Enhancing nurse education to support the provision of quality nursing care for people who identify as transgender: an action research study

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Abstract

Aim

The study discussed in this doctoral thesis sought to assess a potential mechanism through which communities, who previously did not have a voice, could influence practice and systems. The research question was: ‘How can engagement with the community influence an existing nurse education programme, with regards the provision of quality care for transgender people? It was based on a research informed perspective that transgender people experience significant disparities in health and barriers to healthcare access. The research was posited on a view that nurses are well positioned, if appropriately informed, to enhance the healthcare encounters for transgender people.

Methodology

The study used an action research methodology, underpinned by a social constructionist epistemology and a philosophy of practical knowing. Action research was selected for this study because, when networking, I discovered that there were people in the organisation who saw a need for action, I believed that people from the transgender community needed to inform our actions. An action research approach would enable those that could instigate change to collaboratively work with those that should inform change.

Method

Our study adapted a method outlined by Coghlan (2019) that provides a process for undertaking action research within the researcher’s own organisation. This method involved repeated cycles of constructing, planning, taking action and evaluation. It is an approach that contributed to knowledge through focussing on the learning that occurred throughout the research process. In total, six nurse educators, five community members, one transgender nursing student, and two student support staff members participated, at some point, in the action research project. Data were analysed thematically using reflective thematic analysis (Terry et al., 2017).

Results

Engagement led to a reconstruction of how education could be designed and delivered. This result was described through four themes:

- Engagement made visible the impact of binary normativity.

- The programme was understood to be lacking in diversity content.
- Transgender group members were repositioned as experts in their field.
- Organisational barriers to community engagement became visible.

Engagement led to transformation beyond the nursing programme. This result was described through four themes:

- Collective concern around NE's understanding of non-binary genders.
- Challenging organisational norms to support transgender engagement.
- Opportunities were created that empowered transgender community members.
- Reconstructing the curriculum through influencing change at a national level.

Recommendations

At a first-person level (the researcher), it is recommended that projects align to social change movements and researchers commit to purposeful reflection to support practical knowing. At a second person level, (the group), we found creating a safe space for engagement, was important. We also found that recognising the experiential expertise of community members and using a bottom-up (staff) alongside a top-down (executive level) approach, supported transformative action. At the third person level (wider organisation and beyond), it is recommended that community people are positioned as subject matter experts, in the co-design of new content.

Conclusion

This study found that an action research methodology, underpinned by a social constructionist worldview supported gender affirming practice at a programme, organisational, local community, and national level.

Acknowledgements

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[1] https://www.consulted.ac.nz/

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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.

Glossary

+	Represents the diversity of genders, sexual orientations, and sex characteristics (InsideOut, 2020)
Bisexual	A person who is sexually attracted to people of their own gender and people of other genders (Gender Minorities Aotearoa, 2020)
Cisgender	A person whose identity aligns with the gender assigned to them at birth (Gender Minorities Aotearoa, 2020)
Gay	A person who is attracted to a person of the same gender (InsideOut, 2022)
Non-binary	Used by some who do not identify exclusively as man or woman (Oliphant et al., 2018).
Genderqueer	Similar to queer but the person specifically rejects binary genders, or the conventions associated with a particular gender (Gender Minorities Aotearoa, 2020)
Intersex	Describes a variation of sex characteristics present at birth. Sex characteristics are ambiguous in the context of male/female sex binary (Gender Minorities Aotearoa, 2020)
Lesbian	A woman or gender diverse person who is attracted to women (InsideOut, 2022)
Queer	May be used by people who reject heteronormativity and are not heterosexual. May also be used by heterosexual transgender people (Gender Minorities Aotearoa, 2020)
Rainbow	An umbrella term that is inclusive of people of gender, sexuality, and sexual characteristic variations (InsideOut, 2022)
Takatāpui	A Māori term, for those who are not heterosexual or are not cisgender. Also used by individuals who identify as bisexual, transgender, intersex, or part of the rainbow community (Gender Minorities Aotearoa, 2020)
Transfeminine	A spectrum that includes trans women and people who identify as feminine but not as binary women (Oliphant et al., 2018)
Transgender Or Trans	An umbrella term used by some people whose gender expression and/or identity differs from what is socially constructed as typical of their sex assigned at birth. Trans is an acceptable shortening of transgender (Gender Minorities Aotearoa, 2020)
Trans masculine	A spectrum that includes trans men and people who identify as masculine but not as binary male (Oliphant et al., 2018)

LGBTQAI+	An acronym commonly used to represent members of the rainbow community. That is, lesbian, gay, bisexual, transgender/Takatāpui, queer/questioning, asexual, intersex, and other gender and sexual minorities. Variations of this acronym are used within this thesis.

