It’s like Coming Home: The Influence of an Interprofessional Placement on Māori Nursing Identity

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Mihi Karakia

Unuhia ki te uru tapu nui o Rangi ko Te Ātiawa whai I te au o te tara ki te māra o Te Kōpū Mānia o Kirirkiriroa

I reira wānanga tahi ai ngā kumara o te kōpiha rā

Nō te wāhinga o te rua kumara ka ara ake ko ngā rau whakakakā ko Porou, ko Māhaki, ko Tūhoe Pōtiki, ko Ranginui, ko Kahungunu, ko Puhi, ko Kuri, ko Ruahine

Ko ngā pūmanawa e waru ka ara ake. Ko te paki o Mararikiki ka ara ake

Mai i te Awa o Taranki ki te Awa o Whakatāne te au o taku reo whakamihi e rere nei

Ka kore rawa here ki ō Tūpaengarau iro e whati

Ko te tongikura ki Taranaki te rama arahi i taku rapu i te mea ngaro

Kī mai ki ahau he aha i mata rua ai a ngāi Māori?

Ka kī ake,

Paiheretia te whānau

Paiheretia te pouwhakatere

Paiheretia to akoako

Paiheretia kia wātea au i te horihori, kai wātea i te whiwhi, kia wātea i hara, kia wātea i whakapehapeha, kia wātea i te pūhaehae

Kia wātea, kia wātea!

Āe rā kua wātea!

Rire, rire hau

Paimārie

(Written by Alroy Walker)

Pepeha

Ko Taranaki te maunga

Ko Waitara te awa

Ko Tokomaru te waka

Ko Te Ātiawa te iwi

Ko Ngāti Rahiri te hapū

Ko Owae te marae

Ko Rex tōku pāpā

Ko Gabrielle tōku māmā

Nō Kirikiriroa ahau

Ko Kay Syminton tōku ingoa

Whakamanatanga – Dedication

This thesis is dedicated to my sons Liam, Ethan and Seamus for their aroha and unwavering belief that I could achieve this kaupapa. The best sons a mother could ask for in life.

To my parents, Gabrielle and Rex, thank you for the values, skills, and determination you both instilled in me to be a strong, hard worker, never giving up and always being there for me.

Abstract

This research explores how the Rural Health Interprofessional Programme (RHIP), an undergraduate clinical placement, influences Māori nurses' identity and nursing practice. Although there are other professions on this clinical placement, this research explicitly explored the stories of Māori who were nursing students in the programme. The study conducted for this thesis paid particular attention to how the clinical placement on the RHIP programme connected with Māori and the influence it had on their identity and professional practice.

Significant changes have occurred in health and social services over the past ten years. The siloed clinical education of health professionals, however, had been unchanged until the RHIP. The RHIP approach focuses on ensuring that health professionals are collaboratively ready to work in health care delivery in Aotearoa New Zealand, in rural settings, with an emphasis on local Māori (iwi and hapū) communities.

Kaupapa Māori theory informed the design of this research. Data were gathered using whakawhiti kōrero with nine Māori participants who are registered nurses and had been on an undergraduate RHIP clinical placement. All participants were currently practising as Registered Nurses in Aotearoa New Zealand. Seeking the perceptions of Māori nurses who participated in the programme offers a contemporary perspective on what supports Māori identity in a clinical practice placement for an increased understanding of the needs and realities of Māori student nurses. The participants' perspectives provided a better understanding of an interprofessional clinical placement and the impact of this on them as Māori and subsequently registered clinicians. Most importantly, participants shared their stories and perceptions that illuminated common factors found in practices that strengthen Māori identity. Reflexive thematic analysis was used to identify the key themes.

The key findings from this research gave an understanding of the participants' perceptions of the RHIP programme and heartfelt insights into being Māori who are nurses working in interprofessional practice. It is essential to note this programme does not profess to use a Māori education model in its delivery framework. Instead, it uses a community-centred approach to interprofessional education in the rural setting, while simultaneously reframing

the current models of siloed clinical learning and the notion of a one-size-fits-all approach. It offers knowledge of contemporary undergraduate placements from a Māori perspective and could be used to inform more effective clinical practice for Māori who are studying to be nurses.

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Attestation of Authorship

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

22/02/2024

_____ _____

Signature Date

He mihi – Acknowledgements

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Ethics Approval

Ethics Application: **20/84 How does an undergraduate placement in a rural interprofessional programme influence Māori nurses; identity and nursing practice?**

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

Your ethics application has been approved for three years until 5 May 2023.

Chapter 1 Introduction

1.1 My story

I come to this thesis as a woman of Māori and Pākehā whakapapa (ancestry). Through my mother, our tribal links are to Te Ātiawa, a smaller iwi (tribe) in Aotearoa New Zealand. More specifically to Ngāti Rahiri hapū (sub-tribe) in rural Taranaki and Te Ātiawa o Te Waka-a-Māui (northern tip of the South Island, Aotearoa New Zealand) in Whakatū (Nelson). Through my mother, I also have ancestral links to England. Through my Pākehā father, we have ancestral links to Scotland (Douglas/ MacKay Clans). Like many Māori I whakapapa to both Māori and Tauiwi.

I was brought up in my formative years in rural Te Moana a Toi-te-Huatahi (Bay of Plenty), and then in Tauranga, although regrettably, I did not grow up with whānau that passed on knowledge of my Te Āti Awa whānau (family) and whakapapa (connection). As family stories tell us, my mother's maternal grandfather, who was English, became overwhelmed by Māori whānau when my maternal great-grandmother died and moved the whānau away to Rotōrangi in the Waikato. This move away was in a time of assimilation in society, and with distance from our Māori whānau, the stories of our tūpuna (ancestors) became lost to us. Recapturing these stories is an ongoing challenge for me and our whānau.

I also come to this thesis with work experiences as a nurse in Pākehā organisations in Aotearoa New Zealand, and internationally in Australia, the Middle East, and America. These work and life experiences have exposed me to a range of ways of working with people as a registered nurse. I have spent a significant part of my recent career as a nursing academic, teaching both undergraduate and postgraduate nursing. While I was working as a nursing academic, I became interested in ensuring that Māori who wish to study nursing have support and programmes in place that recognise them and what affects them as Māori.

1.2 Whakapapa of this study

My involvement with the rural health interprofessional programme (RHIP) immersive clinical placement since 2015 has driven this research. Anecdotally, I noticed that when semester five (third year) Māori nursing students first commenced on the placement, they could be reserved, unsure, and almost shy. They tended to be reluctant to engage in clinical conversations with other professionals on the programme. During the 5-week placement, the change in them was almost palpable personally and professionally. There was a sense of rangatiratanga (autonomy and leadership) in the way they engaged with those around them, and their mana (strength) grew visibly.

As a Māori nurse and educator, I have been particularly interested in "why" this change seems to occur. Such a change has not been as evident in other clinical experiences, including those in other rural locations or with kaupapa Maori providers. Of interest were the Māori students – what was it about this placement that seemed to engender such a change, what was the change and finally, what does this mean for their practice once they have graduated?

The notion of dedicated interprofessional clinical placements for undergraduate health professionals is well recognised internationally (World Health Organisation, 2010; Gittell, Godfrey & Thistlethwaite, 2013; Thistlethwaite, 2016); however, New Zealand has been slower to implement such dedicated clinical practice experiences (Crawford et al., 2016; Pelham et al., 2016).

1.3 Aims of the research

Te Tiriti o Waitangi (discussed below) expects Māori to experience the same standards of health as non-Māori. In addition, it enables Māori to contribute to the development of health services. The nursing profession in New Zealand has recognised the relevance of Te Tiriti o Waitangi to professional practice and an expectation to be responsive to Māori since the early 1990s (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand, 2013). To contribute to the establishment of the best available evidence related to clinical education for undergraduate education in nursing, the primary aim of this study was to explore how RHIP interprofessional clinical placement influenced Māori nurses' identity. The second aim was to explore, from the Māori nurses' point of view, how their RHIP

clinical placement informed their nursing practice as registered nurses. The final aim was to examine how this dedicated interprofessional clinical experience impacted the Māori nurses' interprofessional collaborative practice.

1.4 Māori Nurses

Reviewing the Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand Nursing workforce statistics reveals that nurses who whakapapa Māori represent just 8% of the 52083 registered nursing workforce (2019). In contrast, Māori comprise 17.5% of the population (Statistics New Zealand, 2022). In 2018, the Ministry of Education identified 19% of nursing students identified as Māori. Based on the numbers practising in 2019, there is a significant attrition rate from the nursing programmes in tertiary study.

In a study by Wilson et al. (2011) there was recognition that completing nursing education in Aotearoa New Zealand for Māori meant overcoming ongoing and numerous barriers. Their study called for a response to move beyond the rhetoric of increasing the Indigenous workforce to undertaking actions that support the retention of these students. This sentiment is still evident in more recent literature (Chalmers, 2020), which supports the relentless tide of information demonstrating inequity in education.

Inequity is not a new phenomenon, and there are many reports exploring the adoption of a Māori pedagogy approach that can strengthen outcomes for Māori ākonga (students) (Ministry of Education, 2021; Ministry of Education, 2018; Sciascia, 2017). In 2020 (para 2), the Ministry of Education released the Statement of Education and Learning Priorities and the Tertiary Education Strategy, where their stated learning focus is on ensuring that learning spaces are free from racism, discrimination, and bullying. They also state that learning spaces will focus on incorporating te reo Māori and tikanga Māori into everyday activities.

Nonetheless, there remains a long-standing failure to address the Māori Health workforce inequity which, in turn, has failed Aotearoa New Zealand Māori and Māori whānau (Ministry of Health, 2021). There is recognition that the nursing pipeline is a critical issue (Hetaraka, cited in Health Workforce New Zealand annual report 2020; Te Whatu Ora, 2023). Wilson and Barton (2012) identified over a decade ago that a culturally matched health workforce

makes a significant difference to health outcomes and addressing known health inequities. There seems to be a significant disconnect between knowing and overcoming the ongoing barriers in education and health.

1.4.1 Māori Identity

There is evidence that Māori nurses walk in two worlds, Māori and non-Māori (Wilson & Baker, 2012; Wilson et al., 2011; Simon, 2006) and that this is a challenge for Māori nurses. Wilson et al., (2011) looked at the retention of Māori students, identifying that the conflict between a Māori worldview and that of the dominant nursing Western culture resulted in the student going through a process of acculturation. Wilson et al. (2011) noted this lack of affirmation of identity as Māori impacted the successful retention of Māori student nurses. Several studies identified an awareness from the study participants that they saw themselves as Māori first and nurses second, but many of the programmes ask of them to be nurses first and Māori second (Foxall, 2013; Simon, 2006; Wilson et al., 2011).

1.5 Te Tiriti o Waitangi

The rationale for this study ultimately comes from Te Tiriti o Waitangi and its relationship to educational success and Māori health. Therefore, it is important to situate this study within the historical context of Aotearoa New Zealand. Besides this condensed view, the discussion on Te Tiriti is expanded in Chapter 6 (Discussion).

Before colonisation, Māori had established complex collective structures that supported beneficial living and were engaged in international trade with several other nations worldwide (O'Malley et.al., 2013). In the early 1800s, there was unprecedented overseas travel and migration in the form of imperial expansion into Aotearoa New Zealand (Pool, 2015), with an established aim of colonising Māori: "In justifying the subjugation of Māori, many British saw themselves as physically and morally superior to the natives" (Pool, 2015 p 28). Colonisation changed the fabric of Māori life forever regarding our economy, cultural identity, and the sociopolitical landscape of Aotearoa New Zealand.

Te Tiriti o Waitangi was to formalise the arrangement for the agreed co-existence between Māori and the Crown (Orange, 2013). Over the eight months following the signing of the

Treaty on the 6Th of February 1840, original copies and versions of the Te Tiriti were taken to Māori communities, where they were signed by over 500 chiefs (Orange 2013). The two texts, English and Māori, were not direct translations of each other, and they did not talk to each other:

> Neither version of the Treaty was a translation of the other...the English version gave the Crown governance or kawanatanga, while Māori maintained tino rangatiratanga (Chieftainship). However, as these terms were understood, they envisioned a sharing of power. Both versions of the treaty guaranteed the protection of Māori resources and land rights. However, soon after the signing the treaty was practically ignored, and what followed was a familiar pattern of expropriation of land and cultural marginalisation of the indigenous people (Rumbles, 1999, p2).

Differences between the Māori text and the English text led to different understandings of the meaning and implications of te Tiriti (Orange 2013). In the first two articles of the English text, Māori ceded "sovereignty to the British Crown but retained "full exclusive and undisturbed possession of land, forests, fisheries and other property. In the first two articles of the te reo Māori (Māori language) text, the chiefs ceded "kāwanatanga" (government) of the lands but retained "tino rangatiratanga" (entire supremacy) of land, settlement, and all personal property. Article three of both texts states that the Crown gave Māori protection and the same rights as British subjects. Durie (1998, p. 84) interpreted the twentieth-century implications of the Treaty of Waitangi as follows:

> Article One: Parliament's right and authority to govern.
>
> Article Two: Tribal right to exercise tino rangatiratanga.
>
> Article Three: Māori individuals' right to expect a fair share of society's benefits.

That there is a different understanding of the two texts has been the pervading understanding until Fletcher (2022), who now argues that the versions are more aligned than previous scholars believe. He suggests that there has not been a close enough review of the English versions of Te Tiriti. Nonetheless, the fundamental differences in translation, application and interpretation in the years that have followed the signing have contributed to harmful flow on effects in all aspects of life for the Māori population (Pool, 2015).

However, it is the ongoing breaches of te Tiriti that have had a devastating effect on Māori lives.

The Stage One report of the Waitangi Tribunal health services outcome inquiry, known as WAI2575 (2019), recognised and confirmed the Eurocentric and systemic racism that permeates the health system in Aotearoa New Zealand. The report identifies that Māori are entitled to outcomes equal to those of non-Māori and appropriate health services. Beginning to address the outcomes of the report can be seen in the development of Whakamaua: Māori Action Plan 2020-2025 (Manatū Hauora Ministry of Health, 2020), which is directed by WAI2575 and informed by Te Tiriti o Waitangi (Waitangi Tribunal, 2019).

The WAI2575 report also informed the recent changes to the health delivery structures, including the establishment of Te Whatu Ora, Health New Zealand and Te Aka Whai Ora, the Māori Health Authority. Both of these entities have been designed to update services to deliver locally supported health care that is in partnership with Māori (Pae Ora, 2022; Future of Health, 2023). The health system is charged with recognising, respecting, and actioning the Crown's responsibility in supporting Māori-Crown partnerships to ensure that its governance, management, and operations give effect to Te Tiriti o Waitangi.

1.6 Kawa whakaruruhau

Kawa Whakaruruhau is the legacy of Dr Irihapeti Ramsden and has become a unique taonga (treasure) in nursing in Aotearoa New Zealand. In 1990 Ramsden wrote:

> Only one word needs to be altered in order to suitably change the old nursing philosophy to become appropriate for the end of the 20th century and onward to the 21st. That word is irrespective. By adjusting it to become respective, the objective of nurses to give appropriate service delivery can be achieved. Nurses provide care, respective of the nationality of human beings, the culture of human beings, the age, the sex, the political and the religious beliefs of other members of the human race (p 35).

The right to have Māori culture validated through teaching that did not put that culture at risk while regarding the values and beliefs of Māori is a fundamental tenet of her cultural safety guideline for nursing education (Ramsden, 1990).

Kawa whakaruruhau was developed by Māori for Māori. Like many changes that start as mana enhancing approach for Māori, the notion of cultural safety in nursing, as intended by Ramsden, has been homogenised to better sit in the Eurocentric culture of Aotearoa New Zealand. In her recent opinion piece, Roberts (2019) argues that Te Kaunihera Tapuhi o Aotearoa (Nursing Council of New Zealand) responded to what can only be seen as white fragility and privilege when the Council guidelines centred on cultural safety as a broad concept for all people, rather than for Māori as it was intended. She goes on to argue that this constitutes colonial power and control and calls for a collective professional nursing challenge to this. Although the ongoing rhetoric of Te Tiriti responsiveness is evident across the Ministry of Health, particularly in achieving mana taurite (equity) in reality, this is an aspiration impeded by layers of Eurocentric privileging throughout current systems and practices (Health and Disability System Review, 2020; Roberts, 2019).

1.7 Study Context: Rural Health Interprofessional Programme

The World Health Organization (2010) defines interprofessional practice as working as a team competently, and interprofessional education is the essential precursor to being a competent interprofessional practitioner. Frenk et al. (2015) offer that interprofessional education has not matched the challenges of developing a competent professional workforce that can respond to the ever-changing health needs in the 21st century. Stating that the current approach to health professional education internationally is outdated and fragmented, they are clear that any significant reform for practice must include interprofessional education. The World Health Organization (2010) and Frenk et al. (2015) define such education as when students from two or more professions learn from and about each other, intending to collaborate effectively for improved health outcomes.

In recognition of the need for dedicated interprofessional practice experiences and the unique needs of rural practice in New Zealand, the Ministry of Health 2010 called for proposals that attracted students to undertake more of their training in rural settings, with a particular focus on attracting Māori and Pacific student participants. The University of Auckland and the Clinical School of the Eastern Bay of Plenty District Health Board were successful in their proposal, and through Health Workforce New Zealand's voluntary

bonding scheme funding, the Rural Health Interprofessional Programme (RHIP) (University of Auckland & University of Otago, 2011) was established in Whakatāne in 2012.

The RHIP clinical practice placements, along with associated non-clinical experiences, are determined and timetabled by the RHIP Academic Coordinator in Whakatāne. These placements are timed to meet the clinical practice timetable for medical students from the University of Auckland. The tertiary education providers for other cohorts of health professionals then determine the fit of the overall programme with their curricular needs when placing their students in the clinical experience. The unique interprofessional nature of the placement and the funded accommodation in a coastal location plays a large part in its appeal in terms of its choice as a clinical placement for health students.

Briefly, the programme involves:

- Students volunteer to attend the placement.
- Primary health placements in the Eastern Bay of Plenty.
- A five-week experience
- Cohabitation in assigned accommodation with other health professionals (medicine, pharmacy, paramedicine, occupational therapy, social work and so on).
- Between 3-4 students per whare (house)
- 3-4 whare (houses) might be involved with each placement
- Clinical placement from Monday to Friday, and
- Attending educational days as planned by the local clinical coordinator for the programme throughout the clinical experience.

These elements provide the baseline understanding for this thesis and represent the RHIP placements discussed by the research participants.

1.8 Overview of the research

By focusing attention on Māori nurses, this study seeks to uncover the experience of learning for Māori nurses in a rural interprofessional clinical placement. A particular focus will be on the ways in which this placement supports (or does not) the development of their own identity, nursing practice and interprofessional collaborative practice. This study will test my observations of noticeable changes in the Māori nursing students and seek

clarification about how and why those changes have occurred. A kaupapa Māori approach will guide the research to challenge, question and critique the traditional delivery of clinical experiences for Māori undergraduate nurses. Ultimately, recommendations from this study can advise nursing and other health educators in developing placements that affirm Māori and enhance Māori nursing practice and interprofessional collaboration.

1.9 Structure of the thesis

Chapter One introduces the research and researcher and provides the background context for the study.

Chapter two outlines the whakapapa of tertiary education alongside nursing education in Aotearoa New Zealand, to understand its context in relation to this study.

Chapter three explores the existing literature that informs this research. The literature search and results are charted and presented, illustrating the existing gaps and limitations in the current literature and highlighting the focus of this research.

Chapter four outlines the kaupapa Māori approach to research and its applicability to the methodology, method and data analysis process undertaken in this dissertation.

The voices of the participants and the new knowledge they shared are presented as the findings in chapter five.

Chapter six discusses the themes that emerged from the whakawhiti kōrero and articulates the implications for mana enhancing clinical nursing education in Aotearoa New Zealand.

Chapter seven concludes this study, considers the learnings, and contemplates future pathways in nursing education.

Chapter 2 Background

2.1 Introduction

Nursing education commenced in the 1890s in Aotearoa, New Zealand; in the subsequent 140 years, there have been structural changes in nursing education and the health system, intending to improve health outcomes. In this chapter, I aim to provide an overview of key moments throughout three main sections: tertiary education, the health system and care delivery, and nursing education and qualifications in Aotearoa New Zealand. Finally, there is a discussion related to what is known about the impact of colonisation on Māori identity in relation to education and health care. The critical events presented in each of these sections have been chosen subjectively to provide an overview and background understanding of the context of this study and are important to understand the long standing impact of colonistion on our Māori experience education and health in Aotearoa New Zealand.

2.2 Aotearoa New Zealand Education Sector

2.2.1 Historical Education and Tertiary Reforms:

Māori had a well-instituted history of knowledge, learning and teaching integral to their culture and social organisation (Stephenson, 2009) prior to the arrival of Pākehā, which was disseminated in the process of colonisation. The introduction of colonial education happened quickly (Table 1). By 1853, just a few short years after their arrival, missionary schooling was established, modelled on the English and Scottish systems (Simon, 1994 & Stephenson, 2009), with an aim to convert Māori to Christianity.

Table 1:
Summary of Education Legislation and delivery in Aotearoa New Zealand.

Summary
1847 Education Ordinance Act
1858 Native Schools Act
Native Schools Code

Summary
1870 New Zealand University Act
1877 The Education Act
Removal of academic subjects such as Latin, algebra and geometry from the curriculum at Native Schools
1904 University Degrees Act
1906 Policy to discourage and punish the use of Te reo Māori at Native Schools
1914 New Zealand University Amendment Act
1926 University Amendment Act
1946 Establishment Technical Correspondence School (for vocational training)
1981 First modern wānanga established (Te Wānanga o Raukawa)
1989 Education Act
1990 Education Amendment Act
1999 Education Amendment Act
2000 Tertiary Education Advisory Commission established
2019 Te Pūkenga New Zealand Institute of Skills & Technology established
2020 Education (Vocational Education and Training Reform) Amendment Act 2020

The introduction of Western education would become one of the most significant processes of the assimilation of Māori. The programmes in the colonial schools that were established in the mid-1800s taught lessons of British superiority and Māori inferiority (Hetaraka, 2022). The Education Ordinance Act 1847 provides what can now be seen as the first example of how the Crown and subsequent Aotearoa New Zealand Governments would consider education for Māori, using Pākehā law to control Māori. Tertiary education was also established quickly in Aotearoa, New Zealand, with the introduction of the University Act in 1870. The subsequent education was based on the English education system, and The University of New Zealand was established as “an overarching entity to which local colleges were affiliated” (Pollock, 2012, p. 1). The University of Otago was established in 1869; however, with the enactment of the University Act it became an affiliated college (although it was allowed to keep its name). This was rapidly followed by Canterbury College (1873), Auckland University College (1893) and Victoria University College (1899) (Pollock, 2012.) So ingrained was the English influence on tertiary education that examination papers were marked only in the United Kingdom until 1939. Establishing a tertiary education system so

early could be seen as progressive and even advantageous for Pākehā; however, access to tertiary education for Māori was limited through the Native Schools Act of 1858 and the Education Act of 1877, limiting Māori exposure to academic topics.

Alongside the creation of universities in Aotearoa, technical schools were also introduced in the late 1880s. These were run by the local school boards and delivered trades training in the evening. They targeted students who entered the workforce straight after primary school. The students were paid fees to attend classes. In 1905, day classes were added, and funding remained in the control of the Department of Education; there was also a change in name at this time from Trade training to Technical schools. By 1986, the then Minister of Education led the standardisation of the institute names to polytechnics; this was alongside the cutting of funding in such schools for non-vocational training (Pollock, 2012).

The Labour government (1935-1949) recognised an increase in funding was needed in tertiary education and established the University Grants Committee (UGC) in 1948. The UGC used a funding model whereby they granted block funding to the Colleges. The Colleges could then spend these funds as they saw fit. This funding model remained unchanged until the 1960s when increasing student numbers, enrolment patterns and staff-to-student ratios were reviewed. What followed was essentially the first big reform in the tertiary system since its inception in 1870 (Pollock, 2012). The University of New Zealand was disestablished following the Universities Act 1961 enactment. This allowed for the existing colleges to be established as independent universities. This independence signalled the emerging liberal policies and beliefs that were also occurring simultaneously in the health systems. The education system was said to be fragmented (Ainscow, 2016), impeding education from being responsive to changing community and societal needs. With the fourth Labour Government (1984-1990) election, there was a determination to make sweeping changes across society and in government administration. Education was no exception (Hawke, 1998). All encompassing reforms were made, beginning with the Education Act 1989. It would become the statutory framework for all tertiary education and saw the abolishment of the University Grants Committee and Department of Education. At the same time, all tertiary education institutions were given autonomy, moving away from the notion of central control. The Act required that individual tertiary educators had control over their capital spending (McLaughlin, 2013).

Crawford (2016) argues that the broad directions of the 1989 reforms have endured over the last 25 years; however, he offers a clarification, stating that this is not the same as signifying the original purpose for change was achieved. The broad direction of the reforms led by the Labour government (1984-1990) may have been accepted, but the details have been contested, both by the tertiary sector in general and with an ongoing rub between universities and other tertiary education providers. There was an acceptance that central decision making was vulnerable to political pressure rather than the actual cost of providing education. At the time, the Treasury argued that making education providers more dependent on student choices would reinforce answerability to the consumer and away from the government. This competitive market model was supported and maintained by the National Government (1990-1999). 1999 saw a change in government back to Labour and rising concerns around the competitive model being implemented. Labour quickly made changes to reduce the costs for the student; however, the competitive market-based model continued (McLaughlin, 2003). This time of reform also offered significant changes for Polytechnics. The Education Amendment Act 1990 meant they gained substantial managerial and financial autonomy. Perhaps the most significant change was the ability to offer degree courses. Degree courses had only previously been offered at universities. This continued the competitive market environment and resulted in a changing landscape of polytechnic providers following merges of schools as well as changes from polytechnic to gain university status (Pollock, 2012).

The second major reform was when the Tertiary Education Advisory Commission (TEAC) was asked how to increase collaboration and cooperation across the tertiary sector and to guide Government financial support in tertiary education (Crawford, 2016). The response was to establish the Tertiary Education Commission in 2000. The commission was then charged with managing tertiary education, distributing funding, and monitoring the meeting of government defined targets. Once again, these targets were directed at efficiencies, for example, retention rates or course completions (Tertiary Education Commission, 2018a). These targets consider cost-effectiveness; they did not examine how the students were educated or whether the notion of solid connections from education to employment was being met. Crawford reported that an underlying criticism has been that there is a lack of incentive for innovative delivery and performance outside of the standard model for

education and meeting student needs (2016). By 2005, there was a budget blowout that signalled the next reform. Uncapped equivalent full-time student (EFT) numbers and frozen fees saw the government become even more determined to re-introduce some increased central control. The overall outcome was a significant funding shift towards universities and away from the vocational programmes offered at polytechnics and wānanga (Ministry of Education, 2014).

The end of 2000 saw a change in Government, and in keeping with a historical pattern, a change in government ideology signaled a policy change. This government developed and introduced the Education Performance Indicators (EPIs) as a means to measure course and qualification completions, retention and progression. They revealed that some Institutes of Technology and Polytechnics (ITPs) were not performing at the expected level for student outcomes, which found some ITPs in the position of returning funding to the crown. The problem was that all outcomes were measured against the same criteria of retention, performance and completion (Tertiary Education Commission, 2014), resulting in a significant disadvantage when looking at the prior educational achievement of the student (Tertiary Education Commission, 2018b). ITPs have continued to face increasing financial pressure, which has meant they have used cost-cutting initiatives, such as restructuring, mergers and targeting international enrolments. According to Crawford (2016), fiscal sustainability and affordability for consumers is one of the tertiary education reform themes. I argue that universities charge ever more for essentially the same service as ITPs but with fewer challenges to their funding streams.

2.2.2 Aotearoa New Zealand Tertiary Education Today

(ITPs / Te Pūkenga)

Tertiary education has a long intellectual tradition of transformation based on higher learning. The early policy reforms suggested some movement away from the notion of higher learning but towards a competitive funding model that intended the schools to be accountable to the learners' needs. Fiscal responsiveness became the driving force rather than responding to community needs. Alongside this is a continued colonial approach in Aotearoa New Zealand, where the accepted pedagogical epistemology and ontology is that

of the dominant European culture. This is despite the Ministry of Education (2007; 2014), alongside many social and professional bodies, requiring that tertiary educators consider the cultural requirements of students by implementing culturally applicable learning and teaching methods. In turn, this indicates that the most significant risk in the direction of tertiary education policy reforms has been the failure to engage with culturally supportive learning and its pedagogical foundations. The lack of focus on the outcome of higher learning has seen the concept become marginalised, with universities being overly focused on research activity to continue to access a wider funding pool. Research can be seen as evidence that higher learning is occurring; however, as Curzon-Hobson (2014) noted, research alone cannot fulfil the function of higher learning.

In 2005, Codd and Sullivan argued that there is now a dominant managerial culture within educational institutions. This dominant culture is more concerned with what can be recorded, documented, and reported than the educative process itself. Of course, there can be little argument that a blend of research and teaching is needed for the transformation of learning experiences. However, funding models continue to enforce research output priorities. It is here where ITPs may have been disadvantaged. Some attempt at addressing this is seen in the introduction of Education Performance Indicators (EPIs); however, this has only gone so far. There is a gap in the current funding approach as the EPIs are using the same measuring stick for Universities and ITPs (Tertiary Education Commission, 2018a). These two tertiary education systems have different delivery models, which means this funding favoured the universities, not the ITPs. There are only three Universities that deliver undergraduate nursing programmes in Aotearoa New Zealand; Auckland University of Technology, University of Auckland and Massey University, and one further programme delivered at Te Whare Wānanga o Awanuiārangi (NCNZ, 2021)

As discussed earlier in this section, the centralised funding model for tertiary education was disestablished in 1989. In 2020, the Education (Vocational Education and Training Reform) Amendment Act 2020 cemented the establishment of Te Pūkenga – New Zealand Institute of Skills and Technology (Tuohy, 2022). It also signalled the return of centralised funding for vocational education and training schools. Te Pūkenga aims to support work-based, campus-

based and online learning as a single system across Aotearoa New Zealand. Te Pūkenga is also to be a system to uphold and enhance Māori-Crown relationships (Tertiary Education Commission, 2023). Entities operating under Te Pūkenga are known for the delivery of vocational education. Delivering nursing education in a vocational institute, as it is a degree-based professional qualification, is outdated and misrepresents the professional status of nursing in education. Significant changes to the delivery of health professional education, specifically nursing education, have yet to be made. However, there is a call for a single national curriculum as a starting point. These and other proposed changes to nursing degrees will be discussed in more detail in relation to the findings in Chapter 6.

2.3 New Zealand Health Sector

Aotearoa New Zealand, has experienced dramatic health and healthcare delivery changes over the last century (Parliamentary Library Research Paper, 2009). The legislative and funding changes are summarised in (Table 2).

Table 2:
Summary of Aotearoa New Zealand Health System and Funding Reforms.

Summary
Between 1872 and 1885 the following Acts and systems changes were introduced:
1872: Public Health Act
1885: Hospital and Charitable Aid Act
1938: Social Security Act
1956: Health Act
1983: Area Health Boards Act
Establishment of 14 Area Health Boards 1983-1993
1997: Area Health Boards (RAH) replaced by 4 Regional Health Authorities
1998: The 4 RHAs were combined into one purchasing agency Health Funding Authority.
Establishment of 23 Crown Health Enterprises (CHEs)
2001: 21 District Health Boards established
2002: Primary Health Organisations were developed to manage primary healthcare
2010: Health Act Amendments 1956
2022: Pae Ora - Healthy Futures Act 2022

2.3.1 Early Colonial Health Care Development in Aotearoa New Zealand

Early health care in Aotearoa New Zealand was provided by private and voluntary agencies (Miskelly, 2006). There were various providers, including Western medicine and traditional Indigenous medicine. The settlers brought with them traces of the British system, which privileged Western medicine (Miskelly , 2006). In the mid-1800s, Governor Grey established public hospitals for the purpose of treating Māori and the poor Pākehā. The care of Māori was free, with the belief that such an approach would assist with the assimilation of Māori into a European society (Bryder, 2018; Gauld, 2009).

