Te Ara Whakamua:
The Stasis of Māori Nursing Over 4-Decades in Aotearoa:
An Indigenous Case Study

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Abstract

This thesis investigates the static state of the Māori nursing workforce in New Zealand over the past 40 years; exploring the barriers to recruitment, retention, and progression within the profession. Despite Māori comprising 19% of the New Zealand population, their representation in the nursing workforce remains disproportionately low at approximately 7%. This disparity persists despite numerous policies, strategies, and calls to address inequities in the health system. A robust Māori nursing workforce is critical for achieving health equity, as it ensures culturally concordant care and addresses the systemic and institutional barriers that contribute to health disparities for Māori.

Using a qualitative case study approach, guided by Kaupapa Māori principles, this research set out to explain how systemic, cultural, and historical factors impacted the Māori nursing workforce. Three embedded units of analysis—Māori student and registered nurses, key stakeholders, and a review of grey literature—provided the foundation for this inquiry. These data sources were systematically analysed to identify recurring themes and eventually develop key interpretations. The findings revealed entrenched issues of systemic racism, economic hardship, ineffective leadership, and political indifference that have collectively hindered the growth of the Māori nursing workforce.

Three interpretations emerged from the synthesis of data: False Hope and Empty Promises, highlights the failure to implement long-standing recommendations to support Māori nurses; Smoke and Mirrors, examines the superficial measures that create an illusion of progress while failing to address root causes; and Complicit Disregard, identifies systemic neglect and inaction that perpetuates disparities within the profession. These interpretations demonstrate the persistent barriers to equity in nursing and highlight the urgency of systemic change. This thesis proposes the Taurakohia Model, a comprehensive framework designed to address these challenges and promote meaningful change. Drawing on decades of research and the voices of participants, the model offers actionable recommendations to support recruitment, retention, and professional development for Māori nurses. It emphasises the need for culturally responsive education, robust support systems for Māori students, and the establishment of more Māori-led nursing programmes to create pathways aligned with Māori aspirations.

The findings of this research have significant implications for nursing education, leadership, and policy in New Zealand. Addressing the disparities within the Māori nursing workforce requires an unwavering commitment to honouring Te Tiriti o Waitangi and dismantling systemic racism within healthcare institutions. By implementing the recommendations from this research, it is possible to create a more equitable and inclusive nursing workforce that meets the needs of

Māori and contributes to a more just and effective health system for all New Zealanders. This thesis concludes by highlighting the need for further research into political advocacy, nursing governance, and a review of cultural safety as an effective framework for implementing transformative praxis. It calls for longitudinal studies to evaluate the implementation of Bachelor of Nursing Māori programmes and their impact on workforce development. By addressing these gaps, the findings of this research offer a pathway to sustainable change for the Māori nursing workforce.

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Attestation of Authorship

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

Signed:

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Glossary

A
Aroha – Compassion; love
Āta – The principle of growing respectful relationships
H
Hapori – Community
Hapū – Sub-tribe
Hōhā – Frustrated
Hui – Meeting
I
Iwi – Tribe
K
Kai – Food
Kaiako – Teacher
Kaitiaki – Guide
Kaitiakitanga – Guardianship
Kapa Haka – Māori traditional dance
Karakia – Prayer
Kaumātua – Elderly man/Elders
Kaupapa – Topic
Kaupapa Māori – Māori approach; Māori topic
Kawa whakaruruhau – Cultural safety in a Māori context
Koha – Gift; present; offering
Kōrero – To talk/narrative
Kotahitanga – Unity; unified
Kuia – Elderly female
M
Mana – Dignity; authority
Manaakitanga – Hospitality, kindness, generosity, support; reciprocity
Māoritanga – Māori way of life
Marae – Traditional meeting house
Mātauranga Māori – Māori knowledge systems
Māui – Famous Polynesian ancestor; demi-god
Maunga – Mountain
Mihimihi – Greeting
Mihi Whakatau – Informal welcome
Moana – Sea/ocean
P
Pākehā – New Zealander of European descent
Pepeha – Tribal motto
R
Rūruhi – Elderly female
T
Tainui – People who descend from the Tainui Waka
Tainui Waka – One of several ancient canoes that brought the Māori people to Aotearoa from the Pacific circa 1200
Tangata Whaiora – Patient
Tangi – Ceremony for the dead
Tauira – Student
Tauiwi – Non-Māori
Taurakohia – Gathering rope

Te Ao Māori – The Māori world
Te Ao Wairua – The spiritual world
Te Reo Māori – The Māori language
Te Taitokerau – Māori name for Northland, New Zealand
Te Tiriti o Waitangi – The Treaty of Waitangi (Māori version)
Te Whare Tapa Whā Model – A holistic model of health based on Māori concepts
Tikanga Māori – Traditional practices; customs
Tino Rangatiratanga – Sovereignty; self-determination; independence
Tohunga – An expert
Tupuna – Ancestors

W

Wānanga – A reflective practice of deep contemplation and discussion
Waiata – Song
Wairua – Spirit
Whaea – Mother; aunt
Whakapapa – Genealogy
Whānau – Family
Whanaungatanga – Relationship; kinship; family connection
Whakawhanaungatanga – Process of establishing relationships
Whenua – Land; placenta

Chapter 1: Introduction

“I ngā rā o mua, e rere tere haere a Tamanuiterā”

In days gone by, the sun moved quickly across the sky

The critical need to increase the Māori health workforce has brought renewed attention to the importance of growing the Māori nursing workforce. Both the New Zealand government and the Nursing Council of New Zealand (NCNZ) have identified this need as a priority. However, despite efforts, the recruitment and retention of Māori nurses have remained relatively static, averaging around 7% over nearly 4-decades. This stagnation is particularly alarming given that Māori comprise 19% of the New Zealand population. Achieving parity between the proportion of Māori nurses and the Māori population is not only a realistic target but an essential step toward reducing health inequities and achieving equitable health outcomes for Māori. Yet, the nursing profession has struggled to address this disparity.

This chapter sets the foundation for the research by providing an overview of its scope and focus. It begins by defining the research question and aims, situating the study within the broader context of the New Zealand nursing workforce. It introduces a historical view that forms the basis for understanding the systemic issues that have contributed to the static state of the Māori nursing workforce. The chapter then shifts to a Kaupapa Māori perspective, introducing whānau (family), whakapapa (genealogy), and kōrero (narrative) outlining the motivations behind this inquiry, which are deeply rooted in personal and professional experiences. Finally, an overview of the thesis structure is provided, guiding the reader through the subsequent chapters and illustrating how each contributes to addressing the central research question.

Research Question and Aims

This research addresses a critical question within New Zealand’s healthcare system: **Why has the Māori nursing workforce remained static over the past 40 years?** Despite numerous government policies and initiatives aimed at increasing Māori representation within the nursing profession, the workforce has remained at approximately 7%—far below the 19% needed to reflect the Māori population. This disparity is significant, as a robust Māori nursing workforce is crucial for delivering culturally responsive care, improving health outcomes, and addressing long-standing inequities in the healthcare system.

The primary aim of this study is to investigate the systemic, institutional, and social factors that impede the recruitment and retention of Māori nurses and to identify strategies for sustainable

workforce growth. A case study approach, guided by five research propositions, underpins the inquiry. These propositions, developed from existing literature and theoretical frameworks (Yin, 2017), focus the research and provide a framework for data analysis:

1. **Policy outcomes have enabled equitable access for Māori into nursing programmes.**
2. **Nursing and health leadership have adequately planned for the future of New Zealand's nursing workforce.**
3. **Nursing has been effectively marketed as a viable career option to Māori.**
4. **Māori new graduate nurses are provided with appropriate support in their first year of practice.**
5. **Systemic racism significantly contributes to the static state of the Māori nursing workforce.**

These propositions guide the exploration of the challenges facing the Māori nursing workforce, narrowing the focus to key areas that influence recruitment and retention. By examining these areas, this study seeks to uncover systemic barriers and opportunities for meaningful change. Through this research, the ultimate goal is to contribute evidence-based insights and strategies that can inform policy and practice, fostering a nursing workforce that reflects the diversity of New Zealand's population and supports equitable healthcare outcomes for whānau (extended family), hapū (sub-tribe), and iwi (tribe).

Nursing Workforce Historical Context

The first nurses trained in 1883 under the nightingale system introduced into Auckland and Wellington hospitals where "well educated ladies may be serving their apprenticeships with other probationers" (Department of Health as cited in Kinross, 1984, p. 193). This system of training soon expanded into other hospitals across the country. While there were efforts to move away from the apprenticeship model—as early as 1912—towards recognising nursing as a profession with university-based education, these proposals were met with resistance (Kinross, 1984; Lambie, 1951; Salmon, 1983). Practical, apprenticeship-style training was considered the best preparation for nurses, though postgraduate study was suggested for those aspiring to roles in administration and education. By 1920, a postgraduate nursing school was proposed at University of Auckland, followed by the establishment of a 1-year postgraduate programme at Victoria University in Wellington in 1928. Thus, by the late 1920s, the predominant nursing education model was a 3-year apprenticeship, followed by 1-year of postgraduate study, a pattern that persisted for the next 50 years (Lambie, 1951).

The catalyst for the introduction of Māori women into nursing occurred as a result of recommendations made to the government by the General Conferences of Māori Council held in Rotorua in 1903 and 1905. Māori doctors – Maui Pomare and Peter Buck, and other Māori leaders concerned about Māori mortality and morbidity at that time, envisaged a Māori nursing workforce that would easily enter Māori communities and deliver health promotion and disease prevention education to Māori. They had hoped to engage and then enrol young Māori women from around the country into the programme. Eventually securing funding for the initiative off the government, they promoted the programme and advocated for its utilisation. However, their vision of a thriving Māori nursing workforce was undermined by prejudice and systemic racism, with only three Māori nurses successfully completing their training under this initiative (Lange, 1999; McKegg, 1992; McKillop et al., 2013; Wood, 1992). These early setbacks set the scene for the enduring challenges of systemic inequities that have persisted into the present day.

Between the 1940s and the mid-1960s, hospital-based training continued, albeit with some changes. For example, obstetric nursing was integrated into general nursing in 1957, male nurses could register from 1940, and psychiatric nurses began registering in 1945. Up until the 1960s there had been a number of reviews of hospital and related services in New Zealand making recommendations to reform nursing education but these generated very little interest from government and no action was taken (Department of Health, 1988). By the late 1960s, however, issues within nursing education were becoming apparent. Changes in the United Kingdom (UK) had rendered New Zealand nursing qualifications non-transferable, and only 18 of New Zealand's 41 nursing schools were deemed acceptable for registration in the UK (Department of Health, 1988).

By the 1960s, 139 different nursing programmes were being delivered across 62 hospitals, with around 7,000 students entering each year. However, approximately 45% of students failed to complete their programmes (Salmon, 1983). By 1966, high attrition rates among student nurses became a national concern, with only 60.4% graduating over the period 1960-1964. Theoretical content was cited as a key reason for 27.6% of withdrawals, while 23.8% left for marriage (Department of Health, 1988). While ethnicity data were not collected until the 1990s, anecdotal evidence suggests that Māori participation in nursing increased during this time. Nursing was regarded highly within Māori communities, often conferring mana and pride upon whānau (Te Ao Māramatanga, 2016).

In 1964, the Nurses and Midwives Board made recommendations for nursing education reform, reflecting similar trends seen internationally. The Department of Health proposed three types

of nursing programmes: a university-based programme, a diploma programme, and a shorter programme for nurses performing tasks requiring less judgment (Kinross, 1984). The proposed reform would involve a "major change in the attitude, philosophy and practice of nursing" (Nurses and Midwives Board, 1964, p. 2 as cited in Kinross, 1984).

The proposed reforms had significant implications, prompting the government to seek international assistance to align New Zealand's nursing programmes with international standards. The government approached the World Health Organization (WHO), and Dr. Helen Carpenter was commissioned to conduct a comprehensive review of the nursing education system (Carpenter, 1971). As a result of her review, nursing education in New Zealand transitioned from the traditional apprenticeship model to a tertiary education model, marking a pivotal shift in how nurses were trained. Data suggest that Māori nurses possibly made up less than 2% of the nursing workforce at that time (NCNZ, 2000).

This brief historical account of nursing in New Zealand provides essential context for understanding the development of the Māori nursing workforce, particularly following the nursing education reforms of the 1970s. A more detailed discussion will be provided in Chapter 7. It is within this context that Māori nursing has remained over the last 50 years, with little progress made in addressing the persistent underrepresentation of Māori within the profession.

Personal and Professional Influences

A Whānau of Māori Nurses

This section offers insight into my motivation for undertaking this research; a motivation deeply rooted in the legacy of my whānau of Māori nurses. It also links to my lived experience as a Māori nurse and resonates with the themes of this research. My father, Charles Cyril Walter (Wally) Barton, set the foundation for my connection to nursing. At age 17-years, in the late 1940s, he joined the navy, hoping to serve in World War II. However, the war had just ended, and his journey, instead, took him to Europe and the Middle East, eventually leading to his service in the Korean War. By the late 1950s, after leaving the navy and uncertain of his next steps, he was encouraged by his sister, Esther Kirianu Graham (née Barton), to consider nursing. Esther, then a nurse at Tokanui Hospital, introduced her brother to the profession, and he soon found his calling. He later transferred to Porirua Hospital, where he dedicated 40 years of his life to nursing.

My father was not alone in his journey. His oldest sister, Laura Rangihuia Tooman (née Barton), also trained as a nurse at Waikato Hospital. However, even before my father and his sisters entered the profession, our family held a legacy of healing and care. My great-great-

grandmother, Te Atakohu Te Ake, was a renowned tohunga among her Tainui people. As a midwife, she delivered countless babies and served as an advisor to King Tāwhiao, the Māori King, her wisdom and skills earning great respect within our iwi.

I share these stories to establish the foundation of this doctoral research and to highlight my position as a proud Māori nurse, continuing the traditions of my whānau. Nursing was not a planned career for me—it 'just kind of happened'. Yet, reflecting now, I believe I had little choice. My tūpuna (ancestors) guided me here. During this PhD journey, I came across an interview with a Māori nurse who trained at Porirua Hospital (Te Ao Maramatanga, 2016). In the interview, he mentioned my father, acknowledging how my father and other Māori nurses had supported Māori students through their training. He credited that support as the reason he was able to qualify as a nurse. Hearing his words affirmed that my work continues the legacy of my father and whānau.

My nursing career has been rich with experiences that resonate with the themes of this research. In true Māori tradition, this thesis begins by introducing my whakapapa and whānau, establishing my place in this journey. The chapter now transitions to my personal narrative as a Māori nurse, linking my experiences to the research and setting the scene for the journey ahead.

A Whānau of Māori Nurses: A Personal Journey

I whakapapa to Kāwhia, a small coastal settlement on the west coast of the North Island, the final resting place of the Tainui waka and home to many of my ancestors. Some of my earliest memories are of long journeys from Wellington to Kāwhia in the back of a van. The winding metal road leading to the edge of Kāwhia Harbour and the small, serene town at its heart are vivid recollections from childhood. These trips, frequent during my early years, were more than visits—they were journeys to the whenua (land) of my father's people.

When I was 5-years, my parents separated. My mother relocated us to Whangarei, Northland, near her whānau. Concerned that my mother could not cope as a single parent of six children, my grandparents decided to send my brothers and me to a Catholic boarding school in the far North. My grandparents were good Irish Catholics, and believed sending us there was the best solution for my 'suffering' mother but, more so, the right decision for our everlasting souls.

In the late 1970s, at the age of 6-years, with my two younger brothers alongside me (our youngest brother joined us later), I was introduced to a whole new world. Our lives completely changed, becoming dominated by the dual realms of Catholicism and te ao Māori (the Māori world). Our days revolved around school, the church, and the marae (traditional meeting

house). The school had a roll of about 100 children, 60 of whom were boarders, aged 4 to 13-years, all Māori. Our days were filled with collective living and chores to maintain order—cleaning, laundry, preparing meals, tending gardens, milking cows, and caring for the younger children. When we were not in the classroom or doing chores, we were attending church and events at the marae.

While the church influenced our daily structure, it was te ao Māori that truly shaped me. It was here that I became immersed in the Māori world. Te reo Māori was spoken daily, and although English was the preferred language, we naturally blended te reo and English in our everyday conversations. We spent much of our time at Kahukuraariki marae, where we practised waiata and kapa haka and learned traditional arts. Our lives were consumed with preparing for the Te Taitokerau kapa haka and Māori speech competitions, always under the watchful guidance of the local people of Ngāti Kahu ki Whangaroa (the local tribe).

The marae became my entrance into te ao wairua (the spiritual world)—a process that did not happen in the church. When there was a tangi (ceremony for the dead), we all attended and helped. The speeches, the tears, the emotions—it became my understanding of a natural part of death, a perspective that stayed with me until I attended my first Pākehā (New Zealanders of European descent) funeral at age 17-years. Despite my grandparents' best efforts to save my everlasting soul, it was not the Catholic Church that left an indelible mark on my wairua; rather, it was Māoritanga (Māori way of life) that shaped and anchored my identity and sense of self in that little place in the far North. I left the school at 13-years, not realising then how deeply it would remain woven into my life.

Two Worlds Collide

During the school holidays, we would return home from boarding school to stay with our mother. We lived in one of the poorest communities in Whangarei, where all our neighbours were Māori. My family stood out as the 'white kids' on the street. When I left boarding school at 13-years, I moved back to my mother's home. She enrolled me in the local high school—a girls' school with over 1,000 students, predominantly Pākehā. I struggled to adapt. There was very little connection to the world I knew and understood; te ao Māori was absent in nearly everything I did there. Although the school offered a te reo class, access to te reo on a daily basis became rare. I felt isolated and lonely, realising how my peers found me odd. Looking back, I see how traumatic the whole experience was. I could not wait to get out of high school.

At 15-years, as soon as exams were over, regardless of whether I passed or not, I left high school. I had no concept of my decision at the time. It was the mid-1980s, a time of high unemployment and limited job prospects, but I was fortunate to find work. Then, at 17-years, I

applied for and was accepted into the Enrolled Nursing programme, still a hospital-based course at that time. Nothing in the enrolled nursing programme reflected my Māori worldview; however, it was here I found my passion and skill for working with Māori. When I reflect on my experience at that time, I was young and naturally drifted towards Māori nurses and patients. I was often called upon by non-Māori staff to help with Māori patients, especially the kaumātua. I loved it. I became a surgical nurse, often caring for Māori in very stressful times.

Although my journey into nursing began almost accidentally, I now recognise the influence of my upbringing and my whakapapa. From Kāwhia to Kaeo, from te ao Māori to surgical wards, my path has been shaped by my whakapapa, my whānau, and my lived experiences.

Introduction to Racism

It did not take long for me to realise that enrolled nursing was not enough— my observations made it clear that if I wanted to influence change and access more opportunities, becoming a registered nurse was essential. This was the late 1980s, during the final phase of transitioning from hospital-based training to tertiary, academic-based nursing programmes. I knew my strength lay in hands-on practical experience, and I wanted to continue earning an income while pursuing further education. However, without the necessary academic qualifications for the comprehensive nursing programme, I applied to Greenlane Hospital, in Auckland, hoping to join the last hospital-based nursing programme in the country. I was not accepted.

Determined to continue, I eventually applied for and was accepted into the comprehensive nursing programme at the local polytechnic. Just like high school, the curriculum did not resonate with my Māori worldview. By this point, however, I had become more accustomed to the Pākehā world, which helped me adapt—although I would not have made it through without the support of my friends. During this time, cultural safety was beginning to emerge in nursing curricula. Looking back, it was ironic that there was so little in our training that was relatable to Māori, especially given that we were studying in an area that had one of the largest populations of Māori in the country.

About 2-months before our State final exams, we were informed that we could not sit the exams until we had completed training in cultural safety. Up until that point there had been no reference to it in our education. I remember the uproar among my predominantly Pākehā classmates, but the Nursing Council insisted it was necessary; so arrangements were made for us to attend a marae in the far North. Perhaps I was young and ignorant, or maybe it was the circles I moved in, but up until that time I had not noticed the undercurrent of racism that existed in nursing. Perhaps it became more noticeable in this instance because it was openly

and glaringly in my face. This marked a turning point in my understanding of racism and discrimination within nursing.

Defining Māori Nursing Practice

Upon graduation, I could not secure a job. It was 1992, and the government health sector reforms were underway. All I knew was that a large portion of my graduating class faced unemployment; I did not really understand why. Broke and disillusioned, I enrolled on the unemployment benefit. During my training the government had removed free tertiary education, I had a student loan to pay and was desperate to work. I had intended to return to surgical nursing, and my former charge nurse was keen to have me back; however, the only jobs available were in mental health. Desperate for a job I agreed to do some casual work in the local mental health unit. I intended to work there for a short time until a vacancy became available in surgical.

After only a few shifts in the mental health unit, I realised this was where I was supposed to be. No matter how hard I tried to deny it, mental health nursing was where I had to be, kei roto i taku toto—it was in my blood. At the time, mental health services were going through a period of change. Dr Mason Durie had developed Te Whare Tapa Wha model, and mental health services were supporting the evolvement of Māori units across the country, such as Whaiora at Tokanui Hospital, Whare Marie at Porirua Hospital, and Whare Paia at Carrington Hospital. The influence of these units on mental health practice trickled into mainstream services, and some Māori practices were acceptable and seen to be useful and practical ways of engaging with Māori patients. It was timely for me.

It was during these early years as a newly graduated registered nurse that I began to understand how deeply te ao Māori influenced my practice. This realisation came while working alongside other Māori nurses. I noticed that when we cared for Māori patients, our approach was distinct from that of our non-Māori colleagues. Many times, I found myself drawing on te reo Māori, engaging in whanaungatanga, and integrating Māori ways of knowing into my practice through karakia (prayer), waiata (song), and kōrero pūrākau (traditional narratives). When I worked within a team of Māori nurses, the ward environment felt different—there was a familiar sense of connection and respect.

One morning, while taking a group of patients for a walk, I ran into my former charge nurse from the surgical ward. Surrounded by mental health patients, she remarked that she had heard I was working there and commented, “What a waste”. I replied, “No, it’s not a waste; I love it”. Reflecting on what led me to change the entire trajectory of my career, I know it was the experience of entering that unit, seeing so many brown faces, hearing te reo Māori daily,

and reconnecting with words and practices I had not engaged with since childhood. For the first time I was in an environment where I could make a difference for Māori, where aspects of my culture were welcomed and encouraged; however, I thought we could do more.

It was evident that the ward often had a high Māori occupancy; at times, all the patients were Māori. We frequently heard from whānau about their struggles in accessing mental health services, their experiences of poor-quality care, or the lack of culturally appropriate engagement. Many patients came from rural areas where health services were already challenging to access, with mental health support being even more limited.

Māori patients often arrived in states of distress, sometimes escorted by the Police, dishevelled and very unwell. Some would only communicate in te reo Māori, while others presented with complex delusional beliefs or elevated moods. Integrated amongst their presentations were Māori ways of seeing and viewing the world. Their distress frequently required spiritual intervention and specific cultural approaches. Recognising these needs, I began writing letters to management advocating for better resources to support Māori patients and their whānau. I argued that mental health care needed to respect and incorporate Māori forms of treatment, addressing both spiritual and cultural dimensions of care. It became my mission to push for practices that honoured *te ao Māori* and provided better outcomes for our people.

Institutional Racism

During this period, each change in government brought a new restructuring of the health system. It was an unsettling time, as we went through four major shifts in the span of 10-15 years. Neoliberal policies introduced a free-market approach, with the government seeking to separate funding from the delivery of health care services. It was during this period we saw the emergence of dedicated Māori health services.

One day, I received a message at work: a community Māori mental health nurse, Charmaine Te Aika Kopa, wanted to see me. I had seen Charmaine in passing but had never spoken with her, nor had I cared for any of her patients. She had a reputation for being tough and fiercely patient-centred. I had no idea why she wanted to meet with me. I have to admit I was a little worried.

It turned out that she had heard about my efforts to advocate for improved access to resources for Māori within the ward environment. Charmaine had been approached by the general manager of the mental health service to explore the possibility of developing a Kaupapa Māori mental health unit. Charmaine invited me to join the project team working on the proposal.

In this initial team, I had the privilege of meeting Whaea Moe Milne, a highly respected kuia from Ngāti Hine in the far North. Over time, the proposal evolved into a plan for a community-based team, and I became a founding community nurse of Te Roopu Whitiora Māori Mental Health Services for Northland District Health Board—a service that remains in operation today.

However, the formation of Te Roopu Whitiora was met with overt racism from many non-Māori colleagues. The most common criticism questioned the need for a separate service for Māori. These detractors misunderstood our mission: it was not about creating division but about providing choice—giving Māori the option to engage with Kaupapa Māori mental health services rather than being confined to mainstream care. Opposition ranged from vocal objections to covert resistance, such as non-Māori staff refusing to refer Māori patients to our service, arguing that their own care was sufficient.

Despite these challenges, many Māori patients with high and complex needs were referred to Te Roopu Whitiora. As a consequence, after-hours services were frequently interacting with patients, which was interpreted as evidence that our service was ineffective, further fuelling opposition. One defining moment came during a patient consultation meeting with a psychiatrist, a team leader, and another nurse—all non-Māori men. They questioned the need for a Māori-specific service, with one remarking sarcastically, “What about the Irish people on my caseload? Should we create a separate service for them too?” My attempts to explain the importance of a Kaupapa Māori approach were dismissed outright. The unique needs of Māori patients and the obligations of the health service under *Te Tiriti o Waitangi* were disregarded.

Despite the overt racism and systemic resistance, our non-Māori general manager stood firm in his support for Te Roopu Whitiora. Without his advocacy, the programme likely would not have launched, given the significant opposition from within the organisation.

While I was already aware of structural racism in the health system, my involvement in Te Roopu Whitiora revealed the mechanisms by which it operates and the resistance that arises when the power of the dominant culture is challenged. This experience highlighted to me the deep-seated inequities within the system and the ongoing struggle to ensure that Māori patients receive care that aligns with their cultural needs and aspirations.

Health Care Inequities

When my dad retired, he returned to Kāwhia, the place of his childhood, and built a home on our whānau papakāinga (traditional family land). Every holiday, I would travel down from Whangarei to visit him. During one visit, he mentioned experiencing nocturia, frequent urination, and blood in his urine. He had seen the local GP, who assured him it was nothing to

worry about. Alarmed, I insisted that haematuria was not normal and urged him to seek further medical advice.

The next time I saw Dad was just before I left for my big OE (overseas experience) in Europe. He made the long journey to Auckland airport to see me off, which at the time I thought was unusual. Three months into my travels, I received an urgent message to call home. My sister, through tears, explained that Dad had been diagnosed with prostate cancer that had metastasised to his bones. When I spoke to him, he admitted he had known about the diagnosis at the airport but did not want me to cancel my trip. Within days, I was on a plane back to New Zealand.

For the next 2-years, I cared for my father in Kāwhia until he passed away on his 71st birthday. I kept him at home, overlooking his moana, gazing up at his maunga, and surrounded by his whānau. It remains one of my proudest achievements, being able to care for him through his final days.

At the time, I was so focused on caring for Dad that I did not stop to reflect on the preventable nature of his illness. It was not until later that I realised how the systemic failures in his medical care had contributed to his premature death. Like many Māori men, Dad found it challenging to discuss intimate health concerns. Yet, despite his discomfort, he returned to his GP multiple times as his symptoms worsened. It was eventually a visiting locum who finally sent him for further testing, leading to the diagnosis.

It pains me to know that my father, a man so central to our whānau, died much younger than his sisters, most of whom lived well into their 90s. His story is not unique but emblematic of the broader health inequities faced by Māori in New Zealand. This experience emphasised for me the deep-seated disparities in healthcare access that continue to affect Māori health outcomes today.

A Māori Worldview

During the years I cared for my father in Kāwhia, I reconnected with my people and immersed myself in my whakapapa, marae life, and iwi politics. Living in Kāwhia also exposed me to the stark realities of healthcare inequities, particularly in rural communities with large Māori populations. I saw whānau members dying far too young, often from preventable illnesses like diabetes. Several of my uncles were on dialysis, and it was through observing these experiences that I began to understand how Māori viewed health, disease, and the mainstream healthcare system.

At a hui one afternoon, I sat at a lunch table with several kaumātua and ruruhi. Many of them diabetic, added custard to their bowls of steamed pudding. I turned to my uncle, who was on renal dialysis, and hesitantly asked if it was wise to eat the pudding, considering its effect on blood sugar. He laughed, and soon the whole table was laughing. He then said, "I don't want to be like those Pākehā—I don't want to live forever. I've had a good life, and if I want to eat steam pudding, I will. The damage is already done". In that moment, surrounded by their laughter and wisdom, I had a profound realisation: for many Māori, quality of life and cultural values around well-being often outweigh the pursuit of longevity. This encounter stayed with me and later became the catalyst for my Master's research, shaping my understanding of how cultural perspectives deeply influence health choices and priorities.

Developing a Deeper Understanding

On Christmas Eve 2003, while driving from Kāwhia to Hamilton for work, I hit a patch of diesel and lost control of my car. The accident left me with severe injuries requiring extensive surgery on both legs and an 8-week hospital stay. This was my first experience as a recipient of healthcare services and, overall, the care I received was good. My nursing friends had arranged for the hospital's Māori services to visit me, but it was not necessary; when my elders heard of my aitua (accident), many travelled to the hospital to say karakia over me. Their presence deeply humbled me.

Upon discharge, I was wheelchair-bound with both legs in plaster, completely reliant on those around me for support. During this time, my niece, Vicki Simon, a Māori nurse educator, suggested I consider post-graduate study while recovering. With the recent establishment of the Nurse Practitioner role, I saw an opportunity to pursue this path in mental health services. Supported by a Te Rau Puāwai scholarship, established by Dr. Mason Durie to grow the Māori mental health workforce, I began my post-graduate studies.

Through these studies, I gained a deeper understanding of how colonisation had shaped healthcare inequities for Māori. I became more aware of the broader political, social, and environmental impacts on Māori health and developed a clearer articulation of what distinguished Māori nursing practice. Drawing from my experiences and those of other Māori nurses, I co-authored an article defining Māori nursing practice (Barton & Wilson, 2008).

However, after consulting with my tuakana (older sister), a mental health nurse in management, and my niece Vicki, I ultimately decided against pursuing the Nurse Practitioner pathway. At the time, the role in mental health lacked clarity, with uncertain career prospects and appropriate remuneration. This decision was challenging, as I had hoped to use the role to improve care for Māori. Instead, I shifted my focus to research, inspired by my uncle's words about quality of life

and the stories of whānau about their healthcare experiences. This led me to explore and document these experiences in my Master's research (Barton, 2008), deepening my commitment to improving healthcare for Māori.

Efforts at Leadership

When I eventually returned to work after recovering from my accident, I rejoined the inpatient unit in mainstream services. It was disheartening to see that nothing had improved; in fact, the situation seemed worse. There was immense pressure on beds, an increased demand for mental health services, and a significant number of acutely unwell Māori patients—many of whom were my own people.

Throughout my career, I had never been particularly ambitious, often following where the job led me rather than setting specific career goals. Leadership roles, in particular, had not been my focus. However, with the confidence gained from my post-graduate studies, I began to understand that driving change required a seat at the table. This realisation motivated me to seek senior clinical roles. Eventually, I applied for a Clinical Nurse Specialist position in one of the busiest acute mental health wards. In this role, I became actively involved in service reviews, led consultation groups, and made recommendations aimed at improving services for Māori. My responsibilities expanded to include policy development, quality initiatives, and professional development, all with a strong focus on addressing the needs of Māori patients and staff.

As I advanced in my career, however, I began to feel the isolation of being one of the few Māori nurses in a senior role. The higher I climbed, the lonelier it became. A senior Māori nurse, recognising my confidence in te ao Māori, encouraged me to apply for the newly established Director of Nursing (Māori) position, a role that spanned the entire organisation. I was initially hesitant, especially given that two Māori nurses had already left the position—a potential red flag. Nonetheless, bolstered by my recent Master's degree and the encouragement of my Māori colleagues and whānau, I decided to apply.

In the interview, I presented myself authentically, staying true to my values and identity—perhaps not the best strategy in hindsight. The (non-Māori) Director of Nursing later called to inform me that I had been unsuccessful. While she praised my interview, she added that the panel was concerned "your passion had the potential to burn you out". I interpreted this as, 'You're too Māori for this Māori role', a clear indication they were looking for someone who would preserve the status quo. I was not that person. Although disappointed, I accepted the outcome, trusting that my tūpuna had other plans for me—and indeed, they did. Incidentally, the role was never filled and was eventually disestablished.

Be Aware of Career Limiting Behaviour

I became a mother later in life, and my son instantly became the centre of my world. My beautiful Māori boy was strong and healthy in his first year. However, when I returned to work and he started daycare, frequent illnesses, asthma, and febrile convulsions became part of our lives, often leading to hospital visits. It was a scary time, and as a single mum, balancing work and motherhood became increasingly difficult. I made the decision to return to the North to be closer to immediate whānau, knowing that strong whānau connections and ties to Kāwhia would always be part of our lives.

After 18 years away, I arrived in Whangarei with my 4-year-old son and a few belongings, staying with my sister while I searched for a job and a home. I naively believed that my years of experience and qualifications would make securing a mental health nursing role straightforward. I applied for a mental health nurse educator position at the local hospital, but I sensed hesitation during the interview process. I was eventually informed of a hiring freeze and told they were reconsidering the recruitment altogether.

Desperate for work, I reached out to friends still in the field and learned about a vacancy at Te Roopu Whitiora, the very service I had helped establish years earlier. I eagerly inquired about the position, only to discover that the service had undergone significant changes during my absence. It was now more closely integrated with mainstream services, and its senior manager was a non-Māori nurse who had openly opposed the establishment of Te Roopu Whitiora all those years ago.

Despite my enthusiasm, 3-weeks passed with delays, vague responses, and excuses. Eventually, I realised my past advocacy for Māori services had ‘come back to bite me’. I realised that the manager was likely holding onto a bias. Recognising that I would not get the opportunity I deserved, I shifted my focus and applied for a nursing educator role at another organisation instead. To my relief, I was successful in securing that position.

This experience was a stark reminder of the challenges Māori nurses face in navigating workplace dynamics. The very passion and advocacy that contribute to meaningful change for our people can also be perceived as threatening in environments resistant to progress. It reinforced the importance of being aware of the power, and how speaking up for equity can, unfortunately, marginalise and limit career prospects.

The Lived Experience

In reflecting on my journey, I see how deeply intertwined my personal and professional paths have become, each experience building upon the other to shape the nurse—and person—I am

today. I began nursing almost by chance, yet I now recognise that my pathway was guided by my tūpuna, who instilled in me a commitment to serve and uplift our people. This narrative has highlighted some key themes that have consistently surfaced throughout my career: the challenges of institutional racism, the power of cultural identity, the tension of dual competence, and the profound impact of whānau and community support.

As a Māori nurse navigating mainstream and Kaupapa Māori services, I learned that the healthcare system is fraught with inequities that disproportionately affect our people, particularly in rural communities. This realisation was sharpened by my personal experiences—caring for my father, recovering from an accident, and watching whānau struggle with preventable illnesses. These moments served as reminders of the pressing need for culturally responsive care and a healthcare system that genuinely values a Māori worldview.

Throughout my career, I encountered overt and structural racism, witnessing firsthand the resistance to change when Māori-led initiatives were introduced. Yet, each setback strengthened my resolve, pushing for a healthcare landscape that honours Te Tiriti o Waitangi and embraces Māori ways of knowing and healing. The development of services like Te Roopu Whitiora was a testament to our resilience and a step toward a more responsive system, although the journey was not easy.

I also came to understand the concept of dual competence—the constant balancing act of maintaining both cultural and clinical expertise. This is a core dilemma for Māori nurses who work within a system that does not support or acknowledge it. Navigating this duality has deepened my understanding of the complexities Māori nurses face and fuelled my desire to bring these issues to light through my research and practice.

Ultimately, my career has been a journey of resilience, advocacy, and reconnection. From the influence of my father's legacy to my own evolvement as a mother and a nurse leader, each part of the journey has reinforced my commitment to uphold the traditions of my Māori nurse whānau and make a meaningful difference for our people. I share these stories as the foundation for this paper, to provide context for my perspective as a proud Māori nurse.

The Journey From Here

This chapter began by situating the research within the historical context of Māori nursing, exploring the systemic factors that have shaped its development. It also provided a personal account of my journey into nursing, establishing the foundation for the research and the kaupapa that guides it. Finally, the chapter concludes with an overview of the thesis structure,

outlining how each chapter contributes to answering the research questions and addressing the aspirations of the Māori nursing workforce.

Chapter 2: Literature Review–Te Take

This chapter provides a comprehensive overview of the existing research and theoretical frameworks relevant to the study of the Māori nursing workforce in New Zealand. The chapter examines historical, systemic, and cultural factors influencing Māori representation in nursing. By synthesising key themes and identifying knowledge gaps, the review establishes the foundation for the research, situating it within the broader academic and healthcare context. It also integrates international Indigenous nursing workforce literature to offer comparative insights and concludes by identifying critical gaps, including the lack of long-term evaluations of strategies, fragmented national coordination, and the role of systemic racism. These gaps frame the need for the current research.

Chapter 3: Methodology–Whakamārama

This chapter outlines the research methodology, employing Kaupapa Māori research to ground the study in Māori values and aspirations, while integrating case study research to allow for a comprehensive, context-specific examination. Kaupapa Māori research provides the philosophical foundation, prioritising decolonisation and amplifying Māori voices, while case study methods enable in-depth analysis of the static state of the Māori nursing workforce. The chapter also introduces the use of intersectionality as a lens to explore the overlapping dimensions of inequality affecting Māori nurses. Data collection methods, ethical considerations, and strategies to ensure research rigour are described to provide transparency and methodological robustness.

Chapter 4: Findings–Kohikohia: Māori Students and Registered Nurses

Chapter 4 presents findings from interviews with Māori registered nurses and students, focusing on their experiences within nursing education and clinical practice. Key themes include the impact of systemic racism, cultural disconnects in curricula, and the dual burden faced by Māori nurses in providing both clinical and cultural expertise. Participants also highlight economic barriers, professional isolation, and the importance of support in overcoming challenges. These findings offer valuable insights into the barriers that hinder Māori recruitment and retention within nursing.

Chapter 5: Findings—Kohikohia: Key Stakeholders

This chapter explores the views of key stakeholders in nursing education, health policy, and workforce planning, who were interviewed to identify systemic factors influencing Māori representation in nursing. Themes include the failure of leadership to address systemic inequities, a lack of national coordination in recruitment and retention of Māori nurses, and endemic racism within nursing education and practice. These perspectives provide critical insights into the policy and institutional dynamics that perpetuate disparities.

Chapter 6: Findings—Kohikohia: Systematic Critical Review of Grey Literature

This chapter analyses government policies and strategies from 1970 to 2023 that have impacted the Māori nursing workforce. Drawing on 18 key documents, the review highlights inconsistencies in policy implementation, short-term focus, and a lack of accountability in achieving sustained growth for the Māori nursing workforce. The analysis reveals patterns of neglect and tokenism in policy development, offering a historical and contemporary lens on systemic barriers.

Chapter 7: Discussion of Findings–Explanation Building

Here, the findings from the three subunits of analysis are discussed. Through combining findings with existing literature, the process of explanation building is initiated. Each set of findings is analysed to examine the underlying factors contributing to the static state of the Māori nursing workforce. Linking themes and data paves the way to develop key interpretations through the process of triangulation. This chapter lays the groundwork for deeper insights into systemic barriers and opportunities for change.

Chapter 8: Interpretations–Whakatinana

This chapter brings together the findings from the three subunits of analysis, weaving together participant narratives, stakeholder perspectives, and insights from grey literature. By synthesising the data, the chapter identifies three overarching interpretations that explain the systemic and cultural challenges facing the Māori nursing workforce:

1. **False Hope and Empty Promises** – Examines the consistent failure to implement recommendations aimed at increasing Māori representation in nursing, revealing a pattern of unmet commitments over decades.
2. **Smoke and Mirrors** – Highlights superficial strategies and token efforts that give the appearance of addressing disparities but fall short of delivering substantive, meaningful change.

3. **Complicit Disregard** – Explores the systemic neglect and lack of accountability that perpetuate inequities, pointing to a collective failure to address these long-standing issues.

These interpretations provide a lens through which the static state of the Māori nursing workforce can be understood. They also offer a foundation for exploring strategies to dismantle these barriers, fostering equity and sustainable growth in the nursing profession.

Chapter 9: Conclusion–Kua Tau

The final chapter reflects on the research findings, addressing the original research question and summarising the study's contributions to understanding the barriers and opportunities for growing the Māori nursing workforce. It offers practical recommendations based on the findings, grounded in Kaupapa Māori principles, and outlines implications for policy, nursing education, and clinical practice. The chapter concludes with a vision for achieving equity in Māori representation within nursing, emphasising the importance of systemic change and sustained commitment.

Conclusion

This introductory chapter has laid the groundwork for understanding the significance of the research within the broader context of New Zealand's nursing workforce. The persistent underrepresentation of Māori in nursing, despite being identified as a priority by both the government and the NCNZ, highlights the urgency of addressing systemic barriers that have hindered progress for nearly 4-decades. This disparity impacts the professional development of Māori nurses and perpetuates inequities in health outcomes for Māori.

The research outlined in this thesis is both timely and necessary, seeking to explore the underlying reasons for the static state of the Māori nursing workforce and to identify actionable strategies to foster growth. By grounding this study within Kaupapa Māori principles and engaging with historical, cultural, and systemic contexts, the research positions itself as a meaningful contribution to addressing these entrenched disparities.

The chapter has also outlined my motivations for undertaking this inquiry, highlighting personal, professional, and societal drivers that align with the research goals of fostering equity and inclusivity within the nursing profession. Finally, the chapter has provided a roadmap for the thesis, offering a clear guide to how the subsequent chapters will build upon one another to answer the central research questions. This foundation sets the stage for a critical and transformative exploration of the factors impacting the growth of the Māori nursing workforce and the pathways toward achieving meaningful change.

Chapter 2: Literature Review–Te Take

“He tino poto ngā rā, a, he tino roa anō ngā pō”

The days were very short, and the nights were extremely long

The Ministry of Health (2008; Minister of Health, 2023) has stressed the need for the New Zealand health workforce to better reflect the population it serves. While nurses make up the largest group of healthcare professionals in New Zealand, currently, only 7% of the nursing workforce is Māori, despite Māori comprising 19% of the country’s total population (NCNZ, 2024c; Stats NZ, 2024).

Research consistently highlights that ethnic concordance within the health workforce is a critical factor in improving health outcomes for Indigenous and minority populations (Cooper et al., 2003; Curtis, Wikaire, et al., 2012; Komene et al., 2023; LaVeist & Nuru-Jeter, 2002; Rearden, 2012; Te Tāhū Hauora Health Quality & Safety Commission, 2024; Wilson, 2018). Despite widespread acknowledgment of these benefits, the recruitment of Māori into nursing has remained static since the 1980s, with little progress made to address this persistent inequity (Ratima et al., 2007; Wilson, 2018; Wilson, Barton et al., 2022).

The Ministry of Health (2016) had aimed to increase the Māori nursing workforce to 15% by 2028, which translates to an additional 10,000 Māori nurses. However, amidst ongoing disparities, racism, and inequities in healthcare, very little has been done to achieve this aim. Also, Māori assert that merely seeking to increase the workforce diversity is too simplistic. Instead, efforts should be driven by the goal of significantly contributing to Māori aspirations, which, in turn, is likely to lead to better health outcomes for Māori (Baker & Levy, 2013; Durie, 2003; Wilson, 2018).

The underrepresentation of Māori in New Zealand’s nursing workforce has persisted as a critical issue, despite numerous government strategies and reports highlighting the urgent need for change. This literature review explores the historical and contemporary factors influencing the recruitment, retention, and development of Māori nurses; as well as broader systemic barriers within the nursing profession and healthcare system. By reviewing literature from the past 5-decades, this chapter aims to provide a foundation for understanding the persistent challenges and opportunities for increasing Māori representation in nursing.

To ensure a comprehensive review, a systematic approach was undertaken using the PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) framework. The review focuses on literature published between 1970 and 2023, capturing pivotal developments in

Māori and Indigenous nursing workforce research and policy. Inclusion criteria targeted studies and reports relevant to Māori and Indigenous nursing and health workforce development, while exclusion criteria omitted literature primarily focused on cultural safety theory, enrolled nursing, non-Indigenous nursing workforces, and Māori health outcomes. A total of 224 articles were reviewed, with 70 meeting the inclusion criteria.

Search terms included: “Māori nurs* AND workforce”, “Māori health workforce”, “Māori AND health workforce”, “Māori health AND recruit*”, “Māori nurs* AND recruit*”, “indigenous AND nurs* AND workforce”, and combinations of “Indigenous”, “native American”, “Māori”, “native”, “aboriginal”, “Alaskan”, “Hawaiian”, “First nation”, “nurs*”, “workforce”, “recruitment”, “retention”, “turnover”, and “Cultural congruence AND nurs* AND workforce”. The databases searched from the Auckland University of Technology library Medline included CINAHL, Cochrane, Joanna Briggs, and Scopus. Search terms were also applied in Google Scholar.

The chapter begins by examining the broader health sector reforms of the 1990s and their impact on the nursing profession. It then transitions into an analysis of the current nursing workforce, highlighting issues such as the reliance on internationally qualified nurses (IQNs) and its implications for domestic workforce planning. Following this, the focus narrows to the Māori nursing workforce, presenting a rationale for increasing representation and addressing the systemic inequities that hinder growth.

Key themes explored include barriers to Māori nursing workforce development, the influence of international Indigenous nursing experiences, and strategies for enhancing Māori recruitment and retention. The chapter concludes with a synthesis of the findings, identifying gaps in the literature and areas requiring further investigation. This review highlights the critical need for actionable strategies to align the nursing workforce with the aspirations of Māori, contributing to both equitable representation and improved health outcomes for Māori. By addressing these issues, this research seeks to advance the discourse on creating a culturally concordant and sustainable nursing workforce in New Zealand

Defining the Context

The Health Workforce

From the late 1980s and through the 1990s the New Zealand health system underwent a considerable period of upheaval. The changes occurred during a time of economic restructuring that positioned New Zealand towards neoliberalism and a free market economy. In response to fiscal constraints, major changes were implemented within the national health service. As the government restructured the health system there was decreased emphasis on a

centralised workforce approach; Consequently, hospitals and health services were left responsible for monitoring and developing their own workforce, leading to a loss of strategic focus at the national level (Cook, 2009; Health Workforce Advisory Committee [HWAC], 2003; Masters-Awatere, 2017; Ministry of Health, 2002; North, 2011).

By the early 2000s, the impact of these healthcare reforms on the health workforce became increasingly apparent. The nursing sector experienced a significant reduction in Full-Time Equivalent (FTE) positions across all areas, resulting in an erosion of morale and a stressed and stretched health system. This lack of employment growth was accompanied by a decline in the number of nurse graduates, high rates of emigration, and occupational detachment, eventually leading to nursing shortages (Carryer et al., 2010; Hornblow et al., 2002).

In 2001, the Ministry of Health established the HWAC. This committee's key tasks were to assess workforce capacity, including future workforce projections, and to provide advice on a national strategy. Through this process, it was identified that Māori were significantly underrepresented in the health workforce (HWAC, 2003). In 2006, a comprehensive review of the Māori health and disability workforce was undertaken. At that time, Māori represented only 5.7% of the total regulated health workforce. Retention issues were examined, with retention levels determined to be between 60% and 80% across all health professions. The review aimed to inform a "strategic framework for Māori health and disability workforce development over the following 10-15 years"(Ministry of Health, 2006, p.2).

Nursing Workforce

Projections suggest that an aging population and increased life expectancy will significantly impact healthcare utilisation in New Zealand in the near future (Cook, 2009; Nana et al., 2013). Highlighted during the global pandemic, the demand for a skilled health workforce capable of adapting to future needs and changes in the healthcare environment has become critically urgent. This urgency is compounded by an aging nursing workforce. With 40% of nurses aged 50-years or older (NCNZ, 2023), there are dire projections of up to 50% of the nursing workforce retiring by 2035, leading to a potential shortage of 15,000 nurses. In response, the Nursing Council of New Zealand (NCNZ) has identified growing the nursing workforce as a priority, recognising that 'business as usual' will not suffice to meet future needs (Nana et al., 2013).

Cook (2009) suggested that New Zealand was not well-organised in planning for future nursing workforce needs. The localisation of recruitment into programmes and the lack of a national approach have hindered the ability to identify and address these needs (Holloway & Baker, 2009). This is evident in workforce data. Since the late 1990s New Zealand has increasingly

depended on IQNs to fill workforce gaps, making it vulnerable to international labour flows (Chalmers, 2020; New Zealand Nurses Organisation [NZNO], 2018; Zurn & Dumont, 2008). Currently, IQNs represent 47% of the New Zealand nursing workforce. The World Health Organization's ([WHO] 2020) recent report on the state of the global nursing workforce warned of an impending international nursing shortage, which is likely to intensify New Zealand's competition in the global market for nurses in the future.

Nana et al. (2013) argued that New Zealand's dependence on Internationally Qualified Nurses (IQNs) to address workforce shortages has led to a nursing workforce that does not align with the ethnic diversity of the population. Wilson (2018) added that a one-size-fits-all approach to healthcare privileges the dominant culture, which has had ongoing detrimental effects on Māori health outcomes (Reid, 2021). To address these inadequacies, increasing the Māori health workforce is crucial. However, despite efforts to grow the Māori nursing workforce, the number of Māori nurses remains insufficient to meet demand. It has been proposed that the lack of significant growth in the Māori nursing workforce over the past 40 years correlates with the rise in health inequities experienced by Māori (Wilson, 2018; Wilson, Barton, et al., 2022).

Cook (2009) emphasised that strengthening the Māori nursing workforce is essential for maintaining the leadership role Māori nurses have played in enhancing Māori responsiveness within the healthcare system. Over the past 30 years, Māori nurses have consistently advocated for greater investment in their workforce, calling for a national strategic response to address health workforce inequities (Baker, 2009; Chalmers, 2020; Kainamu, 2013; Nuku, 2015b; Ramsden, 1990, 2002; Walker, Heneghan et al., 2016; Wilson, 2018). The lack of significant progress in this area has led Māori nursing representatives to file a claim with the Waitangi Tribunal, a truth and reconciliation body established to address Māori historical grievances. They argue that the current situation is unethical and violates Te Tiriti o Waitangi (Waitangi Tribunal, 2019).

The Māori Nursing Workforce

Efforts to increase the Māori nursing workforce have faced persistent challenges since the introduction of a Māori nursing scheme in 1898 (Dow, 1999; Gage & Hornblow, 2007). While the number of Māori nurses has gradually risen, the stagnation in growth over the past 3-decades reflects a lack of strategic planning and commitment from nursing leadership and the government (Barton et al., 2021; Cook, 2009; Nuku, 2015b; Wilson, Barton et al., 2022). Ramsden (2002) recognised 2-decades ago that, despite well-meaning rhetoric, the general lack of political will has perpetuated the absence of a national approach to implementing targeted strategies.

Recent statistics show that the Māori nursing population has reached a record high of 4,681 nurses, though this still accounts for only 7% of the total nursing workforce (NCNZ, 2023). An analysis of data from 2005-2020 shows an increase of 1,353 Māori nurses over 15-years, averaging just 90 new nurses per year.

Why More Māori Nurses are Needed

Māori Health Outcomes.

It is well-established that compared to non-Māori, Māori experience poorer health outcomes and are overrepresented in nearly all disease categories. Māori have higher morbidity and mortality rates in conditions such as diabetes, rheumatic fever, cardiovascular disease, and most cancers (Miner-Williams, 2017; Ministry of Health, 2015; Sheridan et al., 2024; Tin Tin et al., 2018; Waitangi Tribunal, 2019). Mortality statistics suggest that Māori are likely to die 7-8-years younger than non-Māori and experience higher rates of suicide (Ministry of Health, 2015; Waitangi Tribunal, 2019). Despite these alarming statistics, Māori face significant barriers in accessing primary healthcare, are less likely to receive referrals for specialist care (Lao et al., 2016; Sheridan et al., 2024; Waitangi Tribunal, 2019), and are less frequently offered elective surgical interventions (Aumua et al., 2018; Rahiri et al., 2018).