Note:

- Terminology related to gender is evolving, and individuals may define their identity differently to definitions above. It is important to use the descriptive term used by the person. It should also be noted that an individual's identity or expression of identity may change often or over time.
- New Zealand is often referred to, within New Zealand, as Aotearoa. This study used the Te Reo Māori, indigenous word Aotearoa when referring to New Zealand.

CHAPTER ONE: BACKGROUND AND OUTLINE OF THIS THESIS

1.1 Introduction

Health disparities in Aotearoa indicate a need to better prepare health professionals for the provision of quality care for transgender people (Gamble Blakey & Treharne, 2019). Within Aotearoa, nurses make up the largest group of healthcare professionals (Ministry of Health, 2016). However, initial personal correspondence with nursing schools within Aotearoa (2018) conducted prior to this study, indicated that nursing education programmes provided little or no transgender patient care content within their respective nursing programmes. The study discussed in this thesis sought to better understand how engagement with people from the transgender community and their allies, using an action research (AR) process, could influence the revision of an existing undergraduate nurse education programme. The overarching aim was to better support the provision of quality care for transgender people. The research question for this study was: How can engagement with the community influence an existing nurse education programme, with regards the provision of quality care for people who are transgender? This study sought to contribute to practical knowing and was underpinned by a social constructionist worldview.

This chapter will firstly provide a rationale for this study. It will then present my position by outlining my personal interest in this topic, my epistemological view, and the reasons for the methodological approach adopted. An overview of nursing education within Aotearoa, alongside an understanding of my organisation's nursing programme's regulatory environment and factors influencing this study's curriculum design and content will also be presented. An outline of the thesis' chapters will then be provided.

1.2 Rationale for this study

There is a global growing need for a change in practice with regards people who identify as transgender. Studies outside of Aotearoa, have shown that transgender people experience significant disparities in health. Transgender people have higher than general population rates of unemployment, homelessness, poverty, and societal marginalisation (Chisolm-Straker et al., 2017). They also have higher rates of substance abuse (Grant et al., 2010), depression (Hyde et al., 2014), and suicidality (Reisner et al., 2015). Young transgender people may face intolerance at home, or experience discrimination at school, which could significantly impact on their health and social wellbeing (Winter et al., 2016).

Transgender people in Aotearoa experience similar disparities. An Aotearoa study (Tan et al., 2020), involving 1176 survey participants concluded ‘trans and non-binary’ people were more likely, than the general population, to have experienced psychological distress; to have considered or attempted suicide; to have used cannabis; and/or to have experienced sexual violence. This study also found transgender and non-binary people were more likely than the general population to experience unemployment, financial hardship, and periods of homelessness. Fenaughty et al. (2021) found that transgender and non-binary school students in Aotearoa were less likely to have someone they felt cared for them; less likely to feel connected at school or safe in their neighbourhood; and far more likely to report symptoms of depression.

International studies have shown transgender people also experience numerous barriers to accessing healthcare. Such barriers include: challenges to navigating and accessing gender affirming health care or being refused treatment (Roberts & Fantz, 2014); previous experiences of violence or harassment when accessing healthcare (Shires & Jaffee, 2015); providers refusing to use requested pronouns (Bradford et al., 2013; Grant et al., 2010; Lim et al., 2014); patients needing to educate providers on transgender patient care (Bauer et al., 2014; Grant et al., 2010); and the blaming of health conditions on gender affirming procedures (Legal, 2010). These studies exemplify that globally many transgender people experience discrimination, or inept care when they attempt to access healthcare. Discrimination within healthcare settings is a salient issue for members of gender diverse communities (Jaffer et al., 2016). Fear of discrimination deters transgender people from accessing appropriate and timely healthcare (Bauer et al., 2014; Grant et al., 2010) and may be subsequently detrimental to health outcomes (Fowler et al., 2018).

An Aotearoa study (Tan et al., 2020) argued health inequities for transgender and non-binary people were exacerbated by factors that presented barriers to healthcare access. Over a third (36%) of the participants in their study reported having avoided seeing a doctor because they were worried about being disrespected or mistreated. These findings reflect the findings of the 2008 survey undertaken by the Human Rights Commission (Aotearoa) which found many transgender people in Aotearoa did not want to seek medical help even for minor matters due to previous negative health care experiences. Such experiences included misgendering, moral lectures and the use of dehumanising language (Human Rights Commission [HRC], 2008).

In Aotearoa, when accessing healthcare, individuals have the right to be treated with dignity and respect, and to receive care of an appropriate standard that is free from discrimination. These rights are set out in New Zealand's Health and Disability Commissioner Act (Ministry of Health, 1996, [reviewed 2014]) and in International Human Rights Law (Hairsine, 2018). However, there are significant gaps in healthcare provider education that impact on the ability of healthcare practitioners to competently, provide appropriate healthcare for members of the transgender community (Gamble & Treherne, 2019). So, despite these rights, in Aotearoa, healthcare practitioners are not educated to provide an appropriate standard of care for transgender people.