In subsequent decades, there continued to be an ad hoc approach to the development of health services. As the population of Aotearoa New Zealand grew, and in the face of increasing strain on the health system, the first Public Health Act was introduced in 1872 (Gauld, 2009) with the Hospital and Charitable Aid Act following shortly after in 1885. The Public Health Act of 1872 required establishing a regional Board of Health in every province. This would prove to be a source of conflict following the establishment of the local hospital boards through the Hospital and Charitable Aid Act in 1885, both in terms of governance and funding (Gauld, 2009). The hospital boards would remain in place for more than a hundred years.

Although the system was initially put in place to support Māori, historically, Aotearoa New Zealand's health system developed to respond to the needs of Pākehā (this is discussed more in relation to Māori later in this chapter). Cheyne, O'Brien, and Belgrave (2008) note that the post World War II period saw the development of a hybrid political philosophy that embraced both incremental socialism and liberalism. Labour intended to introduce universal care based on citizenship rather than need (Starke, 2010); however, ultimately, universality was only able to be partially achieved. Secondary care in Aotearoa New Zealand became a universally comprehensive system, the first of its kind worldwide. However, the primary

care sector reforms simultaneously (1947) proved much more complex, with doctors remaining independent and as private practitioners (Gauld, 2009). The government at the time introduced subsidies for general practitioner (GP) fees through the General Medical Services Benefit (GMS). At its introduction, the GMS covered two-thirds of the entire doctor's fee (Gauld, 2009; Starke, 2010).

This system of health care provision remained in place until the 1970s, when the pressure for reform began to build in relation to cost containment and better access to services (Gauld 2001). Politically, this signalled the rise of the 'new right' or neoliberalism, where the market is the central institution (Cheyne et al., 2008). During this time of rampant inflation, the GMS was now only covering one-third of GP fees. There were increasing urban populations who lacked adequate medical services. The then Labour government released some recommendations in the form of the 1974 White Paper. The paper reviewed different areas of the health system and suggested some significant organisational changes, including decentralisation and increased responsibilities for regional authorities (McGuigan, 1975). The suggested restructuring from the white paper was not a stance the government chose to implement. It was, in fact, the incoming National government that mirrored the White Paper proposals. Taking them one step further through a process of consultation, they gained support from the medical profession and the Hospital boards. The National Party chose to pilot the change to the Hospital board system by introducing Area Health Boards (AHBs) (Starke, 2010). These AHBs were responsible for planning and managing services in their regions; however, this responsibility did not mean that the AHBs were independent of the central government. Therefore, the convoluted funding and decision-making processes that have surrounded health delivery in Aotearoa New Zealand continued (Starke, 2010).

In the late 1990s, when what Starke terms 'the revolution' took place, the conservative National government was in office again and had taken up the notion of purchaser-provider split and an internal market that had been suggested to the previous Labour-led government but had not been implemented. The AHBs were replaced by just four Regional Health Authorities (RHAs). Each would be given a separate budget to fund the provision of primary, secondary and disability support services (Gauld, 2009; Starke, 2010). Funding such as this was new as these services have been funded separately in the past. Starke (2010) draws on the work of Ashton (1999), who suggested that what had been even more radical

was the reorganising of public hospitals and community services into 23 revenue-orientated Crown Health Enterprises (CHEs), making them compete with private hospitals, general practitioners and other organisations for contracts from the RHAs (Starke, 2010). This revolution was short-lived as it proved to be too controversial and out of line with the fabric of health care in Aotearoa New Zealand - the provision of universal hospital care. It is not clear what the impact of these reforms was on sector performance, however there are some accepted known positives, such as greater cost transparency and innovation in health services, notably Māori Health providers, and the establishment of the Pharmaceutical Management Agency (Pharmac), a Crown entity that decides which medicines and pharmaceutical products are subsidised for use in the community and public hospitals (Gauld, 2009).

Ashton and Tenbensel (2012) offered a comprehensive review of the health system funding and subtle policy reforms in the years from 2008-2009, since the last significant legislative changes in 2000. They noted the increasing shift from population health outcomes focus to system efficiency. Arguing that this shift from equity to efficiency may be at the expense of improving the health of the community, Ashton and Tenbensel argued that some of these reforms smack of déjà vu in relation to changes introduced in the 1990s. The rapid restructuring then was heavily criticised and failed to yield the expected gains. The early 2000s period was characterised by a series of reforms attempting to address the shortfalls. For example, the establishment of the District Health Boards (DHBs) reflected an economic approach last seen in the disestablished Area Health Boards.

2.4 Health Care Strategy and Delivery, in Aotearoa New Zealand

Since 2000, there has been an abundance of health strategies released with an emphasis on population health outcomes, signalling a shift away from the previous focus on efficiency and cost-effectiveness. The strategies are summarised in Table 3. This table shows an array of health strategies introduced to meet the needs of the public system implemented in 1938 and the increasing complexity of health care.

Table 3:
Focused Summary of Health Strategies.

Summary

2000: New Zealand Health Strategy

2001: New Zealand Disability Policy

2001: Improving Māori Health Policy

2001: Primary Health Care Strategy

2001: Kia Piki te Ora Māori Suicide Prevention Strategy

2002: PHARMAC Māori Responsiveness Strategy launch

2006: Treaty of Waitangi statements are no longer included in Ministry of Health policies, action plans or contracts. Focus instead on improving Māori health outcomes and reducing health inequalities for Māori

2007: Te Uru Kahikatea: Public Health Workforce Development Plan

2007: E Ara a Tauwhaiti Whakarae – National MāoriPublic Health Workforce Development Plan

2014: The Guide to He Korowai Oranga: Māori Health Strategy

2016: The New Zealand Health Strategy Refreshed

2022: Te Pae Tata Interim New Zealand Health Plan 2022

2023: Rural Health Strategy is expected in July 2023

In 2011 a revised set of health targets was introduced, which moved services further away again from population health outcomes towards improved economic service delivery. This approach was noted by Starke (2010) to be 'hitting the target but missing the point' with no improvement in population health outcomes.

The Health Strategy in 2000 was the beginning of a national shift from service-centred to people-centred care, alongside widening the focus from the individual to the whānau and family (Ministry of Health, 2016). It was also a beginning move away from the professional-dominated top-down approach that put the responsibility on the people while the system was working against them to a more collaborative person-centred slant (Gauld, 2018). In the context of this study, it is fitting to examine the strategies related to rural health delivery, as this is a primary focus of the Rural Health Interprofessional Programme.

2.4.1 Staffing Rural Health Services

The literature reveals that rural health services have been consistently under-supported from a political standpoint. In 2002, the Ministerial Centre for Rural Health was closed

(Ministry of Health, 2018). Then, in 2018 came an announcement by the Rural Health Alliance Aotearoa New Zealand group that they too would go into hibernation as they had failed to secure government funding to continue (Houlahan, 2018). Prior to 2022, there was no dedicated steering group commissioned to address rural health practice and development in Aotearoa New Zealand. There is now the promise of the development of a Rural Health Strategy that will be able to support and address the long history of and complex challenges of health care delivery in rural areas and, particularly in Māori communities (Manatū Hauora Ministry of Health, 2023). Gauld (2016) identified that Aotearoa, New Zealand, had the most restructured healthcare system in the Western world from the 1980s to 2000. He also noted that there are systemic failures that are a result of the compromises made with the funding of the primary medical services, specifically GPs, dating from the enactment of the Social Security Act of 1938. This has meant that rural primary practices face ongoing challenges related to funding and being able to offer equitable services to their patients. When considering staffing, it also means that the salaries offered in primary healthcare practices have been unable to be matched with the public health sector, so they are recruiting from a limited pool of health professionals.

In an attempt to respond to the challenges of staffing rural communities over the past two decades, there have been a number of postgraduate funding schemes with the goal of increasing the number of health practitioners in rural practice (Adams, 2017). These have met with only limited success, as all rural areas continue to be recognised as hard-to-staff areas (Health Workforce Advisory Board, 2022). What is also of interest is that the funding is disproportionately focused on medicine, with nursing only receiving a small portion of the available funding. In the previous health strategy (Ministry of Health, 2016a), there was no specific rural health action. However, rural health should have fallen under the named priority area of ‘services closer to home’. The central tenet of this priority was to keep people living well in their own community, including rurally, so they remain actively engaged in maintaining and improving their health.

Health Workforce Aotearoa New Zealand (HWFNZ) is of interest because of its role in the training and development of the health and disability workforce. Primarily, this focuses on support for postgraduate qualifications, usually in the first year of practice, to facilitate

nurses, midwives, doctors and pharmacists in their transition to practice year ([first year post graduation] Ministry of Health, 2018). There have been limited studies on the effectiveness of this committee; it is more common for HWFNZ to publish their own studies reflecting information reporting. Of particular interest to this research is the HWFNZ's recent acknowledgement that the current funding model is unresponsive to changing community needs (Manatū Hauora Ministry of Health, 2018 p 13). They have proposed a revised funding model, which they believe will be able to respond to future health needs rather than only to historical conventions. The report is clear that the Minister of Health will have final approval, but future decisions will be underpinned by the following aims:

- Improving the patient experience of care,
- Improving the health of populations and
- Reducing the per capita cost of healthcare

2.4.2 Health System Changes 2022

The new health system launched in 2022 promises to be more straightforward and coordinated with the goal of more consistent care (Future of Health, 2023). This latest iteration has been received with some caution as Aotearoa New Zealand has a long history of health reforms and not all of them have resulted in an improvement in the existing system (Stokes & Goodyear Smith, 2022). The government was clear that the changes to the system structure would not immediately change where and how people receive care. The reforms are outlined in the Pae Ora (Healthy Futures) Act of 2022; the 20 District Health Boards have been disestablished and replaced with Te Whatu Ora – Health New Zealand. Over time, the functions of the 20 former District Health Boards (DHBs) will be woven into regional divisions and district offices. Te Whatu Ora will have a national planning mandate, with regional delivery and the expectation of increased local input into their development plans. Alongside Te Whatu Ora, Te Aka Whai Ora – Māori Health Authority has been established (Pae Ora Act, 2022). The Pae Ora Act requires the new institutions to give effect to the health sector Treaty principles of partnership, equity of outcomes, and delivery by communities for communities (Pae Ora Act 2022).

Recognition of the Treaty of Waitangi Health Services and Outcomes Inquiry findings (WAI 2575), which attributed the persistent and insistently poor outcomes of Māori to Crown breaches of Te Tiriti o Waitangi, is cited as one driver for the development of a Māori Health Authority (Ahuriri-Driscol et al, 2022). Therefore, the formal launch of Te Aka Whai Ora, the Māori Health Authority, on July 1, 2022, was seen as the most significant transformation in Aotearoa New Zealand's recent history. On their website, Future of Health (2022), the government has proposed that designing a system that includes Māori models of health and the application of mātauranga Māori in the health system will build a more robust Māori workforce and encourage more innovation in health services that deliver better outcomes for Māori. A recent Manatu Hauora Misintry of Health report (2024) reports that funding for Mōari health providers had increased 101.6% in 2022/23, however it caustions that this remains a small part of Vote Health representing just 3.9% in 2022/23.

At this time, many unanswered questions remain as to how the reforms will be fully implemented, what the ultimate strength of Te Aka Whai Ora will be, or if the entity even has a future under the newly elected National coalition government. These significant reforms were not in place at the time of data collection for this study, and to date there has been little opportunity for the ongoing health reforms to have an impact on the need for a more responsive health system.

2.4.3 Nursing Legislation in Aotearoa New Zealand

Within the timeframe of Aotearoa New Zealand's colonial history, nursing has been regulated for 120 years (Table 4).

Table 4:
Nursing Regulation Legislation

Summary
1901 Nurses Registration Act
1928 Nurses and Midwives Act
1939 Nurses and Midwives Amendment Act
1945 Nurses and Midwives Act
1971 Nurses Act

Summary

1977 Nurses Act

1990 Nurses Amendment Act

2003 Health Practitioners Competence Assurance Act 2003

2018 Health Professionals Competency Assurance Amendment Act

The first nursing legislation was the Nurses Registration Act of 1901. Aotearoa New Zealand was the first country internationally to establish standards for public safety through a register with set entry criteria (Burgess, 2008). Alongside this was a standardisation of training expectations for nursing practice based on standards adopted from England. Following a review, both nursing and midwifery were bought together under the Nurses and Midwives Act of 1928. The legislation was revised in 1945 (Lambie, 1951), and this version of the legislation would remain in effect until the Nurses Act 1971 was introduced.

The introduction of the 1971 Nurses Act saw the Nursing Council of New Zealand established and the registration functions separated from the Department of Health. The last Nurses Act was introduced in 1977 and remained in place for more than 25 years when, like its predecessors, it became outdated. Additional regulations to accompany the Act were added in a band-aid fashion as amendments were made to address its shortcomings (Burgess, 2008). The Act was then switched to a more umbrella legislation covering all of the health professionals of the time. This became the Health Practitioners Competence Assurance Act 2003.

2.4.4 Health Professional Competency Act 2003

The Health Practitioners Competence Assurance Act 2003 (HPCA Act) has an emphasis on public health and safety. The prior Nurses Acts implied that the public could trust that those on the register would be safe and capable of practising as a nurse. Competence, however, had never been as explicit as it is in the HPCA Act. The HPCA Act delegates the authority for nursing competence and registration to Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand (NCNZ), which means that the NCNZ is tasked with ensuring public safety and confidence in nursing practice. It is now through the HPCA Act that the title of Registered Nurse is conferred ("Health Practitioners Competence Assurance Act," 2003) and that the

NCNZ is required to be satisfied with the nurse's competence. Just as with the Acts that preceded this one, amendments have since been tabled in Parliament. These included, in April 2018, the following amendments:

- Performance of the authorities is to be assessed by independent reviewers on a five year cycle.
- Greater transparency of decisions made by the Health Disciplinary Tribunal and to include notification of the outcome to the complainant and,
- Better teamwork amongst health practitioners with a focus on interprofessional communication and supporting integrated healthcare.

These revisions did not alter the HPCA Act's intent in relation to practising as a Registered Nurse. Still, they added accountability in decision-making and recognised the need for interprofessional practice in health care delivery.

Alongside assuring that Registered Nurses are competent, The Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand is responsible for prescribing the qualifications and education standards for all scopes of practice (NCNZ, 2022). They then audit and approve proposed curriculums from Schools of Nursing alongside Mana Tohu Mātauranga o Aotearoa New Zealand Qualifications Authority (NZQA). However, they are not responsible for the delivery of education.

2.5 Māori

Policies implemented over the last 120 years have placed Māori in an undesirable position in relation to education, health and wellbeing (Table 5). Dow (1999) suggests that at the outset of colonisation, Pākehā were keen to extend institutional care to Māori, who were, in turn, eager to avail themselves of government services. Overall, though, throughout the mid-1800s, when hospitals were being established, fewer hospitals were developed in areas where Māori lived; of the 38 hospitals built in 1885, less than half of these were located in Māori settlements (Lange, 1999). These early inadequate provisions of health services would affect Māori health outcomes for years to come. By the early 1850s, the patients cared for in hospitals were predominantly European, outnumbering Māori 2:1. Although Governor Grey had established the initial hospitals to be services for the indigent and Māori,

as the demand for care increased, there was a call for user pays. The requirement to pay was validated and supported by the government of the time; again, this would work against Māori, as Europeans who could pay were accepted, whereas patients who could not pay were turned away (Dow, 1999; Lange, 1999; Rice, 2001). With the increasing focus (1850-1900) on assimilation rather than upholding the right to tino rangatiratanga, Māori uptake of Western medicine was increasingly limited. In reality, the te ao Māori worldview of healing was considerably different to that of Western medicine. As such, Western Medicine was viewed suspiciously by Māori (Lange, 1999), So much so that in 1857, the hospital in New Plymouth was classed as tapu by local hapū and, therefore, was no longer used by Māori (Dow, 1999). This was followed by a violent colonial Act of suppressing Tohunga (Māori traditional healers) with the enactment of the Tohunga Suppression Act 1907. This was most certainly a breach of Te Tiriti o Waitangi (Dow, 1999).

Table 5:
Summary of Māori Specific Nursing Education and Health Care Delivery

Summary
Mid-1800: Indigent care in hospitals
1850s: user pays was introduced and supported by the government
1885: 38 hospitals built less than half were in locations to support Māori
1896: First Māori Trained Nurse Mereana Tangata
1907: Tohunga Suppression Act
1911: Establishment of District Nurses for Māori – Māori Nurses
1958 Studies in Inequities between Māoris and Pākehā in regard to polio immunity and Incidence and the treatment of Bronchiectasis
1960 Comparative statistical report Māori and European standards of health
1976 Waitangi Tribunal established
1983: Te Kaunihera o Ngā Neehi Māori National Council of Māori Nurses established
1984 Māori Health identifies as a priority in the Ministry of Health
1989 Ministerial Advisory Committee on Māori Health
2022: Establishment of Te Aka Whai Ora Māori Health Authority

Along with historical policies of assimilation, land alienation, and the Tohunga Suppression Act 1907, Came and Tudor (2017) draw attention to ongoing policy changes that undermined both Te Tiriti o Waitangi and Māori health, stating that these changes did not specifically protect either partnership or participation in the development of health plans to meet the needs of Māori. According to Came and Tudor, before the 2014-2016 health reforms, there was no longer a requirement for the DHBs to develop a separate Māori Health Plan. It was accepted that the service provision for Māori be reported in the broader health plan. However, what is of more significant concern is that the requirement for consultation with Māori stakeholders had also been removed. Such reporting means again that Māori had no voice in the development of their health future and were positioned as having plans made for them.

The introduction of colonial education followed similar policies of assimilation and the enactment of legislation discussed in the Aotearoa New Zealand section of this chapter. As acknowledged by Hetaraka (2022), education has been most significant in assimilating Māori and teaching Māori cultural inferiority. This is seen when deficit theorising was introduced in the late 1960s as explaining poor outcomes for Māori in the education system (Hetaraka, 2022). This approach positioned the Māori individual to blame in historical processes over which they have no control.

There is little argument that both the colonial health and education delivery approaches were used as vehicles of colonisation and assimilation, undermining and limiting the way in which Māori are able to show up as citizens of Aotearoa New Zealand as Te Tiriti o Waitangi (1840) intended. These colonial systems reflect a long history of legal attempts to undo Māori social structures and language, fracturing Māori cultural reproduction and knowledge (Hetaraka, 2022).

This also underpins and re-enforces deficit theory thinking in education settings. Deficit thinking is associated with Indigenous peoples, ethnic minorities and low-income students and their families (Watson, 2020). It reflects a belief and justification that there is something inherently wrong with the learner. For example, they are unmotivated or lack family support and this results in poor academic outcomes. Thinking such as this highlights the now recognised and accepted educational disparities between Māori and Pākehā peers while at

the same time absolving the Eurocentric educational system of any responsibility for the outcome (Watson, 2020).

2.6 Nursing Education

I have focused on the current delivery of undergraduate nursing education in my thesis study. However, there is a significant history of formalised nursing education in Aotearoa New Zealand from which the current approaches have been developed (Table 6).

Table 6:
Summary of Timeline of Nursing Education in Aotearoa New Zealand

Summary
1884-1891: Nursing training schools in Wellington Hospital (1884), Auckland and Christchurch Hospitals (1891) and Dunedin Hospital (1896)
1928: Post Graduate Nursing courses offered in Wellington
1975: Establishment of Tertiary education for Nurses with the intent of moving from apprentice-based education to vocational education. Hospital education was phased out by the mid-1980s
1991: Introduction of Kawawhakaruruhau into nursing curriculums
1995: Professionalisation of Nursing education being offered as a degree

2.6.1 Qualifications and Education

Aotearoa New Zealand was an early adopter of formal education for nurses; from the early 1880s, an apprentice-based learning approach was utilised for educating nurses in the rapidly expanding colonial centres Wellington, Auckland, Christchurch and Dunedin. Nursing training remained hospital-based until the 1970s when the Carpenter Report (1971) on nursing education recommended that nursing education be moved from apprentice-based to tertiary education. Universities were not seen as the place for vocational education at that time; consequently, nursing education moved into what were then known as Polytechnics (Papps, 1998). This change was difficult as many hold a personal view of nursing and what a nurse does. Such personal discourse has certainly impacted the nursing profession's ability to define nursing (Papps, 1998). This move occurred over a period of ten years, and by the mid-late 1980s, hospital-based nursing training had been phased out.

The introduction of kawa whakaruruhau in the 1990s has been one of the most significant changes to nursing education since the move to tertiary institutes in the 1970s (Hunter & Cook, 2020). Its significance is that it recognised Articles I & II of Te Tiriti o Waitangi in nursing cohorts who had, for the previous 100 years, had a colonial approach to nursing education and content. With this came an increasing focus on inequities in health, social determinants, and culturally safe care. A focus which has resulted in a shift of educational focus to support developing an awareness of the cultural context of clinical practice. For example, this can begin with establishing a foundational understanding of health inequities and inequalities in general.

Kawa whakaruruhau and cultural safety align with the notions of person centred care and requires robust practice experiences to develop. Such practice experiences are not mandated where the clinical experience must be, just that they must be varied and focused on meeting a Registered Nurse's scope of practice competencies (Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand, 2022) . Beyond Te Kaunihera Tapuhi o Aotearoa Nursing Council of New Zealand requiring contextual learning in a variety of clinical areas where nurses work, there are no guidelines. Knowledge and skills are initially learnt in the decontextualized classroom context, and the student is then expected to apply that learning to the real world of practice. The planning and delivery of learning in clinical practice environments present a challenge to undergraduate nurse education. Bevis (1998 cited in Vandeveer & Norton, 2005 p 233) offers this in regard to nursing education; it should be two-fold to “ensure safety (cognitive knowledge) and to provide the climate, structure and dialogue that promote praxis”. The task then for educators is to ensure students are aware of the cultural context in which praxis occurs, and I would argue that they must also keep students culturally safe while this learning occurs. As I write, NCNZ are drafting a revision of registered nursing competencies.

2.6.2 Dedicated Interprofessional Education

Interprofessional education has been adopted in several different ways internationally and in Aotearoa New Zealand. Practising interprofessionally invokes the ideal healthcare delivery model where the patient is at the centre and professional perspectives merge seamlessly (Flood et al., 2022). The concept and need for dedicated interprofessional clinical

placements for undergraduate health professionals is well recognised internationally (World Health Organisation, 2010; Gittell, Godfrey & Thislethwaite, 2013; Thislethwaite, 2016); however, Aotearoa New Zealand has been slower to implement such dedicated clinical practice experiences (Crawford et al., 2016; Pelham et al., 2016). The expectation to date is that this learning to work together as a health professional team occurs spontaneously in a clinical placement but is not usually a focused outcome of a clinical experience in an undergraduate health programme (Gallagher et al., 2015).

2.7 Summary

The delivery of both health care and education is a complex blend between meeting the needs of many and addressing the care or education of one. The enactment of Pae Ora Healthy Futures Act 2022 could potentially change the siloed, fragmented approach to care to a more integrated social response (Pae Ora, 2022). However, such intents will require that there be some active response related to educating health professionals to meet such an approach, which has been slow to be adopted in Aotearoa New Zealand.

This chapter has provided a focused discussion of the regulation and education of nurses, the tertiary education system and the health care system. The impact of moving from liberalism to neo-liberalism is evident in all three systems, alongside the ongoing underlying colonisation effect on Māori health and educational achievement.

Interprofessional clinical education is yet to be established as a standard approach to health professional education, and to date, nursing education continues to deliver curricula reflecting Western approaches to education. It is from this context that consideration of this study must be given. In the next chapter, I will present a review of the current literature.

Chapter 3 Literature Review

3.1 Introduction

This research study privileges a Māori way of thinking and engagement with the world, confronting the Western-based knowledge system's power and control. Colonisation has disrupted Māori ways of learning and health structures. The current systems have primarily developed to serve Pākehā, including the approach used for clinical based learning for health professionals, as discussed in Chapter 2.

For this study, I have looked at literature that relates to Māori in undergraduate nursing education, interprofessional education and new graduate nurses. The review process involved a systematic literature search and then the screening of articles to determine the relevance to the research question. Articles were then selected, appraised, and the findings synthesised.

3.2 Aim of the Review

The aim of this chapter is to synthesise the literature related to this study's research question on how an undergraduate placement in a rural interprofessional practice influences Māori identity and nursing practice. What was evident in this search is that there are no kaupapa Māori studies relating to interprofessional education placement or the influence of such placements on identity. The literature review, therefore, was conducted to evaluate the understanding of the experience of being in an interprofessional clinical placement for registered nursing students and what interprofessional education offers to nursing practice.

3.3 Scope of the review

This study is related to a dedicated interprofessional experience of Māori nursing students and aims to document how such a placement influences their Māori identity and how education clinical practicum influenced their practice as registered nurses. The review focused on studies examining the experience of being in an interprofessional educational clinical placement. I have used a systematic process organised around a focus on the

perspectives of students that were inclusive of the nursing voices and the experience of interprofessional clinical practice, not a simulated experience or case-based review. The search was conducted using the Auckland University of Technology databases for English language articles that looked at interprofessional education experience within Aotearoa New Zealand. The database's collections searched were Scopus, BMJ Best Practice US, BMJ Clinical Evidence, ERIC, Australia/New Zealand Reference Centre, MEDLINE, Cochrane Database of Systematic Reviews, JSTOR Journals, CINAHL Complete, Emerald Insight and Journals@OVID.

These electronic databases were searched initially using the following search terms: Māori or Maori, interprofessional education or IPE or interdisciplinary education or interprofessional learning, nursing or nursing student, and experience or perceptions or attitudes or views or feelings or qualitative experiences. When the searches were combined, no articles were retrieved; therefore, the search terms Māori or Maori were removed. Only publications from 2010-19 were included as source material (See Table 7). The period of nine years (2010-2019) was used as this captured the release of the international position paper from the World Health Organization (2010) on interprofessional education and the emerging issues for interprofessional education after the WHO paper release. Relevant research published after 2019 is included in the discussion (Chapter 6). Finally, additional filters were used to limit the source material to literature from Aotearoa New Zealand. The results presented limited studies, primarily from one known interprofessional clinical experience, with multiple student cohorts being reported in the samples. The review was expanded to include Australia, as the New Zealand data was limited.

Table 7:
Search terms and results

Auckland University of Technology	**Search Terms (Journal articles, English, Published 2010-2019)**	**Articles (n)**
Search 1	TI Contains Māori OR Maori OR New Zealand	407,808
Search 2	TI Contains Interprofessional education OR IPE OR Interprofessional training	35,537
Search 3	SU Contains nursing education OR nursing student OR undergraduate student	120,173
Search 4	SU contains experiences OR perceptions OR attitudes OR views Or Feelings OR qualitative experiences	4,793,578

Auckland University of Technology	Search Terms (Journal articles, English, Published 2010-2019)	Articles (n)
Search 5	S1 + S2 + S3 + S4	0
Seach 6	S2 + S3 + S4	192
Search 7	Filter: Exclude Simulation OR Case learning OR Mental Health	136
Search 8	Filter: Include New Zealand Aotearoa AND Australia	57

3.4 Study Selection and Appraisal

The AUT database yielded 367 potential studies. Then, using filters to exclude non-New Zealand or Australian studies, studies not published between 2010 and 2019 reduced these to 192. These were reviewed by title and abstract, and 135 were excluded. Removing the duplicates left 39 studies. The titles and abstracts were scanned for what interprofessional education had been undertaken, with the exclusion criteria in mind, and articles not published prior to 2010, that did not include a dedicated interprofessional clinical experience (not simulation or case study or role play), and studies that did not include nurses as participants were removed.

Following a full-text assessment and appraisal process, a further 28 studies were excluded. I then did a rapid review of the references in the remaining ten (10) articles, and five (5) additional studies were included; they are listed in Table 8. Other grey literature, such as reports and discussion papers, were also sought through the above methods and were particularly useful in exploring the emerging issues in Aotearoa New Zealand interprofessional education but were not used in the review.

I did not use a critical appraisal tool such as the Critical Appraisal Programme (CASP) checklist for assessing the selected literature. Graham and Masters-Awatere (2020) identify it as a colonial approach that aligns with the dominant Western construct of methods, regardless of the academic contribution a study may make. They go further to remind us that this can be a tool used to delegitimise perspectives and experiences particularly related to kaupapa Māori based research, arguing that “even low-quality articles can offer high quality data” (Graham & Marsters-Awatere, 2020, p195). Instead, I have drawn on an approach which required a number of readings of each possible article to become familiar with the content. This reflexive approach aligns more with my study using kaupapa Māori

theory. All of the final 15 studies contribute valuable understanding of the experience of an interprofessional clinical practicum both from what learning the participants said they experienced, the organisation and structure of the clinical experience and why placements such as these are needed.