Systemic racism and discrimination within New Zealand's healthcare system further exacerbate these disparities, contributing to high rates of adverse medical events and substandard care for Māori. These inequities are reflected in average length of hospital stays, higher readmission rates in both surgical and medical settings, and an overrepresentation in mental health services (Edmonds et al., 2022; Espiner et al., 2021; Graham & Masters-Awatere, 2020; Harris, et al., 2012; 2019; Reid et al., 2019; Rumball-Smith et al., 2013; Wilson & Barton, 2012). Māori are also more likely to receive diagnoses of schizophrenia (Mellsop & Tapsell, 2019), experience more restrictive forms of care (McLeod, 2017), be prescribed significantly higher doses of antipsychotics (Kake et al., 2016), and are subjected to compulsory treatment at higher rates (Ministry of Health, 2017a).

Past government initiatives aimed at reducing health inequities for Māori and minority groups have recognised the importance of culturally concordant healthcare delivery. A central aspect of these initiatives has been the understanding that the Māori health workforce should reflect not only the population but also the specific health needs of Māori communities (Health and Disability System Review, 2020; Ministry of Health, 2019b). Wilson (2018) supported this view, describing the Māori nursing workforce as "critical enablers and a major lever" (p.2) in addressing Māori health inequities. Wilson, Barton et al. (2022) further suggested that an

overrepresented Māori nursing workforce may be essential to reduce the mortality and morbidity burden in the Māori population.

However, the recent change of government has seen a shift away from Māori health initiatives, citing that health service provision should be based on 'need not race' (Department of the Prime Minister and Cabinet, 2024; Loring et al., 2024). The implications of this policy change for the development of the Māori nursing workforce remain uncertain. Notably, there is a lack of discussion among nursing leadership on how to address both the pervasive health inequities and the shortage of Māori nurses (Barton, 2018; Komene et al., 2023). Despite the evidence that there is the need to increase the Māori nursing workforce, no targeted interventions have yet been implemented.

Culturally Concordant Care.

Māori nurses often find themselves mediating between the cultural expectations of patients and whānau and the professional expectations of their role. Wilson and Baker (2012) suggested that Māori nurses serve as the "guardians of spiritual well-being" (p.1077) for the Māori they care for. They often navigate tensions that arise from balancing opposing and conflicting worldviews, striving to integrate cultural and clinical practices by 'bridging the two worlds'. Simon (2006) emphasised that Māori nurses are uniquely effective because their cultural identity and mātauranga Māori (Māori knowledge systems) inform their practice. According to Barton and Wilson (2008), Māori nurses work differently from non-Māori nurses when caring for Māori, integrating nursing knowledge with mātauranga Māori to enhance patient care. Similarly, Huria et al. (2014) suggested that Māori nurses use both clinical and cultural skills, enriching the healthcare experience for both patient and nurse.

Moreover, Hunter and Cook (2020a) highlighted that Māori nurses feel a deep responsibility to ensure and advocate for the proper care of every Māori individual they come across. Māori nurses bring with them their own cultural context and, despite the mainstream western setting they often work in, they continue to exist as Māori within this environment, attempting to negotiate their way around existing impediments for the betterment of their people. It is well-established that Māori nurses play a critical role in maintaining cultural integrity in healthcare, contributing to equitable access to health services (Baker & Levy, 2013; Barton & Wilson, 2008; Hunter, 2019; Komene et al., 2023; Walker, Heneghan et al., 2016).

International literature supports national research, indicating that patients are more satisfied and more likely to use preventative services when cared for by providers of the same ethnic background (Cooper et al., 2003; LaVeist & Nuru-Jeter, 2002; Rearden, 2012). Ensuring equitable Māori participation in the health workforce will address the anticipated workforce

shortages and help reduce health inequities. Māori nurses are crucial for applying the cultural context needed within the health system. Expanding the Māori nursing workforce is a vital step toward addressing the disparities in healthcare experienced by Māori (Te Rau Matatini, 2015).

Workforce Equity.

Te Tiriti o Waitangi, signed between Māori and representatives of the British Crown in 1840, asserts that the Crown is responsible for actively protecting Māori health and well-being, including ensuring equitable policy outcomes. This was confirmed by the findings of the Wai 2575 Health Services and Outcomes inquiry. The inquiry, presented to the Waitangi Tribunal—a government-established committee in the 1970s to address Māori historical grievances—was initiated by Māori who argued that the Crown had failed to deliver equitable health outcomes for Māori, thus breaching the Te Tiriti o Waitangi (Came et al., 2020). The Tribunal's findings highlighted persistent health disparities between Māori and other New Zealanders, attributing these to a profound system failure. The Crown acknowledged that the ongoing health inequities experienced by Māori indicated institutional racism within the health system, including primary health care, where personal racism and stereotyping negatively impact Māori (Came et al., 2020; Waitangi Tribunal, 2019).

During the Tribunal process, Māori nurses also submitted a claim (Wai 2713) supporting the view that inadequate Crown intervention has led to persistent Māori health inequities. They emphasised that growing and enhancing the Māori nursing workforce would significantly contribute to addressing these inequities and disparities (Waitangi Tribunal, 2019). Chalmers (2020) suggested that the Tribunal's findings provide timely context for responding to policy failures and developing the Māori nursing workforce. These failures are reflected in the systemic racism present in nursing education, regulation, and leadership (Barton & Wilson, 2021; Came & Kidd, 2019; Hunter & Cook, 2020a; Huria et al., 2014; Komene et al., 2023; Nuku, 2015b; NZNO, 2018; Ramsden, 1990; Walker, Heneghan et al., 2016; Wiapo et al., 2024; Wilson, Barton et al., 2022). Furthermore, there is a need for a concerted effort from nursing leadership and the entire nursing workforce to own and address the systemic racism that exists within the profession.

Identifying the Barriers to Māori Nursing Workforce Development

To address the underrepresentation of Māori in nursing, it is essential to understand the barriers they face in participating and succeeding in the profession. Ratima et al. (2007) identified several key categories that either hinder or facilitate Māori workforce development: structural, systemic, organisational, and individual. This discussion will overview these factors

concerning the barriers to recruiting and retaining Māori in the nursing workforce, followed by an examination of international literature.

Barriers to Recruitment and Retention

Structural barriers, including the socio-economic position of Māori and institutional racism, significantly hinder the recruitment and retention of Māori in the healthcare workforce. These barriers extend beyond the health and education sectors, they filter into every aspect of New Zealand society, suggesting the need for a comprehensive and integrated approach (Curtis, Wikaire et al., 2012; Ratima et al., 2007). For example, Tupara and Tahere (2020) identified economic deprivation as the second most significant factor impacting retention and completion rates in midwifery programmes. Similarly, Baker (2009) explained that financial hardships contribute heavily to Māori attrition rates in nursing programmes, highlighting the need for stronger financial support from pre-entry to postgraduate levels.

Wilson et al. (2011) and Foxall (2013) further highlighted that financial difficulties affect both Māori nursing students and their whānau, adding to pressures that lead to higher dropout rates. The financial burden is consistently identified as a critical barrier to both recruitment and retention of Māori nursing students (Baker, 2009; Chittick et al., 2019; Foxall, 2013; Gray, 2020; Te Rau Matatini, 2015; Wilson et al., 2011; Zambas, 2020).

Māori encounter a variety of challenges linked to institutional racism, both before and during their nursing careers. Their marginalisation in secondary education is clear, with low numbers of Māori students advancing to higher education. These same issues are reflected in nursing programmes, which often lack cultural diversity and do not adequately include Māori perspectives, values, and experiences (Baker & Wilson, 2012; Barton & Wilson, 2021; Chittick et al., 2019; Foxall, 2013; Ramsden, 1990; Wilson et al., 2011; Zambas et al., 2020). In the workplace, Māori registered nurses continue to experience institutional racism, manifested through wage inequities, resource allocation disparities, and work environments dominated by a Eurocentric perspective (Brockie et al., 2023; Chalmers, 2020; Hunter & Cook, 2020a; Huria et al., 2014; Komene et al., 2023; Nuku, 2015a; NZNO, 2018; Walker, Heneghan et al., 2016; Wilson, Barton et al., 2022).

Systemic barriers reinforce the failures of primary and secondary education systems in serving Māori, impacting their ability to access tertiary education. These barriers include poor access to quality health career information, a lack of Māori-centred health and science career promotion, inadequate career guidance, and insufficient information regarding course options and the range of professions (Cook, 2009; Curtis, Wikaire et al., 2012; Foxall, 2013; Ratima et al., 2007). Baker (2009) noted that insufficient access to quality career information and

educational planning leaves students uninspired and underprepared for tertiary health studies. Recruitment and marketing efforts often fail to focus on rangatahi (young people) and frequently reinforce outdated stereotypes of nursing as an aging profession. Similarly, Foxall (2013) suggested that low confidence in pursuing tertiary education, coupled with the challenging enrolment process, can further impact recruitment efforts.

The tertiary education system presents additional challenges for Māori aspiring to enter the nursing profession. Rigid entry criteria, high course costs, and low awareness of funding sources create significant barriers. The often-distant locations of institutions, the digital divide impacting online course participation, and the length of courses combined with perceived heavy study workloads, further deter many potential students. Moreover, inadequate Māori-specific support programmes compound these difficulties (Baker, 2009; Barton & Wilson, 2021; Chittick et al., 2019; Cook, 2009; Curtis, Wikaire et al., 2012; Foxall, 2013; Ratima et al., 2007; Wilson et al., 2011).

A low presence of Māori role models and mentors in the health and education sectors, coupled with a lack of formal links between academic departments and Māori communities, exacerbates these issues (Barton & Wilson, 2021; Ratima et al., 2007; Wilson et al., 2011). Curtis, Wikaire et al. (2012) emphasised the need for support throughout the educational pipeline, from secondary school through tertiary education and into vocational training (post-graduation).

Systemic barriers within the work environment are reflected in health sector funding mechanisms, low levels of system flexibility, a low Māori presence in the sector, and poor pay rates and opportunities. Health sector funding issues particularly disadvantage Māori providers, resulting in pay inequities and limitations on workforce development (Came et al., 2018; Ratima et al., 2007; Waitangi Tribunal, 2019).

Ratima et al. (2007) further explained that if Māori students successfully enter tertiary education, they encounter additional organisational barriers. These include an absence of institutional commitment to Māori, with institutions and programmes failing to create Māori-friendly environments. The system lacks opportunities for Māori to work in ways that align with their cultural values (Baker, 2009; Curtis, Wikaire, Kool et al., 2015; Durie, 2005a; Ratima et al., 2007; Tupara & Tahere, 2020; Wilson et al., 2011). Personally mediated racism persists in education and the workplace, influencing perceptions of limited employment opportunities (Barton & Wilson, 2021; Brockie et al., 2023; Chalmers, 2020; Gray, 2020; Hunter & Cook,

2020a; Huria et al., 2014; Kainamu, 2013; Smith et al., 2021; Wilson, 2018; Wilson et al., 2011; Wilson, Barton et al., 2022).

The low numbers of Māori nurse educators and tutors with academic, clinical, and cultural experience present a significant challenge for schools of nursing (Baker, 2009; Barton & Wilson, 2021; Chittick et al., 2019). Additionally, Wilson et al. (2011) identified a significant correlation between Māori student nurses who had to "travel to study with difficulty in accessing faculty, unsuitable teaching and learning approaches, an unsupportive and culturally unsafe learning environments, and not being able to access to Māori role models and mentors" (p. 63). Curtis, Wikaire et al. (2012) further explained that Māori students often leave their families, communities, and support networks to enter a non-indigenous, unfriendly, and foreign environment, leading to feelings of isolation and cultural alienation within the tertiary environment.

Organisational barriers within the workforce highlight the pressures on Māori nurses working in mainstream roles, with added expectations to handle Māori matters or dual responsibilities to employers and the Māori community, leading to unrealistic workloads. Cultural competencies are often undervalued, reflected in low levels of Māori cultural competence among colleagues, along with minimal or no access to Māori cultural support, supervision, or culturally competent Māori health professionals. These factors frequently lead to burnout, influencing the decision to leave the profession. Workplace racism, isolation from other Māori colleagues, and difficulty with 'being Māori' in predominantly Eurocentric workplaces also contribute to these challenges (Baker & Levy, 2013; Barton & Wilson, 2021; Foxall, 2013; Hunter & Cook, 2020a; Huria et al., 2014; Komene et al., 2024; Ratima et al., 2007; Walker, Clendon et al., 2016; Wilson, Barton et al., 2022).

Personal barriers faced by Māori in nursing include limited exposure to tertiary education, a lack of familiar role models who have studied or worked in the health sector, and commitments to whānau, hapū, and iwi. The absence of role models and mentors within whānau who recommend nursing or a health profession, along with the pressures to meet the expectations of whānau and the Māori community, further complicate their journey (Baker, 2009; Barton & Wilson, 2021; Gray, 2020; Ratima et al., 2007; Wilson et al., 2011).

Several factors likely contribute to attrition in the nursing workforce, including inadequate management, low flexibility, poor access to professional development opportunities, heavy workloads, and a lack of clear career pathways (Baker, 2009; Barton & Wilson, 2021; Brockie et al., 2023; Komene et al., 2023; Ratima et al., 2007). Baker (2009) noted that many Māori nurses view ongoing professional development as vital for their retention in the workforce. Issues

such as pay disparity for nurses working in Māori providers, unsupportive work environments, and ineffective management and leadership in supporting and valuing Māori staff significantly influence job satisfaction and retention. Whānau commitments and the high expectations of Māori communities are recurring personal barriers to retention (Ratima et al., 2007). Wilson et al. (2011) further explained that whānau commitments significantly impact student engagement and retention, often causing conflict or tension when students must prioritise these commitments over their studies.

Māori face substantial barriers to both recruitment and retention in the nursing workforce, stemming from structural inequalities, institutional racism, and financial hardships. These challenges permeate the entire educational pipeline, from secondary education through to tertiary studies, where a lack of cultural support, financial assistance, and Māori role models exacerbate feelings of isolation and disengagement. In the workplace, Māori nurses continue to struggle with pay inequities, cultural undervaluation, and additional pressures tied to their cultural identity. Addressing these issues is essential for improving Māori participation and retention in the nursing profession.

International Literature

The international literature reviewed examined the experiences of Indigenous peoples in Australia, Canada, and the United States of America (USA), providing a basis for comparing the Māori experience with that of Indigenous groups in other countries with similar histories of colonisation and marginalisation. The most significant factor affecting the recruitment and retention of indigenous people in nursing and health professions is the economic strain of entering tertiary education. Financial hardship causes considerable stress, particularly for students who must fund their education while also working to support themselves and their families. This economic burden is a primary barrier to recruitment and a significant reason for high attrition rates among Indigenous students (Curtis, Wikaire, Kool et al., 2015; Harrigan et al., 2003; Meehan et al., 2019; Milne et al., 2016; Rearden, 2012; Slatyer et al., 2016; Taylor et al., 2019; West et al., 2010).

Academic preparation is another significant barrier. Many Indigenous students lack the completion of prior education and the necessary academic preparedness, placing added pressure on them and requiring additional support (Anonson et al., 2008; Curtis, Townsend et al., 2015; Meehan et al., 2019; Taylor et al., 2019). This issue is also reflected in the workforce, where nurses often lack career pathways and professional development opportunities (Lai et al., 2018). A lack of integrated support networks providing social, cultural, and academic support significantly contributes to attrition rates among Indigenous students. Many students

move from remote rural communities to urban tertiary institutions, away from their families and communities, leading to anxiety and feelings of isolation. In the workforce, this lack of support is seen in the absence of mentoring and management support (Lai et al., 2018).

Organisational issues such as institutional racism, discrimination, and cultural insensitivity by non-indigenous faculty create culturally unsafe environments. The lack of Indigenous content in the curriculum and the dominance of Western pedagogy further exacerbates these issues, adding pressure and stress to students (Curtis, Wikaire, Jiang et al., 2015; Harrigan et al., 2003; Milne et al., 2016; Rearden, 2012; Taylor et al., 2019; West et al., 2010). Some also challenged the dominance of the Western pedagogy, highlighting the 'whiteness of nursing' and lack of diversity in the nursing curriculum (Anonson et al., 2008; Nielsen et al., 2014; West et.

Personal barriers discussed included the competing obligations experienced by Indigenous students, often issues that were not particularly well understood by non-indigenous faculty and staff. Students were seen to naturally prioritise family obligations, which involved being available to support family while completing study as well as the expectations to participate in cultural responsibilities. Often these additional obligations accumulate and overwhelm students, leading to them eventually deciding that the pressure is too great and leaving nursing (Anonson et al, 2012; Curtis, Wikaire, Kool et al, 2015; Harrigan et al, 2003; Slatyer et al, 2016; Taylor et al, 2019; West et al, 2010).

Racism was seen as the most significant factor to influence the retention of Indigenous nurses in the clinical setting. Racism was demonstrated politically, culturally, and, most obviously, economically, where Indigenous nurses experienced inadequate remuneration and often experienced heavy workloads and demands. For Indigenous nurses, the desire to improve health outcomes for their communities is often hindered by the location of services and the lack of appropriate resources needed to perform their jobs effectively (Lai et al., 2018).

The international literature highlights common challenges faced by Indigenous people in nursing across Australia, Canada, and the USA, which mirror the Māori experience in New Zealand. Economic hardship remains the most significant barrier to recruitment and retention, with financial stress contributing to high attrition rates. Academic under-preparedness, lack of support networks, institutional racism, and cultural insensitivity further compound the difficulties Indigenous students and nurses face. Personal obligations and systemic discrimination in the workforce also hinder Indigenous nurses' ability to thrive and improve health outcomes for their communities, emphasising the need for targeted, culturally appropriate interventions.

Strategies to Increase the Recruitment of Māori into Nursing

Following a review of the Māori health workforce in New Zealand, significant efforts have been made to identify and understand the underrepresentation of Māori in the health sector, particularly in nursing, and to devise strategies to address this issue. Much of the literature reviewed spans the past 20 years, with one seminal study conducted in the early 2000s.

Research suggests that strategies to increase the recruitment of Māori into the health and nursing workforce have been well-documented and defined. Over a period of 13-years, numerous journal articles and reports have provided clear guidance and recommendations on improving the Māori nursing workforce. The following discussion reviews some of these articles and reports, and summarises their recommendations.

Efforts to address the underrepresentation of Māori in the nursing workforce have been ongoing for over 2-decades, with numerous studies and reports providing clear strategies for improvement. One key framework, "*Rauringa Raupa: The Māori Health Workforce Development Plan*" (Ratima et al., 2007) was developed for the Ministry of Health to guide the sector over 10-15 years. The plan outlines three primary goals: "to increase the number of Māori in the health and disability workforce, to expand the skill base of the workforce, and to enable equitable access for Māori to training opportunities" (p. 1).

The research behind the plan utilised Māori methodologies and involved a combination of qualitative and quantitative data, including interviews, focus groups, and surveys. Four key categories were identified as influencing Māori workforce participation: structural, health and education systems, organisational, and personal factors. The plan proposes a multi-level approach to address these barriers, focusing on six areas: "leadership and collaboration, monitoring and research, policy, funding, technical and cultural competence, and recruitment and retention interventions" (Ratima et al., 2007, p. xxiii).

Key goals include increasing the number of Māori in the workforce, expanding skillsets, and ensuring equitable access to training opportunities. Addressing various structural, organisational, personal, and systemic barriers, the plan recommends leadership and collaboration, comprehensive policy development, and targeted recruitment and retention strategies. These efforts focus on enhancing both technical and cultural competencies, with the goal of fostering a more robust and sustainable Māori health workforce.

The report "*Nga Wawata o Nga Naahi Māori: Responses from Māori Nurses and Midwives Nationally*" (Te Rau Matatini, 2009), commissioned by the Ministry of Health, explored the Māori nursing and midwifery workforce through a combination of qualitative and quantitative

methods, involving 313 Māori nurses and midwives. The research focused on key areas such as attraction, recruitment, education, professional development, and leadership. Key findings emphasised that supporting Māori nursing students at all educational levels, from pre-entry to post-tertiary, including providing financial assistance, is critical for success. The presence of Māori educators, flexible learning options, and more Māori content in nursing programmes were identified as enablers for success.

For registered nurses, the study highlighted the importance of organisational support for professional development, particularly for rural nurses who face challenges accessing affordable education. Cultural professional development was also deemed essential, with mainstream organisations needing to better understand and support it.

Leadership development was identified as a priority, with the report recommending specialised leadership programmes that are regionally led and locally delivered to strengthen Māori leadership within nursing. The report calls for a coordinated effort to engage young Māori in nursing, more flexible education pathways, and enhanced support for professional growth, especially in rural areas. Additionally, fostering leadership opportunities will create pathways for Māori nurses to advance and take on key roles in management and education.

Curtis, Wikaire et al. (2012) conducted a review of Indigenous literature related to the recruitment of Indigenous students into tertiary health programmes, aiming to understand broader recruitment strategies and inform best practices with potential international relevance. Using a Kaupapa Māori methodology, the review examined 70 articles, 31 of which focused on nursing and midwifery. The authors found that while many studies were descriptive, few provided evidence of effective interventions. Though specific 'best practices' could not be pinpointed, the authors identified six broad principles to guide Indigenous health workforce recruitment: 1) Initiatives should be informed by Indigenous rights and practices, 2) Institutions should commit to Indigenous workforce goals through policy, 3) Recruitment must address local barriers, 4) An integrated 'pipeline' model spanning secondary and tertiary education is essential, 5) Recruitment must engage whānau and Indigenous communities, and 6) Programmes should evaluate and share data. Curtis, Wikaire et al. recommended that international institutions adapt these principles to their own Indigenous contexts and emphasise that achieving equity in the Indigenous health workforce should remain both a political and ethical priority.

The report "*Māori Mental Health Nursing: Growing Our Workforce*" (Te Rau Matatini, 2015) outlines best practice guidelines for strengthening the Māori mental health nursing workforce, offering key stakeholder guidance on how to improve responsiveness to Māori needs. While

there have been advancements in making nursing more inclusive for Māori, the development of the Māori mental health nursing workforce has been hindered by a lack of research and resources. The report is framed around the Māori health promotion model, Te Pae Mahutonga (Durie, 1999), which draws on the symbolism of the Southern Cross constellation. Each of its six points represents key concepts essential for growth: Mauriora (cultural identity), Toiora (healthy lifestyles), Waiora (physical environment), Te Oranga (participation in society), Ngā Manukura (community leadership), and Te Mana Whakahaere (autonomy).

Culturally relevant professional development, including te reo (language), tikanga (protocols), and mātauranga Māori (knowledge systems) is emphasised, promoting excellence through mentoring, supervision, and ongoing career development. The report advocates for safe and nurturing environments that support Māori mental health nurses, as well as high-quality, accessible training pathways that focus on recruitment and retention. It stresses the importance of incorporating Māori perspectives in nursing education, particularly for Māori student nurses. The report also highlights the need for strategic, sustainable leadership to foster strong, transformative Māori leaders in mental health nursing. Overall, it presents a comprehensive framework for the self-determined growth of the Māori mental health nursing workforce, aligned with collective aspirations and sustainable practices.

Walker et al. (2016) examined the experiences of Māori nurses as they navigate the demands of fulfilling culturally specific responsibilities within their whānau, hapū, and iwi, alongside their roles as nurses and students. Using a Kaupapa Māori methodology, the research involved interviews with 15 participants. Four key challenges were identified: whānau responsibilities, cultural obligations, struggles, and organisational issues. Participants suggested strategies to address these challenges, such as “Increasing cultural awareness, implementing more flexible workplace policies to enable cultural obligations to be met, and building an ethos of collegial and managerial support for Māori nurses” (p. 366).

.A workforce survey was carried out to address the gap in detailed information about the experiences of Māori health workers and to determine future workforce priorities. Māori health workers aged 18-years and over were invited to participate in an online survey that gathered demographic information such as age, education, iwi affiliation, and employment settings, as well as factors affecting workplace satisfaction. A total of 2,056 responses were analysed (McClintock et al., 2019). The findings indicated that workplace satisfaction was moderately associated with having a professional development plan, receiving employer support for involvement with marae, hapū, and iwi, and having access to cultural supervision. Stronger associations with workplace satisfaction included feeling valued and receiving fair compensation for one’s contribution. The report recommended sector-wide improvements,

particularly in recruitment, with an emphasis on integrating Te Tiriti o Waitangi and improving cultural competence. Retention strategies included providing cultural supervision, expanding culturally responsive professional development (e.g., learning te reo Māori and engaging with marae, hapū, and iwi), and ensuring salaries reflect employee contributions. These actions were identified as essential for strengthening the Māori health workforce (McClintock et al., 2019)

A variety of strategies have been proposed and implemented to increase the recruitment and retention of Māori nurses, addressing the significant underrepresentation of Māori in New Zealand's health workforce. Key frameworks, such as "*Rauringa Raupa: The Māori Health Workforce Development Plan*", emphasise the need for culturally informed policies, leadership development, and equitable access to education and professional opportunities. While some progress has been made in supporting Māori nursing students, significant challenges remain, including systemic barriers and the need for sustainable leadership development. Ongoing efforts must focus on creating culturally supportive environments, fostering Māori leadership, and providing comprehensive, long-term solutions to ensure the growth of a strong, capable Māori nursing workforce.

Indigenous Literature

Lai et al. (2018) conducted a literature review of 15 articles examining the enablers and barriers to the retention of Indigenous Australians within the health workforce. The aim of the review was to provide strategies to inform workplace practices within Australian healthcare settings. Findings from the review identified a lack of published strategies aimed at improving retention, with more emphasis placed on removing barriers rather than empowering Indigenous Australians.

Important factors identified through the review included the significance of culturally safe and supportive workplace, positive attitudes among leaders and colleagues, and access to mentoring, supervision and training. Clearly defined roles, scopes of practice, and responsibilities were seen as essential, along with improvements in salary levels and job security in Indigenous health services. The review also highlighted the need for a greater focus on the collection of national Indigenous health workforce data to better understand retention and turnover rates and the development of effective retention strategies (Lai et al., 2018).

In Canada, the rapid population growth of Aboriginal youth presents an opportunity for targeted strategies to support the recruitment and retention of First Nations youth in baccalaureate nursing programmes in Saskatchewan (Anonson et al., 2012). Eleven community, government, and educational institutions collaborated to provide multi-layered approaches to

enhance success. These included interventions at the *recruitment phase*: Staff and faculty worked together to raise awareness of nursing programs in high schools. *Educational preparation*: A 10-month academic preparatory programme was established to provide the necessary academic requirements for entering graduate health studies, with an emphasis on nursing. *Support services*: Academic advisors and student counsellors were available to meet students' academic and personal needs. *Programme flexibility*: was highlighted as a significant enhancer for students with family commitments, often in distant locations. Flexibility allowed staff to arrange make-up time, with faculty encouraged to engage with Indigenous students holistically and inclusively. These interventions aim to support the success of First Nations youth in nursing programmes by addressing both academic and personal needs.

Cultural interventions were implemented to address the fact that nursing programmes are often taught within the dominant paradigm and are not conducive to Indigenous worldviews. The presence of Elders on campus was seen as a way to bridge the cultural divide between Aboriginal students and their nursing education. Extracurricular activities involving students, family, and staff helped create a sense of community. Childcare and study spaces were essential to accommodate mothers in the programme, with provisions such as breastfeeding rooms and allowing newborns in the classroom. Role models and mentors were significant enhancers of student retention, with senior students mentoring junior students, especially during the transition from academic to clinical settings. Formal mentorship programmes, in addition to existing preceptorships, were being planned. Financial support remained a significant issue, with academic counsellors and faculty providing necessary information to students. The retention strategy was described as a holistic approach to nurturing student nurses, acknowledging that the greatest asset to success was the commitment of faculty to quality education and the students' determination to attain it (Anonson et al., 2012).

A successful model for graduating Aboriginal nurses in Australia was an Aboriginal nurse-led programme at the University of Southern Queensland, it has seen the successful completion of 80 graduates over 12-years. They suggested four strategies for all university nursing and midwifery schools in Australia: 'employing Indigenous nursing academics, developing an Indigenous health curriculum, creating Indigenous-appropriate marketing materials, and providing personalised mentoring and support for Indigenous students' (Best & Stuart, 2014, p. 65). Best and Stuart (2014) suggested that implementing these recommendations can lead to successful outcomes for Indigenous students.

The international literature aligns closely with findings from research on the Māori nursing workforce, emphasising the importance of culturally supportive environments, mentorship, and flexible programmes in retaining Indigenous health professionals and students. Key

strategies include enhancing workplace cultural safety, clearly defining roles and job security, and offering comprehensive academic and personal support. Successful interventions, such as Indigenous-led mentorship and community-building initiatives, play a crucial role in improving the retention and success of Indigenous students in health programmes.

Conclusion

This literature review has outlined the critical efforts and strategies that have been undertaken to enhance the recruitment and retention of Māori within nursing in New Zealand. Over the past 2.5-decades, there has been a concerted effort by researchers, government bodies, and Māori health leaders to address the static state of the Māori nursing workforce, which has hovered at approximately 7% of the total nursing population for nearly 4-decades. While this issue has been acknowledged by nursing and government, this review has highlighted gaps in the literature and in the implementation of effective, sustainable strategies that align with Māori nursing aspirations and address the main barriers impeding progress.

A central theme throughout the literature is the recognition that structural barriers—such as institutional racism, economic disadvantage, and inequities within the education system—continue to pose significant challenges to increasing the Māori nursing workforce. Māori nurses and nursing students face multiple systemic obstacles that result in high attrition rates, underrepresentation in leadership roles, and professional isolation. While many studies, reports, and reviews have identified these barriers and proposed strategies to overcome them, there remains a significant gap in the long-term evaluation of these strategies and their outcomes.

One of the most obvious gaps in the literature is the limited data on the effectiveness of recruitment and retention strategies. There exists very little research that provides robust evidence of the effectiveness of recommendations, nor identifying what has worked. For example, while financial support, culturally responsive education and workplaces, and academic mentoring have been identified as key factors for improving recruitment and retention, few studies have thoroughly evaluated the long-term impact of these interventions. Moreover, where interventions have been implemented, there is little evidence of sustained efforts to monitor and adjust these strategies based on feedback and changing contexts.

Another significant gap is the lack of a cohesive, nationally coordinated approach to growing the Māori nursing workforce. The literature consistently highlights the fragmented nature of recruitment and retention efforts, often with localised initiatives failing to align with a broader, national strategy. For example, while some nursing schools and health organisations have implemented Māori-focused support programmes, these efforts tend to be isolated and not

integrated into a national framework that ensures consistent access to resources, mentorship, and career development for Māori nurses across New Zealand. This lack of coordination has contributed to the slow progress in achieving the Ministry of Health's target of increasing Māori nurses to 15% of the total nursing workforce by 2028.

Furthermore, the literature reveals a lack of understanding the specific experiences of Māori nurses at different stages of their careers; rather, focussing on the challenges of recruitment and retention at the undergraduate level. This is particularly relevant given that Māori nurses often carry the additional burden of navigating both professional and cultural expectations, which can lead to burnout, isolation, and a lack of professional advancement. Research needs to focus more on the post-graduate experiences of Māori nurses, particularly their leadership opportunities, workplace support, and pathways to career advancement.

Another area that remains underexplored is the role of systemic racism within health and education. While many studies acknowledge the presence of institutional racism as a barrier, there is minimal in-depth research that investigates how this racism intersects with the experiences of Māori nurses and nursing students. Understanding the specific ways in which systemic racism intersects with Māori nurses' educational and professional journeys.

Examination of international Indigenous nursing workforce literature from Canada, USA, and Australia provides an opportunity for comparison. However, the transferability of international strategies to the New Zealand context remains unclear, and further research is needed to understand and adapt successful models used in other countries to improve Māori nursing workforce development.

Lastly, the literature currently lacks analysis on how political influences have affected Māori nursing recruitment and retention efforts. Given the potential for policy changes that significantly influence healthcare workforce strategies, future research should consider the impact of these shifts and explore how Māori nurses and nursing leaders can continue to advocate for equitable workforce development in the face of changing political priorities.

In summary, while the literature provides a comprehensive overview of the barriers and strategies for improving the recruitment of Māori into nursing, it also highlights several gaps that require further examination. These include a need for more robust evaluations of existing strategies, a nationally coordinated approach to workforce development, a deeper exploration of post-graduate experiences and leadership opportunities for Māori nurses, more nuanced research into the impact of systemic racism within nursing education and practice and an understanding of the effects of changing political priorities on Māori workforce development. Addressing these gaps is crucial to growing the Māori nursing workforce and ensuring that

Māori nurses can thrive in their careers and contribute meaningfully to improving Māori health outcomes. Using a Kaupapa Māori research methodology and a case study approach, this research plans to examine some of the issues highlighted through this literature review.

Chapter 3: Methodology–Whakamārama

“Me hopukina te rā”

The sun must be caught

The ongoing underrepresentation of Māori in New Zealand’s nursing workforce remains a significant issue despite numerous government reports highlighting the need to address the disparity. Although the problem has been widely acknowledged, progress in increasing the Māori nursing workforce has been limited, with the workforce remaining static at 7% for nearly 4-decades. This chapter outlines the methodologies and methods used to investigate the factors contributing to this issue, with a particular focus on Kaupapa Māori research and case study research. Together, these approaches provide a culturally grounded and methodologically rigorous framework for exploring both individual and systemic barriers.

Kaupapa Māori research serves as the philosophical foundation of this study. Deeply rooted in Māori values and worldviews, it prioritises Māori perspectives while promoting decolonisation within the research process. As a research methodology, it seeks to empower Māori voices and ensure that the study reflects the lived experiences, needs, and aspirations of Māori. By challenging dominant Western research paradigms that have historically marginalised Māori, Kaupapa Māori research prioritises Indigenous ways of knowing (L. T. Smith, 1999, 2017, 2021).

This methodology uses mātauranga Māori in data collection, analysis, and interpretation, offering a more realistic representation of participants’ lived experiences. By prioritising Indigenous approaches, Kaupapa Māori research addresses historical issues associated with research conducted on Indigenous communities—specifically, how narratives were collected and represented (G. Smith, 2017; L. T. Smith, 2012). Meaningful relationships formed between researchers and Māori lead to research outcomes that are more relevant and hold the potential for transformative change (G. Smith, 2017).

Alongside Kaupapa Māori research, a case study research method is utilised to create a framework for an in-depth investigation of specific cases within the broader field of nursing. Case studies offer a detailed understanding of the phenomena being studied and, through the triangulation of various data sources, enable a thorough analysis (Yin, 2017). Combining Kaupapa Māori research with case study methods allows for a comprehensive examination of both personal and systemic factors influencing the Māori nursing workforce. Through the integration of Kaupapa Māori research with case study methods this study reflects the dual commitment to cultural integrity and methodological rigour.

This chapter is organised into five key sections, providing a comprehensive overview of the research methodology and methods used in this study:

1. **Kaupapa Māori Research Methodology:**

This section begins by outlining the foundations of Kaupapa Māori Theory, followed by an explanation of its epistemological underpinnings. The core principles of Kaupapa Māori methodology are defined, accompanied by a detailed discussion of its ethical framework. This includes the integration of Kaupapa Māori and case study ethical considerations. The section concludes with a description of an analytical framework, grounded in traditional Māori knowledge systems, which has guided this research process.

2. **Case Study Research Methods:**

This section focuses on the case study research design and analysis. It provides a detailed description of the tools and techniques employed, including semi-structured interviews, thematic analysis, and the review of grey literature. These methods were selected to facilitate a deep exploration of the research questions.

3. **Management of the Research Process:**

The third section describes the practical aspects of managing the research, including the sampling strategies and participant recruitment process. It also addresses the dimensions of rigour applied throughout the study to ensure the credibility, dependability, and integrity of the research.

4. **Integration of Knowledge Systems:**

This section explores how Indigenous and Western knowledge systems were blended within the research. It highlights the synergies between Kaupapa Māori methodology and case study methods, demonstrating how their integration generates innovative solutions and enriches the study's findings.

5. **Intersectionality as a Framework:**

The final section discusses how intersectionality is employed as an analytical framework to examine the multidimensional inequalities affecting Māori nurses. It provides insights into how intersectionality deepens the understanding of systemic barriers and informs strategies to address disparities within the Māori nursing workforce.

By combining Indigenous and Western approaches, this chapter illustrates how the "energy from two systems of understanding" (Durie, 2005b, p. 141) can be harnessed to generate

innovative new insights into the static state of the Māori nursing workforce. This chapter outlines the theoretical and practical elements of the research design and serves as a roadmap, guiding the reader through the methodologies and methods applied throughout the study.

1. Kaupapa Māori Research Methodology

Theory

Kaupapa Māori research is grounded in Kaupapa Māori Theory, a framework whose foundations are based on Māori concepts, values, and belief systems (L. T. Smith, 2021). Pihama (2015) described Kaupapa Māori Theory as a "culturally defined theoretical space" (p. 7). To understand the evolution of Kaupapa Māori Theory, it is essential to consider the history of colonisation in New Zealand. At the time of first contact with European explorers, traders, and whalers, the Māori population was estimated to be between 100,000 and 120,000 (Lange, 1999). However, the introduction of foreign diseases and the intensification of intertribal warfare—exacerbated by the acquisition of muskets—led to a significant population decline, occurring alongside a rapid increase in European immigration.

As the settler population grew, so too did pressures on Māori land. The New Zealand Land Wars of the 1860s resulted in further population decline and widespread land loss for Māori. By the late 19th century, the Māori population had decreased to approximately 40,000, largely due to high mortality rates stemming from colonisation. Furthermore, Māori had lost around 80% of their land by the turn of the 20th century through confiscation, legislation, and political interventions designed to facilitate the transfer of land to Pākehā (King, 2003; Lange, 1999; Walker, 1990).

While Māori child mortality rates and overall immunity began to improve in the early 20th century, leading to a gradual rebound in population, many Māori were left living on small, fragmented remnants of tribal lands, often unable to sustain their families. By World War I, many Māori sought work opportunities in cities, initiating a migration that became one of the fastest urban transitions of any population. In 1945, only 26% of Māori lived in urban areas; by 1986, this number had surged to 80% (Durie, 2001; Loring et al., 2022; Meredith, 2005; Poata-Smith, 2013). Rapid urbanisation, coupled with government policies that promoted Māori assimilation into Pākehā culture, led many Māori to become disconnected from their social and cultural identities. The physical separation from tribal homes and traditions resulted in a loss of culture, language, and customs—a process known as deculturation (Durie, 2001).

Amid this environment of cultural and language loss, Kaupapa Māori emerged during the political and cultural revolution of the 1970s and 1980s. This movement, which extended far

beyond language revitalisation, represented a profound 'mind shift' among Māori. It ignited Māori conscientisation and politicisation, described as "a reawakening of the Māori imagination that had been stifled and diminished by colonisation processes" (G. Smith, 2003, p. 2). This period witnessed a revitalisation of Māori cultural aspirations, values, and practices (Durie, 2012, 2017; Pihama, 2015; G. Smith, 2003; L. T. Smith, 2021).

Kaupapa Māori, as defined by L. T. Smith (1999), is the practice and philosophy of living a culturally informed Māori life. During this era, Māori communities began asserting rangatiratanga (self-determination), legitimising their cultural and educational values in response to the Pākehā-centric education system that had been failing them (G. Smith, 2015, 2017; L. T. Smith, 2021). This led to the creation of movements such as kōhanga reo (Māori language preschools) and kura kaupapa Māori (Māori immersion schools). Kaupapa Māori theory emerged from Māori concerns about the impacts of colonisation, urbanisation, and assimilation, and also represented the broader struggle for Māori self-determination (Durie, 2017; Pihama, 2015; G. Smith, 2017). It challenged existing power structures and societal inequalities (G. Smith, 2017), functioning as "resistance to the hegemony of the dominant discourse" (Bishop, 1999, p. 2).

Pihama (2015) proposed that Kaupapa Maori Theory threatens the oppressive social order as an Indigenous theoretical framework. Kaupapa Māori Theory critiques the dominant discourse derived from imported 'scientific' paradigms, which often misrepresented Māori understandings for non-Māori audiences (Bishop, 1999; Cram & Adcock, 2022). These external frameworks frequently lacked validity, misappropriating and marginalising Māori knowledge while elevating external 'experts'. Kaupapa Māori Theory asserts that Māori had well-established ways of accessing, defining, and protecting knowledge long before Pākehā arrived in Aotearoa New Zealand (L. T. Smith, 2021).

Kaupapa Māori establishes a research space that validates and upholds Māori epistemology, philosophies, concepts, and practices as legitimate (Pihama, 2015; Wilson, Mikahere-Hall et al., 2022; L.T. Smith, 2017). It ensures that mātauranga Māori dominates the ideological framework guiding the research process (L. T. Smith, 2021). Royal (1998) defined these cultural traditions as mātauranga Māori, which understands the earth as Papatūānuku, the sky as Ranginui, and the world we inhabit as Te Ao Mārama.

Pihama (2015) proposed that while the theoretical assertions of Kaupapa Māori Theory are new, Kaupapa Maori is not, it is a framework firmly embedded in ancient ways of knowing. Furthermore, she suggested that a strong Kaupapa Māori theoretical framework includes historical and cultural realities (Pihama, 2015). This theory emerged as a response to the

negative impacts of colonisation, urbanisation, and assimilation, which led to a significant decline in the Māori population and the loss of land, language, and identity. Kaupapa Māori Theory supports rangatiratanga, challenges Western scientific paradigms, and asserts the legitimacy of mātauranga Māori. It seeks to decolonise research practices, elevate Māori perspectives, and promote Māori cultural revitalisation (Royal, 2012; G. Smith, 2017; Wilson, Mikahere-Hall et al., 2022).

Mātauranga Māori / Māori Epistemology

A powerful example of mātauranga Māori reflecting a Māori pedagogical perspective is the story of the origin of knowledge, symbolised by the journey of Tāne-nui-a-rangi to the 12th 'universe' to gain knowledge (Marsden, 2003). Māori traditions recount that Tāne climbed to Mātangireia (the 12th universe) to retrieve ngā kete wānanga (the baskets of knowledge) from Io, the supreme being or Creator. According to Buck (1949), during this journey, Tāne recovered three distinct kete, each containing a different form of knowledge. The first, Te Kete Uruuru Matua, held knowledge of peace, goodness, and love. The second, Te Kete Uruuru Rangi, contained prayers, incantations, and rituals. The third, Te Kete Uruuru Tau, encompassed knowledge of war, agriculture, woodwork, stonework, and earthwork.

A tribal variation of this story, as shared by Marsden (2003), also describes Tāne's journey but uses different names and contents of the baskets. In this version, Te Kete Tuatea (the basket of light) held all present knowledge, Te Kete Tuauri (the basket of darkness) contained the knowledge of all things unknown, and Te Kete Aronui (the basket of pursuit) held the knowledge that humans currently seek. Marsden emphasised that while these stories might appear as fairy tales told to children, they are actually part of a sacred body of knowledge, traditionally not openly shared. This knowledge was so revered that its deeper meanings could only be grasped by those with the necessary skills and expertise.

Cram (2006) highlighted that such knowledge was not freely available to everyone but was entrusted only to those who possessed the ability to understand and apply it for the benefit of the entire community. Without this specialised understanding, the deeper insights remained inaccessible. Nevertheless, the lore, passed down orally through generations, was carefully preserved and respected within Māori society. Despite variations in how different tribes recount Tāne's journey to obtain the baskets of knowledge, these traditions reflect the importance of tribal knowledge systems.

> It was a basic tenet of Maoridom that the inner corpus of sacred knowledge was not to be shared with the tūtūā – the common herd – lest such knowledge be abused and misused. Such sacred lore was not lightly taught and was shared only with the selected

> candidates who after a long apprenticeship and testing was deemed fit to hold such knowledge. (Marsden, 2003, p. 57)

In ancient times, mātauranga Māori was dynamic and adaptive, continuously evolving to survive in changing environments and contributing to social transformation. Similarly, Kaupapa Māori methodology has evolved as a distinct research approach, drawing from the foundational principles of mātauranga Māori. While Kaupapa Māori is recognised as a research methodology, mātauranga Māori is regarded as an ever-evolving body of knowledge that informs both practice and understanding (Durie, 2017).

The epistemological aspect of mātauranga Māori centres on the sacred and deeply respected nature of knowledge within Māori traditions. Tāne's retrieval of the ngā kete wānanga (baskets of knowledge) reflects the structured, layered forms of knowledge, available only to those with the proper skills and training. This knowledge system, passed down orally and guarded by select individuals, highlights a Māori worldview in which understanding is closely tied to tikanga Māori. The epistemology of mātauranga Māori informs Kaupapa Māori research methodology, highlighting its ability to evolve in response to changing environments and contexts.

Kaupapa Māori Research Principles

The negative impacts of research conducted on Māori by non-Māori researchers have acted as a catalyst for increased Māori involvement in research (G. Smith, 2015). Māori recognised the inclusion of mātauranga Māori in research methods would ultimately benefit Māori (Durie, 2017). Kaupapa Māori research emerged both as a means of ensuring these benefits and as a response to decolonise the dominant research discourse. It challenges Pākehā hegemony by emphasising research that is conducted by Māori, with Māori, and for Māori. Grounded in Māori worldviews and frameworks, Kaupapa Māori research is guided by mātauranga Māori and incorporates elements of scientific collaborative research theories, such as critical theory and participatory action research (Bishop, 1999; Cram & Adcock, 2022; Hudson et al., 2010; Pihama et al., 2002; Rangiwai et al., 2023; G. Smith, 2015).

Defining Kaupapa Māori research, however, can be complex, as it challenges accepted norms and assumptions about knowledge. Bishop (1999) noted that the very act of having to define and explain Kaupapa Māori research reflects the power of colonisation. Unlike other research approaches, Kaupapa Māori research goes beyond defining Māori research aspirations—it focuses on determining benefits for the collective. A fundamental feature of Kaupapa Māori is tino rangatiratanga (self-determination) for Māori (Hudson et al., 2010; L. T. Smith, 2021).

Scientific colonialism arises when researchers maintain complete control over the research process, imposing their views on participants and extracting knowledge for personal gain, often without challenge. In this process, researchers are frequently elevated as 'experts' whose reputations are enhanced, while the communities they study are marginalised (Cram, 2006). Kaupapa Māori research seeks to challenge and transform this paradigm by promoting tino rangatiratanga and integrating a Māori worldview.

> Cultures pattern perceptions of reality into conceptualisations of what they perceive reality to be; of what is regarded as actual, probable, possible or impossible. These conceptualisations form what is termed the 'worldview' of a culture. The worldview is the central systemisation of conceptions of reality to which members of its culture assent and from which stems their value system. The worldview lies at the very heart of the culture, touching, interacting with and strongly influencing every aspect of the culture. (Marsden, 2003, p. 56)

Kaupapa Māori research is conducted by individuals with cultural, linguistic, subject, and research expertise, using methods that are culturally appropriate. It is evaluated against Māori-relevant standards and respects Māori cultural preferences throughout (Bishop, 1996; L. T. Smith, 2021). Several key features distinguish Kaupapa Māori research from traditional Western research: its transformative potential through the automatic validation and legitimacy of Māori perspectives, the imperative to ensure the survival and revitalisation of the Māori language and culture, and the critical importance of the struggle for autonomy over Māori cultural well-being and lives (G. Smith, 1990 as cited in L.T. Smith, 1999; Wilson, Mikahere-Hall et al., 2022).

Methodological Framework

G. Smith (2017) explained the transformative elements are the key to Māori resistance initiatives. Eight core principles serve as the foundation of Kaupapa Māori research, providing transformative guidance. Below, these principles are defined and explained in relation to how they were applied in this study:

1. Tino Rangatiratanga: The Principle of Self-determination or Relative Autonomy.

Tino rangatiratanga, often found to be at the heart of Kaupapa Māori initiatives, refers to sovereignty, self-determination, and independence. It is best understood as having complete control and authority over one's life and well-being. From this perspective, the decolonisation of the research process must begin by placing kaupapa Māori at its core (Pihama et al., 2002). This allows the researcher autonomy to pursue areas of study that may not align with the priorities of the dominant culture or be defined by Western ideals of relevance or significance.

In this research, tino rangatiratanga is demonstrated by ensuring the research is conducted by Māori, for Māori, with Māori. The selection of a topic that is both personally significant to the researcher and relevant to Māori, specifically Māori nursing, further reflects this principle. Additionally, the choice of methodology centres the research within Māori pedagogy, affirming the researcher's autonomy and cultural alignment.

2. Ngā Taonga Tuku Iho: The Principle of Validating and Legitimating Cultural Aspirations and Identity

In Kaupapa Māori research, there is no need to justify being Māori—this is inherently accepted. Te reo, tikanga, and mātauranga Māori are all considered valid and legitimate. Mātauranga Māori shapes the research perspective, validating the Māori worldview, while te reo helps form the narrative, and tikanga bridges the spiritual and physical worlds (Pihama et al., 2002).

In this study, Māori forms of engagement were prioritised. Whanaungatanga (relationships) is a significant and essential aspect of engagement within te ao Māori. Through whakawhanaungatanga (getting to know each other), tribal connections were identified and acknowledged, fostering mutual trust and respect. Te reo Māori was used where appropriate, especially during introductions, mihimihi (greetings), karakia (prayers), and waiata (songs). However, the interviews were conducted in English, as this was the participants' preferred language. This choice reflects the ongoing impact of colonisation, as many Māori today do not speak te reo fluently. Nevertheless, common Māori words were used throughout the interviews by both myself and the participants.

Although this research is written in English, te reo Māori is used wherever possible to describe concepts or ideas that emerged during the interviews. Tikanga Māori guided the engagement process, providing the necessary cultural protocols and boundaries, such as the traditional sharing of whakapapa (genealogy) and the use of respectful language when addressing elder participants. Lastly, mātauranga Māori was essential in interpreting and understanding the participants' narratives, particularly when they described spiritual or culturally specific experiences.

3. Akoranga Māori: The Principle of Culturally Preferred Pedagogy

Ako Māori recognises teaching and learning practices that are distinct to Māori, including those that may not be inherently Māori but are preferred by Māori. For instance, digital resources were used to gather and collect narratives, whereas traditionally Māori relied on the oral transfer of knowledge. Kaupapa Māori served as the preferred pedagogical framework, ensuring that all aspects of the research were rooted in mātauranga Māori. In this study, Kaupapa Māori methodology provided the foundation, applied in conjunction with a case study

approach. While this case study approach represents a Western framework, Kaupapa Māori remained central to all aspects of the research.

4. Kia Piki Ake I Nga Raruraru o te Kainga: The Principle of Socio-economic Mediation

This principle emphasises the need for research to consider and help alleviate the disadvantages faced by Māori. As such, Kaupapa Māori research must ultimately benefit Māori communities and support Māori-led initiatives by addressing relevant issues. This research topic tackled several pressing concerns, such as the recruitment, retention, education, and support of Māori nurses—areas crucial for improving the quality of healthcare received by Māori. Additionally, an intersectionality framework examines the inequities experienced by Māori nurses by understanding how the many layers of oppression interconnect and are mutually reinforcing.

5. Whānau: The Principle of Extended Family Structure

Whānau is central to Kaupapa Māori research, reflecting the importance of whakapapa and connections to all things. Whānau, along with the process of whanaungatanga, forms the foundation of Māori society and culture. This principle reminds researchers of their responsibility to demonstrate manaakitanga (care and respect) towards both the participants and the research process. In this study, whānau referred to the Māori nursing community, with participants recruited through Māori nursing networks. Whanaungatanga naturally guided the recruitment and engagement process.

6. Kaupapa: The Principle of Collective Philosophy

The collective vision and aspirations of iwi Māori are key drivers for this research, which also reflects the broader goals of the community. As such, the research topic and its interventions are viewed as vital contributions to the overall kaupapa. This collective vision includes aspirations for the future of Māori nursing in Aotearoa New Zealand, and, by extension, the future well-being of iwi, hapū, whānau, and hapori Māori.

7. Te Tiriti o Waitangi: The Principle of the Treaty of Waitangi

Te Tiriti o Waitangi defines the relationship between Māori and the Crown and affirms Māori rights as tangata whenua and citizens. Te Tiriti provides the foundation from which Māori can analyse, challenge, and affirm their rights. In this research, Te Tiriti o Waitangi was central, guiding the examination of inequities and injustices affecting Māori health since its signing. The research aims to contribute to addressing these disparities.

