Beginning the journey of becoming a Tiriti-partner: a critical reflection

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Attestation of Authorship

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

Signed:

Date: 28/10/2022

Abstract

Te Tiriti o Waitangi is a contractual agreement between Māori and the Crown promising kāwanatanga, rangatiratanga, ōritetanga and wairuatanga. Despite these promises, extensive breaches of Te Tiriti o Waitangi have occurred since its inception creating significant health inequities for Māori which continue to this day. Within the health system, the dominant biomedical model of practice prioritises Western views of health which continues to reinforce colonial systems and reduce equity for Māori. There is a critical need for healthcare practitioners to work alongside Māori, working as Tiriti-partners. This practice project aims to explore Māori experiences of health services within the literature through the lens of Te Tiriti o Waitangi and use these understandings to critically reflect on my practice and to use this knowledge to help me work as a Tiriti-partner in my physiotherapy practice. A literature search was completed exploring Māori experiences of hospital and rehabilitation services. The articles of te Tiriti o Waitangi were used as a framework for analysis. Utilising the key learnings which came from the framework analysis, a case was chosen from my practice to undergo analysis through critical reflexivity. This practice project has demonstrated how clinicians and hospital services influence the experience of Māori. These are influenced by how clinicians interact with Māori during the healthcare encounter and clinicians' previous experiences through their training and own values or beliefs. Systemic structures also contribute to health and well-being through increasing financial and social constraints, institutional racism and bias. Through critical reflexivity, I propose ways of thinking and working that can support clinicians to reduce health disparities by creating space, prioritising, and being an equal participant in whanaungatanga, acknowledging Māori kāwanatanga and rangatiratanga, and supporting wairuatanga using te reo Māori and knowledge of tikanga. By acting in these ways, clinicians can begin to reduce inequities experienced by Māori in healthcare. However, acting in this way is just the first step in becoming a Tiriti-

partner and only one of the pieces required to reduce inequities. To fully achieve pae ora, healthy futures, for Māori, we must make critical reflexivity and challenging our personal assumptions a life-long journey.

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Introduction

Beginning the journey

I am a male Pākehā physiotherapist working at Waikato District Health Board. Several events have brought me to undertake this practice project. The first is personal. My Nana lived in remote Northland with limited access to healthcare and with worsening chronic obstructive pulmonary disorder. Her partner was her lifeline to access healthcare and remain in her home. Unfortunately, her partner passed away due to unrecognised bowel cancer. Subsequently, Nana was admitted to hospital and quickly taken away from her home, forced into a residential home without consultation with her family. As a result of moving into residential care, her whole world was contained within one room and her quality of life was significantly reduced. This experience sparked a desire for me as a young physiotherapist to provide the best, holistic case possible for my clients. These events reflected a second, professional, motive: to work better for the people I serve.

At the time these events were occurring for my Nana, I was working for Hawkes Bay District Health Board in their rehabilitation ward. The situation with my Nana made me look deeper into what I was doing for the people I was serving. Similar to Northland, Hawkes Bay has a high proportion of people living rurally, and of these, the majority are Māori (Statistics New Zealand, 2018). Serving the community in Hawkes Bay meant that I saw several situations where Māori in rural communities were being uprooted from their homes and taken away from their whānau due to various illnesses, lack of education by healthcare practitioners and rural healthcare. As a person with power due to my role as a health professional (Crawford & Longridge, 2022; Hotere-Barnes, 2015), albeit what I felt as limited power as a junior physiotherapist at the time, I wondered if there was something else that I could do to assist those that were in the same position as my Nana. Acknowledging my position, the events that occurred with my Nana, and those that

were happening to Māori I was serving, I investigated different ways of working with people to help support people I work with to walk alongside them in partnership. My Nana's experiences were reflective of the experiences of the Māori clients in Hawkes Bay I was treating. These events brought me to initiate my journey of attempting to become a Tiriti-partner. I define being a Tiriti-partner as a decolonising practice, learning about injustices and taking action, being in an active role of working alongside Māori to support their solutions and building trustworthy, reliable and long-term relationships (Berghan et al., 2017; Came & Tudor, 2016; Margaret, 2013).

The research journey

This practice project began as a traditional practice project, a literature review investigating how to uphold Te Tiriti o Waitangi (referred to as 'te Tiriti' for the remainder of this dissertation) and becoming an active Tiriti-partner as a Pākehā healthcare professional. A literature search was undertaken based on the following two questions:

1. How do Māori and Pākehā describe the core traits of those working as Tiriti-partners?
2. What is the journey of people who are working as effective Tiriti-partners?

The intention of these two questions was to inform how physiotherapists can begin their journey to becoming authentic Tiriti-partners. It is perhaps unsurprising that this traditional scientific approach was inadequate for achieving the end goal of this practice project: beginning the journey of becoming a Tiriti-partner. The meaning of being a Tiriti-partner is difficult to describe and not often the focus of traditional research. This initial literature review provided insight into the complexity of becoming a Tiriti-partner and highlighted that this topic could not be understood by the traditional Western means of evidence-based practice that, as a healthcare professional, has been so guiding in my learnings throughout my career thus far.

The initial literature review prompted me to take a step back and become more reflexive with the literature and develop questions based on my readings to delve further into this complex issue. Acknowledging that the initial literature review wasn't sufficient, it allowed for a shift in methods, utilising Te Tiriti as a framework to analyse literature and base my reflections on moving forward.

In this Introduction chapter, I will explore how Te Tiriti is currently acknowledged within Aotearoa with its history and how it impacts the health system, physiotherapy as a profession and finally, back to the healthcare practitioner. I will then describe the concept of Tiriti partnership in more detail, before showing how I will bring the articles of Te Tiriti and critical reflexivity together as a focus of inquiry.

Te Tiriti and Aotearoa

Te Tiriti is one of Aotearoa's founding documents. Te Tiriti is a contractual relationship between Māori and the Crown, establishing an agreement for co-existence and governance between these two groups (Waitangi Tribunal, 2020). During the signing of Te Tiriti, ngā iwi Māori (tribal groups) were promised partnership, kāwanatanga (governance), rangatiratanga (sovereignty), ōritetanga (equity) and wairuatanga (spirituality) which is briefly defined below and further defined in the Results chapters. However, Te Tiriti has not been upheld by the Crown with a history of extensive breaches resulting in widespread inequities experienced by Māori (Robson & Harris, 2007; Waitangi Tribunal, 2019). Breaching Te Tiriti has provided opportunities for tauiwi (non-Māori) to have significant benefits of governance, land, health, and development of tauiwi communities (Selak et al., 2020). The breaching of Te Tiriti has subsequently resulted in reduced access to transport, housing, education, healthcare, employment, and land, significantly contributing to inequities experienced by Māori (Graham & Masters-Awatere, 2020; Waitangi Tribunal, 2019).

An initial scoping of the literature identified some of the elements that are important as one becomes a Tiriti-partner. These elements include understanding of history, power and privilege, and respectful relationships (Berghan et al., 2017; Margaret, 2013). Whilst traditionally there has been a focus on acknowledging and working in line with the principles of The Treaty of Waitangi, the Waitangi Tribunal has been clear that doing so has continued to contribute to inequities experienced by Māori (Waitangi Tribunal, 2019). There is an increasing need for tauiwi working as Tiriti-partners to honour the *articles* of Te Tiriti, (Waitangi Tribunal, 2020). Whanaungatanga, the preamble, is an active process of building relationships through shared experiences and connections, recognising each other's influences and provided space for authentic collaboration between Māori and tauiwi. Kāwanatanga refers to Māori governing their own people and ensuring they are present in all levels of decision making, ensuring Māori have a voice in Māori futures. Rangatiratanga is defined as Māori making decisions for Māori and being in control of their own decisions on their taonga (all that is valuable to Māori). Ōritetanga acknowledges equity between Māori and tauiwi in all aspects, including health. Breaches in Ōritetanga in the perspective of health are avoidable, unnecessary and unjust (Graham & Masters-Awatere, 2020). Finally, wairuatanga, the oral clause of Te Tiriti, protects Māori faith and customs. Wairuatanga is a complex construct including holistic values that promotes links to ancestry, ancestral land, culture, and close kinship ties to extended whānau and Te Ao Māori (Māori worldviews). In its nature, the preamble and all four articles of Te Tiriti are interconnected and provide a framework for working alongside Māori and promoting Māori health (Durie, 2001).

The health system in Aotearoa

The current health system in Aotearoa, is failing Māori in all aspects of health including social determinants, service provision, access, referral rates and outcomes (Graham & Masters-Awatere, 2020; Waitangi Tribunal, 2019). There is a need for action to be taken to achieve equity for Māori communities. Healthcare in Aotearoa privileges Western knowledge and a biomedical model approach, where the absence of disease is the focus of health (Main et al., 2006; Selak et al., 2020). Inherent within the biomedical model, developed by colonisers, is a power differential contributing to institutional racism and inequities for minority groups including Māori and their whānau (Crawford & Longridge, 2022; Davis & Came, 2022). Within the health system and the biomedical model of healthcare, te Tiriti is not honoured therefore Māori rights to exercise rangatiratanga, kāwanatanga or wairuatanga are not honoured, further contributing to disparities. Likewise there is a clear lack of ōritetanga (Waitangi Tribunal, 2019). With predominantly tauiwi working within this health system, the majority of structures and policies are created by tauiwi without Māori consultation further exacerbating power dynamics in favour of tauiwi. Having health services developed by tauiwi without Māori consultation creates inequitable access to these resources, bias against Māori and their whānau, and embedding Pākehā privilege within this biomedical model of care (Came et al., 2019; Crawford & Longridge, 2022; Curtis et al., 2019).

The Waitangi Tribunal has acknowledged through WAI2575 that current health systems are continuing to fail Māori (Waitangi Tribunal, 2019). These failings have brought about a system review and developed Whakamaua: Māori Health Action Plan 2020-2025 (Ministry of Health, 2020b), underpinned by the principles of Te Tiriti directed by WAI2575 (Waitangi Tribunal, 2019). These principles include:

1. Tino rangatiratanga: the guarantee of Māori self-determination in the design, delivery and monitoring of health and disability services,

2. Equitable outcomes for Māori,
3. Active protection,
4. Options for, and resourcing of Kaupapa Māori health and disability services alongside all health and disability services being provided in culturally appropriate ways supporting and recognising hauora Māori models of care,
5. Partnership affirming Māori as co-designers of the primary health system and working in partnership in governance, design, delivery and monitoring of health and disability services.

The results from WAI2575 informed the development of a new health structure including Te Whatu Ora, Health New Zealand, and Te Aka Whai Ora, the Māori Health Authority. The changes to our health system are designed to streamline services to deliver locally supported health that is in partnership with Māori (New Zealand Government, 2022). Pae ora, Healthy Futures, is the overarching aim of He Korowai Oranga. Pae ora recognises mātauranga Māori (Māori knowledge) underpinning health and recovery. Its focus is on mauri ora, healthy lifeforce of individuals, whānau ora, healthy families, and wai ora, healthy environments (Ministry of Health, 2020a). Recognition is needed for all concepts as all three elements of Pae Ora are interconnected and contribute to future Māori health. Pae ora is an important step for the Ministry of Health in recognising Māori health as holistic as Pae Ora is not being achieved by the current biomedical model of healthcare.

Physiotherapy in Aotearoa

As physiotherapy is a regulated profession, physiotherapists are required the meet the cultural competency standards set by the Board of Physiotherapy New Zealand and Health Practitioners Competence Assurance Act to remain registered and, more importantly, meet our obligations under Te Tiriti (Parliamentary Counsel Office, 2020; Physiotherapy Board of New Zealand, 2018, 2021). Cultural safety

can assist physiotherapists in contributing towards the overall aims of He Korowai Oranga (Ministry of Health, 2020b). The Physiotherapy Board of New Zealand has also recently released He Kawa Whakaruruhau ā Matatau Māori: Māori Cultural Safety and Competence Standard. He Kawa Whakaruruhau ā Matatau Māori was developed in collaboration between Māori, Māori physiotherapists, and Māori health consumers (Physiotherapy Board of New Zealand, 2021). It is a document that places particular emphasis on the relationship between Māori, and tauiwi healthcare practitioners through Te Tiriti. It also aligns with the five principles highlighted in WAI2575 outlined above (Physiotherapy Board of New Zealand, 2021; Waitangi Tribunal, 2019). This standard specifically addresses cultural safety when working with Māori, whānau, and communities as opposed to the Cultural Competency Standard which is generalised for all health consumers. He Kawa Whakaruruhau ā Matatau Māori has three broad statements which help to provide guidance for the treating physiotherapist towards a more culturally safe practice (Physiotherapy Board of New Zealand, 2021). These include:

1. Awareness of a person's own culture and understanding how culture impacts Māori
2. Application of Māori cultural safety skills and knowledge in practice
3. Ongoing reflection.