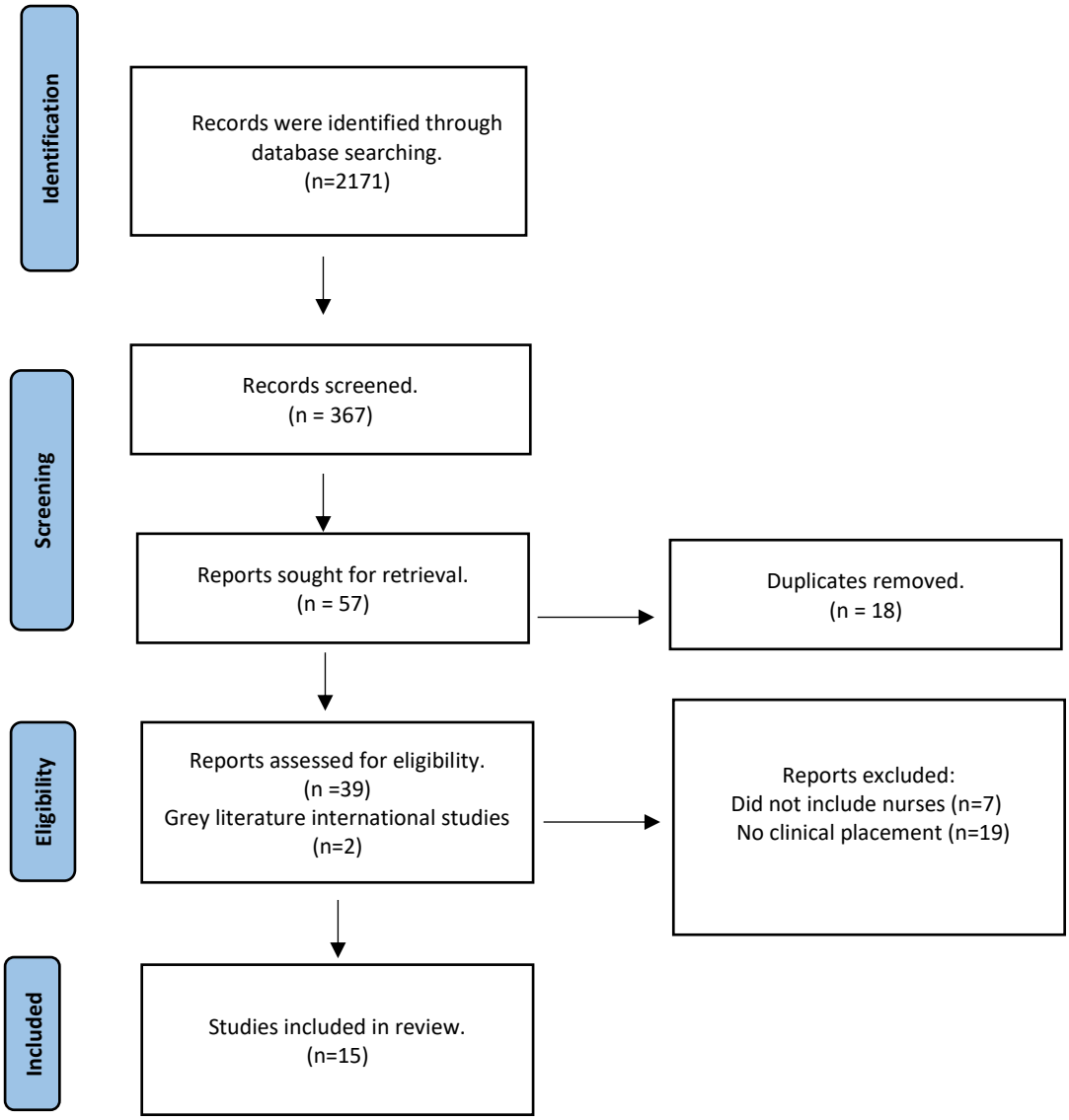


Figure 1:
Process of identification, screening and exclusion of studies according to PRISMA protocol (Preferred reporting items for systematic review and meta-analysis) – Interprofessional Education

Table 8:
Included Articles on interprofessional education

Author/s year	Aim	Research Approach	Participants	Setting	Country	Analytical approach
Brewer et al. 2013	Assessment of Students' collaborative practice in the interprofessional education ward	Quantitative survey/student observation	N=79 Medicine 39% Nursing 22 % Allied Health 42%	Interprofessional student led ward.	Australia	Observational rating and quantitative analysis
Crawford , et al, 2016	After engaging in an IPE programme, how do groups of students from mixed professions talk about nurses and nursing	Descriptive Analysis	151 nurse comments from transcripts	Interprofessional rural clinical placement	Aotearoa New Zealand	Comparative thematic analysis
Croker et al. 2015	Explore co-location and how students learn to work together	Hermeneutic Gadamer	n=29 Medicine 4 Nurse 1 Allied Health 5 Clinical supervisors 17	Interprofessional clinical placement	Australia	Thematic analysis
Falk et al. 2013	Assess how the students experienced collaboration and learning	Descriptive survey	n=454 Medicine 113 Nursing 234 Allied Health 114	Interprofessional clinical ward	Australia	Iterative process
Gallagher, et al., 2019	What contribution did the experiential component of an immersive IPE programme make to further Indigenous health beliefs and practices	Exploratory Case study	n= 157 (participants in focus groups)	Interprofessional rural clinical placement	Aotearoa New Zealand	word search and analysis
Jakobsen et al., 2017	To understand the authentic learning experience in an interprofessional outpatient setting. Supporting moving IPE from ward-based experiences into an outpatient clinic setting	Exploratory case study	N=7 3- nurses 4 Medicine	Student Led outpatient clinic	Denmark	systematic text condensation - iterative process

Author/s year	Aim	Research Approach	Participants	Setting	Country	Analytical approach
Kent, et al., 2016	How do interprofessional student teams interact in a primary care clinic? A qualitative analysis using activity theory.	Realist synthesis	n= 48 Medicine 20 Nurses 6 Allied Health 22	Interprofessional clinics	Australia	Activity theory framework – open coding
Lawlis et al. 2016	Attitudes towards collaboration after active involvement in an Interprofessional education practice	Case study – survey and qualitative questions	n = 12 Nurses 4 Occupational therapy 4 Advanced care diploma in aged care 4	Residential aged care facility	Australia	Thematic analysis
McKinlay et al., 2016	Social learning shared accommodation and interprofessional education: I think those conversations that you have at the dinner table…	Qualitative survey and focus group	n=216 including nurses	Interprofessional rural clinical placement	Aotearoa New Zealand	thematic analysis
Mpofu et al. 2014	Perceptions of students in the IPE experience and how this influences their intention for future practice rurally	Qualitative focus groups	n= 23 including nurses	Interprofessional rural placement	South Africa	Thematic analysis
Prout, et al., 2014	What most triggered and enhanced student learning during Country Week?	Reflective Journal analysis Triangulation through staff observations and field notes from staff	n=27 nursing was in the cohort	Clinical workplace learning 'Country Week'	Australia	Thematic analysis
Pullon et al., 2016	The study aimed to determine differences between students who participated in a rural interprofessional programme and a cohort of their non-participant peers and to investigate participant student experiences.	Pre and post Cohort Study	n=131 nursing was in the cohort	Interprofessional rural clinical placement	Aotearoa New Zealand	Qualitative analysis

Author/s year	Aim	Research Approach	Participants	Setting	Country	Analytical approach
Saunders et al. 2019	Evaluate the IPE practicum for medical and nursing students in ambulant care	Descriptive Survey	n=92 medicine 72% Nursing 26%	Ambulatory care	Australia	General inductive approach
Saunders et al. 2016	Explore written reflections of nursing students following IPE in ambulatory care	Reflective Journal analysis	n = 23 Pre-registration Master of Nursing	Ambulatory care	Australia	Deductive analysis
Seaman et al., 2018	Examine student beliefs, behaviours and attitudes concerning interprofessional socialisation before and after the 2-week clinical placement in ambulatory care	Descriptive matched before and after	n=62 Cohort included nurses	Ambulatory care	Australia	Thematic Analysis

3.5 Findings

The systematic process reduced the 2171 identified articles to 15 appropriate articles for use in this literature review (See Table 4). Articles by Pullon et al., 2016; McKinlay, et al. 2016; Gallagher et al. 2019 draw on the same participant set participating in the Tairāwhiti interprofessional education programme. These also represent the only articles from Aotearoa New Zealand. Nine articles come from interprofessional placements in Australia, one of which involved a dedicated rural practical experience, seven involved ambulatory placement or outpatient clinics, and one was in an aged residential clinical placement. One article from Denmark was based in a student-led outpatient clinic. The final article was from South Africa, set in an interprofessional rural clinical experience.

Table 9:
Interprofessional Education experiences and influence on clinical practice

First author, Date	**Learning and Interactions Interprofessional interactions/ Learning and knowing from others**			**Structural Organisation of Practicum**		
	Communication	**Role clarification /Confidence**	**Hierarchical change**	**Communal living**	**Cultural learning**	**Social learning**
Brewer, 2013	✓	✓	✓			
Crawford, 2016	✓	✓				✓
Crocker, 2015	✓	✓		✓		✓
Falk, 2013	✓	✓				
Gallagher, 2019		✓		✓	✓	✓
Jakobsen, 2017		✓				
Kent, 2016		✓	✓			✓
Lawlis, 2016	✓	✓				✓
Mckinlay, 2016		✓		✓		✓
Mpofu, 2014		✓	✓			✓
Pullon, 2016		✓		✓	✓	✓
Prout, 2014				✓	✓	✓

First author, Date	Learning and Interactions Interprofessional interactions/ Learning and knowing from others			Structural Organisation of Practicum		
	Communication	**Role clarification /Confidence**	**Hierarchical change**	**Communal living**	**Cultural learning**	**Social learning**
Sauders, 2019		✓				✓
Saunders, 2016	✓	✓	✓			✓
Seaman, 2014		✓	✓			

Findings are categorised into interprofessional interactions, learning and knowing from others and structural organisation of the interprofessional practicum. The interprofessional participants from across the 15 articles included studies that describe development and changes in their understanding of roles and working in an interprofessional team. All the studies reported positive outcomes related to developing the health professional's practice; differences were noted in the set up and delivery of each clinical practicum, which then influenced the experience of those participating. The findings from the articles confirmed that there were similar themes across the literature (See Table 9).

3.6 Interprofessional Interactions

The following section will explore interprofessional interactions. The outcomes from the review of interprofessional education empirical studies have been categorised according to different experiences of being in an interprofessional education clinical placement.

3.6.1 Communication

Participants from the included studies were conscious of an increased awareness of the other health professionals on the clinical placement and a resulting change in communication. This was, in part, aligned with this being a requirement of some of the clinical experiences. For example, in the study by Jakobsen et al. (2017) the clinic was student led, and all communication was directed at the student led interprofessional participant team rather than the qualified practising preceptors. The Brewer et al. (2013) study spoke of humanising the interprofessional roles. Humanising roles as a notion was also reflected in the studies in Aotearoa New Zealand (Crawford et al., 2016; McKinlay et al., 2016b).

Many of the studies relied on self-reporting surveys (Crawford et al., 2016; Falk et al., 2013; Lawlis et al., 2016; Pullon et al., 2016; Saunders et al., 2019). A concern was raised by Brewer et al. (2013), who had used pre and post ratings, that there was not a statistically significant change. Both nursing and medicine students notably reported themselves as having good communication before the clinical experience and then very good communication post experience. In their study, they also used observation to triangulate the findings and students were observed to be more proactive in their communications with each other.

Although improved communication was a finding in half of the studies reviewed, there was no consensus as to why this occurs, especially in those studies that only asked about communication in a survey and no further exploration in focus groups or qualitative open questions explicitly related to communication. Nonetheless, improved communication was credited to several factors; for example, as suggested by Brewer et al. (2013), the humanising of the professional was seen as a common reason. Humanising is noticing that the professional is a person rather than the unknown professional (Brewer et al., 2013), and it is this noticing of being a person that is indicated as one reason for improved communication. Crocker et al. (2015) offered ideas of giving and receiving respect and the notions of developing bonds with each other. Again, this can be attributed to seeing a professional as a person rather than their designated role. A few of the other studies (Prout et al., 2014; Kent et al., 2017; Jakobsen et al., 2017) identified the impact of authentic learning as being a reason for improved communication resulting from deeper, more realistic learning. Finally, links were made to the development of an understanding of their own role, which contributed to confidence and proactive communication (Jakobsen et al., 2017; Mpofu et al., 2014; Seaman et al., 2018).

As discussed earlier in the study by Brewer et al. (2013), observation reported participants were more proactive in their communications. Although not fully explored in the studies reviewed, such proactiveness may be related to the clear expectations of engaging in interprofessional communication and decision making while in the clinical experience, and this was actively assessed or observed. In addition, this study attributed a 95% client satisfaction rating to better communication (Brewer et al., 2013, p484). They also offered evidence of client comments as an example of the perception of better care. One of which was shared “was shown more kindness and respect in Room G than in any other ward”

(Brewer et al., 2013, p 486). Therefore, although there is no consensus as to why there is improved communication, it is a positive outcome for both the health care professionals and the delivery of patient care.

3.6.2 Professional role clarification and confidence

Narratives from across the studies (see Table 9) highlighted the development of professional identity of self and others. This shift in understanding was reported more frequently by nursing students than medicine students; however, it was seen as contributing to developing and strengthening team roles and patient outcomes. As mentioned previously, role clarification was thought to impact on improved communication. It resulted in overcoming what was reported in one study as the challenge in the clinical environment of balancing your own professional responsibilities with those of the teams and patient needs. One study had participants work in interprofessional pairs where they noted that in completing tasks, they needed to articulate why tasks were being done. In explaining their thinking to others, it developed their understanding of their professional role (Brewer et al., 2013). Crawford et al., 2016 suggested that the specific focus of an interprofessional placement offered opportunities in clinical practice that offered a broader view to a more expansive belief of the potential of nursing practice. Through this, there was a resulting development of the understanding of their role. Crawford et al., 2016 did not offer precisely why there was a more expansive view of professional practice; however, it seems to be aligned with a concept discussed by Crocker et al., 2013. This was to be in a clinical experience where the professions were positioned to be inclusive, and health care is broader than their own professional contribution.

Role clarification was linked in a few studies (Falk et al., 2013; Pullom et al., 2016; Crocker et al.,2015) specifically to collaborative practice, where needing to work together and making joint decisions informed role development. In essence, the participants were able to learn about other professions and their activities. In turn, this increased knowledge of their role and offered the opportunity to improve care from the team. Participants from the reviewed studies were primarily in the final year of their professional practice, so this may have impacted their role development as well, in that they were practising from a more professionally developed knowledge base, were more confident in their clinical role and may have a greater ability to reflect on their practice. Alongside this is the expectation

of actively engaging with other professions in the clinical placement, therefore increasing the awareness of the contributions of other professions; thus, being aware of other professions makes us more aware of ourselves. Exploring other roles through articulating your own led to a deeper understanding of self and working with others in clinical practice. Finally, the study by Lawlis et al. (2016) has suggested from participants' reflections that the observation of the other professions enables a focus for the participants who were able to strengthen their understanding of their roles. This is important not because there is a deeper understanding of other professional roles, but instead, there is a collaborative focus on the roles of each of the team members, which allows for the development of their clinical practice.

Overall, collaboration was a notion that was mentioned and explored (Crocker et al., 2015; Jackobsen et al.; Falk et al., 2013; Pullon et al., 2013) as impacting other outcomes of interprofessional practice. Crocker et al., 2015 noted that the healthcare environment is a complex phenomenon of collaboration, so this is not unique to interprofessional practice. Croker et al. (2015) noticed that the interprofessional practice should not be an opportunistic interaction but should be planned for. In the interprofessional clinical studies, participants recognised that operating in a team required collaboration and interaction with others. In a study comparing participants in an interprofessional placement and those not in the interprofessional placement, findings showed a significant understanding of the critical aspects of interprofessional working (Pullon et al., 2016). Brewer et al. (2013) offered this about noticing increased collaboration in the study of a student led interprofessional ward, where being solely responsible for the care of the patients highlighted the awareness of needing to work together. This taking on of graduate level responsibilities related to the care of patients and decision making led to a better understanding of the interprofessional care environment, the appreciation of each other's skills and practice and the part that their professional role plays in the delivery of care.

3.6.3 Hierarchical Position

Overall, a change in what is thought of as the hierarchy of practice was not explored extensively in the studies reviewed; however, I have included it in this review for the potential of what a dedicated interprofessional undergraduate clinical placement may offer students and their future graduate clinical practice.

Falk et al. 2013 found that doctors naturally took a leadership role. They attributed this to having had this role modelled in the past in other clinical experiences. Although not mentioned in the study, this implies that a hierarchy is a reality of health practice and that other professions demonstrate less leadership. It was also suggested that the medical students had a better understanding of the software being used in the clinical area and, therefore, could more easily access the patient information in the clinical setting where the study was undertaken. This again implies that other professions were either less capable or did not see understanding the patient software as part of their role. This perhaps highlights a potential gap in clinically based learning when considering what is role modelled to students. Seaman et al. (2016) drew attention to the socialisation of students in clinical practice and what is role modelled in terms of establishing interprofessional identities. Interprofessional role modelling may only be viewed through what Croker et al., 2015 termed opportunistic interactions.

The division of labour and leadership can be seen to be assumed, being informed by discipline personality, culture, and confidence rather than negotiated in most clinical placements. In the absence of usual ways for students to conduct a shared consultation was seen to be strongly influenced by the task and the tools in use (Kent et al., 2016). The structured interprofessional practice was considered to offer some disruption to usual roles and enable team care development rather than silo professional care delivery, which was expressed as usual practice (Brewer et al., 2013; Kent et al., 2016; Mpofu et al., 2014; Seaman et al., 2016).

While there is the potential for a shift in hierarchical practice traditions, what it is in an interprofessional clinical practice experience is not yet understood. However, it does seem to have the potential for change in practice and warrants further exploration in relation to interprofessional practice.

3.7 Structural organisation of the practicum

This section considers where the students saw their professional learning occurring, particularly in relation to the structural organisation of the clinical placement.

3.7.1 Social learning

Ideas of learning outside of formal learning experiences were seen as significant and even more so in studies that included communal living accommodation (Crawford et al., 2015; McKinlay et al., 2016; Prout et al., 2014; Pullon et al., 2016; Mpofu et al., 2014). The studies by Mckinlay et al. and Crawford et al. use the same student sample cohort, and the participants are housed in dormitory style accommodations. In the other two studies, it was identified that the participants were co-located, but further description of this was not offered.

The significance of social learning was expressed as having fun together rather than as a teaching tool such as group work. This was communicated in studies where there was some form of shared accommodation and social activities outside of the clinical experience. The opportunity to get to know the other students and learn more about their health perceptions and what their professional roles are was valued by the participants (McKinlay et al., 2016; Pullon et al., 2016). The participants spoke of learning so much outside the classroom, being able to talk to others and forming relationships (Crawford et al., 2016). The social space was seen as a supportive environment where ideas could be exchanged (Gallagher et al., 2015). What is significant with these findings is that this reported social learning was not being used as a teaching tool. Rather, the participants learned what they needed without being guided or directed in this learning.

Learning from discussing thinking and sharing experiences was also seen as social learning (Saunders et al., 2016; Saunders et al., 2019). This allowed participants to deepen their understanding of their roles, yet this was not considered formal learning. Instead, this was seen as opportunistic learning and was highly valued by the study participants. Working in what were described as communities of practice where people came together to address a task or to complete an activity was also mentioned. Social learning, such as this, can be seen as needed because the participants were required to engage with each other to have successful learning outcomes (Jackman et al., 2016; Prout et al., 2014), suggesting that they formed a community of practice. Lave and Wenger (1991) have argued that strong and highly functional communities of practice cannot be constructed, stating that they are an organic coming together to support the needs of the community members. Therefore, the use of this term needs to be viewed with caution. Perhaps a further exploration of how this

concept is being used is needed to ensure the notion is not increasingly being applied to a more traditional team or group work model. Although the participants reported developing a deeper understanding of their roles and that of others, they did not seem to value this learning in the same way expressed in the studies where the learning was more opportunistic.

3.7.2 Communal Living

One Australian study (Prout et al., 2016) and all of the studies from Aotearoa, New Zealand (Crawford et al., 2016.; Gallagher et al., 2015; Pullon et al., 2016, McKinlay et al., 2016). were known to have used shared accommodation, and the experience was seen as invaluable for its fun factor, which was linked to 'authentic learning'. What was not expanded was how authentic learning was defined beyond it not being in a classroom or simulation-based practice. Such a notion seems to be invaluable to the learning experience. It should be investigated in future studies so that a deeper understanding of what is seen as authentic learning is better understood.

What was explored and articulated across the studies was that the participants developed relationships with each other which are not merely professional in nature. Developing social relationships is thought to have impacted their understanding of each other's professional roles. This can be linked to the notion of humanising that was presented as a strength in clinical practice in the study by Brewer et al., 2013.

McKinlay et al 2016 went on to suggest that sharing accommodation may be a means to addressing areas of what they termed the hidden curriculum, of stereotypes and hierarchies of practice that represent the Western and colonial practices upon which the health care system here in Aotearoa New Zealand is built (First discussed in Chapter 2 Background). As discussed earlier in the chapter, the notion of hierarchical position and the understood division of labour and leadership was thought to be disrupted through social learning, especially when the professional is seen as a person first and their profession after. Further explicit study of this would better determine if this does occur.

3.7.3 Cultural Understanding.

Most of the studies reviewed spent time preparing participants for the interprofessional clinical experience; what is of particular interest to practice is specific cultural preparation related to working with Māori.

Gallagher et al. (2019) looked at students' perceptions of cultural immersion during an interprofessional education experience. Noting that conversations about Hauora Māori consistently came up in the focus groups from a wider study, they conducted a secondary analysis. The transcripts from the focus groups were searched using the find function in Microsoft Office for references to “Hauora Māori”. Fifty-five references were identified from the focus group transcripts.

The participants spoke of having formal classroom learning related to Hauora (health) Māori, including cultural practices; they did value this as what they saw as ‘authentic learning’ or the experience of being engaged with Māori culture. There was a recognition that experiencing culture as a way of life was more fully explored in the immersive nature of the IPE clinical placement. These experiences were related to planned and incidental community activities while on the assigned clinical placement. In an earlier study, Prout et al. (2014) concurred that there is a benefit to cultural experience in an immersive environment. They identified that the clinical experience was structured to improve the understanding of Aboriginal people in a rural community. What is evident from these studies, and suggested by Jackman et al. (2016), is that this understanding is related to connecting what was previously positioned as classroom learning to connection in practice to the concepts they have experienced. Although Hauora Māori was not the focus of the Gallagher et al study, participant narratives included statements like,

“It was really good that the theory that we were learning in class …was kinda coupled into a situation where we could put into practice…”(Gallagher et al., 2016, p 265)

Gallagher et al. (2016) state the participants became acutely aware of the task they faced in understanding the reality of Hauora Māori in practice. In this understanding, these experiences are perceived as transformative for the participants. Further study is needed to explore how this learning and knowing is transferred into post-graduate practice and used outside of an immersive clinical experience.

3.8 Strengths and Limitations of this review

Māori researchers conducted none of the 15 studies in this review, which was a significant limitation along with the limited 10-year timeline. It was also acknowledged earlier that some additional grey literature was not included in the review that could further support and potentially extend this review. For example, the 2010 WHO report and recommendations on interprofessional practice and various guidelines from the Otago University Interprofessional Education Group (IPE).

A vital strength of the review is that a number of studies from Aotearoa New Zealand had a large cohort of interprofessional students in clinical placements. My review considered the similarities of experiences across interprofessional clinical placements. These experiences, although from different clinical placement structures, are beneficial when considering what dedicated interprofessional clinical experiences may offer for developing graduate clinical practice.

3.9 Summary

The 15 studies covering a 9-year time frame 2010-2019 of undergraduate student experiences in a dedicated interprofessional clinical practice experience tell of the value of having focused interprofessional educational experiences in clinical practice. Participants consistently spoke of practice development and building their own understanding of skills when working in an interprofessional health environment.

Articles included evaluations of interprofessional educational programmes, and the outcomes are overwhelmingly positive, with improved confidence in the individual as well as in the interprofessional team practice. There is strong evidence that communication and teamwork improve with interprofessional education, and it is thought that this results in enhanced interprofessional collaborative practice. Several studies suggest this is strongly related to a better understanding of the professional roles of self and others. These findings are consistent with the World Health Organization's definition of the significance of interprofessional practice. Such positive clinical interprofessional experiences could begin to address stronger health teamwork by shifting such learning from being an incidental expectation of clinical practice to being a planned expectation of the clinical experience.

Further research is needed into how nurses experience interprofessional education to understand the relevance of nursing as a profession and to continue to inform the development of interprofessional collaborative practice. Finally, little is known about the ways Māori nurses experience immersive interprofessional programmes and how such programmes might influence their Māori nursing identity. This thesis, therefore, was developed to address the following research question: How does an undergraduate placement in an interprofessional rural programme influence Māori nurses' identity and nursing practice? In the next chapter I explore how the research question was investigated using kaupapa Māori methodology to inform the research design.

Chapter 4 Methodology

4.1 Introduction

In this chapter, I present how this study's research design is located within kaupapa Māori theory while drawing from critical and constructivist theory. I first present how the study research question and rationale influenced the research methodology, methods and ethical guidelines. I then discuss the narrative inquiry whakawhiti kōrero used to gather the participant data. Then, I introduce and discuss the reflexive thematic analysis that was used to analyse the participants' narratives. Narrative inquiry and reflexive thematic analysis do not threaten the cultural integrity of kaupapa Māori research because they are aligned and interact in ways that kaupapa Māori principles and the tikanga or protocols of the methodology will guide. Whakawhiti kōrero realised the principles of whakapapa and whakawhanaungatanga for and with the nurse participants. Also included in the chapter are details and rationale for research choices, including participation criteria, recruitment process, and the analysis processes. Finally, I discuss the data analysis progressions, detailing my reflective thematic analysis.

4.2 Research Question

As presented in Chapter One, this study aimed to establish evidence related to the RHIP clinical practice experience for Māori nursing students. Particularly how this clinical placement has influenced their identity, registered nurse practice and interprofessional collaborative practice.

Developing the 'just right' research question took some time, and many potential questions were considered in light of expectation of cultural safety, as evidenced by the Registered Nurse Competencies (Nursing Council of New Zealand [NCNZ], 2016) and in the Guidelines for Cultural Safety, the Treaty of Waitangi and Māori Health in nursing education and practice (2011) (see Appendix A: for a table showing my question development). The research question needed to recognise that being a Māori student in contemporary nursing education and clinical practice presents challenges to cultural self-identity as Māori. This study has therefore used this question:

- How does an undergraduate placement in a rural interprofessional programme influence Māori nurses' identity and nursing practice?

4.3 Kaupapa Māori Philosophy

Te ao Māori (Māori world view) and a kaupapa Māori approach guided how the researcher and the participants explored this study's research question as Māori. Applying a kaupapa Māori lens ensured this study privileged Māori knowledge and ways of knowing. In this thesis, I have chosen to use the terms kaupapa Māori theory or kaupapa Māori research rather than methodology. Kaupapa Māori is not easily defined and is better to be considered a philosophy rather than a methodology (Cram, 2001; L.T. Smith, 2011).

As transformative research, kaupapa Māori theory aims to effect change that will benefit Māori. Pihama (2011) and L.T. Smith (2012) remind us that research involving Māori has not always been beneficial for Māori or delivered what Māori want to know. Historically, research has been "on Māori" using methods that reflect and prioritise the dominant Western worldview, leaving Māori knowledge being interpreted through a Western lens (Bishop, 1996; Cooper, 2012; Cram, 2001; L.T. Smith, 1999). Kaupapa Māori research aligns with other Indigenous frameworks or theories, as noted by Pipi et al. (2004):

> Kaupapa Māori is an emancipatory theory that has grown up alongside the theories of other groups who have sought a better deal from mainstream society, for example, feminist, African American and worldwide indigenous theories. At a high level, these theories have commonalities and similar concerns, including the displacement of oppressive knowledges and a social change agenda. At a local level, kaupapa Māori addresses Māori concerns in our own land. Kaupapa Māori research operates out of this philosophical base and is guided by practices that reflect a Māori "code of conduct". (p. 141)

Kaupapa Māori theory's primary aim is not about protecting Indigenous knowledge but about amplifying the understanding of Māori through the dehegemonization of philosophical theories in Aotearoa New Zealand (van Meijl et al., 2019). In essence, it is about reclaiming ways of thinking and knowing as Māori and thus preventing the construction of Māori knowing by cultural outsiders who are not connected to Māori. Kaupapa Māori theory simply accepts the existence of Māori knowledge, language,

and culture (L.T.Smith, 2015), and it is empowering in that Māori have control of the investigations into Māori lives (L.T Smith, 2012). The concept of kaupapa Māori theory, when applied in research such as this, is grounded in Māori worldviews and identity as Māori. G.H. Smith (2017) states that kaupapa Māori is not so much a set of principles but rather a space in which Māori can work and be free of the constraints and pressures of the more dominant western culture.

4.4 Te Ao Māori

In the Māori world, "te ao Māori" is clustered around identity (L.T Smith, 2012) found in whakapapa, the "genealogical ties that bind people with people, with the environment and the cosmos (Cram 2019, p.1512)". According to Barlow (1991 p173), "Whakapapa is the basis for the organisation of knowledge related to the creation and growth of all things." Barlow reminds us that everything has a whakapapa: cosmos, gods, man, canoes, animals and plants. This worldview is our connectedness, not only the familial ties but also emphasising spirituality and spirit. Whakapapa is the ancestry that gives me the license to be Māori; it identifies who I am and where I am from. In doing so it binds me to te ao Māori. Whakapapa is not limited to just genealogy; it is a framework to understand and locate oneself holistically in time and space (Cram, 2019; Barlow,1991; Mead, 2016). Graham (2009) spoke of a contemporary view that recognises whakapapa as being the interconnectedness between the people and their physical and spiritual connections to the whenua (land) and not just the notion of biological connections. In essence, whakapapa is said to be the most essential way Māori think about and come to know the world (Cram, 2019; Graham, 2009).

4.4.1 Tikanga Māori Principles

Tikanga is also situated in a Māori worldview. Our ancestors developed ways of conducting themselves in any situation; this is *tikanga*. Tikanga is not rigid, and practices have been amended, added to or changed through the generations to the present day (Mead, 2016). Kaupapa Māori studies are no exception to these developments and changes. Adaptation of G.H. Smith's (1997) and then later Crams (2019) tikanga Māori principles have been critical in this research. They have guided both the design and the analysis of the data. These principles are now well established

within kaupapa Māori and practice (Cram, 2001; Cram, 2019; Hudson et al., 2010; L.T. Smith, 2012). The principles used are:

- Tino Rangatiratanga (self-determination)
- He taonga tuku iho (cultural aspirations)
- Āko (culturally preferred pedagogy)
- Whānau (extended family structure)
- Kaupapa (collective philosophy)
- Kia piki ake i ngā raruraru o te kainga (socioeconomic mediation)

4.4.2 Tino Rangatiratanga (self-determination)

The significance of tino rangatiratanga has been emphasised at many hui around the country since 1840, when Māori sovereignty was guaranteed in Article 2 of Te Tiriti o Waitangi. This study strives for Māori self-determination and empowerment as the study's control is in Māori hands (Bishop, 2005; Walker et al., 2006). The most powerful and insistent message supported is that of “by Māori for Māori” (Te Puni Kōkiri, 1994), underpinned by the notions of emancipation from oppression (L.T. Smith, 2012).

4.4.3 He taonga tuku iho (Cultural Aspirations)

Cultural aspirations here shift Māori from being ‘others’ to being ordinary as they were before the arrival of Pākehā, affirming that Māori knowledge is valid and valuable. In truth, tikanga (customs), te reo (language), and mātauranga (knowledge) are seen as taonga (treasures) passed from tīpuna (previous generations) (Cram, 2019). This study reflects the aspirations of the ākonga (students) to be successful in their studies and to be able to care for our people by being able to bring their whakapapa and mātauranga into health practice with them.

4.4.4 Āko (Collective learning)

To learn and to teach is a shared meaning of the word ‘āko’, recognising that everyone has something to learn and something to share. This certainly underpins this study in that I am already a nurse, the participants are nurses, and I want to speak with them about their learning. At the same time, with the participants sharing their experiences,

I am learning as a Māori, an interviewer, a researcher, a colleague, and as a teacher, now learning from the students.

4.4.5 Whānau (Extended family structure)

L. T. Smith (2012) suggests that the whānau principle is a way of organising a study. The idea of whānau has become known as those to which you may be related; however, in kaupapa Māori theory and in this study, whānau is not limited to just immediate family or previous generations. Bishop (2005) spoke of the whānau as where research meets Māori and Māori meets research. In this study, research participants become the whānau of interest along with the research supervisors. This study included layers of concurrent collaboration between me (the researcher) and the nurses (as research participants); myself and nurses, and the research supervisors (as research mentors). These nurses (participants) and supervisors (research mentors) feature in my reflective journaling and vignettes. The concept of whānau will be further explored in relation to the research participants in chapters five and six.

4.4.6 Kaupapa (Collective Philosophy)

Māori hold a collective vision that ties people together, whether this is through kin or, as Cram (2019) described, through a kaupapa (philosophy). This study expressly explores the participants' experience to understand what influence the Rural Health Interprofessional Placement (RHIP) experience had on their Māori nurse identity and nursing practice. The study is underpinned by the collective yearning of Māori for positive cultural and social wellbeing outcomes for our people.