8. Āta: The Principle of Growing Respectful Relationships

Āta serves as a guide for building, nurturing, and understanding relationships and well-being when engaging with Māori. In this study, āta was employed to ensure the well-being of participants through manaakitanga, which was upheld throughout the research process and beyond. Āta was demonstrated by ensuring that participants were well informed, felt comfortable and safe discussing their experiences, and were acknowledged when speaking about challenging or difficult subjects. Manaakitanga was further expressed through the sharing of food and the giving of gifts. Additionally, participants will be provided with a link to view this study on its completion, maintaining the relationship and connection with each participant.

This research, grounded in Kaupapa Māori principles, prioritises Māori worldviews and aspirations. Key principles like tino rangatiratanga, whānaungatanga, and consideration of Te Tiriti o Waitangi ensured that the research was relevant and beneficial to Māori. Focused on Māori nursing, the study explored issues of recruitment, retention, and education, with the aim of reducing inequities in health and education. Through the incorporation of whakawhanaungatanga, manaakitanga, and āta, the research fostered meaningful relationships, upheld the mana of participants, and supported the collective vision of improved healthcare and well-being for Māori.

Kaupapa Māori research emerged as a response to the negative impacts of research conducted on Māori by non-Māori, promoting culturally appropriate methods led by Māori, for Māori. Grounded in Māori values and worldviews, it incorporates mātauranga Māori and decolonises Western research paradigms. Key principles, such as tino rangatiratanga, whanaungatanga, and manaakitanga, guide the research process. This research focuses on addressing inequities in Māori nursing through issues of recruitment, retention, and education. Kaupapa Māori methodology ensures the validation of Māori knowledge, respect for Te Tiriti o Waitangi and promotes the well-being of Māori. It is a framework of resistance against colonisation, enabling Māori to reclaim identity, language, and self-determination in research and education.

Ethics

Ethics play a critical role in research, ensuring that the rights, well-being, and dignity of participants are respected while maintaining the credibility and integrity of the research process. In this study, ethical considerations were guided by two distinct yet complementary frameworks: Kaupapa Māori research ethics and case study research ethics. Together, these frameworks ensured that the research aligned with Māori cultural principles and met established ethical standards for case study research.

Kaupapa Māori Research Ethics

In Kaupapa Māori research, ethical considerations extend beyond safeguarding individual participants to also ensuring the well-being of Māori as a whole. Historically, research conducted by non-Māori has often led to harmful outcomes for Māori communities. For Māori, ethics are deeply rooted in tikanga, which embodies Māori concepts, values, and belief systems. Kaupapa Māori research ethics aim to respect and protect the rights, interests, and cultural sensitivities of Māori (Cram & Adcock 2022; G. Smith, 2003; L. T. Smith, 2021). Table 1 outlines culturally specific ethical considerations essential for conducting Kaupapa Māori research. Alongside are examples of how I considered Kaupapa Māori ethics in practice.

Table 1.

Ethical Considerations Essential for Conducting Kaupapa Māori Research

Kaupapa Maori research ethics (G. Smith, 2003; L. T. Smith 2021).	Definition	Examples of KMR ethics application in this research
Aroha ki te tangata-a respect for people	Emphasises treating people with respect, allowing them to create their own space and engage on their own terms. It ensures that the researcher does not assume a position of hierarchy over the participants, fostering equality throughout the research process.	An example took place during an interview with a group of Māori nurses in their work environment, which began with a mihi whakatau (informal welcome) that required a response from me. Following, we engaged in whakawhanaunga, where the participants and I shared our iwi affiliations and our connections to the whenua.
Kanohi kitea-the seen face	An established form of engagement in te ao Māori. It implies a physical presence, the importance of meeting in person, face-to-face with participants builds connections and trust, which are essential for a meaningful and respectful research relationship.	Achieving kanohi kitea was difficult during COVID-19 restrictions, as interviews had to be conducted online, making it challenging to establish trust. In these instances, sharing lived experiences proved valuable in fostering whanaungatanga and building trust. Once restrictions were lifted, I was able to conduct some interviews face-to-face, which strengthened the connection with participants.
Titiro whakarongo…kōrero-look, listen speak	Requires patience from the researcher—observing, listening, and waiting for the appropriate moment to speak	Conducting interviews online required me to listen more intently to ensure I did not miss cues or nuances, which was especially

Kaupapa Maori research ethics (G. Smith, 2003; L. T. Smith 2021).	Definition	Examples of KMR ethics application in this research
	or ask questions. It ensures that the researcher has time to understand the deeper meanings behind words, as Māori often communicate through metaphors and narratives that require careful consideration.	challenging when interviewing groups. To address this issue, I made it a point to seek clarification regularly. When speaking with kuia (elderly participants), it was essential to allow ample time for their narratives to unfold, honouring the importance of their stories and perspectives.
Manaaki ki te tangata-sharing, hosting, being generous	Collaborative research with Māori is key, recognising that knowledge creation is a two-way process that values the contributions of both the researcher and the participants. Giving back to the community is central to Kaupapa Māori research, demonstrated through providing kai (food), a koha (gift), and sharing the research findings.	When arranging online interviews, I was keenly aware of the limitations in demonstrating manaakitanga through the traditional sharing of food. While participants were understanding of this, koha in the form of a voucher from a supermarket was mailed to each participant. In contrast, when meeting with participants in person, manaakitanga was demonstrated more fully through personal interaction. Additionally, the findings from this research will be shared with each participant, continuing the commitment to reciprocity and respect.
Kia tūpato-to be cautious	Respect for Māori values, history, and culture is vital. This includes the expectation that researchers will be politically astute, culturally safe, and reflect on their position in the research community. Balancing the position of an insider with access to the community and that of an outsider representing the academic world is essential.	Understanding my position as a researcher was crucial, especially since, as an insider, I knew many of the participants personally. To address this, I ensured that participants were well-prepared for the interview process through informed consent, which helped balance my dual roles as both an insider and, at times, an outsider. There were occasions when participants shared experiences where it was necessary to be conscious of my primary responsibility as a researcher over

Kaupapa Maori research ethics (G. Smith, 2003; L. T. Smith 2021).	Definition	Examples of KMR ethics application in this research
		my relationship as a peer. For instance, when registered nurses offered critiques of nursing programmes where I had friends teaching. I had to carefully navigate maintaining my role as an insider (someone who shares the same frustration), with my role as an outsider (someone who understands the challenges), while respecting the integrity of the research.
Kaua e takahia te mana o te tangata-do not trample the mana of the people	Respect for the participants' mana (dignity and authority) is crucial. The research must be conducted in a way that values the views and knowledge of all involved, ensuring that the outcomes benefit the broader Māori community.	In many cases, I felt incredibly privileged to have the opportunity to interview the participants. It was a humbling experience to hear their stories and, in some instances, witness their pain. Throughout, I was careful to ensure that each participant's mana was respected and upheld.
Kaua e māhaki-do not flaunt your knowledge	The researcher must understand the community's expectations regarding the research findings and communicate their own expectations clearly. The research should accurately represent participants' realities, empowering both the participants and the community rather than serving the researcher's interests alone.	There were occasions during the interviews when participants raised issues that I felt knowledgeable enough to provide additional information about. However, I refrained from doing so. Similarly, when interviewing students, I was mindful of my position as a researcher rather than a kaiako (teacher). It was important to avoid offering further reading or directing them to additional resources, as this would have blurred the boundaries between researcher and kaiako.

These principles ensured that the research upheld the mana and dignity of participants while contributing to the collective empowerment of Māori.

Case Study Research Ethics

The ethical considerations of case study research focus on safeguarding the rights, integrity, and privacy of participants while maintaining research credibility (Creswell & Poth, 2018; Yin,

2017). Ethical approval for this study was obtained from the AUTEC ethics board (application 21/265) on 25th August 2021 (see Appendix A). Key ethical practices included:

- Informed consent: Participants received detailed information letters outlining the research purpose, process, and their rights. Consent forms were signed, and participants were informed of their right to withdraw at any stage.
- Confidentiality and privacy: Identifiable information was excluded from all transcriptions, and the transcriber signed a confidentiality agreement. Data were securely stored and will be retained for 6-years before being destroyed.
- Minimising harm: To address potential emotional or spiritual distress, participants were provided with contact details for myself and local Māori health services.

These practices ensured the research adhered to established ethical standards and respected participants' privacy and autonomy.

Integrating Ethical Frameworks

The integration of Kaupapa Māori and case study ethical frameworks ensured that the research was both culturally grounded and methodologically rigorous. Kaupapa Māori ethics emphasised the collective and relational aspects of the research, reflecting Māori values such as manaakitanga and whanaungatanga. Case study ethics provided the structural and procedural safeguards necessary to protect individual participants and maintain research integrity. Together, these approaches created a robust ethical foundation that respected Kaupapa Māori while meeting institutional requirements. This dual framework allowed the research to contribute meaningfully to both academic knowledge and the well-being of Māori.

Kaupapa Māori Research Analysis

Durie (2012) noted that Kaupapa Māori methodology has evolved into a distinct approach, grounded in mātauranga Māori and stemming from Kaupapa Māori Theory. However, he also highlighted a recurring issue: researchers often prioritise ethics aligned with Kaupapa Māori principles but revert to conventional Western research methods when analysing data. This tendency overlooks the unique analytical frameworks embedded in mātauranga Māori, which are fundamental to the validity and integrity of Kaupapa Māori research.

When developing a Kaupapa Māori research analysis framework, various approaches in the literature were reviewed. One notable approach is the use of pūrākau (traditional Māori narratives) (Lee, 2006). While mātauranga Māori is sometimes perceived as ancient or static, Durie (2012) emphasised that it has evolved over time while retaining core values that remain highly relevant and applicable in contemporary research contexts.

The use of pūrākau exemplifies how mātauranga Māori can inform data analysis in Kaupapa Māori research. Lee (2006) asserted that pūrākau acknowledges Indigenous ways of knowing, which are often excluded or overlooked in conventional research methodologies. Pūrākau are not merely stories but are repositories of philosophical thought, epistemological constructs, cultural codes, and worldviews that are fundamental to Māori identity (Lee, 2009). They preserve tribal knowledge and serve as a lens through which data can be analysed and interpreted. For example, the pūrākau of Māui demonstrates how traditional narratives can guide contemporary research practices. By drawing on the symbolic and epistemological insights of pūrākau, researchers can ground their data analysis in Māori worldviews and values, ensuring that the interpretation of findings aligns with Kaupapa Māori principles.

Pūrākau in Analysis

Pūrākau: How Maui Caught the Sun

Māui, also known as Māui-pōtiki or Māui-tikitiki-o-Taranga, is a revered figure in Māori and many Polynesian cultures. Often described as a demi-god or atua, Māui's feats of courage and cunning brought many useful arts and practices to mankind. Many of the pūrākau of Māui's achievements lay the foundations for mātauranga Māori—our understanding of the world and how we engage with it.

The pūrākau of Māui catching and slowing the sun is an example of how traditional narratives can offer guidance and insight into modern concepts and practices. In the context of research, pūrākau provides a framework for traditional approaches to problem-solving and analysis, integrating Indigenous knowledge into contemporary research methodologies.

The story recounts how Māui and his whānau were frustrated because the sun moved swiftly across the sky, making the days too short to complete their tasks. No sooner had they began to prepare for the day, the day would end, and the night would arrive. There was no time for essential activities like gardening, hunting, fishing, and preparing kai (food). Māui told his brothers that he planned to capture the sun and force it to slow down, thereby lengthening the days. Although his brothers were initially doubtful, Māui developed a plan and eventually persuaded them to help. Together, they plaited strong ropes, saying karakia (incantations), enchanting the ropes as they weaved. "Māui had to teach them how to spin the fibre into flat, round, and square ropes with three and five strands" (Reed, 1983, p. 28).

Once Māui had located the resting place of the sun, Te Rua o te Rā (The Cave of the Sun), he and his brothers embarked on the long journey. Following Māui's instructions, they coiled their enchanted ropes over the sun's head and shoulders so that as the sun rose above the horizon, Māui and his brothers pulled on the ropes, restraining him. While his brothers held the sun,

Māui approached with his weapon and, chanting a powerful karakia, began to strike the sun. In pain, the sun cried out, “Are you trying to kill Tama-nui-te-Rā?”—speaking his name for the first time.

Māui responded that he would stop only if Tama-nui-te-Rā promised to move more slowly across the sky. When the sun refused, Māui struck him again and again until he weakened. Eventually, Māui released him, and from that day forward, Tama-nui-te-Rā limped across the sky, allowing ample daylight for people to complete their tasks (Reed, 1983).

Māui identified a problem and, through careful assessment and planning—despite his brothers' doubts, he decided to change the situation, knowing it would benefit everyone. He recognised an opportunity to improve people’s lives by slowing the sun’s progression across the sky. Māui considered how to manage a problem, developed the necessary technology, and achieved a successful outcome that has benefited humanity ever since.

Māui’s story illustrates a problem-solving framework applicable to Kaupapa Māori research. By identifying an issue, developing a plan, and gathering the necessary tools, Māui created a lasting solution. This approach parallels research practices in which issues are addressed through culturally grounded, carefully planned methodologies that benefit the wider community.

Table 2 below illustrates how a mātauranga Māori approach to problem-solving can be applied as a framework for research analysis within Kaupapa Māori research. This model will be applied in the analysis of the data and will help formulate interpretations.

Kaupapa Māori Analysis Framework

This framework uses the traditional pūrākau (story) of Māui capturing the sun as a metaphor for addressing complex issues within the Māori nursing workforce. Table 2 outlines how the pūrākau of Māui informs a Kaupapa Māori analysis framework, guiding the research process.

Table 2.

Ko te Hoputanga o Māui i te Rā

He pūrākau (traditional narrative)	Tātaritanga (analysis framework)	Tātaritanga (for this research)
The sun moved too quickly across the sky He tino tere te rangi	Te Take: Māui identified the issue	Identify the issue: The Māori nursing workforce has been static for 40 years
Māui told his brothers that he planned to capture the sun Me hopukina te rā	Whakamārama: Māui explained the situation and made a plan	Seek clarification: Identify what participants believe are the most significant issues affecting recruitment and retention and what they believe would improve the situation
Māui needed ropes to capture the sun Ka raranga rātou i ngā taura harakeke	Kohikohia: Māui gathered the necessary resources	Gather supporting information: Review and gather supporting information from literature
Māui located the sun's resting place and tied it down I kaha herehia te rā ki te taura	Hei whakatinana: Māui implemented his plan	Implementation: Collate and synthesise findings from participants and supporting information
The sun moved slower across the sky Ka whakaoti i ngā mahi hira i a rā	Kua tau: Māui achieved his goal	Benefits: Develop and disseminate findings

The Ko te Hoputanga o Māui i te Rā framework, based on traditional problem-solving techniques, guided the analysis in this research. Through the incorporation of mātauranga Māori, the research process ensured that Māori concepts, values, and belief systems were central to the analysis and findings. By using traditional narratives in research analysis, the framework enhances the depth of the research and aligns with Māori worldviews.

Wilson, Mikahere-Hall et al. (2022) explained that adopting a paradigm that prioritises Indigenous ways of knowing and being enables the use of more culturally relevant methods for

analysing data and interpreting findings. This approach provides a more authentic representation of participants' lived experiences, ultimately producing evidence that is more meaningful and better suited to shape transformative policies and practices.

Kaupapa Māori analysis emphasises transformative potential through decolonisation and validation of Māori knowledge. Ensuring that Māori voices are at the forefront of the research, allowing for meaningful, culturally relevant analysis that aligns with Māori values like whanaungatanga, manaakitanga, and kaitiakitanga.

Durie (2012) highlighted the confusion that sometimes arises when applying this methodology, as researchers may prioritise ethical considerations but revert to Western research paradigms, neglecting the unique Māori worldview. To address this, this research incorporates pūrākau, to guide the analysis. The story of Māui catching the sun, serves as a representation for problem-solving and analysis in research. Just as Māui identified and addressed a significant issue with careful planning and collaboration, this research applies a similar framework to address the static state of the Māori nursing workforce.

Summary

The Kaupapa Māori research methodology outlined in this chapter highlights the transformative potential of Indigenous research approaches that prioritise Indigenous worldviews, values, and knowledge systems. Kaupapa Māori research emerged as a response to the legacy of colonial research conducted by non-Māori, which marginalised and misrepresented Māori experiences and knowledge. Grounded in mātauranga Māori and guided by core principles, Kaupapa Māori research represents an Indigenous methodology that challenges conventional Western paradigms.

A key feature of Kaupapa Māori research is its focus on empowering Māori communities by ensuring that research is conducted by Māori, with Māori, and for Māori. It emphasises the importance of decolonising the research process, both in terms of methodology and the ways that knowledge is generated, validated, and applied. By prioritising Māori voices and perspectives, Kaupapa Māori research rejects the dominance of Western-centric research approaches that have historically positioned Māori as the 'other' and took Indigenous knowledge for external gain. Instead, it promotes a research process that is collaborative, reciprocal, and rooted in Māori traditions and aspirations.

Throughout this chapter, the principles of Kaupapa Māori research have been demonstrated as central to the research design, data collection, and analysis processes. These principles are not only theoretical concepts but practical guides that shape how research is conducted. In the

context of this study, tino rangatiratanga is reflected in the focus on Māori nursing, a topic that is significant to myself, Māori nursing, and the Māori community. The emphasis on self-determination ensures that the research aligns with Māori needs and aspirations, particularly in addressing the recruitment, retention, and education of Māori nurses, who play a crucial role in improving healthcare outcomes for iwi Māori.

Moreover, this section has illustrated how Kaupapa Māori research integrates pūrākau (traditional narratives), into the research process. By drawing on the pūrākau of Māui catching the sun, the research acknowledges Māori ways of knowing and employs a traditional narrative as a framework for analysis and problem-solving. The use of pūrākau demonstrates the adaptability and relevance of mātauranga Māori in contemporary research, reinforcing the idea that Māori knowledge is evolving rather than static or outdated.

Kaupapa Māori research ethics also emphasises the importance of whakawhanaungatanga and tikanga Māori in establishing trust and respect with participants. This research demonstrated the application of these principles, whether in online interviews or in face-to-face meetings, ensuring that the research process followed tikanga and was responsive to the needs and preferences of Māori participants. The use of koha and the commitment to sharing the research findings with participants further highlighted the reciprocal nature of Kaupapa Māori research, which seeks to give back to the community and acknowledge participants' contributions.

By prioritising Māori epistemologies and fostering self-determination, Kaupapa Māori research represents a process for decolonisation and for addressing the structural inequities that continue to affect iwi Māori. In this study, the application of Kaupapa Māori principles allowed for an examination of the systemic barriers faced by Māori nurses and provided an opportunity for identifying solutions.

In conclusion, Kaupapa Māori research is not just a methodology, but a paradigm shift that reclaims Māori knowledge and autonomy in the research process. It provides a means of addressing the historical and ongoing impacts of colonisation. By privileging Māori worldviews, Kaupapa Māori research ensures that Māori voices, experiences, and aspirations are at the heart of the research process, contributing to both academic knowledge and Māori aspirations.

2. Case Study Research Methods

Research Design

Although many people are familiar with case studies from their work or education, there continues to be a lack of agreement on what exactly defines a case study and how it should be

conducted. This disagreement stems from several factors, but the most significant issue is the diverse epistemological perspectives held by foundational theorists. These differing philosophical perspectives result in varied interpretations of how case studies should be approached, leading to confusion and disagreement over their definition and execution. While this ongoing debate highlights the flexibility and adaptability of case studies, it also complicates efforts to standardise their implementation and clarify their role in academic research (Merriam, 1998; Simons, 2009; Stake, 1995; Yin, 2017). In this context, my focus primarily centres on Robert Yin's theoretical perspective, while incorporating views of other foundational theorists where their theories align.

Case study research is a qualitative approach that rises out of the desire to understand complex social phenomena within their real-world context. This method is particularly suited for answering 'how' or 'why' questions, especially when the researcher has little or no control over the events being studied and when the phenomena cannot be easily separated from their context (Merriam, 1998; Simons, 2009; Stake, 1995; Yin, 2017). Case study research method was chosen because it enables an in-depth examination of a specific phenomenon of interest, such as an event, organisation, individual, or group. It provides a holistic view that is especially useful for studying contemporary issues with multiple connected variables (Hentz, 2017; Stake, 1995; Yin, 2017).

According to Yin (2017), case study research can be considered a methodology, method, or design, with the specific approach determined by the nature of the phenomenon being investigated. Yin also highlighted that there is no standardised way of conducting a case study; instead, the design and execution should be guided by the research questions or hypotheses. Hentz (2017) emphasised that the rigour of case study research comes from designing studies in alignment with clear research aims and questions, ensuring that findings are both reliable and accurate. By using multiple data sources such as interviews, observations, and documents, case study research provides a unique understanding of the subject matter (Merriam, 1998; Simons, 2009; Stake, 1995; Yin, 2017). Yin further suggested that research design serves as the logical connection between the data gathered and the original research question, highlighting the importance of alignment between the design and the data.

An important feature of case study research is its ability to provide an insider perspective on social phenomena. This approach is particularly useful for researchers seeking to explore phenomena that cannot be easily controlled or manipulated, providing a detailed and contextual understanding of the issues at hand. The method's flexibility allows it to be used in

both qualitative and quantitative research, making it adaptable for a wide range of disciplines (Hentz, 2017; Merriam, 1998; Simons, 2009; Stake, 1995; Yin, 2017)

Yin (2017) suggested that a key strength of case study research is its ability to accommodate different epistemological orientations. He explained that case studies are often grounded in a realist perspective, which assumes the existence of a single, objective reality that can be studied independently of the observer. However, case study research can also align with a relativist perspective, which acknowledges the existence of multiple realities, depending on the observer's viewpoint. Furthermore, this adaptability makes case study research a useful method for addressing complex social issues where different interpretations may exist. The ability to draw from multiple sources of evidence further strengthens the method's capacity to provide comprehensive and robust findings.

In case study research, five essential components of research design must be considered: the research question, research propositions, units of analysis, the linking of data to the propositions, and the criteria for interpreting the findings (Yin, 2017). There are three types of case studies: explanatory, descriptive, and exploratory. This study aims to provide an explanation by addressing the question, why has the Māori nursing workforce remained static over the last 40 years? Yin (2017) asserted that case study research is particularly well-suited for addressing 'why' questions, as it often requires in-depth explanation.

Explanation building involves the systematic analysis of data derived from subunits of analysis, structured in a narrative form, and aligned with theoretically significant propositions. This process entails comparing findings against initial propositions and revising these propositions in light of new insights. A potential challenge in this approach is the risk of straying off-topic. However, this can be mitigated by maintaining a consistent focus on the original research question and purpose of the inquiry. Regularly revisiting and reviewing the explanations ensures alignment with the central topic and enhances the coherence and relevance of the analysis (Yin, 2017).

Research propositions play a key role in case study design, directing attention toward specific aspects that should be examined and suggesting where to look for relevant evidence. Propositions are statements or hypotheses that reflect the researcher's assumptions or theories about the subject being studied. Often developed based on existing literature, prior research or theoretical frameworks, they aim to clarify key aspects under examination (Yin, 2017).

Examples of propositions in this study include: "*Policy outcomes have enabled equitable access for Māori into nursing programs*" or "*Nursing and health leadership have adequately planned for the future of New Zealand's nursing workforce*" or "*Nursing has been effectively marketed as a viable career option to Māori*" or "*Māori new graduate nurses are provided appropriate support in their first year of practice*" and "*Systemic racism significantly contributes to the static state of the Māori nursing workforce*". These propositions helped shape the direction and focus of the research. They guide the case study by narrowing down the scope, and indicating what to focus on, laying a foundation for linking data to the research questions (Yin, 2017).

A defining characteristic of case study design is the use of multiple sources of evidence, with analysis occurring through triangulation. This approach can be applied through either a single- or multiple-case design. In this research, a single-case embedded design was utilised, relying on multiple sources of evidence from more than one sub-unit of analysis. This design facilitates the combination of both qualitative and quantitative methods in a single study, allowing for a more in-depth exploration of the subject (Crowe et al., 2011; Hentz, 2017; Yin, 2017). The inclusion of sub-units of analysis enables a deeper level of inquiry, enriching the research process. However, for this study only qualitative methods were used.

One of the unique features of this approach is its ability to combine various information sources such as documents, interviews, and artifacts. Rather than confirming a single interpretation, the goal is to develop multiple insights from the data. Through this process key interpretations are generated and, ultimately, conclusions are drawn (Merriam, 1998; Simons, 2009; Stake, 1995; Yin, 2017).

The design of this particular case study involves defining both the context and the case itself. In this research, the context is defined as "*the New Zealand nursing workforce*", while the specific case under examination is "*the static Māori nursing workforce*". Three embedded units of analysis are employed (see Fig. 1):

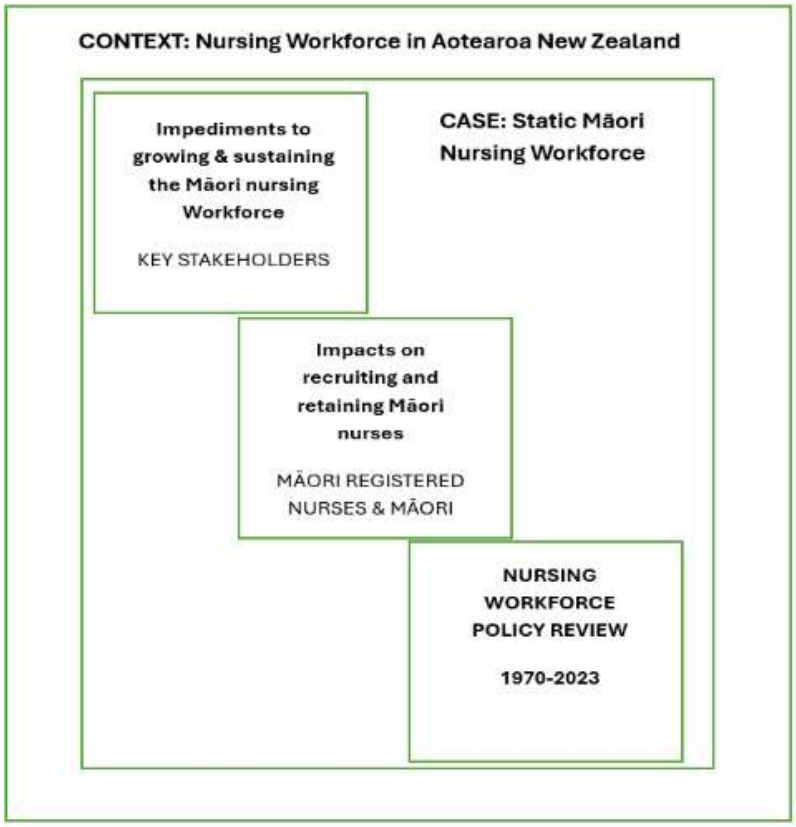
1. **Māori registered nurses and undergraduate students' nurses views**: Exploring their views on perceived barriers related to recruitment and retention within the nursing profession.

2. **Key stakeholders' perspectives**: Determining the impediments to growing and sustaining the Māori nursing workforce.

3. **Policy document review**: Examining policies related to the Māori nursing workforce from 1970 to 2023 to understand how policy has either facilitated or hindered the development of the Māori nursing workforce.

Through triangulation, analysis of data will reveal key themes, which will ultimately inform the research question and provide meaningful insights into the static state of the Māori nursing workforce.

Figure 1. *Case Study Research Design*



Case Study Research Analysis

Analysis of data in this study was guided by mātauranga Māori, ensuring that Māori concepts and belief systems were integral to the process. This approach aligns with the overarching Kaupapa Māori methodology, which frames the research within a Māori worldview, emphasising cultural relevance and respect for Māori knowledge systems.

Methodology: The Analytical Framework

Case study research, as described by Yin (2017), involves a systematic approach to understanding complex phenomena within real-life contexts. This methodology enables the identification of patterns, themes, and insights that address the research questions through a multi-stage process. The process includes organising, coding, categorising, and interpreting data to construct a comprehensive understanding of the case.

Analysis was further informed by the propositions developed at the outset of the research, which acted as a framework to ensure alignment between the research questions and the data

interpretation. Explanation building, as outlined by Harding and Whitehead (2016), was employed to generate theoretical insights rather than draw definitive conclusions, consistent with the explanatory nature of this research.

Throughout analysis, triangulation was a key methodological strategy. Yin (1999) explained that triangulation enhances the credibility and validity of case study research by integrating evidence from multiple sources and perspectives, reducing bias, and providing a more comprehensive understanding of the phenomenon under investigation.

Methods: The Analytical Process

The analysis of the collected data involved the following steps:

1. Data Organisation:

   Analysis began with transcribing interviews to prepare them for textual analysis. All data, including interviews and grey literature, were organised systematically for easy access and review.

2. Coding and Categorisation:

   Following a thorough reading of the transcripts, coding was used to identify recurring themes, concepts, and categories relevant to the research questions. This process ensured that key insights were highlighted for further analysis.

3. Thematic Analysis:

   The identified codes were grouped into themes that reflected patterns across the data. Thematic analysis allowed for a deeper understanding of the static state of the Māori nursing workforce, aligning the findings with the case study propositions.

4. Cross-Case Analysis:

   Findings were compared and contrasted across the cases to identify broader patterns. This process helped refine the themes and ensure that the interpretations were robust and consistent.

5. Triangulation:

   Triangulation was applied in two stages:

   - Data Collection: Evidence was gathered from diverse sources, including interviews with Māori student nurses, registered nurses, key stakeholders, and grey literature. This ensured depth and consistency in the findings.

- Data Synthesis: Findings from multiple sources were integrated to generate key interpretations. This approach strengthened the conclusions by validating the results through cross-verification.

6. Synthesis and Interpretation:

   Synthesis of data provided a detailed description of the case, linking evidence to theoretical insights. The findings were then contextualised within existing theories, generating new insights and potential theoretical contributions (Harding & Whitehead, 2016; Yin, 2017).

Strengthening Validity through Triangulation

As Yin (2017) emphasised, triangulation is critical for cross-checking and validating findings from various perspectives, reducing biases, and enabling a more well-rounded understanding of the phenomenon. In this study, triangulation strengthened the robustness of the analysis by integrating multiple data sources and ensuring credibility through comparison and validation. This approach enhanced the depth of the findings and provided a comprehensive and culturally aligned perspective on the research questions.

3. Management of the Research Process

This research aimed to investigate why the Māori nursing workforce in Aotearoa New Zealand has remained static at approximately 7% over the past 40 years. It explores key propositions, including whether policy outcomes have enabled equitable access for Māori into nursing programmes, the extent to which nursing and health leadership have planned for workforce diversity, and the effectiveness of marketing nursing as a viable career option for Māori. Additionally, the research examines the support provided to Māori new graduate nurses and the role of systemic racism in perpetuating these disparities. These propositions shape the study's focus and guide the analysis. The following discussion outlines the fundamental parts of the research process that must be followed.

Sampling and Participants

Māori Nurses and Nursing Students Focus Groups.

A purposive sampling method was employed initially to intentionally recruit both Māori student nurses and registered nurses from across New Zealand. A purposive sampling method is a non-probability sampling technique used in qualitative research where researchers select participants or data sources based on specific characteristics, knowledge, or experiences relevant to the research question. The inclusion criteria required participants to identify as Māori and either be currently enrolled in an undergraduate nursing programme or employed

as a registered nurse. Recruitment was primarily facilitated through established Māori nursing networks such as: *Wharangi Ruamano*: The Māori Nurse Educator Group; *Te Kaunihera o Ngā Neehi Māori:* The National Council of Māori Nurses; and *Te Runanga:* A division of the NZNO.

To increase participant numbers for the focus groups, I also utilised snowball sampling, a method where existing participants refer additional participants (Parker et al., 2019). Participants were encouraged to share the research information with other Māori nurses and nursing students who might be interested in taking part. I also provided my contact details to facilitate direct communication with potential participants. Snowball sampling proved to be successful with the total of 37 participants agreeing to be interviewed across six focus groups.

I provided potential participants with an information letter (see Appendix B) that outlined the research objectives and gave an overview of the questions to be discussed during semi-structured interviews. Semi-structured interviews were chosen to allow participants the freedom to express their individual experiences. Participants were given the opportunity to ask questions and seek clarification before signing the consent form. They were informed that the interviews would be audio-recorded to ensure accurate documentation of their responses. To maintain confidentiality, interview data were securely stored and transcripts anonymised.

Key Stakeholders

Purposive sampling was employed to recruit key stakeholder participants, all of whom were current or former senior nurse leaders with extensive experience in nursing workforce development. These individuals had been actively involved in shaping, implementing, or critiquing policies and strategies relating to the nursing workforce in Aotearoa. Participants were drawn from a range of organisations, including the Ministry of Health, the New Zealand Nurses Organisation (NZNO), national nursing leadership groups, the tertiary education sector, Wharangi Ruamano, and Te Whatu Ora – Health New Zealand.

Collectively, the stakeholder group represented a wealth of knowledge spanning decades of service, with most having entered the nursing profession between the 1960s and 1980s. Their expertise encompassed diverse domains, including clinical practice, nursing education, health governance, and iwi health leadership. Several had held executive roles such as Chief Executive Officer of an iwi health provider, senior leadership positions within Te Whatu Ora, and senior academic roles at both undergraduate and postgraduate levels. A number had served on the Nursing Council of New Zealand, while others held governance positions in national and professional nursing bodies, including as chairs and representatives. One stakeholder had held a senior post within central government. Most had occupied senior nursing leadership roles

throughout their careers, and their collective insight offered a rich, informed perspective on the enduring challenges of the Māori nursing workforce.

I contacted key stakeholders directly to invite them to participate in semi-structured interviews. Interested participants were provided with an information sheet detailing the research objectives and the interview questions. They were also given the opportunity to ask questions and seek clarification before providing their written consent. All interviews were recorded using a digital audio recorder with participants' consent. Informed consent was obtained prior to each recording.

To ensure confidentiality, interview data were securely stored and transcripts anonymised. However, key stakeholder participants were informed that, due to the relatively small size of New Zealand and the nursing workforce, the information they provided might be identifiable. They were assured that every effort would be made to maintain their anonymity. Those who agreed to participate signed consent forms acknowledging the possibility of being identifiable.

Policy Documents Review

The policy documents selected for review were chosen for their reference to either the Māori health workforce or the Māori nursing workforce, or because their findings had implications for Māori nursing. The documents reviewed spanned from the 1970s to 2023. Examples of the reviewed documents include government policies, and any policies and strategies related to the nursing workforce, education and regulation. The documents were identified through online search databases such as Google, Google Scholar, and the Auckland University of Technology library. Through the literature review process, documents meeting the inclusion criteria were identified; a total of 18 documents were eventually reviewed and analysed.

Challenges Due to the COVID-19 Pandemic

Recruitment for interviews took place during the height of the COVID-19 pandemic lockdowns, which posed significant challenges to tikanga Māori, making the intended kanohi ki te kanohi (face-to-face) meetings impossible. As a result, many interviews were conducted via digital platforms, with participant consent. Through this process some tikanga Māori protocols could still be followed; however, when restrictions were lifted, face-to-face meetings were conducted wherever possible. For this reason, it took up to 12-months to complete all interviews.

Transcribing

Transcription occurred through converting all audio recordings into written text by an accredited transcriber who was identified and signed a confidentiality agreement. Through this process the spoken words were as accurately as possible documented to facilitate coding and

interpretation. In this case, the transcriber was non-Māori, so was advised that any Māori words could be left blank with an associated timing number so that I could review the recording and transcribe te reo Maori.

I carried out quality checking ensuring that the transcription process was reliable and that the resulting text accurately reflected the original audio or video data (Yin, 2017). This process occurred through listening to the audio and reading the transcript simultaneously to identify and correct any discrepancies, misinterpretations, or omissions. In some cases, participants were asked to verify the accuracy of their statements, helping to avoid misrepresentation.

Establishing Research Rigour

Establishing rigour in research ensures the credibility and integrity of the study's findings (Korstjens & Moser, 2018; Lincoln & Guba, 1985). In this study, the principles of Kaupapa Māori methodology and case study research inform the approach to rigour, with an emphasis on ensuring that the research reflects Māori worldviews, cultural integrity, and methodological robustness.

Key Dimensions of Rigour

Rigour in this research is underpinned by the cultural principles of Kaupapa Māori methodology, which prioritise Māori voices, relationships, and ways of knowing. This includes upholding tikanga Māori throughout the research process, ensuring that the findings are meaningful and transformative for Māori. Additionally, the use of case study research methods provides a systematic framework for in-depth exploration of the research questions, contributing to methodological robustness.

To align with these methodological principles, the study incorporates credibility, transferability, dependability, and confirmability. Credibility ensures confidence in the accuracy and authenticity of findings, and was achieved through cultural and methodological practices. For example, cultural credibility was established by engaging with participants through kanohi kitea (the seen face) and whakawhanaungatanga, fostering trust and openness during data collection. Methodological credibility was supported by member checking during interviews, where key points were clarified and summaries were confirmed with participants. Data triangulation, integrating interviews and grey literature, further ensured that findings were not biased by any single perspective.

Transferability concerns the applicability of findings to similar contexts or populations. In this study, a rich description of the research context, participants, and methodology ensures that readers can assess the relevance of findings to other settings. By grounding the findings in

Māori cultural and professional contexts, this research also offers insights that may inform practices in similar Indigenous or marginalised populations.

Dependability reflects the consistency and stability of the research process over time (Creswell & Poth, 2018; Lincoln & Guba, 1985). This was maintained through regular academic and cultural peer supervision, ensuring that the study adhered to both Kaupapa Māori principles and methodological standards. Peer discussions also allowed for reflection on cultural responsibilities and research integrity.

Confirmability involves ensuring that findings are shaped by the participants' voices and data rather than researcher bias. It was achieved through, maintaining a reflective journal documenting decisions, insights, and reflexive considerations throughout the research journey. Creating an audit trail of research processes allows for transparency and validation by others (Korstjens & Moser, 2018).

The principles of rigour in this study align with qualitative research traditions and reflect the unique requirements of Kaupapa Māori research. This integration ensures that the findings honour Māori knowledge systems while maintaining methodological robustness. By combining these approaches, the research contributes both to academic knowledge and to the empowerment of Māori communities.

Limitations of this Research

This study has several limitations, particularly in its methodological approach and scope. As a case study informed by Kaupapa Māori methodology, the research prioritises depth and Kaupapa Māori relevance over broad generalisability. While this aligns with the study's goals, it also presents challenges inherent in qualitative research and case study methods. These challenges include generalisability of the research findings, the scope and boundaries of the study, issues related to theoretical rigidity and emergent insights, sample size, and the positioning of the researcher.

Case studies inherently focus on specific contexts; therefore, findings are not easily generalisable to wider populations. However, this study emphasises rich, detailed insights into participants' experiences to inform specific solutions rather than seeking universal applicability. The use of purposive sampling further supports this goal, ensuring relevance to the research questions but potentially limiting the variation of perspectives (Crowe et al., 2011; Stake, 1995).

The study's scope and bounded nature means it examines only selected cases within the Māori student and nursing workforce and key stakeholders. While this provides depth, it does not

capture the full diversity of experiences across all regions or contexts. Efforts to define and adhere to the boundaries of the case helped mitigate this limitation.

While this approach ensures alignment with theoretical frameworks, it may risk overlooking emergent insights and unique aspects of the data or suppress participants' authentic voices (Creswell & Poth, 2018; Yin, 2017). To address this issue, data collection and interpretation were guided by the principles of Kaupapa Māori methodology, which emphasise the centrality of participant voices and lived experiences.

The relatively small sample size, typical of case studies, limits the representativeness of the findings. However, the study's aim was to provide in-depth insights into the lived experiences of participants, making rich, contextual data more valuable than statistical generalisability (Crowe et al., 2011; Stake, 1995).

Being an insider researcher, with dual roles as a Māori nurse and a researcher, potentially introduced biases in data collection and interpretation. Reflexivity and peer supervision were used to navigate these complexities and maintain the integrity of the research. By acknowledging these limitations, this study contributes nuanced insights into the challenges and opportunities within the Māori nursing workforce while recognising the constraints inherent in its methodological approach.

4. Integration of Knowledge Systems

This study integrates Kaupapa Māori methodology and case study research to explore the lived experiences and systemic factors impacting Māori nursing workforce development (see Fig. 2). These approaches complement one another, offering both a culturally grounded framework and a practical research design for in-depth exploration.

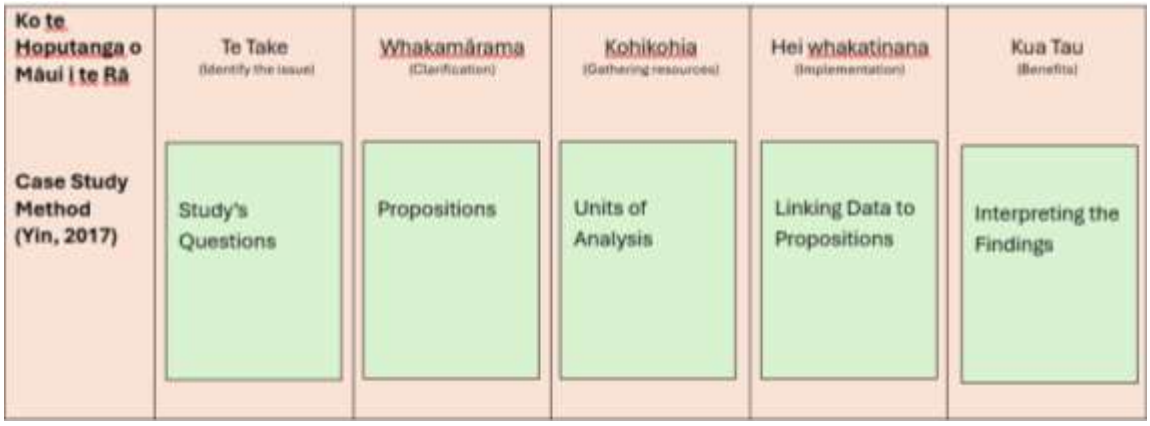
Kaupapa Māori research is grounded in mātauranga Māori and when paired with case study research allows for a deep exploration of issues important to Māori, providing detailed descriptions of Māori lived experiences. In the process of carrying out this research utilising the case study approach, Kaupapa Māori principles were prioritised. Case studies focus on exploring specific cases or instances in great detail and, when combined with Kaupapa Māori research, allows for a thorough and sensitive exploration of the social, historical, and political contexts that impact on Māori experiences. The case study's focus on real-life contexts aligns well with Kaupapa Māori's emphasis on lived experiences, and provides a holistic understanding of phenomena.

Case study research accepts a mix of qualitative methods such as interviews and document analysis. This aligns with Kaupapa Māori research, which places a strong emphasis on narrative

and oral histories as ways of understanding Māori experiences. Both Kaupapa Māori research and case study research can be transformative. Kaupapa Māori seeks to challenge colonial structures and promote social justice for Māori, while case studies often aim to provide solutions or insights into real-world problems. When used together, they can generate practical, culturally responsive recommendations that can propose actions for positive change. By blending Kaupapa Māori and case study approaches, this research contributes to academic knowledge and empowers Māori communities through culturally relevant and practical findings.

Figure 2.

Example of the integration of Kaupapa Māori and Case Study



5. Intersectionality as a Framework

Intersectionality serves as an overarching lens in this study, providing a critical framework for understanding the numerous dimensions of inequality that traverse New Zealand society. This research applies intersectionality to explore the lived experiences of Māori nurses within nursing education and healthcare environments, examining how these dynamics influence Māori recruitment and retention within the nursing workforce.

The concept of intersectionality was first developed by Kimberlé Crenshaw in 1989 to explain how multiple forms of discrimination—such as racism, sexism, classism, and ableism—interact and reinforce one another. Crenshaw (2013) argued that social identities and systems of oppression cannot be understood in isolation; instead, they are interconnected and mutually reinforcing. For example, her early work on male violence against women highlighted how the experiences of women of colour differ from those of white women, as they are shaped by the combined patterns of racism and sexism. Intersectionality reveals how overlapping systems of power create unique experiences of oppression, making it an essential tool for examining the complex realities faced by marginalised groups.

This concept is particularly pertinent to Māori women, who often experience intersecting layers of marginalisation due to their ethnicity, gender, and socioeconomic status. As Indigenous women, Māori are subjected to systemic racism and sexism, compounded by the ongoing impacts of colonisation. Historical dispossession and the loss of land and resources continue to affect their economic and social status. Urbanisation has contributed to cultural disconnection, alienating many Māori from their whakapapa and traditional practices. Further, the effects of intergenerational trauma persist, influencing health and well-being and creating additional barriers to equity and inclusion. These intersecting factors shape the experiences of Māori women in unique ways, amplifying disparities across multiple domains.

In this research, intersectionality is employed to examine how power structures and inequalities intersect to sustain disparities within the Māori nursing workforce. Māori nurses working in Māori health services often experience additional marginalisation due to systemic underfunding and lack of resources, demonstrating how overlapping structures of power and identity, such as race, gender, class, and sexuality, shaped their professional experiences. This includes the troubling dynamic where indigenous nurses may be positioned as agents of the colonial sate in the delivery of care to their own people. Through intersectionality, the research interrogates how these interlocking forms of oppression create and maintain barriers to the recruitment and retention of Māori in the nursing profession.

The use of intersectionality enriches this study by offering a nuanced framework for analysing inequalities and oppression. It allows for a deeper understanding of the systemic and structural factors that perpetuate disparities within nursing education and healthcare environments. By uncovering these dynamics, this research contributes to a clearer picture of how intersecting oppressions affect marginalised groups.

Conclusion

This research demonstrates the synergy achieved by integrating Kaupapa Māori research methodology with case study methods to investigate the static state of the Māori nursing workforce. The case study approach, with its focus on in-depth exploration of specific phenomena, aligns seamlessly with Kaupapa Māori research, which prioritises understanding Māori experiences within their social, historical, and political contexts. This methodological combination provides a holistic and culturally grounded framework, making it particularly effective for addressing complex and real-world challenges.

Case study research is well-suited to answering ‘how’ and ‘why’ questions, offering a nuanced understanding of why the Māori nursing workforce has remained static over the past 4-decades. By employing multiple data sources—including semi-structured interviews with Māori

nurses and students, key stakeholders, as well as a systematic review of relevant policy documents—this research achieves robust triangulation. Triangulation strengthens the credibility of the findings and ensures a comprehensive analysis of the factors influencing the recruitment, retention, and support of Māori nurses.

Challenges associated with the research, such as the limitations inherent in purposive sampling, were mitigated through careful alignment of data collection with the research questions and a transparent and culturally relevant approach to analysis. While the purposive sampling method restricts the generalisability of the findings, it enables a detailed exploration of the specific experiences of Māori nurses, providing valuable insights into the structural and systemic barriers they face.

In conclusion, this study illustrates the value of employing a case study approach within a Kaupapa Māori framework to investigate culturally significant and systemic issues. The research sheds light on the persistent challenges facing the Māori nursing workforce and lays a foundation for future studies. By fostering an understanding of these challenges, this work contributes to the broader aim of achieving equity and increasing Māori representation in the health sector.

Chapter 4: Findings–Kohikohia: Students and Registered Nurses

'Ka raranga rātou i ngā taura harakeke'

They weaved the flax into ropes

Overview of Findings Chapter

This research adopts an embedded single case study design, which focuses on a primary case while incorporating multiple units of analysis. This approach enables a comprehensive examination by delving into distinct, yet interconnected, sub-units, providing rich insights and a deeper understanding of the overall context (Crowe et al., 2011; Hentz, 2017; Yin, 2017).

The context for this research is the New Zealand nursing workforce, with the primary case being 'the static state of the Māori nursing workforce'. Within this framework, three embedded subunits of analysis are explored:

1. Study 1: Semi-structured interviews with Māori registered nurses and Māori nursing students to gain their perspectives on barriers and facilitators affecting recruitment and retention within the nursing profession.

2. Study 2: Insights from key stakeholders—leaders and decision-makers in healthcare—on systemic impediments to growing and sustaining the Māori nursing workforce.

3. Study 3: A review of policy documents spanning 1970 to 2023, examining how historical and contemporary policies have influenced the development of the Māori nursing workforce.

Each sub-unit is analysed individually across three parts comprising Chapter 4, 5 and 6 with key themes presented and supported by participant quotes or excerpts from the grey literature. To ensure confidentiality and clarity, unique identifiers are used throughout the findings: student groups are denoted as 'T', registered nurse participants as 'R', and key stakeholders as 'K'. Numbers are assigned to these identifiers to indicate specific cohorts and individuals.

The findings presented in Chapter 4, 5 and 6 address the central research question: Why has the Māori nursing workforce remained static for the past 40 years? And provides the foundation for deeper discussion in Chapter 7, where the identified themes are critically examined in relation to the research aims and objectives. Finally, Chapter 8 synthesises the findings, offering three key interpretations that illuminate systemic barriers and propose actionable pathways to address the ongoing static state of the Māori nursing workforce.

Introduction – Māori Student Nurses and Registered Nurses Findings

Chapter 4 presents the findings from the first unit of analysis in this embedded single case study: interviews with Māori registered nurses and Māori nursing students. These findings offer critical insights into the challenges and barriers impacting the recruitment and retention of Māori within the nursing profession.

The chapter addresses the central research question of this thesis: Why has the Māori nursing workforce remained static over the past 40 years? Specifically, it explores the lived experiences of Māori nurses and students, highlighting systemic and personal factors that influence their engagement with the profession. This chapter contributes directly to the first research aim, which seeks to understand the barriers that Māori nurses and students face within nursing education and practice. The insights derived from these findings lay the groundwork for the subsequent discussion and interpretation chapters. The findings are organised into thematic sections, with each theme supported by participant narratives to illustrate their experiences. The chapter concludes with a summary of key insights, paving the way for the exploration of the second and third sub-units of analysis in the chapters that follow.

Research Overview

This study presents findings from semi-structured interviews conducted with eight focus groups, consisting of 37 participants, all identifying as Māori. The focus groups comprised student groups and registered nurse groups. The discussions aimed to uncover the issues related to the recruitment and retention of Māori within nursing. The study included 21 student participants across four cohorts:

- Two groups comprised of third-year students
- One group consisted of first-year students
- One group included a mix of students from all 3-years of the programme

Participants came from both urban and rural settings across New Zealand's North and South Islands and had whakapapa to various iwi. The student participants represented several tertiary institutions, with the majority coming from the polytechnic sector.

Registered nurse participants included 16 nurses across five cohorts. These groups were drawn from both mainstream and Māori health services across New Zealand, working in various areas such as medical, surgical, paediatrics, mental health, nursing education, and primary health care.

Student Nurses Findings

The findings are organised into thematic sections, capturing the unique experiences and challenges faced by Māori student nurses. Barriers such as economic hardship, a lack of culturally relevant curriculum, and experiences of racism and isolation were particularly significant. These challenges were categorised into two key sub-themes:

1. **Navigating challenges**
    - Economic hardship
    - Being visible and relatable
    - Culturally relevant curriculum
2. **Coping with racism and isolation**
    - Differential and inequitable access
    - Feeling isolated

Navigating Challenges

Economic Hardship.

Participants described numerous challenges when considering tertiary education, with economic hardship emerging as the most consistently challenging issue across all interviews. Economic hardship significantly impacted the recruitment and retention of Māori in nursing education. Many participants cited financial hardship as a crucial deciding factor when considering entering a nursing programme. When potential students weigh up the combined costs of completing a 3-year programme, many believed it was just too hard.

> *Having the cost of doing the course. That's a big off-putter as well. This one year alone is over $7,000. So, it's hard enough now to pay rent and pay bills, let alone take on another bill and not work. And then when you are working and then go on placement and go home, look after the kids, go to work and then try and study, everything just starts piling up. And that's where you just end up leaving the programme or not even joining at all.* (T02:2)

> *I think in terms of attracting younger people, especially with the cost of living, and stuff continually going up* [in costs]*, it just becomes less and less appealing to study for 3, 4, 5-years.* (T04:2)

The attraction and desire to become a nurse are often driven by altruism. Participants expressed varied motivations for becoming a nurse, most often motivated by their concerns for the well-being of their people (Māori). Despite these altruistic motivations, realities of life and their whānau responsibilities often overshadow their aspirations. The brutal realities that

confront them are generally related to their economic situation, which limits their dreams of becoming a nurse. Participants believed that financial hardship, in particular, was a significant deterrent for potential Māori nursing students.

