (p. 124)	
Ramsden (2000b)	Aotearoa New Zealand	A personal reflection – 10 years since kawa whakaruruhau emerged	• Nursing is part of the story of poor access to culturally safe health services • At times, cultural safety watered down to only be included to meet requirements by the NZNC • Racism comes in many forms such as access to resources	Code 1 Highly relevant to the conceptualisation of Kawa Whakaruruhau and exploring the whakapapa of the same
Ramsden (2001)	Aotearoa New Zealand	Book chapter	• Discusses differences as important aspect of care • Discusses biculturalism and multiculturalism and the dominant discourse that challenged the implementation of cultural safety into education • Discusses culture as separate to ethnicity	Code 1: Highly relevant - adds to the whakapapa and development of Kawa Whakaruruhau and cultural safety in New Zealand
Ramsden (2002)	Aotearoa New Zealand	PhD thesis - personal narrative discussing the evolution of kawa whakaruruhau in Aotearoa and Te Wai Pounamu	• Discusses the evolution of cultural safety – 4 eras defined • Highlights that the broadening of cultural safety was to stop the conflation of race with culture • States that the changes to cultural safety were more about the education review boards and nursing council than service users • Discusses the importance of staying away from check boxes as that reinforces the health services as the norm and 'others' diversity • Re-focusses on the importance of safety, remaining with the subjective experience of the health user	Code 1: Architect of Kawa Whakaruruhau highly relevant to understanding the conceptualisation of Kawa Whakaruruhau
Ramsden & Page (1993)	Aotearoa New Zealand	Discussion paper	• State examination by multi choice unable to measure communication and advocacy skills in nursing • Opposes multiple-choice exam for state examination	Code 1 Highly relevant to whakapapa of Kawa Whakaruruhau – identifies a challenge of cultural safety assessment

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Richardson & Carryer (2005)	Aotearoa New Zealand	Qualitative research investigating the experiences of teaching cultural safety with 14 nursing educators - 5 Māori and 9 Pākehā	• Identified TOW as an examination of power in New Zealand • Using broader concepts of cultural safety made it more socially tolerable than about Māori health alone • Cultural safety affects students and teachers personally and has political implications • Competing discourses in New Zealand challenging and open forum in cultural safety class • Burnout and fatigue evident for teachers	Code 2 Gives practice examples that support Ramsden's work
Richardson (2021)	Aotearoa New Zealand	Commentary	• Cultural safety challenged the coloniser/colonised binary • Cultural safety challenged power imbalances in the nurse/patient relationship • Cultural safety challenged Māori health inequalities and poor health outcomes as normative • Progress has been made but tauiwi need to understand and make an authentic recommitment to understanding and applying cultural safety	Code 2 Relevant analysis of cultural Safety challenging power. Focuses on cultural safety and Māori health as related content
Richardson (2004)	Aotearoa New Zealand	Discussion paper	• Biomedical positivist view of health focuses on; individual accountability, science-heavy • Western dominance based on the assumption of universalism • Early rhetoric around Māori health based on the assumption of evolution • Western society is strongly influenced by eugenics	Code 2 Relevant to understanding the dominance of western perspectives in nursing in New Zealand
Robinson et al. (1996)	Aotearoa New Zealand	Discussion paper	• Power relations in healthcare under the spotlight • Identified Māori disadvantage and Māori-Pākehā differing views of health and well-being as two main constructs of cultural safety • Calls for "subjugated' knowledge to be elevated alongside Western knowledge (p. 372)	Code 2 Relevant to the whakapapa of Kawa Whakaruruhau
Roberts (2020)	Aotearoa New Zealand	Critical commentary	• Kawa Whakaruruhau and cultural safety are two different concepts • Critiquing te ao Pākehā is necessary for authentic implementation of TOW	Code 2