4.4.7 Kia piki ake i ngā raruraru o te kainga (socioeconomic mediation)

The principle of kia pike ake i ngā raruraru o te kainga speaks to changing the impact and outcomes of social determinants and inherent institutional racism. Educating Māori as nurses can be seen as a successful intervention to mediate socioeconomic disadvantage and negative pressure often experienced by whānau in our education system and health sector (Cram 2001). The notion of socioeconomic mediation continues to reflect the emancipatory nature of kaupapa Māori theory (Pihama, 2010; Cram, 2001). This study wants to elevate the success of Māori who study to be nurses

and, therefore, be able to support their whānau, hapū and iwi in hauora (wellbeing/health).

4.5 Approach

While it is important to note that Māori world views differ from iwi to iwi, hapū to hapū, and whānau to whānau, some commonly recognised beliefs permeate many Māori realities. There is a distinct process by which Māori organise knowledge, which is known and is being revived as mātauranga Māori (Mead, 2016). Mead reminds us that mātauranga Māori incorporates all aspects of knowledge past and present and knowledge which are developing:

> Mātauranga Māori has no ending it will continue to grow for generations to come. Each year its knowledge base is expanded through research, written papers, theses, books, seminars, conferences, debates, and discussions (p338).

A common modern understanding is that mātauranga Māori describes knowledge, wisdom, understanding, skill, and education (Moorfield J. C, 2003-2024). It is the unique Māori way of viewing the world that encompasses both traditional knowledge and culture (Waitangi Tribunal, 2011). What western non-Indigenous scholars may have struggled with in the past is that mātauranga relates to universal phenomena of life experienced by all living things, not just specifically human beings (Environmental Protection Authority, 2020). In contrast to a Western paradigm that typically first focuses on deep analysis of something or someone in isolation, Māori first try to understand the relationships and connections between all things, human and non-human.

Mātauranga should not just be seen as only a repository for Māori knowledge, but instead, as a set of tools for thinking and organising information, ethical protocols and how we care for the knowledge we have. Mead (2016) identified that mātauranga is the knowledge that helps Māori to feel comfortable with all things Māori. Durie (2017) talks of the organic nature of mātauranga, that it is constantly evolving but is an underlying knowledge that can guide practice and understanding. Wilson (2008) talks of systems of knowledge built upon relationships between things rather than the

things themselves. The way in which knowledge is said to build on relationships further supports the notion of mātauranga being more than a single knowledge repository.

Mātauranga Māori comes with people; new mātauranga Māori comes from people connecting past and new knowledge in new places, making sense of the changing world (Mead, 2016). Mātauranga has strong oral traditions, and it is shared in a variety of forms such as whakapapa (genealogical connections), waiata (song), haka (to perform dance), whakatauāki, whakataukī[1] and pūrākau (legend, story), and as in this study, through kōrero.

As Māori experiences are at the centre of this study, kaupapa Māori is the philosophy that is centred on exploring understanding for Māori in relation to rangatiratanga (self-determination) and the empowerment of Māori. At the same time, the control of the research remains in Māori hands (Brewer et al., 2014). In this study, I wanted to give a voice to Māori nurses and their construct of a Māori nurses' worldview in a way that is mana enhancing and resisting the often deficit theorising by which tertiary education and Māori can be researched and classified. Within Māori research, the notion of the expert researcher is turned on its head, with the researcher being the non-expert and the one who has come to 'look, listen and learn' (L.T. Smith, 1999). This study is not able to capture mātauranga-a-iwi, which describes the values and practices of a particular iwi as participants have come from differing iwi, but rather, the broader view of mātauranga Māori (Kerr & Averill, 2021) as the notion of generally recognised and applied knowledge. Mātauranga Māori and its impact in this study is not just about creating space for Māori ways of being but, in fact, is about valuing the richness of the whakaaro (ideas) and the kōrero brought by the participants and making sense of the knowledge this brings. The Māori nurses who participated in this study are the subject matter experts on their own lives and in articulating what they saw and how they related to the Rural Health Interprofessional Programme clinical experience.

Throughout the discussions in chapter two, the impact of colonisation was evident for Māori as citizens of Aotearoa New Zealand. G.H. Smith (2017) drew on the work of

[1] Whakatauāki: a proverb where the person who said it first, is known – often used in reference to the past and or ancestors. As opposed to Whakataukī which is a proverb where the person who said it first is not known

Freire (1972) and his notion of conscientization – developing a consciousness that has the power to transform reality, and asserted that identifying Māori knowing is a fundamental understanding of kaupapa Māori theory. Conscientization aligns with the notion that kaupapa Māori is emancipatory and contributes to the decolonisation of Māori (Pihama , 2001). It is also seen as a home grown form of critical theory. Pihama, Cram and Walker (2002) suggest that critical theory can direct attention to the right of Māori to be Māori and explains what we know through research. Critical theory assumes that human nature functions in a world based on a power struggle, and therefore it can be used to enable change for the benefit of those oppressed by power (Lincoln, Lynham & Guba, 2018). Such critical transformation fits with this study, which seeks to know how the rural interprofessional programme influenced Māori nurses' identity, and in doing so, it offers an opportunity for social change. This critical tradition insists we pay close attention to structural analysis and everyday practice, both of which inform the other (L.T Smith, 2012). Kaupapa Māori theory has always been integral to the opposition to Western hegemony and the unequal power relationships in society (Bishop, 1996; G.H. Smith, 1997). Kaupapa Māori theory is in fact celebrated as being a homegrown form of critical theory that focuses on the emancipation of Māori (Bishop, 1998 & L.T. Smith, 1999, cited in Moyle, 2014).

More recently, there has been a tentative movement away from kaupapa Māori research being a critical theory to a more constructivist theory, shifting the gaze from the oppressor to Māori and enabling their autonomy to develop practices as they see fit (Hollis-English, 2012). This does not negate critical theory, which seeks to challenge and transform oppressive structures (Bhambra, 2021; Wilson et al., 2021; Pihama, 2001; L.T Smith, 2012) and has underpinned kaupapa Māori theory from its resurgence in the late 1990s. Eketone (2008) suggests that kaupapa Māori theory is also tightly linked to constructivist theory. Constructivism is the belief that society, reality, and sense are constructed and corroborated through our interactions with the world (Crotty, 1998; Tolich & Davidson, 1999). If knowledge is socially constructed as a result of cultural and community forces, it becomes valuable and powerful (Eketone, 2008). Based on a constructivist approach to knowledge, it follows that Māori, particularly the participants in this study, will have constructed their worldviews and values based on their own experiences and adaptations to change, thus incorporating these changes

into their worldview. This thinking goes back to a tenet of mātauranga Māori, which asserts that understanding is achieved by questioning what it is that I am seeing here and how I relate to it (Mead, 2016). In essence kaupapa Māori theory is perhaps the two intertwined threads of critical and constructivist theory, each informing and supporting the other. Nonetheless, the emancipation of Māori mātauranga remains evident in this understanding, in that through the notion of tino rangatiratanga (self-determination), Māori are defining Māori knowledge.

Kaupapa Māori research differentiates itself from other research as it is grounded in Māori philosophy and mātauranga (knowledge), reflecting the use of customary practices, values, and beliefs (Eruera, 2005). Kaupapa Māori research continues to exert the right of Māori people to make sense of their time and place in Aotearoa New Zealand, and the world. This is the tika (correct) configuration of the values and concepts that underpin this study and provides the necessary guidance for my engagement with the participants and their kōrero. Within this study, critical theory purposefully conceptualised the sociocultural along with the socio-historical focus of kaupapa Māori theory by contributing to a series of individual whakawhiti kōrero (focused discussions) where I posed questions from which stories, reflections, and thoughts emerged. These kōrero reflected our cultural, social and, at times, political consciousness. This also, on occasion, led to new questions. It is what Bishop (1996) described as spiral discourse, where “dialogue is continually coming back on itself at the same time moving forward” (p 211), that the influence of constructivist theory is realised through the exploration of the research participant's worldview following their interaction with the experience of the RHIP placement.

Utilising kaupapa Māori, critical theory and constructivism offers a space that is intentionally aimed to encompass autonomy and self-determination, ensuring that all participants can safely share their personal and professional experiences. In this research, the notion of safety relates to the ability to engage in conversations without needing to make clear, justify or defend culturally influenced talking or responding (Benet-Martinez et al., 2002). As the researcher, it enabled me to engage critically in their shared stories as Māori and as a nurse.

4.6 Ethical considerations

In te ao Māori, ethical considerations involve what would be considered what is tika (right) and pono (true). These are complex words that cannot be expressed as a single idea. Instead, these kupu (words) encompass concepts of truth, correctness, directness, justice, fairness, righteousness, right, facts and validity. Cram (2019) identifies that for Māori, ethical considerations are about maintaining and strengthening relations and the cultural processes that help ensure this. The notion of collective concern for people's wellbeing is evident in te ao Māori in that it is related to who we are, what values we ascribe to, and our place in the Māori world. According to Cram (2009; 2019) of kaupapa Māori ethical assumptions, a key element is the attention given to cultural customs and practices of the community where the research is taking place.

Cram (2001) and L.T. Smith (1999) have described the following seven "community up" values and the ethical protocols associated with them. An overview of these and how they have been applied in this study can be found in Table 10.

Table 10:
'Community Up' approach to study conduct

Cultural Value (Smith 1999)	Researcher guidelines (Cram 2001)	Practices used in this study
Aroha ki te tangata	A respect for people, allowing people to define their space and meet on their terms	• Participants were able to meet in places convenient to them • Acknowledging and strengthening previous relationships as kaiako and ākonga • Use of karakia to open and close our whakawhiti kōrero
Kanohi ki te kanohi	the seen face: that is, understanding the importance of presenting yourself to people face to face	• The researcher and participants were known to each other. • Kōrero was led by Māori • Kōrero was respectful, and each other's roles were made clear • Kōrero was conducted in person with the participants.

Cultural Value (Smith 1999)	Researcher guidelines (Cram 2001)	Practices used in this study
Titiro, whakarongo, … kōrero	look, listen, develop understanding, and then talk	• Whakawhiti kōrero were recorded, allowing the researcher to focus fully on the kōrero • Observations and notes were made during the kōrero • Paraphrasing was used to reflect some ideas that were expressed
Manaaki ki te tangata	share and host people; be generous; take a collaborative approach and aspire to reciprocity	• A supermarket voucher was shared with each participant as koha for the knowledge shared and time taken • Kai was shared at each hui • Participants were given the time and support they needed during our time together. • A second interview was conducted to discuss the interim findings.
Kia tūpato	be cautious; be politically astute and culturally safe; be reflexive about your insider/outsider status	• Karakia • The researcher maintained her outsider role by allowing the participants to tell their stories. • The method was guided and supported by supervisors • Participants and the researcher were kept safe by meeting in agreed upon locations where privacy could be maintained
Kaua e takahia te mana o te tangata	do not trample over the mana of people; engage fully and meaningfully when discussing ideas, informing people, and disseminating results	• Allowing space for the participants to tell their stories enabled them to represent their lived realities • Initial analysis was shared with the participants to allow time for them to reflect on the findings and how this reflected their experience • Kaupapa Māori theory practices were maintained
Kia māhaki	be humble in your approach and attitude; do not flaunt your knowledge; also, share your knowledge and use your understanding	• Made clear that the participants were the subject matter experts in the kōrero

Cultural Value (Smith 1999)	Researcher guidelines (Cram 2001)	Practices used in this study
		• The findings can be used to develop further and enhance nursing clinical practice curriculums for all students while prioritising Māori wellbeing and worldviews

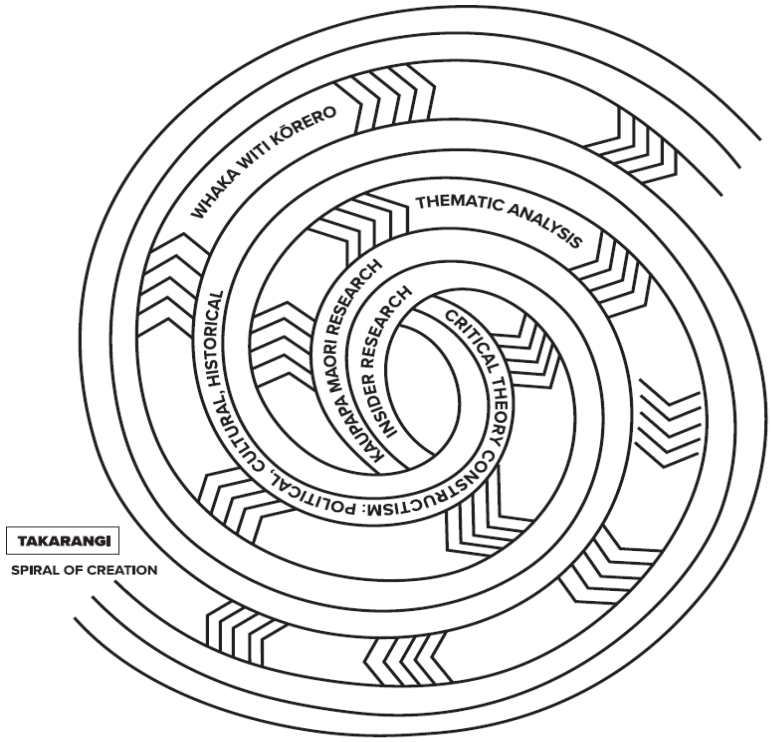
Over time, there have been few changes to the notions of axiology in relation to kaupapa Māori research. One change, however, was specifically including Te Tiriti o Waitangi (Pihama, 2001). Te Tiriti o Waitangi confirms the right to conduct research using tools and approaches that make sense to us; in short, exercising tino rangatiratanga (self-determination). Te Tiriti o Waitangi adds further weight to the principle of tino rangatiratanga, asserting that this is not only a worldview for Māori but also an ethical principle for engaging with Māori. Another modification was adding ātu (respectful relationships). Pohatu 's (2005) ātu adds further weight to the notions of kia tūpato, kaua e takahia te mana o te tangata and kia māhaki. Ensuring these community up protocols were used strengthened and supported the safety of the research space for the research participants to share their personal and professional experiences of the RHIP programme. These protocols build relational accountability with notions of respect, responsibility, and reciprocity with the participants (Wilson, 2008).

In addition to the kaupapa Māori research kawa (protocols), the study protocol was approved by the Auckland University of Technology Ethical Committee (AUTEC). This included informed consent processes, whakawhiti kōrero (interview) schedule and safety protocols. The AUTEC approval reference is 20/84. (Appendix B)

Figure 2 is an image of a spiral of creation depicting the very making of the universe known as Takarangi. It illustrates how this study wove together kaupapa Māori theory using whakawhiti kōrero with a critical constructivist lens and reflexive thematic analysis drawn from Western research. For this study, the solid spirals represent kaupapa Māori research and the critical constructivist lens. The space revealed in between the solid spirals contains the uncovering of the research participant's stories through whakawhiti kōrero and thematic analysis. Through this design, the

interconnections of each part are brought through to show the whole of this study's research design.

Figure 2:
Research methodology and method



4.7 Method

Kaupapa Māori research design does not instruct a way of working (method) but is a philosophy that guides Māori researchers. It allows for an emergent design that, as Lincoln and Guba (1985) suggested, describes the indeterminate nature of qualitative descriptive research. In the broad sense, kaupapa Māori research is aligned with qualitative methodology, and it was chosen for this project because the core aim is to explore and understand the experience of the nurses during their clinical experience on RHIP. Qualitative inquiry, like kaupapa Māori theory, also recognises that the researcher is, in fact, part of the research project. Denzin and Lincoln (2005, p3) define qualitative research as when '…qualitative researchers study things in their natural settings, attempting to make sense of or interpret phenomena in terms of the meaning people bring to them'.

Such a study as this seeks to interpret and construct contextual or local knowledge rather "…than the discovery of universal laws or rules" (Willis, 2007, p.99). From critical constructivist writings, subjectivity and interpretations result from our location in the various contexts (historical, social, cultural, Indigenous, economic, and political) of our realities (Coghlan & Brydon-Miller, 2014). Positioning this study within kaupapa Māori theory required an organic research space that could respond culturally, professionally, and personally to the research participants as Māori nurses. Using an emergent design, this study responded to participants, needs and the dynamic nature of our whakawhiti kōrero.

4.7.1 Participants

The Rural Health Interprofessional Programme was discussed in detail in chapter 1. However, as a brief reminder to contextualise the potential research participants, the programme involves:

- A primary health placement in the Eastern Bay of Plenty.
- A five-week experience
- Cohabitation in assigned accommodation with other health professionals (Medics, pharmacy, paramedicine, occupational therapist, social workers and so on).
- Having between 3-4 students per house
- A clinical placement from Monday to Friday and
- Attending educational days as planned by the clinical coordinator for the programme throughout the clinical experience.

The study was advertised through professional networks and the RHIP programme. Potential participants were invited to participate through advertisements (Appendix C: Research Flyer) with Te Kaunihera o Ngā Neehi Māori (The National Council of Māori Nurses) Māori Nurses' Newsletter. Social media proved the strongest recruitment strategy; the invitation to participate was posted on the RHIP Public Facebook page and two private groups with a membership that could include the study's potential participants on Facebook. To participate in the study, the following criteria needed to be met:

1. Māori nurses who were placed in the RHIP programme in the last three years (Jan 2016- Dec 2019)
2. Stayed in the arranged RHIP accommodation for the placement and
3. Are currently practising as a Registered Nurse in Aotearoa New Zealand.

Contact was initiated via email by potential participants in response to the advertisements. I then emailed each participant a copy of the participant information sheet (Appendix D: Paticipant information sheet) that provided details about what would be involved and the time they would be committing to. We then negotiated a time and place to meet once they confirmed and consented (Appendix E: consent form) to their project participation. As the nurses who were placed on the RHIP programme knew each other, an additional recruitment process was to ask those who responded to share the proposed research study with their RHIP whānau (those on the placement with them) as another means of making the study known to other potential participants. This use of snowball sampling was included to ensure adequate participants were recruited, as the study population was limited.

An unexpected layer of complexity to planning hui with the research participants was that we found ourselves in a pandemic, and the potential participants were essential workers, a vital part of Aotearoa New Zealand's national pandemic response. Therefore, much thought was given to negotiating time for whakawhiti kōrero and the location of these hui to ensure both the participants and researcher remained safe from a health perspective and to enable participation even when travel was restricted. Nonetheless, seven of the initial interviews were able to be conducted kanohi ke te kanohi, and two were achieved using the Zoom platform (video calling).

The data collection method of whakawhiti kōrero (Elder & Kersten 2015; Pihama, Campbell & Greesill, 2019) is founded in a Māori worldview, and it was a deliberate decision to use this rather than the non-equivalent term semi-structured interview. Whakawhiti kōrero can be illustrated by examining the two terms whakawhiti and kōrero.

The root word whaka indicates causing something to happen or cause to be. Whiti means to change, turn, exchange, transfer, transpose, and swap. Whakawhiti,

therefore, means to discuss or deliberate when followed by kōrero (Moorfield J. C, 2003-2024). Kōrero means to converse and refers to the expression of ideas (Moorfield J. C, 2003-2024). The cultural importance of kōrero is depicted in this whakataukī found in Elder (2019, p91): "*he aha te kai a te rangatira? He kōrero, he kōrero, he kōrero (what is the food of leaders? It is communication.)".* It asserts that discussion is the sustenance of chiefs and that to kōrero is a chiefly endeavour. It also recognises the chiefly status of those who kōrero, sharing their stories and influencing the way topics are discussed. This was reflected in my interactions with the participants and the outcome of our kōrero. Such collective kōrero is consistent with an Indigenous paradigm (Kovach 2010, p.45) and, therefore, kaupapa Māori research with its values of respect, relevancy, reciprocity, and responsibility.

Most simply, 'whakawhiti kōrero' is the discussion and exchange of ideas. This method predates the notion of semi-structured, open, and in-depth interviews as part of mātauranga (knowledge) acquisition (Elder & Kersten 2015). Ware, Breheny and Forster (2018) identify the importance of using methods that privilege Indigenous knowledge, voices, and experiences. As Kovach (2019) recognised, Indigenous methods like whakawhiti kōrero embrace relational assumptions as central to its core approach.

Kaupapa Māori research honours orality as a means of transmitting mātauranga (knowledge). As used in this research study, whakawhiti kōrero is a Māori narrative inquiry approach with a specific implication for gathering kōrero representing the research participants' understanding of their experiences and their stories associated with that experience. It is based on Māori oral tradition of discussion, drawing on the shared understanding and experience of being a Māori nurse. Furthermore, the understanding of whakapapa locates the individual kōrero in a web of interrelationships and the layering that influences each person's story. Bishop (2005) terms narrative inquiry as a 'collective storying' process because the participants and researcher make meaning from the expressed narratives.

4.7.2 Gathering the kōrero

In applying whakawhiti kōrero, I, as the researcher, was involved in the gathering of the Māori nurses' stories. The participants self-identified as Māori, were registered

nurses and had been on a clinical placement on the RHIP programme in the last three years (2016-2019). Nine Māori nurses fulfilling these criteria agreed to share their kōrero about their experience of the RHIP programme and their first year of practice as registered nurses. Terry, Hayfield, Clarke and Braun (2017) suggest this number of participants is enough to enable in-depth data analysis. They contend this is a controversial and argued topic; however, they go back to the notion that the data gathered is rich and layered and reflects patterns across the dataset. They add weight to their position by asserting that sample size reflects the idea of quantity and that the core of qualitative studies is, in reality, 'quality'. With the number of nurses in the pool of potential participants being limited (n=20), this sample (n=9) represents rich quality data for analysis.

The participants were practising either in primary or tertiary care in the Midlands region of Aotearoa New Zealand. The participants had between 6 months to 4 years of clinical practice experience as registered nurses and were diverse in terms of their iwi affiliations, age, and gender. To protect the research participants' anonymity, only the year on RHIP and iwi affiliations are presented (Figure 2). They each had been placed on a RHIP clinical placement during the final year of their undergraduate degree. Drawing on their experience during RHIP and since registering as nurses, the participants willingly got involved in the research study.

Table 11:
The Participants: Year on RHIP and Iwi affiliation

The Participants: Year on RHIP	Iwi Affiliation
2016	Te Ātiawa
2016	Ngāti Porou, Te Ātanga-a Māhaki, Ngai Tūhoe
2017	Tainui, Ngāti Rangainui,
2017	Ngāti Kahungunu.,Ngāti Tuwharetoa, Te Arawa
2018	Ngāpuhi Te Tai Tokerau
2018	Ngāpuhi Whaingaroa, Ngāti Kuri,
2018	Ngāti Porou, Ngāti Kahungunu,
2018	Ngā Ruahine, Ngāpuhi Whaingaroa, Tainui
2019	Ngati Porou

As noted previously, the participants were able to select the time and location of the whakawhiti kōrero that was comfortable for them. All the participants had a sense of me as an academic tutor as I had been part of their educational journey to becoming a Registered Nurse. What was new for us was to meet as colleagues and researchers. Whakawhanaungatanga was necessary to re-engage relationally and establish a clear sense of relational accountability. The fact that we had some preexisting knowledge of each other already offered a sense of credibility and trustworthiness for the participants and me. This place of trust enabled deeper conversations and, consequently, the potential for deeper understanding. This deeper connection was most notable with participants I had not seen for some time.

Each whakawhiti kōrero was audio recorded, and I kept handwritten field notes, recording my observations of nonverbal language and other potentially significant information. The whakawhiti kōrero began by me asking them, “Tell me about your experience while on the rural interprofessional programme”. When their stories ended, the kōrero shifted and continued with other discussion points (Appendix F: whakawhiti kōrero guide), exploring how the placement influenced their Māori nurse identity and nursing practice. For example, there were prompts about the experience of living together, friendships developed (or not), managing whānau, change they noted in themselves, events that made this experience different from others and the impact or not of the experience on their practice as a Māori registered nurse.

Each participant had their own experience, so using the questions in the interview schedule as prompts rather than fixed points in an interview allowed flexibility for both of us. At times, this meant the conversation veered naturally away from the prompts and into areas the kōrero was guiding us towards. This collaborative storytelling that captures and responds with and to research participants in a culturally informal way is found in many Māori practices such as hui (Bishop, 2005). This enabled the research participants to be positioned as the storytellers of their own stories in the context of this study (Lee, 2009).

In sharing their experiences of RHIP, the kōrero gathered is highly contextualised and a powerful source of knowledge. The whakawhiti kōrero varied in its timeframe from

one to one and a half hours. In the very first participant interview, I found myself listening carefully before responding, talking, or asking further questions. The whakawhiti prompts did not constrain the course of the kōrero. Instead, they aimed to elicit the participants' thoughts and reflections on their RHIP experience and their clinical practice as nurses. Titiro, whakarongo, … kōrero (look and listen…talk) is culturally significant in this study and allowed me to develop an understanding of their perspectives before I sought clarification or responded (Cram, 2019; L.T Smith, 2012). It also enabled me to capture observations made during the whakawhiti kōrero and the context in which they occurred, for example, non-verbal language and reactions in my field notes. These have been used as a source of reflexive data for checking and enhancing my analysis.

I found I experienced a greater awareness of the diverse personal and professional lives of the participants with each of the kōrero and how they saw themselves as Māori. The hui process of whakawhiti kōrero enabled us to develop our trust more and added to our relationship as ākonga (student) and kaiako to nurse and research colleagues.

> Our kōrero had a depth of connection I was not expecting, and it was a humbling experience. I had known the participants at times through their nursing degree and was excited to be part of the next stages of their careers. Some seemed to require less lead in this mahi, this was what I remembered as well of them in class – there was no holding back on their kōrero, they willingly shared their thoughts. Participants also said I would not have participated if I did not already trust you; I'm surprised by how I don't remember the detail but know the feeling still so well. (Field Notes -Reflective Journal, March 2021)

4.8 Kōrero Analysis

Māori knowledge can only be a product of Māori analysis (Cunningham, 2000); however, kaupapa Māori theory does not stipulate how the analysis is to be done, only that the analysis must be positioned within te ao Māori to recognise and amplify Māori aspirations (Pihama,2001; L.T. Smith 2012). With the notion of deciding which analysis approach to take for this study, I considered it essential for the data collection and analysis to occur concurrently so each is informed by the other (Thorne, 2016). This is because the primary focus of kaupapa Māori theory is to critically question how this

data is relevant to Māori, so concurrent analysis allows for the data collection to be continually checked and adapted to ensure its alignment with te ao Māori (Pihama, 2001, L.T. Smith 2012, Cunningham 2000). Cunningham (2000) clearly states that the Māori interpretation or meaning of the data moves a study from being Māori centred research to kaupapa Māori research.

The analysis approach for this study needed to be theoretically flexible. With that in mind, several analysis approaches were considered for their applicability to this project, particularly in relation to their adaptability to a Māori worldview. When done well, thematic analysis can function beyond being a means to organise the data (Byrne, 2022). I have settled on Braun and Clarke's (2022) reflexive thematic analysis. Reflexive thematic analysis is embedded in the wider research method in use, underpinned and surrounded by the values, assumptions and practices that collectively make up the associated method (Braun & Clarke, 2022; Terry & Hayfield, 2021). For this study, that meant that the data analysis was guided by kaupapa Māori theory embedded in and reflective of te ao Māori. This was significant to this study. As Kovach (2019) notes, the thematic grouping of the kōrero can fragment the data, so it is the power of the researcher to determine a coherent progression of ideas throughout the analysis.

Braun and Clarke's reflexive thematic analysis is a means to identify themes and patterns across the kōrero data set through a six-phase method. The authors noted in 2006 that thematic analysis had been widely used when they first published their method, but the choices and decisions that needed to be made were not always made explicit. Thus, they subsequently offered clear guidelines related to conducting rigorous thematic analysis. This process is both an accessible and flexible process that is able to be culturally aligned with kaupapa Māori theory while offering structure, analysis and reporting to find themes within the kōrero data (Nowell et al., 2017).

While reflexive thematic analysis appears to be linear, Braun and Clarke (2022) warn not to expect a linear progression, likening it to more of a trajectory that can and will involve going sideways, backwards and at times in circles. The flexibility of this method certainly permitted me as the researcher to operationalise the analysis in ways that may be idiosyncratic: I could have drawn out a series of mind maps, colour connectors, or word clusters. What I came to appreciate was that this method did not impose a

strict process; rather, it allowed me to work in a way that suited both my thinking and the data.

The six phases of Braun and Clarkes (2022, p35) reflexive thematic analysis are as follows and are described in detail in the next sections:

1. Familiarising yourself with the dataset
2. Coding
3. Generating initial themes
4. Developing and reviewing themes
5. Refining, defining, and naming themes
6. Writing Up

4.8.1 Reflexivity

In this study, reflexive thematic analysis was an inductive process, with meaning driven by the data and by my own positionality as a Māori woman, nurse, educator and researcher (Braun & Clark, 2022). In essence, my subjectivity became a tool of the analysis. As such, this method of data analysis does not claim to be objective nor precisely accurate (Braun & Clarke, 2022; Terry & Hayfield, 2021). Braun and Clarke (2022) celebrate subjectivity as unproblematic, seeing it as an asset, especially when reflexivity is used. It is from the position of an aware, questioning, and multifaceted researcher that the data analysis was undertaken.

Some discussion of the notion of reflexivity is needed. Braun and Clarke (2022) identify reflexivity as involving the practice of critical reflection on the role as a researcher, as well as the practice and the process of the research. Reflexivity is also essential in relation to the cultural value of kia tūpato (see Table 10, p 62) by remaining mindful of my insider and outsider status. Reflexivity in this study was undertaken through supervision, by journaling (see, for example, my journal extract on page 75) and by recognising myself in this study. I am both Māori and a registered nurse; I was also a Nurse Academic at the commencement of this study, reflexivity was used to critically consider the potential impact on how these would shape this study

4.8.2 Phase One – Familiarity with the data

My familiarisation of the participants' koha (gift) of kōrero for this study is the centre of what may arguably be the most critical stage of the analysis: becoming familiar with the data (Terry & Heyfield, 2021). In essence, you are getting the lay of the land; at this stage, the goal was to identify the parts of the kōrero that were likely to be helpful in addressing my research question.

The audio recordings of the whakawhiti kōrero were transcribed using Otter Ai (2019) an online transcription tool and then manually corrected for the Kiwi dialect, Māori kupu (words) and conversation. The transcription tool was a paid version and is not used to train artificial intelligence (Ai) or other large language models (LLMs). The data was then taken off the online sever and stored on a portable hard drive protecting the data sovereignty.

These transcriptions formed the raw data set. I then reviewed each of the transcripts with my field notes, adding comments to the transcripts for each of the research participants. This process already offered a good deal of familiarity with the research participants' stories, but at this point, following the process outlined by Braun and Clarke (2006; 2022) and Terry and Hayfield (2021), I began to engage myself further with the data, making additional notes on the transcripts, at the same time listening to the recordings repeatedly, noticing the richness of their language, and what was of importance to them. I did this to develop an understanding of the primary areas addressed in each interview, unburdened by the task of note taking I had engaged in during each kōrero.

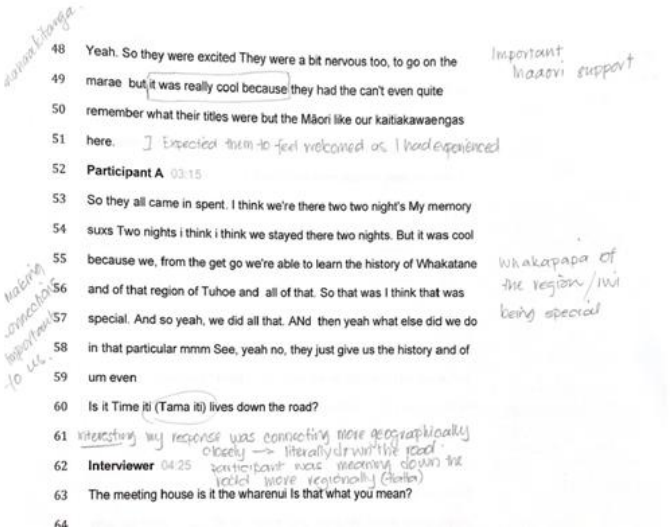
From the inception of the study, I had intended to analyse the data concurrently so I could adapt any prompts to include aspects of participants' experiences that had not been anticipated and to remain sensitive to the directions set by the nurses. At this phase, I also documented my thoughts and feelings regarding both the data and the analytical process in a research journal (See Appendix G: excert from my journal).