> *You don't get paid when you're on the course and having one income, and you've got tamariki* [children] *and whānau; financial* [hardship] *is a huge one that I found. Whānau of mine won't go and do the degree because where's the money going to come from when they're studying?* (R01:1)

> *All parking for students should be free. The cost of petrol and transport is through the roof [high] and let's say you get $200 or $230 a week, to do like kai, rent, power. You've got nothing left over, let alone paying for your tamariki, if you've got them. You know you might have had the flu, so you weren't able to work – you have very limited funds. So yes, you get to placement, but you can't pay the $10 per day* [parking] *fee so then you're whacked with a $45 ticket* [fine] *you know.* (T02:3)

Many believed that the socioeconomic disadvantage borne by Māori are a symptom of the cumulative effects of historical experiences of colonisation. Participants further described the ongoing financial challenges experienced by Māori nursing students once they are enrolled in a nursing programme. The hardship is exacerbated by maintaining the financial responsibilities for their whānau, covering course and clinical placement-related costs, reliance on student loans, and impending debt. The difficulty is compounded by the need to juggle study with whānau commitments, often requiring them to contribute to household income by working nights and weekends.

> *I think this is in general, with the education system it has failed us a lot, due to colonisation but also, the requirements to get into tertiary is also very hard*. (T02:5)

> *A lot of us in our programme, most of us, have children and families at home. So, we wear three hats because we're students, and then we're parents, and then we also have to work, and so we don't get days off.* (T02:2)

Frustrated by the constant need to juggle their lives to survive, hold down jobs, and manage whānau as best they could, participants reported injustices they felt over the disparity between student allowances and unemployment benefits. Particularly when they believed they were attempting to improve their lives and the lives of those around them. Participants believed this disparity further contributed to the reluctance of those receiving welfare benefits to enter tertiary study.

> *Unemployment benefits – you get paid way more. Whereas when you're a student, you're trying to better yourself, you're trying to make something of yourself. You know, as a mama, I'm trying to better my future for my little whānau, and I feel like I'm just punished, and I'm like living off the bones of my arse* [living off very little]. *Trying to get through just so that I can get money long-term. It's like we struggled straight for 3-years. What about those tauira* [students] *who don't have the comforts of living at home? You know it's struggle street.* (T02:3)

Scholarships are available to students to help alleviate some economic hardship. Various scholarships are available to student nurses from the Ministry of Health, the NZNO, and, for some students, through their own iwi. All students must complete an application process, which will lead to the possibility of being awarded the scholarship. When participants were asked about scholarships, it was apparent that some were unaware of commonly available scholarships. This highlighted the poor information available to student nurses about scholarship programmes and how being awarded a scholarship can assist in alleviating financial pressures. Most participants knew about iwi scholarships but few applied, many citing that the expectations, such as knowing whakapapa associated with being an iwi scholarship recipient, were too great.

> *Yeah, because it's hard to even apply for scholarships. You know. I applied for a couple and when you get rejected it's just like, "Oh, I'm not doing that again!"* (T04:5)

> *She didn't know her pepeha* [Māori introduction] *so it's like even that is a barrier to getting scholarships sometimes because you look at all the things that you have to do as a student, as in the way of paperwork, and then you look at the scholarship, and then you're just like what am I going to do. You're this urbanised Māori that doesn't know their whakapapa. Too hard*. (R01:4)

Participants over 40-years-old spoke of feeling economic pressure. In 2014, the Government introduced changes to the criteria for student allowances, limiting the number of weeks of eligibility for allowances from 200 (equivalent to 5-years) to 120 weeks (equivalent to 3-years) for students over 40-years-old (Ministry of Social Development, 2024). Māori students over 40-years often enter nursing through academic preparation programmes. This disadvantaged them financially, sometimes extending the time required to obtain a degree from 3 to 4-years. This policy decision had significant repercussions for mature students choosing to study later in life. A student over 50 years of age explained how she managed.

> *I have to work. I work nights. And weekends. Just have to. And I do lots of work over the summer. Get a nest egg. But on the other hand, if you're working every day of your*

holidays when you're supposed to be having a rest, when do you get to rest? When do you get to have a break? Because you're going to burn out, it's going to happen. So, you know, like it's all those things. (T02:6)

Financial hardship emerged as a consistent barrier, profoundly affecting both the recruitment and retention of Māori students in nursing programmes. The costs associated with nursing education, combined with the economic responsibilities many Māori students shoulder, make it difficult for them to complete their studies. Despite available scholarships, many students find the application processes burdensome and the expectations unrealistic, further exacerbating their financial struggles.

Being Visible and Relatable.

As described earlier, most participants shared what had attracted them to nursing. Significantly, for many, marketing campaigns were not influential. Every focus group agreed that marketing to Māori communities was poor and lacked culturally appropriate engagement. Additionally, information about nursing programmes, expectations, and preparation was not available early enough. Most participants navigated the often-complicated application process without support, figuring out the prerequisites and preparation required as they progressed through the process.

There should be an ad for Māori to look after their own. So that's what they should be advocating and pushing like within nursing. Show them the figures, then they should be able to see and make the decision for themselves that they need to get in there [nursing]. *Because you know, who's going to look after your koro* [grandfather]*? Who's going to look after your nana* [grandmother]*?* (T03:4)

Be introduced to it early on [the application process] *so you're aware. Be aware of the whole Studylink system like how it all operates, what is even on offer, what it means – just all of it.* (T03:6)

Participants who had recently transitioned from secondary school to nursing programmes noted the lack of visibility of nursing as a career option from school career guidance counsellors and at many of the career expos they attended. They emphasised the need for more comprehensive advice for high school students considering nursing, including guidance on the appropriate study topics to prepare for entry into an undergraduate nursing programme.

Because I was a teacher's aide for high school, you didn't see nursing in career days. You saw the army and the navy. (T03:4)

> *About the [nursing workforce] pipeline, like doing early intervention work. Working with, as early as Year 9, promoting even Year 11, to start promoting there because if you start early enough and work on pushing for health and chemistry like all the science, to get into health education by the time they're Year 13 they have those UE* [university entrance] *credits and also the subjects for health education. So, I think the strategy is really to do early intervention where you're getting those students into the subjects that they actually want to do.* (T02:2)

The visibility and relatability of nursing as a career choice for Māori are hampered by ineffective marketing strategies that fail to engage Māori communities. The lack of early and accessible information about nursing programmes and the necessary academic preparation limits the opportunities for Māori students to pursue a nursing career path.

Culturally Relevant Curriculum.

Nearly every participant believed that nursing education needed significant changes. The primary issues highlighted were the dominance of Eurocentric and biomedical content and discourse within the curriculum, the methods of delivery, and the scarcity of Māori nurse educators. Several participants pointed out the hypocrisy in cultural safety education, noting that the classroom environment often did not feel culturally safe for Māori students. Many expressed that the curriculum lacked relevance to a Māori worldview, causing personal challenges and prompting them to seek guidance from their kaumātua (elders).

> *So you come into* [the nursing programme] *you get a pōwhiri* [traditional welcome] *into this beautiful marae. And that's Māori focussed. You get your whanaungatanga, you get all that. You do a course, and then that part of your culture is put aside. It just stops. Park it right here, and for the next 3-years, we don't want to hear about it. That's right, but you might have some tutors that adopt it throughout. We had a couple that were okay, that tried to do a karakia [prayer] in the morning and let us have a waiata [sing].* (R01:4)

> *What they* [kaumātua] *turned around and said is, 'If you want to pass [an exam], you have to separate your head from your heart.'* [This advice means to compartmentalise cultural values and adhere to a curriculum that did not align with Māori perspectives] *That's what you've got to do. Or you can just turn around and leave right now and forget it, but if you want to pass, that's what you got to do. What it meant for me was that I knew the answers that were required to pass the paper, but I did not believe them or agree with them, nor would I practice them, and they were never going to be a part of my value base. But if I wanted to pass that paper… well*. (R05:2)

The dominance of Eurocentric curricula and the lack of integration of Māori perspectives creates feelings of exclusion and cultural disconnect among Māori students. This often leads to a conflict between their cultural identity and the academic expectations placed upon them.

Coping with Racism and Isolation

Differential and Inequitable Access.

Racism and experiences of discrimination were common themes among all participants. Many described both covert and overt instances of racism within nursing programmes and clinical environments. These experiences were often subtle or expressed in ways that made students aware that they, or the patients and whānau, were being treated differently.

> *Cultural safety is huge. Māori nurses, in particular, don't feel like they can bring their side of their culture into their work environment. It just makes working a whole lot harder, and institutionalised racism is a huge one too. It's hard to be Māori and to fit in with the kaupapa* [topic] *that's been set and almost demolished* [marginalises] *what it means to be Māori and bring that part of your identity into your work environments. It's pretty rough to try and remain who you are, but also to conform to what the* [Eurocentric] *system has built.* (T01:3)

This participant's reflections highlight how institutionalised racism, and the lack of cultural safety represent systemic barriers that contribute to inequitable access. By forcing Māori nurses to navigate a Eurocentric system that marginalises their cultural identity, the profession implicitly excludes their cultural contributions, making it harder for them to thrive and fully participate. This inequity extends beyond individual experiences, influencing the broader Māori nursing workforce and limiting their access to supportive, culturally safe environments.

> *We need nurses out there to look after our kaumātua. I mean they don't get treated like they should. They get treated like Pākehā. We need Māori nurses out there to look after our elders and our babies and everybody. I want to go out there, and hopefully, I get to influence tauiwi* [non-Māori] *to do the same, to treat our patients, our clients, our tangata whaiora* [patients] *how I want to treat them.* (T02:5)

This participant highlights the inequities in patient care and access to culturally concordant nursing. The absence of a robust Māori nursing workforce perpetuates inequitable healthcare outcomes for Māori. Without equitable access to Māori nurses, kaumātua and whānau face care that fails to meet their cultural needs, reinforcing disparities within the health system.

> *So, I think the Māori workforce has remained stagnant at that percentage because nursing has a particular culture that doesn't necessarily like to be overly inclusive of other worldviews in my personal opinion.* (T01:1)

This sentiment reveals the entrenched exclusivity within nursing culture, which resists accommodating Indigenous worldviews. Such resistance represents a structural barrier to the inclusion and advancement of Māori nurses, perpetuating inequitable access to professional opportunities.

Participants believed that addressing the issues of racism within nursing education and clinical practice is crucial for creating a culturally safe and supportive environment for Māori nursing students. They also considered the inclusion of mātauranga Māori and tikanga Māori in nursing practice to be significant factors influencing Māori student retention.

Participants commonly believed that many academic barriers to tertiary education were rooted in implicit biases within New Zealand's education system. These biases resulted in many Māori students completing secondary school without the necessary qualifications. Consequently, some participants had to complete an academic preparation programme to meet the prerequisites for entry into nursing. Several participants acknowledged that they would not have succeeded in nursing education without undergoing such a programme, reinforcing its necessity. However, this did not alleviate the bitterness of the underlying inequity.

> *Colonisation of our parents, and grandparents, being told that, being passed down, what has been instilled in them from the colonisers that you're nothing, you're not clever. So they may have a fear of, feeling they're not brainy enough or clever enough to become a nurse, to help people. Except just to stay home and have babies.* (T02:3)

> *Requirements to get into tertiary* [education] *are also very hard. And with schooling and NCEA and stuff like that, predominantly Māori, because the system has failed us, it's hard for us to reach those qualifications. So, coming into tertiary it would also be, harder because we don't have those qualifications.* (T02:5)

Participants highlighted common themes of racism and inequitable access within nursing education and clinical practice. They shared experiences of both overt and covert forms of racism, which made it difficult to integrate their cultural identity into their practice. The lack of cultural safety in nursing environments, coupled with structural racism, created additional challenges. Furthermore, participants expressed concerns over academic barriers stemming from the failure of the education system, which often left Māori students underprepared for tertiary education. Many had to complete additional preparation programmes to meet entry

requirements for nursing, emphasising the need for systemic change to better support Māori students in their educational and professional journeys.

Feeling Isolated.

Many participants highlighted the lack of support for Māori student nurses during their educational journey. This included the inability to access culturally appropriate pastoral care. It was seen as especially difficult in programmes with low numbers of Māori students or few Māori nurse educators. Participants reported feeling isolated and unsafe. They noted that having relationships with other Māori student nurses, Māori nurses, and Māori nurse educators significantly improved their experiences and positively influenced retention.

> *Yeah, isolated from your peers. You don't see many Māori students, you don't see many Māori tutors, and it's not a safe space.* (T01:4)

> *In my year, we only have four Māori students, and it's hard. We've only just got our second Māori tutor. Being around people who were in the field already or working towards it, have the same motivation, the same goals, and the same sort of background. I think if you're exposed to people like you, it just makes it more bearable to get through all the bullshit*. (T01:2).

Across the groups, support from Māori nurse educators was considered a protective factor due to their relatability to the students' lived experiences. However, participants acknowledged that the Māori nurse educator workforce also faced challenges related to recruitment and retention.

> *Treasure your kaiako* (nurse educator) *that are Māori. We have such a high turnover of lecturers who just drop off because they're not supported. The way that they teach isn't supported* [by faculty] *and the functionality behind it just seems to have no solid foundation.* (T01:2)

> *My kaiako understand life. They get it, and if my tamariki are unwell or have to attend class with me to ensure that I can come and learn and don't miss out, then that's cool. So, I've had to do that, I'm fortunate enough to be surrounded by such beautiful wāhine [women], and we've built a solid sisterhood.* (T02:5)

Many participants spoke of the lack of support within their programmes and having to develop their support networks, seek out other students, check on each other, and help each other through the programme.

> *Tapping in and saying, "Hey, how are you doing?" You know, it's making those connections still to keep them on board, and I know just by looking at some people, they're struggling. If we know, we feel it, ask them. Don't need to tell everyone else but ask them.* (T03:4)

Narratives highlight the isolation faced by Māori student nurses, stemming from inadequate culturally appropriate support and the inability to access support from Māori peers and educators. This leads to feeling unsafe and disconnected. Building relationships with other Māori students and educators is crucial for improving their experience and retention.

Registered Nurses Findings

Once registered, Māori registered nurses face pressures to assimilate into their clinical practice setting and meet additional expectations to provide clinical and cultural expertise within their environments. Being a Māori registered nurse results in an added burden not required of other registered nurses. This increased pressure impacts their retention in the nursing workforce and leads to Māori registered nurses trying to avoid burnout. Issues impacting the retention of Māori registered nurses have two key sub-themes: Assimilation and expectations, and Feeling the demands.

1. **Assimilation and expectations**
    - Having to assimilate
    - Meeting additional expectations
2. **Feeling the demands**
    - Increased pressure
    - Trying hard not to burn out

Assimilation and Expectations

Having to Assimilate.

Racism and workplace marginalisation were commonly observed and experienced across the registered nurse focus groups. Many nurses reported encountering racism from colleagues. Notably, they coped with this racism by either blocking it out or becoming desensitised to it. Their various experiences of interpersonal and institutional racism were described across a wide range of contexts.

> *I'm used to it. They are racist at work. They're so racist towards each other, the staff and then the patients I try not to get involved. You just get used to it.* (R03:1)

> *Well, you know what? I teach the professional practice paper right. Now you've got the code of conduct, code of ethics, all the regulations under the sun, legislated and yet*

> *they still can't get it right, competencies, all of those things, and I'm thinking where in that does it say, that it's okay to be racist, to have that horizontal violence towards students, towards patients, towards the family?* (R04:2)

> *I've seen racism my entire career. I haven't always had the words for it, but I mean, it continues today. It's never stopped. It's just a little bit more undercover now than it was back then.* (R05:1)

The bullying culture within nursing is well known for its damaging effects. However, participants believed that for Māori, the impact is even more severe. Participants' experiences demonstrate that racism forms the basis of much of the bullying and horizontal violence they experienced.

> *So, the layer upon layer of bullying that happened, but at the core of it was racism. Absolutely, and the intent was, it was actually two-fold. If you're staying, know your place and stay down low. It's very much like, "I've got my foot on your head, and you stay down, don't you think about rising above your station".* (R05:2)

> *There have been periods during my nursing career that I do lack that confidence depending on what's kind of happening and who you're actually interacting with, the horizontal violence that kind of goes on between different colleagues, and I don't mean my immediate colleagues I just have to say but different colleagues over the years that you've worked with, and how you feel and what your self-worth is, but you know I think being honest, calling it as it is, being really unapologetically Māori.* (R03:1)

> *I got quite badly bullied, so much so that I got post-traumatic stress disorder from it.* (R05:1)

Māori registered nurses are acutely aware that they work in a racist system, and they strive to protect patients and whānau by going above and beyond, hoping to minimise the impact of racism and discrimination in health care. One participant described her role within her whānau as the "*door opener*", using her status as a registered nurse to bypass systemic barriers that would otherwise limit her whānau's access to health care. She worried about who would fulfil this role if she was not there. Another participant, despite feeling burned out, felt guilty about leaving because she was concerned about what might happen to the Māori patients she would be leaving behind.

> *There's a local thing that goes on here, and I get into trouble for it a lot. You get the phone call from home* [family], *and, it's "Hey this is going on and we need to get in the*

door [of health services]*". You know, my thing is, if I'm not there, who is the door opener? You have to have a friendly white person to get in the door.* (R05:2)

I feel scared for my people who are here because who else is going to care for them and think about them that little bit extra if I'm not here? That's why I haven't moved [resigned] *yet. That guilt, that responsibility, is still there now, and until you know it's not as bad or I've given up on that, then I think I'll still be here for a little bit.* (R03:1)

Participants described deeply embedded racism and highlighted the need to create a supportive and equitable environment. They emphasised that despite the anti-racism rhetoric within nursing and health care organisations, there is a serious need to enforce existing nursing professional practice guidelines and organisation policy more effectively.

Meeting Additional Expectations.

Dual competence was a significant issue that registered nurses grappled with in their work environments. Many described the assumptions and expectations placed on them to care for Māori patients, while also being asked by their non-Māori colleagues to address Māori issues that arise in the workplace or assist with Māori patients not on their caseload. This occurred while they were simultaneously exposed to racism from colleagues. Participants believed that their non-Māori colleagues had little understanding of the pressure and added workload from the dual competence aspect of the Māori nurse role. They considered the cultural competence of non-Māori essential but acknowledged that current NCNZ competencies were inadequate. They cited examples of working alongside IQNs, many of whom needed to learn and understand the cultural context.

The education system from birth to tertiary is not balanced enough and it's quite racist. Then when you get into tertiary education it's subtle, but the status quo persists and sometimes it's even openly racist, and you can pick your system whether it's health, education, or all those things. And so, when people [students] *get out into practice, they are the token Māori. Or they are expected to be the expert on all things Māori, with very little understanding or shift from the status quo, it's monocultural in the majority and it's also shaped by what we were talking about today – land loss, language loss, and the impact of colonisation.* (R04:1)

More support for Māori and the importance of cultural competency in the workplace… I've had to interject on many occasions when they would call an emergency code. I'm like what for? And it's just a misunderstanding, it's just those communication barriers, one of four Indian nurses talking to a Māori family that is frustrated because no one's listening to their concerns. And so their voices are loud. They're not being aggressive or

violent or abusive, they've just got loud voices. Just hoha [frustrated]. *Like, let me go and have a chat, let me see what's going on but I often have to go in there and just de-escalate. This is what happened and why it happened. They should not be in positions of power when you cannot work with Māori. That happens a lot.* (R02:1)

Some participants shared their feelings of inadequacy when called upon by their non-Māori colleagues to assist with a Māori patient or whānau.

It is more difficult I think also, particularly if you are the only Māori on the ward when things around cultural issues come up, you get looked at. Okay doesn't matter that you might not know the tikanga very well or you can't speak te reo. You get looked at as being the go-to person, so that adds I think another layer, of that whole stress around being Māori and being in the workforce here when it's predominantly not Māori. (R03:2)

Whether they like it or not they see a brown face in a new grad or any Māori nurse, they have a higher expectation of us immediately whether or not we know our stuff [Māori language and protocols] it's just an expectation. But then they come back to, well actually your job description's the same as everybody else, well then don't expect me to do anything extra if you're going to pay me the same as everybody else. (R05:3)

Even though many acknowledge that their culture helps them to work with Māori, the irony is that they enter a work environment that does not encourage or support them being Māori.

Having a workplace, that actually values you as Māori and doesn't say leave your Māori at the door or don't come in. (R01:6)

Like you have to park who you are at the door [of the hospital]. *And sell yourself out. No, thank you. Felt like I was in a whole different country when I worked at the hospital. The culture, and then you think how we feel, just imagine how our whānau feel.* (R01:8)

Some participants described their frustration at how colleagues who are supposed to be culturally competent in their practice will often defer to Māori nurses. Identifying that these expectations to take on these extra responsibilities without support or acknowledgement from colleagues and management of the extra workload can lead to burn out.

We just need more support because myself and one other are the only Māori nurses where I work, and it's like forever dial a Māori, [asking] *what do you reckon I should do here? Or you know we're going to go out to a marae and vaccinate, can you work this Saturday or can you work this Sunday? It's overtime for our people* [Māori nurses]

> *which I don't mind but it's always just me and my other colleague and we're burnt out because of the fact that we are the only Māori public health nurses. It's hard.* (R02:2)

> *Well, they could actually acknowledge the extra that Māori bring. Not just say okay get the Māori in there to do that… because they've* [non-Māori nurses] *done that little tick box, on a line, so they're now culturally competent. Oh, the whole competencies thing is just shite, sorry.* (R01:4)

Māori nurses are often expected to provide dual competence, managing both clinical and cultural responsibilities. This dual role increases their workload and pressure, as they are frequently called upon to address Māori-specific issues and assist with Māori patients, often without adequate support or recognition. The lack of understanding and appreciation from non-Māori colleagues exacerbates these pressures, contributing to stress and burnout.

Feeling the Demands

Increased Pressure.

Many participants reflected on their qualifications with pride, recognising the intergenerational transfer of negative beliefs about themselves as Māori and their ability to succeed. Despite the bias and stereotyping they faced, they managed to complete their education and qualify.

> *I always used to think I was too dumb to do anything. Like the fact that I have a degree absolutely blows my mind still.* (R02:3)

> *We're brought up in tougher lives, and I think that's what stops a lot of us from doing a degree and I think if we were to get out there* [talk to Māori] *and say look, I know where you're coming from, you're not actually that dumb and you know, your life experiences will probably make you a better nurse*. (R02:6)

Some participants described their first year of nursing as very stressful due to poor support, lack of mentoring, and expectations to take on more responsibility, often before they felt ready for it. The academic requirements of the Nurse Entry to Practice (NETP) and Nurse Entry to Specialist Practice (NESP) programmes add to the pressure.

> *As a new grad, you're thrown into the deep end. I think at 3-months, I was in charge of new students. So, I'd just come out of the game* [training], *and I'm in charge of the students, orienting them to the ward. Then, at 6-months, I was in charge of the ward on night shifts. I immediately transitioned to being in charge of PM* [afternoon] *like it was too much, too fast.* (R02:1)

> *It's a lot to study and to work when you're trying to learn at work, learn and study. And also, depends on what kind of rostering you've got. I think I did a lot of night shifts so I could* [study], *it was really hard to find time to study and I'm so exhausted from all the learning on the job.* (R02:2)

Participants spoke of the appropriateness of postgraduate education, professional development, and compulsory training, particularly in subjects that were deemed by them to be of little use to their career plans. They often felt that it was more about meeting organisational obligations than about the unique professional development needs of Māori nurses.

> *How did this happen? How the hell did this happen that an Indian, the poor thing not her fault, came to teach all of these nurses, and us* [Māori nurses], *how to work with Māori? I said, how in the hell did this happen? So, we go to the Māori Directorate, and I recommend to them, I'm going to create an engaging with Pākehā course, and I'm going to get a Māori to teach it! And she's trying to calm me down because I've ripped into the general manager 'how dare you allow this!'. (R05:1)*

> *I don't understand but I think it's all rhetoric I think they're doing it so they can say they're doing it. It's a tick box, it ticks the box.* (R05:2)

The increasing pressure to meet academic and professional development requirements adds another layer of stress. Many Māori nurses felt overwhelmed in their first year by the expectations to complete postgraduate studies while simultaneously managing their professional responsibilities. The misalignment between their career goals and the professional development opportunities available further contributes to their frustration and potential to burnout.

Trying Hard Not to Burnout.

Many participants described work environments that added pressure and stress to their already busy workloads. In some cases, participants recognised they were burnt out or had already moved on due to burnout.

> *It would be absolutely amazing* [increasing the Māori nursing workforce]. *We need it because all of our patients are Māori, and nobody knows how to look after them except for Māori, and there's only 6% of us, and we're all burnt out!* (R02:2)

> *Because I tell all my students, I wouldn't have chosen this job if I knew what I knew back then* [that the job is stressful]. *I wouldn't have, and I don't think it's worth it.* (R03:1)

> *And they say they're the DHB values, like the DHB values* [include people first, respect, caring, communication and excellence] *come on? I've worked for them for a couple of years, but going back there, it's like they burn you out, you know. Totally. They just burn you out, burn you out, burn you out.* (R01:4)

The findings suggest that Māori registered nurses experience high levels of pressure and stress leading to burnout. Some participants expressed regret at having chosen a career in nursing and were unsure whether they would recommend it to whānau or friends. These factors have implications for the retention of Māori registered nurses within nursing and will contribute to defining the strategies for increasing the recruitment of Māori into nursing.

Conclusion

The findings from Chapter 4, illustrate the multifaceted challenges that Māori student nurses and registered nurses face in navigating their educational and professional environments. These challenges, deeply rooted in structural inequities, highlight significant barriers to the recruitment and retention of Māori within the nursing workforce.

For student nurses, economic hardship remains a pervasive barrier, with participants describing the financial strain of balancing tuition costs, living expenses, and whānau responsibilities. These economic challenges are compounded by a lack of culturally relevant curriculum, limited visibility of nursing as a viable career path for Māori, and inadequate support structures, leaving many feeling isolated within their programmes. Institutionalised racism and inequities further exacerbate these issues, making it difficult for Māori students to feel safe, supported, and valued in their educational journeys.

For registered nurses, the pressures to assimilate into predominantly Eurocentric healthcare systems and fulfil dual roles of clinical and cultural expertise create significant stress and lead to burnout. The expectation to provide culturally appropriate care for Māori patients, often without adequate organisational support or acknowledgment, adds to the already demanding nature of their roles. Participants described enduring experiences of racism, horizontal violence, and a lack of meaningful professional development opportunities tailored to their unique needs and aspirations.

The systemic challenges identified in this section, highlight the urgent need for transformative change within nursing education and practice. Addressing these barriers is critical both for the recruitment and retention of Māori nurses and improving health outcomes for Māori. These findings set the stage for deeper exploration in subsequent chapters, where the broader

implications of these challenges will be critically examined and synthesised to identify pathways for meaningful change.

Chapter 5: Findings–Kohikohia: Key Stakeholders

This chapter examines the findings from semi-structured interviews conducted with nine key stakeholders to answer the research question: Why has the Māori nursing workforce remained static at 7% for the last 40 years? The participants were all nurses holding or having held influential roles within New Zealand's health sector. Predominantly Māori, they represent diverse communities across the North and South Islands and contribute insights from their experiences in public and private healthcare contexts. Through the lens of Kaupapa Māori methodology and case study research, this chapter explores stakeholder perspectives on the impediments to developing and sustaining the Māori nursing workforce. The findings are presented as two primary sub-themes, each supported by participant narratives:

1. **The Realities for Māori Nurses:**

This sub-theme explores structural and professional challenges that Māori nurses face, including the lack of political will to effect meaningful change, the perpetuation of the status quo within the nursing profession, gatekeeping practices, and the impact of professionalisation on Māori nurses.

2. **Endemic Racism within the Nursing Profession:**

This sub-theme delves into the persistent systemic racism that undermines Māori nurses' ability to thrive. It explores participants' experiences of frustration and disillusionment, particularly in navigating a profession that often marginalises Māori perspectives and needs.

By presenting these themes, alongside direct participant quotes, this chapter provides an in-depth understanding of the systemic barriers identified by key stakeholders. The findings from this chapter will lay the groundwork for the discussion of findings in Chapter 7.

The Realities for Māori Nurses

A Lack of Political Will

With predictions in the late 1980s of a future nursing workforce crisis, most participants described their attempts to impress on the government the need to urgently increase the nursing workforce. However, despite their best efforts, they believed a lack of political will existed over time by the government, no matter who was at the helm.

> *I think because nursing, doesn't have a priority voice in the health sector so there's a lack of support or investment for nursing, let alone anything for our Māori nursing. So, I*

think it's a lack of political will to shift and change the numbers or to invest in the deficit. (K01)

Many considered the government's lack of urgency to invest in nursing was due to the ongoing reliance on IQNs to sustain the nursing workforce.

Because all the Ministry was focused on is the IQNs workforce and not ours, or the fact that we've [Māori nursing workforce] *been static in this space* (K01).

Furthermore, participants believed the lack of investment in the nursing workforce was due to a preferential bias towards medicine, which demonstrated government priorities lay with the medical workforce to the detriment of the nursing workforce.

One answer lies, in how did Otago do it? Increasing the Māori doctors? There are answers in that space, and we know why because pure investment was made into that programme. (K04)

The Māori Directorate held the funding for the Māori workforce. You could see, that they gave greater priority and invested more in the medical programme than they did in nursing. And yes, we had to be grateful that we could have ongoing XXXXX funding, but that was like pulling your nails off to get ongoing funding it wasn't like an easy rollover. It was year by year when the contract came up for renewal, we had to jump through hoops, whereas, for Otago, I'm sorry but, [it was] *easy.* (K04)

But my sense is that for the health workforce particularly, they know that they give like 7/8ths of their money to medicine. So yes, that's the hegemony of medicine. (K05)

When considering the number of nursing workforce strategies and recommendations made to various governments over the last 40 years, participants struggled to share their awareness of any recommendations being implemented by the government.

Who actually manages it [following up on recommendations] *and monitors it and follows up if it doesn't happen? Who is taking ownership and responsibility?* (K04)

So, it's [Māori nursing workforce inequity] *been on their* [the government] *radar for ages and so I think it's a conscious decision not to address it.* (K01)

I can't remember what year, but quite a few years ago, we advised that by 2028, we would have parity in the nursing workforce with the population, with the level of Māori in the New Zealand population. We developed five levers as we saw as important towards achieving that goal, and we gave that advice to Health Workforce New

Zealand, to the Ministry of Health and the Minister and not one of those levers was ever pulled. (K05)

A profound sense of frustration was evident among key stakeholders, heightened by their personal experiences in trying to negotiate changes with government agencies to influence the nursing workforce positively. They believed their efforts were met with ambivalence and indifference.

In the late 1980s, nursing leaders warned of a workforce crisis, urging the government to act. Despite these efforts, participants noted a lack of political will across successive governments to prioritise nursing, especially Māori nursing. The government's reliance on IQNs and its disproportionate investment in medicine over nursing were seen as major issues. Recommendations for improving the Māori nursing workforce were largely ignored, leading to frustration and a sense of neglect.

Protecting the Status Quo

Participants consistently discussed the lack of prioritisation and value placed on the Māori nursing workforce by nursing leadership over the past 4-decades. This sentiment was echoed across registered nurses, students, and key stakeholders, reflecting frustration with leadership's inability to advance the development of Māori nurses.

I think a key driver for it is that nursing leadership, has not seen the value of increasing our Māori nursing workforce (K05).

Participants emphasised that Māori nurses are highly committed to improving Māori health outcomes. However, opportunities for professional growth, leadership roles, and skill development have been consistently limited by systemic barriers, including a 'glass ceiling' that has hindered progress until very recently.

Māori nurses are worth investing in. They're committed to making a difference in Māori health outcomes. But, the glass ceiling, is so low on our Māori nurses. Well it has been until recently, they haven't been given the opportunities to grow, to develop, to get their qualifications, to experience different things in terms of being able to take senior positions. (K05)

Despite their strategic thinking and system-oriented focus, Māori nurses have historically been excluded from leadership tables, reinforcing a perception that their contributions are undervalued and irrelevant.

> *Especially Māori nurses, are strategic thinkers, are system thinkers, we're future focussed. It's an insult to suggest that we're not. But, we're not at that table. Why? Because there's not the will, there's not. We don't seem to be relevant as a workforce and particularly not as a Māori workforce.* (K01)

The lack of effective leadership has left Māori nursing underrepresented in decision-making and failed to create a supportive environment for equitable workforce development.

Leadership Challenges

A key theme among participants was the perception that, despite having a wide and diverse range of leaders within nursing, these leaders have generally failed to deliver effective results for the profession. For example, one participant described her experience as a long-time member of a national nursing group, representing nursing across the sector, that included many highly regarded nurse leaders. Despite its broad representation, including Māori and its potential to influence at a national level, the group still faced issues around effective leadership. She stated that, unfortunately, over her years of involvement, she realised the group was not effective in representing nursing concerns and interests or in advocating for nursing on a national level.

> *Our current nursing leadership has failed Māori and that might be harsh to say, but making decisions on behalf of Māori when we have got more than adequate nursing leaders that could be involved is no longer appropriate. So, I think that's number one, they need to change the culture.* (K06)

> *But XXX* [professional nursing group] *is the most ineffectual group of people. There are some very good individuals on it don't get me wrong. People I have the greatest respect for. But they do not get the power that they hold as a group. They turn up at the meetings, talk, talk, talk with great passion. And then they go away and they forget that XXX ever exists until they come back to the next meeting, and you cannot make an impact like that.* (K05)

Another frequently mentioned nursing leadership group was the Nursing Council. The NCNZ clearly states that its role in healthcare is to ensure that nursing standards within the country are upheld to provide safe and effective care to the public. However, many participants believed that over the years the NCNZ has been inconsistent in its role, negatively impacting the direction and leadership within nursing.

> *It's not helpful to us. It's not a place* [Nursing Council] *that embraces and advocates for public safety.* [Participant in a conversation with a senior staff member from the

Nursing Council] *She also said to me, I have to ask myself the best role that a regulator can do is not be on the front page of the Otago Times or the Herald, and I said that does not mean to say that you're doing your job well.* (K01)

Participants frequently criticised the NCNZ for failing to provide clear guidance and effective advocacy for the nursing profession. Many argued that the Council's narrow focus on regulation and public safety neglects broader systemic issues, such as culturally safe practices and adequate staffing levels—both of which significantly impact public safety, and the quality of care provided. These exceptions not only compromise public safety but also perpetuate inequitable health outcomes for Māori.

Public safety is deeply impacted by staffing. (K05)

They [Nursing Council] *have, absolutely a fierce obligation to support public safety but they do very little to do that especially when it comes to cultural issues where the public is concerned.* (K01)

Participants believed the NCNZ assumes a leadership role in the absence of any other readily recognisable and reliable group.

There needs to be a leadership body and it's not the Nursing Council. They're a registering body they're not the leading body (K02).

Many of the issues described above have had implications for Māori nursing. Several participants noted that the NCNZ isolates Māori from decision-making processes, exacerbating power imbalances and marginalising Māori nurse leaders. This dynamic preserves the status quo and stifles meaningful progress for Māori in nursing leadership.

We are in a position still of being reliant on these people [Nursing Council] *to make good decisions and of course, they're not going to. They're going to make decisions that protect themselves for the status quo.* (K02)

Which is all that we can say that the voice of Māori nurses, means nothing in the sector. So we've had to agitate. We've had to go externally to get some conscience on this. The Waitangi Tribunal was also an opportunity to expose the level of ignorance and to take a wider shot at the whole system. The policy systems that have been negatively impacting Māori, but also the regulatory body that imposes its mono-view on Māori nursing and our practice. (K01)

Division and Fragmentation

Internal divisions within nursing, including Māori nursing, further complicate representation and leadership. Participants described a lack of unity and strategic collaboration, which weakens the profession's ability to advocate for itself and address critical issues. This fragmentation leaves Māori nursing particularly vulnerable to exploitation by those in power.

Despite the consistent call from Māori nurse leaders for 4-decades regarding Te Tiriti o Waitangi, power sharing, and collaboration, their influence has been limited. Māori nurse leaders, until recently, have not been in positions of power, and are frequently the lone voice on a committee or an advisory panel.

> *You know, 40 years later we've got to have gotten wiser. The reason is that we don't have power and control over the direction of any programme that we put up, whether it's in the polytechnic or in a wānanga.* (K07)

Efforts by Māori over the years to influence changes within the power structures of nursing have largely been unsuccessful. Māori believed that non-Māori nurse leaders do not have Māori interests at heart, leading to exclusion and marginalisation in key areas of leadership and workforce planning.

> "*So unless we've got some really clear frameworks and accountability in that system* [Nursing Council]*, we're not going to see huge change*" (K01).

Over the past 40 years, Māori nursing has faced significant challenges due to a lack of support and recognition from nursing leadership. This persistent status quo has hindered meaningful progress for Māori in the profession. As a result, Māori voices remain underrepresented in decision-making processes, limiting their ability to influence nursing leadership and advance the development of the Māori nursing workforce.

Divisions in Nursing

Participant interviews revealed significant confusion regarding responsibility and representation within the nursing profession. Questions arose about who truly represents all nurses, who can speak on behalf of the profession, and who is accountable. This issue was further complicated by internal divisions within nursing, including Māori nursing. The lack of unity and ineffective leadership in nursing has resulted in the absence of a consistent and collaborative voice, as well as a lack of collective strategic direction. Consequently, nursing has been subject to government policy dictates, with any representation being at the behest of politicians.

> *Lack of formalised national strategy to address the issue, no funding for this either. No dedicated funding*. (K04)
>
> *But again, it comes back to no formalised strategy, no significant investment, piecemeal approach and at times tokenism, a word on a page 'Māori, oh yeah Māori'.* (K04)

For Māori nursing, this division causes additional disadvantages. The split loyalties within the relatively small Māori nursing cohort, coupled with public disagreements, create an impression that Māori nursing is divided and disorganised.

> *They* [Nursing Council] *could easily have said that we can have one from each* [group] *but they didn't. They said, well we've got one position and you people* [Māori nursing] *will have to work it out. Of course, they're not going to work it out. They* [Nursing Council] *think they're being so damn clever*. (K02)

This division adds confusion about who is best suited to represent the needs of Māori nurses. Such a dilemma can be easily exploited by those in positions of power. Over the years, Māori nursing has relied on nursing leadership to do the right thing. However, Māori have come to the realisation that nursing leadership is only interested in protecting the status quo.

The nursing profession faces confusion and division over representation and leadership, including within Māori nursing. This division weakens the collective voice, leading to fragmented advocacy, ineffective leadership, and issues in addressing the needs of the workforce, especially the Māori nursing workforce.

The Gatekeepers

Issues with nursing education emerged as a common theme among key stakeholder participants. Nursing education was perceived as a significant barrier to growing the Māori nursing workforce. Participants highlighted the ongoing marginalisation of Māori in schools of nursing and the low rates of Māori recruitment and retention in bachelor degree nursing programmes over the last 30-40 years as major contributors to the challenges in growing the Māori nursing workforce.

The continued marginalisation of Māori staff and the lack of Māori-specific content in nursing curricula hindered the preparation of future nurses to improve quality, safety, and equity for Māori. Additionally, the dominance of Western biomedical knowledge within nursing curricula devalued the role of Indigenous knowledge.

Participants reflected on the initial inclusion of kawa whakaruruhau-cultural safety in nursing education and increases in the Māori nurse educator workforce in the early 1990s, as it appeared to herald a new era of progress for Māori nursing.

> *There was a sense that there would be a lot of change. So, at that time we did see more Māori being employed by the schools of nursing and saw them going out and actively recruiting. Not long after all of this started to happen, it was determined that we needed to have someone in the Ministry of Health who would influence us in terms of driving this. And kawa whakaruruhau was born out of that. And Irihapeti* [Ramsden] *was employed to drive kawa whakaruruhau. There was a lot that happened. A couple of years or so down the track, after Irihapeti had started to drive this, you had the schools of nursing starting to implement kawa whakaruruhau into their programmes. Then you had the Anna Penn incident.* (K02)

The 'Anna Penn incident' refers to a student who complained to the media about the inclusion of cultural safety in nursing education. The resulting publicity caused a backlash, and saw the already limited political will regarding Māori nursing to disappear entirely.

> *Basically, that gave the heads of schools and people who weren't committed* [to cultural safety] *because you had these heads of schools who had committed to doing that, but then you still had a lot of tutors who thought it was a load of rubbish… but it gave people in the Ministry, and within nursing, the right to be racist.* (K02)

Participants believed that progress within nursing schools has never fully recovered. The heads of these schools became the 'gatekeepers' of nursing education, heavily influencing any progress or developments made by Māori nursing. Participants perceived their influence as a significant barrier to advancing Māori representation and incorporating Indigenous perspectives in nursing education.

> *Having met with Wharangi Ruamano and NETS* [Nurse Educators in the Tertiary Sector] *again, I'm sorry, 'Same shit different day' – take me back 15 to 20 years ago to when I was teaching in the BN* [Bachelor of Nursing] *programme, all of the challenges just trying to keep yourself at the table, a voice at the table, continually having to argue the toss, argue for resources, argue for this, argue for that.* (K04)

A participant described attempts to increase Māori nursing faculty, including requests to invest in Māori nursing education for postgraduate study, and to enhance wraparound support to make nursing programmes safer and more supportive for Māori staff and students. However, these efforts were largely unsuccessful.

> *And we outlined just how many of the programmes don't have Māori faculty, etc. But we couldn't make that investment, we could only tell other people to do it. And, between this group, between that group, it all just falls in the cracks*. (K05)

> *But what became evident was the lack of exposure to things like curriculum development and the opportunities to get to upgrade their qualifications to masters* [degrees]*. They would tell you that they are so busy, doing all the things that they have to do, the added pastoral care, and attending to the demands of their non-Māori colleagues, that they're not given the opportunities to grow. They weren't given the same opportunities to get their degrees or their Master's, and they weren't also given the opportunities for promotion as others were*. (K05)

The inability to track ethnicity data within nursing schools continues to be a problem. Participants suggested that school heads' gatekeeping of ethnicity data is evidence that they are aware of their poor performance and their failure to effectively support Māori students.

> *I think ethnicity data is really interesting. I mean it's probably undercounted because there are people who don't want to identify as Māori because of the consequences of doing that. I think that's a sad indictment of our profession. But if we don't have good ethnicity data collected, then we can't track progress. We can't see how well we are doing or how well we're not doing. And this is a problem in our schools of nursing*. (K06)

> *The cynic in me would say that the difficulty in getting a national picture over recruitment and retention and success and progress through programmes is because of the people holding the power, i.e. the heads of schools, know that they're not doing a good job.* (K06)

Accountability for the static state of the Māori nursing workforce was notably lacking, with no clear responsibility taken for addressing and improving the situation.

> *There are clear indications that Māori workforce needs to increase in the workforce planning area. But nobody's been made accountable, so we need to have some accountability, we need to have some targets, and our heads of school need to be accountable; our directors of nursing have to be accountable, our vice-chancellor, CEOs of the tertiary institutions have to have some role in that accountability for that as well. And importantly, they have to be accountable to our whānau, our hapū, our iwi, and our hapori.* (K06)

The issues highlighted by participants reveal numerous obstacles to progress within nursing education; including, ongoing marginalisation of Māori staff, lack of Māori-specific content, and

dominance of Western biomedical knowledge. The backlash generated by cultural safety in the 1990s seemed to stall the little progress made. The heads of nursing schools, acting as gatekeepers, were seen as major obstacles, limiting Māori representation and advancement. Additionally, poor tracking of ethnicity data and lack of accountability have perpetuated the static state of the Māori nursing workforce, with little improvement over decades.

The Professionalisation of Nursing

The shift in the 1970s from a pre-registration apprenticeship model to inclusion within the tertiary education sector represented a fundamental change in nursing education, philosophy, and policy. Nursing was no longer seen merely as a duty or role but as a recognised profession. However, for some participants, the benefits of this transition were questionable, particularly for Māori nursing.

> *I think nursing has lost its way. I think that that needs to go back and determine whether it's a profession because if it's a profession, then why aren't we getting paid the same as other professionals? Why don't we have the same status as other professionals? All of those things. Or are we a vocation? Something that people do for the love of other people and to want to make the world a better place to be in. Because I think, once we've sorted that out, then we can sort out things like career pathways.* (K02)

> *Now in today's world, I think nursing as a whole has got to, go back to the drawing board, and ask themselves, whether the direction that we've been going in, in the last 20 years, has promoted nursing as a profession to anyone, let alone Māori.* (K02)

Some participants perceived the movement of nursing education from hospital-based training to tertiary education as making nursing seem unattainable for Māori.

> *Is it disadvantaged primarily, it moved from a hospital-based programme, which still had a theoretical component, when you are moving from a diploma to a degree, the academic expectations were higher, so that was all in the name of becoming a profession, rather than being a trade, as such, in terms of that. Yes, it did disadvantage Māori because that cut out a whole lot of Māori who would have applied for a programme that otherwise could have got in but wouldn't get in because of their academic achievement.* (K04)

> *Yeah, so they need to go back and review their basic assumptions about why nursing education had to go into the polytechnic system. …Because a lot of the changes that*

have occurred here have occurred as a result of something that's happened overseas. (K02)

Some participants believed that the shift to a tertiary-based academic model has made nursing less accessible and attractive to Māori, primarily due to the educational prerequisites and significant economic burden, a burden not just to the individual but for the whole whānau.

I think what's happened is that it's become in a lot of our people's minds, something that's unattainable. Unattainable for a lot of reasons. Unattainable for cost reasons. You know, I think if they went back into the hospitals and paid them as they worked, you'd probably get a lot more Māori going back into nursing. (K02)

Before 1996, ethnicity statistics were not efficiently recorded, making any attempts to analyse the recruitment rates of Māori into nursing programmes during the hospital-based training period versus tertiary education a futile exercise. This topic will be further discussed in Chapter 7: Discussion of Findings.

Endemic Racism Within the Nursing Profession

A Sense of Frustration

Participants were clear that racism is endemic in nursing, permeating all levels of the profession from the upper echelons down to every faction of the occupation. Systemic racism is also reflected in the continued marginalisation of Māori within the occupation and, until recently, their exclusion from decisions that most affect them.

Let me tell you, it [racism] *came from the top down, and by the top, I mean Nursing Council.* (K07)

So cutting to the chase, 40 years down the track as far as I'm concerned, the key thing of all this is the racism. (K07)

Māori participants described their experiences of marginalisation through acts of racism and a pervasive sense of powerlessness that hinders their ability to influence change.

The Māori voice has been marginalised, the way that we've been written out of any legislation, the way that we haven't been supported, right back from the 1900s. (K01)

Nursing is so deeply entrenched with its own degrees of racism. (K01)

Certainly, in Wellington, for a long, long time, the racism there was just tangible, so if you tried to even talk to them. You know, I have to, unfortunately, say some of our

> *worst enemies were some of our people working in those departments. Because they enabled it* [racism] *they didn't just enable it they actively supported it.* (K02)

The status quo persists in nursing due to the continued reinforcement of the hierarchy of power within the predominantly white nursing profession.

> *I think the biggest thing for me is the imbalance of that power, imbalance right throughout everything. And that's what we're dealing with.* (K03)

> *We can't tell Health Workforce New Zealand they need to invest more money in nurse practitioner training. We can't tell Health Workforce New Zealand that we need to develop Māori nurses into Māori faculty, to create safe spaces for Māori students. We can tell them, but they don't have to take any notice. We have no power.* (K05)

In recent years, Māori nurses have been employed in senior nursing roles at a national level. One participant provided insight into the unease felt by non-Māori regarding this recent shift, as Māori nurses move into positions of power.

> *I think the sort of silent institutional racism in nursing faculty has diminished but not gone away. It's unconscious for them. But I also see a bit of a fragile point at this point in time where the growth and power of Māori leaders in nursing has increased hugely just recently. You know, when I look around the XXX table, what I think about Marg Broodkoorn, Lorraine Hetaraka, Ramai Lord, we're at a dangerous point where I see a little bit of backlash starting. And we're going to have to be very careful about that*. (K05)

Participants described progress through small pockets of innovation where Māori recruitment and retention efforts were successful. However, they expressed frustration as managerial interference often disrupts these innovations, making it difficult to sustain them. This pattern has led to the impression that whenever something benefits Māori, it is changed by others, resulting in a loss of control for Māori.

> *We do not have overall control over the programmes; hence, the other thing I've found is that if the programme is going amazingly along the pathway of recruitment retention, tauiwi* [non-Māori] *seem to say change direction they always seem to come in interrupt the kaupapa* [programme]. (K07)

> *That's what we need to focus on now, 40 years, how much longer, how long does it take for us to realise what they* [non-Māori] *say and what they do are two different things* (K07)

Racism and marginalisation are prevalent challenges faced by Māori nurses at all levels within the nursing profession. These experiences add stress and frustration to their roles, hindering progress and innovation in nursing. Racism significantly impedes the development of the Māori nursing workforce, contributing to its static state. This issue is recognised as one of the most critical factors affecting the advancement of Māori nurses in the profession.

Conclusion

This chapter has provided a comprehensive examination of the perspectives of nine key stakeholders, shedding light on the systemic and institutional barriers that have hindered the growth and retention of the Māori nursing workforce. By focusing on two key themes—The Realities for Māori Nurses and Endemic Racism within the Nursing Profession—this chapter has highlighted the complex and interrelated challenges that perpetuate workforce inequities.

Key stakeholders identified a lack of political will as a critical barrier, with successive governments failing to prioritise nursing and neglecting the specific need to grow the Māori nursing workforce. This inaction, compounded by an overreliance on IQNs and disproportionate investment in the medical workforce, has hindered progress. Within the nursing profession, participants highlighted leadership failures, a lack of accountability, and the perpetuation of the status quo as significant impediments to workforce development.

A recurring theme throughout the chapter was the dominance of Eurocentric values and practices within the profession. This dominance marginalises Māori nurses, limits their opportunities for leadership and professional development, and reinforces existing power imbalances. The structural racism identified by participants has resulted in entrenched inequities, leaving Māori nurses to bear additional burdens as cultural advocates within a system that often overlooks their contributions.

Efforts to improve Māori recruitment and retention in nursing have been sporadic and insufficient, often disrupted by systemic resistance and managerial interference. Participants expressed frustration with the divisions within the nursing profession, which weakens its collective voice and diminishes its ability to effect change. Moreover, the lack of a cohesive national nursing workforce strategy further compounds these challenges, making progress elusive.

Despite these barriers, stakeholders acknowledged pockets of innovation and progress led by Māori nursing leaders. However, they cautioned that such progress remains fragile, with gains often reversed or undermined by broader systemic forces.

In conclusion, this chapter has highlighted the urgent need for structural change, culturally responsive leadership, and a unified approach to addressing the inequities faced by the Māori nursing workforce. These findings provide essential context for understanding the persistent stagnation of Māori representation in nursing and lay the foundation for further discussion. The insights gained here are integral to framing the broader implications and potential solutions that will be explored in the following chapters.

Chapter 6: Findings–Kohikohia: Systematic Critical Review of Grey Literature

This chapter presents a systematic and critical review of grey literature spanning the period from 1970 to 2023, with a focus on government policies, strategies, and regulatory frameworks that have influenced the Māori nursing workforce. The review encompasses policy documents, strategic reports, and government initiatives that offer insights into the systemic barriers and enablers affecting Māori nurse recruitment, retention, and progression. Each entry includes a concise summary and critical evaluation, considering the document's relevance, intent, and contribution to Māori nursing workforce policy.

Rationale for the Time Frame

The selected time frame of 1970 to 2023 is integral to the study's aim of understanding the historical and contemporary influences that have contributed to the static state of the Māori nursing workforce. Beginning in 1970, the review captures pivotal moments in New Zealand's health policy landscape, including the introduction of landmark reforms in nursing education and the increasing recognition of the importance of equity in healthcare workforce planning. This period also allows for the inclusion of more recent policy changes, such as those associated with the establishment of Te Whatu Ora New Zealand Health.

By reviewing literature from this extensive time frame, this chapter seeks to address the research question: Why has the Māori nursing workforce remained static at 7% for nearly 4-decades? Specifically, it aligns with the study's aim of identifying systemic barriers embedded in health and workforce policies that have hindered the growth and retention of Māori nurses. The findings provide context for understanding the stagnation of Māori representation in nursing and contribute to the development of actionable strategies for improvement.