Although these initiatives for culturally competent care are present, it can often be seen as a 'box-ticking' exercise by the practitioner which further perpetuates inequities experienced by Māori whānau they are working alongside (Main et al., 2006). Seeing cultural competency and safety in this manner further perpetuates the colonisation work which has been detrimental to Māori; deconstructing this requires authentic engagement with te Tiriti to decolonise and reduce disparities between tauiwi and Māori.

Physiotherapists need to enhance their own cultural safety as they have a key role in the journey of achieving ōritetanga (Bolton & Andrews, 2018; Ratima et al.,

2006). Curtis et al. (2019) describe cultural safety as healthcare professionals and organisations examining themselves with respect to the potential impact of their culture on clinical interactions and healthcare delivery. There is a need for individuals to have ongoing self-reflection and self-awareness to hold themselves accountable for healthcare interactions and ongoing learning. These reflections allow the individual and the organisation to address their own biases, feelings, thoughts, and prejudices which often affect care provided to minority communities and assists in reducing bias and achieving equity within the workforce and working environment. However, culturally safe care is individualistic and needs to be defined by the client and their community. When working as a Tiriti-partner cultural safety is imperative as bias and racism stems from institutions, the physiotherapy practice, and the person. Therefore, there is a need for critical self-reflection for the practitioner to review themselves in the context of their practice, who they work with and aligning their practice with Te Tiriti.

Moving to become a Tiriti-partner, the practitioner

Becoming a Tiriti-partner comes with its challenges as this process requires moving from a place of unawareness to awareness of social, cultural, economic, or cultural relations (DiAngelo, 2011; Hotere-Barnes, 2015). Becoming a Tiriti-partner can often bring a sense of discomfort and tension as these challenges are laid out ahead of the person undertaking this journey. This process can evoke a sense of fear around getting things wrong and making mistakes, therefore, contributing to the fear of working with Māori clients and ignore the inequities currently occurring within our society (Durie, 2001; Margaret, 2013). This is a form of power and privilege called Pākehā paralysis (Hotere-Barnes, 2015; Margaret, 2013). Being a Tiriti-partner requires the sense of being comfortable with discomfort as most healthcare practitioners have been brought-up with a Western-centric model of healthcare and Western teachings of the history of te Tiriti.

Similarly, the majority of institutions having a Western-dominant view of health (Came, Warbrick, et al., 2020; Hotere-Barnes, 2015). Acknowledging different historical perspectives of te Tiriti can create emotional turbulence and exacerbate misconceptions if people are not given adequate support or opportunity to explore differing cultural perspectives in meaningful ways. Without this support, it can be difficult for someone to begin to engage effectively with te Tiriti and begin on the journey of becoming a Tiriti-partner (Crawford & Longridge, 2022; Hotere-Barnes, 2015). Presently, there is no clear starting point or pathway of 'how' to become an effective Tiriti-partner. It likely requires constant reorientation on the 'why' this is important – to improve health equity, including access, experience and ultimately outcomes of health, by reducing current ethnic disparities (Graham & Masters-Awatere, 2020; Waitangi Tribunal, 2019). The path of becoming a Tiriti-partner is likely one to be uniquely personal, and therefore, challenging to develop a single pathway. However, acknowledging ones positioning throughout the process and constant reflection is one key way to continue to contribute to this area. The starting point for this dissertation was my desire to become a Tiriti-partner in health.

As a Tiriti-partner, one must understand their own cultural identity, unconscious biases and values held as these can impact on their effectiveness when working alongside Māori and wider whānau (Curtis, 2016; Curtis et al., 2019). At a clinical level, being a Tiriti-partner also requires delivery of services with a focus on improving health outcomes by collaborating with Māori health consumers. To collaborate effectively with Māori, Tiriti-partners need to respect rangatiratanga of whānau Māori to facilitate the management of their health and wellbeing (Margaret, 2013). Institutional cultures have their own set of biases which impact significantly on Māori affecting equality and equity. Awareness of institutional biases will allow one to work more meaningfully with whānau Māori and iwi and development of mana-enhancing relationships based on trust and reciprocity to help reduce health inequities (Graham & Masters-Awatere, 2020; Margaret, 2013). Acknowledging

these personal, professional, and institutional biases requires the healthcare practitioner to engage with critical reflexivity, considering factors beyond the individual (Kinsella et al., 2012; Kylie, 2016).

This practice project: Moving on the path of becoming a Tiriti-partner

As a Pākehā male healthcare practitioner attempting to begin on the journey of becoming a Tiriti-partner, I need to acknowledge my positioning throughout this process, especially as my reflections will be interwoven throughout this piece. Being a Pākehā brings about certain aspects of privilege that others do not share. I acknowledge that my lens is my own and not representative of others' views or the views of Māori. This positioning can inherently bias any piece that is written as a reflective piece as everything I have read and experienced is seen through my personal lens of privilege and interpreted by my worldview, education, and culture of a Pākehā physiotherapist. The original intent of this dissertation was to undertake a scientific approach to analyse the core traits of becoming a Tiriti-partner and the process of becoming a Tiriti-partner. However, as I progressed with this work, it quickly became evident that the scientific approach detracted from the original reason of beginning this piece of work as the results favoured the Pākehā gaze on Māori thoughts. These results created a sense of discomfort, and the learnings were not meaningful as they lacked the critical reflexivity required to move forward in developing a culturally safe practice. As a result, the way in which I undertook my inquiry shifted which enabled me to integrate both a Tiriti-informed literature review and a critical reflection on my practice. This approach holds meaningful learnings for not only myself, but other Pākehā or tauiwi seeking to develop their understanding and beginning their journey within this space. This process of Tiriti-based review and reflection supported the main aim of this dissertation: to explore Māori experiences of health services and draw on these to critically reflect on my practice, and to contribute to develop personal, professional,

and practice understandings and work in ways that uphold te Tiriti and demonstrate being an effective Tiriti-partner within physiotherapy.

Methods

Introduction

This project was comprised of two phases. A literature review was undertaken exploring Māori perspectives on health experiences in the hospital setting. Te Tiriti was used as the framework for analysing these experiences. This was followed by a critical reflection based on a single case within my practice and how the learnings gained from the Tiriti-based review were implemented into practice.

Literature review

A structured literature search was performed in the following databases: CINAHL Complete, Australia/New Zealand Reference Centre, MEDLINE, Scopus, and National Library of New Zealand to identify experiences of Māori health consumers within hospital services. Search terms used included:

1. Inpatient OR in-patient OR acute OR ward OR hospital OR rehabilitation OR therap* OR healthcare OR health care" OR service*
2. Experience* OR perspective* OR perception OR satisfaction OR attendance OR engagement
3. Maori OR Maaori OR Māori
4. Qualitative OR interview OR hui OR wananga OR wānanga OR waananga OR korero OR korero OR korero

After I completed the search, duplicate articles were discarded, and a preliminary screen of titles and abstracts retrieved from the search terms was completed to identify potentially relevant articles. Final articles were sent to my primary and secondary supervisors (FB and BJW) for integrity analysis. Additional studies were included by screening the reference lists of relevant articles. I extracted data independently with two articles selected for counter review by my supervisors (FB and BJW). This process is summarised in Figure 1.

Inclusion criteria for articles included:

- Publications between January 2013 and May 2022,
- Presented Māori health consumer perspectives or experiences on hospital services,
- Participants were aged 18 years and older,
- Articles considered access to hospital services including inpatient and outpatient services,
- Studies were qualitative and written in English.

Data analysis

A framework analysis (Gale et al., 2013) was used, with te Tiriti serving as the framework to develop rich understandings of people's experience of care and how these did or did not align with the Crown's obligations under te Tiriti. Discussion was held between myself and supervisors (FB and BJW) regarding the potential use of Critical Tiriti Analysis (Came, O'Sullivan, et al., 2020). However, one of the steps for Critical Tiriti Analysis includes the "Māori final word" which, due to the me being Pākehā, it was deemed inappropriate. I developed definitions of each article for Te Tiriti in discussion with my supervisors (see Results chapter for each definition). Further scoping questions were developed from these definitions and applied to the literature to provide for a framework analysis (see Appendix A – E).

Critical reflexivity

Because this project was intended to consider my own practice, not simply be a review of the literature, I have integrated a process of critical reflexivity (Setchell & Dalziel, 2019). In this, I complete a critical reflection about a recent practice scenario with a Māori client, Mere. To do this, I wrote a summary of Mere's care prior to performing the literature review with significant details changed so she

could not be identified. Details which may or may not have been changed include gender, whānau description, type and mechanism of injury, impairment(s) and severity of these, service(s) used, and time post-impairment. After completing the literature review, I applied the learnings from the framework analysis to underpin a process of critical reflexivity about the scenario with Mere. Critical reflexivity allows the practitioner to examine their assumptions based off of their own beliefs, values, social and systemic structures, and power dynamics and how these shape daily practice and perspectives (Kinsella et al., 2012). Taking part in critically reflexive writing allows the person to become more aware of what they are thinking, feeling, and experiencing. Reflective writing also lets the practitioner take responsibility for their actions by exploring personal and systemic values and ethics. In doing so, the practitioner becomes aware of, and questions power imbalance, and works towards systemic change (Kinsella et al., 2012; Kylie, 2016). Critical reflexivity has been identified as necessary to build cultural safety and, therefore, support the journey of becoming a Tiriti-partner and challenging current systemic and personal biases and racisms (Berghan et al., 2017; Davis & Came, 2022; Margaret, 2010; Selak et al., 2020). My critical reflection will be reviewed utilising te Tiriti as a framework.

Cultural humility

A process of cultural humility is required as a Pākehā analysing Māori experiences (Fahlberg et al., 2016). Cultural humility is a life-long process of being inquisitive, self-reflective, critiquing self, practice and institutions (Fahlberg et al., 2016). Several processes were used to maintain cultural humility. The first was utilising a reflective diary allowing me to capture my thoughts and experiences with clients and to process my own privilege. Secondly, supervision was used to discuss thoughts and perceptions around various cases and my role within this practice project. Thirdly, utilising literature within this space provided a medium to review

how others are currently working as Tiriti-partners, with Jen Margaret's (2013) book “Working as allies” as a key text that I commonly returned to. Finally, discussions with other practitioners working as Tiriti-partners provided another medium to discuss clients and how their contexts relate to the system that we work within.

Results

Literature review

A total of 756 articles were retrieved from CINAHL Complete, Australia/New Zealand Reference Centre, MEDLINE, Scopus, and National Library of New Zealand. After screening for duplicates, 328 were removed. Abstracts and titles were subsequently screened with a further 413 removed for not meeting the inclusion criteria. The remaining 15 articles were reviewed in full text with six not meeting the inclusion criteria. Nine articles met the inclusion criteria and were included in the framework analysis with no further articles identified by checking the references of included articles. The nine included studies are described in Appendix F. The process of study selection is shown in Figure 1. Each article of te Tiriti will be defined prior to the narrative synthesis of the literature.

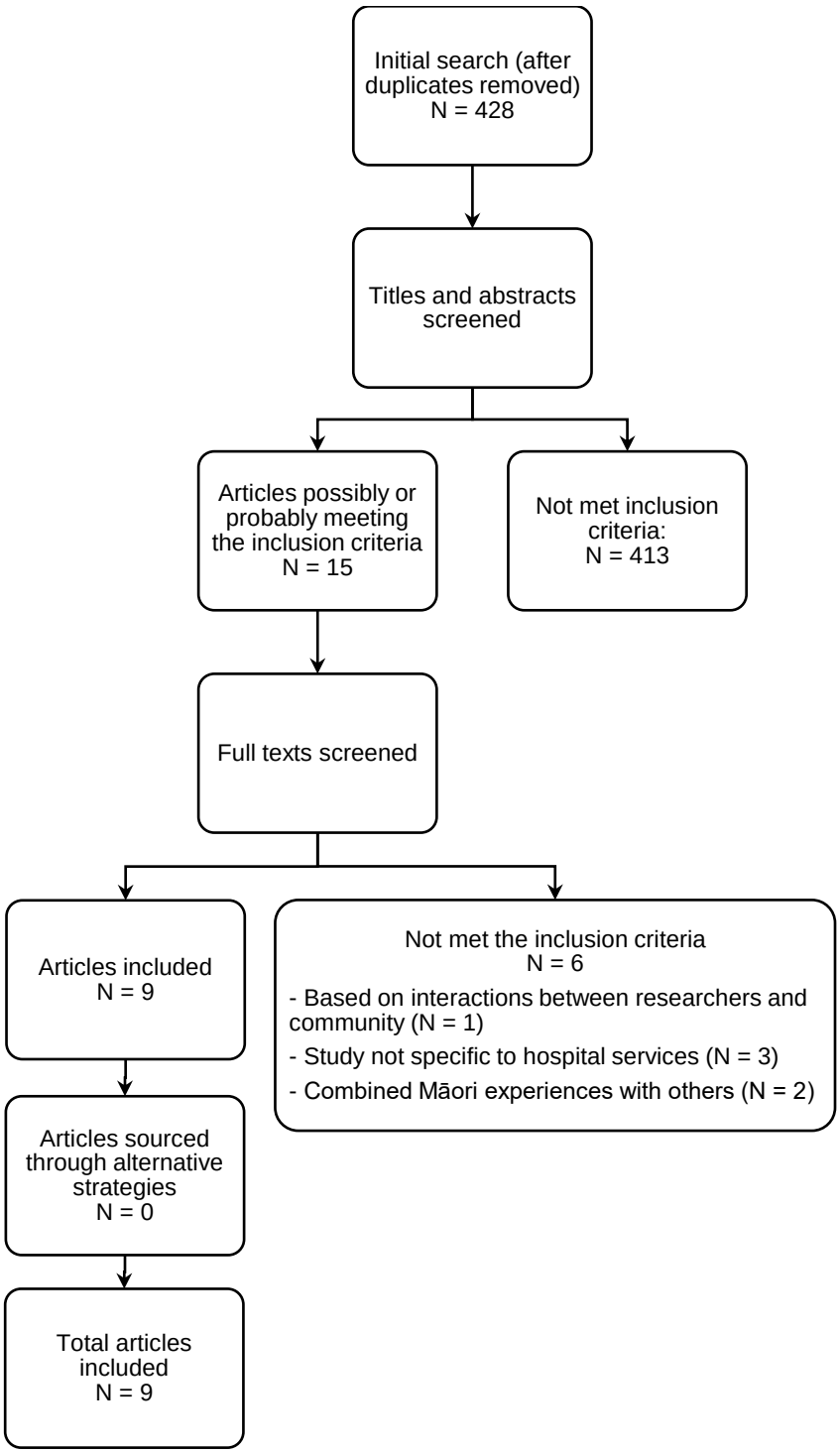

Figure 1 : Literature search process

Whanaungatanga

Whanaungatanga underpins the preamble of Te Tiriti and is acknowledged as critical to Tiriti-based practice and authentic engagement. Whanaungatanga is the active process of building respectful relationships through shared experiences and