4.8.3 Phase two: Generating Initial codes

Codes are the fundamental building blocks of what will later become the themes. Coding is an organic, subjective, evolving and open process of interpretation and meaning making. (Braun & Clarke, 2012; Braun & Clarke, 2021). A brief excerpt of the preliminary coding process of one participant's interview transcript is presented in Figure 3.

I have, in fact, returned to coding more than once, demonstrating the organic nature of this process. Eight broad codes *(connection, collective learning, being seen, othered, mana Māori, whānau, shared values, and navigators)* served as my provisional template used on the data set (Terry & Hayfield, 2021).

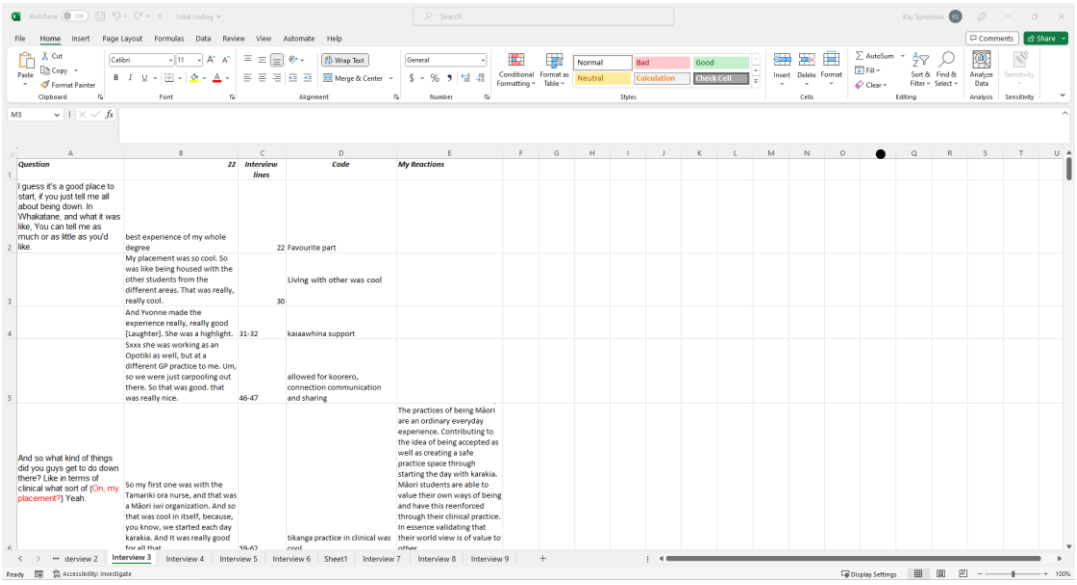
Figure 3:
Preliminary coding process



I tracked the evolution of my codes using a spreadsheet (see Figure 4), documenting each iteration of the codes in each following column. The original transcripts were still regularly consulted. Tracking of the codes in this manner continues to maintain tika and pono while ensuring the participant's stories are respected. It is evident that the process of generating codes is not prescriptive regarding how data is segmented and specified for coding, as well as how many codes or whether the codes are semantic

(researcher driven) or latent (participant driven). Braun and Clarke remind us that these code ranges are best thought of as 'two ends of a spectrum' (2012, p57).

Figure 4:
Tracking initial codes (Excel)

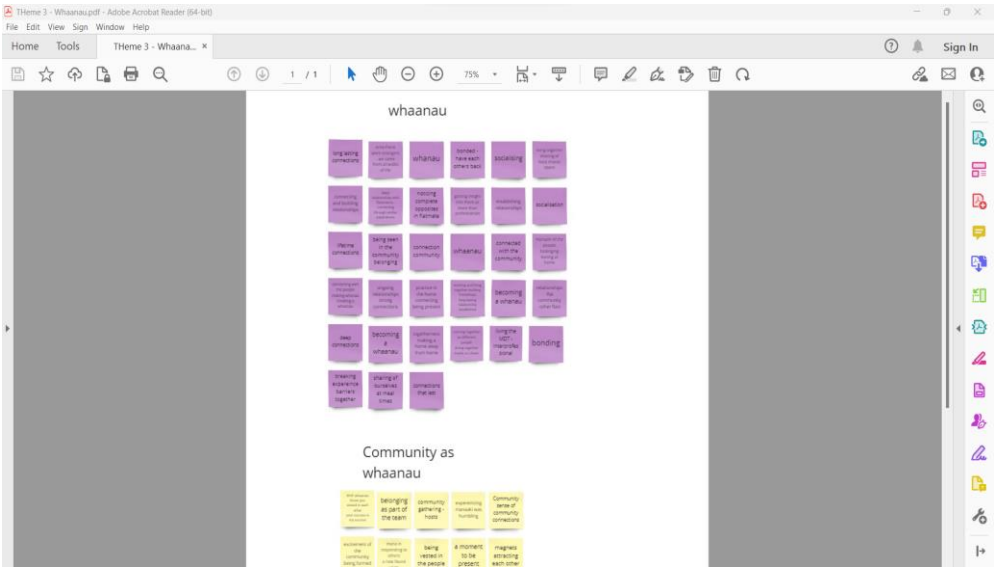


I continued with coding until I had a sense that the dataset was fully coded, and codes were gathered with the necessary richness to be able to examine the patterns in the data and the experiences of the participants (Braun & Clarke, 2021).

4.8.4 Phase 3: Generating themes

This phase is all about shifting the focus from the individual data to interpreting the collected meaning and meaningfulness across the data set. This is known as cross sectional analysis (Braun & Clarke, 2021, Terry & Hayfield, 2021). During this phase, codes were analysed as to how they could be combined according to shared meanings, which in turn developed themes and subthemes (Braun & Clarke, 2021). In 2006, Braun and Clarke acknowledged they implied this was a simple process, and now, in 2021, they caution against merely offering a topic summary, something I have often questioned during this process. Initially, I worked with grouping themes together to represent the story in the data (Figure 5). These were the candidate themes.

Figure 5:
Generating themes (Miro Board).

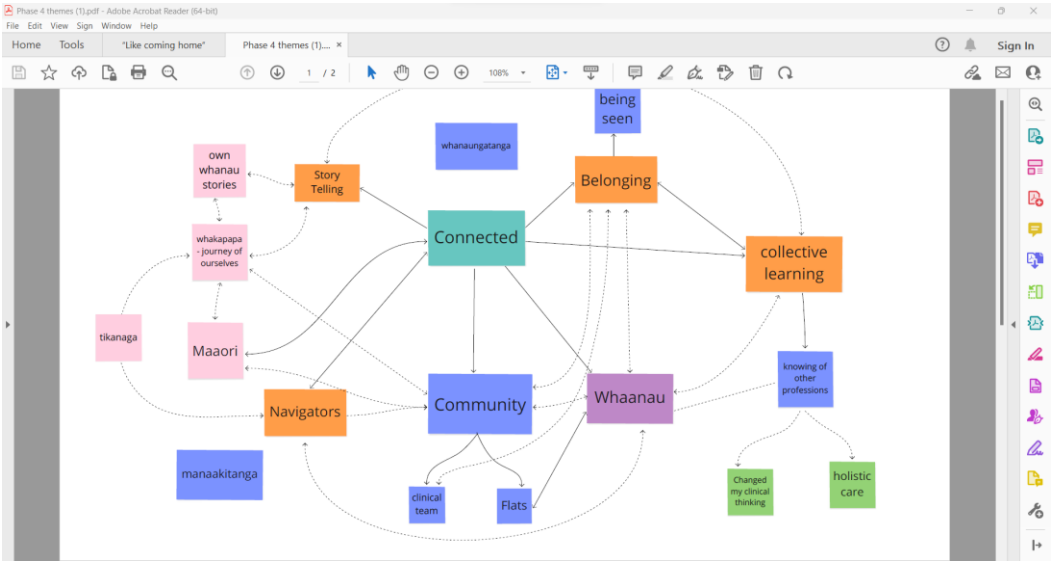


4.8.5 Phase 4: Developing and reviewing themes.

Now that I had a group of candidate themes to work with, I began reviewing and developing them. I spent time ensuring that the story being told with the themes still reflected the evidence from the kōrero data; through this, the mana of the participant's stories are maintained. This process ensured that the combination of the themes tells the best story of the data (Figure 6). This also revealed the space between the candidate themes, beginning to show the interconnectedness of the themes in the data.

This phase took longer than I expected as I went back many times to ensure my understanding as I asked what do these trial themes 'include and exclude'. Another important question I asked of these themes was, 'What are the boundaries of the theme?' There was overlap, but this overlap is also seen in te ao Māori, so it was not unexpected. For example, storytelling being, even those of others, related to the notions of connectedness and belonging (see 4.4.6 Kaupapa).

Figure 6:
Initial data story (Miro Board)



The most important question of the themes was, are they more than a summary of the data ideas?

Through phase four, the themes were revised again until I arrived at what would become the interim final four;

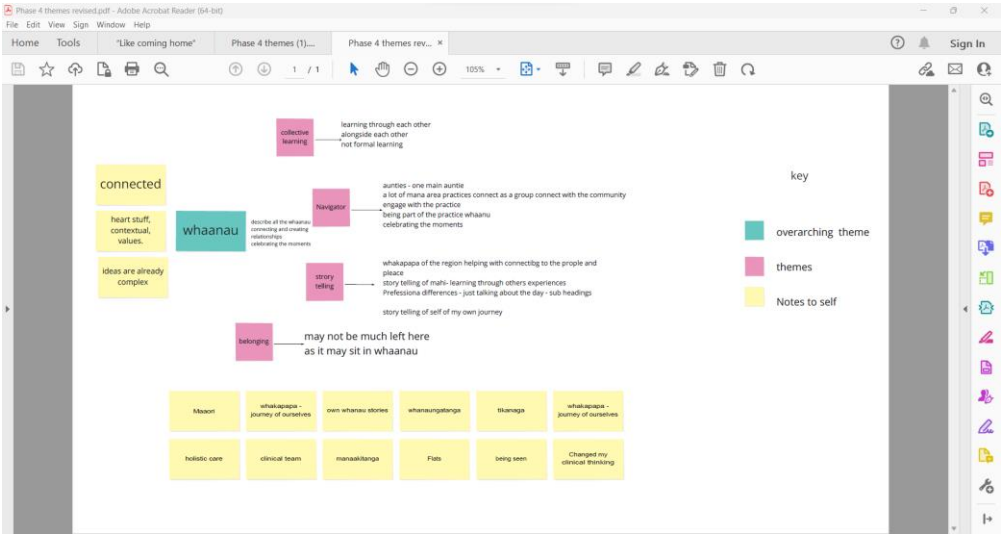
- Whānau
- Navigators
- Collective learning
- Being Māori

4.8.6 Phase 5: Refining, defining and naming themes:

At this point in the analysis, I was looking to define and name the themes. The theme definitions helped to refine the themes further. Terry and Hayfield (2021) advocate that this is not a step to be skipped. In this study, I refined the themes in two ways. Once through conversations with my supervisors, discussing and examining the details of the theme.

The essence of whakawhiti kōrero is sharing, and the collaboration of ideas and the organisation of data requires an ongoing conversation; therefore, the second way I refined the themes was by sharing my initial insights, themes and concepts with the participants.

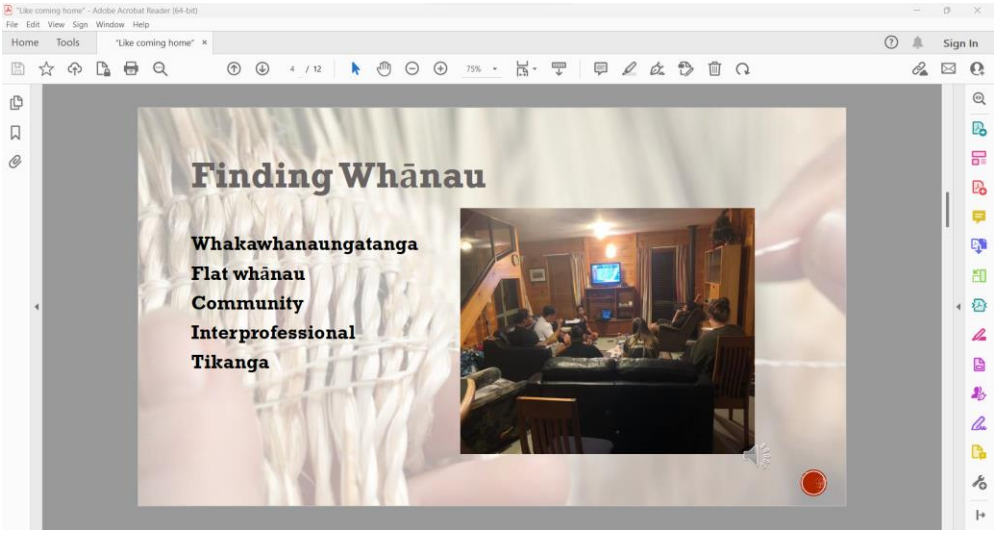
Figure 7:
Revised themes and notes (Miro Board)



4.8.7 Sharing the initial findings

Whakawhiti kōrero involves reciprocity and the sharing of the analysis of the data. The combination of all the data has offered a deeper understanding of how the clinical experience has influenced Māori nurse identity and practice and does not limit the understanding to a single approach (Teodoro et al., 2018). This is discussed in relation to Kauapapa Māori philosophy (section 4.3) and represented by the cultural value of Kaua e takahia te mana o te tangata (See section 4.6), which relates to informing people and disseminating results. The sharing of findings is essential in developing an understanding that is reflective of a Mōri worldview.

Figure 8:
Slide from Like 'Coming Home" Interim findings presented to the research participants. (PowerPoint)



Because of the ongoing challenges related to COVID 19, sharing of initial findings was achieved electronically using a recorded PowerPoint. I then contacted each participant to discuss the findings and to see if any additional insights and understanding could be included in the final analysis. This process supports the collective development of mātauranga (knowledge). It enabled an opportunity for the research participants to reflect on their own experience and how this fitted with the synthesis of the group's experience (Brewer et al., 2014). This ongoing sharing of the analysis supports āta (reciprocity) (Pohatu, 2005) and supports the notion of co-creation from whakawhiti kōrero.

The sharing of analysis process actively solicited further variation or contrasts in the collected data, which added to the richness of the data analysis. The participants offered their own kōrero on the themes that were presented. In these narratives, they made a choice to use āko rather than collective learning, as I had presented. In acknowledgment of this shift in participants' use of language and the collective input into decision-making, the theme was renamed Āko. Such change is underpinned by the Kaupapa ethical principle of Titiro, whakarongo, … kōrero, and the reciprocity of whakawhiti kōrero.

4.8.8 Phase 6: Writing Up

Braun and Clarke (2022) note that writing is integral to the process of reflexive thematic analysis because the analysis takes shape through it. This has involved the interim measures of writing field notes and reflections and drafting chapters and findings. This phase has continued throughout the data analysis and thesis writing. It will continue to evolve as the findings are disseminated through a variety of avenues, including written and oral presentations. The finalising of research in its written form is a demonstration of Western academic thinking that this kaupapa Māori study resists. To achieve transformation, Indigenous research becomes a part of the stories told about, with and around its findings (Pihama et al., 2002); therefore, the writing up of this study reflects this.

4.9 Rigour

Rigour refers to the notion of trustworthiness or goodness and how the reader can believe this in relation to this project. The Māori worldview of the western understandings of trustworthiness or rigour is seen in whakapono (hope, faith) (Cram, 2001). Whakapono recognises the notions of transparency, good faith, fairness and truthfulness. Whakapono is achieved by clearly describing procedures, methodological decisions, a plan for analysing the collected data and the interpretative frameworks used (Cram 2001; Polit & Beck, 2010; Thorne, 2016). Clearly describing what has occurred in this study allows the reader to make decisions about the processes used and whether trustworthiness has been achieved (Braun & Clarke, 2006; Thorne, 2016). Through the keeping of reflective journals, I have been able to identify an audit trail of the study. These journals also showed the project decisions that support the credibility, dependability, confirmability, and transferability of the research findings (Lincoln and Guba, 1985). For this project, important decision points included the ways in which kaupapa Māori theory would inform processes, the development of the research questions, inclusion criteria, data collection methods, and kōrero analysis.

The inclusion of the participants in determining the credibility and resonance of the findings is further evidence of rigour; the gathering and analysis of the data was confirmed as demonstrating an in-depth understanding of the participants' kōrero.

Sharing the initial findings with the participants in a reciprocal forum supported my aim of ensuring that I did not misunderstand or distort the kōrero (Lincoln & Guba 1985). The notions of reciprocity and collaboration used here support whakapono in kaupapa Māori theory through the ongoing co-creation of the findings with participants (Cram, 2001; Nowell, Norris, White & Moules, 2018). As Māori, this process has further recognised both manaaki (honouring and respecting) and āta as expected reciprocity.

4.10 Summary

In this chapter I provided a discussion of the research approach to this study. The identification and rationale of the research question have been described. I have outlined my interpretation of kaupapa Māori theory and methods, which has been explored in relation to te ao Māori, constructivist theory and its emancipatory tradition, and the ongoing development of mātauranga Māori by Māori for Māori.

In this chapter I also explored whakawhiti kōrero as the method used to gather the data and described how the study was conducted and how the data was analysed. Additionally, it provided ethical assurances and a description of the research rigour and approach to analysis while supporting the reflexivity used in this study.

In the following chapter I will outline the rich description of the RHIP programme by the research participants and the overarching themes that were generated from the reflexive thematic analysis.

Chapter 5 Findings

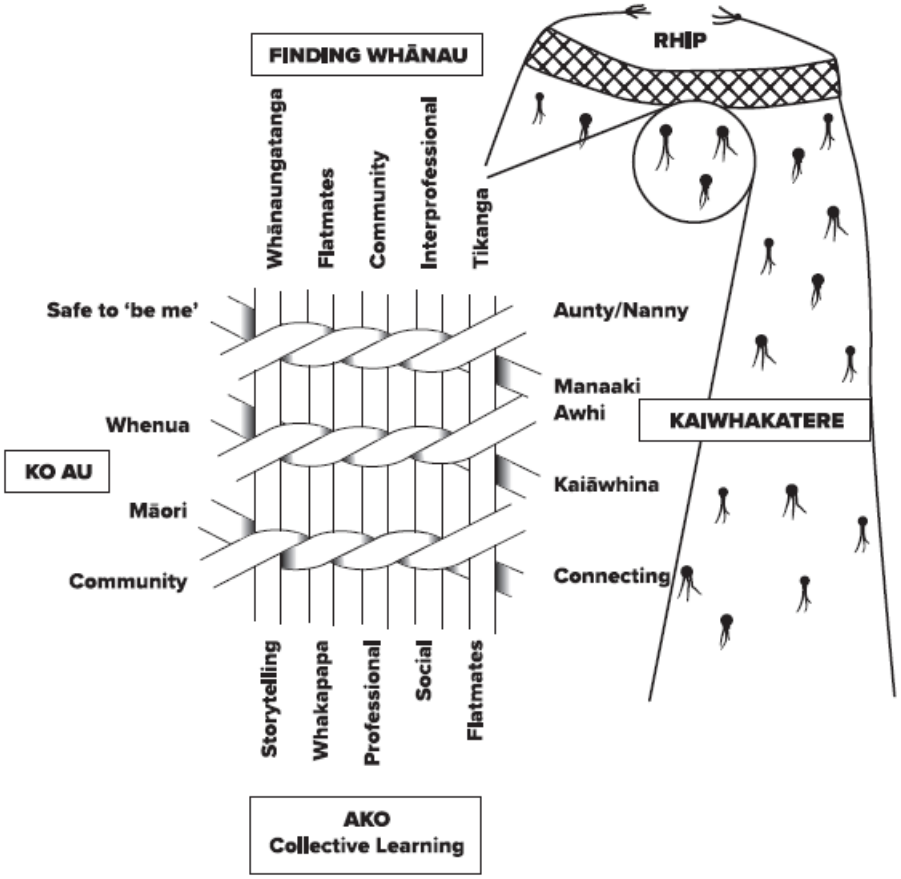
5.1 Introduction

Braun and Clarke (2021) clearly state that reflexive thematic analysis is not linear, but unfortunately, I am not sure that this truly prepares you for the messiness. There is perhaps comfort in knowing that 'messiness' reflects our humanity and life experiences, and this study is no exception. After time and contemplation of the research participants' stories, patterns of interconnectedness emerged. These patterns have formed the fabric of the experience of the rural health interprofessional programme (RHIP) for the nine research participants (described in section 4.7.2, p 72), presented here in the findings chapter.

Throughout this chapter, to respect the tapu of the knowledge and to honour the participants' contribution to the new learning that comes from this, I have kept the data as raw as possible and have minimised interpretation of the findings (Cram et al., 2003). This has allowed the participants' voices to come through rather than over-interpreting their experiences and perceptions of RHIP. This approach to presenting the findings is an intentional part of my kaupapa Māori process and is consistent with whakawhiti kōrero with Māori as Indigenous peoples. In doing this, I recognise the wāhine and tāne research participants as experts of their own experience, allowing them to be truly present in the thesis.

Four themes were identified through the reflexive thematic analysis: finding whānau, kaiwhakatere (navigators), ako (collective learning) and ko au (I am). These themes are presented separately for the purposes of the analysis; however, they are not conceptually independent. These themes are best considered as working together, and it is through their combination and the overlap existing in the spaces between that represents the experience of the participants of the RHIP programme as Māori nurses. As a visual representation, these themes have been conceptualised to be the weave of a whatu kākahu (Figure 9)

Figure 9:
Whatu Kākahu



5.2 Finding Whānau

This theme acknowledges the concept of whānau and the practice of whakawhanaungatanga or relational connectedness as foundational to te ao Māori and an enduring belief of Māori culture. Across the participants' kōrero, the notion and sense of whānau is a fluid term that is context driven. The whakawhanaungatanga process for Māori reaches beyond that of kin to include non-kin relationships who become like kin through shared experiences, such as RHIP. All participants identified intentional kaupapa whānau of their choosing and creation during and ongoing relationships after the RHIP experience. The most common of these was their flat (roommate / shared accommodation) whānau. The participants reported this whānau

as being together in a shared journey with people who understood and knew them. Participant HH described it as this:

> *…we actually lived with different health professionals, but I don't know… It was like a weird sense of whānau …, you create those bonds, those connections, and you're experiencing new things together as colleagues that it's kind of just, you know, you're whānau.*

Many of the participant's stories expressed a sense of apprehension or fear and worry of the unknown; the participants expressed these feelings as a perception of strong anxiety. At the same time, there was also an acknowledgement that the sense of anxiety bonded them from the beginning. It was the idea that together, we are stronger and experiencing the same things. Captured here from Participant GG: *"I think we were all on the same waka in terms of being super nervous to come into a house full of different people".*

The participants recognised the importance of pōwhiri in supporting the connection with each other. They particularly emphasised how this helped them to feel they belonged with this group of people and to connect through whanaungatanga, the practice of relational connectedness and cultural values, which in turn created a strong sense of whānau. Participant EE described it as "…*It was really nice… a great way to start off the practice because it gets everyone out of their shell."* The idea of being brought together and belonging was seen by Participant AA, who spoke about forming the group from the beginning. This would later become seen as both the flat and interprofessional whānau: *"then within the group, you're more solid".*

Participant BB spoke of how this supported them from the beginning to make the connections with the people they would be living with from a place that was Māori and made sense to them. In essence, it was the right place to start:

> *So that was one of the things that's probably my most favourite thing because obviously making connections not only with Whakatāne, or with the Eastern Bay of Plenty, but also with each person that we're going to be, there with for five weeks. I thought that was a cool way to start.*

These chosen kaupapa whānau relationships are enduring, with all participants speaking of still being connected today and noticing these connections are stronger than those they have with many of the colleagues they spent three years with on the degree. The sharing and experiencing mutual manaakitanga, mana and aroha has ensured the relationships are more lasting; for some participants, it had been four years since being on RHIP (see table 11, p74). Participant BB said:

> *One of the ladies, she wasn't in my house even, but she was in Hamilton a few weeks ago. And she messaged me to say, oh, what are you up to? I'm here for a few hours. Shall I come over? And so, we got to catch up. And it was so cool. And her kids, like, she had her grand kiddie with her, and she just instantly hugged me, I heard so much about you.*

This was not a unique story for just those participants who had recently been on RHIP; participants for whom it had been much longer since finishing the clinical experience also commented on the ongoing closeness with RHIP whānau. Participant FF said, *"We're still all close to this day".* From Participant GG:

> *…I now work with one of them. She's a junior surgical registrar. So it's quite nice because they always notice that I speak to [her] a little bit differently than others at work, - how come you get to speak to her? [laughter], I know her far better than any of you do.*

The collective working together in their RHIP homes was also recognised as a way they formed a whānau, bonding as a group. *"Being in the houses together, sorting out like dinners, like all the chores and stuff to do like that also helped us bond together. And now it's just real cool to see" (Participant BB).*

The participants spoke of developing a family in the doing of routine things. Even though they had not flatted (lived in shared accommodation) before:

> *Oh, I've never been flatting. It was my first experience. I'd say I loved it. It was cool. Cuz I and I think, by the end of it, we did become a little family, by probably the second week, in we, Oh, you know, had a little messenger group about who's gonna be home for dinner? (Participant BB).*

There was a lot of laughter and shared experiences that were seen as part of living together but also as a way they connected as a group *"… then there was 'married at*

first sight' … That everyone hated. But every time I turned it on everyone would watch [laughter] (Participant EE). Such connecting was seen as normal, allowing the participants to see themselves as being accepted by the flat whānau. Participants who had not been flatting (shared accommodation) before spoke of togetherness. Collectively making decisions, *"we all got together, we have dinners together would all be like, okay, who's on dinner? Who's doing the rubbish? Who's on dishes? That we had, we actually have a roster" (Participant HH).*

The participants also recognised the wider RHIP rōpū (group) as their collective whānau, talking of spending social time, clinical and learning time together. One participant described it like this:

> *Having those days - like at the beginning, where you would go and have a barbecue all at one of the flats and get to know everyone probably made all the difference. I guess if we didn't have all those interactions, it may have been a different story where everyone was a little bit separated" (Participant DD).*

Through getting to know the wider whānau, the more immediate flat whānau bond was seen to be strengthened. Widening the support network for the participants was noted as a strength of being on the experience while at the same time extending connections and bonds. Participant HH:

> *We'd go to the beach and would have dinners at our houses, each house would have a dinner… we had a Mexican night, and had some other nights. And yeah, it was actually quite cool. And we just like bonded straight away.*

At the same time, connecting with the community was a more contemporary conceptualisation of a whānau relationship in that connecting and knowing the community informed their sense of being part of something. Engaging in activities as part of the community whānau deepened the connection with the people and the whenua, speaking to the wairua (spirit) of the participants as Māori. Participant II: *"I think we started off at the Marae, and that was a good sense of, I don't know, of connecting to the community*". Following tikanga practices of whanaungatanga, pōwhiri, the awhi and manaaki shared with others allowed the participant to see

themselves as part of the community by knowing the people and hearing the karakia and waiata.

The theme 'finding whānau' represents relationships woven through connections, a sense of belonging and learning. It was not limited to one whānau but rather to many; the most significant were flatmates, other clinical practice professionals and the community, which became strong threads to their clinical practice. This affirmed that an individual experience is anchored in one's whānau and interwoven in the connection with their mahi (work) whānau and the wider community. These complex conceptualisations of whānau are rooted in the collectivist values of whakawhanaungatanga and tikanga from our culture.

5.3 Kaiwhakatere (steersman, helmsman, navigator)

In the Rural Health Interprofessional Programme experience, as in life, there were some people to guide you. There was one navigator to whom all the participants attributed the success of their experience. They saw her as a nan, an auntie (not by whakapapa but by choice), a tuakana to look up to and show you the way, and a rangatira (leader):

> *I don't know, like just her- her soul, her ability to connect to help to like … she's just real amazing - I don't know what it was about her, but she so helped me… she was that safe person to go to for anything to ring to call (Participant EE).*

*"Xxxx made the experience really, really good [Laughter]. She was a highlight" (*Participant AA*).* There was a knowing that she was there for them. Participant GG spoke of her role as a helper and advocate:

> *… she was very much a kaiāwhina. …. for whatever reason, too! If you had struggles with your own health, I think I had a sick day down there [you could just call] – Hi xxxxx I'm not feeling well. I've already spoken to so and so. Just letting you know that I'm not going to do these hours today. [she answered] "Fine. I hope you're right. Do you need anything from me? Do you need to go and see a doctor? We can organise for a script …*

Participants identified that this was not what they had experienced with other clinical supervisors, and she went further than mentoring a student nurse into practice. The connection and support were more profound and more complex. This kaiwhakatere was the connection to the wider local community and the entire RHIP. Like many rangatira (leaders) before her, the participants saw her concern for the integrity and success of the people and the land. The participants seemed to know that their success was her success. But more than that, this would mean success for Māori. The participants spoke of being inspired to be leaders themselves and make change in their community: *"That's the goal … To focus on Māori health. Me & Txxxx. We're going to try to think up the next Māori health model and become the next big thing" (Participant EE).*

Many participants also spoke of the manaaki they experienced while on placement. The te ao Māori value of manaaki is related to caring for and showing hospitality towards people. The most important aspect of hosting is to provide a place of peace for visitors to ensure the gathering is a memorable occasion. Participants felt manaaki in many places and from many people. For the participants, manaaki preceded the formal welcome of the pōwhiri. Participant HH described it like this "*We went to one of the houses and had like a whakatau, you know, a nice feed, got to meet the organisers and then got to know each other and that was cool".*

The sense of manaakitanga was again felt at pōwhiri. The calm, peace and safety that the pōwhiri and manaaki gave fortified the RHIP experience as somewhere that, as Māori, this would be a safe space to be. The kuia at the marae were kaiwhakatere for the participants' experiences on the marae. They made the participants feel like they were 'coming home':

> *… just the minute we arrived there; I did feel like a very calming feeling. - I don't know, even meeting, the kuia and that, from that particular marae. I was just like, they were just one of my Aunties, you know that we're just such beautiful people' (Participant BB).*

The sense of peace was also felt off the marae. Still, there was the knowing that this came from starting in the right place "*it was very peaceful, and it was just such a nice*

learning environment just to be down in a rural area and also with that, starting off in the Marae, it was really, really cool" (Participant AA).

If manaaki was the light being used to show the path, the participants expressed that many navigators were holding the light of manaaki to guide them and that there was not just one person at the helm of their experience on RHIP. The community whānau offered them many kaiwhakatere to help and support their journey. There were those who were able to connect them with the whakapapa of the whenua and its people. Kaiwhakatere willingly shared their traumatic experiences of colonisation, racism and inequities to guide participants to know what it meant to be in this rohe and these communities. Captured here by Participant HH:

> *Those other matua and the other whaea, they really helped with explaining everything - not so much protocol, but every aspect of what we were learning throughout [the degree] so like at all the places that we went to, they didn't have to be there. But they were there to explain it. More like, dumbing it down for the people that didn't really understand because they definitely helped with that. But then, it was quite good that they were there*.