Structure of the Chapter

The chapter begins with an overview of the methodology used to conduct the grey literature review, including criteria for document selection and analysis. The findings are then presented in chronological order, highlighting key policy milestones, recurring themes, and gaps in implementation. This chapter provides a descriptive account of key government-commissioned reports and policy documents concerning Māori health workforce development, with a specific focus on Māori nursing. The aim is to examine the recurring themes, recommendations, and gaps that emerge across decades of policy discourse. While descriptive in nature, this chapter lays the foundation for the subsequent discussion and interpretation chapters by

demonstrating how these reports repeatedly highlight similar issues without achieving substantial progress. By presenting this historical and policy-driven context, the chapter seeks to emphasise the systemic inertia and lack of implementation that have contributed to the persistent underrepresentation of Māori in nursing.

These findings provide a critical policy backdrop for the discussion in Chapter 7, where the implications for Māori nursing workforce development are critically evaluated. The interpretation of findings in Chapter 8 further integrates these insights to address the systemic challenges identified across all units of analysis.

Systematic Review

A systematic critical review was employed, identifying a total of 60 documents that met the inclusion criteria: relevance to nursing workforce development and, specifically, their implications for the Māori nursing workforce. The search involved multiple databases, including Medline, CINAHL, Cochrane, Joanna Briggs, and Scopus via the Auckland University of Technology library. Additional searches were conducted through Google and Google Scholar to ensure a range of relevant literature was identified. From the initial 60 documents, 18 were selected for closer examination.

The primary focus of the documents reviewed was to either directly reference the Māori health workforce or Māori nursing workforce, or to present findings with significant implications for these groups. A broad range of policy documents was analysed, including those related to nursing workforce planning, education, and regulation. These documents, originating from government policies to broader workforce strategies, provide critical insights into the political and professional environment over time.

The review is organised chronologically, tracing developments from the 1970s through to the 2020s. This historical approach highlights key trends, challenges, and opportunities over the past 5-decades, offering a clear view of the shifts in nursing workforce planning. Each document is examined in terms of its background and purpose, its specific relevance to the Māori nursing workforce, and any notable issues regarding policy implementation and impact. Following this review, key themes emerging from the documents were identified. These themes form the foundation for the explanation building that occurs in Chapter 7, supported by relevant quotes from participants and additional literature.

The 1970s

The catalyst for the most significant change for the New Zealand nursing workforce occurred during the 1970s. The Carpenter Report laid out a roadmap for change, which when implemented had ongoing effects for the workforce into the future.

1971 An Improved System of Nursing Education for New Zealand (Carpenter Report)

In the early 1970s, growing dissatisfaction with the existing nursing education system in New Zealand was voiced by several key bodies, including the Division of Nursing, the Department of Health, the Nurses and Midwives Board, and the New Zealand Registered Nurses' Association (New Zealand Board of Health, 1974). In response to these concerns, the New Zealand Government, in collaboration with the WHO, appointed Dr. Helen Carpenter, Director of the School of Nursing at the University of Toronto, Canada, as a short-term consultant. Her role was to conduct a comprehensive review of nursing education in New Zealand.

Dr. Carpenter's review aimed to evaluate the current state of nursing education at all levels. It included a comparison with other health professions and a consultation process with key stakeholders about the future direction of nursing education. The review provided critical insights and recommendations to the government on how to address the shortcomings of the system, laying the groundwork for future reforms (Carpenter, 1971).

At the time, nursing schools were overseen by hospital boards, with students employed by hospitals and trained through an apprenticeship model. Dr. Carpenter's review identified several critical issues within this system, the most pressing of which was the high attrition rate among nursing students. Many students struggled to balance their professional development with the increasing demands of patient care. Additionally, as patient care and hospital systems became more complex, the hospital-based training model proved outdated and insufficient to meet the evolving needs of both students and healthcare services. Carpenter also highlighted the isolation of nursing education from mainstream academia, stressing the need for urgent reform to uphold high standards of healthcare. She recommended transferring nursing education from hospital boards to tertiary education institutions, shifting from the apprenticeship model to a more structured educational framework within the tertiary sector (Carpenter, 1971).

The recommendations from the Carpenter Report, along with findings from other reports on the state of nursing in New Zealand (New Zealand Board of Health, 1974), were eventually adopted by the government and played a crucial role in shaping nursing education and the future nursing workforce in New Zealand. This transition was widely viewed as a positive step, enhancing both the consistency and quality of nursing education while elevating the

professional status and autonomy of nurses. However, the Carpenter Report is particularly notable for its failure to address the specific needs and perspectives of Māori, including Māori nursing. This oversight reflects the broader context of the time, when Māori were largely excluded from government policy discussions. Unfortunately, the absence of Māori nursing in nursing workforce policies and strategies was to continue for another 25 years.

The 1980s

The 1980s saw the implementation of recommendations from the Carpenter Report and other reports, which shifted the focus of nursing education from hospital wards to polytechnic classrooms. This decade was marked by ongoing reviews and refinements in nursing education and practice. Additionally, it was during this decade that New Zealand began its healthcare reforms, which primarily focused on efficiency and cost-saving through changes in government structures and funding mechanisms (Gage & Hornblow, 2007; Gauld, 2003). While the immediate implications of these reforms were not fully realised until the 1990s, they would have a lasting impact on the nursing workforce (Adams & Carryer, 2021).

1988 Nursing Education in Transition: The Transfer of Nursing to the General System of Education 1973-1988

The *Nursing Education in Transition* report (Department of Health, 1988) provided an in-depth analysis of the shift in the apprenticeship model of nursing education to the tertiary education sector. This transformation, prompted by the recommendations of the Carpenter Report, was largely welcomed by stakeholders, with broad agreement that significant changes in the nursing education system were needed. Despite minor disagreements, the response to the Carpenter Report was overwhelmingly positive, leading to swift action in implementing its recommendations.

The report offers valuable insights into this critical period of transformation. It outlines the historical context, identifies key issues, and evaluates the sustainability of the nursing workforce. Based on estimates of nursing programme intakes at the time (1,200-1,500 students annually across New Zealand), the report projected a sustainable nursing workforce for the near future, even suggesting a potential oversupply of nurses. It also concluded that the transition from hospital-based training to technical institutes was both successful and fiscally neutral.

One significant aspect highlighted by the report was the introduction of nursing workforce data collection by the Department of Health from 1980. However, it is noted that ethnicity data were not collected, making it difficult to determine how many Māori were registered nurses

during this time. The report includes no specific references to Māori nursing, apart from some general stakeholder feedback. This lack of attention to Māori nursing and the absence of detailed ethnicity data points to a broader issue: the report reflects little interest in understanding how this shift in nursing education might have impacted Māori nurses or students.

The Nursing Education in Transition report provides a valuable historical account of the professionalisation of nursing in New Zealand, particularly the transformation from an apprenticeship hospital-based model to an academic tertiary model of training. However, the report's shortcomings, particularly its lack of focus on Māori nursing, highlighted that there was little interest or understanding of the effect the transition might have on Māori.

1988 Unshackling the Hospitals: Report of the Hospital and Related Services Taskforce (Gibbs Report)

In 1987, a Taskforce was established to conduct a 12-month review of the New Zealand hospital system, with a particular focus on the secondary sector and related services (Gibbs et al., 1988). This review coincided with international developments in health economics and health system management, which saw an increasing adoption of neoliberal approaches to healthcare delivery. A key consideration for the Taskforce was the belief of most New Zealanders that a wide range of health services should be available as a right. However, achieving universal health coverage was becoming increasingly difficult to attain for all New Zealanders (Gibbs et al., 1988).

From the 1970s onwards, there was growing recognition that the government could not provide everything for everyone. Successive attempts by various governments to limit health expenditure resulted in a health sector struggling to keep pace with advancements and public expectations. Notably, services were found to be increasingly unsuitable for Māori, Pacific, and other communities (Gibbs et al., 1988).

The Taskforce did not explicitly discuss the advantages or disadvantages of continued universal health coverage, nor did it make recommendations towards targeted healthcare. Instead, it focused on changes to the funding and provision of services. This meant separating the roles of purchaser and provider of taxpayer-funded health services. By 'unshackling' governmental control of health service providers, the Taskforce hoped to create a more dynamic and creative environment (Gibbs et al., 1988).

The report provided the rationale for the national health sector reforms that began in the late 1980s and continued into the early 2000s. This report sets the context for subsequent

developments over the next decade, the effect on nursing leadership, workforce, and their impact on Māori nursing workforce development.

The 1990s

During the health sector reforms of the 1990s, the abandonment and dismantling of organised health workforce planning and development was driven by an ideology that market forces would naturally drive workforce development. However, due to the competitive nature of the new system that discouraged information sharing and cooperation, this logic was eventually found to be flawed as anticipated workforce gains failed to materialise (HWAC, 2003).

Health workforce policy during this period was reflective of the changes occurring within the sector. Attempts to establish consistent workforce governance during the late 1980s was unsuccessful, and decentralisation led to the neglect of health workforce development. Much of the health industry's history and structure were lost as responsibilities were devolved from the now defunct Department of Health to localised workforce planning (Rees, 2019). By the late 1990s, concerns about the health workforce had grown significantly, prompting the Minister of Health to establish the Committee Advising on Professional Education (CAPE) in 1997 to review and advise on these issues (CAPE, 1997), and then later the HWAC whose key focus was to assess the current workforce capacity and needs, also to advise on national goals and make recommendations (Hornblow et al., 2002).

The CAPE (1997) report highlighted that the focus on short-term financial efficiencies had been detrimental to health workforce development. It proposed the establishment of a health education agency, but this recommendation was not implemented. Instead, employers continued to base workforce development on market needs until the mid-2000s (Rees, 2019). These changes had long-lasting impacts on the health sector, including the Māori nursing workforce, by undermining structured planning and development efforts necessary to meet specific community needs.

For the nursing workforce, the health sector reforms were deeply destructive. Nursing leadership, mostly comprised of women, was excluded from key decision-making processes related to the reorganisation of the nursing workforce. These decisions largely made within hierarchies dominated by white male leadership, resulted in the loss of critical nursing expertise and institutional knowledge. The health sector reforms reflect the enduring influence of white male patriarchy, where power was consolidated in managerial and financial structures that devalued the knowledge and leadership of a predominantly female profession. The resulting instability, loss of nursing specific leadership and constant restructuring contributed

to a chaotic and disempowered workforce environment (Carryer et al., 2010; Gibbs et al., 1988; Hornblow et al., 2002). This will be discussed further in Chapter 7.

1998 Ministerial Taskforce on Nursing

The Ministerial Taskforce on Nursing report, published in 1998, marked the first comprehensive review of the nursing profession in New Zealand in over 15 years. This Taskforce was established in response to concerns about barriers that were preventing the nursing profession from realising its full potential within health service delivery. The primary objectives of the Taskforce were to develop strategies to overcome these barriers and recommend ways to enhance the capacity of nurses; thereby improving patient access to health services.

Extensive consultation occurred with individual nurses, the health and disability services sector, key stakeholders, agencies, Māori, and focus groups. The Taskforce identified several barriers to nursing realising its full potential including attitudinal, structural, legislative, and health purchasing obstacles. Its recommendations encompassed access to funding, education, research, management, and leadership; as well as proposals for developing new roles for nursing by expanding scopes of practice and workforce resourcing (Ministerial Taskforce on Nursing, 1998; Wilkinson, 2008).

Emphasis was placed on the implications for the future of nursing if identified barriers limiting the full potential of nursing were not addressed. Strategies for change envisioned a registered nurse workforce that was more "responsive, innovative, effective, efficient and collaborative in the delivery of health care service for all New Zealanders" (Ministerial Taskforce on Nursing, 1998, p. 9).

A unique aspect of this report was the inclusion of Māori perspectives, which had been largely absent from previous reviews of education and workforce issues in the nursing sector. Consultation was held through a series of six hui (meetings) across the country, involving Māori nurses, health providers, and workers. While many issues raised were related to nursing in general, the report acknowledged specific aspects of nursing relevant to Māori and recognised that "many of the issues for Māori nurses involved wider Māori realities" (Ministerial Taskforce on Nursing, 1998, p. 81). These 'realities' were a reference to the ongoing systemic and structural barriers in health and education limiting Māori advancement.

Recommendations from the Māori consultations emphasised meaningful engagement to contribute to Māori health gains, education incorporating Kaupapa Māori, and delivery modes and environments conducive to Māori. They also promoted support for research by Māori

nurses, a culturally responsive healthcare environment addressing inequities, and the encouragement and promotion of Māori nursing leadership.

The Taskforce investigation identified barriers to nursing practice and proposed actionable recommendations to enhance the role and effectiveness of nurses within the healthcare system. Its recommendations led to the establishment of competency-based certification, expanded scopes of practice to include nurse prescribing, and improved access to primary healthcare. The advancements in Nurse Practitioner roles and the development of postgraduate education can be traced back to the Taskforce's efforts. However, despite the report's potential to empower nurses and improve healthcare delivery, it fell short in advancing workforce development for Māori nurses. Many issues raised during hui with Māori communities were acknowledged but not further developed. Consequently, numerous concerns highlighted by Māori participants in the Taskforce report continued to resurface in subsequent reports over the following 25 years.

The 2000s

During the 2000s, the rapid changes the health sector experienced in the 1990s began to slow, revealing a significant oversight. The health workforce was largely ignored in nearly all of the reforms (Rees, 2019). Nursing shortages emerged as a critical issue (Holloway & Baker, 2009; North, 2011), prompting employers to increasingly rely on international recruitment to fill vacancies (Cook, 2009; Zurn & Dumont, 2008). By the early 2000s, a new government moved to recentralise health workforce development, initiating a period of significant review and evaluation of the national health workforce (Rees, 2019). To address these challenges, several advisory committees were established, along with Health Workforce New Zealand (HWNZ), a centralised health workforce agency that evolved from the former Clinical Training Agency Board. HWNZ aimed to develop a sustainable, affordable, and fit-for-purpose healthcare workforce. Although their influence on workforce development was considerable, HWNZ was disestablished in 2018 due to its failure to achieve its primary objectives (Rees, 2019).

In 2003, the *Health Practitioners Competency Assurance* (HPCA) *Act* was introduced, marking a significant legislative shift for health professionals in New Zealand. While it did little to address existing workforce issues, it was instrumental in establishing the Nurse Practitioner role, a key recommendation from the 1998 Ministerial Taskforce on Nursing report. The HPCA Act was beneficial in unifying nursing, midwifery, and allied health professions under a single legislative framework, streamlining regulatory processes. Prior to its introduction, nursing had been operating under the outdated Nurses Act (1977). The HPCA Act modernised the legal

environment in which nurses functioned, allowing for the expansion of advanced practice roles, including Nurse Practitioners.

During this time, the nursing profession worked to reestablish itself following the impacts of health sector reform. A change in government led to a renewed focus on clinical leadership in hospitals and a gradual return of nursing leadership (Carryer et al., 2010). Nursing strategies and reports from this period concentrated on the review and evaluation of nursing education and practice for the future. Additionally, Māori nursing gained increased visibility, as evidenced by the inclusion of Māori perspectives in various strategies and reports.

2001 Strategic Review of Undergraduate Nursing Education

The NCNZ commissioned KPMG to review undergraduate nursing education. Although its overall focus was on nursing education, many recommendations from the review had broader implications for the nursing workforce. The terms of reference outlined the report's aims, which included recommendations to the nursing council about preparing nurses to better meet the health sector needs by the year 2010. The report followed a three-phase approach, beginning with an environmental scan to understand the current state of undergraduate education. The next phase was to define the future nurse and their scope of practice in the year 2010, based on the current and anticipated future profiles. Finally, the report analysed preparation models for comprehensive nurses in the future, including examining competency, undergraduate curriculum standards, and first year of practice and postgraduate education.

The report outlined the projected future healthcare environment for nurses, emphasising the essential skills and attributes required to meet the evolving demands of the profession. A major focus of the report was the educational preparation necessary for future registered nurses, ensuring they are equipped to provide high-quality care.

Additionally, the report addressed the underrepresentation of Māori in the nursing workforce and the need to implement strategies to attract and recruit Māori into the profession. It acknowledged that Māori aspirations to improve the health outcomes of their own people, while important, would not be a sufficient incentive alone to increased Māori participation. The report identified several barriers to recruitment including geographical location, whānau isolation, different learning styles, financial costs, and a lack of adequate support systems. These factors were highlighted as key challenges that needed to be addressed in order to increase Māori recruitment.

This comprehensive report provided 56 detailed recommendations to help the NCNZ prepare nurses to meet the anticipated health sector requirements by 2010. However, none of the

recommendations were specific to Māori nursing. The absence of targeted strategies to improve Māori recruitment and retention in nursing is a significant oversight. Despite the report identifying various factors that hindered Māori recruitment into nursing, no recommendations were made to address these barriers. The report's lack of specific focus on Māori nursing and the evident implementation gaps highlights the inherent disparity that exists in nursing policy and planning.

2007 Rauringa Raupa: Recruitment and Retention of Māori in the Health and Disability Workforce

Building on the foundation set by the *Raranga Tupuake: Māori Health Workforce Development Plan*, the *Rauringa Raupa: Recruitment and Retention of Māori in the Health and Disability Workforce* report was commissioned by the Ministry of Health and the Health Research Council of New Zealand. This comprehensive report investigated factors influencing Māori entry into the health and disability workforce and examined issues of retention. The report identified a range of critical factors impacting Māori workforce development:

- **Barriers to recruitment and retention**: Highlighting obstacles such as systemic racism, financial barriers, and the lack of culturally supportive environments.
- **Facilitators of recruitment and retention**: Identifying strategies such as mentorship, targeted scholarships, and culturally responsive education.
- **A Māori health and disability workforce development pathway**: Mapping out a structured approach to support Māori progression in the sector.
- **Determinants of Māori workforce development**: Examining key influences such as educational access, family support, and systemic policy frameworks.
- **National and international initiatives**: Reviewing mechanisms within New Zealand and strategies from global contexts aimed at increasing Indigenous and minority workforce participation.

While the report used robust qualitative and quantitative research methods—including a literature review, statistical mapping, and key informant interviews—it did not focus specifically on nursing. Nevertheless, its findings on recruitment and retention are directly relevant to the Māori nursing workforce, as the broader systemic issues identified extend to nursing.

The *Rauringa Raupa* report provided a detailed and evidence-based roadmap for addressing recruitment and retention challenges. However, like many workforce development plans before it, the recommendations were not fully implemented. While pathways for workforce development were mapped, they were not operationalised into actionable, measurable steps. As a result, the plan had minimal impact on addressing the underrepresentation of Māori in

the health and disability workforce, including nursing. This highlights a persistent gap between policy formulation and practical execution.

2009 Future Workforce: Report on the Support of Māori and Pacific Nursing and Midwifery Undergraduate Students

A report commissioned by the District Health Boards of New Zealand's (DNBNZ) Workforce Strategy Group aimed to better understand how to support Māori and Pacific nursing and midwifery students in completing their undergraduate courses. The goal of the report was to develop guidelines for good practice (Future Workforce & DHBNZ, 2009).

Two surveys conducted across 12 Schools of Nursing, 3 Schools of Midwifery, and 15 District Health Boards provided valuable insights into the education and clinical experiences of Māori nursing and midwifery students. The findings from these surveys informed the development of "specifications to guide good practice quality improvements and goal setting, intended mainly for Schools of Nursing" (p. 4).

Recommendations were made to nursing schools, the NCNZ, and District Health Boards to address the retention of Māori student nurses. Good practice guidelines emphasised a range of interventions aimed at reducing attrition rates. These included improving the coordination of information between Schools of Nursing regarding effective support services, as well as enhancing data collection and information sharing practices.

The "*Future Workforce*" report made an important contribution by highlighting the need for better support for Māori and Pacific nursing and midwifery students. However, its impact has been limited, most obvious is the lack of focus on resources and funding, leading to an ineffective implementation strategy, and the absence of follow-up and accountability measures. In the 14 years since these guidelines were developed, only 2 of the 13 recommendations made have possibly been implemented. This report is another example of the gap between the evidence, government agency policies, and their actual execution.

2009 Ngā Wawata o Ngā Neehi Māori me Ngā Tapuhi Māori: Māori Engagement Report Responses from Māori Nurses and Midwives Nationally

The Te Rau Matatini report aimed to gain a deeper understanding of the attraction and recruitment of Māori student nurses, as well as the professional development and leadership of Māori nurses and midwives. Feedback was gathered from 313 Māori nurses and midwives using both qualitative and quantitative research methods, including group interviews, online surveys, and informal discussions with key stakeholders.

The research findings highlighted numerous issues faced by Māori student nurses and the Māori nursing workforce. The evidence from the research provided a comprehensive array of solutions to address the challenges in attraction and recruitment, professional development, and leadership of Māori nurses and midwives.

Te Rau Matatini's report is a significant document in the history of Māori nursing research, highlighting critical issues faced by Māori nurses and midwives. Its comprehensive data collection and inclusive methodology provide robust evidence to support the proposed recommendations. However, the limited implementation of these recommendations highlighted the ongoing issue of funding and resources needed to translate these initiatives into tangible improvements for the Māori nursing workforce.

2009 An Education and Training Board for New Zealand (The 'Cook Report')

The Cook Report, commissioned by the Minister of Health, sought to determine whether establishing a formal education and training board would enhance the leadership and responsiveness of nursing education in New Zealand. The Minister wanted to establish that the nursing profession had access to education and development opportunities similar to those available to the medical profession through the medical training board at the time. Meetings were held with nurse leaders, nurse educators, and key stakeholders, and additional statistical contributions were provided by the Tertiary Education Commission, District Health Boards, the Ministry of Health, and Statistics New Zealand.

This comprehensive review considered how better decisions could be made regarding the appropriate number and mix of nurses needed annually, providing a national focus to inform education and training. The report highlighted concerns expressed in previous reviews about the state of the current nursing workforce and projected shortages due to the changing demographics of New Zealand's population and nursing workforce.

Furthermore, the report suggested that to achieve the necessary changes to grow and sustain the nursing workforce, fundamental shifts were needed. These shifts included affirming nursing as a significant career choice for various age groups, understanding and addressing current attrition rates in nursing education and the workforce, examining the service-wide consequences of annual recruitment decisions in undergraduate programmes, ensuring that the growth of the nursing workforce was not restricted by the availability of clinical placements, and enhancing leadership across all age cohorts within nursing.

The report also included a review of the Māori nursing workforce. Notably, it referenced the use of Māori customs in health practices and the need for more Māori nurses to sustain this

approach to improve equitable health outcomes. It acknowledged barriers to Māori access to secondary education of an appropriate standard to enter nursing bachelor degree programmes, highlighting the risk of Māori being directed towards lower-level training due to these barriers. The report stressed that without targeted initiatives to recruit and retain Māori in nursing, the Māori nursing workforce is unlikely to reach parity with the Māori population.

In the section on managing the contribution of overseas-trained nurses in New Zealand, the report stated that the "recruitment of overseas-trained nurses has undoubtedly contributed to lessening the momentum to develop the Māori and Pacific nurse workforce" (Cook, 2009, p. 29).

Three key recommendations were made to the Minister of Health, none of which were implemented. The Cook Report provided valuable insights into the challenges and opportunities in nursing education and workforce development in New Zealand. It highlighted the unique challenges faced by the Māori nursing workforce, emphasising the need for equity and targeted initiatives to support Māori nurses. However, the report's efficacy is limited by the absence of a detailed implementation plan. Despite being endorsed by the Minister of Health, it represented yet another example of a government-endorsed policy that has failed to produce tangible improvements for the Māori nursing workforce.

The 2010s

A decade of stable government contributed to a period of stability across the health sector; however, historical poor planning and a lack of futureproofing in the health workforce were becoming growing concerns. In response, HWNZ was established in 2009 to address these challenges. HWNZ set up various workforce advisory groups, including a specific nursing taskforce, to provide advice and direction on strengthening the nursing profession. Despite these efforts, the nursing sector continued to experience the residual effects of earlier health sector reforms. A significant challenge was the increasing reliance on IQNs to fill vacancies, as the domestic nursing workforce continued to languish.

2013 The Future Nursing Workforce: Supply Projections 2010-2035

The NCNZ commissioned Business and Economic Research Limited (BERL) to conduct a comprehensive analysis of the nursing workforce from 2010 to 2035, using current workforce data and considering potential changes in population size and structure. The report projected that by 2035, New Zealand's population will reach 5.26 million (New Zealand's current population is 5.21 million), resulting in increased demand for healthcare services. This

increased demand was anticipated to stem from an ageing population and the prevalence of lifestyle diseases (Nana et al., 2010).

The report further explained that because of an ageing nursing workforce, over 50% will retire by 2035. This means there will be a need not only to replace retiring nurses but also to expand the nursing workforce to meet the demands of New Zealand's changing demographics and ethnic diversity.

Scenarios were examined using economic modelling to illustrate how decisions made at the time would likely impact the size and makeup of the nursing workforce by 2035. Modelling suggested that the nursing workforce supply would be adequate until 2020, but due to population growth and demographic changes, a shortfall would continue over the following 15 years, predicting a shortage of up to 15,000 nurses by 2035.

Nana et al. (2010) also assumed that New Zealand would continue to fill vacancies with IQNs from 2020 to 2035 but acknowledged that this would likely become increasingly difficult due to international competition for nurses amid a worldwide shortage. Additionally, the report considered the scenario of fewer nurse graduates, recognising the domestic workforce supply is sensitive to changes in education. Any increase in capacity may depend on developing different models of clinical education and increasing investment, with existing constraints on clinical placements for students potentially contributing to nursing shortages.

The report highlighted the need for strategies to increase Māori recruitment into nursing programmes, emphasising that maintaining the status quo will not yield a nursing workforce reflective of the population or capable of meeting the country's future needs. The NCNZ endorsed the report, highlighting the importance of understanding the existing workforce to develop supply indicators that can be "benchmarked against future models" (Nana et al., 2010, p. 5). The Council expressed its commitment to working with the government, educators, and employers to develop the nursing workforce of the future.

This report provided a valuable foundation for understanding the future challenges and opportunities in New Zealand's nursing workforce from 2010-2035. The inclusion of Māori recruitment and representation in the report demonstrated an acknowledgement of the need for a workforce that reflects the population. However, despite highlighting critical issues likely to impact nursing into the future, the report fell short of offering a clear roadmap to address the projected nursing workforce shortfall and lacked specific policy recommendations or interventions.

2015 Health of the Health Workforce: A Report by HWNZ

Comprised of a multi-disciplinary board and operated within the Ministry of Health, HWNZ was established in 2009 with the primary aim of providing strategic leadership to address workforce issues across New Zealand's health sector. Additionally, it managed and distributed post-entry and postgraduate health workforce education funding through Vote Health (The government funder administered by the Ministry of Health).

HWNZ's 2015 annual report detailed the state of New Zealand's health and disability workforce, highlighting progress in various health professions, including nursing. The report included NCNZ statistics, which provided a snapshot of the nursing workforce at that time. HWNZ's nursing priorities were clearly outlined and included the following objectives:

- Educating, recruiting, and retaining sufficient nurses (including Māori and Pacific nurses) to improve health outcomes for a growing and ageing population.
- Training sufficient nurses to replace the ageing nursing workforce as they retire.
- Addressing Te Tiriti o Waitangi obligations.
- Ensuring a workforce that matches population demographics.
- Reducing reliance on IQNs (Ministry of Health, 2016, p. 10).

The report concluded with a call for "legislation, regulation, and employment practices that support nurses in working to the full extent of their scope of practice in safe, healthy environments" (p.10). However, it did not provide specific details on how HWNZ planned to address these priorities. The report also mentioned an increase in the Māori nursing workforce from 3.6% in 2009 to 6.5% in 2015 but failed to analyse the underlying factors contributing to this increase.

While the report outlined the critical priorities and challenges facing the health workforce, it fell short in providing detailed implementation strategies (NZNO, 2018). There is a clear statement of goals, but an absence of concrete action plans or policy recommendations. This report is another example of the gap between government agency policies and their actual implementation.

2017 Nursing Taskforce on Task

Carryer (2017) outlined the work of a nursing taskforce established by HWNZ, comprising representatives from various sectors of the nursing profession. This nursing taskforce included a dedicated working group tasked with executing the programmes and initiatives set by the broader group. In this update, the Chairperson provided valuable insight into the ongoing

efforts and priorities of the HWNZ Nursing Taskforce. Five major issues were outlined to be addressed by the Nursing Taskforce in 2016:

1. Primary health models of care or service delivery
2. Aged care
3. The Māori nursing workforce
4. Nurse practitioners
5. Review of vocational training funding

Each issue included detailed descriptions of the work and progress made. Notably, the section on the Māori nursing workforce outlined the goal of increasing the percentage of the Māori nursing workforce to match the Māori population by 2028. The plan described four levers to achieve this: the establishment of a cross government working group, increased Māori participation in the health workforce through supporting District Health Board planning, ensuring HWNZ funding recipients have action plans for workforce diversity, and biennial Māori nursing workforce tracking reports. In addition to these goals, the nursing taskforce also agreed that more Māori nurse academics were needed to support Māori student retention. HWNZ's annual report to the Minister of Health in 2017 also stated that the nursing taskforce consider progress towards achieving these aims, and "should include strategic discussions to establish partnership and engagement opportunities between iwi, education providers and employers" (Ministry of Health, 2017b, p. 10).

In the following year, the 2018 HWNZ annual report to the Minister of Health provided an update on the nursing taskforce's work. It reiterated that all HWNZ funding recipients must have a workforce action plan in their regional service plans, with a specific focus on the Māori workforce (whereas the previous year's focus was on diversity). This requirement was also included in HWNZ nursing contracts. However, HWNZ was disestablished in 2019, and any further progress on these goals by HWNZ and the nursing taskforce group from 2018 to 2019 remains elusive. While there is evidence that the nursing taskforce through HWNZ attempted to address Māori nursing workforce deficits, they fell short of providing clear, measurable outcomes and a long-term strategic vision.

2019 WAI 2575 Hauora – Health Services and Outcomes Kaupapa Enquiry

The Māori nurses' claim (WAI 2713) was included in the Waitangi Tribunal's hearing of the *WAI 2575 Hauora Health Services and Outcomes Kaupapa Inquiry*. Their submission broadly supported the WAI 2575 claimants' assertion that the "persistence of Māori health inequities is evidence of insufficient Crown action" (Waitangi Tribunal, 2019, p. 14). The Māori nurses emphasised that "building a sustainable and properly paid Māori nursing and health workforce

is essential to addressing inequities and disparities in Māori health" (Waitangi Tribunal, 2019, p. 14). They highlighted that institutional racism was inherent within the health sector and detrimental to both Māori patients and Māori nurses. Additionally, their recommendations related to pay parity and cultural competency of mainstream health staff (Waitangi Tribunal, 2019).

A critical issue raised in the report is the underrepresentation of Māori within the nursing workforce. Data presented in the report revealed that the proportion of Māori nurses has remained relatively static over an extended period. For example, from 2005 to 2018 the representation of Māori in the nursing workforce increased marginally from 7.5% to 7.6% (Ministry of Health, 2019a). These statistics provided proof of a lack of effective strategies to recruit and retain Māori nurses.

The Waitangi Tribunal's 2019 report on the Hauora enquiry offered a comprehensive overview of the challenges faced by Māori in the health sector. It highlighted persistent health inequities, the underrepresentation of Māori nurses, and pervasive institutional racism. The recommendations provided by the Tribunal outlined a pathway toward a more equitable and effective health system that aligned with Te Tiriti o Waitangi and aimed to improve health outcomes for Māori. Implementing these recommendations would require a bipartisan approach, a commitment to systemic change, and a genuine partnership between the Crown and Māori communities. Whether these recommendations will be fulfilled remains to be seen.

The 2020s (Pre-pandemic)

2020 heralded in the Year of the Nurse, as acknowledged by the release of a report by the WHO (2020) on the state of the international nursing workforce. It highlighted that the world was now entering into an international nursing workforce crisis, calculating a shortfall of up to 5.9 million nurses globally. The report attempted to impress on countries who are over reliant on international nurses to seriously consider investing in their domestic workforce. Before this report had been fully contemplated by nursing in New Zealand, the COVID-19 pandemic was underway.

The early 2020s was focused on the pandemic response. During the response the New Zealand nursing workforce managed to cope; only due to the well managed and coordinated efforts of the government and the willingness of the New Zealand public to cooperate. When comparing to the pandemic experiences of nurses in other countries, the worst-case scenario would have been devastating for the New Zealand nursing workforce. Amid the pandemic response, two key reports with implications for Māori nursing workforce development were released.

2020 Closing the Gaps in the New Zealand Nursing Workforce

This concept paper, developed by the Director of Nursing (DON) Group for New Zealand District Health Boards, began by acknowledging that workforce pressures are expected to worsen in the next 5-10 years. It examined current and future challenges for the nursing workforce, presenting a case for change in the coordination of the undergraduate nursing workforce pipeline. Amid regulatory and organisational pressures and expectations, DONs experienced a sense of "urgency about the development and implementation of coherent nursing workforce planning and policy" (NZDHB, 2020, p. 2). This highlighted the need for a whole-of-systems approach to the undergraduate pipeline, with coordinated and collaborative leadership across government, education, and industry.

Notably, the group endorsed the Cook Report (2009), stating that despite the passage of 11 years, the issues it identified had not only persisted but had worsened, making the situation critical. The DONs supported the following recommendations:

- The establishment of a National Nurse Education and Training Board.
- A dedicated focus on achieving Māori and Pacific health equity through nursing workforce development via the undergraduate pipeline. (NZDHB, 2020).

The report continued by identifying gaps, starting with an understanding of the pipeline. It explained that the sector often lacked a clear view of the workforce, including the number of students and their locations. This was particularly relevant for ensuring the workforce met the local needs of the community it served, such as Māori and Pacific nurses.

The report outlined the hope for the effective planning and oversight of the undergraduate nursing pipeline through the formation of a National Nursing Education and Training Board. The proposed board's role would include:

- The ability to match demand with health need.
- Tiriti based response to Māori health inequity, including through effective workforce development planning.
- All workforce planning driven by robust data and modelling.
- The development of a national undergraduate nursing training workforce plan, which remains a living document.
- Applying the principles and practice of commissioning to the pipeline for undergraduate students.

Progress to date is described as conversations with the NZNO, the Ministry of Health's workforce Directorate, and lead District Health Board DONs to further explore the establishment of a Nurse Education and Training Board.

The “Closing the Gaps in the New Zealand Nursing Workforce” concept paper recognised the challenges facing the nursing workforce and proposed recommendations to address these issues. While initial progress had been made through stakeholder conversations, any further progress appears not to translate into tangible improvements in the New Zealand nursing workforce, particularly for the Māori nursing workforce.

Health and Disability System Review 2020

The *Health and Disability System Review* aimed to assess and propose changes to improve the health and disability system, focusing on achieving better and more equitable health outcomes for all New Zealanders. It included recommendations to enhance workforce planning, training, and support to meet future healthcare demands. Among the recommendations was the development of a 10–15-year Māori health workforce plan with associated funding, as well as a comprehensive list of measures to develop and grow the health workforce.

The recommendations attempted to transform New Zealand’s health system into one that was more equitable, accessible, and sustainable, with a strong emphasis on addressing historical inequities and improving overall health outcomes. Unfortunately, just as many of the reviews recommendations were being implemented, a change in government led to the disestablishment of many proposed systems and mechanisms, resulting in uncertainty about future workforce planning. Once again, efforts to address health workforce disparities for Māori was hindered by a change in government and therefore a change in priorities.

The 2020’s (Post-pandemic)

Once restrictions were lifted and borders reopened, there was a refocus on a radical restructuring of the health system, particularly in response to the Pae Ora (Healthy Futures) Act 2022. The Pae Ora Act (2022) was a government response to the findings from the *WAI 2575 Hauora Health Services and Outcomes Kaupapa Inquiry* and the *Health and Disability System Review 2020***.** Through the implementation of the Pae Ora Act 2022, the health sector again headed into another period of restructure beginning with the establishment of Te Whatu Ora Health New Zealand, a national collective of health services. Additionally, Te Aka Whai Ora – the Māori Health Authority was formed, a statutory entity responsible for ensuring the New Zealand health system met the needs of Māori. A Health Workforce taskforce was also established in 2022 “to enable a whole-of-system view, making recommendations for the removal of barriers to achieve an agile, responsive, inclusive workforce that is underpinned by Te Tiriti o Waitangi, the Pae Ora Act and equitable outcomes” (Te Whatu Ora, 2023 p. 1). The primary focus of the taskforce was the development of a health workforce plan. In 2023, a new

coalition government was formed following the election, leading to the suspension of all prior health restructuring initiatives, including the creation of a Māori Health Authority.

Health Workforce Plan 2023-24

The Health Workforce Plan 2023-24 began by presenting a 'case for change', noting that over the decades, the workforce has not been adequately supported. Despite growth in the sector, there still existed 'material gaps' and a workforce 'under strain'. The plan cited several causes for these gaps, including "poor workforce data, an inability for the health system to articulate its workforce needs, systemic underinvestment resulting from poor data, the relative fragmentation of the former DHBs, and global workforce shortages" (Te Whatu Ora Health New Zealand, 2023, p. 5). At that time, the health system faced a workforce deficit of approximately 4,800 nurses.

A funded workforce plan identified six key action areas to bolster the workforce over the next 12-months. One of the key actions included "growing the pathways for Māori in health" (Te Whatu Ora- Health New Zealand, 2023, p. 10). The plan aims to achieve this action by:

- "Streamlining pathways for tauira (students) Māori into health careers, including investing in Māori retention, and growing programmes that already support Māori students into health.
- Strengthen hauora (health) Māori workforce pathways from whānau, hapū, and iwi including by scaling earn-while-you-learn pathways for Māori into health roles.
- Support for kaimahi (workers) Māori to thrive in the workplace, including by expanding cultural and clinical support and coaching for our Māori workforce" (Te Whatu Ora Health New Zealand, 2023, p. 10).

The plan provides extensive information on closing the workforce gap through training, investing, retaining, finding new ways of working, and regulating, each accompanied by a series of recommendations for implementation. The *Health Workforce Plan 2023-24* is a visionary and forward-thinking document. However, it has yet to achieve its aims.

The new coalition government elected in 2023 disestablished Te Aka Whai Ora – the Māori Health Authority in their first 100 days in office. While the Health Workforce Plan was finalised under the previous government, it remains unclear whether its recommendations will be implemented. Recent media reports indicate that the current government is likely to disregard the health workforce planning efforts of its predecessor (Labour Voice, 2024; Radio New Zealand, 2024b). These changes by the new government sees more uncertainty for the nursing workforce and will likely hinder progress toward growing the Māori nursing workforce.

Conclusion

This chapter has critically examined a range of government-commissioned reports, policies, and strategies related to the Māori nursing workforce from 1970 to 2023. While the reports from the 1990's onward, consistently highlight the importance of addressing the underrepresentation of Māori nurses, a recurring theme emerges: systemic barriers, lack of accountability, and inconsistent implementation of policies have hindered meaningful progress.

The review demonstrates that despite decades of policy recommendations aimed at increasing Māori participation in the nursing workforce the outcomes have fallen short. From the Ministerial Taskforce in 1998 to the recent Health Workforce Plan 2023-24, these documents reveal a pattern of acknowledging the issues without translating them into sustained action. This lack of follow-through highlights systemic inertia and a failure to prioritise equitable workforce development for Māori nursing.

Key barriers identified include the ongoing influence of Eurocentric structures in workforce planning, inadequate investment in Māori nursing initiatives, and the limited integration of Māori perspectives into decision-making processes. Additionally, the reliance on IQNs to address workforce shortages has further diluted efforts to build a robust domestic workforce that reflects New Zealand's demographic makeup.

The chapter underscores the vulnerability of Māori-focused initiatives to political shifts, as demonstrated by the disestablishment of the Māori Health Authority in 2023. Such events reveal the fragility of progress, which remains contingent on shifting political priorities. This recurring 'on-again, off-again' cycle fosters a persistent pattern of hope followed by disappointment, leaving Māori in a state of perpetual uncertainty and undermining efforts toward sustained and meaningful change.

The findings from this review provide critical context for understanding the static state of the Māori nursing workforce. These insights will be explored further in the discussion and interpretation chapters, where persistent challenges and potential strategies for growth will be examined. By drawing attention to the gaps between policy and practice, this research aims to contribute to a broader conversation about equity, accountability, and the future of the Māori nursing workforce.

Chapter 7: Discussion of Findings–Explanation Building

As previously explained in the methodology chapter, this research is an explanatory case study that seeks to find explanations for why the Māori nursing workforce has remained static for 40 years. Yin (2017) stated that explanation building involves systematically analysing the data and comparing to theoretically significant propositions. The process requires a consistent focus on the original research question and purpose of the inquiry. A process employed to generate further theoretical insights.

Propositions for this study include: *Policy outcomes have enabled equitable access for Māori into nursing programmes; Nursing and health leadership have adequately planned for the future of New Zealand's nursing workforce*; *Nursing has been effectively marketed as a viable career option to Māori; Māori new graduate nurses are provided appropriate support in their first year of practice;* and *Systemic racism significantly contributes to the static state of the Māori nursing workforce.*

These propositions have provided a clear framework for the research, shaping its direction and focus while establishing a foundation for linking data to the central research question. This chapter begins the process of analysing findings from the three sub-units of analysis, systematically linking identified themes and aligning them with current literature, to generate insights that build an explanation. By revisiting key themes identified in the findings chapter, this chapter lays the groundwork for a more integrated understanding of the issues impacting the Māori nursing workforce.

Each unit of analysis is discussed separately, with evidence gradually compiled to support the explanation-building process. Revisiting the perspectives of student nurses, this chapter examines *navigating challenges* and *coping with racism and isolation.* For registered nurses, it explores *assimilation and expectations* and *feeling the demands.* Key stakeholder insights are addressed through *the realities for Māori nursing* and *endemic racism within the nursing profession.* Additionally, the themes of *political indifference* and *speaking into the wind* identified from the grey literature review are critically discussed.

Each section contributes to a narrative that deepens the level of inquiry and enhances understanding of the systemic and interpersonal challenges faced by the Māori nursing workforce. This approach aligns with Yin's (2017) emphasis on the value of narrative construction in advancing explanation building within case study research. Finally, Chapter 8 builds upon this foundation, identifying key interpretations derived from the synthesis of data across the entire case study.

Findings from Student Nurses and Registered Nurses

Navigating the Challenges

The findings from participant interviews with Māori registered nurses and students reinforced previous research findings outlined in Chapter 2: Literature review, highlighting the significant challenges faced by the Māori nursing workforce in New Zealand. Among these challenges, financial hardship emerged as the most substantial barrier, impacting both recruitment into nursing programmes and retention throughout their studies.

Former research reinforced these findings, highlighting the pervasive nature of financial difficulties for Māori nursing students. Wilson et al. (2011) found that 75% of Māori nursing students surveyed experienced financial hardship, which also affected their whānau, with 88% of participants reporting that continuing in their degree was a significant challenge. Similarly, Foxall (2013) identified financial hardship as a critical barrier for Māori nursing students due to course-related costs as well as the need to meet family and cultural obligations. Baker (2009) emphasised that Māori nursing students, particularly those living in rural areas, required financial support to successfully complete their studies. Gray (2020) further determined that financial hardship was a constant struggle for Māori students, exacerbated by course costs, the care of dependents, and other financial commitments.

Many participants believed that scholarships are not a realistic means to alleviate financial hardship for Māori students. Many students are either unaware of available scholarships or discouraged by the complicated application process. Iwi (tribal) scholarships are often assumed to be available to all Māori, but this is not necessarily the case. Some Iwi do not have the financial means to provide scholarships to its beneficiaries. Those that do may have expectations that recipients regularly return to their marae (traditional meeting house) for hui (meetings), which can be challenging for students due to their marae often being some distance from their home, work, and whānau commitments. For some students, there is a sense of whakamā (embarrassment) as they have no knowledge of their whakapapa or marae, meaning that iwi scholarships were not accessible to them.

Older participants found the financial burden more challenging. Changes in eligibility criteria for those over 40-yeras, have limited their access to student allowances, exacerbating economic hardships for those entering nursing later in life (Ministry of Social Development, 2024). Many mature students, often enter nursing through academic preparation programmes which adds a further 3-6 months to their education. As a result, their financial burden is extended due to the additional time required to complete their degrees. This extended period

of study, coupled with the need to work to remain on the programme and support their families while studying, increases their burden.

Curtis, Wikaire et al. (2012) highlighted that Indigenous students face significant challenges in participating in and excelling in health education programmes. The high costs associated with a 3-year nursing programme, coupled with an already high cost of living, make the prospect of entering and completing a nursing degree daunting. Despite a strong desire among many Māori to pursue nursing—often driven by a commitment to the well-being of their whānau, hapū, and iwi—financial realities frequently override these aspirations (Barton & Wilson, 2019; Chittick et al., 2019; Gray, 2020).

Colonisation in New Zealand, despite the promises of Te Tiriti o Waitangi, resulted in the loss of Māori sovereignty over land and resources, leading to socio-economic disenfranchisement and the intergenerational transfer of disadvantage (Durie, 2001; Loring et al., 2022). This legacy has entrenched disparities across determinants of health and education, including higher rates of poverty and systemic inequities affecting Māori (Poata-Smith, 2013; Reid et al., 2019). The effects of colonial processes continue to hinder Māori advancement, particularly in accessing tertiary education (Berryman et al., 2023).

Historically, New Zealand's education system has not been responsive to Māori educational needs, particularly at the primary and secondary levels, where Māori students experience low academic success, low engagement, and high attrition rates (Berryman et al., 2023; Zambas et al., 2020). This often results in Māori students lacking the necessary qualifications to directly enter tertiary education. For those hoping to pursue nursing, this means attending academic preparation programmes and needing to acquire NCEA level maths and science as pre-entry requirements (Curtis, Wikaire, Kool et al., 2015; Wikaire et al., 2016; Zambas et al., 2020). These requirements can add 6 to 12 months to the already lengthy and costly nursing degree programme. This extended timeline and additional cost widen the disparity between Māori and non-Māori nursing students (Curtis et al., 2017).

Participants believed that existing marketing approaches present a significant obstacle to attracting and recruiting Māori into nursing (Theodore et al., 2017). Existing marketing drives tend to be Eurocentric, catering for the non-Māori market. Participants suggest that Māori marketing requires focussing on Māori forms of engagement, preferring word of mouth via the whānau kumara vine or through Māori networks and mediums. Poor marketing and a lack of information about nursing in secondary schools limited opportunities for Māori to prepare for

entry into nursing academically, which has significant implications for recruitment (Curtis, Wikaire, Kool et al., 2015; Wikaire et al., 2016).

Participants explained that upon entering a nursing programme, Māori students encounter nursing education heavily biased towards Eurocentric theories, models, and practices. Subjects relevant to Māori are often siloed and rarely integrated across programmes. The dominance of Eurocentric approaches to education and practice often conflicts with the values, beliefs, knowledge, and practices of Māori students and nurses (Baker, 2009; Barton & Wilson 2021; Chalmers, 2020; Foxall, 2013; Wilson et al., 2011). Dedicated Māori nursing programmes are currently only available in three locations, all situated in the North Island. This limited accessibility means that most Māori students do not have the opportunity to engage in a programme that is inclusive of mātauranga Māori and reflects them. Addressing these financial, academic, and cultural challenges is crucial to improving the recruitment and retention of Māori in nursing education.

Coping with Racism and Isolation

According to participants, Māori students and nurses frequently encounter discrimination, bias, and a lack of understanding or respect for their culture. These experiences culminate in feeling unsafe, self-doubt, and uncertainty about who to turn to for support and help. Participants reported fear of being penalised or ostracised by tutors or preceptors if they reported their experiences or observations of racism. Consequently, it is likely that students do not report their concerns, adding to the pressure and stress they feel. Unfortunately, this initial exposure to overt and covert racism as students is a forerunner to what they will encounter as registered nurses (this will be discussed later in the chapter) (Hunter & Cook 2020a; Huria et al., 2014; Wilson, Barton et al., 2022).

Adequate and appropriate pastoral care is a protective factor for Māori students in undergraduate nursing programmes (Curtis, Wikaire, Kool et al., 2015; Zambas et al., 2020). However, faculty and Heads of Schools do not recognise or fully understand its value as a protective factor (Barton & Wilson, 2021). Culturally appropriate support is often difficult to access or unavailable in many nursing schools, with limited access to Māori nurse educators or Māori support services (McAllister et al., 2019). Participants understood and acknowledged the low representation of Māori nurse educators in nursing education. These educators serve as a positive role model and share an understanding of the challenges of being Māori in a Eurocentric educational and clinical environment, often providing significant support and the cultural safety advocated within nursing education but rarely seen in practice in the classroom (Wilson & Barton, 2021; Wilson et al, 2011).

In summary, Māori nursing students frequently encounter bias, discrimination, and racism, leading to feelings of isolation, self-doubt, and fear of reporting their experiences due to potential repercussions. Adequate pastoral care and cultural support are protective factors for Māori students in nursing programmes. However, many schools of nursing lack sufficient access to Māori nurse educators or support services and their importance is often not appreciated by faculty and Heads of School. Māori nurse educators play a crucial role by serving as positive role models and providing kawa whakaruruhau (cultural safety in the Māori context), which is essential for students navigating a predominantly Eurocentric educational and clinical environment.

Registered Nurses

Assimilation and Expectations

Māori registered nurses encounter significant racism and discrimination within the nursing profession and the broader healthcare system, both from colleagues and patients (Hunter & Cook, 2020a; Huria et al., 2014; Nuku, 2015a; Walker, Heneghan et al., 2016). Participants were acutely aware of the differential access to healthcare affecting their whānau, hapū, and iwi. This creates inner turmoil as they are forced to choose between complying with a system that supports and reinforces racism or following their own values and beliefs, risking repercussion (Giddings, 2005; Wilson & Baker, 2012).

The dilemma often leads Māori nurses to either assimilate or risk marginalisation. Marginalisation manifests in various forms including exclusion, bullying, microaggressions, and bias, limiting career advancement opportunities and fostering self-doubt about their professional abilities. Isolation is common, particularly for nurses working with few other Māori colleagues. Eventually, the cumulative pressures can affect their confidence and mental health, leading to burnout or even a decision to leave the profession (Hunter & Cook, 2020a; Huria et al., 2014; Minton et al., 2018; Wilson, Barton et al., 2022)

Participants described their experiences of dual competence, acting as kaitiaki (guardians) for Māori patients and whānau, while being a cultural resource for non-Māori colleagues. These dual expectations place and additional workload burden on Māori nurses and is often undervalued and misunderstood by their peers (Haar & Martin, 2022; Huria et al., 2014; Hunter & Cook, 2020a; Komene et al., 2023; Wiapo et al., 2024; Wilson & Baker, 2012; Wilson, Barton et al., 2022).

The dual expectation frequently leads to inner conflict as Māori nurses struggle to balance their personal and professional values with the demands of a system that often fails to

recognise and support their cultural competence. The pressure to meet these expectations, combined with the limited availability of culturally relevant professional development opportunities, creates a challenging work environment. The additional stress of postgraduate study for new graduate nurses, only compounds the pressures they face (Wilkinson & Gray, 2021).

Feeling the Demands

Considering the pressures and expectations of dual competence, the stress of working in environments where racism is observed or experienced regularly, the lack of adequate support, and the additional burden of ongoing education, it is of little wonder that Māori nurses may experience high rates of burnout. Many nurses expressed frustration with accessing suitable support, particularly in areas where they care for a high number of clinically complex Māori patients. Komene et al. (2023) highlighted that the extra responsibilities tied to cultural loading place a significant burden on Māori nurses, often compromising their cultural integrity (Barton & Wilson, 2021; Hunter & Cook, 2020a; Huria e al., 2014; Walker, Heneghan et al., 2016; Wilson & Baker, 2012).

Intersectionality plays a crucial role in shaping the experiences of Māori nurses and students, who must navigate multiple overlapping systems of discrimination and disadvantage. For Māori nurses, their professional identity is linked with their ethnicity, sexuality, culture, gender, and socio-economic background. These intersecting identities create significant challenges in mainstream healthcare settings, where they often face unsafe work environments dominated by Eurocentric perspectives and western biomedical practices and values (Barton & Wilson, 2021; Hunter & Cook, 2020a; Huria et al., 2014). The lack of representation and support can discourage Māori nurses from pursuing leadership roles or further education, perpetuating a cycle of underrepresentation at higher levels within the healthcare profession (Giddings, 2005).