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Colonisation is a key factor in the development of Kawa Whakaruruhau • Must begin with Māori	Relevant critique of cultural safety and Kawa Whakaruruhau from a Pākehā perspective
Smye et al. (2006)	International collaboration	Discussion paper	• Blindness to culturally unsafe policies • Blindness to assimilation ethos continues through institutional policies and practices • Need to avoid models that reinforce othering and racialisation processes	Code 2 Relevant to understanding the challenges to Kawa Whakaruruhau integration
Stout & Downey (2006)	Canada	Discussion paper	• Identifies the bottom-up approach (nurses) as essential to cultural safety development • Policies and decision-making in health are essential to developing an environment for the flourishing of cultural safety • Cultural safety is strongly interlinked with Indigenous self-determination	Code 2 Relevant to the international context and challenges for the implementation of cultural safety
Vernon & Papps (2015)	Aotearoa New Zealand	Book chapter	• Discusses the HPCA and cultural competence • Discusses cultural safety and ongoing professional standards of practice • Differences between cultural competency and cultural safety • Defines the NZNC cultural competency framework and how that is comprised	Code 2: Relevant to understanding cultural safety in nursing in relation to the HPCA Act (2003)
Walker (2017)	Canada	PhD - qualitative study, situational analysis Participants 20 non-Aboriginal registered nurses. Explores the influences on nurses when working with aboriginal peoples	• Nurses described cultural safety as respectful relationships with Aboriginal people • Learning about colonialism was associated with increased empathy towards Aboriginal health issues • Witnessing the reality of colonialism motivates nurses to advocate for Aboriginal people • The culture of healthcare services is restrictive of culturally safe care • 'Individualism' leads to the denial of racism and viewing individuals as separate from the socio-political context	Code 2 Supports the exploration of cultural safety internationally and applied to real-life nursing practice

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
			• Punitive measures, such as withholding care, are labelled as necessary by some staff to prevent dependency of the patient on service	
Wepa (2015)	Aotearoa New Zealand	Book chapter	• Defines culture, race, and ethnicity • Defines monoculturalism and ethnocentrism • Defines bi-culturalism and multiculturalism • Defines Māori, Pākehā, and New Zealanders	Code 1 Highly relevant-provides the foundation for cultural safety and Kawa Whakaruruhau
Wilson (2008)	Aotearoa New Zealand	Qualitative research using Glaserian grounded theory with a Māori-centred approach 38 wāhine Māori experiences of health services	• Cultural competency is problematic due to the diversity within cultural groups • Measurements of cultural safety are problematic due to nurses and peers assessing • Wāhine Māori wish for their worldview to be respected in healthcare interactions • Overall, findings demonstrate that nursing is still not culturally safe for wāhine Māori • Recommends nurses engage in critical reflections of interactions with Māori • Nurses are unable to determine whether they themselves or their peers are culturally safe in practice	Code 1 Demonstrates where New Zealand nursing was at 18 years after the emergence of cultural safety in New Zealand. Offers suggestions for practice
Wilson et al. (2022)	Aotearoa New Zealand	Discussion paper	• Māori nurses have been marginalised historically in New Zealand • Cultural safety education had the opposite effect • Kawa Whakaruruhau is absent from nursing standards and competencies • Rhetoric is empty – inaction and systemic racism • No official monitoring of Māori nursing students by NCNZ • Underrepresentation of Māori in the NCNZ • Sole Māori representation is tokenism • Dual competency of nurses and emotional labour unrecognised	Code: 1 Highly relevant to the whakapapa of Kawa Whakaruruhau

In-text citation	Context	Research design & methods	Key findings or key concepts	Relevance to what I am doing (evaluation-coded)
Withall et al. (2020)	Australia	Qualitative research with 9 nurses and 1 midwife Semi-structured interviews Exploring how healthcare professionals incorporated cultural safety into their practice	• The incorporation of cultural safety into practice has had interpersonal and organisational challenges: time constraints, limited resources and attitudes of colleagues can be problematic. • Can define cultural safety but not sure how that translates into practice • Aboriginal and Torres strait Islander staff seen as major facilitators to the implementation of cultural safety	Code 2 Relevant to the international perspective of cultural safety in nursing and an Indigenous context
Wood & Schwass (1993)	Aotearoa New Zealand	Discussion paper	• Relationship between Pākehā and Māori the foundational relationship in cultural safety	Code 2 Relevant to understanding the earlier conceptualisations in nursing. Brief writing

Appendix C: Participant Information Sheet

Participant Information Sheet

Information Sheet Produced: 04/08/2023 Approved by the Auckland University of Technology Ethics Committee on 28th August 2023 AUTEC Reference number 23/213

Kawa Whakaruruhau: The impact on Māori nurses practice.

Tēnā Koutou katoa,
Ko Wharepuhunga te maunga
Ko Waikato te awa
Ko Tainui te waka
Ko Ngāti Raukawa te Iwi
Ko Ngāti Huia te hapu
Ko Aotearoa te marae
Ko Jenny Tokomauri McGregor toku ingoa Tēnā koutou, Tēnā koutou, Tēnā koutou katoa.