Through this, they were able to offer a sense of connection and understanding of the people in detail and with no time limit to deepening the knowing of the local people. They acknowledged that the guidance was available whenever and wherever the participants needed it. Again, this reinforced that the participants belonged and, at the same time, led them through their awhi (cherishing/support) of the participants: *"the whaea who came with us…... She was so good throughout it all and like, even with our presentations, you know, she gave us her number and said contact me if you need help with them" (Participant HH).*

Through the awhi and manaaki given, the participants experienced a depth of connection to the place and people. With that connection, the participants felt strengthened. For Māori, we connect on many levels, many of which are intangible. One participant captured this when they identified particular people they met, and those who guided them made them feel like they were at home even though this was not theirs. "*She really helped us to connect to that area while we were down there and feel at home" (Participant AA).*

The people the participants met offered knowledge, guidance, and leadership while facilitating connections. The role of the kaiwhakatere is in connecting with the participants and facilitate connections with other navigators. For the participants, this was seen and felt with ways of being such as a nan or an auntie. The kaiwhakatere were then able to awhi and connect the participants with the whakapapa of the rohe in its broadest sense, beyond that of genealogical connections but to the whenua and stories of the region. The kaiwhakatere relationships also embody the Māori concept of tuakana -teina or relationships between an older and younger sibling. Kaiwhakatere created spaces to talk to explore, showing participants different ways of thinking about and exploring ideas.

> *I think having an open mind and being able to share about well being or have that relationship with XXX or the rest of the group - you are in that sort of very relaxed Tuakana teina /whānau-based model. It just settled the wairua, but you could go and vibrate in your own direction. And you felt safe to do so. I think that's the difference between the RHIP program and other (Participant GG).*

Relationships such as the ones created with the many kaiwhakatere on the RHIP are underpinned by a sense of being home and thus reinforce the notions and values of manaaki in our culture.

5.4 Āko (Collective Learning)

Māori culture is founded on oral traditions, which involve many forms of transferring mātauranga (knowledge), including storytelling, waiata (songs) chants and whakatauāki (Mead, 2016). Participants recognised the value of this way of learning from the initial noho marae and the transmission of cultural knowledge and wisdom as a way of experiencing and learning that is known to help Māori to feel comfortable with all things Māori:

> *We did a noho at the Marae and whakawhanaungatanaga with all the other tutors and mentors that we met. And then we talked about the treaty, we talked about equity, we talked about a lot of stuff, and that really opened everyone's eyes about how Māori are affected (Participant II).*

This contemporary experience of professional learning was extended to the collective learning of the student nurses related to their clinical practice. They felt such cultural knowledge and wisdom helped them to understand their patients' current experiences in a meaningful way. For Participant FF, this was expressed as that learning about the whenua shifted the understanding to what they expressed as "actually knowing" the place rather than what it's known for, as just a holiday destination:

> *It was really nice to actually know, the place rather than know what it's for… To have the deeper meaning and kind of connect with the land and itself, rather than just being a cool beach kind of thing.*

The cultural knowledge gained from the stories of the people and the whenua enabled a deeper connection to their clinical practice in the rohe (area). It served to underpin understandings of ways to work with Māori in clinical practice while at the same time continuing to make and build on their relational practice as Māori and nurses:

> *from the get-go, we're able to learn the history of Whakatāne and of that region of Tūhoe and all of that. So, I think that was special… Anyways, they gave us a heads up on the history of what Māori went through in that area back in the day [Urewera Raids, 2007]. So that we were able to kind of know when we come across Māori in our practice that some of them you know, were still alive around that time, and they still remember what had happened back then (Participant CC).*

The participants noticed that much of their learning about each other's professions had been unintentional because there was no formal lesson plan or recognised Kaiako (teacher) instructing on the topic.

> *I suppose unconsciously we gave anyone who was involved, umm some intrinsic knowledge about our discipline... so I could, for example, say talk about that person's cellulitic leg and, that we were giving them this antibiotic and this antibiotic, the pharmacist could then say, Oh, that's funny, because I, we would usually treat them with this, this and this, or I wonder why they're using this as opposed to that (Participant GG).*

The RHIP ākonga (students) were the teachers within their own professional understanding at that moment, reinforcing the safety of learning from each other and developing their practice through exchanges such as this.

Another participant expressed how learning from the wider RHIP ākonga was a safe space to explore practice or develop knowledge:

> *I learned things about other people through that person in that house. And that person in that house. And so on … if I had a question to ask, or I wanted to talk to someone about something, you could just go and ask, there was that reciprocal relationship sorta - we're in the same boat. We're rowing in the same direction (Participant GG).*

Other participants expressed ideas of how being with the flatmate whānau and the extended whānau relationships established at the pōwhiri and noho marae meant they were able to explore what other professions did on their level:

> *it wasn't like in the hospital, or at the rest home when you're kind of figuring out what they do. And [there] you're like, cool, I've [actually] got no idea what you're saying! [On RHIP] It was like, they were able to put it in a way that we understood. So, if I need to refer to a dietitian, this is how you're going to help me, and the same with OT (occupational therapist) and Speech Language therapists (Participant EE).*

Each profession added its own professional voice, and in doing this, it expanded the understanding of the nurse participants to include their wider clinical knowledge. This reinforced the idea of learning collectively from each other and forming what would be can be seen as an interprofessional community of practice. Collective learning from Participant GG portrayed this as having your cup filled up by others "*… from a nursing background, you thought umm my cups just about full? And then comes the pharmacist and add to her splash. And then the doctor comes in and adds her splash".*

Participants also explained that the knowledge they gained was invaluable in their first year of clinical practice in relation to being able to make sound clinical decisions. The understanding of what the other professional roles were gave them confidence and eliminated their anxiety related to not knowing "*Oh, yeah, I wasn't so scared (before RHIP)… umm then (after) I had a better understanding of what the pharmacists' roles were and caring for our patients …"(Participant II).*

> *I'd say more comfortable because I got a better understanding of what they actually do and how you know how they may be able to help…. So, I've been able to discuss different things with her (Participant BB).*

There was also a sense that they felt more able to engage in professional conversations and see each other through talking to each other about their degrees and roles.

> *I thought it was real daunting having to like, call up the doctor and discuss the patient, and advocate for my patient. But I don't know, through RHIP you know you're just all.., you're people, you know that you're just in it for the same reason? Yeah. Easier to talk. And understanding like these scopes a little bit better (Participant CC).*

What the participants noticed was that engaging with the other professionals became less about what the person's professional role was. Or their pre-existing worry that because of the other person's role, they were going to know more. Instead, there was a realisation I was speaking to another human, a person:

> *There was no sense of hierarchy whatsoever. You know they were just human…I don't know if it's something we have in our own heads or it's an unspoken order, pecking order... it was just you know we're all equal (Participant FF).*

The participants noticed that the 'hierarchy of practice' that they had experienced in other clinical settings was not felt on this placement. Instead, they felt and saw themselves as equals.

While exploring how participants learned about and from other professions, the most significant way that was identified was what can be seen as *dinner conversations*. These were moments when participants noticed someone asked, 'how was your day?'. Often, this was during dinner, or perhaps while washing dishes or with the cuppa after tea and the dishes were done … these conversations were offered as learning and getting to know clinical practice from another profession's experience in the safe learning environment of home:

> *… in my flat, yeah, it was really good. We stayed up to like 10 o'clock, just talking every night. Like we did talk a lot about our jobs or experiences, not just our jobs, I mean, our degrees and our experiences (Participant EE).*

> *Um... a big thing for me was the amount of support provided like talking about the experience and debriefing. You get that kind of out*

> *on the table, you can kind of pick from the experience what has gone well, what has not gone well (Participant AA).*

The learning captured here is intertwined with Māori oral traditions as well as whanaungatanga, the connecting of professionals, and the interprofessional whānau personally extending their knowledge. These ako spaces were seen both as cool and safe to be yourself.

The participants described further personal growth and learning as they reflected that the experiences of the noho and pūrākau (stories) from the tangata whenua were an impetus to explore their own whakapapa and stories. The experiences influenced how they viewed themselves, connecting and reconnecting them to their culture and informing their own identity.

> *I can't remember what his name is. But he had a lot of stories. He came in a few times and just told us stories ... about Whakatāne and how things came about and just stories about whānau that lived around there… Made me want to come back and talk to my whānau and find out more. Especially where I'm from – 'cause I don't really know, either side of my family…I guess I can't know who I am. If I don't know where I come from (Participant DD).*

> *[soft giggle] I don't know. I think for me, I'm still, and I know this is so silly to say, but I still don't feel like I'm Māori enough. It just made me just want to go back to my marae more and more (Participant BB).*

Ako was seen by the participants as storytelling, professional learning, social learning, and learning of the whakapapa of the people, and through this, developing a knowing of self through others. The strong threads of ako are underpinned by finding whānau and are intertwined here with being in spaces to learn collectively, transferring mātauranga orally and collectively, which is a known kaupapa Māori approach to learning. Affirming for participants was that they were in a space where it was safe to learn and explore themselves as much as their professional knowledge. Learning collectively was further reinforced by their connections with each other, the whenua, the community and the tangata whenua.

5.5 Ko au (I am)

In Māori culture, whakapapa is the core of belonging and is a key to participation; it allows Māori to claim, 'I am'. Without it, we are on the outside looking in. All of the participants expressed that they felt connected to the whenua (land) and the people while on the Rural Health Interprofessional Programme, which was initiated with pōwhiri and ongoing through whanaungatanga and supported by the many kaiwhakatere (navigators) the participants met along their journey.

When the participants were asked to think about events or things that affirmed being Māori or what they saw as being good about being Māori, they identified that they saw themselves on the streets and that they felt normal. Most made a version of this statement, "*I was around a lot of Māori people and Māori nurses and Māori. Everyone was pretty much Māori" (Participant HH).* Another participant spoke from the heart, expressing it just as "...*being around other Māori. Yeah!" (Participant II)*

The participants also spoke of hearing te reo Māori everywhere, in the shops, and voiced the idea that being Māori and the language was ordinary or typical as opposed to something unusual or to be experienced. Most simply noted hearing te reo, often and everywhere! "*…Hearing te reo, made me wanna learn" Participant CC.*

You hear it everywhere:

> *… Yeah, yeah. In practice and the streets. Just, you know, just when you go into your shop, or walking down the street kia ora, or…definitely, way more than it has ever been spoken at the hospital all you get is kia ora, but the in the community down there you get like so much. It was cool. I had a full-on conversation with a lot of people. (Participant HH).*

The participants were able to see being Māori as normal "*The normalisation of being Māori. Yep you know more of it, of it, being an expectation rather than a tick box. And just a feeling of being 'accepted' I think would be the biggest thing" (Participant FF).* Hearing te reo made many connections. One was to being Māori and to recognising that the language can be visible in the community everywhere:

> *you'd hear kids and grandmas and everyone speaking to reo which I thought was amazing. I mean, you kind of get it here a little bit, but not*

> *as much as you went down there. You'd sometimes hear people say, talking to their kid and Māori at the supermarket, but there it was, like an everyday thing everywhere I felt like everyone spoke Māori, which I thought was so cool. Also too, you know, with moko kauae (Participant DD).*

Once more, hearing our language connected the participants as they could see themselves as belonging. We were "*Connected to the people and rohe – community*" (Participant FF). The participants also spoke of finding it to be normal to connect with the community or the people of the area:

> *as a Māori, we naturally want to find out or have the inclination to ask, okay, so where are you from? Who are you related to? [Yeah], and how does that connect someone there? So, finding that out I think unconsciously was quite important to how I felt about being able to, I suppose interact with people from that rohe and provide them with care (Participant GG).*

These participants expressed the significance of being part of the community whānau:

> *Like we would go to the quiz nights. You know, see everyone else come around. Well, all the old people [laughter] whipping our butts in the quiz. Nice community just felt welcomed. It wasn't like awkward at all or uncomfortable, ever! (Participant EE).*

They conveyed the idea of being welcomed as something that strengthened the sense of belonging in the community and being safe through having a relationship with the wider RHIP community. The participants also spoke of being in the right place in clinical practice and that their presence was valued and appreciated. Essentially, they saw themselves as part of the team: "*the connection, you weren't just a number coming in and out" (Participant FF).*

When exploring clinical experiences elsewhere, it was sad to note that the participants were not able to confirm such safe connections. They spoke of being othered – not being seen, and they did not feel comfortable or welcome. One participant used the term 'sly racism' "*like being asked "why do you only go with Māori nurses?" …umm my preceptor is Māori [eyebrows raised!] (Participant DD).* These two participants remembered the clinical experiences outside RHIP as almost traumatic: "*Actually, in the majority of the other placements, you could feel that you were not wanted. And it's*

always the aww, 'who wants the student?' and everybody kind of put their head down and walk away" (Participant II).

> *I don't think a nurse even looked our way once. I think I spent like one or two days, giving out meds with the nurse. And then and apart from that, a lot of the time we were just kind of shunned in a corner (Participant EE).*

The participants clearly stated that these experiences were not mana enhancing as expressed in the tuakana teina approach where the older, more experienced person (tuakana) shows /guides the younger learner (teina). The participants shared that they experienced this more culturally appropriate model while in clinical practice on RHIP. Such valuing of others is also anchored in the cultural practice of manaaki. Here, it is the manaaki of the practice staff extended to the students for their learning in the clinical environment. Being valued, noticed, and even seen was what the participants noted as points of difference from their other clinical experiences while on RHIP. They felt seen and heard.

They saw that being part of the team could be seen in being offered wider experiences "*Nothing was too much trouble to make happen…" (Participant AA).* They felt a difference in being part of something:

> *..yep. [raising eyebrows laughter] way different. Like I never felt like I was in the way or wasn't needed. There was always like because it was xxxxx and they sorta had other services in there. They had mental health services. And they found out that I was interested in mental health like, so their team had asked if I would like to go out with them for the day (Participant DD).*

Practice learning was seen as empowering to their journey as Māori who were becoming nurses. "*.. you never felt, I suppose, ashamed. Or whakamā or, nothing, you just went out and did whatever you needed to do." (Participant II)* Or, as this participant noted, they felt their knowledge was valued, further enforcing that they belonged in this clinical practice at this time – they are part of the team, part of the practice whānau "*never once did I feel like I was getting in the way. They generally took my... like my ohh what's the word? My thoughts or? Like what I would recommend? Or what I thought should happen from there on" (Participant EE).*

The idea of belonging was further underpinned when they were able to see practices of importance to Māori being used in clinical practice and that this use was not the exclusive domain of other Māori in clinical:

> *The nurse that I was with she, she was a Pākehā lady, but you wouldn't think she was a Pākehā lady. But the first day I was with her we went to visit a whānau and before we went there, she had stopped at the Countdown and got bread and milk. And I was like, oh, she must be stocking up for like when she goes home or to take it back to work. She came out with a few bags. And then when we got to the house, she's like, 'Oh, can you just grab those bags?' Ohh Okay [eyebrows up]. We're taking some kai in. And then when we finished, she said to me I know that they had a tangi the week before. That's why she couldn't get in and do the immunizations and stuff. So, she thought, she'd take a koha to the whānau (Participant DD).*

The participants identified that a willingness to engage with Māori was something to celebrate:

> *They [clinical professionals] were really willing to, I suppose go out of their way to make the patients feel comfortable. Like one of them was even enrolled in a te reo course just so she could try and understand where each patient was coming from and she, they all greeted them, kia ora and just tried to use as much Māori as they were familiar with, I thought that was great (Participant CC).*

It is important here that it was not one event or happening; it was consistent ways of being and doing that were accepted and allowed the participants to see themselves in this place as Māori. Participants could see themselves in these clinical spaces and the community: "*There was nothing that stopped me from being Māori. It pretty much made me Māori even more. Yeah, like it definitely opened me up, way more being down there" (Participant DD).*

Overwhelmingly, the impression from participants was that being Māori was not unusual or something to be minimised but instead that the participants saw themselves as just 'being' and as this Participant FF expressed a place where you could step into your 'power' "*It was almost so different. [I: how was it different?] It was empowering. [Yeah]. You know, you kind of stepped into your power*".

The overlapping notions of ko au (I am) of belonging are holistic and, like Durie's Te Whare Tapa Whā model (1984) of taha hinengaro (mental and emotional), taha wairua (spiritual), taha tinana (physical), taha whānau (family and social), and more recently actively considered is whenua (land and roots) forming the foundation on which this metaphorical whare (home) sits. Separately, these concepts support the idea of being in the right place for the participants. For the participants, these notions were overlapping, with the strength being that the notions were present in the clinical experience. The participants have expressed that belonging was experienced as more than a physical presence in the right place. It was experienced holistically, with community, the whenua, with other Māori, which collectively underpinned the holistic nature of belonging and the sense of it being safe to be *me*.

5.6 Summary

Participants provided extensive descriptions of the many ways they experienced the RHIP programme as contemporary Māori nurses. Findings showed the experience of the RHIP programme as Māori was fluid and context driven. Interviews with participants revealed important aspects of RHIP, such as spending time with flatmates and other professionals, knowing them, and having rich, authentic relationships both in clinical and the communal community, providing support and opportunities to be together and experience a sense of belonging. The research participants expressed being connected to the people and place, enabling a space where they could listen, do and learn. From the detailed description of the RHIP experience, four overarching themes - finding whānau, kaiwhakatere, ako and ko au, provide definitive qualities inherently found in identity as Māori for the participants. The four themes overlap significantly and collectively influenced the participants both personally and professionally.

In the following chapter, I discuss the themes in relation to contemporary nursing education and interprofessional undergraduate clinical practice.

Chapter 6 Discussion

6.1 Introduction

This research explored how the Rural Health Interprofessional Programme (RHIP) influenced Māori nurses' identity and nursing practice. The perceptions of Māori nurses who participated in the programme offered a contemporary perspective on the effect of the RHIP on Māori identity in a clinical practice placement. Also, they provided an increased understanding of the needs and realities of Māori student nurses.

> E kore au e ngaro, he kakano i ruia mai i Rangiātea
> I will not be lost, as I am one of the seeds scattered from Rangiātea

The metaphorical "seed" spoken of here represents growth, development, and self-realisation. It speaks to the potential in us from Rangiātea (our place of origin), the knowing of who we are and what we bring with us to be able to flourish in the place that we land. This whakataukī reminds us ‘being Māori’ cannot be lost.

This study reflects the potential and awakening that this whakataukī speaks of, adding to the existing literature on Māori identity, focusing on contemporary nursing education, and growing the knowledge around clinical practice models. Ultimately, this knowledge of contemporary undergraduate clinical placements, from a Māori nurses’ perspective, will be used to inform more effective clinical practice experiences and research that addresses and increases Māori success in nursing education. The RHIP immersive interprofessional clinical rural experience has potential implications for improving other placements. In this chapter, I expand on how these collective kaupapa practices may present ways all clinical experiences could be shaped to enhance the experience of Māori who study to become nurses and in other health professions.

6.2 Summary of the Key Findings

The findings from this research provide an understanding of the participants' perceptions of the RHIP programme with insights into Māori who are nurses and had a dedicated interprofessional clinical practice experience in their undergraduate study. This study has established a rich understanding of how the clinical practice placement

was perceived from the perspective of the participants and illuminates the practices that shaped this experience and their future clinical practice.

Data were gathered from nine participants, kanohi ki te kanohi, using the whakawhiti kōrero approach (Elder and Kersten, 2015). From the interviews, I used reflexive thematic analysis to construct four themes. Theme one, finding whānau, captured the significance of being part of a whānau. It highlighted the importance of connections and engaging with purpose. This theme bought to the forefront the reciprocal nature of whānau and that the presence of purposeful whānau contributed to the sense of coming home.

Theme two, kaiwhakatere, captured the importance of navigators and leadership in RHIP. Particularly considering their roles in supporting the flat (roommates) whānau, the clinical and community experiences. It highlighted how practitioners were able to be present as tuakana (older siblings) and support the students as teina (younger siblings), establishing a sense of working alongside them, being available to them, and enhancing notions of being seen. It also reflects the robust engagement with Ngāi Tūhoe in the programme.

Theme three, ako, focused on participants' recognition of learning together informally and formally in a safe space, allowing them to explore concepts safely underpinned by the reciprocal process of learning and kotahitanga (working together).

Theme four, ko au, captured the essence of what the RHIP placement meant for the research participants. RHIP was seen and conceptualised as a transformational educational experience that included mana enhancing connections between nursing, clinical practice, and their Māori worldview. The nurses described contributing as Māori who are nurses, often for the first time in their education. Seeing themselves as Māori in nursing practice rather than nurses who were Māori.

6.3 Contribution to knowledge

This is the first research to examine how the RHIP placement influenced Māori nurses' identity and clinical practice, representing a rich tapestry of pedagogical and engagement practices that influence Māori identity. When considered as a whole, this

study speaks to what it is to be Māori within a clinical practice experience. Drawing on my visualisation ('whatu kākahu': Figure 9 p 87) of the participants' stories, this study is one of an intricately woven fabric made of many different threads. The whatu kākahu envisions the weaving together of the themes whānau, kaiwhakatere, ako and ko au and is implicit in the communication, connections, relationships and tikanga related to those on, and encountered within the clinical placement. The whatu kākahu pattern varies according to the specific needs of the participant and RHIP whānau, resulting in a sense (state of) of mana motuhake (self-determination, independence). The metaphorical threads of this study titled "Coming Home" are symbolic of all the protection and safety of being home.

6.4 Whanaungatanga & Whānau

In the context of this study, whanaungatanga and whānau describe a web of interrelated values and practices of the RHIP placement as well as what the research participants saw as their role while on RHIP. Such values and practices concerned both the spiritual and physical essence of their time on RHIP and involved the protocols, histories, genealogy (whakapapa) and their responsibilities while there.

The participants shared their understanding of what a RHIP placement represented for them as nurses, which revealed a collective meaning of whanaungatanga and whānau related to RHIP placement. There are several comprehensive reviews of whānau concepts (McNatty & Roa, 2002; Lawson -Te Aho, 2010; & Cunningham et al., 2005), so I will not attempt to repeat these efforts; rather, the purpose here is to identify the ways in which incorporating whanaungatanga and whānau would help other clinical practice placements to have improved outcomes for Māori who aspire to become nurses.

Ritchie (1992) cautioned against looking for simple translations of whānau, emphasising that whānau is based on intricate concepts and stressing the significance of Māori values in relationships; this remains true in this study. Looking more closely at the complexity of whānau, Metge (1995) notes in this definition:

> There is the duty to care for each other, expressed in the word's ahu (tend, foster), atawhai (show kindness to, foster), awhi (embrace, foster, cherish), manaaki (show respect or kindness to), taurima (treat

> with care, tend) and whāngai (feed, nourish, bring up). All these words imply meeting not only the physical needs of others but also their need to be nurtured mentally and spiritually… This duty of care for each other includes the responsibility laid upon older generations to teach the young right ways and to hand on knowledge that belongs to and will benefit the whānau as a whole.

The RHIP placement enabled the formation of whānau underpinned by interconnected Māori values and the very principles that Metge suggested, such as manaakitanga, rangatiratanga, and wairuatanga. In te ao Māori, none of these terms have simple translations; however, this does not mean they are too complex to achieve. In the interrelated nature of these values, one draws on several meanings related to others. For example, the participants spoke of the collective unity (kotahitanga) of the flat whānau and how kotahitanga was supported by a sense of reciprocity and caring (manaakitanga) for each other. They were in the same waka (canoe/boat), being in a new place, working towards similar goals and experiencing something new. Mead (2016) explains that the whanaungatanga principle reaches beyond whakapapa relationships and speaks to connecting through shared experiences, regardless of whether whānau is one through 'whakapapa' or 'kaupapa need' connecting a group. The whānau values are underpinned by manaakitanaga, which in this context is seen as showing integrity, sincerity and respect towards Māori beliefs, language and culture. The strength of the RHIP relationship was in the coming together and being able to communicate the nature of these values to each other in ways they understood and knew without needing to re-interpret their cultural understanding to conform to non-Māori norms. While in their RHIP clinical placements, the participants also spoke of establishing relationships and connecting (whanaungatanga). This is where relational clinical practice is seen drawing on the same whānau values of manaakitanga (responsibility of caring, hospitality and reciprocity), rangatiratanga (authority and structure in the group), and kotahitanga (the collective unity of the group).

Some argue that kaupapa whānau, such as these are relationships of choice and ones which the individual can choose to leave (Kruger et al., 2004; McNatty & Roa, 2002; Kukutai, Sporle, Roskruge, 2016). Therefore, they may be perceived as more fleeting, whereas whakapapa whānau (kin relationships) are more permanent and culturally authentic. Some see this distinction as necessary (Irwin et al 2013; Kuktahi & Webber,

2018; McNatty & Roa, 2002). In this study, I found that the intent to contribute to building and strengthening bonds of kinship and giving strength to collective practices of whanaungatanga from the flat whānau have been enduring. The participants spoke of still being in touch with the whānau from the RHIP some years after the experience. They saw this whānau as unique, recognising that although their initial connecting and relationship had been limited (five weeks), it continued to have an impact on their lives at the time of our kōrero. They expressed a significant difference between their RHIP relationships and some of those that they had with other ākonga (student(s)) during their undergraduate study which was significantly longer (three years) – identifying they had already lost touch with many of them.

The regard for Māori values and practices articulated by the research participants in this study has highlighted that health and educational practices incorporating te ao Māori in health and education practices is both legitimate and required when delivering education in health professions. This is partly through robust, authentic engagement and consultation with Māori as partners in the planning and delivery of the RHIP programme and active engagement with tikanga Māori by the local health professionals involved in the programme. This reminds us that in whanaungatanga, there is an expectation of shared responsibility and support from the collective group and a fundamental expectation of support and help from the individual. This study's participants valued the connections made during their time on RHIP, noting the sense of support as individuals and as kaupapa whānau. Despite there being several prominent Māori engagement models in health and education (Durie , 1984; Pitama et al., 2007; Pere, 1997) that outline both the concepts of whanaungatanga and whānau as integral ways of connecting with Māori, the research participants reported that they had not experienced such whakawhanaungatanga in other undergraduate educational contexts. Participants found that other clinical placement experiences were, at best, tick-box activities without a legitimate engagement with tikanga and the weaving of the interrelated values into clinical and professional practice, or, at worst, completely absent.

The RHIP experience integrated te ao Māori practices, which were reported as the main reason participants felt seen as Māori. This was not necessarily associated with connecting with Māori kaimahi (workers) as such. Many of their connections were with

Pākehā, including clinical practitioners, student health professional colleagues, and some of the 'RHIP aunties'. They all supported connecting in ways in which the participants could make sense of and aspire to have in other clinical experiences. In this, they noticed that many of their previous experiences as student nurses were based on a sense of powerlessness. They felt they were treated as outsiders rather than included in the clinical whānau. The participants acknowledged that the clinical practices they were placed with during RHIP exemplified for them an understanding of the importance of being Māori. They saw themselves as being valued and noticed while learning to be nurses in an interprofessional healthcare team. Through the sense of being valued as Māori who were nursing students, the participants spoke of how they have since attempted to actively bring the connections they felt through whanaungatanga into their clinical practice as registered nurses rather than hiding being Māori.

Mackie and Smith (1998) established that self-esteem is influenced not only by our attributes but also by the collective attributes of the groups with which we identify. When belonging to a social group – Māori – is not valued in the clinical or educational space, it is not surprising that Māori may choose not to claim their identity as Māori. Durie (2005) suggested that Māori students experience diverse realities and that ethnic identities may take various forms in response to the context in which they are shaped. This was evidenced by the participants when they suggested they left their Māori selves at the doors of their other clinical placements.

I heard Whaea Moe Milne speak of the struggle to reclaim being Māori when the expectation of becoming a nurse has been to leave being Māori behind (Wintec Workshop -Takarangi framework, 2017 Kai Tiaki editorial team, 2017). As discussed in chapter one, this phenomena for nursing is not new (Wilson & Baker, 2012; Wilson et al., 2011; Simon, 2006). Durie (2017, p.10) has noted that 'the challenge is to adopt and support programmes that foster a secure cultural identity so the Māori might live well as Māori'. The participants in this study celebrated the RHIP programme, fostering a place where they could be Māori.

Communal living together was seen as necessary; being in the flat meant more than just living together for these participants. It was seen as foundational to how the

students connected with each other as whānau, with each other's professions, the wider community, and the clinical practice community. Māori culture and society emphasise ideas of relationships between individuals, communities, and their physical environment. The value of communal living was fundamental to Māori; pre-colonisation and the urbanisation that occurred post World War II, iwi were working and living together and contributing to the wellbeing of the iwi collectively (Barlow, 1991). From the first opportunity for whanaungatanga, the participants felt a sense of a common purpose and the way that they then paddled what they termed as their waka (metaphorically speaking) together for an effective outcome in the RHIP experience. Living together in the flat (shared accommodation), the participants were able to play, work and learn together, supporting opportunities for personal and professional development. As Māori, we do not just learn from people but also from connecting with the whakapapa of the rohe here, the multifaceted, interconnected te ao Māori worldview is seen in action, and in fact, the Pākehā view becomes the 'other' (Stucki, 2012).

6.5 Kaiwhakatere (Navigators/Leaders)

Connecting with others as whānau does not happen out of the blue; there needs to be navigators, leaders, and recognition of how each person will contribute to the relationships. The participants spoke of many kaiwhakatere; however, one RHIP leader worked openly with the participants to make connections from the first meeting through whakawhanaungatanga. There was support in connecting the RHIP colleagues first with each other and then with the wider support group, community, and clinical practice. Through this connection, the participants were invited to become members of their flat whānau and wider collegial interprofessional whānau. They became extended whānau, making connections that allowed them to work together.

For health professionals to be able to work with people in this way, they must be culturally competent and able to understand the needs of the students beyond their professional clinical knowledge development (Waikari, 2012). What was clear from the participants was that this kaiwhakatere navigated with them and with a quality and style of true leadership that guided them on how to get the most out of this clinical experience.

This study found that having someone who was a leader or navigator, not only in the rural community but also for the ākonga (students,) was pivotal in creating the sense of 'coming home'. This conscious process of building relationships is a clear expression of whakawhanaungatanga (Crocket et al., 2017), which underpins the sense of belonging as Māori wherever we may be. The participants also spoke of this person concerning their leadership as someone they could call on, who would speak on their behalf.

The findings indicate that the experience on many levels was underpinned by manaaki; however, the participants reported the generosity and care given by this rangatira as being like that of a Nan or aunty rather than someone who was supervising and supporting the clinical placement. This was seen when the participants spoke of getting calls just to check on them, or after they had completed their clinical and undergraduate degrees, a message to say congratulations on nursing state finals – 'welcome to the profession' when passing state. Again, demonstrating connection and valuing of the student and their developing practice.

Such leadership can be aligned with the attributes of modern Māori leadership. These are portrayed as demonstrating the following qualities:

- Te kai a te rangatira, he kōrero – The food of a rangatira is talk.
- Te tohu o rangatira, he manaaki – the sign of a rangatira is to look after others: generosity.
- Te mahi a te rangatira, he whakakotahi te iwi – the work of the rangatira is binding the iwi (Bishop Bennet cited in Katene, 2013).

What is clear from the findings is that they navigated with the participants in a way that was meaningful and connected with them as Māori. In fact, the kaiwhakatere that the participants spoke of most frequently is not Māori.

The kiawhakatere were not all engaged in the participant's clinical practice; there was also a strong engagement and partnership with the iwi of the area, Ngati Tūhoe and Te Whānau-ā-Apanui. These Aunties and some uncles shared their whakapapa, pūrākau (stories) and tikanga in the same way as the techniques of ancient Māori navigators (Katene, 2013). The kaiwhakatere were essential sources of inspiration for the participants, both professionally and personally. They also motivated the participants

to know more about their own story as Māori. They shared local tikanga with participants and an understanding of the impact of colonisation on the people there. The participants spoke of that through kōrero with these kaiwhakatere; they could use these understandings in clinical practice to better support the patients. Overall, the approach placed Māori at the forefront of the programme development and involved Māori in the decision-making process at every level. More importantly, many aspects of the planned clinical experience are deeply rooted in Māori ideals with the vision to improve the well-being of rural Māori whānau (Crocket et al., 2017). This was apparent in the stories shared by the participants.