Action that supports education for nurses in their care of people from the transgender community would significantly improve the healthcare experience for this population group. This is because, nurses make up the largest group of healthcare providers in Aotearoa (Ministry of Health, 2016) and they move into a wide range of medical and social work fields. Nurses can play a significant role in enhancing the health care experiences of gender diverse patients, particularly in hospitals, emergency departments and inpatient settings (Middleton & Holden, 2017). This is because within such settings they are the health care professionals who have the most direct contact with patients (Riley, 2015). Additionally, nurses can be influential in health institutions' organisational policies (Arabi et al., 2014). Nurses are well positioned, if given the skills and knowledge, to influence healthcare encounters for transgender people and can, if made aware, challenge policies and processes that are not gender affirmative.

Nurses are required to provide culturally safe care for their patients. At the start of this study there were no Aotearoa based studies that had investigated how nurse education supports the provision of quality care (including culturally safe practice) for transgender patients. Nursing programme leaders, in response to an email sent via the 'Nurse Education in the Tertiary Sector' (NETS) network indicated few nursing programmes included content pertaining to transgender health care, (personal correspondence, 2018). For programmes that had content related to transgender healthcare it was a brief one-off presentation session related to LGBT (lesbian, gay, bisexual, and transgender) culturally safe care.

International studies also indicate there is inadequate attention given to the topic of transgender healthcare within nursing literature (Merryfeather & Bruce, 2014) and nurse education (Carabez et al., 2016). According to Nursing Council of New Zealand (2011) culturally safe care is defined by those who receive it, which implies transgender people should inform content related to transgender patient care. At the start of this

study there were no published Aotearoa based studies, and few international studies, that have researched how healthcare educators can engage with transgender people to inform their programmes. Studies of projects that have sought to incorporate transgender healthcare content into an existing nursing programme will be reviewed in chapter two of this thesis.

Within Aotearoa, transgender population groups are becoming more visible, and many organisations are moving towards becoming more inclusive of gender minorities. Health providers within Aotearoa have indicated that the demand for gender affirming services has increased significantly over recent years.

> Increasing recognition of transgender and non-binary gender identities, and associated health disparities, indicate an unaddressed and growing need for teaching about transgender healthcare. Globally, and in Aotearoa/New Zealand there is a corresponding need for high-quality research on how to best deliver this education (Delahunt et al., 2018, p. 104).

The increased need for health services for transgender people has vital implications for healthcare education, research, and practice.

In summary, national and international literature indicates transgender people experience disparities in health and healthcare access. Negative experiences within healthcare settings create barriers to accessing healthcare. Nurses are well positioned to positively impact healthcare experiences for transgender people; however, they are not educated sufficiently to enable them to do this. This study sought to engage with members of the community to influence a nursing programme with regards transgender healthcare.

1.3 Positioning the researcher

Factors that led to my interest in transgender healthcare.

My interest in transgender people's health care was initially sparked by a participant in a previous research project. The previous study was about sexual health vulnerabilities for midlife and older women. I was pleasantly surprised when an older transgender woman responded to the request for participants. Her story was enlightening, but also very saddening when she discussed her health care experiences. This woman's stories saddened me as she described how she had been refused gender affirming therapy by several healthcare professionals. The therapy she was finally prescribed, after some time, she realised was aimed at supressing libido, rather than supporting her as a

woman. She managed to advocate for herself in an unsupportive medical system, and successfully had gender affirming surgery over 50 years ago. I was fascinated by this woman's narrative because she had challenged her poor treatment, and found a way to gain gender affirming surgery, at a time when it was not readily available. While this particular interview was focussed on mid-life women's sexual health vulnerabilities, years later it led me to reflect on transgender people's healthcare experiences.

From my own life experiences, I have seen that there can be tough consequences for those who assert themselves as being outside of western gender norms. As a child, I was a 'tomboy': I was not comfortable with traditional female presentations or interests; my 'boyish' clothes, short hair, deep voice, and muscular physique caused people to ask about my gender. The "are you a boy or a girl?" questioning, as I got older, made me feel uncomfortable. As an adolescent, my masculine look, despite my efforts, by that time, to conform to female norms of presentation, positioned me as 'undatable' and subject to cruel comments from some teenagers and numerous adults. This led to a decade, or more, of eating restrictions to reduce muscle mass to look petite, my perspective then of what feminine should look like; promiscuity and unsafe sexual practices to affirm my desirability as a female; and depression. With marriage, children, age, and a societal shift in attitudes towards muscular physiques of women, I became less offended by people's comments such as "you are so muscular," and "your voice is so, uhm, husky".