Thank you for considering participating in a research study currently being undertaking at Auckland University of Technology (AUT). My name is Jennifer McGregor. I am a registered nurse who works in nursing education and have an interest in recruitment and retention of Māori nurses in the nursing workforce. I am currently employed by Victoria University of Wellington as a teaching fellow on the Master of Nursing Practice program. My particular interest is Kawa Whakaruruhau (Cultural Safety) as a philosophy that is embedded in nursing practice in Aotearoa New Zealand. This research study aims to understand how Kawa Whakaruruhau (Cultural Safety) impacts Māori registered nurse's practice.

This research study is being completed as a requirement of the Doctor of Philosophy (Health Science) qualification at AUT. This study is being funded by a PhD scholarship program from Nga Pae o te Māramatanga.

What is the purpose of this research? Kawa Whakaruruhau (Cultural Safety) was constructed in the early 1990's by a Māori nurse philosopher, Irihapeti Ramsden, as a response to Māori negatives experiences of nursing education and the health care system. It has since been implemented into the nursing education curriculum and nursing competency system here in Aotearoa New Zealand. The overall aim of Kawa Whakaruruhau was to improve the nursing education and health care system experiences of Māori. As part of this research, I will be interviewing Māori registered nurses (RN) about their experiences of Kawa Whakaruruhau in clinical practice and how their practice is impacted by clinical environments that are culturally safe/unsafe.

How was I identified and why am I being invited to participate in this research? You have been invited to participate in this research study because you have responded to an advertisement you have seen at your workplace or on the internet. To be eligible to participate you must identify as Māori, be a registered nurse in Aotearoa New Zealand, have two or more years of experience working as a RN in Aotearoa New Zealand and received your nursing education here in Aotearoa New Zealand.

For ethical reasons, if any of the following apply to you, you are not eligible to participate in this research.

No immediate whānau or current students of the primary researcher, any person who is unable to give their informed consent due to a medical reason (such as severe disability reasons), any person who completed their nursing education at an overseas institution, any RN who has not held an Annual Practicing Certificate in the past 5 years and Enrolled nurses.

How do I agree to participate in this research? You agree to participate in the study by contacting the researcher by email, text or phone to ask any questions and express your interest. You will be sent a consent form and Information for Participants Sheet. Then you can choose to be emailed or phoned by the researcher to organise a kanohi-ki-te-kanohi (face to face) interview or online, if you prefer. Consent to participate can be

given in written format by signing the consent form or provided to me verbally (recorded) at the beginning of the interview.

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 may not be possible.

What will happen in this research? You will be asked to attend an in person (or on Zoom if you prefer) interview of roughly 1 to 2 hours with the researcher. The researcher will come to a place that suits you. During the interview you will be asked to share your experience of Kawa Whakaruruhau (Cultural Safety) in nursing practice and talk about how Kawa Whakaruruhau has influenced your practice as a Māori RN . The interviews will be recorded and transcribed verbatim (word for word). A copy of your transcript will be sent to you for your approval of its accuracy.

The indicative questions for the interviews are:

1. Tell me about a time when you felt culturally-safe/unsafe at work
2. Tell me about what Kawa Whakaruruhau means to you
3. Tell me about what a Culturally safe workplace looks like for you
4. Tell me about how kawa Whakaruruhau has influenced your practice

What are the discomforts and risks and how will they be alleviated? It is not expected that participation in this study will cause any discomforts or risk. However, it is possible that you will be emotionally affected if you are recalling your past experiences of culturally unsafe situations that you may have been in. If this were to happen, you will be given additional time, and the option of not answering a particular question or discontinuing the interview. You do not need to give a reason why and can withdraw at any time.

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9292.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits? This study will help to understand how Kawa Whakaruruhau is experienced by Māori nurses and how their practice is impacted or influenced by workspaces that are considered culturally safe or unsafe. This information may be helpful in the development of culturally safe workspaces for Māori student nurses and nurses.