Clinicians (health professionals) were also seen as kaiwhakatere in practice. Participants spoke of being with them and developing rapport and trust. This enabled the participants to fully engage in teachable moments while in clinical practice, including seeing themselves in rural clinical roles as Māori who are nurses. To allow learning opportunities, a mindset of engaging the learner is needed. This requires that the clinical professional remains focused positively on the student's learning experience working with them in the fast-paced clinical environment (Borrott, N., et al., 2016). Being culturally safe is not new to New Zealand nursing practice; it was introduced following the foundational work of Ramsden in a scrutiny of the strength of alignment with Te Tiriti o Waitangi within cultural competence documents for regulated health professionals in Aotearoa New Zealand (1994). However, implementation remains varying in practice (Manson 2017). Heke et al. (2019) reveal that, at best, cultural competence has been inconsistently articulated by the 18 current regulatory bodies. This has resulted in there being erratic implementation and practice. This is despite cultural safety being a legislative requirement for nursing and other health professional practices since the early 2000s (HPCA Act 2003; Te Kaunihera Tapuhi o Aotearoa, 2011).

The role of kaiwhakatere was significant in all the whakawhiti kōrero and the various ways they supported the participants in making connections. This was a role that was evident from the first whakatau (welcome) to when the ākonga did their presentations at the evening poroaki (farewell). The kaiwhakatere were there in the beginning, supporting connecting with the community “we started at the Marae, and that was a good sense of, I don’t know, connecting to the community, and it was quite different.” Student ID 18017938

The Kaiwhakatere that supported them on the noho and the tangata whenua (local people) connected them to the whenua (land) and the whakapapa (genealogy) of the rohe (area). Connecting on all these levels is encouraging and beneficial for one's self-esteem and was built on by more than one kaiwhakatere. However, the nursing kaiwhakatere were seen as inspirational, offering a clear example of what the participants could become (Katene, 2010, 2013). The nursing kaiwhakatere had almost dual roles in that, at times, they were also tuakana (the older sibling) guiding the teina (younger sibling) in the participants' nursing practice.

Mā mua ka kite a muri, mā muri ka orā mua – those who lead give sight to those who follow, those who follow give life to those who lead. This whakataukī expresses the need for leaders for others to follow and aspire to be. As first described in chapter five, known attributes of Māori leadership were evident with those kaiwhakatere the research participants saw as aunties, uncles, and nannies. The participants used names for the kaiwhakatere that would more commonly be used with whānau members, expressing both the connection they experienced and the safety of the relationship they established. This further embodies the Māori concept of tuakana -teina or relationships between older and younger siblings. When this Māori concept is considered in a learning context, it can describe the relationship between the educator and the learner (Winitana, 2012). Relationship building among clinical practice professionals is expected in a dedicated clinical placement. What was noticed by the participants was the connection with the wider community, those outside of nursing, and the practice placement.

This community of leaders left the participants feeling valued and connected, enhancing their sense of self-worth. Practices such as these are mana-enhancing, where the relationships between people are beneficial to all and built on practices of manaaki and reciprocity. Ruwhiu (1999) spoke of mana being a cultural adhesive that can be enhanced when Māori experience their cultural realities and contexts positively. The participants saw the potential of their influence as Māori in health care, and to lead inherently through this, their mana was enriched.

6.6 Āko

The participants identified collective learning as an important aspect of the RHIP programme. There was formal and informal learning, which, when considered alone, were not unique. What was noticed was that the learning together was in safe physical and emotional spaces. These were places where they felt connected, belonged, and accepted. The RHIP programme for the participants appeared to do this by simply emphasising the facilitation of success for Māori through culturally specific ako techniques. For example, sharing cultural knowledge through the stories shared at the noho marae helped the participants to better understand their patients when they were working with them. Learning such as this was both informal and formal, and participants recognised learning in clinical and personal spaces, allowing them to explore concepts safely underpinned by the reciprocal process of learning and kotahitanga (working together).

Learning with and from each other meant that, for the participants, individual professional roles became clearer as well. This immediately strengthened their clinical practice within the interprofessional team and had a cumulative effect on the participants' Māori and professional identities. Such learning together was, as discussed in chapter three, a benefit of interprofessional education in other settings.The participants in this study felt seen and valued as Māori with valuable Māori mātauranga in their shared accommodation, clinical placements and with the wider RHIP whānau. They were there as Māori, centred in the learning experience being offered.

The recent formation of Te Aka Whai Ora (Māori Health Authority) has been celebrated across Aotearoa New Zealand (Came & O'Sullivan, 2021; Baker, 2022). The formation of the authority is seen as a significant investment in operating differently through indigenising the health system to understand and respond to the needs of whānau Māori (Te Aka Whai Ora Māori Health Authority, 2023a). One of the goals is to grow the Māori workforce by ensuring Māori have a clear pathway to hauora health mahi (work), and that whānau will be the voice and capability that drives the design and delivery of services (Te Aka Whai Ora Māori Health Authority, 2023b). This echoes a move by the tertiary education sector of increased attention being placed on putting

learners back at the centre of work-based training (Te Pūkenga New Zealand Institute of Skills and Technology, 2022)(Te Pūkenga, 2023). Much has been written about changing the educational models for marginalised students, but this still seems to be lost amidst an (as yet) unchanged approach to nursing education, which has an exclusive focus on individuals and generalised approaches. This generalised approach to nursing education is coupled with the Aotearoa New Zealand dominant Western biomedical healthcare delivery model. Both tactics are disruptive to Māori educational kaupapa and the fundamental holistic nursing ideology.

What is needed in nursing education are clinical experiences that reflect the importance of being Māori and value the delivery of health professional education in a Māori way. Such experiences need to engage in a considerate and genuine connection to the land, language, whakapapa of the iwi (tribe), hapū (subtribe) and the kaupapa whānau, alongside a more reciprocal relationship between the kaiako (teachers) and nursing student or better still using a model of tuakana and teina. Rather than the long-standing separated roles of teacher and learner, kaiako and nursing student roles can be a mutual relationship, with both learning from each other (Ako Aotearoa, 2019, Pere 1994). During the RHIP placement, the participants valued connections such as these and how they were integrated into and recognised within the RHIP clinical experience. The relational engagement with ākonga legitimately invited them to be part of the health team. With the recent overt shift to an ‘equity lens’ both in health care and education (Ministry of Health, 2022, Mana Tohu Mātauranga o Aotearoa New Zealand Qualifications Authority, 2021), the findings from this study offer some practical ways forward to address what have been significant negative outcomes in the past for Māori. Through authentic engagement with the community, the programme has provided an environment that is welcoming of Māori values and strengths and offers an opportunity to change the known approach of deficit theorising.

The findings from this research highlight the difference between ongoing colonial biomedical models of clinical learning and one that is community-centred, underpinned by engagement with tangata whenua, which represents a developing authentic Te Tiriti of Waitangi relationship representing partnership in action. The findings offer an understanding of pedagogical practices that acknowledge the centrality of Māori identity in nursing practice. These understandings can be adapted

and used to further inform planned clinical experiences for Māori nursing students in other clinical practice areas, showing a potential way to steer the metaphorical nursing education waka. A programme that is established in partnership with Māori as the RHIP programme has been one way to offer increased opportunities for collective learning. Underpinned by Māori collaborative values, it is a way to offer increased opportunities for collective learning. Co-creating the programme has meant for the research participants that, as Māori, they were not expected to fit into the RHIP programme; instead, te ao Māori has been embedded into it so they could simply be.

6.7 Ko Au (I Am)

From this study's participants, we know that many enduring threads have bound them together. This process began with whanaungatanga, in that it was an intentional process. Alongside this sits the relevance of whakapapa, not in the typical Western concept of genealogy but in the broader mātauranga Māori understanding. The findings from this study suggest that being part of the collective by intentionally relating people to the rohe, the reo, the belief systems, and traditions authentically is an underpinning pou (symbol of support) for being able to see themselves as Māori who were wanting to become nurses. The collective roles and responsibilities that the research participants identified exemplify how Māori operate. Largely, identity is negotiated, specified, and created through our interactions with others, such as whānau and peers, as well as through racial, social, and political messages. Critical influences of Māori identity are connectedness, belonging, knowing what being Māori means, where they come from and what connects them to others (Kukutai & Webber, 2017). Such connectedness is also a response to the colonial assimilation which has been in place for more that 120 years (first discussed in chapter two).

Racism continues to play a significant role in defining how Māori construct their Māori identity. Standard-stream tertiary education primarily maintains a monocultural approach, which is portrayed as 'normal' (as discussed chapter two), which means programmes such as RHIP are positioned as exotic and other (Came et al., 2018). Notions of Indigenous students walking in two worlds (Fish et al., 2022; Walker, 2015) and needing to navigate culturally unsafe experiences are not new (Wilson et al., 2011). In this study, when participants spoke of other clinical experiences, the

experience was similar. In their other clinical experiences, the participants spoke of hiding being Māori (acculturation) or not feeling they were connected to the clinical area. They expressed that they felt rāwaho (outsider, from the outside) and described the need to park being Māori at the door of the educational institute or areas of clinical practice.

Conversely, RHIP was a place where they saw themselves flourishing without needing to fit into the imposed worldview of colonisation, most powerfully expressed by this participant when they acknowledged a feeling of "*stepping into my power".* In this sense, the RHIP programme has been underpinned by and actively practised Māori values and offers a way for nursing students to embrace being Māori, whereas the 'ticking of the cultural' box in other placements has resulted in the research participants feeling their mana has been diminished. The theme of being seen as Māori, ko au, was intertwined with the notions of being valued and recognised and was also present in the finding whānau theme.

Tame Iti, in his 2015 TedTalk, tells us that mana bridges you to your past, present and future. Reverend Marsden (2003) likened mana to charisma – connecting the gods with their human agents through which the power of the gods is manifested. As a rule, mana needs to be respected, and engagements need to enhance the mana of the participants. Historically, mana comes from the parents, with each individual being born with an increment of mana. However, a more modern interpretation includes all individuals' ability to have their mana enhanced through their achievements and with the support of others (Mead, 2016).

Conversely, mana can be diminished when individuals are silenced, ignored or disrespected. Unfortunately, for the Māori participants in this study, more often than not, they reported that clinical practice experiences outside of RHIP were mana-diminishing rather than mana-enhancing. They saw many of these clinical experiences as aggressively monocultural, where they were actively prevented from being their authentic Māori selves or until their shifts were completed. As one participant expressed, as Māori, they were used to meet a need without understanding.

> We started to hui. And then halfway about 10 minutes into the conversation, the facilitator, who I'm not sure identifies as a Māori

> then said ‘oh we should really go back and do karakia first’ and we'd already started and my boss then said to me – inside I went oh here it comes – “you can say it” ... I didn't feel safe doing it…there was no one else I felt I felt safe with there. I was wearing my taonga [clasped their pounamu toki] as I am today, and as everyone shuffled around the papers, one of the other participants went, oh there’s Māori words in here, big Māori words…And I just sat back in my chair, and I put [showing moving their taonga inside their shirt] - and I left it there. It didn't feel nice, it didn't feel good. That is how I felt going on to other clinical placements, too. Where they claim to look after the health needs of all, our Māori. But there's nothing really Māori happening around here (Participant GG).

Mead (2016) spoke of how mana can be affected concerning what he terms ‘principles of identity’ and whakapapa (Māori kinship systems). The participants expressed they felt seen and that the RHIP clinical placement was a partnership of practice. They were included in the decisions made around their learning needs. In the clinical areas, with their flat (roommate) whānau and their RHIP Auntie (Kaiwhakatere), there was a genuine interest in what they expressed as their ‘real’ needs. Re-iterating the notion of being wholly seen, they felt supported to be their best versions while on placement. They also described a desire to pursue being the most authentic versions of themselves when they returned home from the RHIP programme to navigate through their final year of study and into their first years of practice. Such ideas of being seen embody what Ramsden (1992) first proposed in kawa whakaruruhau and what would become the development of culturally safe nursing practice. It also represents Freire’s (1972) notion of conscientisation, which is developing a consciousness that has the power to transform reality, which in this case involves empowering Māori to be Māori. Participants' descriptions of other clinical placements highlighted transactional Western ways of working with students in which they did not feel they were seen as part of the clinical team and that they endured as outsiders. Being positioned as an outsider reinforces the discourse of deficit thinking. Deficit thinking is a discourse of negativity and disempowerment (McCallum, Ryan, and Caffery, 2022), which is evident where Māori ākonga fail to succeed academically, ultimately diminishing their mana.

6.8 Moving Māori achievement policy off the shelf into practice

This study illustrates mātauranga in action. As first discussed in Chapter 4 (Methodology), mātauranga is knowledge that helps Māori to feel comfortable with all things Māori (Mead 2016). There is an organic nature to mātauranga, as something that is constantly evolving. In a clinical practice setting, mātauranga can be an underlying knowledge that is able to guide clinical practice and understanding (Durie, 2017). Critics such as some University of Auckland professors and emeritus professors (who became known as the Listener Seven) penned a letter arguing that mātauranga falls short of being science, stating it was an important concept but merely a cultural practice (Clements et al., 2021). They asserted that its significance lies in cultural preservation and that although it may in some way advance scientific knowledge, it is not science. This is yet one example of the practice of colonisation where Indigenous knowledge is presented as having no value in today's world, perpetuating a belief that mātauranga has remained unchanged since colonisation and, therefore, has nothing to offer. The reality is that the philosophical and practical underpinnings of mātauranga hold true today, as they did in the past and will into the future (Mead, 2016).

Mātauranga understandings from the past in this whakatauāki: “ka pū te ruha, kahao te rangitatahi” – “Once the old fishing net is worn, it is put aside to make way for the new fishing net” (Brougham et al., 1987), can be applied to modern understanding and development of knowledge. In this research, I suggest that the old net is the current dominant Western, professionally siloed clinical learning, which is the primary clinical learning model in use in Aotearoa New Zealand. The new net would relate to culturally inclusive programmes such as RHIP that incorporate funded accommodation and interprofessional learning, which then changes the situational nature of clinical education. The new net forms a space where Māori learn in a way that embraces and enhances their Māori identities.

The experiences of Māori who choose to study and become nurses are reflective of the experience of Māori in much of tertiary education; that is, that study has a detrimental effect on their identity (Walker, 2015; Wilson et al. 2011). Detrimental in that the experience asks Māori to disengage from their language and culture, to adopt and assimilate the dominant Western models of health care being taught in schools of

nursing and practised in clinical settings. Added to this is that, as a result of generations of colonisation, a large number of Māori may enter tertiary education with little knowledge of tikanga and te reo Māori, which are considered integral cultural indicators of being Māori (Stewart, 2021b, Kukutai and Webber,2017). This was not different for the participants of this study, where they had previously experienced a homogenous approach to student clinical placements and tertiary learning and had varying knowledge of tikanga and te reo Māori. The participants spoke of wairua (spirituality) in the placement.

The education provider for this RHIP was an ITP, with none of the University programmes participating. However, there has been a substantial change in the way ITPs have been framed with the development of a national provider (Te Pukenga, 2022). With the advent of Te Pūkenga's nursing curriculum, there is an opportunity to envision the potential of an educational partnership model or to hūtia te punga (lift the anchor) to lift the metaphorical anchor in nursing education. In June 2022, Te Pūkenga consulted with nursing education and industry partners on their Bachelor of Nursing Māori draft. The resulting curriculum change intends to support addressing health inequity for Māori, to respond to the findings from the Waitangi Tribunal in the Wai 2575 report and to further strengthen and develop nursing practice in Aotearoa New Zealand (Te Pūkenga, 2022). They state, "In meeting the needs of tangata whenua/Māori the nursing profession is responsible for providing *health services that authentically sustain tikanga and te reo Māori concepts. Providing authentic health services begins with the preparation of our future Registered Nurses*." (BN Māori June 2022). Using the Values of Te Pūkenga, they have mapped out how Māori who wish to become nurses can be successful in this programme, which is summarised in Figure 10

Figure 10:
Te Pūkenga Bachelor of Nursing Māori Consultation – Te Pūkenga Values alignment p28 -2022

Manawa nui

For nursing this Te Pūkenga value means being open and welcoming of all people and what they bring to care interaction – a "strengths-based approach" to care where the individual and their whānau are the experts in their own health and wellbeing. Recognising we as nurses are part of a bigger picture and seeking the expertise of others to support the best outcomes for whānau.

1. Apply interpersonal, therapeutic communication and relational practice skills as key to health consumers, their whānau, hapū, iwi and hapori centred nursing care (*Domain 2, 3*)

2. Collaborate as part of the interprofessional team in the delivery of safe and authentic nursing care for health consumers, their whānau, hapū, iwi and hapori. (*Domain 4*)

3. Apply Kawa Whakaruruhau philosophy and principles in the delivery of culturally safe nursing care, that results in equitable health outcomes for health consumers, whānau, hapū iwi and hapori (*Domain 1, 2*)

Manawa ora

For nursing, this Te Pūkenga value means we as nurses are not the expert in all things and will work together with whānau and colleagues and utilise research findings to continually improve care and care outcomes.

4. Be safe and competent beginning registered nurses who meet the Nursing Council of New Zealand Competencies for the Registered Nurse Scope of Practice; (*Domain 1, 2, 3, 4*)

5. Work with health consumers, their whānau, hapū, iwi and hapori across the lifespan within dynamic regional, national, and global healthcare and political environments; (*Domain 1, 2*)

6. Utilise science, critical thinking, clinical reasoning, and reflexivity to deliver evidence-based research and rangahau in the management of nursing care for health consumers, their whānau, hapū, iwi and hapori; (*Domain 1, 2*)

7. Deliver nursing care that is underpinned by; lore, tikanga, morals, beliefs, values, legislation and ethics (*Domain 1, 2, 3, 4*)

Manawa roa

For nursing, this Te Pūkenga Value means we will take individual responsibility to uphold the mana and integrity of care planning and provision with colleagues and whānau alike.

8. Provide management of nursing care grounded in Te Tiriti o Waitangi and Mātauranga Māori (*Domain 1, 2, 3*)

9. Role model leadership based on resilience, self-awareness, a commitment to continuing professional development and life-long learning (*Domain 2, 4*)

The changes being made with Te Pūkenga are reflective of an increased recognition of the need for more culturally appropriate approaches to education, which has resulted in a push for a change in the educational landscape ("Education and Training Act 2020"; Ministry of Education, 2020). At the time of the final review of this study, in just

three short years from its inception, Te Pūkenga has been dissolved (Simmonds, 2023). What this means for the delivery of nursing education in the ITP sector is unknown at this time.

What is becoming apparent is that many educational providers have struggled to move these theoretical frameworks from the bookshelf into successful operation in practice. Stewart (2021b, p 2) uses the metaphor of "smoke and mirrors" for a deceptive or flimsy execution when it comes to culturally responsive pedagogy. Stewart goes further to suggest that this does not solely lie in policy development but, in fact, can be related to some key factors. For example, Māori knowledge or forms of Indigenous knowledge are now used as umbrella terms in that they speak to collective mātauranga Māori (knowledge). Considering mātauranga Māori in this way is another restrictive post-colonial notion. Pre-European Māori identities (and therefore knowledge) would have been hapū and whānau (tribal/ kin) based rather than the current prevailing notion of national collective knowledge (Haurak, 2020, Stewart 2021a, Walker 1989). Mahuika (2011) notes that if policies aim to support Māori to connect with their identity, language and culture, then there are inherent limitations. Current tertiary education policies and the potentially the now defunct proposed Te Pukenga nursing curriculum imply there is only one way to act, one way to be Māori, using a one size fits all approach that is the current practice with nursing education in the dominant Western delivery models (Stewart, 2012b). This assumes that all Māori learners are entrenched in their Māori culture, creating the illusion (smoke and mirrors) that these policies will help all Māori learners (Stewart, 2012b). This approach patently fails to address the needs of Māori who are disconnected from, or only recently reconnected to, their culture and trying their best to survive in a post-colonial society (Stewart, 2012b).

Came and Humphries (2014) go further to suggest that senior managers in health services perpetuate the concept of master narratives where institutions do things without questioning the status quo. They described the way that examining existing master narratives can reveal privilege and how they act to maintain inequitable outcomes. The examination of such narratives can provide insight into ways they can be disrupted to introduce remedies, including the amplification of mātauranga Māori in those spaces. These master narratives also enable institutional racism to prevail

within the health and educational systems (Waitangi Tribunal, 2019, Kidd et al., 2022; Walker, 1989) by maintaining a monocultural approach to health professional education and health care delivery. The RHIP programme is challenging this existing master narrative. The regard for Māori values and practices articulated by the research participants in this study highlights the potential to strategically overcome monocultural education and underlying structural racism, while supporting Māori to connect with their identity.

The participants struggled to articulate how the experience impacted their identity as Māori directly, however their stories of being on RHIP revealed the richly interwoven ways in which Māori make sense of themselves. What the participants recognised is the significance of manaakitanga, rangatiratanga, tikanga, ake, and whenua as guiding values of being Māori. However, the most significant value the recognised was mana tangata, the notion of personal authority. For the participants, this was embedded in being seen as Māori and being valued as part of the clinical practice whānau.

The RHIP programme offered education underpinned by whanaungatanga (connectedness), aroha (empathy and compassion) and mana (power and status) enhancing interactions (first discussed in Chapter 5). By implementing an approach of working with and alongside ākonga, RHIP challenges the dominant “expertise of the clinician” (Western) model of learning. This demonstrates the application of an approach that reflects Māori collective understandings, acknowledging the belief that every person is a learner from the time they are born (Pere, 1994). It recognises that in ako, we all have meaning to offer to an experience and that learning can be achieved through actively building relationships and valuing the resulting relational practice. This notion is discussed previously as a tuakana teina approach to learning though leadership (discussed in chapter 5.3). Underpinned by the idea of collective learning and the desire to uphold the mana of the people involved rather than that of the individual alone (Winitana, 2012). This programme gave the participants hope that things could be different and more genuine. It also enabled them to see themselves as part of that difference.

As in any culture, there are multiple ways of being Māori, none of which are more tuturu (authentic) than another (Penetito, 2011). While continuing to question the

definition of a single Māori understanding, Stewart suggests that potential knowledge areas that can be seen as collective 'Māori knowledge' include language, values, facts, metaphors, narratives and perspectives (2021a, p51). These six areas of 'Māori knowledge' were evident throughout this study, despite there being an absence in the RHIP of specific Māori models of practice that are commonly used in the education and health sectors. Nonetheless, a feeling of authenticity was achieved in the RHIP programme for the participants, enhancing mana and re-enforcing the research participants' own sense of personal power.

Gan, Heller and Chen (2018) argue that a state of authenticity breeds a sense of power and can overcome hierarchical power. In this study, authenticity related to the participants' sense of being themselves as Māori in practice and not being asked to walk in different shoes but being enabled to be themselves. The participants reflected on power as having better relationships with other professionals, which subsequently meant others saw their value as nurses. They also saw the power in being able to practice authentically as Māori, using themselves entirely in developing their therapeutic and professional relationships (as discussed in chapter 5)

In Aotearoa New Zealand, there have been many policy and practice drives both in education and health practice with the intent of recognising and strengthening te ao Māori and identity (Crawford, 2016; Ministry of Health, 2016; Stewart, 2021b), but the question remains; can one approach (single policy) meet this need? From this study, it is apparent that an educational placement underpinned by te ao Māori and engagement with iwi and hapū, rather than policy or models, offered a clinical practice that supported the participants of this study.

6.9 Ōritetanga

The findings from this study speak to how placements other than RHIP for the participants embodied normalised racism within the health sector and that a te ao Māori kaupapa is seen as exotic and foreign, and perhaps even in the proverbial 'too hard basket' for programme providers. Came et al. (2020) suggest that this reflects a singular approach to dealing with racism. For example, the development of a singular framework or a policy rather than:

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

Anti-racism theory in Aotearoa New Zealand argues that engagement must be centred on Te Tiriti o Waitangi and involve tangata whenua and tauiwi (Kidd, Came & McCreanor, 2022). They call for an inclusive Tiriti approach, reminding us that racism and, therefore, anti-racism is multifaceted and requires innovative, actively transformative approaches in both the health and educational sectors. However, with both the health and education sectors engaged in the socio-political denial of racism, they have been resistant to change from both within and from the outside (Came et al., 2020).

Equity in both health and education requires the provision of different attention and resources for groups whose outcomes and experiences are affected adversely so equality of access, status and outcomes can be achieved. What is known is that differences exist between groups in service access, status, and outcomes. These differences are underpinned by social justice (Waitangi Tribunal, 2019).

To meet the need for equitable outcomes and overcoming racism means more than just changing curricula or, as Stewart (2021b) suggested, the language of curricula without action. Came et al. (2020) captured it when they suggested *for transformation to occur, te upoko (the head, intellect), te ngakau (the heart and feelings) and nga ringa (the hands) must be engaged (p937).* Without this, a power imbalance that has pervaded health delivery and resulted in health providers failing to meet Te Tiriti o Waitangi obligations (Waitangi Tribunal, 2019) is set to continue even in these times of significant sector reform.

The RHIP programme is an innovative initiative that has been developed collectively with iwi and hapū of the region. It has shown in this piece of research to address the needs of Māori while working with both tangata whenua and tauiwi stakeholders in the development of the clinical experience. Connecting does, however, need to be a process of genuine engagement with tangata whenua rather than just the appearance of consultation. Much like the relationships discussed earlier in this chapter,

particularly related to whanaungatanga and whānau, engagement is more than just an encounter. It means that Māori aspirations and values underpin the clinical placement experience for the interprofessional health ākonga on the RHIP programme. Such engagement encompasses tino rangatiratanga and can be a step in the direction of decolonisation.

6.10 Implications for clinical education provision

This study has raised several issues for health professional education, particularly nursing, to consider.

6.10.1 Engaging with Iwi and hapū:

Some aspects of the RHIP programme should be considered non-negotiable and fundamental to the implementation of any clinical model underpinned by te ao Māori principles. This includes an investment of time and resources in engaging with the iwi and hapū of the rohe where the clinical placement takes place. Māori must be included in and have a voice in all the planning, implementation and evaluation phases.

6.10.2 Practice environment:

Participants in this study thrived in a clinical practice programme delivered within a challenging rural environment with the added complexity of a dedicated interprofessional practice development lens. The focus of the delivery was on whanaungatanga, connecting participants with each other, with hapū, with practice and with the whenua. These efforts were not cloaked in a Māori model of education or health but focused on sharing the stories and joy of living and practising in rural Aotearoa New Zealand. Efforts are needed to ensure that clinical practice environments connect the students with the people and place.

6.10.3 Communal living:

This research revealed the significance of social interactions and learning in everyday life. Being present with each other over food and in the quiet, safe spaces of our private environments, and emphasising the collective learning in which we thrive as Māori. *Ki te kotahi te kaakaho, ka whati; ke te kaapuia, e kore e whati – if a reed*

stands alone, it can be broken; if it is in a group it cannot (Kingi Tukaaroto Matutaera Pootatau te Wherowhero Taawhiao). This whakatauāki emphasises how this private knowing of each other further developed the ability to work in an interprofessional team, which enables healthcare professionals to champion better care outcomes for patients and whānau in practice.

6.10.4 Kaiwhakatere (Navigators):

This research has revealed that the role of the navigator(s) cannot be underestimated. These need to be people who are seen as legitimate members of the practice community to broker clinical and local relationships, particularly with iwi. Their knowledge and connections in the rohe, with the tangata whenua and practice spaces, bring further recognition of moving beyond superficial consultation to engagement and partnerships with iwi, hapū and whānau. They are needed to develop clinical experiences that connect ākonga with the people and their needs and with their role in a health professional team.

6.11 Summary

In this chapter, I have presented a discussion related to the findings of 'Coming Home'. I have emphasised the need for Māori values and beliefs to be at the forefront of clinical learning experiences for Māori who wish to become registered nurses. Highlighted are how other clinical experiences have left the participants believing they must assimilate to a Western way of being and thinking to achieve the expectations of the clinical placement (Brewer et al., 2013; Kent et al., 2016; Mpofu et al., 2014; Seaman et al., 2016).

I have discussed how the delivery of the RHIP programme supports Māori identity and how it offers a way for Māori who wish to become nurses to experience a clinical practice that enhances mana. This piece of research provides some critical insight into designing clinical practice experiences that meet the needs of Māori who are studying to become nurses. I have described how this approach has been able to shift Māori achievement educational policies from the shelf into practice. The changing landscape of both education and health funding also allows for the consideration of using other models of delivery that may have been seen as cost prohibitive in the past.

Internationally, much has been written about the need for strong interprofessional teams in the delivery of health care (World Health Organization, 2010; Darlow et al., 2016; Frenk et al., 2015; Gauld, 2018; McKinlay and Pullon, 2014). However, in Aotearoa New Zealand, there is a limited focus on dedicated interprofessional clinical practice placements. Rather, interprofessional learning, and team development has been left to chance in clinical learning rather than being actively facilitated and planned for as it is during the RHIP clinical experience. It is curious that Aotearoa New Zealand, has been slow to take up dedicated interprofessional educational placements since relational practice and collective learning are inherently aligned with te ao Māori values. Such purposeful collective interprofessional health delivery is positioned to deliver a service that can be more recognisable to Māori.

The changes that are recognised in the education of health professionals with a focus on nursing from this study when applied will meet the needs of Māori, the call for equity and the indigenising of hauora health mahi. These changes are beautifully captured in this whakataukī: *Tūngia te ururoa kia tupu whakaritorito te tutū o te harakeke.* Set the overgrown bush alight, and the new flax shoots will spring up. This metaphorically reminds us that to change, we may need to leave some ways behind to do things differently.

The final chapter will provide a conclusion to this thesis. I will review the research question in relation to the findings and provide an overview of this study's limitations and recommendations.

Chapter 7 Conclusion

Ko te kairapu, ko ia te kite

Ka kohi te toi, ko whai te māramatanga

Those who seek will find, if knowledge is gathered, enlightenment will follow.

This whakataukī reflects the journey of lifelong learning in becoming a nurse who will work to strengthen the health and well-being of Māori. The pursuit of profound knowledge is a pathway towards greater opportunities and one's goals and aspirations in life.

7.1 Introduction

Māori who have studied to be nurses and are now registered nurses are culturally diverse, and those who were on the Rural Health Interprofessional Programme (RHIP) clinical placement are no exception. What this study has revealed and confirmed is that using culturally safe practices is essential to the provision of safe and effective education for Māori studying health. It has highlighted that to do this effectively requires more than consultation with iwi and hapū. There needs to be an authentic engagement leading to the embedding of te ao Māori understandings into the approach and delivery of the clinical experience.

In this Chapter, I will review the research question and consider how the question was explored. I will discuss the limitations of the study and the ways these might be addressed. I will provide an overview of the implications and recommendations identified through the research process. The thesis will end with some of my concluding thoughts related to my observations throughout the research process and my hopes for the work going forward.

7.2 The research question

The idea for this study came from my observations that ākonga (students) returned from their RHIP clinical placement noticeably changed. In this study, I explored what changes were happening and how those changes occurred. In consultation with my

supervisors and Māori nursing colleagues, I developed the following research question to direct the research design:

'How does an undergraduate placement in a rural interprofessional programme influence Māori nurses' identity and nursing practice?'