Prior to starting my doctoral study, I met an amazing young person who identified as gender non-binary. This young person discussed their anxiety, in relation to an impending hospital stay. Their anxiety was based, in part, on what they had heard from other transgender people who had experienced negative encounters when accessing healthcare in Aotearoa. This young person was also anxious because they were uncertain as to how things would be organised with regards the admission process and the ward they would be admitted to. It occurred to me that nurses, particularly nurses working in hospital settings, could significantly influence a patient's healthcare encounter, if they were educated about gender affirming healthcare.

I reviewed national literature but found no studies on this topic. International literature indicated that few nursing programmes included content related to transgender healthcare. Being a science educator within a nursing education programme afforded me some critical distance and allowed me to consider how nurse education is socially constructed, with regards nursing practice and transgender healthcare. I initially considered undertaking a mixed method methodology research to learn more about

transgender people's healthcare experiences, and subsequently contribute knowledge to nursing literature on this topic. However, as the preparation for the study progressed, I realised that an AR approach would better support the study's purpose. This realisation is discussed next.

1.4 Why action research?

Initially, I considered positioning this research within the transformative paradigm that is promoted by Mertens (2010) as an overarching paradigm for mixed methods methodology. This is an emerging paradigm, inspired by, and bearing a close relationship to, critical theory (Romm, 2015). In an earlier work, Mertens (2007), posited that researchers working in the transformative paradigm seek knowledge that holds potential for social justice. Nursing education in Aotearoa must ensure students are committed to social justice (Nursing Council of New Zealand, 2021 [updated 2022]). A commitment to social justice needed a project that sought to challenge oppressive structures and practices that cause individuals to feel disrespected or unsafe or lead to unequal access to opportunities that would enable them to strive. This is not so much about resources, although resources are important, but more about people being able to go about their daily lives without feeling, or being made to feel, inferior to others.

My personal sense of inferiority stems from my school days. At that time, I lived in a council/state house, my mother was unmarried, and her boyfriend lived with us. I attended a high socio-economic Catholic school. I felt, at school, that the girls from the good Catholic families were treated differently to me. Most times the discrimination was quite blatant. My school years were awful. While, I am now in a more privileged situation, I am mindful of how societal norms and structures can lead to the positioning of some people as having more or less value than others. When planning my doctoral study, I wanted to undertake research that would bring about change that had a social justice intent. Lewin (1946), whose work led to the development of AR methodology, argued: "research that produces nothing, but books will not suffice" (p. 35). Over time, I came to the opinion that AR would support social justice related changes within the programme where I worked, and subsequent improvement in nursing practice.

Another factor which influenced my decision to use an AR approach was that several of my work colleagues, who knew of my interest in transgender people's health, approached me individually for support in their developing transgender patient care content for their respective papers. I realised there were people in my organisation who wanted to bring about change but were unsure of how to go about this. Lewin (1946)

described a comparable situation when he sought a research approach that could transform the great amount of goodwill of the people, who saw a need for change but who “felt to be in the fog” (p. 34), into organised, efficient action. I considered co-workers’ requests for change as an opportunity to transform our curriculum, however, I was not an expert on transgender health. I came to realise we needed an approach that would enable nurse educator engagement with transgender people to bring about change. AR was an approach which addressed this need.

1.5 Why a social constructionist epistemology?

My personal world view is that knowledge is socially constructed. For several reasons, a social constructionist epistemology aligned well with this study:

- This study focussed on transgender wellbeing. Transgender wellbeing is impacted strongly by a strong socially constructed view of gender as being normatively binary.
- This study was positioned within an existing nurse education programme. Nursing education is also socially constructed. Nursing curriculums are developed within particular socio-cultural contexts and are influenced by prevailing discourses.
- This study used an AR methodology, underpinned by a philosophy of practical knowing. A key characteristic of practical knowing is that knowledge is socially constructed.

While these are big statements, they are presented here to position the research approach. They will be unpacked and discussed more within this thesis.

In summary, discussions with transgender people led me to seek to understand and address barriers to healthcare access for transgender people. Nurse educators (NEs) within my organisation requested support for change with regards the addition of teaching material related to the provision of quality care for transgender patients. This led me to an AR approach that assumed knowledge at a discursive level and social norms with regards gender are socially constructed. The context of this study, nursing education within Aotearoa, is discussed next.

1.6 Context of this study

Nursing education within Aotearoa/New Zealand.

For nurses to practice in Aotearoa they must have completed a three-year Bachelor of Nursing degree or a two-year Master of Nursing Science or graduate entry programme. All students must also pass a state final examination set by the Nursing Council of New Zealand (NCNZ). 'Bachelor of Nursing' students are required to complete their qualification within five years. 'Bachelor of Nursing' programmes are offered at five universities and 12 polytechnics. That said, all polytechnics in Aotearoa recently merged into a unified body, Te Pūkenga. However, it is likely that the polytechnic sector will undergo further changes in the near future. Graduate entry programmes are offered at six universities and one polytechnic. The NCNZ, approves nursing programmes and administers the 'State Final Examination'.