connections (Berghan et al., 2017; Came et al., 2021). Tiriti-based relationships should promote power sharing, understanding, mutual respect for language, lifestyles and beliefs while also modelling accountability, responsibility and being transparent (Berghan et al., 2017; Came et al., 2021; O'Carroll, 2013). Whanaungatanga in Tiriti-based relationships requires reciprocity, recognising each parties' influences, experiences and learning how to work together. This requires non-Māori to engage in self-reflection and strengthen their cultural safety and competency by considering, imagining and engaging with experiences and worldviews other than their own (Berghan et al., 2017).

Māori clients and their whānau considered whanaungatanga as paramount during interactions with healthcare providers. Participants described the reciprocal relationship between trust and whanaungatanga within the healthcare encounter such as:

> *Well it's like anything, you're not gonna go into a relationship with a doctor … or anybody, unless there's some form of trust … and until you establish that trust … not a lot else exists* (Wilson et al., 2021).

Whanaungatanga requires healthcare providers to create a space which supports connection building and where Māori feel safe to engage (Wilson et al., 2021). One participant highlighted tikanga in relation to whanaungatanga when stating "*The tikanga [protocol] aspect of it – we talk about our whakapapa [genealogy] first, that's all part of whanaungatanga [connection between people], and our stories are very important*" (Levack et al., 2016). Whanaungatanga also requires acknowledging the individual in the wider context of their whānau, interests, culture, and worldviews allowing for a holistic view of the person (McLellan et al., 2014; Wilson et al., 2021). Whanaungatanga requires the healthcare provider to intentionally create space and offering social information about themselves, providing the opportunity for their client to get to know them beyond their occupation. Providing space to build relationships in this way was frequently

described as a means of establishing of safe, trusting, and respectful relationships (Levack et al., 2016; Wilson et al., 2021).

Positive interactions with healthcare professionals were rarely described within the literature. Consistency of a relationship was one of the key drivers for positive interactions with healthcare practitioners. Having consistent relationships provided whānau Māori to feel connected to the clinician and provided space for trusting relationships. These trusting relationships meant that when it was requested, whānau Māori felt supported when navigating the health system (Kidd et al., 2013; Rahiri et al., 2020). Conversely, negative interactions with health professionals, as experienced by whānau, were very explicit throughout the literature and held implications for relationship building (Kidd et al., 2013; Levack et al., 2016; McLellan et al., 2014; Rahiri et al., 2020; Wilson et al., 2021). Examples of these include mispronouncing someone's name which signified a lack of care and respect (Wilson et al., 2021), not providing time to answer questions or concerns (Levack et al., 2016), inconsistency of healthcare providers causing disruption to the relationship (Kidd et al., 2013; McLellan et al., 2014; Rahiri et al., 2020), and the lack of, or poor communication and information provision (Pene et al., 2021). Overall, these contributed to feelings of isolation, disconnect and distrust of the health system and healthcare providers (Walker et al., 2022).

Participants suggested prioritising time and space within the healthcare encounter for whanaungatanga allows for establishing relationships between Māori, whānau and the clinician by seeing who each party is, beyond their condition or profession (Pene et al., 2021; Walker et al., 2017). Doing so allows for understanding of the person and their roles within their communities and seeking what is important to them. Reciprocity is also required within the early healthcare encounter. The healthcare provider needs to be able to reflect on themselves, what is important to

them and be comfortable to engage reciprocally with their clients (Wilson et al., 2021). Levack and colleagues (2016) suggested addition of cultural support services, such as kaitiaki, can assist healthcare providers to engage more effectively with a whānau Māori and build whanaungatanga. Whanaungatanga may also be supported when healthcare professionals attend to all elements of te Tiriti (Levack et al., 2016). Examples of ways to create space for building whanaungatanga in the literature include spending time after sessions with clients to share stories or healthcare providers creating ways for people to access classes such as spending time picking up the person and spending time within their homes (Levack et al., 2016; Rahiri et al., 2020).

Kāwanatanga

Kāwanatanga (article I of Te Tiriti) relates to Māori retaining governance over land, resources and Māori interests while having meaningful involvement with decision making. From a health system perspective, kāwanatanga requires the sharing of power and Māori representation and involvement in decision making throughout the health sector (Berghan et al., 2017; Came et al., 2018). In the context of this review kāwanatanga has been applied as a concept to consider people's experience of health in these ways.

Knowledge, power, and the ability to have kāwanatanga over one's own healthcare journey was frequently reported throughout the literature. Participants in several studies perceived that the lack of knowledge provided within health interactions led to the inability of whānau to advocate for themselves or make informed decisions (McLellan et al., 2014; Pene et al., 2021; Walker et al., 2022; Wilson et al., 2021). This was summarised by a participant when discussing their healthcare "*knowledge is power, and we don't have knowledge. We can't advocate for ourselves because we don't know the words to use, we don't understand the*

process and how we can drive it" (Walker et al., 2022). Actively supporting whānau Māori to gain knowledge provides opportunities for Māori to advocate, determine and govern their own healthcare. There were frequent reports where kāwanatanga was not acknowledged in practice. A participant from Wilson et al. (2021) summarises the negative experiences felt during a healthcare encounter by stating "*'Doctors' were just in 'blah, blah, blah' … and gone! And it's like, well excuse me … I didn't understand any of that*" (p. 16). Providing adequate information not only supports Māori decision making and kāwanatanga within their healthcare journey, but also enables trust within the healthcare relationship building on whanaungatanga.

How information was communicated was also seen as essential to Māori enacting kāwanatanga. Whānau Māori found it beneficial when things were explained in a familiar way or with Te Ao Māori at the centre of the explanation. Two examples of communication impacting on kāwanatanga was evident in Wilson et al. (2021) describing the following interactions:

> *It's not what they tell you … it's the way they convey it.* (p. 17)
>
> *It was very, very awful … and there was no, to me … kindness about the way they were saying it … it was just "Boom! This is how it's gonna be" [cold] and then leave again, and then like I'm all emotional, bawling my eyes out…* (p. 17)

Statements such as this were consistently described by whānau Māori (McLellan et al., 2014; Pene et al., 2021; Walker et al., 2022; Walker et al., 2017). There were occasional instances where whānau Māori had the confidence to address this issue with their healthcare professional in order to gather as much information as possible to ensure they fully understood what it meant in their care (Kidd et al., 2013). This confidence usually came from relationships with their healthcare provider, showing an interplay between kāwanatanga and whanaungatanga.

Access to cultural liaisons, e.g., kaitiaki or kaitakawaenga, was considered a way to help bridge the gap between Māori and tauiwi practitioners. Participants in Pene et al. (2021) described the lack of access to cultural liaisons and provision of culturally-appropriate services. One participant stated:

> *I think all Māori patients should be asked if they want to speak to a Māori liaison staff or someone from the Māori team. Some Māori do prefer to have other Māori with them when being told information about their care* (p. 3207)

This statement describes a sense of wanting Māori liaison or their whānau present when making decisions around their healthcare. Māori whānau described the use of kaitiaki services in McLellan et al. (2014), however, the therapist lacked the skills of delivering culturally safe services. Therefore, the therapist was unable to utilise the kaitiaki's skills and knowledge, thereby not supporting this whānau's kāwanatanga.

Rangatiratanga

Rangatiratanga (article II of Te Tiriti) refers to Māori having absolute authority of their individual and collective affairs (Berghan et al., 2017; Came et al., 2018; Came et al., 2021; Oda & Rameka, 2012). Rangatiratanga requires the removal of barriers and obstacles and re-allocation of resources as well as working alongside Māori healthcare providers. There is also a need to challenge the current social norms of healthcare, improving equity and reducing various forms of racism (Berghan et al., 2017; Came et al., 2018). Rangatiratanga enables Māori to recover personal and cultural coherence so that Māori iwi and hāpū can provide for their own people. Māori need to be involved in design and delivery of Māori-specific health services providing a holistic approach to healthcare (Oda & Rameka, 2012).

Biomedical models of healthcare were reported as a barrier to Māori expressing their rangatiratanga (Kidd et al., 2013; Pene et al., 2021; Walker et al., 2022; Wilson et al., 2021). Māori clients reported that relationships with Māori health

providers provided space for significant cultural, spiritual, social, and emotional benefits (Kidd et al., 2013; Levack et al., 2016; Slater et al., 2013). A participant in Kidd et al. (2013) explained the following:

> *Culturally there is a big difference … we'd rather have [care provided] by ourselves, by our own rather than other people … we know that they're doing their job, but there's this cultural connection whereby our people feel a little bit threatened by other people coming in to help and not knowing the Māori sensitivity and culture.* (p. 130)

Beneficial relationships were also described by Māori participants in Levack et al. (2016) where marae-based pulmonary rehabilitation was utilised and compared to hospital-based services. These relationships included social and cultural connections Māori clients were able to make with Māori healthcare providers and other whānau Māori. Conversely, when biomedical models of healthcare were privileged, this was felt to have significant negative effects on whānau Māori. For example, a participant from Walker et al. (2022) described the following when their whānau offered to be a kidney donor:

> *My beautiful cousin in Australia offered and the doctor said 'you're too obese, you're not going to do it.' And she got really down that she couldn't do it. I mean what a knock down! They didn't talk to her about losing weight; just said 'no'.* (p. 5)

This represents the dominant discourse currently present within healthcare, with healthcare providers taking a power dominant, biomedical approach, which does not advocate for whānau or Māori autonomy.

Rangatiratanga can be acknowledged by healthcare professionals by utilising whānau and community support when whānau Māori make healthcare decisions (McLellan et al., 2014; Slater et al., 2013; Walker et al., 2017). Involving whānau and their community supported rangatiratanga as the clinician could provide options for clients, acting as a guide rather than the decider. This was evident with one participant in McLellan et al. (2014) reporting:

> *There is so much value for Māori people in learning how to cope after strokes, if we understand speech language therapy techniques, and understand what they're for ... We could have had Mum back at a better level earlier if we had understood the process a bit better*. (p. 533)

A participant in Walker et al. (2022) suggested "*we need a person in a position that's got power that can hold them accountable, and a system that's not designed to fail Māori*" (p. 4). These examples show spaces where healthcare professionals can support rangatiratanga or whānau aspirations by taking the lead from Māori and acting as an advocate when requested.

The desire for stronger Māori voice with decision making was expressed by whānau within the literature, to move Māori health forward. Benefits were described when care was provided by Māori health providers, as this provided space for a trusting relationship. (Levack et al., 2016; Slater et al., 2013; Walker et al., 2022; Walker et al., 2017). Having Māori in positions of power was described by Walker et al. (2022) with a participant stating, "*more Māori, to get in the positions to change the systemic racism which comes from the top*" (p. 4).

Ōritetanga

Ōritetanga (article III of Te Tiriti) refers to equitable healthcare and decision making that provides Māori the same levels of health and wellbeing as tau-iwi (Berghan et al., 2017; Came et al., 2018). Inequity in health services and outcomes for Māori have been reported through organisational structures, institutional racism and cultural alienation, staff interactions with ineffective communication, lack of whanaungatanga, and various practical barriers (Graham & Masters-Awatere, 2020). Inequity is a product of colonial systems as the current health system within Aotearoa is designed by Pākehā, for Pākehā and does not acknowledge Māori beliefs, values or worldviews (Selak et al., 2020). This system perpetuates a deficit discourse and culture where blame is placed on Māori for their health status (Davis & Came, 2022; Graham & Masters-Awatere, 2020; Selak et al., 2020).