This study sought to uncover the experience of learning for Māori nurses in a rural interprofessional clinical placement. A particular focus was on how this placement supported (or did not support) the development of their identity, nursing practice, and interprofessional collaborative practice.

7.3 Whakapapa of Education in Aotearoa New Zealand post colonisation

The post-colonisation history of education, both for tertiary learning and nursing, is an important starting point for understanding the current context. Education for Māori was developed and positioned to foster assimilation and to position Māori as less capable of academic achievement. Calman (2012) cited Henry Taylor (1862) from an Appendix in the Journals of the House of Representatives:

> 'I do not advocate for the Natives under present circumstances a refined education or high mental culture: it would be inconsistent if we take into account the position they are likely to hold for many years to come in the social scale, and inappropriate if we remember that they are better calculated by nature to get their living by manual rather than by mental labour.

This racism continues to impact modern education, with re-introduced policies and approaches to support Māori educational achievement still not achieving educational equity for Māori (Stewart, 2021b; O'Regan, 2023). These frameworks and approaches remain exotic or different, and, to date, little is known about how standard stream programmes have integrated or used te ao Māori values and pedagogical approaches to support student learning. And as was demonstrated in Chapter 2, even less is known about how these programmes have influenced Māori identity.

7.4 Constructing the Methodology:

The methodological framework for this research was underpinned by kaupapa Māori theory and the intersecting lenses of critical theory and constructivism. Undeniably, kaupapa Māori is the most culturally appropriate approach for research with Māori participants (Cram, 2001; L.T. Smith, 1999; G. H. Smith, 2017), as its intrinsic decolonising intent aligns with the transformative–Indigenous research paradigm. The participants were interviewed using whakawhiti kōrero, a culturally appropriate approach to capture their understanding of the RHIP as a clinical placement. A follow-up virtual hui provided an opportunity for their constructive feedback on the provisional findings, offering their cultural confirmation of the analysis process and thematic findings.

A strength of this study has been allowing the participant's own words to be used whenever possible. The rich data from the kōrero I had with the participants and my field notes demonstrate the co-constructiveness of whakawhiti kōrero (Elder and Kersten, 2015). While some consider using interviews as the primary instrument for data collection a design limitation because of the ways an interview can be shaped (Thorne, 2016), the oral tradition of sharing stories is a strength from a Māori perspective, where the powerful reciprocal kōrero enhances our understanding.

The experience and the perceptions of the RHIP placement were explored with each of the participants. It is clear that Māori are not a homogenous group, and they did not all experience the RHIP clinical placement in the same way. Yet the placement resonated with the way these Māori nurses viewed themselves or wanted to be viewed. The ways of being and doing while on the RHIP placement allowed for a vision of what it is to be a Māori who is studying to be a nurse. Māori students were able to engage in a clinical experience that did not require that they mask or hide being Māori but that they could be their whole authentic selves in the RHIP placement. This kaupapa Māori study supports and acknowledges the participants' collective knowledge, voice and aspirations that are deeply woven into their identity as Māori throughout this thesis.

7.5 Implications and recommendations

The findings and discussion relating to this clinical experience have contributed to the body of literature pertaining to the education of Māori who wish to be health professionals, mainly to practice in rural community settings. Perhaps more significantly, it offers an alternative model of clinical practice to the current professional silo approach of learning as individual health professions and addresses some of the systemic issues related to workforce development and equity.

7.5.1 Clinical Practice Experience

Ways of optimising clinical practice experiences for Māori undertaking professional health studies need to be considered to address the long-standing assimilation approach in education and health. Culturally appropriate education frameworks are designed to meet the needs of ākonga Māori in the learning space and to support the achievement of the ākonga in their chosen profession of study (Stewart, 2021b; Ministry of Education, 2020). This is dependent on educators moving the developed frameworks off the proverbial shelf and implementing them. Programmes authentically underpinned by Māori values have the potential to create culturally responsive environments that optimise the experience of the students in that space. This was evidenced in this study through the adaptation of these approaches, which contributed to how the participants of this study saw themselves as Māori who were student nurses and made a tangible difference to their educational outcomes and practice as registered nurses. Achieving this required investment in authentic relationships with clinical whānau (clinical Practitioners and patients), hapū and iwi.

Whanaungatanga (connecting) ensures there are relationships with the students and that the students establish relationships with each other. However, the most significant connection for Māori is the relationship fostered with the tangata whenua and their stories of the people and whenua of the rohe (region). This allowed the participants to see themselves as part of the community and created a space where the ākonga were able to establish themselves and learn with a kaupapa whānau.

This study recommends that clinical experiences for Māori nurses need to be positioned beyond the physical location of the practice placement to include

connecting the students with the community, including to the iwi and hapū of the rohe (region). Then, there needs to be an active process of connecting the students with the clinical professionals, such as whakawhaungatanga.

7.5.2 Interprofessional Education

Health professional education programmes fundamentally continue to be taught in professional silos, where each prospective health professional develops and learns the art and science of their single profession. Yet, health delivery relies on a healthcare team to care for patients. There is an implicit expectation that the team approach is learnt in clinical placement without the need to be integrated into the standard health professional curricula. Internationally, there has been an increasing focus on dedicated interprofessional learning, recognising there is a need for collective learning opportunities and peer teaching across professions. Ako (collective learning) is a culturally responsive way of learning for Māori and contributes to students of all professions engaging in each other's clinical practice.

This study has highlighted the importance of kaupapa whānau and learning together in more spaces than just the work environment. The participants of this study valued the learning while being the ringa wera (hot hands – workers) at home, preparing meals, washing dishes, and enjoying kai together within their flat's private, safe space. This reflects establishing a place of wānanga (learning), although traditionally, we assign this meaning to a school. However, this study supports that we learn many things from our whānau before entering a dedicated whare wānanga (building for learning). Being immersed in collective learning supported by a kaupapa whānau more closely aligns with a te ao Māori understanding of learning. It establishes learning spaces where health professionals are able to work together in the clinical environment. Decreasing boundaries between professions can lead to shared knowledge and professional familiarity in the workplace. Such communities of practice enable enhanced communication between health professionals. This, in turn, supports meeting the needs of patients and their whānau as a team, thus supporting better health outcomes.

Planned interprofessional education experiences would be recommended from this study. Such an approach could offer opportunities for enhanced clinical teamwork resulting in better health outcomes for patients. Such a clinical experience needs to include ideally a noho marae (stay on a Marae) where the ākonga are able to engage in collective learning.

7.5.3 Re-imagining relationships with ākonga.

The participants in this study described how they were heard and valued as part of the clinical health team. The clinical team were practitioners who did not pass judgment on them, were interested in them as themselves, and valued them as members of the professional team. As discussed in Chapter 6, this is one way of supporting learning that aligns the mana enhancing principle of a tuakana (older or more senior) and teina (younger or more junior) relationships (Mead, 2016). The participants reported feeling being worked with rather than done to in their RHIP experience, leaving them with a sense of control over what they achieved on the RHIP programme. Enabling the participants in such a way as this is, in fact, the embodiment of mana motuhake (self-determination, autonomy, and control).

The relationships established were experienced as being authentic and, therefore, powerful. The genuine relationships and connections supported a sense of being in a safe environment, which, in turn, created space for being their authentic selves. The strength of an authentic relationship is said to be able to overcome hierarchical pressure (Maunz & Glaser, 2023). It is critical in successful clinical placements for Māori studying to become nurses. What was also evident from this study was the need for Kaiwhakatere (navigators/leaders), where the relationship is based on manaakitanga and reciprocity. This study found kaiwhakatere in many of the contextual connections the participants made. What was important was their ability to navigate with the ākonga to support the learning journey in more than the practice environment and to champion embedding them as community whānau in the fullest sense while on this clinical placement.

This study's complex, interrelated themes wove a whatu kākahu for the participants, offering them protection and strength, which meant they did not feel the need to hide

as Māori. As such, it allowed them to be intentional as Māori everywhere they were. O'Sullivan (2021) reminds us that citizenship is most simply the right to deliberate. What determines the effectiveness and fairness of a system is the where, how and why of the deliberation. The participants did not see themselves positioned to only be Māori on their marae or in their homes. They were able to show up in the RHIP programme as Māori citizens. In the context of being empowered to 'show up', the participants in this study can be seen metaphorically as coming home.

To enable Māori to be Māori where ever they are is the final recommendation of this study. To support this, there needs to be recognition of the need for leaders to navigate and teach. Such leaders need to be both from the community and from practice. In such a model, there is genuine potential to shift nursing education from a biomedical western model to one that embodies Mana Motuhake.

7.6 Limitations of the present study

There are some limitations to this research that must be acknowledged. The findings from this research are highly contextualised. The sample pool of participants was small (see Chapter 4) and included students who volunteered for the RHIP experience. Therefore, their experience may not reflect all Māori students on such a placement. This clinical placement sits within Ngāi Tūhoe rohe, and although the shared understanding of beliefs and customs amongst Māori is wide-ranging (Fox et al. 2018), the knowledge and traditional understandings may vary between iwi, hapū and whānau. The amalgamation of there being one Māori way is a consequence of our colonial past and needs to be considered in the context of multi-iwi research such as this study.

It is also essential to consider which voices are not present in this study. Despite using purposeful sampling to recruit a sample reflecting all the Māori nurses who had a clinical placement on RHIP, I was unable to recruit any participants from other kura (schools). I acknowledge that this study may have been strengthened had I been able to explore understandings and points of view from more participants educated in a more diverse range of kura.

A further limitation could be seen as my closeness to the research topic as a nurse educator who is Māori, but also as a nurse who is not fluent in te reo Māori and exploring their own identity as Māori. For example, I used a reflexive practice to explore my assumptions and beliefs, providing an example in the analysis discussion. However, my journey allowed for empathy with the participants and an interview approach that supported them to share their understanding of the RHIP programme openly. I also used the participants' own words whenever possible to allow their voices to be heard and visible rather than mine. Despite the several reflexive strategies I have utilised to visibly account for my own experiences, it could still be a case that my personal experience continued to influence the research in implicit ways.

7.7 Future Research

Initially, this study had intended to look at the impact of the interprofessional focused clinical in the participant's first year of clinical practice as a registered nurse. Although the whakawhiti kōrero did give an opportunity to include how the clinical placement experience was used in the first year of their practice as registered nurses, the participants made few comments regarding this. It may be valuable to explore this topic further in association with preparing work-ready nursing graduates in a future study.

Secondly, this study looks explicitly at Māori who were nurses; this means there remain gaps around what an interprofessional learning community residential placement means for other Māori health professionals. Future research with the other professional cohorts is required as this was not canvassed explicitly within this study.

Thirdly, this study highlights the need to develop a framework that could enhance any clinical placement, not just interprofessional placements as on RHIP. The te ao Māori principles and supportive ākonga, kaiako, organisations, hapū and iwi could be relevant across clinical settings to advance and strengthen nursing education for Māori. Further research is needed to test the usefulness (if any) of applying the recommended clinical framework in other clinical settings.

7.8 Concluding thoughts

The ongoing impacts of colonisation continue to be felt 180 years following the signing of Te Tiriti o Waitangi, with Māori experiencing structural and institutional racism throughout their engagement with both education and health services. Despite the status of being treaty partners in both education and health, the education of health professionals continues to primarily reflect a monocultural approach to clinical learning. As such, the approach maintains a method of equality of services rather than equity of outcomes. There is a responsibility in nursing education when honouring Te Tiriti o Waitangi to engage in transformative change to achieve equity for Māori. This study offers recommendations to achieve this in clinical learning practice in the community.

On a personal note, my experiences as a Māori nurse academic were challenged in the writing of this thesis. I was a kaiako of ākonga rōpū, who whakapapa Māori. The kaupapa of this rōpū is to deliver education reflecting a te ao Māori lens. Nonetheless, I realise I was not impervious to the demands of teaching and accepting processes that reflected the needs of the Western-based education system in which the programme was delivered. This often involved making decisions that did not support the ākonga but rather the institutional requirements. With distance from the responsibilities of being a kaiako, and through writing this thesis, I can see the limitations of the academic processes and policies surrounding my educational decisions. It reminded me of how easy it can be to become part of the system that re-enforces education inequity for Māori. Instead of changing the system, I was part of a system and positioned the ākonga to be part of that system, too. This study has emphasised how abandoning an approach that reflects assimilation and moving to authentic engagement has the potential to lift the anchor on Māori achievement, as the participants in this study articulated. This is achieved by creating pathways or connections to a collective way of being in a clinical practice experience, in a community, and in the kaupapa whānau.

I wanted to present a piece of research that prioritised and championed the voices of Māori nurses in a Māori way. Their stories and the interpretation of them has bought shape to the message of this thesis. My intention was to understand how the RHIP

programme connected with ākonga who were studying to become nurses and experienced a rural interprofessional clinical experience. In this research, what is currently positioned as an alternative model of clinical learning has been explored as to how its approach informed the identity of Māori who were studying to be nurses. In the future, it may be used to address inequities in health education, with the vision that this will have a positive impact on health services for Māori.

E kore e taea e te whenu kotahi

Ki te raranga I te whāriki

Kia mohio tātou ki a tātou

Mā te mahi tahi o ngā whenu mā

Te mahi tahi o ngā kairaranga

Ka oti tēnei whāriki

The tapestry of understanding cannot be known by one strand alone. Only by the working together of the strands and the weavers will such a tapestry be completed.

This whakataukī speaks to the nature of what is needed to engage with Māori who are studying to become nurses and the findings of this study. Firstly, the study has underlined how Māori collective culture is deeply entwined and woven throughout all of Māori learning experiences, both physically and metaphorically. Secondly, it highlights how kaupapa Māori research weaves the researcher and participants together to produce new collective understandings. Lastly, it recognises the value of connectivity, knowledge and revolutionization to bring about new ways of educating Māori who want to become health professionals, informing a vision of a different clinical learning model for Māori who are studying to become Nurses. Ultimately, this knowledge of contemporary undergraduate interprofessional clinical placements from a Māori perspective can be used to inform more effective clinical practice experiences, increasing Māori success in nursing education.

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Glossary

Aotearoa	New Zealand
Ako	To learn, study, instruct, teach, advise
Ākonga	Student learner
Aroha ki te tangata	A respect for people
Au	I, me
Awa	River
Awhi	to embrace – to give support
Hapū	Sub-tribe
Iwi	Tribe
Kai	Food, to eat
Kaiāwhina	helper, assistant, contributor, counsel, advocate.
Kaimahi	worker
Kākahu	garment, clothes, cloak,
Kaiwhakatere	Steersman, helmsman
Kanohi ki te kanohi	Face to face
Karakia	Prayer, incantation
Kaua e takahia te mana o te tangata	Do not trample over the mana of people
Kaupapa Māori /kaupapa	Māori ideology
Kāwanatanga	Government
Kawa whakaruruhau	A safe place made from principles
Kia māhaki	Don't flaunt your knowledge
Kia tupato	Be cautious
Kōrero	Narrative, talk, to talk
Kuia	Female elder
Kura kaupapa Māori	Māori immersion primary school
Māmā	Mother
Mana	Prestige, dignity, strength
Manaaki	to support, take care of, give hospitality to, protect, look out for - show respect, generosity and care for others.
Manaaki ki te tangata	Share and host people, be generous
Manaakitanga	Hospitality
Mana motuhake	separate identity, autonomy, self-government, self-determination, independence, sovereignty, authority - mana through self-determination and control over one's own destiny.
Māori	The Indigenous peoples of New Zealand
Marae	Traditional meeting place
Mātauranga	knowledge
Maunga	Mountain
Mauri	Life force, life principle, ethos
Mihi	Greeting, to greet
Moko kauae	Women chin tattoo
Nehi	nurse

Noho /noho marae	To stay on a marae
Pākehā	Non-Māori, usually used to refer to New Zealand Europeans
Pāpā	Father
Pono	Truth,honest,be true
Poroaki	To take leave/farewell
Pūrakau	myth, ancient legend, story.
Pōwhiri	A welcoming ceremony
Ōritetanga	equality, equal opportunity.
Rāhui	to put in place a temporary ritual prohibition
Rohe	boundary, district, region, territory, area, border (of land).
Taha hinengaro	The mental side
Taha tinana	The physical side
Taha wairua	The spiritual side
Taha whānau	The (extended) family side
Tangata whenua	The people of the land, refers to the Indigenous status of Māori in New Zealand
Taonga	Property, treasure
Te Kaunihera Tapuhi o Aotearoa	Nursing Council of New Zealand
Te Aka Whai Ora	Māori Health Authority
Te Ao Māori	The Māori world
Te reo Māori, te reo	The Māori language
Te Whatu Ora	The weaving of wellness
Teina	Younger brother or younger sister junior relatives
Tēina	Younger brother or younger sister junior relatives - plural
Te Whare Tapa Whā	Literally the house with four walls. A Māori model of health
Tika	
Tikanga	Customs, correct practice
Tino rangatiratanga	Absolute sovereignty, self-determination
Titiro, whakarongo… Kōrero	Look, listen…Speak
Tīpuna	Ancestor
Tohunga	skilled person, chosen expert, priest, healer
Tuākana	elder brothers (of a male), elder sisters (of a female), cousins (of the same gender from a more senior branch of the family).
Tuakana	elder brother (of a male), elder sister (of a female), cousin (of the same gender from a more senior branch of the family), prefect.
Tūpuna	Ancestors

Waiata	Song
Wairua	Spirit
Wairuatanga	Spirituality
Waka	Canoe
Wānanga	Seminar
Whaea	Mother. Used as a term of respect for female elders
Whakaaro	Thoughts, opinions, feelings
Whakamā	Shy, embarrassed, loss of mana
Whakapapa	Genealogy
Whakatau	to welcome officially, welcome formally.
Whakatauāki	a proverb where the person who said it first, is known – often used in reference to the past and or ancestors
Whakataukī	to welcome officially, welcome formally.
Whakawhanaungatanga	A process of establishing relationships
Whakawhiti	to exchange, swap
Whānau	Family extended group aand as defined in this study
Whatu	to weave (garments, baskets, etc.), knit

Appendix

Appendix A:
Research Question Development:

Question	***Goldilocks Test (too large, too small – just right)***	***Russian Doll Test: Studies the Aspect I actually want to look at***	***Methodology***
What is the impact of immersive interprofessional community-based experiences on the development of your practice with Māori		Would need to look at the impact both for the student and the community – large Hard to define what would be noticed in the community Moves away from supporting the need for this type of clinical experience	
How has the immersive clinical placement impacted on practice	Luke warm	Assumes there is a change, very broad	

Question	***Goldilocks Test (too large, too small – just right)***	***Russian Doll Test: Studies the Aspect I actually want to look at***	***Methodology***
How did the immersive clinical placement impact on your practice	Too vague	Assumes there is an impact and that the skills are transferrable	
How has the immersive interprofessional clinical experience impacted on your practice as a navigator for Māori in health	closer	• Targets Māori • Removes notion of practice must be in rural setting • Asks about impact • Minimises assumptions • Does it include cultural competence?? • What supports the role of navigator with Māori	
What was the experience of being on the rural interprofessional programme (immersive clinical experience) and how has the experience	??Just right seems big...	• Targets Māori • Removes notion of practice must be in rural setting • Asks about impact • Minimises assumptions • Does it include cultural competence??	

Question	***Goldilocks Test (too large, too small – just right)***	***Russian Doll Test: Studies the Aspect I actually want to look at***	***Methodology***
impacted[2] on your practice as a navigator for Māori in health		• What supports the *role of navigator* [3]with Māori • Explores the lived experience	
Aims to discover how nurses use the experience of an immersive interprofessional education in their first year of practice		• What happens with the knowing of the experience in registered practice • Could explore all of the above	• Grounded Theory • Glaserian
Working Research Question			
What do nurses get out of engaging in an immersive interprofessional education program?	Seems right	• Removes notion of first year of practice must be in rural setting • Asks about perception of effect if the experience • Minimises assumptions	• Descriptive Interpretive • Kaupapa Māori

[2] Is this the right word? Shaped , ~~changed~~, guided???
[3] Will this need to be defined for the study….

Question	***Goldilocks Test (too large, too small – just right)***	***Russian Doll Test: Studies the Aspect I actually want to look at***	***Methodology***
• What was the experience of being on the rural interprofessional health program? What are the perceptions of the effect of participating in the programme on your first year of practice?		• Explores the lived experience • Looks at first year of practice • Specific to nursing practice/role in interprofessional collaboration • Experience of the setting of IPE can be explored • Perception of care with Māori could be considered	• Māori Philosophy

Appendix B:
Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology

D-88, Private Bag 92006, Auckland 1142, NZ

T: +64 9 921 9999 ext. 8316

E: ethics@aut.ac.nz

www.aut.ac.nz/researchethics

5 May 2020

Jacquie Kidd

Faculty of Health and Environmental Sciences

Dear Jacquie,

Re Ethics Application: **20/84 How does an undergraduate placement in a rural interprofessional programme influence Māori nurses; identity and nursing practice**

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

Your ethics application has been approved for three years until 5 May 2023.

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 in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research 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.

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

For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

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

The AUTEC Secretariat

Auckland University of Technology Ethics Committee

Cc: kay.syminton@wintec.ac.nz; Jane Koziol-McLain

Appendix C:
Research Flyer

Would you like to take part in a new & exciting research Study?

Kia Ora koutou, ko Kay Syminton taku ingoa, I am a doctorate student at Auckland University of Technology (AUT), investigating the experience of Māori nurses on the Rural Health Interprofessional Programme (RHIP). Particularly this study seeks to uncover the experience of learning for Māori nurses. Participation will involve kōrero with me to explore your experience on RHIP and how you may be using the experience now in your nursing practice.

You can take part if you are Māori, participated in the RHIP programme in the last 3 years (2016-2019), stayed in the arranged RHIP accommodation for the placement and are currently practising as a Registered Nurse in Aotearoa/New Zealand.

If you are interested, nau mai, haere mai, please contact me, so we can meet kanohi ke te kanohi (face to face) either in person or online. You can email me at kay.syminton@ wintec.ac.nz and I will email you the participant information sheet.

Researcher Contact Details:

Kay Syminton MN, RN

Centre for Health & Social Practice

Waikato Institute of Technology

Hamilton.

Phone: 07 834 8800 ext 8425

Email: kay.syminton@wintec.ac.nz

Project Supervisor Contact Details:

Dr Jacquie Kidd, PhD, RN

Clinical Sciences - Nursing

Auckland University of Technology

Auckland.

Phone: 09 921 9999 ext 7329

Email: jacquie.kidd@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 05/05/2020 AUTEC Reference number 20/84

Appendix D:
Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

1 May 2020

Project Title

How does an undergraduate placement in a rural interprofessional programme influence Māori nurses' identity and nursing practice?

Ko Taranaki te maunga

Ko Waitara te awa

Ko Tokomaru te waka

Ko Te Atiawa te iwi

Ko Ngati Rahiri te hapū

Ko Owae te marae

Ko Kay Syminton toku ingoa

I am a Doctoral of Health Science candidate in Health and Environmental Sciences Faculty in the School of Clinical Sciences at Te Wānanga Aronui o Tāmaki Makau Rau / Auckland University of Technology. As part of my doctorate, I am undertaking a research project. I would like to invite you to participate in this research project which aims to uncover the experience of learning for Māori while on placement in the rural health interprofessional programme (RHIP).

What is the purpose of this research?

I am seeking to understand how you see the experience on RHIP informing (or not) your identity as Māori nurses and your subsequent clinical practice. This Kaupapa Māori study focuses the attention on your experience as a Māori nurse and will test my own observations of noticeable changes in Māori students during this placement.

The intent of this study is to highlight opportunities for influencing change within interprofessional health education to inform affirming approaches to clinical education for Māori nurses.

The findings of this research may be used for academic publications and presentations.

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

As this study looks specifically at the experience of Māori on the Rural Health Interprofessional Programme (RHIP), to participate you will need to be Māori, have had a placement on RHIP from January 2016 to Dec 2019, have stayed in the provided accommodation and be currently practising as registered nurses in Aotearoa/New Zealand.

How do I agree to participate in this research?

To participate you will need contact me to schedule a hui time. If you choose to meet in person, you will be able to sign your consent form at that time. If you would prefer our hui to use an online platform then you will be sent a Consent Form with the Information Sheet which will sign, scan or photograph, and

return to the me. 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, the removal of your data may not be possible.

What will happen in this research?

The Te Ao Māori approach whakawhiti kōrero (meaning the exchange of ideas and discussion) will be used. It is thought that this kōrero will take about an hour of your time. The hui will be arranged to occur in a mutually agreed place that is comfortable and allows privacy to talk about your experience of the RHIP placement. This may be at your workplace, home, community location, or using an online video calling platform where only the audio will be recorded. The kōrero (dialogue) will be open, encouraging you to tell your story. The kōrero will be recorded and following the hui it will be transcribed. You will have the opportunity to read and review the transcript.

As the essence of whakawhiti kōrero is sharing and the collaboration of ideas, you are also asked to participate in a second interview that will be guided by the insights, themes and concepts that have emerged from the initial data analysis. This will be shorter and may take up to half an hour of your time.

How will these discomforts and risks be alleviated?

It is thought that this study presents minimal risk to you as the participant as you will be offering your own experience and there are no right or wrong opinions of the interprofessional clinical placement. I do recognise that there can be a risk when recounting a personal experience, it can be upsetting. If you do not have someone that can support, you if you find the interview has been upsetting for you AUT Health Counselling and Wellbeing 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 centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992

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 http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling
During to the current Covid-19 level 4 and 3 restrictions counselling sessions are being offered over the phone and through video calling. There is also a Māori Counsellor who is able to offer support.

What are the benefits?

Your contribution to this research will help to inform effective interprofessional health education practices for Māori who are being educated to be registered nurses and practice in interprofessional health care.

The findings of this research project will assist in obtaining my Doctorate in Health Science. The findings will be widely disseminated within Māori and health educator communities, as well as within academic health care journals and at national and international conferences.

By participating in this research as a registered nurse you will meet the Nursing Council of New Zealand Competency 4.3 (Participates in quality improvement activities to monitor and improve standards of nursing).

How will my privacy be protected?

The number of nurses who have gone through the RHIP programme is relatively small, so it is possible that people who read the research may be able to identify you based on the information you share. I will use strategies such as pseudonyms and omitting data that might identify you. If you choose to be interviewed online our korero will be recorded You will also have the opportunity to see your transcript and suggest further ways I can protect your identity.

Electronic records such as the transcription or video recordings of the whakawhiti kōrero will be password protected and stored separately from the returned consent forms. Both will be kept in separate locked cabinets.

The data collected for this project will be retained in secure storage and password protected electronic files, for six years as required by Te Wānanga Aronui o Tāmaki Makau Rau / Auckland University of Technology, after which paper data will be shredded and electronic data will be securely deleted.

What are the costs of participating in this research?

As identified earlier you will need to be able to offer an hour of time for the initial kōrero and then another half an hour for the second hui after the initial analysis has been completed. If you choose to participate you may like to accept a koha of a $20 voucher.

What opportunity do I have to consider this invitation?

You have up to one month from the date of the email to consider this invitation.

Will I receive feedback on the results of this research?

Participants can receive a summary of the findings, copies of publications and an invitation to the study findings presentation.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Jacquie Kidd at Jacquie.kidd@aut.ac.nz (+649) 921 9999 ext 7329.

Concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, ethics@aut.ac.nz, (+649) 921 9999 ext 6038.

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Kay Syminton MN, RN

Centre for Health & Social Practice

Waikato Institute of Technology

Hamilton.

Phone: 07 834 8800 ext 8425

Email: kay.syminton@wintec.ac.nz

Project Supervisor Contact Details:

Dr Jacquie Kidd, PhD, RN

Clinical Sciences - Nursing

Auckland University of Technology

Auckland.

Phone: 09 921 9999 ext 7329

Email: jacquie.kidd@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 05/05/2020, AUTEC Reference number 20/84

Appendix E:
Consent form

Consent Form

Project title:	***How does an undergraduate placement in a rural interprofessional programme influence Māori nurses' identity and nursing practice.***
Project Supervisor:	***Associate Professor Jacquie Kidd***
Researcher:	***Kay Syminton***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 28 January 2020.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- ○ I understand that interviews undertaken online will only be audio recorded and then transcribed.
- ○ I understand that this research project may involve a second interview.
- ○ I understand that the data from this project will be used to inform health education practices.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, the removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one):
  Yes○
  No○

Participant's signature:.....

Student ID 18017938

Appendix F:
Whakawhiti kōrero guide

Whakawhiti kōrero (Interview) Schedule:

- Karakia – centring practice
- Giving of koha
- Whakawhānaugatanga (relationship connections)
- Blessing of Kai/Kai (sharing of Food)
- Kōrero (Dialogue) will be open encouraging the participants to tell their stories.

Opening question "tell me about your experience while on the rural interprofessional programme" will be used.

The participants will be encouraged to think and relate to the experience of the clinical placement, eliciting the details of what the experience was for them.

Other areas of interest are:

Question "tell me about the living arrangements"

The participants will be asked to explore the influence of living together with others for the duration of the placement. Eliciting details of what communal living meant for them.

Question "tell me what supported/hindered your identity as Māori".

The participants will be asked to explore what affirmed or hindered their identity as Māori during the clinical experience.

Question "How do you see that your placement experience has influenced your clinical practice as a Māori registered nurse?"

The participants will be asked to explore how they see the clinical experience has influenced their current practice. Eliciting details of their practice as a nurse as well as their interprofessional practice.

Karakia (closing of the hui)

Appendix G:
Overall Dataset Familiarisation Notes

As a Māori nurse I feel I might know something about what informs our identity and having been on many of the RHIP powhiri and presentation this data set relates to me. However, when I started to engage analytically and read the experiences of the students as data, quite a few things struck me. Initially after familiarisation I noticed that:

- There was far less naming of tikanga or te ao Māori views than I expected – rather there was naming of emotions in the RHIP experience.
- There was a really strong thread relating to being noticed – in everything experienced there from individual interactions to the wider community.
- I am saddened that participants were noticing for the first time they felt normal – not just as a student nurse but as Māori – they lack value they have experienced makes me angry (we, society, have failed – I have failed 😟)

Combined on the surface this would suggest that it isn't related to being Māori but more to connecting. This is great!

But I still feel that it is in that connecting that allows us to be ourselves as Māori and this suggesting that there is more going on with this data. As I engaged more with the data, I started to notice a few other things, not least of which was that there were in fact a number of te ao Māori and tikanga practices being used but that they were less obvious much of the time. There seemed to be a lot of ways of practicing there that had a base in tikanga contrasted with other experiences that were riddled with assumption and judgements of both the student, them as nurses and the patients.

- Demonstrating manaaki and care for the patients - through knowing your community – taking kai to a visit because there had been a tangi the week before for example.
- That whānau is more than those we are biologically connected to -flatmates, wider Rhip family.
- Being wanted in clinical and not othered both as students and Māori

- Knowing the stories of the people and the land connects us – changing the experience of being there.
- The learning – in what was a safe environment for us - making them want to know even more about themselves.
- That so many had not flatted before…and were worried about living with potential duds or that they would be the dud, bring those ideas of less than with them – feeling the fear and going anyway! -probably not relevant to my TA but might connect to themes as these develop
- Lots of positive cases of impowering clinical experiences – often highlighting being seen as both a nurse and Māori
- RHIP coordinators – seen as the exoskeleton and navigators of the experience in its entirety.
- All professions learning from each other (especially away from formal learning environments)
- Being treated as though they have something to contribute'.
- Expectations on RHIP different to those of other placements??? – this seems to be present but are the participants also practicing differently in other clinical?

I have finished the familiarisation process excited by the richness of my small dataset but realising the data could answer several research questions, so I am glad that I have a question that is appropriate for TA specifically.