Māori nurses face significant pressures due to the expectations of dual competence, along with the challenges of working in environments where racism is prevalent. The lack of adequate support, adds to their stress, often leading to burnout. The responsibilities tied to additional cultural expectations within their roles, largely go unrecognised and unregulated, further exacerbating their workload. Intersectionality also plays a critical role in shaping their experiences, as Māori nurses must navigate overlapping systems of discrimination based on race, culture, and socio-economic background. The pressure to conform to the dominant nursing culture leads to emotional and psychological stress, increasing the risk of burnout and dissatisfaction with nursing.

Summary

Thus far, this chapter has explored the multifaceted challenges faced by Māori nursing students and registered nurses within New Zealand's education and healthcare systems. Much of the findings drawn from their experiences have been identified in previous research studies. However, key themes emerged that reinforce the barriers to recruitment, retention of Māori nursing students, and professional satisfaction for Māori nurses.

Economic hardship remains a significant obstacle, with high costs associated with undertaking nursing education, limited financial support, and additional pressures from whānau responsibilities. The lack of visible and relatable Māori role models within nursing further compounds the challenge of recruitment. Eurocentric curricula and environments often leave Māori students feeling isolated and unsupported, particularly in the absence of sufficient Māori nurse educators or support staff.

Registered nurses face ongoing challenges tied to cultural expectations and systemic inequities. The additional responsibility of providing culturally competent care, often without acknowledgment or support, adds to their workload. Many participants described the emotional toll of navigating environments rife with racism and microaggressions, which can lead to burnout and, in some cases, attrition from the profession.

The findings highlight the complex and intersecting barriers that have hindered the growth of the Māori nursing workforce. These challenges are deeply rooted in historical, cultural, and systemic inequities that continue to affect Māori nurses and students, shaping their experiences within the education and healthcare sectors.

Key Stakeholder Discussion

A Lack of Political Will

Key stakeholders identified a lack of political will as the most significant barrier to the development of the Māori nursing workforce and the nursing workforce as a whole. This lack of political commitment to the nursing workforce was evident through several mechanisms, including the government's reluctance to follow the advice and recommendations put forth by nursing leadership, minimal engagement with evidence based nursing strategies and planning documents, and the resistance of government agencies such as HWNZ and the Māori Directorate to address nursing workforce deficits through targeted funding (Cook, 2009; Future Workforce & DHBNZ, 2009; KPMG, 2001; Ministerial Taskforce on Nursing, 1998; Ministry of Health, 2020b; Ratima et al., 2007; Te Rau Matatini, 2015).

Participants identified two key factors driving the government's underinvestment in the nursing workforce. First, an ongoing reliance on IQNs to address workforce shortages. Second, a preferential bias towards investing in medicine.

The recentralisation of health workforce development during the latter stages of the health sector reforms of the 1990s made it clear that New Zealand was facing a nursing workforce shortage (CAPE, 1997; Holloway & Baker, 2009; HWAC, 2003). It was during this period the IQNs workforce began to increase. Since that time, the IQNs workforce has increased to the extent that they now represent 47% of the total nursing workforce; a figure that ranks as the second highest among OECD countries (NCNZ, 2025; OECD, 2023). The increase in IQNs highlights the successive government's ongoing reliance on this workforce, which requires minimal investment beyond adjustments to immigration policies (Brownie & Broman, 2024; Chalmers, 2020; Cook, 2009; Head, 2014; NZNO, 2018). This will be discussed further in Chapter 8.

Additionally, participants noted that lobbying by the medical profession has allowed them to have a disproportionate influence on political decision-makers (Adams, 2021; Adams & Carryer, 2021). This perspective is reinforced by evidence that highlights the considerable disparity in investment between the nursing and medical workforces (Adams, 2021; Adams & Carryer, 2021; College of Nurses Aotearoa New Zealand, 2019; NZNO, 2018). Despite nursing representing the largest regulated workforce in New Zealand, it consistently receives less financial and strategic support compared to the medical workforce. This disparity will be analysed further in Chapter 8.

The political and regulatory rhetoric surrounding efforts to increase the Māori nursing workforce only added to participants' frustration as it has failed to translate into meaningful action (Ministry of Health, 2016; Nana et al., 2013). Participants were acutely aware of this enduring political apathy, attributing the lack of political will and investment in nursing, particularly Māori nursing, as the most significant factor contributing to the current static state of the Māori nursing workforce and the overall state of the domestic nursing workforce in New Zealand.

The persistent lack of political will is a significant barrier to the development of both the Māori nursing workforce and the broader nursing workforce in New Zealand. Despite clear evidence and recommendations from nursing leadership, the government has been reluctant to make meaningful investment, instead relying heavily on IQNs. This approach, coupled with a preferential bias toward the medical profession, has resulted in significant underinvestment in nursing, particularly in efforts to increase the Māori nursing workforce.

Protecting the Status Quo

Participants identified numerous systemic issues that extend beyond a lack of political will, including deficits in nursing governance, leadership, and accountability, alongside the absence of a cohesive national nursing workforce strategy. These challenges are further compounded by divisions within the nursing profession and the ambiguous leadership role of the NCNZ. Many participants linked ineffective nursing leadership to a lack of unity within the profession, hindering the profession's ability to garner effective political influence (Adams, 2021; Longmore, 2024; Wilkinson, 2008).

A recurring concern was the inadequate advocacy for Māori nurses within the broader nursing leadership, which was perceived as intent on maintaining the status quo (Wilson, Barton et al., 2022). This lack of advocacy has contributed to the ongoing static state of the Māori nursing workforce and limitations on leadership roles (Chalmers, 2020; Brockie et al., 2023). Participants expressed dissatisfaction with nursing leadership, describing them as ineffective in driving change or influencing decision-making.

Additionally, participants described instances where the Nursing Council intentionally fostered divisions within Māori nursing, reinforcing the perception that Māori nursing was fragmented and unable to collaborate effectively. This undermined Māori nurses, further marginalising their voices. Despite Māori nurses' reliance on the Nursing Council and broader nursing leadership to advocate for their needs, participants believed these groups were more interested in protecting the status quo.

Efforts to secure equitable representation for Māori nurses on the Nursing Council board illustrate this resistance to change. While recent achievements, such as 50% Māori representation on the board, mark progress, participants noted that these gains were hard-won through sustained advocacy and remain tenuous. The absence of Ministry-appointed positions to secure Māori representation highlights the limited commitment to Te Tiriti o Waitangi and equitable governance (NCNZ, 2024d).

For over 4-decades, Māori nurse leaders have called for the nursing profession to honour Te Tiriti o Waitangi through equitable power-sharing and collaboration (Ramsden, 1990; RPIEN National Action Group, 1991; Wilson, Barton et al., 2022). Yet, Māori nursing's influence has remained constrained. Although recent years have seen Māori nurses in some national leadership roles, the locus of power within nursing remain predominantly with Pākehā.

The systemic protection of the status quo within nursing governance and leadership continues to hinder the growth and representation of the Māori nursing workforce. Divisions within the

profession, coupled with the Nursing Council's ambiguous role and insufficient commitment to equitable change, have further marginalised Māori voices. While strides have been made to increase Māori representation on the NCNZ, these advances remain fragile, reflecting an ongoing reluctance to fully embrace the transformative changes needed to address structural inequities.

Divisions in Nursing

Participants expressed frustration over the divisions within New Zealand's nursing profession, which they believed negatively affect public perception, dilute political influence, and create confusion over who represents the voice of nursing (Adams, 2021; Wilkinson, 2008). These divisions were seen as a barrier to achieving the collective strength needed to address pressing workforce issues and advocate for meaningful change.

The nursing profession in New Zealand is represented by various groups, including professional associations, academic organisations, practice-specific bodies, and unions. While these groups provide expertise to inform nursing practice, their fragmented and siloed nature often prevents collaboration and limits their influence. The lack of a unified approach has made it challenging to establish a cohesive national representative body capable of driving strategic direction and policy advocacy (Adams, 2021; Cook, 2009).

Efforts to overcome the divisions of the past within Māori nursing are currently being addressed, with Māori nursing leadership working to unify groups and work collaboratively to address the significant issues facing the Māori nursing workforce now and into the future. At the national level, the National Nursing Leaders group has attempted to bridge divisions among nursing groups. Despite these efforts, participants noted the continued absence of unity, strong leadership, and strategic direction across the nursing workforce. In this vacuum, the Nursing Council has assumed the de facto role of representing the profession. However, participants saw this as problematic, given the Council's primary regulatory mandate and its perceived lack of advocacy for workforce development.

The persistent divisions within New Zealand's nursing profession reflect broader challenges in governance, leadership, and collaboration. For Māori nursing, these divisions compound existing inequities, making it difficult to address systemic barriers and support workforce growth effectively. Recent efforts toward unifying Māori nursing leadership provide a model for collaboration, but the lack of collective strategic direction across the profession remains a significant obstacle. This fragmentation highlights the systemic barriers that have hindered progress for Māori nurses, reinforcing the need for more inclusive and cohesive workforce strategies to ensure equitable representation and development.

The Gatekeepers

The introduction of kawa whakaruruhau-cultural safety education in the 1980s marked a significant shift in New Zealand's nursing education. Kawa whakaruruhau-cultural safety was primarily developed as a means to address the power in the nurse-patient relationship and attitudinal change of nurses when caring for Māori. Kawa whakaruruhau was also considered a reciprocal obligation of accountability and responsibility within the context of Te Tiriti o Waitangi (Ramsden, 1990). It aimed to enhance the quality of care provided to Māori and, subsequently, challenge the dominance of Eurocentric discourse within nursing education.

The introduction of cultural safety was not without controversy. In 1993, the 'Anna Penn incident', as referred to by a participant, occurred when a student nurse publicly criticised the inclusion of cultural safety in nursing education. Her complaint was sensationalised in the media, ultimately leading to a government inquiry into nursing education (Ramsden & Spoonley, 1993). Despite the controversy, cultural safety education has remained a part of the nursing curriculum. However, participants believe that the momentum gained for Māori representation in nursing education at the time has never fully recovered. Furthermore, even after more than 30 years of cultural safety education, there has been little progress in improving Māori health outcomes. Māori still face differential access to healthcare and continue to experience racism within the healthcare sector. (Barton, 2018; Came & Kidd, 2019; Ministry of Health, 2020b, 2015; Reid et al., 2019; Waitangi Tribunal, 2019). Hunter and Cook (2020b) highlighted that there is still a need to embed cultural safety as an "ethic of care into everyday practices of all nurses when working with Māori" (p. 18).

Participants highlighted the issue of 'gatekeeping' within nursing education, particularly concerning the underrepresentation of Māori within the profession. A key concern was the recruitment and retention of Māori nurse educators, which some participants saw as indicative of a broader reluctance to support the growth and development of Māori nurse educators and Māori nurse leaders in education (Barton & Wilson, 2021).

As previously discussed, Māori nurse educators play a vital role as role models and are seen as protective factors for Māori nursing students. However, Māori nurse educators often face additional workload pressures due to their dual competence; with expectations to provide academic and cultural support to students and colleagues (Haar & Martin, 2022; Huria et al., 2014; Hunter& Cook, 2020a; Wiapo et al., 2024; Wilson, Barton et al., 2022; Wilson & Baker, 2012). Despite their importance, Māori nurse educators in undergraduate programmes currently comprise only about 3-4% of the total nurse educator population (NCNZ, 2023). This underrepresentation limits the availability of culturally competent academic support and

pastoral care for Māori students and perpetuates the challenges of recruitment and retention in Māori nursing.

Registered nurse and student nurse participants highlighted the dominance of the Eurocentric curriculum, which key stakeholder participants viewed as another form of gatekeeping within nursing education. The failure to meaningfully integrate Indigenous perspective into nursing education reinforces marginalisation and devalues Indigenous knowledge, further demonstrating nursing leaderships commitment to preserving the status quo.

Another key issue considered by participants as gatekeeping was the lack of ethnicity data collected by Schools of Nursing. Access to robust data on the recruitment and retention of Māori nursing students has been challenging (Brownie & Broman, 2024). Currently, there is no comprehensive national information on the interventions used by nursing schools to attract, recruit, and retain Māori students, nor is there a standardised process to maintain data on attrition rates (Ngā Manukura ō Āpōpō, 2014).

Recent evidence indicates that Māori students face disproportionately higher attrition rates in nursing programmes. However, the reliability of this data is questionable, as it is collected at a national level and often overlooks nuanced insights that are more apparent at a local level. Furthermore, there is a lack of comprehensive information about which retention strategies have been successful or where improvements are needed (Technical Advisory Services, 2021; Te Tāhū Hauora Health Quality & Safety Commission, 2024). Cook (2009) argued that evaluating attrition rates and variations across schools of nursing would help identify effective practices that could be implemented and supported on a national scale. Attempts to gather data regarding attrition rates among Māori nursing students have led to inconsistencies and reports of discrepancies with the integrity of the data (Brownie & Broman, 2024).

Ratima et al. (2007) stated that there is a pressing need to strengthen Māori health workforce research to inform decision-making and actions. This requires improving the quality and scope of Māori workforce data collection, management, and reporting (Ratima et al., 2007; Sewell, 2017). Understanding the variations in nursing programmes across the country, including the impact of Bachelor of Nursing Māori programmes on retention and completion rates, is critical for understanding the issues. This gatekeeping not only hinders efforts to address disparities but also limits the ability to evaluate the success of initiatives aimed at increasing Māori representation in the nursing workforce.

Gatekeeping within New Zealand's nursing education system has significantly hindered the advancement of Māori representation. Despite the introduction of kawa whakaruruhau-cultural safety education in the 1980s, the momentum for Māori inclusion in nursing has

struggled to recover from early setbacks, such as the 'Anna Penn' incident. Today, the underrepresentation of Māori nurse educators, the dominance of a Eurocentric curriculum, and the reluctance of Schools of Nursing to collect and share ethnicity data all contribute to ongoing barriers for Māori nursing students. These issues perpetuate a status quo that marginalises Indigenous knowledge and perspectives and limits the effectiveness of initiatives aimed at improving Māori health outcomes and representation within the nursing profession.

The Professionalisation of Nursing

The professionalisation of nursing in New Zealand was significantly shaped by the Carpenter Report in 1971, which laid the foundation for major reforms in nursing education and professional development. Commissioned by the Department of Health, the report highlighted the inadequacies of the existing hospital-based nursing programmes, including their struggle to keep pace with advancements in healthcare technology, the increasing complexity of patient care, and the shift towards primary healthcare (Department of Health, 1988). Carpenter (1971) advocated for a more advanced and comprehensive nursing education system that balanced academic rigour with practical clinical experience, ultimately leading to the transition of nursing education from hospital-based training to the tertiary sector (Gage & Hornblow, 2007).

One participant suggested that the professionalisation of nursing has caused the profession to "lose its way", moving from being a vocation—a personal calling driven by a deep sense of purpose or passion—to a structured profession (Nuku, 2015b). The participant questioned whether nursing is truly considered a profession, citing low wages and poor working conditions as evidence to the contrary. She expressed doubts about whether the direction nursing has taken over the last 20 years has truly elevated the profession's status.

Traditionally, nursing was viewed as a vocation by many Māori whānau, who took pride in sending their daughters to train at large urban hospitals with the expectation that they would return to serve their communities (Te Ao Maramatanga, 2016). However, some participants believe the transition from hospital-based training to tertiary education appears to have made nursing programmes less accessible and attractive, mainly due to the economic hardship associated with tertiary education.

The professionalisation of nursing in New Zealand, initiated by the Carpenter Report, marked a significant transformation in the education and practice of nursing, shifting from hospital-based training to a more academically rigorous, tertiary-based system. The transition to tertiary education introduced economic barriers that disproportionately affect Māori students, making nursing less attractive and accessible. The move from viewing nursing as a vocation to a profession has also sparked debates about whether the change has truly enhanced the status

of nursing, as evidenced by ongoing struggles for pay parity. Ultimately, while professionalisation aimed to advance the nursing profession, it created disparities that have impacted on Māori, as evidenced by the static state of the Māori nursing workforce.

A Sense of Frustration

Participants expressed deep frustration with systemic racism and marginalisation within the nursing profession, describing it as endemic and deeply entrenched at every level. This systemic racism has perpetuated the marginalisation of Māori nurses and hindered efforts to address the inequities within the Māori nursing workforce (Hunter & Cook, 2020a; Nuku, 2015a; Ramsden, 1990; Walker, Heneghan et al., 2016; Wilson, Barton et al., 2022). Despite decades of workforce strategies and reviews highlighting these inequities, tangible progress remains absent, further exacerbating feelings of disillusionment among participants (Baker, 2009; Chalmers, 2020; Kainamu, 2013; Wilson, 2018).

Participants consistently identified racism as a key factor influencing decision-making processes that disproportionately disadvantage the Māori nursing workforce. Many felt that these acts of exclusion fostered a sense of powerlessness, limiting their ability to enact meaningful change. The persistence of the status quo was attributed to the hierarchical and predominantly white power structures within the nursing profession (Anonson et al., 2008; Nielsen et al., 2014; West et al., 2010).

Puzan (2003) defined the concept of the ‘whiteness of nursing’ as the structural power that enables white privilege to shape the norms, rules, and accepted knowledge within the profession. This dominance dictates who is included in conversations, what knowledge is valued, and which languages and practices are considered legitimate. These embedded practices, often racially influenced, remain largely unchallenged and significantly shape the profession’s institutional frameworks. Giddings (2005) expanded on this idea, highlighting how discriminatory practices rooted in the ‘White good nurse’ ideology have become normalised within nursing’s everyday routines, rendering systemic discrimination invisible.

The impact of this dominance is reflected in participants’ lived experiences. One participant described the unease posed by the promotion of Māori nurses into nationally significant roles, noting that the growing influence of Māori nurse leaders could provoke a backlash. This reaction highlights the perceived threat associated with a potential shift in power dynamics. Another participant described the systemic disruption of Māori-led innovations in nursing education and workforce development by non-Māori, undermining progress toward improving Māori recruitment and retention.

These dynamics stifle the advancement of Māori nurses and impede broader efforts to address the static state of the Māori nursing workforce. The lack of meaningful action to dismantle these systemic barriers perpetuates inequities within the profession, reinforcing the urgent need for transformative change to support Māori nurses in achieving equitable representation and influence within nursing.

Conclusion

The challenges faced by the Māori nursing workforce in New Zealand are deeply rooted in a complex interchange of political apathy, entrenched systemic racism, and the enduring 'whiteness' of nursing. The lack of political will to invest in the nursing workforce, coupled with a reliance on IQNs and a bias toward the medical profession, has perpetuated significant underinvestment in nursing, particularly in efforts to support and grow the Māori nursing workforce. This situation is exacerbated by divisions within the nursing profession, ineffective leadership, and leadership that protects the status quo over meaningful change.

The professionalisation of nursing, while intended to elevate nursing to a profession, has created barriers for Māori students, whose representation in the workforce remains static. The shift from hospital-based training to a more academically focussed, tertiary-based model has introduced economic hardships that disproportionately impact Māori, further complicating efforts to recruit and retain Māori nurses. Additionally, the dominance of Eurocentric curricula and the reluctance of Schools of Nursing to collect and share ethnicity data have reinforced gatekeeping practices that marginalise Māori.

Participants in this study expressed deep frustration over the pervasive racism within the nursing profession, which they see as a significant barrier to progress. The 'whiteness of nursing', manifests in the power to dictate the rules, norms, and knowledge within the profession, ultimately marginalising Māori voices and reducing innovation. The limited power and influence that Māori nursing has over nursing development and direction highlight the ongoing challenges faced by the Māori nursing workforce.

Grey Literature Review Discussion

This section expands on the key findings identified in the grey literature review. A total of 18 documents were selected for their relevance to nursing workforce development with a specific focus on their implications for the Māori nursing workforce. The documents were reviewed chronologically, spanning from the 1970s to the 2020s, to trace the historical progression of nursing workforce planning over the past 5-decades. Each document was examined in terms of its background, purpose, and the information it provided regarding the Māori health and Māori

nursing workforce. Additionally, each was critiqued for issues related to policy implementation and its impact on Māori nurses. The following discussion provides analysis of the findings.

The grey literature review identified a variety of factors contributing to the static state of the Māori nursing workforce. These factors are organised into two overarching themes: Political indifference and Speaking into the wind. These themes offer a structured approach to understanding the context while highlighting the absence of effective and sustained government action to support the growth and development of the Māori nursing workforce.

Political Indifference

This theme refers to politicians consistently and intentionally disregarding or neglecting nursing policy and planning. It includes:

- **Health Sector Reforms**: Repeated structural changes that occurred within the health sector over the 1990s that continue to impact on nursing workforce and Māori nursing workforce development.
- **A Pattern of Inaction**: A consistent failure to implement policies that would support Māori nursing development.
- **The Back-up Plan**: Stopgap measures that impede on the issues faced by the Māori nursing workforce.
- **Tinkering Around the Edges**: Minor adjustments or superficial solutions that fail to create long-term and sustainable improvements.

Speaking into the Wind

This theme refers to the challenges of repeated advocacy and research, where recommendations for Māori nursing workforce development are largely ignored or not acted upon. It includes:

- **Māori Nursing Research Fatigue**: The weariness experienced by Māori nurses, researchers, and leaders who repeatedly highlight the same issues, only to see little or no meaningful government response or action.

Political Indifference

Health Sector Reforms

The health sector reforms of the 1990s were driven by a neoliberal agenda that promoted a business-oriented approach to healthcare delivery. It led to the introduction of market mechanisms aimed at increasing competition and efficiency (Gibbs et al., 1988). The market-driven environment resulted in the decentralisation of healthcare delivery, separating funding from service provision, with the ultimate goal of reducing expenditure and achieving economic

efficiency (Adams & Carryer, 2021; Gage & Hornblow, 2007; Gauld, 2003; North, 2011). Consequently, the nursing practice environment was completely restructured.

Many senior nursing positions were disestablished, and experienced (and expensive) nursing managers were replaced by less experienced (and cheaper) non-nursing managers. There was also a push towards casualising the nursing workforce, leading to increased workloads and stress. This restructuring virtually wiped-out nursing leadership, changing many senior nursing roles and responsibilities. The uncertainty and increased pressure associated with these reforms negatively impacted nurse morale and job satisfaction (Carryer et al., 2010). The reforms posed numerous challenges, including job insecurity and increased workloads, which were later found to negatively influence patient outcomes sensitive to nursing (McCloskey & Diers, 2005).

> *So, the 90s you'll remember was the health reforms we saw the increase in the casualisation of our nursing workforce. We lost a huge number of nursing leaders during that time. Through the introduction of neo-liberal business practices.* (K06)

During the health sector restructuring, nursing workforce development was decentralised, leaving decisions about workforce supply to local entities and individual employers under the belief that market forces would drive workforce development (HWAC, 2003). With each change of government and iteration of the health system (four health systems over 1-decade) (Gauld, 2003), nursing endured a constant state of change. Workforce development remained decentralised, lacking a national approach or focus, resulting in inconsistent nursing supply across the country. Reports at the time insisted there was an oversupply of nurses, with many new graduate nurses unable to secure jobs locally, resorting to looking for work overseas. By the early 2000s, after a review of the national health workforce, workforce development was recentralised. It was then revealed that New Zealand was experiencing a national nursing workforce shortage (CAPE, 1997; Holloway & Baker, 2009; HWAC, 2003).

> *It was all driven financially, driving the cost down and those sorts of things, but I still come back to nursing enabled that to happen. That if they were a strong nursing workforce they would have gone in there, they would have done their homework and they would have demonstrated that by doing that* [restructuring] *it was actually going to decimate the nursing workforce and it was going to create recruitment problems and a whole lot of other things at the time.* (K02)

Nursing leadership was decimated through the reforms, and when senior nursing roles were re-established in the 2000s, many of their former functions no longer held the same influence.

Most had lost control over budgets and were now required to report to non-nursing managers (Carryer et al., 2010; Gage & Hornblow, 2007).

Māori During the Health Sector Reforms.

The decentralisation of nursing workforce development combined with the lack of robust ethnicity data had implications for the Māori nursing workforce (NZNC, 2000). With a focus on localised recruitment and retention, there was no national understanding of the Māori nursing workforce or what it meant for Māori; although Māori nursing leadership were vocal about recruitment issues at this time (Thompson, 2014).

During the health sector reforms, the shift towards a market-driven environment opened up opportunities for new iwi Māori, pan-tribal entities, and existing Māori social services to enter the health sector (Baker & Levy, 2013). This was facilitated through government-funded health contracts that were largely focused on primary healthcare. Initially, this was celebrated as a government commitment to addressing health disparities. However, it was later revealed that the funding provided was substantially less than what was allocated to mainstream services (Came et al., 2018; Waitangi Tribunal, 2019). During this period, Māori nursing played a crucial role in leadership and innovation within Māori health services (Cook, 2009; Ministerial Taskforce on Nursing, 1998).

The reforms aimed to improve operations and reduce costs consequently highlighted the vital need for strong nursing leadership. By the early 2000s, the recentralisation of workforce development and the reinstatement of some senior nursing roles were measures taken to address the shortcomings of the earlier reforms. Despite the leadership opportunities provided to Māori nurses by Māori organisations, opportunities for Māori nursing leadership across all areas of nursing have remained limited. Nursing leadership never fully recovered from the effects of the reforms and is most evident in the ongoing ineffectiveness of nursing leadership, which has significantly impacted the development of the Māori nursing workforce. While the health sector reforms were aimed at reducing costs and improving efficiency, they ultimately destabilised nursing leadership and workforce development, with lasting negative consequences for both the nursing and Māori nursing workforce.

A Pattern of Inaction

The grey literature review supports the findings from the interviews with key stakeholders. Many discussed the challenges of navigating the political environment to try to achieve satisfactory outcomes for the nursing workforce, particularly for Māori nursing. The grey literature review identified ongoing and reoccurring recommendations within government

plans and reports to address the Māori workforce disparity. Despite these recommendations, it was revealed that there has been very little implementation.

Lack of Political Will

Successive governments' lack of political will to address impending nursing workforce shortages is most glaringly evidenced by their inaction. It is apparent that since the late 1980s, successive governments have been aware of the ageing nursing workforce and impending shortages. Policy advice has consistently indicated the need for a concerted investment to ensure the future nursing workforce meets the needs of the New Zealand population (Gorman, 2012; Gorman et al., 2009). Numerous government-commissioned reviews and projections on the state of the health workforce, including the nursing and Māori health workforce, have provided consistent advice recommending various interventions to avoid a nursing workforce crisis and increase the diversity of the nursing workforce to meet Māori needs (Cook, 2009; Future Workforce & DHBNZ, 2009; Ministry of Health, 1997; Gorman et al., 2009; HWAC, 2003; Ministerial Taskforce on Nursing, 1998; Ratima et al., 2007). Despite this, reports and planning documents have done very little to motivate any government to follow through on these recommendations.

> *But, coming back to HWNZ, there's something fundamentally flawed about the way bureaucracies work and they're almost paralysed by their circular thinking. They're buffeted by political will, political will changes. They* [government agencies] *have high staff turnover. They're forever appointing new swanky young people who you have to start all over with again.* (K05)

Reports have consistently highlighted the ageing nursing population and the urgent need for investment in workforce development to meet the needs of New Zealand's diverse population. However, these recommendations were largely ignored, and government agencies remained stuck in bureaucratic inefficiencies. As a result, interventions necessary to avoid a nursing workforce crisis and support Māori nursing development have not been realised.

Lack of Political Influence

Analysis of government investments in the health workforce reveals an inherent bias from successive Ministers of Health who have predominantly favoured investment in medicine (College of Nurses Aotearoa New Zealand, 2019; NZNO, 2018). One participant emphasised the inequity of the funding application process, highlighting that it is significantly more challenging and arduous for nursing than for medicine. This disparity emphasises the lack of political influence nursing holds, reflecting the undervaluing and marginalisation of a predominantly female profession. In contrast, the predominantly male field of medicine has benefited from

substantial government investment in recent years (NZNO, 2018) which appears to be paying off, with statistics indicating increases in the medical workforce and its diversity (Medical Council of New Zealand, 2020).

One participant encapsulated the frustration felt within the nursing sector regarding these disparities, stating:

> *They've* [HWNZ] *undertaken numerous meetings and projects to work out how to use their money differently. But at the end of the day they lack the courage to tell medicine to bugger off* [stop their lobbying] *basically. Because the medical colleges just shout and stamp, and Health Workforce obeys. And so, they haven't had the money to invest, to follow through with the advice that nursing has consistently provided.* (K05)

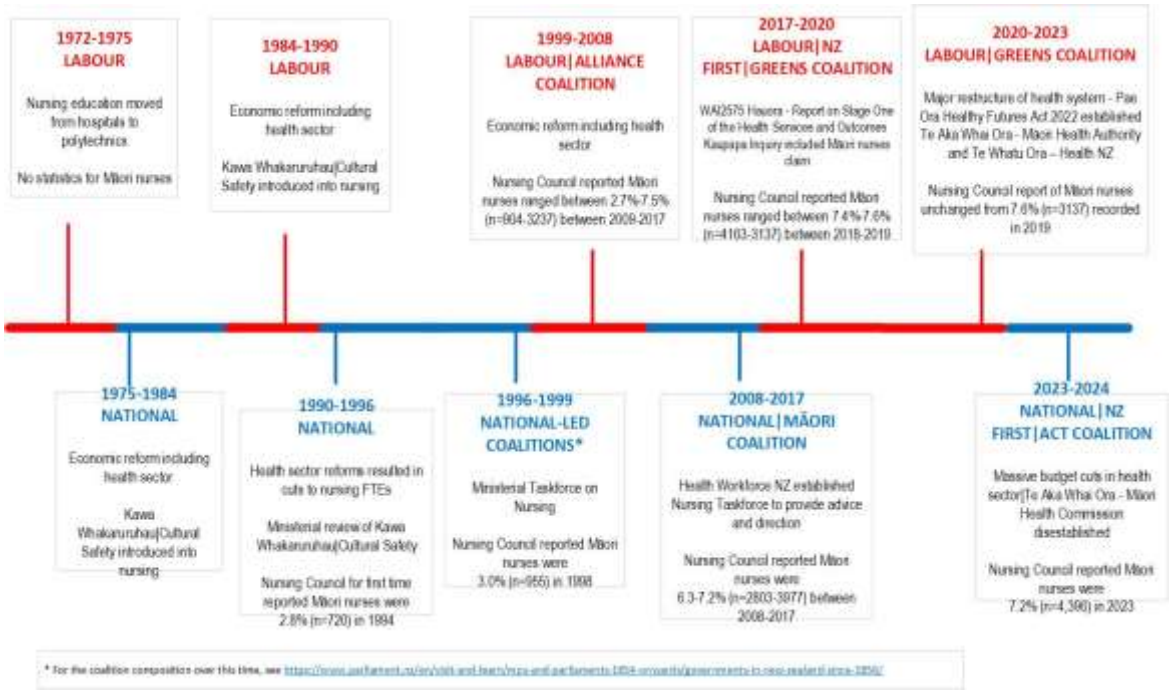
This quote highlights the systemic challenges nursing faces in advocating for equitable funding and resources. Despite the critical role that nurses play in healthcare, the profession's limited political influence has hindered its ability to secure the necessary investment for workforce development and innovation. Meanwhile, medicine continues to command both attention and resources, perpetuating the disparity within health workforce development.

Lack of Bipartisanship

The research highlights a recurring and troubling trend: successive governments have access to comprehensive information to address Māori nursing workforce inequities but have consistently lacked the political will to act. The grey literature review reveals a clear pattern beginning in the 1990s. Each new Minister of Health would initiate a review of the health or nursing workforce, commissioning research that culminates in a report with detailed recommendations. However, once a new government takes office, the incoming Minister of Health often dismisses the work of their predecessor, abandoning the recommendations and restarting the process again from scratch.

This cyclical lack of bipartisanship perpetuates stagnation, as progress is repeatedly undermined by changing political agendas. Compounding the issue is the weakness or indifference of nursing leadership, which wields limited influence. Without a unified and robust voice to advocate for meaningful change, nursing leadership has been unable to break through the political inertia. Furthermore, the absence of a formal national nursing strategy exacerbates these challenges, leaving no enduring framework to guide workforce development or ensure accountability (See Fig. 3).

Figure 3. *Political Influences on Nursing Workforce Development*



The review of grey literature and interviews with stakeholders reveals a longstanding pattern of inaction regarding the development of the Māori nursing workforce. Despite consistent government-commissioned reports and recommendations since the 1990s, successive governments have failed to address the growing nursing workforce shortages and the underrepresentation of Māori within the profession. A combination of political inertia, bureaucratic inefficiencies, and a systemic bias toward investment in medicine has compounded the problem. This bias reflects a broader undervaluing of nursing, a profession predominantly made up of women, when compared to the traditionally male dominated field of medicine. However, this gendered dynamic is beginning to shift. Recent data shows that the proportion of female doctors has increased from 32.6% in 2000, to 47.9% in 2023, with projection indicating women will outnumber men in medicine by 2025 (Medical Council of New Zealand, 2023). How this demographic shift might influence future health workforce planning and resource allocation remains uncertain.

The lack of bipartisan cooperation exacerbates the issue, as new governments often disregard the recommendations of their predecessors. Additionally, nursing's limited political influence, combined with ineffective leadership and the absence of a national nursing strategy, has further hindered progress in addressing these workforce disparities.

The Back-up Plan

It was during the period of the health sector reforms and the decentralisation of nursing workforce development that an increase in managers filling their vacancies with IQNs occurred (NZNO, 2018). Overreliance on the immigration of IQNs is considered by many the reason for the government's lack of investment in the domestic nursing workforce (Chalmers, 2020; Head, 2014; North, 2011).

The WHO examined New Zealand's health workforce and migration policies, particularly focusing on doctors and nurses (Zurn & Dumont, 2008). It found that New Zealand had one of the highest proportions of migrant nurses among OECD countries, highlighting the relative ease for potential immigrants to attain their qualifications and be approved to immigrate. It warned of New Zealand's ability to sustain its recruitment of international nurses in the face of increasing global competition for skilled nurses, questioning New Zealand's long-term capacity to compete in the global market (Chalmers, 2020; Zurn & Dumont, 2008).

> The national training of nurses has usually been below long-term needs, as recruitment overseas is more immediately responsive, and generates fewer commitments past the current financial year (Cook, 2009, p. 21).

IQNs provide a cheap and quick alternative to training locally that requires minimal government investment and can be adjusted through immigration policy to meet fluctuating workforce demands, a process that has recently become easier in the wake of the COVID-19 pandemic (Longmore, 2022; NCNZ, 2024).

The reliance on IQNs has become a significant part of New Zealand's strategy to address nursing workforce shortages. This approach is favoured by politicians and government agencies due to its cost-effectiveness and the immediate availability of a skilled workforce, reducing the need for long-term investment in domestic training programmes. However, this reliance has led to a chronic underinvestment in the domestic nursing workforce, with training levels consistently falling short of long-term needs (Chalmers, 2020; Head, 2014; North, 2011; NZNO, 2018). Increased recruitment of IQNs has undoubtedly impacted the investment in and development of the Māori nursing workforce.

Tinkering Around the edges

The ongoing underinvestment and marginalisation of nursing have led to a widespread perception that governments are merely tinkering around the edges in response to pressure from their health workforce reports and those provided by nursing.

There have been heaps of reports put into the government about how they can improve the Māori workforce and what needs to happen and none of them have been acted on really. Pushed around the edges a bit but none of them have been acted on. So, it's not as though we're saying anything new, we've been saying the same thing for 30 or 40 years. And all they have to do is go back and implement. (K02)

Lack of formalised investment, piecemeal ad-hoc approaches and token gestures. (K04)

Initially, the government engages with nursing innovation and progress but interest often wanes, becoming almost obstructive to nursing workforce development (Head, 2014). Many recommendations made to the government remain unimplemented. Those that are implemented, often fall short, being short-term, underfunded, or failing to allow nursing to reach its full potential.

A clear example of this persistent 'tinkering' is the Nurse Practitioner role, a role that was initiated through the Ministerial Taskforce on Nursing report in 1998. Initially it was promoted as a means for nursing, particularly Māori nursing, to improve access to primary health care for Māori, reduce health disparities, and provide primary health care to underserved communities. Its ad hoc and inconsistent implementation across the country is an example of nursing innovation and progress that is highly susceptible to government 'tinkering' through inadequate and uncertain funding support (Adams & Carryer, 2019; Finlayson et al, 2012). There is growing evidence of the clinical and cost-effectiveness of Nurse Practitioners compared to General Practitioners, presenting a realistic solution to medical practitioner shortages. However, despite these advantages, ongoing government barriers prevent Nurse Practitioners from realising their full potential (Adams & Carryer, 2021).

The ongoing effects of the neoliberal policy environment, which supports free markets with competitive contracting and privatisation, continue to limit the development of the Nurse Practitioner workforce (Adams, 2021; Adams & Carryer, 2021; Finlayson et al., 2012; Gauld, 2008; 2020). Adams and Carryer (2021) contended that the involvement of governments, District Health Boards, Primary Health Organisations, and general practices has resulted in a highly fragmented and complex primary healthcare sector. This fragmentation hinders Nurse Practitioners from advancing their roles and prevents them from making significant progress in addressing health inequities.

International research indicates that the barriers to expanding nursing roles in New Zealand are similar to those faced in countries like England, Canada, the USA, and Australia. These challenges primarily involve regulatory, and funding constraints associated with employing

Nurse Practitioners and the continued employment of practice nurses within general practices (Finlayson et al., 2012).

Another example of government tinkering around the edges was highlighted by a key stakeholder participant describing the arduous process of applying annually for the same funding to sustain a Māori registered nurse training initiative. The incessant requirement to reapply for funding highlights the impression that despite clear evidence of the need for Māori nursing workforce development and the success of these programmes, consistent funding is far from guaranteed.

Despite numerous reports and recommendations over the past several decades, politicians continue to tinker around the edges, in lieu of taking any substantive action. Overall, the persistent lack of formalised investment, reliance on piecemeal approaches, and token gestures have severely hampered the development of the nursing profession in New Zealand and has, subsequently, impeded the development of the Māori nursing workforce.

Speaking into the Wind

Māori Nursing Research Fatigue

A disappointing realisation from this research and the review of grey literature is that Māori nurses, students, and health workers have been asked the same questions repeatedly over many years, only to provide the same responses. The issues raised by Māori students and nurses in this research have been consistently highlighted in previous reports (Baker, 2009; Future Workforce & DHBNZ, 2009; KPMG, 2001; Ministerial Taskforce on Nursing, 1998; Ratima et al., 2007; Te Rau Matatini, 2009; 2015). Each report develops recommendations that ultimately go unheeded.

The 1998 Ministerial Taskforce on Nursing report, for instance, included a chapter dedicated to the consultation process with Māori, discussing the “main barriers and strategies” (p. 81) identified. Remarkably, every concern raised by participants during the Taskforce Hui in 1998 has resurfaced in this research, 25 years later. The research themes have truly reached saturation, with the same issues repeated over and again in nursing literature over the years; yet, very little progress has been made (Baker, 2009; Barton & Wilson, 2021; Chalmers, 2020; Chittick et al., 2019; Curtis et al., 2015; Foxall, 2013; Gray, 2020; Hunter & Cook, 2020a; Komene et al., 2023; Wilson, 2018; Wilson et al., 2011; Wilson, Barton et al., 2022).

Over the last quarter-century, research and reports concerning the Māori nursing workforce have seen no significant action from the government, with no one taking responsibility or accountability. Māori nursing students and nurses continue to participate in research, often

unaware of its historical context and outcomes. They participate hoping to contribute to improving the situation for Māori nursing.

Lack of Political Will and Systemic Barriers

A stark example of the lack of political will to address inequities in the Māori nursing workforce was shared by a participant who served on the nursing advisory group for HWNZ within the Ministry of Health in 2016. The group developed five key recommendations (or levers) aimed at aligning the Māori nursing workforce with the Māori population by 2028. However, as the participant recalled:

> *We developed five levers we saw as important towards achieving that goal* [increasing the Māori nursing workforce]*, and we gave that advice to HWNZ, to the Ministry of Health and to the Minister and not one of those levers was ever pulled*. (K05)

For over 30 years, Māori nurses have consistently advocated for greater investment in their workforce, seeking a national strategic response to address longstanding inequities (Baker, 2009; Chalmers, 2020; Kainamu, 2013; Nuku, 2015a; Ramsden, 1990, 2002; Walker et al., 2016; Wilson, 2018; Wilson et al., 2022). A significant contributing factor is the failure of nursing leadership to prioritise and value the development of the Māori nursing workforce. Māori nurses continue to face systemic racism and marginalisation across all levels of nursing as they strive for workforce equity. Even on the Nursing Council board, representation has been neither inclusive nor equitable. Recent changes to increase Māori representation on the NCNZ board came about only through persistent advocacy and agitation by Māori nurses, not through leadership-initiated reform or a commitment to justice.

> *The long-term goal at the time of Te Kaunihera was that we would actually have our own School of Nursing, that was the long-term goal, and this was the means of getting there. We were quite sure that there weren't enough Māori nurses at that time. So, it was to get nurses into a place of influence, Māori into a place of influence to be able to change policy and promote health and well-being amongst our people.* (K02)

Further evidence of the systemic barriers faced by Māori nurses was highlighted in the WAI 2575 Hauora-Health Services and Outcomes Kaupapa Inquiry, conducted by the Waitangi Tribunal. The inquiry revealed that despite the introduction of nursing education programmes designed by and for Māori, these initiatives have not done enough to grow the workforce to meet the needs of Māori. The claim highlighted that, as a partner to Te Tiriti o Waitangi, the Crown has done very little to support the development and growth of the Māori nursing workforce.

Summary

This section has provided a comprehensive exploration of the key themes derived from the grey literature review on nursing workforce development, particularly focusing on the Māori nursing workforce. The analysis revealed that despite decades of government reports and strategies, the Māori nursing workforce remains static due to ineffective policies and a lack of sustained action. The two overarching themes, Political Indifference and Speaking into the Wind, illustrate how superficial responses and unheeded advocacy have contributed to the ongoing challenges faced by Māori nurses.

Political Indifference describes the shortcomings of the health sector reforms, a consistent failure of policy implementation through a pattern of inaction and an overreliance on international nursing recruitment, which undermined domestic workforce growth, especially for Māori nurses. Token efforts to address issues, characterised by minimal action and short-term fixes, have failed to address the long-term needs of the Māori nursing workforce. Meanwhile, Speaking into the Wind highlighted the frustrations of Māori nurses, leaders, and researchers whose recommendations have consistently gone unheeded, resulting in ongoing marginalisation and underrepresentation of Māori within nursing, nursing leadership, and workforce development.

In summary, the grey literature reveals a persistent pattern of systemic inertia. Decades of reports and strategies have repeatedly identified the same barriers to Māori nursing workforce development, yet meaningful progress remains elusive.

Conclusion

This chapter has explored the multifaceted challenges faced by the Māori nursing workforce in New Zealand through the perspectives of student nurses, registered nurses, key stakeholders, and insights drawn from grey literature. Each sub-unit of analysis has revealed systemic barriers that have hindered recruitment, retention, and advancement for Māori nurses over the past 40 years.

The findings from interviews with Māori nurses and students highlight intersecting challenges of financial hardship, racism, and marginalisation within an education and healthcare system that prioritises Eurocentric norms. These burdens are compounded by expectations for Māori nurses to provide dual competence, without sufficient institutional support. Key stakeholders reinforced these themes, identifying ineffective nursing leadership, entrenched systemic racism, and political inaction as major impediments to meaningful workforce development. Grey literature further contextualised these issues with decades of unimplemented

recommendations, superficial policies, and overreliance on international recruitment, which have collectively undermined efforts to address Māori nursing inequities.

Despite these challenges, this chapter has highlighted the urgent need for systemic changes to address deeply embedded barriers within nursing education and professional practice. By honouring Te Tiriti o Waitangi and embedding culturally responsive practices, the nursing profession has an opportunity to foster an equitable environment.

In Chapter 8, the findings across all three units of analysis will be synthesised to build a cohesive explanation for why the Māori nursing workforce has remained static for 4-decades. Through the process of triangulation, key Interpretations will be defined which will deepen the understanding of systemic barriers and provide a foundation for developing strategies that will promote equity and provide the interventions needed to grow the Māori nursing workforce.

Chapter 8: Key Interpretations–Whakatinana

'I kaha herehia te rā ki te taura'

The sun was bound tightly with the rope

This chapter synthesises the findings from the three embedded units of analysis explored in this study, offering key interpretations that address the central research question: Why has the Māori nursing workforce remained static for 40 years? Drawing on data gathered from interviews with Māori student nurses, registered nurses, and key stakeholders, as well as a comprehensive review of policies and strategies spanning 5-decades, this chapter seeks to unravel the systemic barriers that have impeded the growth of the Māori nursing workforce and proposes ways to address and mitigate these challenges.

The interpretations presented in this chapter are the result of a deliberate process of wānanga—a reflective practice of deep contemplation and discussion. Grounded in Kaupapa Māori principles, this process enabled the author to engage with the data holistically, re-evaluating historical themes while integrating emerging insights to form an explanation for the static state of the Māori nursing workforce. Wānanga, as a method, goes beyond conventional analysis, providing the space to critically examine both the data and broader socio-political context in which these findings exist. Through this process of wānanga, three key interpretations emerged (see Figure 4, p. 155):

1. **False Hope and Empty Promises**: Despite numerous strategies and policies over the past 4-decades, there has been a consistent failure to implement recommendations to support the growth of the Māori nursing workforce, leaving many promises unfulfilled.

2. **Smoke and Mirrors: Maintaining an Illusion**: Government and their agencies efforts often give the appearance of addressing disparities, yet these measures remain superficial, creating an illusion of progress while failing to enact meaningful change.

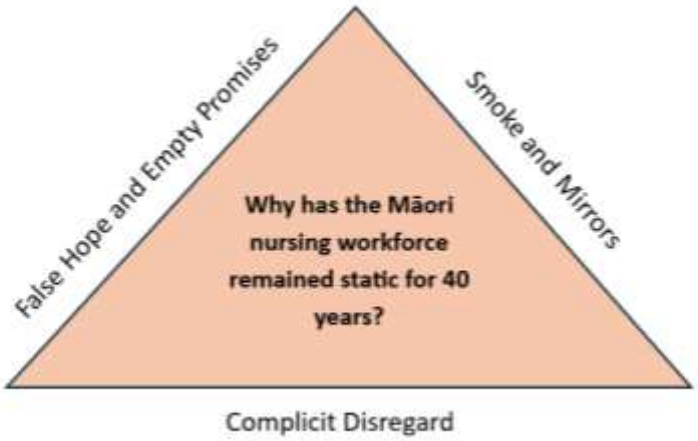
3. **Complicit Disregard**: A systemic lack of accountability and action perpetuates the disparities in the Māori nursing workforce, revealing a broader indifference to addressing these inequities.

These interpretations provide an explanation for the persistent and multifaceted barriers that have prevented the growth of the Māori nursing workforce for over 4-decades. By contextualising these barriers within the frameworks of systemic inequities, political inertia, and superficial interventions, this chapter offers a critical lens through which to understand

the static state of the Māori nursing workforce. The following sections will delve into each interpretation, unpacking its implications and its connection to the broader findings of this research. Following each discussion, key statements are defined, and actionable recommendations are offered to address the issues raised.

Figure 4.

Triangulation of Key Interpretations



Part A: False Hope and Empty Promises

Through the process of wānanga and reflection on the past 40 years of nursing in New Zealand, one recurring interpretation emerges from both participant insights and the literature review: a deep sense of frustration caused by an enduring cycle of hope, followed by disappointment. The history of Māori nursing is fraught with instances where promises of positive change have consistently fallen short, marked by inaction or insufficient efforts to fulfil commitments.

This section examines the persistent challenges in workforce planning, policy development, working conditions, and nursing leadership that contribute to the static state of the Māori nursing workforce. Drawing from the synthesis of data, key statements are presented alongside a discussion of strategies to address the barriers underpinning these False Hopes and Empty Promises. The analysis aims to identify actionable solutions to foster meaningful and sustained progress for the Māori nursing workforce.

Promises of Positive Change

A recurring theme identified in this study is the enduring cycle of hope followed by disappointment. Insights from participants and findings from the literature review illustrate a history marked by promises of positive change that consistently fall short. This cycle has hindered the recruitment and retention of Māori nurses, a central focus of this research. The

synthesis of data reveals persistent issues in workforce planning, policy implementation, challenging working conditions and nursing leadership, all of which contribute to the static state of the Māori nursing workforce.

The lack of a bipartisan approach to nursing workforce planning further compounds these challenges, a point frequently raised by participants. Each political cycle sees the same routine playing out time and again. Political parties repeatedly disregard the work of their predecessors (See Figure 3, p. 147), resulting in fragmented efforts and little or no progress. Lack of political cooperation undermines long-term efforts to address workforce inequities and perpetuates the status quo. This finding is central to addressing the research question, as it highlights how systemic inefficiencies have stalled Māori workforce growth.

The reliance on IQNs has been another recurring issue raised by participants. This study highlights how the preference for importing nurses over investing in domestic workforce development, including Māori nursing, reflects short-term cost-saving measures that neglect long-term sustainability (Brownie & Broman, 2024; Chalmers, 2020; Cook, 2009; Head, 2014; Health Quality & Safety Commission, 2024; Zurn & Dumont, 2008). By prioritising IQNs recruitment, policymakers have directly deprioritised Māori workforce development, as evidenced by the continual increasing proportion of IQNs in the workforce (47%) compared to Māori nurses (7.2%) over the last 3-decades (Chalmers, 2020; Cook, 2009; NCNZ, 2025). This systemic reprioritisation aligns with the study's findings regarding the marginalisation of Māori in workforce planning and development.

Political transitions exacerbate this issue, with successive governments reversing previous initiatives aimed at addressing health and education inequities. For example, the dismantling of the Māori Health Authority (Came et al., 2024) and halting the centralisation of tertiary education providers and the unification of nursing programmes (Gerritsen, 2024; Mullaine et al., 2023) have both directly undermined opportunities for Māori nursing workforce growth. These political decisions consistently hinder pathways that would have supported Māori nursing development.

Despite repeated calls to expand the Māori nursing workforce (Barton et al., 2021; Ministry of Health, 2020a), effective policies remain lacking. This ongoing cycle of political inaction continues to undermine efforts to address critical workforce issues. Ramsden (2002) highlighted this challenge, noting that while good intentions and rhetoric are common, the lack of political will has consistently prevented the development of a national strategy to support Māori workforce growth. Without genuine political commitment, policies remain ineffective, perpetuating persistent challenges in recruitment, retention, and job satisfaction for Māori

registered nurses (Chalmers, 2020). For over 30 years, Māori have raised concerns about these workforce issues, only to be met with cycles of 'false hope and empty promises.'

Political Apathy

Political apathy becomes particularly evident when examining nurses' working conditions. Ineffective workforce planning and inadequate investment create a cyclical pattern of 'boom and bust'. In the 'bust' phase, nursing staff face intensified pressures from shortages and a poor skill mix, resulting in heavier, more complex caseloads. This strain can lead to 'missed care' incidents, where essential care is delayed or omitted, potentially leading to adverse patient outcomes (Griffiths et al., 2018; Willis et al., 2017).

Conversely, in the 'boom' phase, as seen currently, IQNs are frequently recruited to fill vacancies. However, the lack of national oversight in international recruitment means that many domestically trained nurses in New Zealand may struggle to secure employment upon graduation (Barton, 2024; Gower, 2024). This situation risks driving New Zealand-trained nurses to seek work overseas, potentially weakening the Māori nursing workforce. Such an outcome could have far-reaching consequences for the healthcare system, limiting access to culturally concordant care and impacting Māori communities.

The lack of effective workforce planning and policy development has particularly significant consequences for Māori nurses, due to dual expectations from both colleagues and the Māori community to be both clinically proficient and culturally responsive (Baker & Wilson, 2012; Hunter & Cook, 2020a; Komene et al., 2022; Wilson, Barton et al., 2022). Inadequate investment in growing the Māori nursing workforce intensifies these pressures. Many Māori nurses feel a strong sense of responsibility to provide culturally responsive care to Māori patients, increasing their stress levels and the risk of burnout (Hunter & Cook, 2020a; Huria et al., 2014). Culturally concordant care is known to improve healthcare experiences for Indigenous populations (Health Quality & Safety Commission, 2024; Komene et al., 2023). However, the limited number of Māori nurses results in a disproportionate strain on those currently practicing, as they strive to meet the healthcare needs of their people.