Multiple barriers to healthcare access were described in the literature. These ranged from access to information, trusting relationships with healthcare providers or support groups, access to providers or health services, financial constraints and timing of appointments (Kidd et al., 2013; Levack et al., 2016; McLellan et al., 2014; Pene et al., 2021; Rahiri et al., 2020; Slater et al., 2013; Walker et al., 2022; Walker et al., 2017). Clear throughout the literature were whānau perspectives regarding the expectations health professionals held for Māori, particularly regarding preventative care. Self-blame and disengagement from healthcare resulted from the healthcare professionals assuming Māori having knowledge on conditions, causing Māori to often felt whakamā (embarrassed) during interactions with healthcare professionals (Walker et al., 2022; Walker et al., 2017). A participant in Walker et al. (2017) described these experiences:

> *I hated going to the doctor, being told off, but now when I think back, I was dumb, I didn't go, didn't take my insulin, didn't take my pills, drunk too much, smoked, you know everything you shouldn't do*. (p. 4)

This example shows how the interaction between healthcare providers and Māori can have an impact on their engagement with the system. Another barrier to accessing information was the lack of longstanding relationships and support from healthcare providers (Slater et al., 2013). Without these longstanding relationships, trust with the practitioner was often not formed and therefore lacked the support to gain information. Access to information was limited by the timings or potential cost of appointments or programs, which could hold financial implications (Kidd et al., 2013; Levack et al., 2016). Subsequently, Māori clients being blamed for their health or being labelled as 'troublesome' or 'non-compliant' from not following health advice could develop disengagement from the health system (Selak et al., 2020). These experiences facilitate Māori to disengage from health services by not holding Māori beliefs and values, such as whanaungatanga and rangatiratanga, at the forefront of the consultation, perpetuating inequity within our systems.

Practical barriers frequently reported regarding access to healthcare included transport (to and from services) and appropriate carparking. These areas were seen to contribute to levels of engagement or disengagement for Māori receiving care (Kidd et al., 2013; Levack et al., 2016; Pene et al., 2021; Slater et al., 2013). Whānau Māori in Levack et al. (2016) described barriers to transport as being common knowledge with healthcare practitioners as one client stated,

> *I said to her 'am I the only Māori coming?' And she said 'well there's meant to be others, but they're not coming.' And I said 'probably because you have to find your own way.'* (p. 500)

However, it was not clear whether staff had acted on this knowledge of an existing access barrier. Participants also described provision of free transport for Māori increased the accessibility of their program and therefore, uptake of the program (Levack et al. (2016). Free access to transport for clients can improve access to resources provided by healthcare practitioners (Levack et al., 2016). It was clear that healthcare has significant costs associated. Beyond transport, the cost of parking was seen as a burden, impacting whānau ability to support family members attend services (Kidd et al., 2013; Levack et al., 2016; Pene et al., 2021). One participant explained the impact of carparking as "*not only a monetary loss but emotional with whānau finding it too expensive*" (Pene et al. (2021). This statement described the financial and social implications the cost of services has and the system failing to recognise the role whānau have in Māori health and recovery. Cost of services was also described when other topics, such as financial availability of food recommended by dieticians for weight loss and primary care visits, with some Māori reporting seeking alternatives to recommended advice (Kidd et al., 2013; Rahiri et al., 2020).

Being racially profiled within the healthcare system was another barrier reported to equitable services. This was particularly present when Māori perceived healthcare professionals were making assumptions based on appearance alone (Rahiri et al., 2020; Walker et al., 2022). A participant in Walker et al. (2022) described

overhearing conversations from healthcare professionals "*non-compliant, they're not following the rules, they're being rude, they're missing their appointments*" (p. 6) putting blame onto Māori. This was also expressed in Rahiri et al. (2020) when describing an experience during a presentation

> *The surgeon introduced himself and he goes … it's so wonderful to meet everybody and whatever excuse you make up for you not getting weighed, coming to your sessions, doing as you're told, this is the one that we hear often; 'I went to a tangi.' …* (p. 303)

These assumptions are based on cultural bias and give the impression that healthcare professionals think Māori lack the integrity to take control of their own health. Alongside these experiences of racism, participants in Walker et al. (2017) felt ignored by healthcare professionals when concerns were raised about their diagnosis or doctors had failed to take notice of their health earlier, given some diagnoses were more prevalent in Māori compared to non-Māori. Together, these create a negative experience for whānau Māori receiving healthcare.

Trust of healthcare providers is viewed by Māori as one way to achieve equitable care. Two statements from Walker et al. (2017) describe how trust of healthcare professionals can either engage or disengage clients:

> *If they understood more about you they'd do things better and you'd do things better and then I'd trust them if they told me I could go home and do home, you know, but they don't know me and I'm not going to tell them if I don't think they care* (p. 5)

> *I guess a lot of that was trusting, and then feeling comfortable about what [name] were telling me, I needed to hear it from someone I trusted* (p. 5)

These quotes show ways in which the healthcare provider can engage with Māori in providing equitable care by first engaging with whanaungatanga to build trusting relationships and shows the inter-connectedness of whanaungatanga and ōritetanga. Walker et al. (2022) and Rahiri et al. (2020) describe how public awareness of certain diseases, such as prostate and breast cancer, is common knowledge. However, obesity and kidney disease which affect a high proportion of Māori, is not. Public awareness of these diseases was reported as a form of

institutional racism and created further negative outcomes when described alongside trust of healthcare professionals.

Prior positive experiences in programs and information provision by Māori going through similar experiences were deemed as beneficial for positive outcomes for Māori (Levack et al., 2016; Rahiri et al., 2020). Allowing time for peer support, interactions with health professionals who delivered the programs and initial positive health outcomes were described by participants as reasons for continuing with these programs allowing for ongoing, positive healthcare (Levack et al., 2016; Rahiri et al., 2020). These experiences show how building positive relationships and achieving results with whānau Māori can reduce inequities experienced by Māori by allowing space for whanaungatanga and rangatiratanga.

Wairuatanga

Wairuatanga (oral clause of Te Tiriti) is a fluid, complex construct which includes holistic values promoting links to tūpuna (ancestors), ancestral ties and connection with them, their actions and intentions, connection to people, self, and future generations, ancestral land, culture, and close kinship ties (Moewaka-Barnes et al., 2017; O'Carroll, 2013). Wairuatanga protects Māori faith and customs including te reo Māori and tikanga (Berghan et al., 2017; Came et al., 2018; Came et al., 2021). Within Māori culture, all life is considered sacred and interdependent. If problems arise within the physical world, these can be reflected with disruptions in the spiritual world, or vice versa (Berghan et al., 2017; Elder, 2013; Florence & Mikahere-Hall, 2019; O'Carroll, 2013).

Māori clients reported being able to feel the presence of wairua within healthcare professionals and their environments helped with building trusting, meaningful connections (Kidd et al., 2013; Levack et al., 2016; Pene et al., 2021; Slater et al.,

2013; Wilson et al., 2021). In the study by Wilson et al. (2021), when participants were asked to describe wairua, they reported "*Well, it's something within … whether it be spiritual, it's just something that you feel … you can't really explain it*" (p. 13) and "*… it's a spirit thing … you can feel the connection, you can 'feel' them…*" (p. 15) describing an intuition for wairua beyond the physical. Wairua serves to bring people together, particularly in an unfamiliar environment such as the hospital which often have significant negative connotations for whānau Māori such as disease or death (Walker et al., 2017; Wilson et al., 2021).

Staff interactions with an individual can also influence wairuatanga and can build connections with healthcare practitioners (Kidd et al., 2013; Levack et al., 2016). For example a participant in Kidd et al. (2013) commented on his cancer journey:

> *… "Man, your time's up". But when I heard this young fulla [a new specialist in another service] say to me 'We can cure you' that lifted me up. So from a downer I went to an up. Just a couple of words could change the way you feel about your illness.* (p. 134)

Alternatively, how clinicians treat Māori clients could just as easily disengage them. One participant explains:

> *…but to [the staff] it's just a job. Get them better, throw them out the door, who cares about their spiritual or whatever. Like we say to them 'We're humans too, and I want to be treated like one.*' (Kidd et al., 2013).

These examples show how treating Māori and their whānau can foster wairuatanga by providing space for hope and treating the person holistically instead of letting the constraints of the service healthcare professionals are in dictate the service they provide.

Clinician's cultural safety and alignment with Te Ao Māori and tikanga Māori facilitated wairuatanga within the healthcare encounter (Kidd et al., 2013; Levack et al., 2016; Pene et al., 2021; Walker et al., 2022). Lack of cultural safety and awareness of tikanga Māori was felt as a source of racism and further exacerbated prior negative experiences with the health system (McLellan et al., 2014; Walker

et al., 2022). Walker et al. (2022) described an experience where a Māori client missed getting blood tests performed secondary to attending a tangi, causing staff to assume they were disengaging from the service. This example shows one instance where a staff member's lack of cultural safety exhibited racism within this person's care. Examples where cultural safety was not present was consistently reported throughout the literature resulting in detrimental healthcare for whānau Māori. Māori acknowledging a lack of cultural safety shows the systemic racism and lack of wairuatanga present within Western healthcare systems (Kidd et al., 2013; McLellan et al., 2014; Pene et al., 2021; Walker et al., 2022).

Māori health providers were described to provide wairuatanga within healthcare (Levack et al., 2016; Walker et al., 2022). Levack et al. (2016) looked at the use of pulmonary rehabilitation within a marae setting. Participants within this study described having the program within the marae connected them to their community and having the use of tikanga Māori such as waiata, and conversations with other participants who shared common experiences, cultural backgrounds and life experiences provided significant social and spiritual benefits to whānau Māori. Walker et al. (2022) also describes a similar approach where both Māori and tauiwi healthcare providers who have cultural competence have capacity to help restore a person's trust and build connections with health services by "*understanding of Indigenous values and practices in care delivery*" (p. 4) and "*[making] a connection straight away*" (p. 4). These examples show the responsibilities tauiwi have in establishing connections with Māori clients which support wairuatanga.

The support and experience of other Māori going through the same journey could help to relieve sensations of isolation and provide a sense of belonging when going through their health journey, acknowledging a person's wairua (Pene et al., 2021; Rahiri et al., 2020; Walker et al., 2017). This was also reported when having whānau along with them on their healthcare journey as "*…it's not just a personal*

journey but it's a whole family thing." (Rahiri et al., 2020). This sensation was mostly consistent throughout the literature (Kidd et al., 2013; Pene et al., 2021), although some participants also reported reluctance to involve whānau support as they didn't want to be "*a burden to them*", or to "*retain their independence*" (Kidd et al., 2013). A participant from Pene et al. (2021) describes how whānau contribute to wairuatanga as "*Having them visit is what gives us strength, the support they can give is the most important support of all*" (p. 3206). Therefore, having whānau involvement, or Māori who are going through a similar journey, can support one's sense of wairuatanga.

Acknowledging the person as Māori and their roles and responsibility in the community is another contributor to wairuatanga (Kidd et al., 2013; McLellan et al., 2014; Walker et al., 2017). Generally, when considering their health, Māori males in particular saw a negative social stigma of being unwell, causing them to disbelieve or not pay attention to the symptoms and even feel whakamā about their situation. This also had implications for choice of treatment, particularly if it enabled them to continue to participate within their communities or reduce the cost of accessing health practitioners (Kidd et al., 2013; Walker et al., 2017). Māori men participating in Kidd et al. (2013) and Walker et al. (2017) see themselves as strong workers, providing financially for their whānau. Being unwell gave some a sense of being weak and inferior to their peers which can subsequently cause disengagement from their own healthcare. Acknowledging the person, their responsibilities and supporting them to make choices, can foster engagement and input within their healthcare (Kidd et al., 2013; Walker et al., 2017). Alongside this, acknowledging the person for their background and actively participating in whanaungatanga can contribute towards ones wairuatanga (Kidd et al., 2013; McLellan et al., 2014). McLellan et al. (2014) describes a situation where this was not present within a healthcare encounter which negatively impacted Māori and whānau relationships with the provider as the client's cultural values within te Ao

Māori were not valued. This significantly impacted the person's rehabilitation and ongoing trust of the service also signifying how acknowledging cultural values within te Ao Māori within the healthcare encounter can help to acknowledge wairuatanga.

Clinical Reflection

The clinical reflection will begin with a typical physiotherapy-style of a case study. I will then use critical reflexivity with te Tiriti as a framework for building on knowledge gained from the framework analysis and how I changed my practice by challenging both myself and the system.