The NCNZ is the regulatory body for nursing in Aotearoa. In addition to administering the state final examination, this body approves providers' curricula and sets the standards for Bachelor of Nursing, Enrolled Nursing, and Master's programmes. The standards include programme length, contact hours, clinical locations, and placement hours. NCNZ regularly audits nursing programmes to ensure standards are met, and subsequently determines if a tertiary provider can continue to run its nursing programme. NZNC also maintains a register of people able to practice nursing in Aotearoa. NZNC reviews cases where a particular nurse has been accused of malpractice and can subsequently remove a person from their register which means they are no longer able to practice as a registered nurse.

NCNZ policy and practice are influenced by the health sector. For example, the Health Practitioner Competence Assurance Act (HPCAA), ensures safety of the general public; it is a driving document for the NCNZ. The NCNZ seeks advice from the sector through its education reference group and the Nurse Executives of New Zealand (NENZ). The education reference group is comprised of chairs of: The Council of Deans of Nursing and Midwifery (CDNM); Nurse Educators in the Tertiary Sector (NETS); and Wharanga Ruamano (Māori Nurse Educators). NENZ, is a network of nurse leaders who collaborate with groups and agencies on matters relating to nursing practice and nurse education. These bodies collaboratively develop position papers to address issues members have observed in the field of nursing. Thus, nursing programmes in Aotearoa, while governed by the NCNZ are indirectly informed by industry. NCNZ must also align itself with international regulatory authorities, to enable New Zealand nurses to register

in other countries. For example, NCNZ has a trans-Tasman agreement where NZ nurses get automatic registration in Australia and vice versa.

Providers of nursing education, within Aotearoa, must also meet the requirements of their respective academic governing body. Polytechnics must have their programmes approved by the New Zealand Qualifications Authority (NZQA). This body manages the national qualifications framework and school assessments, and quality assures non-university tertiary programmes. Universities must have their programmes approved by the Committee on University Academic Programmes (CUAP). Provider institutions must also comply with their own academic statutes, and their programme's curriculum document. An institute's academic statue lists the general rules for programmes and courses. A programme's curriculum document outlines the details of the programme, it must conform to the institute's academic statute and its external regulatory requirements.

The NCNZ programme standards (2021 [updated 2022]) require programmes ensure "students' development of knowledge, skills, behaviours, values and attitudes is congruent with… a commitment to social justice … cultural safety… equity, diversity and inclusiveness … addressing the community aspirations for health" (p. 6). However, the latest curriculum document (2022) of the nursing programme of the organisation where I work, advises that when possible clinical specialists contribute to the development of course content and be guest speakers. The word 'clinical' implies that those who experience disparities in health and healthcare access, unless they are clinical specialists, do not get the opportunity to be guest speakers or influence course content. The curriculum document, in my view, contravenes the intention of the standards. How does a programme reflect a commitment to social justice, cultural safety, and diversity when its guest speakers are limited to clinical specialists? How does this programme address community aspirations when it positions clinical specialists as the community experts that will advise on course content?

Traditional nursing education pedagogies have focussed on content, information recall, and skill acquisition, (Horsfall et al., 2012). For example, skill acquisition, using simulation is commonly emphasised in Aotearoa. Within this pedagogical approach lecturers are the undoubted experts. Such a teacher centric approach prioritises lecturer knowledge over other sources of knowledge (Horsfall et al., 2012). In teacher centric approaches students have fewer opportunities to develop critical thinking and problem-solving skills (Serin, 2018). Some authors, for example, Richards et al. (2020) suggest that nursing education in Aotearoa is based on learner-centric pedagogies.

However, from my experience, teacher centric pedagogy is still the most dominant approach. In a teacher centric approach, nurse educators plan and design all course content, this is discussed next.

Course content, in the programme I work in, is not influenced by people in the community who experience disparities in health and healthcare access. It is usually developed by lecturing staff who develop content to meet prescribed learning outcomes. Nurse educators are kept informed of what is happening in local practices through formal stakeholder engagement, involving local provider of placements; the monitoring of students out on placement (workplace practice); and attending local healthcare provider meetings and presentations. Specific content might also be influenced by educators' personal experiences and their professional development, for example, their undertaking postgraduate study, or attending conferences. Thus, content in the programme which I work in is not influenced by recipients of care.

The International Council of Nursing, an international body that seeks to represent nursing worldwide, works to promote 'health for all' at a global level (International Council of nursing, n.d.). Nursing education that supports a principle of 'health for all' may require nursing pedagogies that support the challenging of systems and practices that perpetuate inequities. Such pedagogies include critical pedagogies and transformative learning pedagogies.