Decades of Rhetoric

The findings reveal that ineffective and indifferent leadership has significantly hindered the development of the Māori nursing workforce, aligning directly with the research question's focus on systemic barriers. Participants consistently identified leadership issues as a substantial impediment, a theme echoed in grey literature. Despite decades of rhetoric advocating for Māori nursing workforce growth, little meaningful progress has been made.

The Nursing Council exemplifies these false hopes and empty promises through its approach to Māori workforce development. Like the government, the NCNZ has commissioned a number of reports on nursing education and workforce projections (KPMG, 2008; Nana et al., 2018; NCNZ, 2020), each of which has emphasised the urgent need to grow the Māori nursing workforce. However, despite the urgency highlighted by its own findings, participants noted the Council's failure to move beyond its rhetoric and advocate meaningful action. This lack of follow-through highlights the systemic disregard for Māori workforce development, a key barrier identified in this research, as the Nursing Council and nursing leadership have failed to leverage opportunities to advocate for Māori nursing.

Weak political advocacy and representation over the last 30 years have compounded these issues, marginalising the interests of nurses, especially Māori nurses. Nursing lacks a strong, unified voice in healthcare policy, and workforce planning is often siloed and fragmented (College of Nurses, 2019; Ministry of Health, 2022; NCNZ, 2020; NZDHB, 2020; NZNO, 2014, 2021; Technical Advisory Services, 2021). The lack of advocacy and representation at the political level further disadvantages Māori nurses; participants stating that they believe this occurs because non-Māori do not have Māori interests at heart. Therefore, issues of relevance to Māori are less likely to be elevated or supported. Any political responses have been minimal, largely superficial, focusing on surface issues rather than root causes. The absence of robust advocacy has contributed to unsafe working conditions, inadequate wages, low morale, and high attrition rates among nurses (NZNO, 2018).

Key stakeholder participants provided clear examples of ineffective nursing leadership, outlining their consistent failure to garner political influence. O'Rourke and Outly (2024) argued that nursing advocacy and political engagement tend to be reactive rather than proactive, resulting in limited effectiveness. According to the College of Nurses Aotearoa New Zealand (2019), New Zealand nurses face considerable restrictions in their lobbying efforts and health policy involvement. Nurse leaders are often excluded from crucial discussions, limiting their ability to present compelling arguments—unlike other professional health groups and industries. This underrepresentation is particularly notable given that nursing constitutes over 50% of the regulated health workforce (NZNO, 2018). Rafferty (2017) observed that while nursing is the largest regulated workforce, with degree-level entry requirements, prescribing authority, advanced practice roles, and leadership in new healthcare models, it has historically played a limited role in policy development and political influence. However, Wilson and Butters (2021) suggested that, by virtue of its sheer size, nursing holds great potential to increase its influence if it capitalises on this collective strength.

Participants highlighted that despite consistent advice provided by nursing advisory groups over many years to government agencies, there is little evidence that this advice has led to concrete responses. As Adams (2021) suggested, nurses must have a unified voice and take every opportunity to be included in decision-making, as lobbyists from other professions work the corridors of power to protect self-interests and the status quo. Political decisions significantly influence the allocation of funding and resources. Therefore, nursing's lack of political clout, shaped by its historical status as a feminised profession, has hindered its ability to secure adequate investment in workforce development. This failure has significantly impacted nursing representation and its capacity to influence policy at the highest levels. As Aspinall et al. (2023) observed during the formation of Health New Zealand, established to take over governance of 20 District Health Boards, "the newly appointed board revealed evidence of gender balance, some representation of our Pacific and Māori communities, businessmen, lawyers, and doctors but, sadly, no nurses. Once again, nursing is absent from the decision-making table" (p. 2478).

Despite representing the largest regulated health workforce in New Zealand, nursing leadership continues to struggle for recognition and political traction within systems still shaped by colonial and patriarchal hierarchies (Wilson, Barton et al., 2022; Wilson & Butters, 2021). Māori nursing has suffered the most from this marginalisation. Participants described ongoing failure to prioritise Māori nursing development. The concept of false hope and empty promises encapsulates the systemic failures identified throughout this study, addressing the research question by exposing the recurring barriers that have frustrated Māori workforce growth. These findings demonstrate how political inaction, ineffective leadership, and inadequate investment have contributed to the static state of the Māori nursing workforce over the past 40 years. Furthermore, these systemic barriers impede not only the professional development of Māori nurses but also the delivery of culturally concordant care, directly impacting Māori health outcomes. The challenges Māori nurses face, such as political invisibility, underinvestment and systemic disregard, are not isolated, but part of an intersecting matrix of colonialism, gendered labour and institutional inequity.

Key Statements from the Synthesis of Data

Government

- Successive governments have consistently failed Māori through their inaction.
- New Zealand's heavy reliance on the international nursing workforce undermines efforts to build and support a robust Māori nursing workforce.

- A lack of bipartisan approach to health workforce planning has been detrimental to Māori nursing workforce development.
- Government short-sightedness in its lack of investment in the domestic nursing workforce will see New Zealand struggling to maintain health services in the future due to increasing demand and falling international recruitment as global competition for nurses heats up.

Nursing

- Nursing leadership has failed to leverage the Māori nursing workforce cause on the back of government identified priorities.
- Nursing leadership has failed to advocate for Māori nursing to the detriment of Māori health and well-being.
- Nursing leadership has never had Māori interests at heart and is preoccupied with maintaining the status quo.
- Nursing has consistently failed to garner political influence despite it representing over 50% of the regulated health workforce.

Ways to Address 'False Hopes and Empty Promises': Kotahitanga and Rangatiratanga (Unity and Self-determination)

Participants in this study described New Zealand's nursing workforce as fragmented and divided, a profession still grappling with the residual effects of the 1990s health sector reforms. Despite numerous efforts to gain professional recognition, nursing faces continued challenges, with ineffective leadership and resistance to change identified as significant barriers. As the largest regulated health workforce in the country, nursing lacks cohesive governance, resulting in inefficiencies and disparities that disproportionately impact Māori nurses. Participants were particularly critical of current nursing professional groups, viewing them as largely ineffective and lacking the unity necessary to drive systemic change. They observed that these groups often operate in silos, prioritising the status quo rather than challenging established norms or advancing representation and opportunities for Māori nurses.

The Need for Nursing Governance

In 2009, Len Cook conducted a comprehensive review of New Zealand's nursing profession, outlining critical recommendations for the Minister of Health. At the forefront was the proposal to establish a national nursing governance board to unify expectations for nursing education and workforce development. Cook envisioned that such a board would provide

leadership and collaborate closely with existing networks, enhancing their capacity to support national health goals.

A National Nurse Education and Workforce Board could fulfil this role, serving as a unifying governance entity for the nursing profession across New Zealand. Representing diverse nursing perspectives, the board would advocate for and engage with political and industry stakeholders through collaboration with professional nursing bodies. Its mandate would encompass workforce planning, data collection, and monitoring to ensure alignment with workforce needs, including oversight of new graduate placements, postgraduate funding, and national advocacy for equitable healthcare access. Prioritising local solutions, the board would promote Māori nursing workforce development and innovative approaches to strengthening New Zealand's domestic nursing workforce (Head, 2014). As Brownie and Broman (2024) argued, the absence of comprehensive nursing workforce data reveals a fragmented system lacking centralised governance, funding oversight, and accountability.

For Māori nurses, and the nursing sector as a whole, challenges have been exacerbated by decades of extensive health and public sector restructuring (Gauld, 2003; Zurn & Dumont, 2008). This upheaval dismantled nursing leadership structures and career pathways, reducing the influence nursing once had within the healthcare sector (Adams & Carryer, 2021). However, even if nursing had retained its former influence, structural issues affecting Māori workforce development would likely persist, a topic discussed further in this chapter.

North (2011) contended that a sustainable nursing workforce should primarily consist of domestically trained nurses to mitigate shortages and reduce reliance on immigration. However, a lack of national oversight has created a cycle of 'boom or bust' where currently the unmonitored recruitment of IQNs jeopardise jobs for new graduates (Barton, 2024). A National Nurse Education and Workforce Board could provide essential oversight, guiding workforce supply, setting strategic directions, and ensuring the profession has a unified voice at the national level.

Promoting Māori Leadership and Representation

Participants expressed frustration with nursing leadership, noting that despite the rhetoric, they have not prioritised the interests of Māori nurses and appear to be committed to maintaining the status quo. They were resolute in their belief that Māori no longer needed non-Māori to make decisions on their behalf, as there were already Māori nursing leaders capable of doing so. Instead, they emphasised the need to focus on expanding leadership opportunities for Māori within nursing, education, and the broader health sector.

Brockie et al. (2023) argued that establishing Indigenous leadership is essential; without deliberate strategic direction, leadership, and adequate resources, the Indigenous nursing profession will struggle to grow. Māori must have a voice in nursing policy and practice decisions, with targeted initiatives focusing on recruitment and retention to increase the representation of Māori within the workforce. There is a critical need for workforce strategies at national, regional, and service levels to actively recruit and retain Indigenous nurses (Brockie et al., 2021). Achieving this goal requires effective governance structures with equitable Māori representation and the inclusion of Māori nursing leaders at every level of decision-making.

Enhancing Political Advocacy in Nursing

Participants expressed frustration over the lack of political will to address the long-standing recommendations to grow the Māori nursing workforce. Many attributed the static state of the Māori nursing workforce to the absence of strong nursing leadership and its limited political influence (Wilson & Butters, 2021). Political advocacy and activism, though similar in their goals for change, differ in approach. Advocacy generally works within established political channels, engaging policymakers through lobbying, expert testimonies, and research to influence specific policies or reforms. In contrast, activism often uses more public and disruptive methods, like protests and campaigns, to bring immediate attention to social issues and rally broad community support. Ultimately, advocates focus on incremental, long-term policy influence, whereas activists seek to prompt immediate awareness and societal change (Arif, 2024: Johnston & Gulliver, 2022). Traditionally, New Zealand nursing has leaned towards political activism (NZNO, 2018).

O'Rourke and Outly (2024) argued that nursing has traditionally been viewed as an apolitical profession with limited political influence, with significant advancements driven by external forces rather than the nursing profession itself. To change this dynamic, the nursing profession must shift from a reactive to a proactive approach in advocacy, empowering nurses to engage more effectively in political processes. Establishing a National Nursing Education and Workforce Board would be a catalyst for this transformation, helping to develop comprehensive policies and plans that will strengthen nursing's political influence and ensure that its voice is heard.

While some nurses are politically active, many feel less prepared to navigate the political landscape when compared to other professionals, particularly physicians, who have historically held greater political influence. This disparity reflects more than just professional hierarchy; it also underscores the gendered dynamics of health leadership, where medicine, a traditionally male-dominated profession, has enjoyed sustained structural advantage, while nursing, a predominantly female profession, has been systematically undervalued. An intersectional

analysis highlights how gender, profession, and power intersect to shape differential access to influence. Further research is needed to explore the barriers that limit nurses' political engagement (Wilson & Butters, 2021). Nevertheless, there is an urgent need to strengthen advocacy and political involvement within nursing. O'Rourke and Outly (2024) suggested that professional nursing organisations should actively recruit, and support members interested in advocacy, while Wilson & Butters (2021) emphasise the importance of introducing nursing students to public policy and advocacy early in their education. The establishment of a National Nursing Education and Workforce Board would provide a much-needed platform for consistent advocacy and a stronger voice within the corridors of power (Adams, 2021).

Active political advocacy through the proposed nursing governance group would ensure that key areas in government planning and priority setting remain focused on nursing needs. As previously discussed, the importance of growing the Māori nursing workforce was acknowledged as a priority; yet, nursing leadership did not capitalise on this opportunity. Establishing a governance group with a mandated, influential voice could prevent similar situations where nursing interests are overlooked, even when identified as government priorities.

Ongoing fragmentation within the nursing workforce, compounded by the impact of health sector reforms, means there is a need to establish national nursing governance to advance the leadership and development of nurse education and the workforce. Establishing a National Nursing Education and Workforce Board, as recommended by Len Cook, offers a viable solution to addressing inefficiencies and disparities in the profession. Such a board could provide central oversight for nursing education and workforce development and serve as a powerful advocate for the profession, helping to unify its voice and enhance political influence.

Centralised data management, workforce planning, and targeted strategies to address disparities are essential, particularly for the Māori nursing workforce which has historically experienced ad-hoc data analysis, poor engagement in workforce planning, and ongoing workforce disparity. The underinvestment in Māori nursing and lack of leadership opportunities for Māori nurses are issues to be addressed to foster equitable growth within the profession. A dedicated governance structure can tackle these challenges, promote Indigenous leadership, and create pathways for Māori nurses to assume more prominent roles in shaping the future of nursing in New Zealand.

Furthermore, strengthening political advocacy within nursing is crucial. Ensuring nurses are equipped to engage in advocacy efforts could contribute to advancing the profession. By incorporating Māori perspectives and leadership in decision-making, nursing can move toward

a more inclusive, competent, and sustainable future. Implementing these recommendations—particularly through the establishment of a National Nursing Education and Workforce Board—will benefit the nursing workforce as a whole and contribute to a more culturally responsive and resilient healthcare system in New Zealand.

Rangatiratanga

Growing Māori Nursing Programmes.

Māori nurses at all levels of the national health system and within educational institutions frequently encounter racism and discrimination. These experiences often include workplace marginalisation and bias, adding additional stress to the already complex task of caring for Māori patients (Hunter & Cook, 2020a; Huria et al., 2014; Wilson & Barton, 2011). Wilson, Barton et al. (2022) argued that the ongoing oppression of Māori nurses is rooted in both structural and interpersonal racism within the nursing profession. For participants, the challenge of addressing these deeply embedded forms of racism seemed nearly insurmountable. Consequently, they viewed empowerment and progress for Māori nursing as achievable only through tino rangatiratanga—self-determination.

Participants expressed frustration with the status quo, feeling that despite the efforts of Māori nurse leaders over the past 30 years, attempts to embed Indigenous perspectives into nursing education and practice have been largely unsuccessful. A significant gap persists between the rhetoric and reality of the indigenisation of nursing education and practice. Promoting rangatiratanga, or self-determination, within the nursing workforce requires a genuine commitment to Te Tiriti o Waitangi and supporting Māori aspirations. Many participants believed that the development of kaupapa Māori nursing programmes, practice, and institutions that respect and integrate mātauranga, tikanga, and Māori values, is viewed as the only way forward to achieve these aspirations.

These programmes prioritise mātauranga Māori and align with NCNZ education standards, focusing on values such as whanaungatanga to enhance student engagement and social integration—core strengths of kaupapa Māori nursing education (Gray, 2021). However, meaningful advancement in kaupapa Māori nursing programmes hinges on substantial investment in developing the Māori nurse educator workforce, which currently represents 3-4% of the total nurse educator workforce (NCNZ, 2024a). Without a serious increase in this workforce, further expansion of kaupapa Māori nursing programmes will remain limited.

Empowering Māori communities by fostering local health solutions, investing in their workforce, and collaborating with Māori organisations will build a strong, Māori nursing

workforce that will meet the specific health needs of their communities. Ultimately, these initiatives honour Te Tiriti o Waitangi and uphold the aspirations of Māori, paving the way for a more equitable and inclusive healthcare system.

Conclusion

The experiences of Māori nurses in New Zealand reveal a consistent theme of 'false hope and empty promises', driven by a lack of political will, ineffectual policies, and ineffective nursing leadership. Despite decades of recommendations and rhetoric, tangible progress for Māori nursing remains minimal, with successive governments failing to adequately invest in Māori workforce development. This has led to persistent workforce challenges, barriers to leadership for Māori nurses, and an enduring cycle of frustration and disappointment.

The establishment of a National Nursing Education and Workforce Board, as first proposed by Len Cook and supported by the DHBNZ DON, offers a transformative pathway toward unified governance. Such a board would provide national oversight of nursing education and workforce planning and act as a strong, unified advocate for the profession within the political environment. This governance structure would be critical for addressing long-standing issues in the workforce, securing sustainable funding, and creating a framework that actively promotes equity and Māori representation.

Empowering Māori leadership and embedding Māori perspectives in all levels of governance is essential to the growth and retention of the Māori nursing workforce. A commitment to rangatiratanga aligns with the principles of Te Tiriti o Waitangi and is crucial for addressing disparities within the profession. By fostering Māori-led programmes, establishing kaupapa Māori nursing curricula, and supporting Māori nurse educators, the profession can make significant moves toward a more culturally responsive health system.

Moreover, strengthening political advocacy within nursing is key to ensuring the profession's voice is heard. As nursing comprises half of New Zealand's regulated health workforce, its influence in policy and decision-making processes could be considerable. Equipping nurses with advocacy skills and introducing policy training within nursing education are vital steps toward shifting from a reactive to a proactive stance in political engagement. This approach would allow nursing, particularly Māori nursing, to advocate more effectively for policies that are important to their needs and challenges.

To achieve meaningful change, the nursing profession must move beyond divisions and align with a collective, strategic vision. Establishing the National Nursing Education and Workforce

Board with dedicated Māori representation is a critical step toward addressing systemic disparities within the workforce and in health care.

Part B: Smoke and Mirrors: Maintaining the Illusion

The phrase 'smoke and mirrors' aptly captures a situation where appearances are crafted to suggest meaningful action or progress, while the reality reveals little to no substantive change. Through the process of wānanga, this interpretation emerged strongly from both participant insights and the literature review, highlighting the deliberate maintenance of an illusion of progress that ultimately obscures the systemic barriers faced by the Māori nursing workforce.

This section begins by examining inadequate funding and resourcing, delving into how chronic underinvestment undermines efforts to advance the Māori nursing workforce. It then explores mechanisms that maintain the illusion, uncovering the tactics and practices that perpetuate the façade of progress. Finally, the role of the NCNZ is critically discussed, investigating how its actions—or lack thereof—reinforce the status quo.

Drawing from the synthesis of data, this section presents key statements alongside a discussion of strategies to dismantle these barriers in Addressing 'Smoke and Mirrors' in Nursing: Kōrero Pono (Speak the Truth). The analysis seeks to uncover actionable solutions aimed at fostering genuine, sustained progress for the Māori nursing workforce, moving beyond illusions to create a truly equitable and inclusive nursing workforce.

The Illusion of Investment

Political austerity measures introduced in the 1990s to reduce government spending and debt had a profound and adverse impact on the nursing workforce, especially with the adoption of neoliberal policies (Carryer et al., 2010; Cook, 2009; Gage & Hornblow, 2007; North, 2011; Wilson & Butters, 2021). Willis et al. (2017) noted that health reforms, restructuring, and government rhetoric around increased health investment often masked cuts in health expenditure, which significantly reduced funds for workforce development (Association of Salaried Medical Specialists & NZNO, 2024). Although adequate funding and resources for growing the domestic nursing workforce have been identified as critical for meeting the future needs of New Zealand's population (Ministry of Health, 2020a), these priorities have received minimal political backing.

The situation is reflected in Māori nursing workforce development, despite extensive research and numerous recommendations advocating for strengthened support for the Māori nursing workforce, targeted investment remains notably absent (Barton et al., 2021; Ministerial

Taskforce on Nursing, 1998; Ministry of Health, 2016, 2020a; Ratima et al., 2007; Wilson, 2018). Economic hardship, consistently highlighted as a major barrier to the recruitment and retention of Māori nursing students, continues to impact these efforts, alongside other documented challenges (Baker, 2009; Barton et al., 2021; Barton & Wilson, 2021; Chittick et al., 2019; Foxall, 2013; Ratima et al., 2007; Wilson et al., 2011). Despite clear evidence identifying these obstacles, meaningful investment in initiatives to reduce these barriers has been limited. The Ministry of Health (2020a) concurred, stating:

> despite significant Māori academic evidence, statistical data, policy advice and iwi and whānau advocacy addressing this criticality over many years, the step change required at a whole of system and inter-sectoral levels to attract, educate and train, recruit and retain Māori health workers to achieve equity and reflect Te Tiriti has failed to occur. (p. 9)

Reflecting findings from every Māori nursing study since 1998, participants in the current study emphasised that economic hardship remains a significant issue for Māori nursing students. Current student allowances and scholarships (for those fortunate enough to receive them) are insufficient to alleviate this financial burden (Barton et al., 2021; Foxall, 2013; Wilson et al., 2011). Despite ongoing efforts to encourage government action, responses have largely been met with indifference. Recently, there appeared to be a shift in this stance, with the government planning to explore an 'Earn as You Learn' (EAYL) model aimed at addressing disparities within the Māori nursing workforce (Te Whatu Ora Health New Zealand, 2023), an initiative supported by the Health and Disability Sector Review (2020). However, with the introduction of austerity measures by the new government, the future of EAYL remains uncertain (Gower, 2024).

The stalling of any progress on initiatives to relieve the economic hardship exemplifies the 'smoke and mirrors' approach that continues to frustrate Māori nursing, particularly when contrasted with the government's recent $10,000 grants designed to attract IQNs to New Zealand (Barton, 2022; Te Whatu Ora, 2024). Māori nurses' sense of disbelief is justified, as this decision clearly highlights the government's lack of commitment to strengthening the Māori nursing workforce. By channelling resources toward incentivising IQNs, rather than developing Māori nursing capacity, the government once again creates an illusion of support for sustainable workforce growth, masking the reality of inadequate investment in initiatives that would drive lasting change for Māori nursing.

Participants also described the inequities in the allocation of health funding, revealing a clear political bias favouring medicine over nursing. The limited investment in the nursing workforce

underscores the structural devaluation of a profession that is both feminised and underrepresented in health system leadership. In contrast, medicine not only a historically male-dominated profession, also a politically privileged field, continues to attract significantly greater resourcing. For example, in 2018, per capita investment in the medical workforce was $6,963, reflecting a 5% increase from the previous year. In contrast, the nursing workforce received only $278 per capita, with no increase since 2017 (College of Nurses Aotearoa New Zealand, 2019; NZNO, 2018; Wilson & Butters, 2021). This disparity is not merely fiscal, it reflects the intersection of gender, profession, and political influence. Nursing workforce strategies and policy recommendations are often treated as symbolic gestures, mere smoke and mirrors, while funding continues to flow towards groups with stronger lobbying power and greater institutional status.

One participant illustrated this discrepancy, describing her attempts to negotiate nursing funding, only to see any progress wiped out as soon as medicine 'stamped its feet'. This imbalance in investment reflects broader inequities within the health workforce and, as a consequence, has implications for proposed investment in Māori nursing workforce initiatives.

The ongoing reliance on the international nursing workforce has enabled successive governments to divert essential investments away from Māori nursing and nursing in general (Barton, 2024; Cook, 2009; Gage & Hornblow, 2007; Zurn & Dumont, 2008). The ultimate smoke and mirrors tactic lies in strategy after strategy proposing that the government actually intends to invest in the domestic nursing workforce. The reality is that currently there is little need, as successive governments rely on the international nursing workforce to meet staffing needs. As previously discussed, the IQNs workforce can respond more swiftly to workforce fluctuations and at a lower cost than developing the domestic nursing workforce. Utilisation of IQNs allows the government to sidestep its own strategies and policies, with recommendations serving as a mere distraction, while a readily available workforce fills the gaps. However, this model is not sustainable as competition for the international workforce heats up (Health and Disability System Review, 2020; WHO, 2020).

Yet, to project a commitment to domestic workforce growth, successive governments frequently resort to 'tinkering around the edges'—offering short-term, fragmented investments that lack both stability and long-term commitment. One participant characterised this approach as inconsistent and piecemeal, with funding that fails to offer the continuity necessary for real progress. Chapter 5 delved into this issue within the Nurse Practitioner programme, where frustration is felt over the relentless struggle to secure sustained funding for an initiative that has demonstrated value to the health workforce and promise improved Māori healthcare access (Adams & Carryer, 2019). The cycle of short-lived nursing initiatives,

which ultimately disappear due to inadequate government support, exemplifies the smoke and mirrors strategy—a façade of support that obscures the reality of insufficient commitment.

Governments' reliance on IQNs has allowed them to bypass substantial investment in the domestic nursing workforce, especially for Māori. Despite numerous reports and recommendations, the government's approach remains fragmented, offering only minimal and inconsistent support for sustainable workforce development. Economic barriers continue to limit Māori nursing recruitment, while the enduring disparity in funding between medicine and nursing illustrates a political bias. This pattern of short-term, smoke and mirrors initiatives, coupled with a lack of commitment to Māori nursing, highlights a pressing need for authentic, sustained investment in New Zealand's domestic nursing workforce.

The Illusion of Equality

In the 1980s, as the ongoing impact of colonisation on Māori health outcomes became more apparent and the "difficulties Māori faced in interacting with Western-based nursing services" (Ramsden, 2002, p. 110) were recognised, Māori nursing leaders initiated a significant shift in discourse. They introduced the theory kawa whakaruruhau or cultural safety, noting that the concept of mātauranga Māori and nursing knowledge were not mutually exclusive. Nursing leaders proposed that merging both views could bring about attitudinal changes in nurses and improve the experiences of Māori patients receiving care (Ramsden, 1990). Significantly, the theory also emphasised the need for the "safety of Māori individuals training and practising as nurses" (Ramsden, 1990, p. 47). Despite the efforts by Māori leadership to change the discourse within nursing, nearly 35 years later very little has changed. Māori continue to experience poor health outcomes and Māori students and nurses continue to feel culturally unsafe and vulnerable in their work and study environments (Hunter & Cook, 2020b; Huria et al., 2014; McClintock et al, 2019; Walker et al., 2016; Wilson & Baker, 2012; Wilson et al., 2011).

In 1991, a model was developed that described a shared power structure in nursing, promising equal professional representation between Māori and Pākehā (RPIEN National Action Group, 1991). Despite its intentions, the model was never utilised. The power differential within nursing has changed very little since that time; inequity within nursing continues and is evident in all aspects of the profession, from the underrepresentation of Indigenous views within curriculum development and delivery to a lack of representation in leadership that could lead to positive changes in Māori nursing workforce development (Barton & Wilson, 2021; Bhandal et al., 2023; Brockie et al, 2023; Richardson, 2021; Wilson et al., 2022).

Efforts by Māori to influence change within the power structures of nursing have largely been unsuccessful. Racism and white privilege undoubtedly play central roles in the continued

colonisation of the nursing profession, evident in the preservation of a hierarchical power structure within a predominantly white workforce (Barton & Wilson, 2021; McAlister, 2019; McGibbon et al., 2014; Puzan, 2003; Wilson et al., 2022). Nursing leadership has maintained its influence by upholding systems that create barriers to equal opportunity, representation, and advancement. At the core of this issue, Māori believe that non-Māori nurse leaders have not prioritised Māori interests, resulting in exclusion and marginalisation in critical areas such as leadership and workforce planning.

The Illusion of Inclusiveness

Participants highlighted a perception that the nursing profession lacks effective leadership, particularly critical of the NCNZ. An interesting finding across all participant groups was the perception that the Nursing Council is the representation of leadership within the profession, despite the presence of multiple other nursing bodies. Given New Zealand's nursing structure, it is understandable why the NCNZ is perceived as the primary authority. In reality, the profession is represented by two key organisations: the NZNO, the largest workforce union (up to 62,000 members), and the Nursing Council, the regulatory authority.

While the NZNO aspires to be the 'voice of nursing' due to its extensive membership, the Nursing Council often assumes this role by default, likely due to its advisory role to the government on nursing-related issues. This perception of the Council as the profession's leadership persists, despite its mandate under the HPCA Act 2003, which is focused on regulatory oversight and public protection rather than workforce advocacy or development. Consequently, the Nursing Council's position as the default voice of nursing stems more from a gap in effective representation than from a mandate or an explicit mission to lead the profession. Participants believe that the lack of effective leadership and indifference towards Māori nursing workforce development has had a detrimental impact on the direction of the profession and its ability to progress issues important to nursing.

Further complicating these issues is the influence of the 'old girls' network', a powerful group whose various members project an image of inclusivity and collaboration but operate in ways that are exclusive and protective of the status quo, often undermining progressive and inclusive efforts. This influential group, typically composed of white, middle-aged nurses in leadership roles across the workforce and education sectors, wields significant yet often unspoken influence within nursing circles. Their primary role is to uphold the status quo, exerting power in ways that marginalise those who do not conform to their views. Additionally, they play a key role in selecting individuals who will continue to support and perpetuate this established order. Some participants in the study recognised this network's influence,

attributing the lack of progress in Māori nursing workforce development in part to this group's resistance to change and desire to maintain the status quo.

The most prominent example of this influence lies within nursing education and is evident in the role of Schools of Nursing as gatekeepers, as discussed in Chapter 4. Participants in this research highlighted nursing education as a significant hurdle for Māori seeking entry into the profession (Barton & Wilson, 2021; Curtis, Townsend et al., 2012). Perhaps the most striking illustration of this gatekeeping and failure to support Māori lies in data from 2005-2020, which show an increase of only 1,353 Māori nurses over 15 years (NCNZ, 2015, 2017, 2019, 2023). This equates to an average of just 90 new Māori nurses per year—or approximately five graduates per year from each School of Nursing. This slow progress highlights the challenge for Māori and, as Chalmers (2020) explained, is the reason why it has taken over a decade for the Māori nursing workforce to grow by a mere 2%.

Additional evidence of the old girls' network influence emerged during the early development of the unified nursing programme, where resistance to proposed changes became notably intense (Mullane et al., 2023; Rook et al., 2022). This programme, introduced by the government as part of an initiative to merge 17 polytechnics, aimed to create a unified nursing curriculum across 13 Schools of Nursing. The goal was to standardise nursing education and indigenise its content by integrating a Māori worldview alongside Western scientific perspectives in nursing. Some involved in the programme's development perceived the opposition to these changes as rooted in racism, suggesting that such resistance was primarily fuelled by a reluctance to embrace Indigenous perspectives.

A change of government sought to halt the process of amalgamation, and eventual disestablishment of the unified nursing programmes occurred, hindering progress toward an inclusive and representative curriculum (Gerritsen, 2024). Although no direct evidence links the old girls' network to the political decisions behind dismantling the unified programme, many within Māori nursing see the outcome as unsurprising, aligning closely with the network's aim to preserve the status quo.

Recently, nursing marked the 50th anniversary of nursing education's transition to the tertiary sector. A ceremony was held to celebrate this shift from hospital-based apprentice training to tertiary education, initiated in response to the Carpenter Report (Carpenter, 1971). The event featured speakers who explored the history of nursing and the transition to tertiary education, with a particular focus on Māori engagement and the importance of cultural safety (Longmore, 2023; Wilkinson, 2023).

The professionalisation of nursing, embodied by this shift in education, was a recurring theme among research participants. One participant questioned whether professionalisation has genuinely benefited the field, asking if nursing is truly recognised as a profession with the associated benefits (Wilson & Butters, 2021). However, the most pressing concern raised by participants was how the transition from hospital-based training to tertiary education has benefitted Māori nursing. Although data on the effectiveness of hospital-based programmes in producing Māori nurses is limited, current statistics reveal that since the introduction of tertiary based training, the Māori nursing workforce has not significantly increased. Since ethnicity data collection began in 1994, Māori representation has remained relatively static at 7%. Participants argued that this stagnation indicates the current system is not working.

Participants identified economic hardship and stringent academic prerequisites as substantial barriers for Māori seeking entry into tertiary nursing programmes, suggesting it may be time to reassess the system to improve accessibility. Notably, the UK has reintroduced apprenticeship nursing programmes after recognising that tertiary-based nursing programmes were not accessible to all (Baker, 2018; National Health Service, 2024; Puthenpurakal, 2023). This model, run alongside tertiary based programmes, has shown considerable success, offering an example of how nursing education could be restructured to better serve Māori. However, within New Zealand, there was some discontent at the prospect of the reintroduction of an apprenticeship type model, with fears it could send nursing back to the 'bad old days' and undermine what is perceived as progress toward establishing nursing as a credible profession (Garbett, 2017). Considering the evidence, it is clear that Māori nursing have been collateral in a 40-year experiment that has yielded little benefit to Māori. This raises the critical question: can the nursing profession reasonably justify maintaining the status quo? (Barton, 2022).

Māori nursing advocates were hopeful that New Zealand might adopt an alternative nursing education model when the government considered an EAYL approach. Unfortunately, this initiative was recently shelved by the current government due to austerity measures, a decision met with significant disappointment from Māori nurses who see it as a missed opportunity to make nursing education more accessible to Māori (Pennington, 2024).

Nursing Council, the Ultimate Illusionist

Perhaps the most significant 'elephant in the room' is the ongoing health disparities faced by Māori. There is no question that nursing plays a role in perpetuating these inequities (Barton, 2018; Komene et al., 2023; Wilson et al., 2022). As explained earlier kawa whakaruruhau-cultural safety was developed to address poor Māori health outcomes and create safe practice environments for Māori students and nurses (Ramsden, 1990). However, in response to public

backlash grounded in racist views, kawa whakaruruhau was separated from cultural safety and evolved into a broader theory addressing the needs of any minority or marginalised group (Papps & Ramsden, 1996; Ramsden & Spoonley, 1993; Roberts, 2019).

Throughout this research, participants frequently raised cultural safety, often with criticism. Many saw it as an example of rhetoric without real follow-through, citing it as a theory that has not translated effectively into practice. Concerns were also voiced regarding the competence of the non-Māori nursing workforce, with participants questioning the Nursing Council's competency programme, which is presented as proof of workforce competency. They argued that cultural safety has been largely ineffective in improving Māori health outcomes, a view supported by the minimal improvements seen in Māori health since cultural safety was integrated into nursing education and practice (Heke et al., 2019; Johnstone & Kanitsaki, 2007).

Persistent evidence shows that Māori continue to experience racism when accessing healthcare, with racism recognised as a critical determinant of health (Cormack et al., 2020; Graham & Masters-Awatere, 2020). Research consistently demonstrates that Māori are more likely to encounter disparities in access to healthcare and treatment compared to non-Māori (Harris et al., 2019; Ministry of Health, 2015). As the largest regulated workforce with direct bedside care, there is no denying that nursing is complicit in these inequities (Barton, 2018; Wilson et al., 2022). This issue will be explored further in this chapter.

Given that cultural safety was introduced into nursing education to address these issues, a critical question arises: if after 35 years, cultural safety has not been effective in improving outcomes for Māori, why does it continue to hold relevance in nursing education and practice? The answer, participants suggested, lies with the Nursing Council. Despite its duty to protect the public, it appears that this duty does not explicitly extend to addressing Māori health disparities. The NCNZ's promotion of cultural safety is the 'ultimate illusion', in that the Council is fully aware of cultural safety's ineffectiveness in addressing these disparities, yet continues to endorse it (Heke et al., 2019; Wilson et al., 2022).

Roberts (2019) argued that the original intent behind kawa whakaruruhau has been overshadowed, a situation she believed reflected ongoing colonial power and control within the nursing profession, asserting that nursing urgently needs to challenge this status quo. Moreover, Roberts contended that shaping education and practice should not fall solely on regulatory bodies but should be a collective responsibility across the profession. A counterargument suggests that nursing practice and competency are primarily driven by regulatory frameworks; if regulators are reluctant to drive change, it is unlikely that others will feel compelled to do so.

One participant recounted an interaction with a Nursing Council member who indicated that the Council's main objective was to avoid negative media coverage, likely referencing the public backlash from cultural safety's initial introduction into nursing (Papps & Ramsden, 1996; Ramsden & Spoonley, 1993). The Council is often cited internationally as a leading regulatory body for its incorporation of cultural safety to address healthcare inequities, contributing to an image it seeks to uphold. However, participants argued that, in reality, the Council maintains a façade of support for Māori health equity while knowingly perpetuating an ineffective measure that ultimately preserves the status quo.

The implications for Māori nurses are profound. Not only are they tasked with ensuring culturally competent care for Māori patients on their own caseloads and any Māori they encounter, but they also bear the added responsibility of providing cultural guidance and support to non-Māori colleagues. This dual role exposes them to significant pressures and stress within their work environment, as they navigate their responsibilities while often facing racism themselves (Hunter & Cook, 2020a; Huria et al., 2014).

Despite possessing the resources and capacity to undertake such an initiative, Nursing Council has not prioritised reviewing the effectiveness of cultural safety in achieving transformational change within nursing practice. For many Māori, this inaction is perceived as a deliberate decision to maintain the status quo. By failing to act, the Council is complicit in the perpetuation of Māori health inequities. In effect, by allowing culturally unsafe practices to persist, the Nursing Council is neglecting its duty to protect the public. As participants noted, if the Council were effectively fulfilling this responsibility, the current disparities in Māori health outcomes might not be as severe.

The concept of "smoke and mirrors" serves as a lens to examine the illusion of progress in addressing the systemic barriers faced by the Māori nursing workforce. Despite decades of research and numerous policy recommendations, chronic underinvestment and fragmented initiatives continue to perpetuate inequities. Political austerity and the reliance on internationally qualified nurses (IQNs) have enabled governments to sidestep the need for meaningful investment in the domestic workforce, particularly for Māori.

The illusion of equality is evident in the Nursing Councils inaction over the limited effectiveness of cultural safety, preferring to focus on preserving its public image. Regulatory frameworks fail to enforce substantive changes, leaving Māori nurses to shoulder the dual burden of providing culturally competent care while often facing systemic racism.

Efforts to introduce alternative education models, such as an "Earn as You Learn" approach, have been undermined by political shifts and entrenched resistance within nursing leadership.

The efforts to maintain the status quo, coupled with limited Māori representation in education and leadership, further highlights the exclusionary structures within nursing. Participants also highlighted the role of an "old girls' network" that preserves traditional power dynamics, hindering progressive reforms. Without accountability and action, the façade of progress will continue to mask systemic inequities, perpetuating health disparities for Māori.

Key Statements from the Synthesis of Data

- The government has little incentive to invest in the domestic nursing workforce due to its reliance on a readily accessible international workforce to manage workforce fluctuations.
- The government's piecemeal funding approach to nursing workforce development is inequitable, disproportionately disadvantaging Māori.
- The nursing profession lacks effective, accountable, and transparent leadership.
- The Nursing Council perpetuates culturally unsafe practice by maintaining the status quo.
- The nursing profession systematically marginalises Māori to maintain the established order.
- Nursing contributes directly to Māori health inequities.

Addressing 'Smoke and Mirrors' in Nursing: Kōrero Pono (Speak the Truth)

Strategic Direction and Priorities

This research underscores the need for a unified nursing governance structure to consolidate strong collective representation within the profession. A key responsibility of such governance would be developing a unified workforce strategy that is robust and sustainable, irrespective of changing government agendas. Currently, professional nursing groups tend to operate in silos, each formulating their own strategies. This fragmented approach creates an impression of division and disorganisation within nursing. Without a cohesive vision for the workforce, there is a lack of sustainability and consistency, leading to a reactive rather than proactive approach to government policies.

A National Nursing Workforce Strategy would be essential to reduce ambiguity and minimise opportunities for 'smoke and mirrors' approaches. Brockie et al. (2023) suggested that developing workforce strategies at national, regional, and service levels is crucial to actively recruit and retain Indigenous nurses. Without intentional strategy, strong leadership, and adequate resources, the Indigenous nursing workforce will face significant challenges in achieving growth and representation.

Such a strategy would also guide regional efforts, with a targeted focus on expanding the Māori nursing workforce and strengthening the domestic nursing workforce overall. By setting clear strategic goals, a National Workforce Strategy would align stakeholders around common objectives and foster a shared vision for the future of nursing, ensuring a unified approach toward workforce sustainability and equity.

Key Priorities for the National Nursing Workforce Strategy

A National Nursing Workforce Strategy should prioritise expanding the domestic nursing workforce, with a primary focus on strengthening the Māori nursing workforce. This would require establishing well-defined strategies grounded in research and robust data collection, aiming to identify, promote, and implement best practices for growing the Māori nursing sector. The strategy should also prioritise the recruitment and retention of New Zealand-trained nurses, reducing dependence on IQNs and fostering a sustainable, long-term workforce (Chalmers, 2020; NZNO 2018).

Incorporating alternative training models, such as EAYL or apprenticeship programmes, like those currently being implemented in the UK, could enhance accessibility to nursing education, providing diverse pathways into the profession, and, most significantly, alleviate economic hardship. A flexible approach to training would create new opportunities for individuals to enter the nursing field, addressing barriers to entry and meeting varied learning needs. Additionally, intersectoral collaboration across education, health, and government sectors is essential to align workforce policies, training programmes, and funding with the evolving demands of the healthcare sector (Barton et al., 2021).

Political Influence and Advocacy

Political influence and advocacy are equally important. O'Rourke and Outly (2024) contended that nursing has traditionally been viewed as an apolitical profession with limited political influence. They posited that often, significant developments in nursing practice stem from external forces rather than internal initiatives. For the nursing profession to shift from a reactive to a proactive stance, it must enhance its advocacy efforts, empowering nurses to participate more actively in political processes (Wilson & Butters, 2021). Establishing a National Nursing Education and Workforce Board could be transformative, serving as a catalyst for developing a comprehensive National Nursing Workforce Strategy that amplifies nursing's political influence and strengthens its voice in policymaking.

A truly inclusive nursing workforce requires an intersectoral approach to health organisations' policies for addressing implicit bias and racism (Aspinall, 2021). Supporting workforce equity, particularly for Māori nurses, involves investing in policy measures aimed at achieving

equitable outcomes (Chalmers, 2020). This commitment must extend to employment sustainability, including equitable pay, accessible professional development, and adequate staffing. Aligning nursing positions with financial support for entry-to-practice programmes, postgraduate education, and creating sufficient new graduate registered nurse roles will help foster long-term retention and job satisfaction (Barton, 2024; Foxall et al., 2017; Head, 2014; Moloney et al., 2018; Wilkinson & Gray, 2022).

The development of a National Nursing Workforce Strategy, with specific attention to the needs of the Māori nursing workforce, is essential to create a sustainable and equitable future for nursing. By aligning with stakeholders through a cohesive strategy, the profession can become more unified and resilient, better equipped to meet the demands of a changing healthcare landscape.

Developing Recruitment and Retention Strategies

Student Nurse Retention Strategy

Developing recruitment and retention strategies to address workforce disparities and reduce attrition is a key priority within the National Workforce Strategy, supported and endorsed by the National Nursing Workforce and Education Board. All participants highlighted the challenges they faced as student nurses, highlighting the need for targeted interventions. The following recommendations offer evidence-based steps, drawing on decades of research, to reduce barriers to recruiting and retaining Māori students in nursing programmes.

One of the key challenges in recruiting Māori into nursing is the barriers they face even before reaching tertiary education. Curtis, Townsend et al. (2012) highlighted obstacles Māori secondary school students face, including challenges related to education, information, aspirations, and access. Addressing these barriers requires the development of interventions early in their exposure to health career pathways.

A comprehensive and integrated pipeline approach is crucial for effectively recruiting Māori students (Curtis, 2012; Hetaraka, 2018; Middelton et al., 2019; Technical Advisory Services, 2021; Tranter, 2018). This involves collaboration among secondary, tertiary, community, and workforce stakeholders. Even with specific Māori initiatives, access to secondary education at the standard required for entry into nursing degree programmes remains challenging (Cook, 2009). Initiatives within the education sector must ensure that all secondary schools offer relevant teaching in subjects such as science and mathematics (Curtis, Townsend et al., 2012).

It is essential to support Māori staff, role models, or mentors to provide career advice and address the deficit or failure discourses career advisors draw on (Curtis, Townsend et al., 2012).

Effective information exchange through whakawhanaunga (Māori forms of engagement) is more influential than mass marketing, making decision-making more collaborative and informed (Leach & Zepke, 2005). Health science academies are emerging as promising approaches to help Māori and Pasifika students prepare for health careers (Middleton et al., 2019).

Strategies for pre-entry in to nursing include working collaboratively with schools and kura kaupapa Māori. This may mean meeting with school career advisors and providing advice and direction on appropriate subjects for potential students. Active recruitment activities would involve attending career expos and offering training academies for high school students, allowing them the opportunity to try out nursing. Engaging whānau early in the process so that they are aware of expectations and scholarship opportunities, and marketing that is inclusive of Māori forms of engagement are additional recruitment activities.

Enhancing Student Preparation and Foundation Programmes

According to Milne et al. (2016), many Indigenous students enter higher education through alternative pathways and often lack the same academic preparation as non-Indigenous students. This can lead to challenges in navigating university systems and meeting academic requirements. They also note the Indigenous students are often the first in their families to attend university, facing unique experiences. Bridging or foundation programmes targeted at Indigenous and ethnic minority students can enhance academic outcomes during the first year of degree-level study (Curtis et al., 2017). These programmes are vital, given the inequities in secondary education faced by Indigenous students globally. Optimal learning environments for adult Māori learners engaging in foundation programmes are holistic, establish connectedness and belonging through whanaungatanga, providing academic and pastoral support, Indigenous-focused content and flexibility (Anderson et al., 2024; McMurchy-Pilkington, 2013). However, participants noted that the additional time and financial costs of completing these programmes place a disproportionate burden on Māori students.

Student Retention

Retaining Māori students in nursing programmes requires culturally responsive support and mentorship. Bishop (2010) and Berryman et al. (2024) developed the kotahitanga teaching principles which utilise Māori teaching and learning principles used with Māori school children. These principles remain relevant as Māori students transition from secondary to tertiary education. Kotahitanga principles emphasise the importance of whānau as a protective factor and the need for culturally responsive support systems (Berryman et al., 2024).

Institutions must extend recruitment programmes beyond enrolling students to provide comprehensive retention and completion support (Curtis et al., 2012). Support programmes for Māori students should deliver high-quality academic and pastoral support, offer a 'safe-haven' within often culturally and socially alienating environments, and foster student cohesiveness within a cultural context (Curtis, Wikaire, Kool et al., 2015; Durie, 2009). Strategies such as involving whānau in the interview and orientation process, developing Tuakana-Teina (peer mentoring) programmes, and providing culturally safe spaces and access to Māori kaiako (teachers) are essential to creating an inclusive learning environment.

Addressing Economic Hardship

Financial hardship is a significant barrier for Māori nursing students. Many Indigenous students work part-time to support their families, with women in higher education more likely to have caregiving and additional cultural responsibilities adding to their risk of attrition (Barton et al., 2021; Barton & Wilson, 2021; Curtis, Wikaire et al., 2012; Evans & Bonner, 2023; Gray, 2020; Ratima et al, 2007; Tranter, 2017; Wiapo et al., 2023; Wilson et al., 2011). Financial support should come from various sources, including government, universities, Indigenous communities, and philanthropic organisations (Milne et al., 2016). However, participants have stated that more often these sources of financial support are insufficient to alleviate the hardship.

Reducing socio-economic inequalities by enhancing financial support will help Māori students pursue higher education and reduce attrition, ultimately contributing to a more equitable nursing workforce (Durie, 2009). Introducing other ways to alleviate economic hardship such as introducing EAYL models or apprenticeship programmes could alleviate these pressures.

Inclusion of Mātauranga Māori in the Curriculum

Integrating Māori knowledge, values, and practices into nursing education is crucial to creating a more inclusive and supportive learning environment. Evidence demonstrates that Indigenous students are more engaged when interactions with teachers are flexible, supportive, include Indigenous knowledge, and effective teaching and learning practices (Bishop, 2010; Curtis, Wikaire, Kool et al., 2015; Curtis, Wikaire et al, 2012; Foxall, 2013; McMurchy-Pilkington, 2013; Milne et al., 2016; Mullane, 2011; Ratima et al., 2022). Blended learning approaches and teaching in short, intensive blocks help Indigenous students balance education with work and family responsibilities (Ratima et al., 2022).

A nursing programme that incorporates Indigenous knowledge and pedagogy into the curriculum and educates students on the impact of colonisation on the health and well-being of Indigenous peoples creates learning environments that are culturally safe and responsive

(Barton & Wilson, 2021; Chittick et al., 2019; Foxall, 2013; Gray, 2020; Milne et al., 2016; Wilson et al 2011). Indigenous/Kaupapa Māori nursing programmes, which privilege mātauranga Māori and utilise Māori teaching and learning practices, alongside nursing curriculum, are likely to provide environments conducive to retention for some Māori students.

Monitoring Recruitment and Retention Data

The lack of comprehensive data on the Māori nursing workforce pipeline has presented significant challenges as it obscures essential information on gaps and provides limited transparency around trends in the undergraduate nursing pipeline, including attrition rates and the distribution of nursing graduates across regions (Barton & Wilson, 2021; Brownie & Browman, 2023; Chalmers, 2020; Cook, 2009; Lai et al., 2018). Collecting national data is crucial for understanding attrition patterns and evaluating the impact of interventions aimed at enhancing the recruitment and retention of Māori nursing students. Such data would help establish a clear national picture of the workforce pipeline and support ongoing research and monitoring efforts to address workforce disparities.

Addressing Racism

Participants reported multiple experiences and observations of racism. This will be discussed further in the chapter. However, structural and interpersonal racism are significant challenges that Māori student nurses face daily, during their education and throughout their nursing careers (Barton, 2018; Barton & Wilson, 2021; Brockie et al., 2023; Chalmers, 2020; Chittick et al., 2019; Gray, 2020; Hunter & Cook, 2020a; Huria et al., 2014; Kainamu, 2013; Wilson, 2018; Wilson et al., 2011). To foster a safe environment, healthcare organisations must implement zero-tolerance policies for racism and provide clear, safe mechanisms for reporting incidents without fear of retribution. Training for non-Māori staff that fosters critical consciousness of implicit biases and increases understanding of Māori worldviews is essential to create a supportive work culture.

The recruitment and retention of Māori nursing students requires a comprehensive, culturally responsive approach that addresses their unique challenges throughout their educational journey. A more inclusive and equitable pathway into the nursing profession can be created NOW by implementing strategies that support Māori students from the pre-entry phase through to graduation.

Key strategies include developing a robust pipeline that addresses barriers at the secondary school level, offering targeted academic preparation programmes, and providing culturally responsive support systems that extend beyond enrolment. Addressing economic hardships through scholarships EAYL programs and other financial support, integrating mātauranga Māori

into the curriculum, and ensuring a culturally responsive learning environment are also critical components of this approach.

Additionally, ongoing monitoring and data collection are essential for assessing the effectiveness of these interventions and making necessary adjustments. By fostering an educational environment that is responsive and supports Māori, we can enhance the recruitment and retention of Māori nurses.

Registered Nurses Retention Strategies

Registered nurse participants expressed significant frustrations with their work environments, particularly concerning the lack of support and the additional workload due to dual competence responsibilities and expectations. Additionally, new graduate nurses reported feeling increased pressure to complete postgraduate study in their first year of practice. Many of the participants cited experiences of racism and discrimination as factors impacting their career decisions. This discussion explores key strategies for retaining Māori nurses, emphasising the importance of support, recognition of dual competence, access to postgraduate study opportunities, and the need to address workplace racism.

Clinical / Cultural Supervision

Māori nurses integrate both their cultural and clinical expertise into practice, utilising Indigenous approaches such as whakawhanaunga, manaakitanga, tiakitanga, and aroha (empathy and compassion). However, when practising within Western biomedical environments, Māori nurses frequently encounter additional cultural expectations, which increase their workload and are often not acknowledged. Additionally, Eurocentric work environments can present challenges for Māori nurses, as they may not fully accommodate or respect the personal cultural values and beliefs of Māori nurses. Moreover, they may experience bullying and microaggressions related to their refusal to assimilate into and accommodate the dominant nursing culture leading to marginalisation. This causes stress and frustration (Barton & Wilson 2008, 2021; Hunter & Cook, 2020a; Komene et al., 2023; Wilson & Baker, 2012).

A supportive workplace that includes respect for Indigenous culture, alongside access to clinical and cultural supervision and mentoring, has been found to significantly improve job satisfaction, reduce work-related stress, and alleviate emotional fatigue, stress, and burnout—all of which are linked to better retention (Lai et al., 2018). Haar and Brougham (2011) further noted that Māori employees who feel their cultural values are respected and understood in the workplace demonstrate increased loyalty. When employees perceive support for their cultural

identity, they respond with greater commitment and positive behaviours, reinforcing the importance of fostering an inclusive, culturally supportive environment in healthcare.

Providing Māori nurses with access to clinical supervision is essential for mitigating the unique challenges they face. Clinical supervision, which promotes reflective practice to maintain and enhance nursing skills, offers significant benefits for organisations, professional development, and patient care. When implemented effectively, clinical supervision enables nurses to manage job demands more efficiently, reduces the likelihood of job turnover, builds resilience and job satisfaction, and alleviates stress and anxiety. Additionally, it has been shown to improve the quality of care and create a positive work environment (Rothwell et al., 2021).