Introducing Mere

Mere is a Māori woman in her 60's who was diagnosed with peripheral neuropathy sixteen years prior. This diagnosis eventually resulted in peripheral muscle weakness, loss of sensation and full contractures of her upper and lower limb. These impairments have gradually resulted in the inability to perform basic activities of daily living independently such as getting dressed and toileting, particularly worsening over the last 5 years. Mere lives at home with her husband, three children and grandparents in a low socioeconomic area. She had limited access to rehabilitation due to previous experiences within the hospital environment with the lack of respectful relationships and an extensive history of non-attendance to hospital appointments. My first encounter with Mere was during a handover session with the previous treating physiotherapist. Impairments identified included reduced cardiovascular fitness and reliance on a quad stick to mobilise secondary to a significant contracture of her right foot into a plantarflexed, inverted position and flexion contracture of her upper limb. These contractures significantly limited her function as she was unable to mobilise in her wheelchair unassisted, therefore being reliant on her whānau to push her around the home in

a wheelchair for basic activities of daily living. With Mere being so dependant, her whānau had to resign from work to provide 24-hour care for her. After the last 5 years of care, this has caused significant carer strain on Mere's whānau. Mere's primary goal was to become mobile again and was seeking orthopaedic input regarding her foot at which time they stated that the surgery would be very beneficial but not without significant risk including loss of limb or life. Therefore, the aims of physiotherapy were agreed upon between Mere and her previous physiotherapist to get Mere as reconditioned and mobile as possible to allow for greater post-surgical potential.

Whanungatanga

When I initially met Mere and her whānau, myself and her previous treating physiotherapist begun with the biomedical model at the centre of the encounter. Our initial encounter focussed solely on Mere's outcome measures which, from our standpoint, she was not achieving. Neither myself nor my colleague provided space or opportunities for whanaungatanga by sharing of stories and finding connections. This initial encounter was focussed solely on her impairments and giving her and her whānau a "*telling off*" for her health status – a term she later said when she was telling us about what that original session felt like. Experiences provided by Māori participants in the research undertaken establishes the tikanga of whanaungatanga where Māori "*talk about their whakapapa first*" (Levack et al., 2016), creating a connection between two people and establishing a trusting relationship (McLellan et al., 2014; Wilson et al., 2021). Because my colleague and I continued the physiotherapy and biomedical model of impairment focussed care (Selak et al., 2020), and in fact, did not even question this because this is so deeply entrenched in 'how we do things' in healthcare and in physiotherapy. No care was given for tikanga or whanaungatanga in the initial interaction, therefore, potentially making it difficult for Mere to form a sense of trust with me.

How clinicians prioritise their time is another barrier the system has engraved in us that stops whanaungatanga being established in the clinical encounter (Graham & Masters-Awatere, 2020; Levack et al., 2016). Time was not provided by me or Mere's original physiotherapist during the initial interaction which goes against tikanga Māori values of building whanaungatanga through whakapapa. Reflecting on the initial encounter with Mere, there *was* time for us to engage in whanaungatanga. However, we, as clinicians, prioritised our impairment and outcome measure testing above whanaungatanga as we had a task to perform which included measuring our success or failures based on how Mere presented that day. The outcomes that were important to us professionally were what we privileged under the biomedical model of healthcare. That day, Mere presented in the worst condition that my colleague had seen her in. We could not understand why this had happened and asked many questions about why this was. Mere later opened up to me about this experience as "*being back at the principal's office*" and "*ignoring what you fullas were saying*". Mere also advised that her and her whānau's priorities were not with her, but with the extended whānau as she had several tangihanga (traditional Māori funeral) to attend as well as celebrations such as weddings and childbirths. Rehabilitation was not at the forefront of her mind which, from our biomedical perspective, it should have been. As physiotherapists, we expect patients who come to our service to abide by our recommendations and be 'good patients' or we have a 'firm word' and threaten discharge. If we undertook this approach, we would have been going against what the health system is currently attempting to achieve through pae ora and not acknowledging mauri ora or whānau ora (Ministry of Health, 2020a). However, we would have been acting in accordance to how we have been trained by our institutions and previous seniors by reinforcing the power dynamic and further perpetuating Māori inequities in health. What is needed is a process to challenge these entrenched and unquestioned habits and implementing them in future practice.

Māori clients within this review have described consistency of care as another element of whanaungatanga which provided for trusting relationships (Kidd et al., 2013; Rahiri et al., 2020). As static rehabilitation physiotherapists, we rotate around the rehabilitation wards and outpatients. For our long-term clients, which Mere had been for the previous therapist, this meant change of therapists at certain times of the year. This rotational system is designed to benefit the therapist so that they do not get too burnt out in one area. However, Mere's experience demonstrates the unintended consequences for patients, whose needs are not foregrounded in this service design. For Mere, this was important as she and her whānau needed to trust her therapist to advocate for her in the case of her surgery being denied. Due to the current systems in place and timings of rotations, relationships may not have been prioritised or established when she was notified that her surgery was denied. Without these relationships in place, there is a possibility that Mere and whānau may not have trusted the physiotherapist, or the physiotherapist not taking up the role of being an active advocate for her. Being a consistent part of Mere's journey over the last year provided Mere, her whānau and myself awareness of Mere's priorities and needs, and I was able to advocate for her to receive surgery escalating the surgical team denying her surgery to a higher level when barriers to surgery were put in place. If Mere was denied surgery at a time I had rotated on or I had just rotated into the position, I do not feel I or her new therapist would have the relationship to support Mere in getting the surgery. We may have fallen to the easiest option of conforming to the decision made by the surgeon, or not recognised the issues and injustice that the last of surgery meant for Mere, therefore not acting as an advocate. Having therapists rotate in this system demonstrates how the health system is designed to benefit the clinician and does not acknowledge continuity of care, essential in whanaungatanga. Continuing this rotational system will continue to prioritise the needs of the clinician above the

needs of the client and disrupt continuity of care reported by Māori as essential in trusting relationships (Kidd et al., 2013; Rahiri et al., 2020).

Whanaungatanga requires intentionally creating space to meaningfully engage with building connections with Māori so that both whānau and the therapist come to know each other beyond the person's condition (Levack et al., 2016; McLellan et al., 2014; Wilson et al., 2021). When I reflect on my interactions with Mere, I did not prioritise whanaungatanga for the first six months of treating her. It wasn't until performing this literature review that I acknowledged what meaningful whanaungatanga looked like and how it was integral to being a Tiriti-partner that I then created space for whanaungatanga to occur. The reciprocal exchange of information went strongly against my professional beliefs at the time as I had been taught throughout my degree and professional career that sharing personal information was unethical and relationships were not to be established within the clinical encounter. Professional boundaries are valued in my discipline, and in most healthcare disciplines (Davis & Came, 2022; Selak et al., 2020). I started to intentionally share aspects of myself to provide Mere with a sense of who I am – talking about my wife and I expecting a baby and the reasons for us moving back to the Waikato. I chose these topics as a starting point for providing Mere a sense of who I am as they were relevant to who I am within the present space, and where I have come from. Opening the space for whanaungatanga by sharing aspects of myself was the turning point of my relationship with Mere; it allowed us to dive deeper into our connections and we were able to connect back to Northland where both our families were originally from. Initially, I was not comfortable sharing most of this information as it was against what I had been taught so religiously throughout my learning and career to date. However, opening up to Mere improved our professional relationship significantly and changed her body language and interactions with me significantly. Prior to engaging in whanaungatanga with Mere, she was closed off, always looking at the ground and not answering questions and

I felt challenged with how I could engage with her, and, if I couldn't, I may have labelled her as a challenging client. After creating the opportunity for whanaungatanga with Mere, she began to engage in conversation, look up and around more during therapy sessions, and initiated the conversation about further investigations around her surgical input. From a seat of power, providing space for whanaungatanga initially created a safe space for Mere to also share in a similar fashion. Speaking from a position of power and how I initially felt uncomfortable with sharing aspects of myself demonstrates how hard it can be for Māori or clients who are at a disadvantage to create that space. This highlights the importance of the person in power to take the first steps to provide a safe space for whanaungatanga.

Kāwanatanga

Information provision and how clinicians communicate was considered important for how Māori govern their health (McLellan et al., 2014; Pene et al., 2021; Walker et al., 2022; Wilson et al., 2021). Reflecting further on the initial interaction between myself and Mere, the information I provided focused on Mere's deconditioning and the health of her hands, which stemmed from an impairment-oriented perspective. Providing information in this way reflects what I have been taught in physiotherapy in the past which unconsciously has shaped my practice going forward. Focussing on Mere's impairments and how they relate to her function provides me with a way to help Mere in the context of my clinical environment that I have control over. However, Mere's environment isn't that of the clinic, but of her whānau and what is going on in her day-to-day activities. Establishing whanaungatanga allowed me to reflect on how I had been attempting to communicate the impairment-based information early on in our encounter. I changed the way I framed this discussion with Mere and her whānau about how they saw her impairments and the implications they have on her future self. This sense of control within the clinical

environment also shows how I value my power in this situation; without this control, I feel powerless (Bolton & Andrews, 2018). However, I feel that after this conversation with Mere and her whānau, my sense of power was not only maintained, but it was shared between us providing space for Mere and whānau to have an informed choice in her decision-making.

Being part of decision making described in the framework analysis was also important for Mere having kāwanatanga (McLellan et al., 2014; Pene et al., 2021; Walker et al., 2022; Walker et al., 2017). Mere reported conversations with her surgeon as largely positive; this was also evident in the reports that followed around the potential for Mere's surgery. So, it was a surprise to all that Mere had been declined for surgery, as Mere described, "*on the basis of a questionnaire*", which turned out to be a surgical risk assessment form. Mere and I discussed what we could do to get the information from the surgeon about why this decision was made. Mere consented to me writing a letter requesting more information from the surgeon. After the first month without a reply, we discussed alternative ways in which we could seek an answer. It was at this point Mere and her whānau requested the use of kaitiaki services and discuss the case with the equity committee for further advice. These services assisted with initiating a discussion with the Chief Surgical Officer around the reasons why Mere was declined. This situation shows the difficulties of navigating the health system, restricting people's ability to become fully informed on why decisions are made, limiting kāwanatanga. In Mere's case, having surgery declined made her become very despondent. We eventually discovered through the Chief Surgical Officer and the support of the equity committee that Mere was declined because the surgeon thought that surgery would be too detrimental to Mere's health potentially causing loss of limb or life, and she would not have significant improvement in her quality of life. This was represented on the surgeon's section of the questionnaire, accounting for two thirds of the rationale for surgery, that then led to Mere scoring below the threshold

for surgery. Mere's perspective was limited within this part of the decision-making process and kāwanatanga sat with the surgeon. Having a surgeon who is outside of Mere's day-to-day functioning say how a surgery which can potentially allow her to walk makes me ask further questions about the bias that these questionnaires hold. These questionnaires are heavily weighted toward the surgeon's understanding of this person, but they can only see what is happening from their lens and do not take into consideration the perspectives of others that are involved in her care. The surgeon having all the power in Mere's situation shows the hierarchical discourse which is continuing throughout healthcare where the doctor has the final say without discussions with the wider team, including Mere, her whānau and myself, her physiotherapist. We are currently seeking alternatives for Mere's rehabilitation, including serial casting, and in the process of seeking a second opinion.

Rangatiratanga

The lack of whanaungatanga and kāwanatanga in the initial and subsequent sessions with myself created a power-dominant relationship in my favour. The initial space I had created was one where Mere's rangatiratanga or autonomy was not recognised or respected, and Mere's perspectives (or that of her whānau) were not prioritised in potential treatment decisions. This was unintentional, however showed my inherit biases of working with a biomedical lens where therapist knowledge is prioritised with a focus on 'fixing' the person (Main et al., 2006; Selak et al., 2020). While undertaking this practice project, providing space for whanaungatanga was an area that I needed significant development. By actively and consciously developing my practice in this area, created opportunities to foster a sense of relationship between myself and Mere, where I valued Mere's rangatiratanga while listening or asking about what was meaningful to her (Kidd et al., 2013; Pene et al., 2021; Walker et al., 2022; Wilson et al., 2021). Having a

relationship established also enabled a space where I had clearer understanding of Mere's desires, in relation to her surgery, and what was important to her. This understanding supported not only my ability to better advocate for Mere, on her behalf, but also Mere to feel more comfortable that I was being guided by, and acting in her best interests, as determined by her. This included Mere's decisions for a letter to be written, with her oversight of the letter, and to involve the kaitiaki and equity committee to investigate her care and decision making around her surgery when answers were not received. Working in this way, which was more in active partnership with Mere, acknowledged her rangatiratanga in her care plan, and I to work in ways which supported her autonomy. This required me to challenge my own practice and decisions within the system of healthcare Mere was receiving, which worked at odds to this process. However, respecting Mere's rangatiratanga eventuated better outcomes than I could have facilitated by undertaking the biomedical model which may have meant the case was dropped and she subsequently discharged from our services.