Nurses are influenced by and can also influence the social forces that intersect to privilege some identities over others (Pitcher & Browne, 2023). With reference to nursing praxis, an intentional adoption of a critical pedagogy, as seen in Freire (1970) and Giroux (1997), for example, is necessary to support their critical questioning of practice (Pitcher & Browne, 2023). The use of a critical pedagogy to support the development of a course focussed on anti-discriminatory practice was demonstrated by (Garland & Batty, 2021). They found that the use of a critical pedagogy not only supported students' awareness of social justice but also supported a rebalancing of power in the classroom and action to dismantle oppressive structures.

Transformative learning pedagogies also support the critical reflection of the impacts of social norms and hegemony on daily life (Ryan et al., 2022). These authors suggest learning experiences that trigger emotions are needed to develop empathetic and critically reflective health care professionals. Transformative pedagogies differ from traditional pedagogies that are based on the lecturer imparting their knowledge, and instead support the critical questioning of pre-existing perceptions, gained from prior

experiences, and problem solving and adaptation to unforeseen circumstances (Tsimane & Downing, 2020).

Cultural safety.

Cultural safety is an aspect of NCNZ's standards and competencies (NCNZ, 2011). Cultural safety is a term developed from the term 'cultural competence'. Cultural competence was first defined by Cross et al. (1989) in their workshop designed to develop a model for improving health care delivery to "children of color" (p. 6), as "a set of congruent behaviours, attitudes and policies that come together in a system, agency or among professionals and enable that system, agency or those professionals to work effectively in cross cultural situations" (p. 7). The model developed by Cross et al. (1989) highlighted the importance of valuing and adapting to diversity, through having the capacity for self-assessment, having cultural knowledge, and an awareness of the dynamics of cultural interaction. While both the definition and the model have been further developed and revised by many since 1989, the work was a seminal piece in cultural competence understanding and as profoundly influenced future health care provision.

A review undertaken by Alizadeh and Chavan (2015) of 31 publications related to cultural competence identified a consensus of cultural competence. The consensus indicated that cultural competence is the ability to work and communicate effectively and appropriately with people from culturally diverse backgrounds. In both Cross et al. (1989) and the aforementioned review, cultural competence is viewed as being associated with ethnicity. Indeed, the association between culture and ethnicity is so strong in the literature related to cultural competence that the terms could be considered to be synonymous. Cultural competency was later refined to cultural safety. Cultural safety requires, in addition to cultural competence, the provider considers how the power dynamics within a patient-provider interaction influences the provision of care.

According to NCNZ, nurses are required to practice in a culturally safe way. The concept of cultural safety (kawa whakaruruhau) arose from a nurse's Hui (meeting) held in Christchurch, Aotearoa/New Zealand in 1988. This Hui sought to address issues related to the recruitment and retention of Māori nurses. Cultural safety moves the power from the provider to the recipient of the care. It "requires healthcare providers question their own biases, attitudes, assumptions, stereotypes and prejudices that may be contributing to a lower quality of healthcare for some patients" (Curtis et al., 2019, p. 13), and that they provide a "safe, appropriate and acceptable

service which has been defined by those who receive it" (NZNC, 2011, p. 4). According to NCNZ, "unsafe cultural practice comprises any action which diminishes, demeans or disempowers the cultural identity and well-being of an individual" (NCNZ, 2011, p. 13).

A commitment to cultural safety within nurse education programmes did not come without opposition. It was argued that such an emphasis on political correctness detracted from the provision of a comprehensive nursing education programme and lowered standards (Papps & Ramsden, 1996). This controversy, Papps and Ramsden suggested, lies in the confusion as to what cultural safety means, and the belief that it requires students learn Tikanga Māori (customs) and Te Reo (language). This was not the case. Papps and Ramsden (1996) emphasised that culture is different from ethnicity.

Defining culture is beyond the scope of this work however, if we accept a broad definition of culture as "what we create beyond our biology" (McNaughton, 2003, p. 14) then culture must also include gender. Gender being the socially constructed expectations of behaviours and presentations often imposed on children from birth. Since its introduction in 1992, cultural safety, within the nursing competences developed by NCNZ, has been expanded to include age, gender, sexual orientation, socio economic status, ethnicity, spiritual beliefs, and ability.

While NCNZ (2011), in its most recent set of core competency requirements, considers gender to be an aspect of an individual's cultural identity, gender identities, beyond male and female, are not commonly discussed within nursing programmes in Aotearoa. This suggests gender has been perceived, by nursing education providers, as relating to male or female. The growing recognition of genders beyond binary male and female, indicates a need for NCNZ to update its current set of competencies to ensure nurse education providers are preparing students to provide culturally safe care for transgender and gender non-binary patients. The studies that have discussed cultural safety initiatives in relation to nursing care for transgender people will be discussed in the literature review of this thesis.