For Māori nurses caring for Māori patients within Western health services, culturally responsive clinical supervision is essential. This approach supports Māori nurses in their dual-competency roles, integrating both cultural and clinical expertise. Well-resourced, culturally responsive clinical supervision should be considered best practice, providing Māori nurses with the support needed to succeed in the cultural and clinical aspects of their roles (Komene et al., 2023). Fostering a supportive workplace culture that acknowledges and accepts Māori nursing practices is vital for the retention and well-being of Māori nurses.

Māori Professional Development and Recognition Programmes

Incorporating the dual competence of Māori nurses into the Professional Development and Recognition Programmes (PDRP) is a strategic approach to validate their cultural contributions. This inclusion ensures their efforts are formally recognised and appropriately remunerated within their professional development. An existing PDRP programme, such as Huarahi Whakatu (Te Rau Ora, 2024), could be promoted and supported by nursing leadership for use by Māori nurses.

New Graduates and Post-Graduate Study

The availability of postgraduate study options is a critical factor in retaining registered nurses, offering them avenues to advance their careers and enhance their skills. However, new graduate nurses often face the pressure of completing postgraduate courses in their first year of practice while simultaneously striving to build their clinical experience and competence (Foxall, 2017; Wilkinson & Gray, 2021). Additionally, there is a need to ensure that the courses offered align with the career aspirations of new graduates.

Cook (2009) highlighted a considerable disparity in funded career pathways, noting that advanced practice roles in nursing lack the support available in training programs for doctors. He suggested that this gap may stem from limited collaboration between the Ministry of Health,

Te Whatu Ora Health New Zealand, the Tertiary Education Commission, and postgraduate nursing education providers. Lack of intersectoral collaboration restricts the alignment of educational opportunities with the healthcare sector's employment needs and nursing career choices—a gap that advocacy through a Nurse Education and Workforce Board could address.

To support retention, equitable funding is needed to expand postgraduate study options for nurses, ensuring access to a variety of educational opportunities and providing more supportive, less pressured pathways for new graduates to pursue postgraduate qualifications (Foxall et al., 2017; Wilkinson & Gray, 2022). This approach will allow nurses to advance their careers in ways that are both professionally fulfilling and aligned with sector needs.

Addressing Racism and Ensuring Kawa Whakaruruhau

Workplace racism remains a significant barrier to retaining Indigenous nurses (Barton & Wilson, 2021; Foxall et al., 2017; Hunter & Cook, 2020a; Huria et al., 2014; Komene et al., 2023; Wilson, 2017; Wilson et al., 2011). According to Lai et al. (2018), racism and stigma pose significant challenges for Indigenous health professionals. Wilson, Barton et al. (2022) further noted, "it is structural racism supported by interpersonal racism that enables the oppression of Māori nurses" (p. 13).

Racism and discrimination within the healthcare system are also major obstacles to advancing the Māori workforce (Ratima et al., 2007). Aspinall et al. (2021) highlighted that healthcare organisations must implement an intersectional approach in their policies related to workforce equity and the opportunity to tackle implicit bias and racism within the workforce effectively.

To address racism and uphold kawa whakaruruhau, healthcare organisations must establish secure, accessible pathways for Māori nurses to report instances of racism without fear of retribution or marginalisation. Participants shared experiences where they encountered or witnessed racism but did not feel safe enough to report it. Designating a 'safe' person within the organisation to whom Māori nurses can report such incidents, coupled with transparent policies and procedures that respond to these reports, would offer much-needed assurance that their concerns will be acknowledged and addressed.

Additionally, providing ongoing professional development for non-Māori staff to build critical awareness of implicit biases and a deeper understanding of Māori perspectives would help mitigate these issues (Berryman, 2016). Cultivating a culturally safe environment is essential for the retention and well-being of Māori nurses, ensuring they feel respected, supported, and valued in the workplace.

Retaining registered nurses, particularly Māori nurses, demands a multifaceted approach that addresses the unique challenges they encounter in the workplace. Integrating dual competence into professional development frameworks, such as the PDRP, is essential for validating their contributions and ensuring appropriate compensation. However, even with such recognition, Māori nurses still face additional expectations due to the inability of colleagues to deliver culturally informed and safe care to Māori patients. This ongoing burden highlights the need for organisational support that genuinely addresses systemic shortcomings in cultural competence across the nursing workforce.

Expanding postgraduate study options and aligning them with career aspirations is also vital for retention, particularly for new graduates who face significant pressures in their early years of practice. Ensuring that these educational opportunities are accessible and relevant will help nurses advance their careers and feel supported in their professional growth.

Moreover, addressing workplace racism is essential for creating a culturally safe environment where Māori nurses can thrive. Providing secure mechanisms for reporting racism, coupled with ongoing professional development for non-Māori staff to raise awareness of implicit bias and promote understanding of Māori worldviews, is necessary to combat the structural and interpersonal racism that contributes to burnout. A holistic approach that includes support through clinical supervision, recognition of dual competence, expanded educational opportunities, and a commitment to addressing racism is essential for retaining Māori nurses and ensuring their well-being within the New Zealand healthcare system.

Conclusion

Persistent underinvestment and inconsistent commitment from the government and nursing leadership has perpetuated the illusion of progress in fostering an equitable nursing workforce for Māori in New Zealand. Despite the clear evidence of the vital need for a sustainable, culturally responsive nursing workforce, Māori nurses continue to bear the burden of inadequate support and recognition in a system that often prioritises short-term solutions over meaningful, transformative change. This chapter has highlighted how smoke and mirrors undermine real efforts for change, particularly through policies and funding structures that only superficially address workforce disparity; ultimately, leaving Māori nurses unsupported and undervalued.

A nursing governance group, along with a national nursing strategy, are both critical to dismantling these illusions and creating truly equitable nursing education and practice. Establishing a National Nursing Workforce Strategy with specific attention to the unique needs of Māori nurses could ensure that nursing workforce policies are both sustainable and

genuinely inclusive. Such a strategy must extend beyond rhetoric, incorporating robust data collection, intersectoral collaboration, and comprehensive funding to create a pipeline that supports Māori students from secondary education through to advanced practice. This approach would reflect and meet the needs of Māori nursing representation at every level.

Additionally, the role of culturally responsive clinical supervision and support for Māori nurses cannot be overstated. Māori nurses operate under dual competencies, integrating both cultural and clinical skills in their practice. However, this unique contribution remains largely unrecognised in mainstream professional development frameworks. Integrating cultural competencies into PDRP or offering existing programmes and offering culturally responsive clinical supervision would help to validate the work of Māori nurses and compensate for the additional workload.

Workplace racism continues to pose a major barrier to both recruitment and retention of Māori nurses. To uphold kawa whakaruruhau (cultural safety), healthcare organisations must adopt zero-tolerance policies towards racism and establish clear, accessible pathways for Māori nurses to report instances of discrimination without fear of reprisal. Moreover, a proactive commitment to ongoing professional development for non-Māori staff is crucial to fostering critical awareness of implicit biases and promoting an inclusive workplace culture. By developing an understanding of Māori worldviews, non-Māori colleagues and leaders can become allies in creating a work environment where Māori nurses feel valued and respected.

In essence, the smoke and mirrors approach must be replaced with transparent and accountable processes. This transformation will require an honest assessment of existing structures, as well as a willingness to adopt innovative models, such as EAYL programmes, that address financial and accessibility barriers for Māori. While the task of decolonising the nursing profession and addressing racism to create a supportive environment for Māori nurses may seem insurmountable, this chapter illustrates that there are approaches that can help to alleviate the pressure. By prioritising a strategic approach, the nursing workforce can be seen to be unified and working collaboratively to achieve key priorities and committed to addressing the persistent health disparities affecting Māori. Only by moving beyond the illusions of progress and investing in real, enduring change can the nursing profession truly represent the population it serves.

Part C: Complicit Disregard

"Complicit disregard" describes situations where individuals or groups knowingly ignore or overlook wrongful actions, thereby becoming complicit through their failure to intervene or voice concerns. This section employs an intersectional framework to explore how overlapping

identities, and systemic structures reinforce a culture of complicity, particularly in the experiences of Māori nurses. These nurses encounter entrenched systemic and interpersonal racism, compounded by gendered expectations within a predominantly female profession, and bear the additional burden of serving as cultural advocates and providers of culturally safe care for Māori patients.

This section begins by examining the pervasive impact of racism on Māori nurses, including the concept of dual competence and the added burdens they face. It explores how these factors affect quality of care, outlines the presence of racism in nursing leadership, and delves into the broader implications of intersectionality in perpetuating inequities. Drawing on the synthesis of data, this section presents key statements alongside actionable strategies to dismantle these barriers in Addressing Complicit Disregard in Healthcare: Ōritetanga (Equity). This analysis aims to provide a critical understanding of the systemic inequities faced by Māori nurses and to highlight tangible pathways toward achieving meaningful and sustainable change, fostering an equitable and inclusive health care workforce.

Impact on Māori nursing

Māori registered nurses in the New Zealand health system frequently encounter discrimination, often manifesting as persistent bullying, microaggressions, and implicit biases. Māori nurses who resist assimilation into the dominant culture experience further marginalisation and alienation which can severely impact their confidence and well-being (Hunter & Cook, 2020a; Minton et al., 2018). Intersectionality highlights that this discrimination does not occur in isolation but intersects with gender, socio-economic status and cultural expectations.

These experiences were echoed throughout interviews with student and registered nurse participants. One participant became tearful while recounting years of sustained bullying and microaggressions from colleagues. Despite her approaches to management, the harassment persisted, ultimately taking a toll on her mental health and overall well-being. She firmly believed racism was at the core of this treatment. The emotional toll of dealing with racism not only affects Māori nurses' health and well-being but also diminishes job satisfaction. These conditions contribute to stress, anxiety and burnout, and ultimately, the decision to leave the profession (Foxall, 2013; Komene et al., 2023; Tabakakis et al., 2020; Zambas et al., 2020).

Student nurse participants expressed feelings of bitterness upon realising that to succeed, they must conform to dominant cultural norms, feeling "torn" between their authentic selves and the culture of the nursing profession. This struggle highlights how intersectional identities are shaped by systemic racism and the expectation to assimilate. Many Māori students described the experience of leaving their "culture at the door" upon entering the nursing environment, a

decision that has personal and professional implications. This forced assimilation particularly impacts Māori women in nursing, who encounter both racial and gendered expectations to adhere to the dominant cultural norms while trying to meet Māori patients' needs. One participant aptly described the profession as lacking inclusivity of other worldviews, stating, "It’s hard to be Māori and fit in."

Dual Competence and Added Burdens

The lack of support to cope with discrimination and the additional workload required to deliver dual competent care highlights the systemic barriers Māori nurses and nursing students face in performing their roles effectively (Hunter & Cook, 2020a; Huria et al., 2014; McClintock et al., 2019; Komene et al., 2023; Walker, Clendon et al., 2016; Wilson & Baker, 2012; Wilson et al., 2011). Participants provided numerous examples of dual competence, illustrating the added expectations placed on Māori nurses due to non-Māori colleagues’ lack of cultural proficiency.

Huria et al. (2014) suggested that advocating for Māori patients in often hostile clinical environments significantly increases the workload for Māori nurses. Despite these challenges, Māori nurses continue to enhance the quality of culturally concordant care for Māori patients and their whānau (Barton & Wilson, 2022; Hunter & Cook, 2020a; Komene et al., 2023; Wilson & Baker, 2012).

Participants provided many examples that illustrate the added burden placed on Māori nurses to compensate for the cultural incompetency among non-Māori staff. In all situations, managers appeared complicit. This complicity in ignoring Māori nurses’ and students’ experiences of racism and disparity is deeply embedded in the profession. Non-Māori managers and nurse leaders know there are staff members who lack the skills to provide culturally competent care to Māori, but they overlook this issue because they rely on Māori nurses to shoulder the extra responsibilities.

This situation creates a complex issue for Māori nurses: on one hand, they understand that their culture is not fully welcomed in the clinical setting; on the other, they are called upon to draw on their cultural knowledge to ensure safe and appropriate interactions with Māori patients, compensating for colleagues who lack the required cultural competence.

As previously discussed, the Nursing Council's stance on cultural safety appears as “smoke and mirrors,” projecting the illusion of enforcement through standards and regulations, when all the time knowing that the standards and regulations are having little impact. However, the Council is also complicit in disregarding the impacts of racism and disparity on Māori nurses, as non-Māori nurses are not held accountable for culturally unsafe practices and cultural

incompetence. Nursing leaders are fully aware of these issues and share in the complicity. Intersectionality highlights the added expectation to provide dual competent care, with the pressures Māori nurses face as both caregivers and representatives of their culture (Huria et al., 2014; McClintock et al., 2019; Walker, Clendon et al., 2016).

Impact on Quality of Care

Systemic racism within healthcare institutions continues to result in disparities in the access to and quality of care for Māori patients (Came et al., 2020; Graham & Masters-Awatere, 2020; Ministry of Health, 2020b; Waitangi Tribunal, 2019). Evidence suggests that the lack of cultural concordance between patients and health professionals can lead to reduced patient satisfaction, access to healthcare, and adherence to treatments (Espiner et al., 2021; LaVeist & Nuru-Jeter, 2002; Cooper et al., 2003; Wilson, Barton et al., 2022).

Māori nurses are acutely aware of the healthcare access disparities affecting their whānau, hapū, and iwi, including higher morbidity and mortality rates and shorter life expectancy. Navigating a healthcare system that is inherently racist, marginalises and underserves iwi Māori, places a significant strain on Māori nurses, both personally and professionally (Hunter & Cook, 2020a; Huria et al., 2014). One participant illustrated the challenges by describing how, when a whānau member needed to access health care, they would call her, as she was seen as the "door opener," recognising that she had the necessary skills to facilitate access. She expressed concern about "who would be the door opener if I was not here,", revealing how Māori nurses' intersecting identities (as caregivers, family members, and cultural advocates) are leveraged within a system resistant to Indigenous practices. This intersectional burden illustrates that Māori nurses operate within a healthcare system that requires them to override inherent racism to ensure Māori patients receive adequate care.

Racism in Nursing Leadership

The persistent complicit disregard of nursing leadership to address inequities has entrenched disparities within the nursing workforce. As previously discussed, Māori nurses face discrimination, lack of support, and added pressures to provide dual competent care, contributing to higher levels of stress, job dissatisfaction, and burnout (Huria et al., 2014; Hunter, 2019; Wiapo et al., 2024; Wilson et al., 2022). The lack of value and recognition from nursing leadership has not only affected Māori nurses' professional identities but also has far-reaching implications for recruitment and retention.

International research shows that such marginalisation is common among Indigenous nurses (Brockie et al., 2023). Although recent developments have seen Māori nurses' step into nationally significant roles, these advancements often occur in isolation, supported by Māori

nursing rather than mainstream nursing leadership. However, despite the elevation of Māori nurses into national roles, the locus of power within nursing remains firmly with Pākehā (New Zealanders of European descent).

The marginalisation and oppression experienced by Māori nurses was vividly illustrated through two separate interviews, participants described the intense suppression they felt when attempting to elevate themselves within the profession. Both using the analogy of a 'foot' being applied to the head as a way of maintaining dominance and ensuring suppression. Their statements provided a powerful visual representation of oppression. It is no coincidence that "the foot" is used to symbolise the force of suppression, while "the head"—the most sacred part of the body to Māori—is the targeted point of pressure. In both accounts, the oppression is depicted as life-threatening, highlighting the severe impact on Māori nurses' sense of safety, well-being, and professional potential.

Māori nurses, positioned at the intersection of racial identity, gender, and cultural expectations, face complex challenges within the nursing profession. Indigenous women frequently experience systemic racism and discrimination rooted in colonial ideologies that perpetuate both gender and racial inequities. This is evident in the health systems where Western paradigms dominate and marginalise Indigenous knowledge and practices, exacerbating health inequities for Indigenous people (Toyibah & Riyani, 2022). These challenges highlight the need to move beyond tokenistic cultural safety policies and address the compounding oppressions Māori nurses encounter (Aspinall et al., 2023; Brockie et al., 2021).

This synthesis of the data highlights the pervasive impact of "complicit disregard" and systemic racism within New Zealand's nursing profession, particularly on Māori nurses, who navigate compounded forms of discrimination shaped by intersecting identities of race, gender, and cultural expectations. Despite obligations under Te Tiriti o Waitangi, successive governments and nursing leadership have failed to address longstanding disparities, contributing to an environment where Māori nurses experience higher workloads, discrimination, and a lack of institutional support.

The intersectional lens applied in this analysis reveals that Māori nurses' experiences are not only shaped by racism but also compounded by gendered expectations within a predominantly female, Pākehā-dominated profession. To achieve equity, healthcare institutions and nursing leadership must shift beyond superficial cultural safety policies and address the entrenched structures that perpetuate discrimination.

Key statements from synthesis of data

- The government and the nursing profession are complicit in disregarding the ongoing racism, discrimination and marginalisation of Māori within the nursing workforce

- The government's actions do not uphold their responsibilities under the Te Tiriti o Waitangi

- Nursing Leadership and Nursing Council have been complicit in reinforcing superficial cultural safety policies and entrenched structures that perpetuate discrimination

Addressing Complicit Disregard in Healthcare: Ōritetanga (Equity)

Māori nurses continue to face widespread racism, discrimination, and marginalisation in New Zealand's healthcare and educational institutions. Many participants attributed the static state of the Māori nursing workforce over the past 40 years to systemic racism. Despite numerous reports advocating investment in the Māori nursing workforce, little meaningful action has been taken (Barton et al., 2021; Brockie et al., 2023; Health Workforce Advisory Board, 2020). The persistent rhetoric from regulatory and government agencies about the need to increase Māori representation, without substantial progress, reinforced participants' belief that racism is the root cause of this inequity.

To dismantle this ingrained racism and build a safe, inclusive environment for Māori nurses and students, addressing structural racism within healthcare is critical. This requires a comprehensive approach, including understanding racism and bias, establishing secure and effective complaint channels, and ensuring complaints are managed in ways that protect nurses from retaliation or further marginalisation.

Zero Tolerance Policy and Implementation

A key aspect of these efforts is a robust zero-tolerance policy for racism. Clear processes for managing complaints about racism are essential to create a supportive environment for Māori students and nurses, ensuring they can return to their work or education without fear of retribution. Implementing these policies means setting defined performance expectations and clear consequences for racist behaviours or practices that restrict access to equitable care. Such measures are crucial to reassure Māori nurses and students that effective processes are in place to protect them from systemic harm.

Kawa Whakaruruhau and Transformative Praxis

Education is another vital component of this approach, specifically through training that aligns with kawa whakaruruhau. Understanding the historical context of Māori marginalisation within

New Zealand and the lasting impacts on Māori health determinants is essential for fostering an inclusive environment. This training helps all staff comprehend the systemic disadvantages Māori have endured, building a foundation of respect and empathy that is critical to addressing these inequities.

A nuanced understanding of bias is equally important. Labelling bias as "unconscious" can sometimes downplay its real impact. King's (1991) concept of 'dysconsciousness', an uncritical acceptance of inequity that justifies the status quo, encourages a more critical consciousness in examining personal biases that shape decisions and actions (as cited in Berryman et al., 2024). Transformative praxis education is therefore recommended as part of professional development, enabling staff to cultivate awareness and challenge ingrained biases in their work.

Cultural safety remains a fundamental aspect of New Zealand's nursing curriculum and competency frameworks. However, the limited impact of cultural safety on improving Māori health outcomes highlights the need for a more active approach to challenging dominant discourses and improving attitudes toward Māori and other underrepresented groups.

Addressing systemic and structural racism within healthcare is essential for the advancement and well-being of the Māori nursing workforce. By instituting effective complaint processes, enforcing zero-tolerance policies, and embedding kawa whakaruruhau education, healthcare and nursing education can begin to break down the barriers that have impacted Māori. A deeper understanding of bias and a commitment to transformative praxis are further steps toward building a more equitable and supportive environment for Māori nurses and students.

The call for change goes beyond just increasing Māori representation; it requires a health and education system that respects, protects, and values Māori contributions and perspectives. However, genuine progress can only be made when racism is not passively accepted (or complicitly disregarded), but is actively eliminated at all levels, setting a new standard for accountability and inclusivity across the sector.

Conclusion

This chapter has illuminated the entrenched systemic and interpersonal racism faced by Māori nurses, compounded by gendered expectations and their unique role as providers of culturally concordant care. Through an intersectional lens, the analysis has revealed how overlapping identities, and institutional structures reinforce a culture of complicity, perpetuating discrimination and inequities within the nursing profession.

The persistent challenges Māori nurses encounter—including dual competence burdens, a lack of institutional support, and the systemic marginalisation of Māori voices—highlight the failure of nursing leadership, government, and regulatory bodies to address these issues meaningfully. The ongoing rhetoric around equity and cultural safety policies remains insufficient, failing to translate into tangible improvements for the Māori nursing workforce.

To achieve ōritetanga (equity), it is imperative to dismantle the entrenched structures and practices that perpetuate systemic racism within healthcare and nursing. This requires implementing robust zero-tolerance policies for racism, fostering transformative praxis through education, and embedding kawa whakaruruhau as a guiding framework. Addressing these challenges is not only critical for improving the well-being and representation of Māori nurses but also has the potential to enhance the overall quality of patient care.

The findings from this chapter underscore the urgent need for action that goes beyond superficial promises and cultural safety rhetoric. Acknowledging and addressing "complicit disregard" at all levels is essential to create a safe, inclusive, and equitable environment for Māori nurses and, ultimately, to ensure better health outcomes for whanau, hapū and iwi.

Chapter 9: Conclusion–Kua Tau

‘Ka whakaoti i ngā mahi hira i a rā’

Now the important tasks for the day can be completed

This concluding chapter summarises the key learning from the research, providing an explanation for what has hindered the growth of the Māori nursing workforce in New Zealand over the past 40 years. Guided by the central research question, Why has the Māori nursing workforce remained static for 40 years?, this chapter synthesises insights from interviews with Māori nurses and students, key stakeholders, and a review of grey literature and policy documents.

The findings have considered the enduring effects of colonisation, systemic racism, and political indifference on the Māori nursing workforce. These structural inequities have been perpetuated by inadequate workforce planning, ineffective leadership, racism and discrimination, that fail to address the root causes of disparity. While many of the themes identified in this research have been repeatedly raised by Māori nurses over the last 30years, this study has developed a deeper understanding of the challenges of the broader sociopolitical context that has reinforced these barriers.

This chapter reflects on the implications of the research findings for nursing education, leadership, and policy in New Zealand. It revisits the central research question and the propositions that guided the study, highlighting the new knowledge generated through the research. Recommendations are presented as a pathway toward meaningful and sustainable change for the Māori nursing workforce, offering practical solutions grounded in the research findings. The chapter concludes by identifying areas for further research, aiming to support ongoing efforts to address systemic barriers and promote equity in the nursing profession.

Addressing the Research Question

This research set out to examine why the Māori nursing workforce has remained static over the past 40 years and to identify potential strategies for change. At the outset, five key propositions guided the case study approach, helping to shape the research scope and define areas of focus. These propositions provided a foundation for linking data to the core research question:

1. Policy outcomes have enabled equitable access for Māori into nursing programmes.

2. Nursing and health leadership have adequately planned for the future of New Zealand's nursing workforce.
3. Nursing has been effectively marketed as a viable career option to Māori.
4. Māori new graduate nurses are provided with appropriate support in their first year of practice.
5. Systemic racism significantly contributes to the static state of the Māori nursing workforce.

The data gathered and analysed in this study provides a clear connection to each of these propositions, addressing the original research question and providing a well-developed explanation on the persistent underrepresentation of Māori in the nursing profession.

New Knowledge Generated Through this Research

Synthesis of the data and development of interpretations in this research have highlighted new insights into the systemic barriers that continue to marginalise Māori within the nursing workforce. Through a focused examination of the themes of *false hope and empty promises*, *smoke and mirrors*, and *complicit disregard*, this research advances a deeper understanding of the broader sociopolitical and structural factors that sustain inequities in the profession.

One of the significant achievements of this synthesis is the contextualisation of the Māori nursing workforce challenges within the historical and political landscape of New Zealand. By connecting decades of unfulfilled recommendations, political inertia, and reliance on international recruitment, the findings describe how successive governments have failed to prioritise the development of an equitable and sustainable nursing workforce. Through this process the systemic neglect that perpetuates persistent disparities in investment for Māori nursing workforce development has been identified and revealed how essential political will is to strategic planning and addressing inequities.

Additionally, this research has critically examined the superficial measures implemented by nursing leadership and government that create an illusion of progress. The theme of *smoke and mirrors* captures how short-term, fragmented funding and initiatives, as well as ineffective cultural safety measures, have perpetuated inequities rather than addressing them. By identifying the Nursing Council's ongoing endorsement of cultural safety as an 'ultimate illusion', the synthesis exposes the limitations of existing policies that fail to deliver meaningful, transformative change. This analysis both critiques the policies and challenges the nursing

profession to confront its exclusionary practices, including the entrenched old girls' network that reinforces the status quo.

The synthesis has also brought attention to the intersectional challenges faced by Māori nurses, including systemic racism, gendered expectations, and the emotional toll of providing kawa whakaruruhau within a discriminatory system. The theme of *complicit disregard* highlights the ways in which nursing leadership and the government have knowingly perpetuated these inequities, failing to uphold their obligations under Te Tiriti o Waitangi. By integrating intersectionality into the analysis, this research has provided a comprehensive view of how colonial structures and discriminatory practices intersect to create significant ongoing challenges for Māori nurses.

Importantly, this synthesis critiques existing systems and offers a framework for understanding the root causes of disparity and the steps needed to address them. It highlights the need for transparent, transformative leadership and accountability in both the political and professional domains. By prioritising the voices and lived experiences of Māori nurses, this research advances the call for structural change, advocating for equity-focused policies, investment, and workforce planning.

Ultimately, the synthesis of data and interpretations achieved in this research offers an insightful critique of the entrenched systems that marginalise Māori nurses, while simultaneously providing a roadmap for meaningful change. It underscores the urgency of dismantling colonial structures, fulfilling the obligations of Te Tiriti o Waitangi, and fostering a more inclusive, equitable nursing workforce that reflects the principles of social justice and kawa whakaruruhau.

Recommendations

Taurakohia Model: Strategies for Increasing the Recruitment of Māori into Nursing

In response to the challenges described above, the Taurakohia model (see Fig. 4) draws inspiration from the pūrākau 'Te hopukia te rā e Māui'– the story of how Māui slowed the sun. In this pūrākau, Māui crafted a magical rope from flax, which he used to slow the sun's journey across the sky. The model conceptualises the strands of Māui's rope as tools for binding and gathering. Just as Māui's rope held the sun, the Taurakohia model utilises these symbolic strands to gather and connect the essential strategies needed to increase the recruitment and retention of Māori in nursing. This model, Figure 5, proposes a structured approach to addressing barriers through collective and strategic action.

Figure 5.

Taurakohia

Recommendations and Implications

The Taurakohia model offers a comprehensive set of recommendations developed through this research. Over the past 30 years, extensive studies have been conducted on Māori nurses and nursing students, yet researchers continue to revisit the same questions, often without implementing meaningful change. This model consolidates the wealth of existing knowledge, providing clear and actionable solutions to address the issues identified both in this study and previous research. It serves as a pathway to move beyond repetitive inquiry, offering a foundation for meaningful action and systemic transformation.

Addressing the challenges faced by Māori in nursing requires a collaborative, multi-sector approach involving government, educational institutions, healthcare organisations, and the nursing profession. Buchan and Calman (2004) provided a useful framework that includes workforce planning, recruitment and retention, deployment, performance, and skill mix—each critical to building a sustainable workforce. Despite advocacy and evidence-based information from Māori nurses, these systemic changes remain largely unimplemented.

Based on the findings of this research, the following recommendations offer evidence-based interventions to increase Māori representation in nursing. The Taurakohia model proposes four strategic strands to address Māori nursing underrepresentation.

TAURA 1: Addressing Racism

To improve Māori representation, tackling both structural and interpersonal racism in healthcare and nursing education is essential. Addressing systemic racism is foundational to enhancing the Māori nursing workforce and improving healthcare outcomes for Māori. Key recommendations include:

- Implementing a zero-tolerance policy for racism in all organisations, paired with clear complaint management processes, to create safer and more inclusive work environments for Māori nurses and students.
- Mandating kawa whakaruruhau across healthcare and educational settings to foster understanding of the historical and ongoing challenges faced by Māori.
- Moving beyond cultural safety to a commitment to transformative praxis that challenges and addresses existing inequities in the profession.

Implementing these recommendations aligns with the original intent of kawa whakaruruhau, as conceptualised by Irihapeti Ramsden (1990), creating a safer environment for both Māori nurses and Māori patients. By establishing inclusive and culturally informed workplaces, these measures will provide a more supportive framework for Māori nurses and foster a healthcare system that better meets Māori health needs.

TAURA 2: Rangatiratanga

Promoting self-determination and leadership for Māori within nursing education and the broader healthcare system is essential for achieving equitable outcomes. To realise this, the Māori nursing workforce must be expanded. Establishing kaupapa Māori nursing programmes and work environments, with autonomy from mainstream systems, will provide Māori nurses with a supportive framework in which they can learn and thrive. These initiatives—Māori-centred teaching methods, culturally engaging support and supervision, and active collaboration with whānau, hapū, iwi, and Māori organisations—will help build a resilient Māori nursing workforce for the future. However, achieving this vision requires an urgent increase in the capacity of the Māori nurse educator workforce.

Promoting and supporting rangatiratanga honours Te Tiriti o Waitangi and fosters equity across New Zealand's healthcare system. By prioritising Māori recruitment, addressing systemic racism, and promoting rangatiratanga, the nursing profession will be better equipped to meet the specific health needs of Māori. This approach will also help create a more inclusive, culturally engaged, and responsive healthcare system that meets the needs of the Māori population.

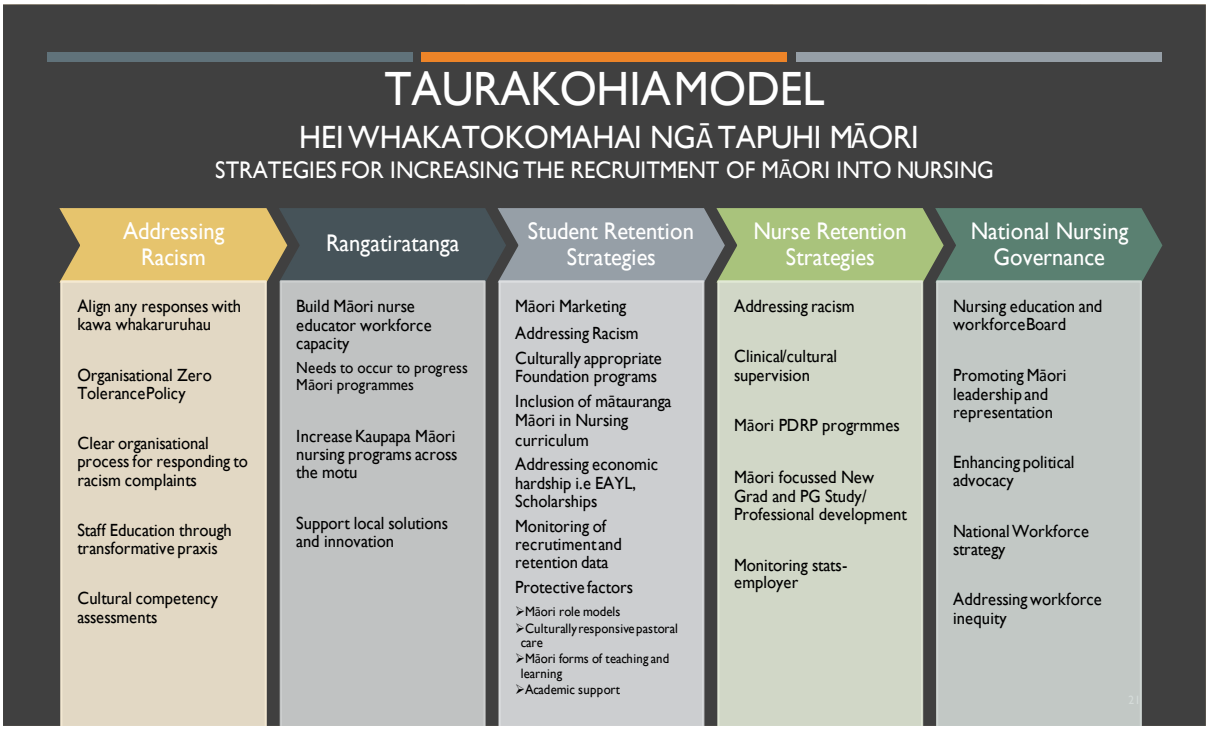
TAURA 3: Recruitment and Retention Strategies

Durie (2009) emphasised that increasing Māori participation in higher education should be measured through several key outcomes: tribal engagement, culturally relevant curricula, campus facilities that reflect Māori culture, Māori research capabilities, staff representation, and effective policy implementation. True participation goes beyond inclusion; it aims to transform organisational culture to support Māori success. Employers and leaders in healthcare and Schools of Nursing must implement targeted strategies to recruit and retain Māori students and registered nurses (see Figure 6, p. 198). Many of the recommended interventions draw on nearly 2-decades of evidence-based research, which has established effective practices for supporting Māori participation in both education and the healthcare workforce (Curtis, Wikaire et al., 2012; Curtis & Reid, 2013; Durie, 2009; Haar & Brougham, 2011).

The Taurakohia model as outlined in Figures 5 and 6, provides a strategic framework to guide the future of Māori nursing development, ensuring equitable representation of Māori within the nursing profession and fostering a healthcare environment that is inclusive and culturally responsive.

Figure 6.

Taurakohia Model



TAURA 4: Establishing National Nurse Education and Workforce Governance

Cook (2009) highlighted the importance of establishing distinct Māori nursing leadership within health services to ensure alignment with Māori needs and perspectives. He also emphasised the necessity of a consistent influx of Māori nurse graduates to sustain and strengthen this leadership.

To address the current fragmentation in New Zealand's nursing workforce—which has resulted in inefficiencies, disparities, and a lack of strategic direction, especially for Māori nurses—a cohesive and culturally responsive governance structure is essential. Establishing a National Nurse Education and Workforce Governance body would enable centralised oversight, data management, and strategic advocacy to support a unified and equitable nursing workforce. Given that nursing is the largest sector of New Zealand's regulated health workforce, a dedicated governance authority is crucial for implementing effective policies, shaping equitable recruitment strategies, and ensuring the interests of Māori nurses are actively represented.

A critical function of the proposed governance structure would be to exercise political influence and advocate for nursing workforce priorities at the national level. This includes establishing a unified voice for nursing in political arenas and proactively lobbying for policies that include Māori workforce development, address systemic racism, and support health equity. Political advocacy, facilitated by the National Nursing Education and Workforce Board, would enable the profession to hold policymakers accountable for commitments to equity and kawa whakaruruhau and to influence resource allocation, ensuring that Māori nurses receive the support necessary to thrive within the profession.

A National Nursing Education and Workforce Board would unify the nursing profession and strengthen its political presence and influence. By prioritising Māori representation and advocating for culturally responsive policies, this body would ensure that the voices of Māori nurses are both heard and acted upon. This governance framework would be a cornerstone in advancing a more inclusive, strategically aligned, and politically engaged nursing workforce in New Zealand.

Future Research

This research highlights several critical areas requiring further exploration to address the systemic issues facing the Māori nursing workforce. The following recommendations for future research are proposed.

Political Advocacy and Lobbying

Investigating political advocacy and lobbying in healthcare, particularly nursing, could provide valuable insights. Comparative studies examining how advocacy is effectively conducted in other countries, how it is taught in educational or professional settings, and its potential application in New Zealand are necessary. Such research could inform strategies to strengthen nursing representation and influence in policy-making processes, particularly for Māori nurses.

Nursing Governance Bodies

A comparative analysis of the roles and functions of nursing governance bodies internationally could provide lessons for improving governance structures in New Zealand. Understanding how these bodies operate in countries with successful nursing workforce strategies may help inform reforms that better address the needs of Māori nurses and other underrepresented groups.

Cultural Safety: Evaluation and Redesign

Cultural safety has been a cornerstone of New Zealand's nursing education and practice for decades, yet its impact remains questionable. Research should critically review the efficacy of cultural safety, exploring whether it remains fit for purpose or if alternative frameworks could better serve the profession and Māori health outcomes. Any replacement model must include measurable outcomes to ensure accountability and effectiveness.

Longitudinal Research on Bachelor of Nursing Māori Programmes

Aspects of the Taurakohia model could be trialled and implemented through dedicated Bachelor of Nursing Māori programmes. Longitudinal studies tracking the outcomes of these programmes would provide evidence of their efficacy in supporting Māori nursing students and enhancing their retention and success rates. Research is already underway, offering an opportunity to evaluate the model's real-world application and impact.

These areas of research will be pivotal in achieving equity within the nursing workforce and creating a more inclusive and supportive environment for Māori nurses. By addressing these gaps, future research can contribute to systemic change, enabling the nursing profession to better meet the needs of Māori and New Zealand as a whole.

Conclusion – Speaking into the Wind

Many of the themes highlighted in this research echo those identified in earlier studies—tragically, very little is new. Māori nurses have been 'speaking into the wind' for so long that their voices have grown hoarse. This research aims to sustain their efforts and push beyond empty rhetoric, ensuring that these voices no longer drift unheard.

Historically, Māori nursing has been undervalued; building a strong Māori nursing workforce consistently deprioritised. As Reid et al. (2019) observed, “As long as oppressive systems that re-inscribe racism and white privilege persist in our communities, including academic institutions, coloniality continues to discriminate” (p. 8). This research stands as a call to action, advocating for systemic changes to recognise, support, and uplift Māori nurses within New Zealand.

By adopting the strategies outlined in the Taurakohia model, stakeholders across government, healthcare, and education have the opportunity to transform the future of Māori representation in nursing. Much like Māui’s magical ropes, which held and slowed the sun, the Taurakohia (gathering rope) model binds the essential strategies needed to address workforce inequities and guide the nursing profession toward true cultural responsiveness.

The journey forward requires unwavering commitment to equity, rangatiratanga, and structural transformation. Through the Taurakohia model, New Zealand’s healthcare system can catch and hold the light of equity and inclusion, evolving to serve the diverse needs of its people and honouring the voices of Māori nurses who have long fought to be heard. Each step forward brings the country closer to a future where Māori nurses are empowered to lead, inspire, and create lasting change for their whānau, hapū, and iwi.

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Appendices

Appendix A: AUT Ethics Confirmation

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

5 August 2021

Denise Wilson
Faculty of Health and Environmental Sciences

Dear Denise

Ethics Application: 21/265 Strategies for increasing the recruitment of Māori into nursing

Thank you for submitting your application for ethical review. We are pleased to advise that the Auckland University of Technology Ethics Committee (AUTEC) approved your ethics application at their meeting on 2 August 2021, subject to:

1. Provision of a step-by-step overview of how participants will be recruited for the research. Inclusion in each of the Information Sheets of advice on this in the 'how was I identified' section;
2. Provision of an assurance that google docs will not be used as storage during the data analysis stage as noted in the Data Management Plan. Provision of a revised plan for this research stage, referring to AUTEC's guidelines and data storage matrix which are available on the Research Ethics website at http://aut.ac.nz/researchethics;
3. Amendment of the Information Sheet for stakeholder interviews as follows:
    a. Use of the current template with all the relevant sections which can be found on the Research Ethics website at http://aut.ac.nz/researchethics;
    b. Disclosure of the research funding;
    c. Inclusion of the time required of participants in the costs section;
    d. Removal of the sentence referring participants to confidential counselling. Instead include the verbatim wording for counselling from AUT Health Counselling and Wellbeing which can be found on the Research Ethics website at http://aut.ac.nz/researchethics;
    e. Inclusion of advice on the duration and location of interviews;
4. Amendment of the Information Sheet for focus groups as follows:
    a. Use of the current template with all the relevant sections which can be found on the Research Ethics website at http://aut.ac.nz/researchethics;
    b. Inclusion of the time required of participants in the costs section;
    c. Disclosure of the research funding;
    d. Addition of advice that your own students are excluded from participation;
    e. Removal of the sentence referring participants to confidential counselling. Instead include the verbatim wording for counselling from AUT Health Counselling and Wellbeing which can be found on the Research Ethics website at http://aut.ac.nz/researchethics;
    f. Inclusion of advice on the duration and location of focus groups;

5. Inclusion in the Consent Form for stakeholders of a yes/no tick box alongside the bullet point asking participants if they consent to being named in the research.

Please provide us with a response to the points raised in these conditions, indicating either how you have satisfied these points or proposing an alternative approach. AUTEC also requires copies of any altered documents, such as Information Sheets, surveys etc. You are not required to resubmit the application form again. Any changes to responses in the form required by the committee in their conditions may be included in a supporting memorandum.

Please note that the Committee is always willing to discuss with applicants the points that have been made. There may be information that has not been made available to the Committee, or aspects of the research may not have been fully understood.

Once your response is received and confirmed as satisfying the Committee's points, you will be notified of the full approval of your ethics application. Full approval is not effective until all the conditions have been met. Data collection may not commence until full approval has been confirmed. If these conditions are not met within six months, your application may be closed and a new application will be required if you wish to continue with this research.

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

We look forward to hearing from you,

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

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: pbarton@northtec.ac.nz

Appendix B: Participant Information Sheet- Focus Group

Participant Information Sheet- Focus Group

Date Information Sheet Produced:

20 Aug 2021

Project Title

Strategies for increasing the recruitment of Māori into nursing

An Invitation

Tēnā Koe

He mihi mahana tenei ki a koe

Ko Tainui te waka, Ko Pirongia te maunga, Ko Ōparau te Awa, Ko Kāwhia te moana, Ko Waipapa toku marae, Ko Ngāti Puhiawe me Ngāti Horotakere ōku hapu, Ko Ngāti Hikairo toku Iwi. Ko Pipi Barton toku ingoa. Tēnā koutou katoa. He whakamārama tenei e pā ana ki ngaku mahi rangahau PhD, Ko te kaupapa ake o te rangahau nei he whakatokomaha i nga Naahi Māori mo te wā heke, no te mea, e mohio ana tatou, ma tatou ano e whai i te oranga mo ngo tatou iwi Māori. No reira, ko ēnei ngaku wawata e hora nei.

My name is Pipi Barton and I whakapapa to Ngati Hikairo ki Kawhia. I currently work as a nurse educator in the Bachelor of Nursing program at Northtec in Whangarei and I am a PhD student at AUT. I have received a Scholarship from the New Zealand Health Research Council to research the Māori nursing workforce as part of my PhD study. I am writing to request an opportunity to interview you for my PhD research. The research topic is *Strategies for increasing the recruitment of Māori into nursing.*

What is the purpose of this research?

The evidence is clear that the Māori nursing workforce has remained static for 40 years, at 6-7.5%. The aim of this research is to ascertain the issues that have contributed to the static state of the Māori nursing workforce and to understand what you believe will improve the situation. Therefore my research further asks; why has the Māori nursing workforce remained static for 40 years? And what strategies could change the situation? The findings from this research may be used for publications and presentations, and this rangahau will contribute to my PhD qualification.

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

You have been invited to participate in this research because you meet the inclusion criteria, being either a Māori nursing student enrolled in an undergraduate nursing program or a Māori Registered Nurse. Students currently enrolled in the Bachelor of nursing at Northtec in Whangarei are excluded from this study.

I intend to interview other Māori nursing students and Registered Nurses as well as Key Stakeholders. I will also review policy documents related to Māori health and the nursing workforce from 1980-2020, to understand how policy has aided or hindered the growth of the Māori nursing workforce.

How do I agree to participate in this research?

If you agree to be interviewed, you will need to sign a consent form agreeing to participate in this research, I am happy to meet with you in person (Covid levels permitting) or via zoom if you require more information. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Your privacy and confidentiality will be protected by the removal of all identifying features and the use of a special identification number system, used for all references to the interview in any publication or presentation.

Please contact me by the 31st July 2022 at pbarton@northtec.ac.nz if you would like to participate in this research and a consent form can be forwarded to you to sign.

What will happen in this research?

If you choose to participate in this research, I will arrange a time and a place to meet. You will be joining a focus group so there will be up to six other Māori students or Registered Nurses in the group. Once everyone has arrived, we will begin with a karakia and whakawhanaungatanga. A digital recorder then will be turned on and I will proceed to ask the questions outlined in the interview schedule. If we meet in person, a Kai will follow the interview and we will close the hui with a karakia.

What are the discomforts and risks?

There is a potential risk that what is discussed in the interview may cause some discomfort, but this is considered minor.

How will these discomforts and risks be alleviated?

If you do experience some distress, AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Your participation in this research includes generating new Māori nursing workforce knowledge, which ultimately may lead to developing strategies for growing our nursing workforce. As previously noted this research will also contribute to my PhD qualification.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

What are the costs of participating in this research?

There are no costs related to being involved in this research other than the time taken to participate in an interview for up to an hour and a half.

What opportunity do I have to consider this invitation?

Please respond to me by the 31st August 2022 at pbarton@northtec.ac.nz

Will I receive feedback on the results of this research?

Once the information has been gathered and analysed a summary of the research findings will be provided to you, as well as information on any publication associated with this research.

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

If you have any concerns regarding this research project then please do not hesitate to contact me at, Pip Barton, pbarton@northtec.ac.nz, 021 1409674. Any concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* , (+649) 921 9999 ext 6038.

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

Researcher Contact Details:

Pipi Barton

Email: pbarton@northtec.ac.nz

Project Supervisor Contact Details:

Professor Denise Wilson

Email: denise.wilson@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 25th August 2021, AUTEC Reference number 21/265

Appendix C: Consent Form- Focus Groups

Consent Form (Focus Group)

Project title: ***Strategies for increasing the recruitment of Maori into nursing***

Project Supervisor: ***Dr Denise Wilson***

Researcher: ***Pipi Barton*** ***Date: 16/03/22***

(Please tick)

- O I have read and understood the information provided about this research project in the Information Sheet provided.
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that identity of my fellow participants and our discussions in the focus group is confidential to the group and I agree to keep this information confidential.
- O I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed OR allowing it to continue to be used.
- O I understand however, that if I should choose to withdraw once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one):

YesO NoO

Participant's Name: .....

Participant's Signature: .....

Participant's Contact Details:

.....

.....

..... Date:

Approved by the Auckland University of Technology Ethics Committee on the 25th of August 2021 AUTEC Reference number 21/265:

The participant should retain a copy of this form.

Appendix D: Participant Information Sheet- Key Stakeholder

Participant Information Sheet- Key Stakeholder

Date Information Sheet Produced:

25 August 2021

Project Title

Strategies for increasing the recruitment of Māori into nursing

An Invitation

Tēnā Koe

He mihi mahana tenei ki a koe

Ko Tainui te waka, Ko Pirongia te maunga, Ko Ōparau te Awa, Ko Kāwhia te moana, Ko Waipapa toku marae, Ko Ngāti Puhiawe me Ngāti Horotakere ōku hapu, Ko Ngāti Hikairo toku Iwi. Ko Pipi Barton toku ingoa. Tēnā koutou katoa. He whakamārama tenei e pā ana ki ngaku mahi rangahau PhD, Ko te kaupapa ake o te rangahau nei he whakatokomaha i nga Naahi Māori mo te wā heke, no te mea, e mohio ana tatou, ma tatou ano e whai i te oranga mo ngo tatou iwi Māori. No reira, ko ēnei ngaku wawata e hora nei.

My name is Pipi Barton and I whakapapa to Ngati Hikairo ki Kawhia. I currently work as a nurse educator in the Bachelor of Nursing program at Northtec in Whangarei and I am a PhD student at AUT. I have received a Scholarship from the New Zealand Health Research Council to research the Māori nursing workforce as part of my PhD study. I am writing to request an opportunity to interview you for my PhD research. The research topic is *Strategies for increasing the recruitment of Māori into nursing*.

What is the purpose of this research?

The evidence is clear that the Māori nursing workforce has remained static for 40 years, at 6-7.5%. The aim of this research is to ascertain the issues that have contributed to the static state of the Māori nursing workforce and to understand what you believe will improve the situation. Therefore my research further asks; why has the Māori nursing workforce remained static for 40 years? And what strategies could change the situation? The findings from this research may be used for academic publications and presentations, and this rangahau will contribute to my PhD qualification.

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

You have been identified as a Key Stakeholder in relation to the Māori nursing workforce, and therefore I am contacting you directly to request an interview with you. I intend to interview other Key Stakeholders for this research as well as a number of Māori nursing students and Registered Nurses. I will also review policy documents related to Māori health and the nursing workforce from 1980-2020, to understand how policy has aided or hindered the growth of the Māori nursing workforce.

How do I agree to participate in this research?

If you agree to be interviewed, you will need to sign a consent form agreeing to participate in this research, I am happy to meet with you in person or via zoom if you require more information. Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

Due to the size of Aotearoa, it may not be possible to provide privacy and confidentiality for key stakeholder interviews, therefore I will be seeking your consent to allow for you to be identified or to remove all identifying features but be aware that there may be a risk of identification.

Please contact me by 30 September 2022 at pbarton@northec.ac.nz if you would like to participate in this research and a consent form can be forwarded to you to sign.

What will happen in this research?

If you agree to be part of this research, I will ask that you find sometime in your schedule to meet with me. The interview will take up to an hour. Location and time of interview will be arranged with you. We will begin with a karakia and

whakawhanaungatanga. A digital recorder then will be turned on and I will proceed to ask the questions outlined in the interview schedule. If we meet in person, kai will be provided and we will close the interview with a karakia.

What are the discomforts and risks?

There is a potential risk that what is discussed in the interview may cause some discomfort, but this is considered minor.

How will these discomforts and risks be alleviated?

If you do experience some distress, AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant, and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Your participation in this research includes generating new Māori nursing workforce knowledge, which ultimately may lead to developing strategies for growing our nursing workforce. As previously noted this research will also contribute to my PhD qualification.

What compensation is available for injury or negligence?

In the unlikely event of a physical injury as a result of your participation in this study, rehabilitation and compensation for injury by accident may be available from the Accident Compensation Corporation, providing the incident details satisfy the requirements of the law and the Corporation's regulations.

What are the costs of participating in this research?

There are no costs related to being involved in this research other than the time taken to participate in an interview for up to an hour.

What opportunity do I have to consider this invitation?

Please respond to me by the 30th September at pbarton@northtec.ac.nz

Will I receive feedback on the results of this research?

Once the information has been gathered and analysed a summary of the research findings will be provided to you, as well as information on any publication associated with this research.

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

If you have any concerns regarding this research project then please do not hesitate to contact me at, pbarton@northtec.ac.nz and 021 1409674. Any concerns regarding the conduct of the research should be notified to the Executive Secretary of AUTEC, *ethics@aut.ac.nz* (+649) 921 9999 ext 6038.

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

Researcher Contact Details:

Pipi Barton

Email: pbarton@northtec.ac.nz

Project Supervisor Contact Details:

Professor Denise Wilson

Email: denise.wilson@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on 25th August 2021,

AUTEC Reference number 21/265

Appendix E: Consent form- Key Stakeholder

Consent Form (Key Stakeholder-Amended)

Project title: ***Strategies for increasing the recruitment of Maori into nursing***

Project Secondary Supervisor: ***Dr Stephen Neville***

Researcher: ***Pipi Barton***

PLEASE TICK

- O I have read and understood the information about this research project in the Information Sheet provided
- O I understand that because of the size of the nursing community in New Zealand it cannot be guaranteed that my identity will be confidential therefore:

  I understand that my identity will remain confidential, but it cannot be guaranteed that I will not be identified.
  (Tick) YES O NO O

  I consent to using my name.
  (Tick) YES O NO O
- O I understand that a copy of the transcript will be made available to me to view before any publication or presentation of findings
- O I have had an opportunity to ask questions and to have them answered.
- O I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.
- O I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- O I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- O I agree to take part in this research.
- O I wish to receive a summary of the research findings (please tick one):

  YesO NoO

Participant's signature:

.....

Participant's name:

.....

DATE:

Participant's Contact Details:

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Approved by the Auckland University of Technology Ethics Committee on 25th August 2021,

AUTEC Reference number **21/265. Please retain a copy of this form.**