Ōritetanga

I contributed to Mere's experience of inequity during her health journey with me. Māori reported access to information, and how this information was delivered as contributing to inequity (Kidd et al., 2013; Levack et al., 2016; McLellan et al., 2014; Pene et al., 2021; Rahiri et al., 2020; Slater et al., 2013; Walker et al., 2022; Walker et al., 2017). How I addressed Mere and her health during the initial and subsequent interactions significantly contributed to her engagement in her healthcare. How my colleague and I established, and then I continued, the biomedical model of care created inequities in Mere's healthcare as we did not create space for Mere or her whānau to uphold her rangatiratanga and likely putting her ongoing engagement in rehabilitation at risk. We created an environment where Mere had negative experiences through biomedical interactions. If this

environment did not change, we may have contributed to negative outcomes for Mere and her whānau. Biomedical interactions with healthcare practitioners were described as a source where Māori felt information was not readily available. Providing information in the biomedical model and not incorporating te Ao Māori was reported to contribute to Māori disengagement with healthcare practitioners (Rahiri et al., 2020; Walker et al., 2022; Walker et al., 2017). If whanaungatanga had not been established, Mere may have continued to experience lack of information provision from me due to the way I was presenting the information which may have caused her to disengage from our services, contributing to inequities she has already experienced.

External to the case study presented, there appear to be a low number of Māori attending our clinics and for those who have attended, transport, parking availability and cost of parking appear to be contributors to disengagement with our services. The inability to access services for these reasons is also referred to in the literature as a reason for also disengaging with health services (Kidd et al., 2013; Levack et al., 2016; McLellan et al., 2014; Pene et al., 2021; Rahiri et al., 2020; Slater et al., 2013; Walker et al., 2022; Walker et al., 2017). The closest parking to our service is three 15-minute parking slots with three other disabled parks. The next closest park requires a cost of approximately $3 at a minimum and is between a 5- and 15-minute walk. My clientele is mostly mobility-impaired which makes this journey significantly difficult for most who attend their appointments with me. The parking system is not designed for outpatient or inpatient use and prioritises those who are physically able to access their appointments which creates another barrier to accessing services and contributing to inequity. Discussing alternative options to therapy, such as community therapy can help to reduce these inequities. Recently, I have begun to investigate services for my Māori clients that marae and iwi provide for healthcare, including funding and

therapies, that may help in reducing inequities and reconnecting Māori with their whenua and, in the case of Mere, use of rongoā Māori.

Wairuatanga

Māori views of wairuatanga report it to be a spiritual or innate feeling that exists and connects people together, in this context, female Māori and male Pākehā, or people with their surrounding environment (Kidd et al., 2013; Levack et al., 2016; Pene et al., 2021; Walker et al., 2022; Wilson et al., 2021). My practice context of a hospital outpatient environment is unlikely to facilitate meaningful connection; such places have been described as places of harm and disconnect and have the potential to make someone feel whakamā or have previous experiences of discrimination, racism and repeated historical trauma (Kidd et al., 2013; McLellan et al., 2014; Walker et al., 2017). Whilst we cannot always change the outpatient environment, its impact on wairuatanga may be mitigated using Māori specific resources and how the environment is set up. The relationship Mere had built with her previous therapist meant that she viewed our gym as a safe and trusting place. This trusting relationship was built over time and demonstrates that with cultural safety and awareness of tikanga Māori, unmodifiable factors such as the place of practice can be overcome.

Having joint sessions with clients who are going through similar situations may be a way to create whanaungatanga and support one sense of wairuatanga (Levack et al., 2016). As reported by Māori clients in articles in the literature review, being able to see others who are going through similar circumstances creates an environment of belonging. It also creates a shared space for people to interact and share their stories and build relationships (Pene et al., 2021; Rahiri et al., 2020; Walker et al., 2017). I chose not to do this with Mere as she required one person to assist her with all transfers and mobility. In this situation I used my power to

prioritise safety for the therapy assistant completing Mere's rehabilitation program. Alternative ways for providing group therapy in the case of Mere would be around having an open discussion with Mere and her whānau and seeing if they were happy to provide support for her therapy during this time. This conversation had been raised previously, particularly around home-based therapy, which her whānau seemed apprehensive around. I did not choose to further investigate these apprehensions as I did not want to assume that this care would be provided by Mere's whānau, as also described in this review. This created a space where my own thoughts and perceptions created an unconscious opinion further increasing my privilege and perpetuating a power dynamic already present, potentially further impacting Mere's experience and connection to the encounters and overall wairuatanga.

As indicated throughout this reflective piece, my own knowledge of tikanga Māori impacted the initial relationship and interactions with Mere. Due to my personal upbringing, learnings, and environments I have been privileged to, tikanga Māori has not been at the forefront of my practice. This reflective piece has created insight into the knowledge that I can potentially gain, and the impact that I can have on someone's health journey, just using whanaungatanga alone. Further understandings of tikanga Māori and working in ways that uphold te Tiriti may help me bridge that gap further and address factors in my own approach. Working in this way can transform my practice from unintentionally perpetuating inequities, to actively working as a Tiriti-partner and promoting health equity.

Discussion

This practice project aimed to explore Māori experiences of hospital healthcare for learnings to be used alongside critical reflexivity on a case in my practice. Māori frequently report time not being spent on whanaungatanga and clinicians not acknowledging wairuatanga within interactions. Alongside this, rangatiratanga and kāwanatanga are often not supported in clinical situations because of power dynamics and Western paradigms of healthcare. This has a summative result of Māori not being able to achieve ōritetanga. Reflecting using critical reflexivity has demonstrated that Mere had similar experiences to the literature with my care. However, I was able to address some of these experiences, resulting in increased quality of care. Although I have taken some steps to improve Mere's care, I still need to engage in this practice to ensure I do not solely rely on my Western ways of practice, and ensure the experiences shared between Mere and myself are taken forward to whānau Māori I work alongside in the future. This reflection marks a starting point for me, with many more learnings to come.

Clinical consultations are oriented around biomedical models of care which are unidirectional with impairments at the forefront of consultations while maintaining professional distance (Carlson et al., 2016; Main et al., 2006; Selak et al., 2020; Terry & Kayes, 2020). Creating relationships with the biomedical model at the forefront does not value respectful communication and connection, which often causes clients to feel vulnerable, unsure and outside of their comfort zone (Carlson et al., 2016). As physiotherapists, we perpetuate this model by treating the 'body as a machine', that orients our practice around the body part and not the person we are treating (Nicholls, 2018). The biomedical model of healthcare is contradictory to whanaungatanga and Māori health which requires building respectful, reciprocal, meaningful relationships between clients and clinicians, so each party learns about each other through shared experiences (Carlson et al.,

2016; Terry & Kayes, 2020). If a clinician can connect with their client using whanaungatanga, it allows space for a trusting relationship where both parties learn from each other. Within this review, I have described both how my Western view of clinical engagement has disengaged Mere and created space for Mere to re-engage with our services using whanaungatanga. Through engaging in whanaungatanga, there is the opportunity that clinicians can create trusting relationships with whānau Māori to help re-engage them with our services.

Current systems are governed by Western knowledge, creating power-imbalances in favour of the clinician and the system they serve which results in negative health outcomes and experiences by Māori (Bolton & Andrews, 2018; Graham & Masters-Awatere, 2020; Penney et al., 2011; Waitangi Tribunal, 2019). As demonstrated within my reflection, these Western-dominant processes were established by myself and others who were involved is Mere's care, limiting her decision making and autonomy. Alongside the dominance of Western knowledge, institutional racism is a major barrier towards Māori having kāwanatanga and rangatiratanga within healthcare (Came, 2014; Graham & Masters-Awatere, 2020). Health systems are currently in a state of change which may support kāwanatanga at higher levels through co-governance of healthcare with Te Aka Whai Ora and Te Whatu ora, ensuring Māori are involved and equal partners in decision making (New Zealand Government, 2022). This change in governing structures may see whānau Māori having more autonomy at the systems level. However, the true effect of these changes yet to be seen. Alongside system-level changes, clinicians also need to acknowledge and uphold Māori rangatiratanga. This practice project has highlighted ways in which clinicians can do this, including using Māori health providers or kaitiaki to support engagement with Māori (Levack et al., 2016; Slater et al., 2013; Walker et al., 2022; Walker et al., 2017). However, the clinician also needs to be able to provide culturally safe services, not 'simply' rely on Māori-provided services. Using cultural safety and humility can help the clinician

acknowledge whānau Māori needs for Māori-provided services, and secondly, effective utilisation of these services and the value they have for whānau Māori (McLellan et al., 2014). However, whānau Māori are heterogenous, therefore what works for one group may not work for another. There is, therefore, a need for the clinician to be responsive to each person they interact with.

The colonisation of systems has forced a relocation of power and resources from indigenous peoples to the colonisers, restricting Māori abilities to have rangatiratanga (Selak et al., 2020). Colonisation has created systems that have an inherent bias or racism against Māori within Aotearoa (Davis & Came, 2022; Selak et al., 2020). Having engaged in critical reflection, I can see how colonial systems and institutional racism have had a clear impact on Mere's health and wellbeing, including my contributions within that system. I perpetuated institutional racism by continuing to prioritise medical models of care, therefore not upholding the articles of te Tiriti within my practice. Only through undertaking the lens applied within this practice project was I able to acknowledge how my actions were contributing to the inequities experienced by Māori and further perpetuating the cyclical pattern of colonisation which dominates our health systems (Davis & Came, 2022; Health Quality and Safety Commission, 2019; Selak et al., 2020). Being within a system that denies Māori rangatiratanga through biomedical models of care means Māori are further disadvantaged by not being able to determine their own path. As clinicians, we need to walk alongside whānau Māori, recognising their autonomy and supporting them, regardless of the service constraints placed against us, thereby supporting whānau Māori rangatiratanga. How this looks in practice is likely different in each clinical scenario and clinicians needing to take the lead from whānau Māori and how they want their care to be supported.

Failures to te Tiriti have contributed significantly to inequities experienced by Māori as colonisation and biomedical dominance of knowledge cause a cyclical pattern

of bias and racism against Māori (Graham & Masters-Awatere, 2020; Health Quality and Safety Commission, 2019). These forms of dominance are perpetuated by not only our health systems, but the education systems we learn within (Davis & Came, 2022). As clinicians, we have an opportunity to challenge these dominant discourses by advancing our knowledge in culturally safe practice and providing non-racist experiences for whānau Māori (Graham & Masters-Awatere, 2020). Service design, access to, and cost of services including indirect costs, time off work, and whānau support, are some of the experiences I have noted within my practice, which are also consistent throughout the literature (Graham & Masters-Awatere, 2020; Kidd et al., 2013; Levack et al., 2016; McLellan et al., 2014; Pene et al., 2021; Rahiri et al., 2020; Slater et al., 2013; Walker et al., 2022; Walker et al., 2017). As these experiences of inequity are perpetuated throughout the literature, it is imperative that systems and clinicians act to reduce these disparities to ensure whānau Māori have access to care that is culturally safe and actively acting to reduce the origin of these cost to whānau Māori.

Wairua is central to healthcare (Carlson et al., 2016; Wilson et al., 2021). Wairua is often neglected by clinicians as it can be seen by them as outside the Western paradigm of health, perpetuating experiences of racism within healthcare (Moewaka-Barnes et al., 2017; Pitama et al., 2007). There is a need to integrate wairua into practice through relational care and integrating Māori values and beliefs into the systems we work in to support whānau Māori to feel connected to services (Pitama et al., 2007; Wilson et al., 2021). Practices that support a sense of wairuatanga, as described by whānau Māori, include using te reo Māori, integrating Māori tikanga in practice which is appropriate to the person or place, and prioritising respectful relationships beyond biomedical patient-practitioner dynamics (Berghan et al., 2017; Came et al., 2021; Wilson et al., 2021). Acknowledging whānau Māori as heterogenous may reduce the risk of utilising a cultural checklist which may lead expectations of dominant cultural assumptions

without consideration of specific whānau Māori wants or needs (Main et al., 2006; Pitama et al., 2007). Different models and tools have been developed which prioritise Māori concepts of hauora (including wairuatanga) and can support clinicians to engage with Māori perspectives and facilitate conversations with whānau regarding their unique views. An example of a model includes the Meihana model which is a culturally tailored model of communication that can support wairua within a clinical setting. The Meihana model focuses on Māori beliefs, values, and experiences relevant to the person and whānau by identifying whānau at the centre of intervention, challenging the clinician to see the Māori client as part of a collective (Lacey et al., 2011; Pitama et al., 2007). Another example is Te Waka Kuaka and Te Waka Oranga which provides space for whānau to identify and reflect on their own needs to navigate their health journeys (Elder, 2017). Having a tool that helps whānau identify these needs allows healthcare clinicians to be clear about what these needs are and provide space for both whānau and healthcare clinicians bring knowledge together to serve a common purpose. These models can provide clinicians with frameworks to recognise and create space for wairuatanga, connect and engage with whānau Māori through whanaungatanga, step back, enabling whānau Māori to have kāwanatanga and rangatiratanga while contributing to whānau ōritetanga.