How will my privacy be protected? The interviews will be audio recorded and will be transcribed verbatim (word-for-word). All of your identifying information will be kept confidential, and no real names or workplaces will be used in the research write up, any publications or presentations. Apart from the researcher and primary supervisor, no one will have access to your personal information/details. Your signed e-consent forms will be forwarded to Dr Alayne Mikahere-Hall (primary supervisor) as soon as the researcher receives the form. Your e-consent form will be stored on an external hard drive at AUT Taupua Waiora Māori Research Centre. Once this research is completed, the transcripts (of the pūrākau) (as well as your signed consent forms) will remain stored securely on an external hard drive at the AUT Taupua Waiora Māori Research Centre. It will be deleted after 6 years.

What are the costs of participating in this research? The only cost for you is 1-2 hours of your time to participate in the interview and time to review your transcripts (if you wish). A small koha will be given as a gesture of appreciation of your time and sharing of your experiences.

What opportunity do I have to consider this invitation? You will have 3 months to consider this invitation of participation.

Will I receive feedback on the results of this research? Yes, a summary of the findings from this rangahau (research) will be sent to you. Please indicate on the consent form if you would like to receive a summary of the

results of this research and to be notified when the final dissertation is available to read on the Tuwhera – the AUT open database.

What do I do if I have concerns about this research? If you have any concerns regarding the nature of this research project, please contact the Project Supervisor

Dr Alayne Mikahere-Hall
Taupua Waiora Centre for Māori Health Research, Faculty of Health &Environmental Sciences.
Auckland University of Technology (AUT)
Email: alhall@aut.ac.nz
PH: (09) 921-9999 ext 7115

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, Phone: +64 9 921 9999 ext 6038. Email: *ethics@aut.ac.nz*

Whom do I contact for further information about this research? If you would like to participate in this research or have any further queries about this research, please contact the primary researcher

Primary Researcher Contact Details

Jenny McGregor
Phone: 027 843 6088
Email: jtmcgreg@gmail.com

Project Supervisor Contact Details:

Dr Alayne Mikahere-Hall
Taupua Waiora Centre for Māori Health Research, Faculty of Health &Environmental Sciences.
Auckland University of Technology (AUT)
Email: alhall@aut.ac.nz
PH: (09) 921-9999 ext 7115

Appendix D: Exemplar of Participant Consent Form

Project title: Kawa Whakaruruhau: the impact on Māori nurses and their practice.

Researcher: Jenny McGregor
Primary supervisor: Dr. Alayne Mikahere-Hall
Secondary supervisor: Professor Denise Wilson

- I have read and understood the information provided about this research project in the Participant's Information Sheet dated …….. (please choose one): yes / no
- I have had an opportunity to ask questions and to have them answered (please choose one): yes /no
- I consent to notes being taken during the interview and to the interview being audio-taped and transcribed (please choose one): yes / no
- I agree to take part in this research project and understand that I may withdraw from the study at any time without being disadvantaged in any way (please choose one): yes / no
- I understand that if I withdraw from the research project 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 (please choose one): yes / no
- I understand that the audio recordings will be destroyed after they have been transcribed into written form (please choose one): yes/no
- I would like a copy of the summary of the research findings once the research is completed: yes/no
- I would like to be notified once the dissertation is available on the AUT Tuwhera open database (please choose 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 28th August 2023 AUTEC Reference number 23/213

Appendix E: Examples of Research Questions for Interviews:

1. Tell me about a time when you felt culturally-safe/unsafe at work
2. Tell me about what Kawa Whakaruruhau means to you
3. Tell me about what a Culturally safe workplace looks like for you
4. Tell me about how kawa Whakaruruhau has influenced your practice
5. Tell me about your nursing background and experience
6. Tell me about any Kawa Whakaruruhau or Cultural Safety education you received in nursing education.

Appendix F: Confidentiality Agreement - Transcriber

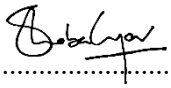
For the Transcriber

Project title:	*Kawa Whakaruruhau: the impact on Māori nurses and their practice*
Project Supervisor:	*Dr. Alayne Mikahere-Hall*
Researcher:	*Jenny Tokomauri McGregor*

Yes I understand that all the material I will be asked to transcribe is confidential.

Yes I understand that the contents of the tapes or recordings can only be discussed with the researchers.

Yes I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: 

.....……

Transcriber's name: ....Shoba Nayar.....……

Transcriber's Contact Details (if appropriate):

……snayar19@gmail.com……..

……..

……..

……..

Date:

Project Supervisor's Contact Details (if appropriate):

***Approved by the Auckland University of Technology Ethics Committee on* 28th August 2023**

***AUTEC Reference number* 23/213**

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