In summary, nursing programmes within Aotearoa are governed by internal and external regulatory bodies. These bodies significantly influence an organisation's programme. Course content is normally developed by nurse educators and is influenced by their clinical experiences. The NCNZ requires nursing programmes prepare its students: to be committed to social justice; to provide culturally safe care; to seek equity, diversity, and inclusiveness; and to address community aspirations. However, the curriculum document of the organisation where I work, does not require

that members of communities who experience inequity in health, and healthcare access, be invited to be guest speakers. Nor does it provide a means by which marginalised community members can influence course content. This contravenes the NCNZ requirement that culturally safe care is defined by the recipients of the care.

1.7 Study focus

This study sought to improve the healthcare experiences for transgender people. The transgender terminology, used in this study, and transgender history within an Aotearoa context, is discussed in this section.

A note on terminology

This study focussed on enhancing healthcare provision for transgender people. Transgender is an umbrella term which is inclusive of people whose gender does not align to the sex assigned to them at birth. Transgender people are commonly positioned as being members of broader population groups, such as lesbian, gay, bisexual, transgender, queer, intersex, plus (LGBTQI+) or ‘Rainbow’ communities. These wider communities include non-transgender sexual minorities, such as gay, lesbian, and bisexual people. The focus on gender minorities here, rather than sexual minorities, is intentional and is discussed next.

It is acknowledged people from sexual minority population groups experience disparities in health (Gonzales & Ehrenfeld, 2018) and often face discrimination in health care settings (Ayhan et al., 2020). However, unlike sexuality status, that in many healthcare encounters is not recorded and may not be known by the healthcare provider, gender status, particularly if gender does not align to sex assigned at birth, might need to be made known to the provider. For some gender minorities this might significantly influence their healthcare encounter. As such, this study initially sought to enhance nurses’ capacity to provide quality care for transgender people as opposed to the wider LGBTQI+ community.

This study used the term transgender rather than ‘gender diverse.’ Gender diverse was defined by Statistics New Zealand (2015) as “having a gender identity or gender expression that differs from a given society's dominant gender roles” (p. 1). In 2015, Stats NZ announced it would add ‘gender diverse’ to its statistical data collection tools. This move would better inform the nation of its future health and social needs. Following this announcement, several health and educational institutes within Aotearoa added the term ‘gender diverse’ to their documentation and made moves towards having gender neutral toilet signage (mostly a sign added to their disability toilets). The

term ’gender diverse’ was not actually included in the census that followed this decision due to a dissatisfaction with the terminology within transgender communities. In 2021, Stats NZ announced it would collect information on “gender, sexual identity, and variations of sex characteristics” (Stats NZ, 2021, para. 4), a move that highlighted the pressure from transgender organisations in Aotearoa that ‘Stats NZ’ is mindful of correct terminology.

I began this study using the phrase ‘people who identify as gender diverse’ as my population of interest. I considered gender diverse to be an inclusive term for a range of gender identities including, but not restricted to, transgender, agender, non-binary, Takatāpui, intersex and genderqueer. I thought it was an appropriate term as it was used by most tertiary education providers, and many other institutions in Aotearoa. However, as this study progressed, I began to feel uneasy with the term ‘gender diverse.’ It seemed to me this term propagated the dominant construction of gender as normatively binary, a construction this study was seeking to challenge. I was advised by ‘Gender Minorities Aotearoa’ that transgender was the most appropriate term for me to use. The recently established Professional Association for Transgender Healthcare Aotearoa (PATHA) also used ‘transgender’ as an inclusive term for gender minorities. I also came to realise that ‘identifies as’, was not commonly used within transgender communities. This is because ‘identifies as’ suggests the person is choosing their gender rather than their gender being their gender. These new understandings, alongside a view that ‘people who identify as gender diverse’ is long and distracting, for readers, within a thesis caused me to reconsider my terminology. As such, I decided to use the term ‘transgender’ when referring to this study’s population group.

This study used the pronouns of the research participants. Misgendering, which means using an incorrect gender pronoun, for example using he/him versus she/her, or they/them or another pronoun of the person, causes significant discomfort for transgender people. A person who identifies as non-binary may have the pronouns ‘they/them.’ This may appear as grammatically incorrect in some sentences. When referring to other studies, this thesis uses the respective authors’ terminology in relation to the population group under discussion. They/them was used when referring to a person who has advised their pronouns are they/them or to people whose gender was not able to be ascertained.

Transgender history.

Transgender people have always struggled to have a voice in western societies. They have gained support through aligning with the ‘Gay Rights’ movement and have gained

advocacy and support through LGBT organisations such as Stonewall and Rainbow. In recent years, the transgender community has increasingly developed an identity separate to LGB, and globally, appear to be on the brink of what the Times Magazine headline as a 'transgender tipping point' (Steinmetz, 2014). The community's recent visibility has focussed on social justice, and the rights for all to a liveable life. Credit for this activism must be given to those earlier transgender activists who spoke out for social justice, despite threats of violence.