Critical reflexivity was an integral part of this practice project. There is an ongoing call, from professional standards (Physiotherapy Board of New Zealand, 2021), system changes (Ministry of Health, 2021; New Zealand Government, 2022) and whānau Māori (Graham & Masters-Awatere, 2020) for clinicians to be critically reflexive, building cultural safety. Being critically reflexive on practice is a process which can help improve the clinician's cultural safety by analysing both seen and unseen practices and how these practices impact whānau Māori. Through this practice project, I have developed a guide (see Appendix G) using te Tiriti as a framework to bring clinicians to the space of critical reflexivity in their practice.

Utilising this guide may challenge unconscious assumptions, values and biases clinicians hold, and hopefully guiding them to engage with te Tiriti in their practice. This template begins by exploring the person's positioning, questioning their past and present. Positioning in this process aims to improve a person's sense of security in their own cultural identity and can be used to acknowledge a person's sense of power or paralysis and move through paralysis (Crawford & Longridge, 2022). Positioning in this way also sets up the person to critique conscious and unconscious power structures and challenge their own culture, privilege, power, and biases rather than becoming competent in other cultures (Curtis et al., 2019). Next in the critical reflexivity tool is identifying and reporting on a case study. The questions within the critical reflexivity tool are designed to make the person dig deeper into their thoughts, feeling, actions and emotions, particularly during the initial consultation. It then explores these aspects in subsequent interactions with the client. Subsequently, questions are asked based around the articles of te Tiriti. These questions were often ones that provoked my thinking more when completing my critical reflection and posed in the literature reported in this practice project from the experiences of Māori. Finally, questions were posed about changing practice and bringing aspects of te Tiriti into practice. These questions include changes next time, immediate implementation, and supports required to make these changes. Acknowledging support is a key aspect to this critical reflexivity template as we are trying to question systems and change practices which have the biomedical model of care engrained into it. By questioning these systems and self-bias likely created tensions for the person undertaking this process, therefore, support is essential in this process, as it has been for me during this practice project (Crawford & Longridge, 2022; Hotere-Barnes, 2015).

The journey of completing this practice project and furthering my steps to becoming a Tiriti-partner have been challenging both personally and professionally. However, I feel my confidence within my practice has significantly increased. First,

acknowledging my own biases, including perpetuating the biomedical model of care and how I prioritise my time, and seeing how I have been contributing to institutional racism has been eye-opening. Receiving feedback from my supervisors was often confronting. Having my inherent biases made visible to me at times created tension within myself and occasionally led me to not wanting to continue down this path. However, social supports through personal links in my workplace and scheduled supervision sessions with my supervisors helped with transitioning me forward and assisting with navigating through this complex process. Alongside these social supports, the feedback gained from my clients within practice also affirmed that I was on the right path, receiving frequent comments such as "*When am I coming back to see you again?"* and "*I can't wait for our next session*." The journey of becoming a Tiriti-partner is a complex, and personally challenging movement, therefore these social supports are integral in acknowledging the person and assisting them in moving forward in their journey (Crawford & Longridge, 2022; Hotere-Barnes, 2015; Margaret, 2010).

Strengths

To my knowledge, this is the first piece of research navigating the turbulent waters of the journey of becoming an effective Tiriti-partner in healthcare. Although my journey still has a long way to go, I believe that the process I undertook may benefit others who are looking at beginning and continuing this journey. Furthermore, first centring the research on Māori voices to seek understanding of what it may mean to be a Tiriti-partner in a healthcare setting is a strength. Attending to Māori voices provided me with a medium to further understand te Tiriti in practice. Utilising te Tiriti as an analytic framework helped me think holistically about practice and was challenging as I needed to first understand complex concepts behind the articles of te Tiriti then use these concepts to further challenge my practice. However,

attending to te Tiriti in this way provided me with a deeper knowledge of te Tiriti and its use in practice.

This practice project also was not a traditional practice project as it blended a 'formal' review with personal experience. Blending the project in this way meant that it was not just an intellectual exercise, but a deeply personal one as it challenged many beliefs and habits within my practice that continue to need further development. Utilising critical reflexivity in conjunction with the literature provided a medium to challenge my practice and implement changes immediately which I believe a formal literature review on its own wouldn't have achieved. Combining the literature review and critical reflexivity has benefited both myself and my clients, and has helped me to prioritise creating a safe, trusting environment built on equal exchange. However, I need to continue to challenge my practice through critical reflexivity to not become complacent within this area. Finally, this project can be utilised by others who are undertaking this journey as a framework to help supplement their learnings and create an environment to help discuss such complex and confronting topics.

Limitations

Being a Pākehā with different experiences and cultural histories means I have limited deeper knowledge of Māori worldviews. As a Pākehā, I have not been exposed to the same elements of cultural connection that some Māori experience such as te reo and appreciating kaitiakitanga for the land, which can limit my interpretation of some of the results provided in this review. This limited interpretation may mean some key concepts from the Māori worldview may not have been interpreted appropriately or misinterpreted altogether. However, I have mitigated these limitations using supervision with a Māori supervisor (BJW) throughout this process and through the general literature search prior to

undertaking this journey. The journey of becoming a Tiriti-partner is uniquely personal with my driver for beginning this process coming from my experiences with health both personally and professionally. This journey reflects a starting point, and it is likely that if I came back to these reflections in the future, they would change further, acknowledging that the process of learning and development is ongoing. The drivers for change are different for everyone undertaking this journey, therefore the learnings I have gained, and processes used in this journey can be a guide to help support others undertaking the path of becoming a Tiriti-partner.

Recommendations for practice

The following are recommendations for tauiwi practitioners and health systems to take into consideration when developing ways of working which are culturally safe and uphold te Tiriti.

Learning and growing knowledge

- Seek out others who are working as Tiriti-partners for supervision or cultural supervision either internally or externally.
- Create education opportunities on te Tiriti, critical reflection, tikanga Māori and topics on equity in healthcare.
- Invite Māori whānau to comment on what is or is not working for them with current practices and environments and purposefully reflect on these recommendations for future change.
- Incorporate te Tiriti into undergraduate knowledge and begin utilising critical reflexivity within these institutions to engage therapists in these discussions from the beginning of their careers. See Appendix G for a template to guide critical reflexivity.

Reflection on self

- Build on learnings developed around te Tiriti, understand how the preamble and articles interact with each other and how to integrate Te Tiriti in practice.
- Reflect on your own positioning so that you ‘know yourself’ and can engage more genuinely and meaningfully in the healthcare encounter.
- Utilise a reflective journal to begin noting thoughts around current practice and inherit biases.
- Further challenge practice by taking your approach and care of a client and be critically reflexive, acknowledging and building on the interactions of institutions, professions and self and inherit biases within practice.
- Utilise a critical reflection template (see Appendix G) to help guide thoughts around te Tiriti in the healthcare context.

Changing practice

- Intentionally create space to engage in whanaungatanga to build relationships through equal engagement throughout the healthcare journey.
- Create time and opportunities for critical self-reflection within the workplace, including during supervision sessions.
- Review current practices around visiting hours and continuity of care e.g., nursing rosters to create space for whanaungatanga and rangatiratanga within the workplace.
- Review work environments and practices for ways to introduce te Ao Māori to further build wairuatanga into the health system.
- Actively recruit and acknowledge ways to retain Māori health practitioners.
- Build partnerships with iwi health providers and Kaupapa Māori non-governmental organisations.

Conclusion

Becoming a Tiriti-partner is unique to the person. For many, it will involve confronting their current normal of practice and the system built on dominant biomedical models of health. Critical reflexivity is one facet that healthcare practitioners need to explore to begin the journey of becoming a Tiriti-partner and building culturally safe practitioners. Critical reflexivity requires the practitioner to reflect on their practice, acknowledging and building on unconscious personal, professional, and institutional biases. Undertaking critical reflexivity has the opportunity to grow the practitioner into a Tiriti-partner or create internal tensions known as Pākehā paralysis. To move through these processes requires social supports both within the practice context and externally through cultural supervision. Within this practice project I was able to critically reflect upon my case with Mere, drawing on my learnings from Māori within the literature in the context of te Tiriti. The process of critical reflexivity and becoming a Tiriti-partner is an ongoing journey. This is just the start of my journey which has already contributed to changes in my practice with clients other than Mere. The process of undertaking this practice project has given me the confidence to be an advocate for my clients by building relationships built on trust and reciprocity. It has also given me a life-long tool to use in my practice to challenge my own perceptions of practice, and to challenge other students and practitioners that I work alongside. Utilising and implementing critical reflexivity as a tool with te Tiriti as a framework of analysis may help to provide equitable care for Māori in the future.

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Appendices

Appendix A – Whanaungatanga

Whanaungatanga

Article	Impact on persons healthcare journey?	Has whanaungatanga been attended to?	Descriptors of how whanaungatanga has/has not been attended to	What does meaningful whanaungatanga look like?	Other

Appendix B – Kāwanatanga

Kāwanatanga

Article	Is kāwanatanga present/visible/what spaces have been provided for Māori to enact kāwanatanga?	Where are the opportunities for Māori to enact or not enact kāwanatanga?	What do Māori and whānau say about what happens to their healthcare when kāwanatanga has been enacted?	Other

Appendix C – Rangatiratanga

Rangatiratanga

Article	How does the system/clinicians enable or constrain rangatiratanga?	How is capability honoured/recognised?	What do Māori say about exercising or not exercising rangatiratanga?	Other

Appendix D – Oritetanga

Ōritetanga

Article	Access	Experience	Outcomes	Other

Appendix E – Wairuatanga

Wairuatanga

Article	How do Māori and whānau see wairua is expressed and respected in healthcare?	How are Māori models of health i.e. mirimiri, Rongoa considered in healthcare?	How do Māori and whānau describe how their worldviews and values are respected in healthcare?	Other

Appendix F – Summary of results

Author	Question or aims of the study	Population	Core findings
Kidd et al. (2013)	Views and experiences of Māori men with chronic disease or cancer, and their whānau within healthcare in relation to whānau ora.	Māori men with chronic disease or cancer, Aged 40-82 years	<u>Whanaungatanga</u> Building longstanding, trusting relationships helps whānau Māori overcome equity barriers such as access. However, whānau Māori often noted that healthcare professionals had expectations or whānau without first getting to know the roles of whānau members. <u>Kāwanatanga</u> Knowledge was seen as power, and protective for preventing their conditions from getting worse, ensuring whānau Māori knew all the details and what it meant to them. <u>Rangatiratanga</u> Social, cultural and emotional beliefs are often not valued within healthcare contexts, disengaging whānau Māori from services. Having services which provide a cultural connection can support the decision-making process by making education more salient to the person and recognising Māori as Māori. <u>Ōritetanga</u> Providing access to healthcare which takes holistic management into account and practical supports (e.g., transport, advocacy services, financial and household support, etc.) assisted with improving equity. Financial considerations such as transport, cost of services and prescriptions were seen as a significant barrier to accessing care.

			<u>Wairuatanga</u> The importance of whanaungatanga was critically important in supporting whānau Māori wairuatanga. Also, acknowledging whānau as support in Māori health context was seen as beneficial for supporting wairuatanga. However, it should not be assumed that whānau will support Māori clients. Spiritual, cultural, and human needs were reported as being inseparable from their illness experience and acknowledging these in relation to the person was seen as beneficial for supporting wairuatanga. Biomedical systems were often reported as mechanical and cold, which removed the relational aspects of wairuatanga. The lack of kāwanatanga and rangatiratanga caused feelings of grief and loss and impacting on a person's mana.
Levack et al. (2016)	Exploring cultural factors influencing the uptake of pulmonary rehabilitation.	Māori and non-Māori, Participating in pulmonary rehabilitation (only views of Māori analysed), Aged 18 years and above	<u>Whanaungatanga</u> Previous negative experiences with healthcare professionals made whānau Māori less trusting and increased disengagement with services. However, culturally meaningful connections supported adherence to programs. Culturally meaningful connections were developed by explicitly making time for whanaungatanga to occur, with both parties getting to know each other beyond their profession or illness and sharing stories. <u>Kāwanatanga</u> No comments made. <u>Rangatiratanga</u> Making time to recruit whānau Māori to services and connecting with them culturally and individually supports rangatiratanga by increasing engagement with services. Clinicians placing importance on adherence supports rangatiratanga as it provides whānau Māori with a sense of accountability,

			therefore encouraging them to make healthy lifestyle choices. <u>Ōritetanga</u> Accessibility of services and programs were a barrier as they often had a cost attached (e.g., parking, whānau taking time off work) or were too far away to access. However, services providing transport was seen as a way to reduce inequities to service provision. Experiences of programs had a major impact on peoples' decisions to continue with it, including peer support, interactions with healthcare professionals, and observed health benefits. <u>Wairuatanga</u> Providing opportunities for whānau Māori that connect them in a culturally familiar environment can serve to support wairuatanga within the clinical encounter. Alongside this, using tikanga Māori within practice supports wairuatanga, including whanaungatanga, the use of te reo Māori, validation of rongoā, and providing opportunities for whānau Māori to have rangatiratanga within the clinical setting all supported a whānau Māori wairuatanga.
McLellan et al. (2014)	Explore Māori experiences of aphasia therapy to ascertain what makes a service culturally appropriate for Māori with aphasia and their whānau.	Māori with aphasia and whānau members, Aged over 18 years with aphasia caused by stroke, >6 months post-onset of aphasia	<u>Whanaungatanga</u> Relationships between whānau Māori and clinicians can impact on the success of therapy and can support engagement with, and adherence to therapy. <u>Kāwanatanga</u> Whānau Māori needed to have an understanding of why specific impairments were happening to they whānau, and the reason for various treatment modalities. In having this understanding, whānau Māori are happy to be active participants in their

			loved one's rehabilitation. Alongside this, utilising kaitiaki services was seen as beneficial, however the clinician needs to have some knowledge of cultural safety to effectively kaitiaki services. <u>Rangatiratanga</u> The lack of information about therapy often frustrated whānau Māori about how they could best support their whānau. Connecting therapy with the person's social context also provides saliency to the therapy provided, improving adherence and giving Māori the opportunity to make decisions. <u>Ōritetanga</u> Use of culturally safe therapeutic resources were seen importing for improving equity in care. Access to services, including if they are financed or not can support access to resources. The environment that encounters are held in can facilitate ōritetanga and facilitate ongoing management of the person's care. Acknowledging the person for their interests and personality can facilitate engagement by making consultations meaningful towards them. <u>Wairuatanga</u> Utilising culturally responsive resources can support a person's wairuatanga by providing whānau Māori a source of connection with the services being provided. Culturally sensitive clinicians also help to support wairuatanga as it supports whānau Māori worldviews and assists with connecting with clinicians.
Pene et al. (2021)	Explore inpatient healthcare delivery experiences of Māori patients and their whānau.	Māori who spent at least one night in hospital	<u>Whanaungatanga</u> No comments made. <u>Kāwanatanga</u>

			Staff can have a positive impact on kāwanatanga through taking time to explain results, procedures, and discharge plans in a way that whānau Māori understand. This is important as it brings whānau Māori into the decision-making process and an active participant in their healthcare. Use of kaitiaki was also seen as protective for a person's kāwanatanga as they were often relatable and could support how information was provided to whānau Māori. <u>Rangatiratanga</u> Hospital staff are so concerned about their tasks, they remove the person from the situation. This removes tikanga from the clinical encounter, such as whanaungatanga, and stops Māori from getting the information they need to support healthy lifestyles. <u>Ōritetanga</u> Reports, both positive and negative, about how staff interactions helped to support whānau Māori engaging with healthcare. Clinicians were barriers for Māori, particularly when whānau involvement in a person's care was wanted. Practical barriers were reported such as access to parking, financial implications which then impacted on emotional wellbeing. <u>Wairuatanga</u> Being culturally sensitive in whānau Māori care and having knowledge of tikanga Māori can provide positive experiences for whānau Māori and support engagement with services. This flowed on to having whānau as support while an inpatient and making sure staff are aware of whānau dynamics, however when making decisions, whānau can be extended

			out to the wider healthcare team if they are appropriately supporting the person.
Rahiri et al. (2020)	Explore Māori perspectives of bariatric surgery.	Māori who had bariatric surgery at Counties Manukau Health, Aged 25-65	<u>Whanaungatanga</u> Having longstanding relationships assists with advocacy and connecting whānau Māori to the health system. Whānau Māori with longstanding relationships often report increased guidance and mentorship to do with changing health behaviours and optimising personal success. Being on the journey with whānau Māori was frequently seen as beneficial as it supports attendance, adherence and provides support for Māori beyond the whānau and the person, making both parties in the relationship equally responsible outcomes. <u>Kāwanatanga</u> Clinicians make whānau Māori feel vulnerable and silenced based on how they communicate information and interact with whānau Māori. This often resulted in whānau Māori choosing not to engage in services. <u>Rangatiratanga</u> Having Māori help design services can bring tikanga into the service and support Māori having governance within their healthcare by supporting local knowledge and information provision which is meaningful to Māori. <u>Ōritetanga</u> Acknowledging how suggestions such as changing diet may have cultural implications, and implications on finances and the rest of the whānau. Whānau Māori feel specifically targeted by statements made by healthcare professionals and explicit/institutional racism. Sharing of experiences with other whānau Māori were seen as positive experiences and

			assisted with engaging with services that were otherwise seen as biased against Māori. <u>Wairuatanga</u> Having whānau support creates an environment which is not just sitting with the person, but their whole whānau is trying to improve their health status.
Slater et al. (2013)	Describe cancer journeys of Māori patients and whānau and identify factors that facilitate or inhibit access to, and through, cancer care services.	Māori and whānau affected by cancer, Aged 30-80	<u>Whanaungatanga</u> Positive, long-term relationships supported accessing information and reducing inequities such as transport, knowledge, and financial assistance with the availability of information being strongly related to the strength of connection with clinicians. Whānau provided personal and emotional support, however whānau needs to be recognised by the clinician to provide this support. <u>Kāwanatanga</u> No comment <u>Rangatiratanga</u> Having whānau support creates an opportunity where information provided by healthcare practitioners can be deciphered and more meaningful towards the person. Māori health providers can also support whānau in this way, and by providing companionship and practical assistance e.g., finding out about car parks and attending appointments. <u>Ōritetanga</u> Lack of long-term relationships with healthcare providers resulting in reduced trust of service providers and access to information. Distance and financial constraints were primary physical barriers, however some DHBs mitigated this by provision of

			petrol vouchers, transport, district nurses etc. The demand of access was greater for those living rurally compared to urban centres. Increased dependence on whānau resulted in increased financial and social costs with missing work, not being able to look after family etc. <u>Wairuatanga</u> Building whanaungatanga was seen as protective in supporting a person's wairua within a service and facilitating engagement with that service.
Walker et al. (2022)	Explore Māori patients', donors' and whānau experiences and views of kidney transplant services to understand barriers for Māori.	Māori going through the process, or have been through the process of kidney transplant, Aged 20->70 years	<u>Whanaungatanga</u> The lack of being acknowledged as a whānau by health systems means that many Māori often feel disconnected from healthcare. <u>Kāwanatanga</u> Knowledge is power, and without this knowledge, Māori cannot advocate for themselves to drive their care. Healthcare professionals removing kāwanatanga from the individual all together by not providing adequate information to whānau Māori. <u>Rangatiratanga</u> Having health systems designed by Māori, for Māori supported rangatiratanga by incorporating tikanga Māori, improving power, connection, and engagement with services. Health systems need to be able to support health changes from not just the individual, but the whole whānau. <u>Ōritetanga</u> Inconsistency of information provided with expectations on Māori changing during the process of being assessed for kidney transplant. Institutional racism and racial profiling in the form of blaming Māori of their health and healthcare professionals

			having underlying assumptions about how Māori respond to healthcare. Lack of awareness of diseases predominant in Māori e.g., kidney disease. <u>Wairuatanga</u> Staff not being culturally sensitive was often seen as negative to a person's wairua, facilitating disengagement from services. The absence of tikanga Māori often aggravated previous negative experiences with health services creating a sense of distrust and powerlessness within the service. However, both Māori and non-Māori health workers who had cultural competence had the potential to restore connections with health services by understanding whānau Māori for who they are and making connections right away.
Walker et al. (2017)	Explore and describe Māori patients' experiences and perspectives of chronic kidney disease.	Māori with chronic kidney disease on dialysis or going through kidney transplant process, Aged 22-72 years	<u>Whanaungatanga</u> Egaging in equal and reciprocal conversations around who the person is, where they fit within the wider social/whānau context and how their illness/disease impacts on these situations assists with supporting relationships within the clinical context. <u>Kāwanatanga</u> Use of familiar language and the importance of communication in discussing the management of diagnoses and the importance of these, ensuring whānau Māori understand what is happening to them and why. <u>Rangatiratanga</u> Previous negative experiences with health systems often meant that whānau Māori chose not to engage with them, however if clinicians actively tried to engage whānau Māori in healthcare, developing

			trust and regaining power in their health, assisted with re-engaging and supporting decision making. Whānau Māori also reported having earlier education on health conditions more prevalent in Māori may support them in making changes earlier to prevent diagnosis, however clinicians need to be able to share their power to provide this kind of support. <u>Ōritetanga</u> Access to care as a barrier to healthcare alongside professionals' expectations that Māori have knowledge of certain disease processes and how to reduce the risk of these. Māori reporting experiences of healthcare professionals ignoring them or telling them off for lifestyles and not knowing who the person is, therefore creating a barrier to trusting relationships. <u>Wairuatanga</u> Social support is beneficial in improving ones wairua as it takes whānau Māori from being isolated to connected and a sense of belonging with others in the environment. Whānau Māori identities makeup their wairua and acknowledging them for who they are can support someone's wairua. However, the stigma of disease can negatively impact wairua, as Māori men often associate disease with weakness and inferiority to their peers. For many, how clinicians acknowledge and appreciate whānau Māori connections to their land and people and connecting with whānau Māori was often seen as beneficial to the relationship and further input with that clinician. Acknowledgment of the person in this way supported their mana.
Wilson et al. (2021)	Explore perspectives of Māori brain injury survivors to	Māori living with neurological	<u>Whanaungatanga</u>

	develop more culturally informed understanding of what matters most for Māori in the development and experience of therapeutic connection.	injury/illness or whānau with experience living closely with someone with neurological injury/illness, Aged 19-70 years	Being able to pronounce names provide a sense of connection with whānau Māori and can support whanaungatanga in the healthcare context. Reciprocity in early contacts with clients can develop genuine two-way relationships. This sense of connection can support engagement and development of trust with clinicians and environments. Whānau Māori need to be seen and valued within the wider context, beyond the individual. This means knowing whānau for their interests, culture, worldviews and insights into their home environment and personal roles and relationships within the wider social context, then appreciating the personal impact of the disease/illness on the person and how this impacts their wider whānau. Providing whānau Māori a sense of the clinician beyond the clinical context assists with reciprocity of care, and supports meaningful, trusting relationships. <u>Kāwanatanga</u> The need for open, respectful conversation allows whānau Māori to engage with the clinician allowing for Māori to have a voice in their care. Alongside this, the use of language which is familiar to whānau Māori was seen as beneficial for providing Māori to have the opportunity to have kāwanatanga and have the opportunity to provide mana-enhancing, equal relationships. <u>Rangatiratanga</u> The feeling of being allowed to speak, rather than being spoken to was vital for whānau to have governance over their healthcare, however, interactions were often reported as paternalistic in nature. Language used can support rangatiratanga

			as using language centred on Western views of healthcare can often limit Māori understanding. <u>Ōritetanga</u> No comments made. <u>Wairuatanga</u> Wairua is innate in nature, with connections being made instantly. Wairua is also a guiding energy which can help whānau Māori position themselves in the context of the clinician and the wider encounter. Wairua can therefore influence how the interaction with clinicians will go, either positively or negatively, with clinicians having an impact on wairua also e.g., being within a familiar environment.

Appendix G – Critical reflection guide

Critical reflection guide

While undertaking this critical reflection, try to integrate you and your cultural history, the systems that you work in and the ‘unquestioned knowledge’ within your system and profession. Link these concepts with current literature and discussions with your supervisor to help guide your thoughts and feelings in navigating this space.

Positioning

Who are you? What brought you to where you are now? What is your history, upbringing, heritage, ancestral ties etc.

How do these experiences and privileges make you the person you are now?

What privileges do you bring to this situation?

Case study

Identify a case study and why this person has come to see you.

What events occurred during the initial consultation?

What did you do during this consultation?

What were you thinking and feeling?

How did the person react?

How do you think they were feeling?

What was the person doing?

Why do you think this?

What occurred during subsequent consultations? Use the previous two points to further explore these engagements.

Outline why this case is important.

How has your positioning impacted this healthcare encounter?

Whanaungatanga

What does meaningful whanaungatanga mean to you and look like?

Why is whanaungatanga important within the healthcare context and for your client?

What have you done to foster whanaungatanga?

How has whanaungatanga been attended to?

What has stopped whanaungatanga from being attended to?

How can you change or impact these factors?

How has your clinical environment or previous knowledge impacted whanaungatanga?

Kāwanatanga

What does kāwanatanga mean to you and look like?

Why is kāwanatanga important?

Within the encounter, what opportunities were there for your client to have kāwanatanga

What did you do to support or not support their kāwanatanga?

Rangatiratanga

What does rangatiratanga mean to you?

Why is rangatiratanga important?

What does rangatiratanga look like in the practice?

How did/didn’t you acknowledge rangatiratanga within this case?

What would you do to honour someone’s rangatiratanga?

Ōritetanga

What barriers are in place (think experience, access, and outcomes) within this scenario?

How can you mitigate these barriers?

What other supports may you need to help mitigate these barriers?

Wairuatanga

What does wairuatanga mean to you?

How did/didn’t you acknowledge wairuatanga for this client?

What supports your clients’ wairua?

What is your role in helping them access the things that support their wairua?

What could you do to better understand wairuatanga within this or other scenarios?

Changes in practice

What tensions has this process caused for you?

What did you do to support these tensions?

What would you do differently next time?

What can you implement directly into practice to make a difference?

What support would you need to make these changes?