Transgender within Aotearoa.

In the 1950s, Carmen Rupe became the first Māori drag queen. It then took more than two decades before gender affirming surgery became readily available in Aotearoa. Transgender people continued to be a mostly invisible and marginalised group for some time after that. The election of Georgina Beyer in 1995 as the world's first transsexual mayor, who, in 1999, became a Member of Parliament, raised the profile of transgender people. More recently, the Human Rights Commission, advocacy agencies, and the internet, enabling greater access to supportive networks, alongside an increased visibility of successful transgender people in popular culture, and legal and institutional policy changes, have supported transgender identities. Aotearoa is also influenced by Pacific Island culture. Transgender identities within Pacific Island culture have long been recognised and valued (Schmidt, 2011). The 2020 parliamentary elections saw Aotearoa elect the "queerest Parliament in the world" (Bull, 2020). Protecting the rights of Takatāpui was affirmed as a priority for the Green party in 2021 (Kerekere, 2021 [email correspondence] 5/2/2021).

Despite an increased visibility and moves within large government organisations in Aotearoa to support inclusivity, many transgender people continue to experience discrimination. This may be experienced as blatant, aggressive, verbal abuse, or micro-aggressions that include subtle, often unintentional, demonstrations of prejudice, such as seemingly innocuous comments, which are particularly hurtful. Within Aotearoa, it is illegal to discriminate on the grounds of gender or sexual orientation. The Human Rights Commission accepts complaints relating to discrimination based on gender identity and there are several legal acts that provide opportunities for redress. For example, the Human Rights Act (Parliament Council Office, 1993 [updated 2022]) prohibits discrimination on the basis of gender or sexual orientation (article 19). The right to freedom is enshrined within New Zealand's 'Bill of Rights' (Parliament Council Office, 1990 [updated 2022]). Internationally, the United Nations Foundation advises that "trans rights are human rights" (Parnell, 2017, para 3). Article 1 of the 'Universal

Declaration on Human Rights' states "all human beings are born free and equal in dignity and rights" (Parnell, 2017, para 4). Despite these legal rights, transgender people in Aotearoa still experience discrimination.

1.8 Aim of this study

This study sought to investigate how engagement with the community can influence an existing nurse education programme, with regards the provision of quality care for transgender people. It is premised on the belief that a nursing education programme could support student nurses in their future provision of culturally safe care for people of all cultures, including transgender people, and that this care is defined as safe by the recipient of the care. This study used an AR methodology. Specifically, it adopted an approach outlined by Coghlan (2019) which is focused on undertaking AR within the researcher's own organisation. It assumes that knowledge is socially constructed, and AR contributes to practical knowing.

The question of this study is:

- How can engagement with the community influence an existing nurse education programme, with regards the provision of quality care for people who are transgender?

1.9 Why this study is important?

This study will contribute to knowledge by showing how change can be brought about, for an existing nursing education programme, through engagement with its local community. Other nurse education programmes, that embark on developments such as programme content revision, which seek to draw on the skills, knowledge, and experiences of people in the community, might benefit from the learnings of this project. The knowledge gained from this project might also be useful to other programmes of study such as social or health related programmes that seek change through engagement with respective communities.

This study will also contribute to AR theory through the researcher's real time reflections of a unique study within a nursing education programme context. An AR thesis seeks to contribute to academia through connecting the events of an AR project to the contexts of the study and AR theory. Coghlan (2019) suggested that this connection is made through reflection of the events that occurred and the researcher's explicit examination of their own assumptions and inferences as the events unfold.

Specifically, this study will contribute to AR theory within the context a tertiary educations organisational practice.

1.10 Outline of this thesis

This study aimed to investigate how an existing nurse education programme could be influenced by engagement with transgender community members. It used an AR methodology, and assumed knowledge is socially constructed. The outline of this thesis is as follows:

- Chapter one, the introduction, outlined the purpose and rationale for this study, the researcher's positionality, and the context within which the study was undertaken.
- Chapter two, the literature review, will further explore the context through a review of the literature associated with developing and including transgender healthcare content within existing nurse education programmes.
- Chapter three, the methodology, will discuss the assumptions of social constructionism; gender as it relates to social constructionism, AR as a methodology and how practical knowing is constructed through AR.
- Chapter four, the methods, will include: a description of how the AR group was established, the ethical issues that were considered, how data was collected and analysed, and a summary of the events that occurred throughout the project.
- Chapters five and six will present the themes derived from the thematic analysis of the data.
- Chapter seven will link an overview of what Coghlan (2019) termed the 'sense making' of the findings with the purpose, context, and literature of the study. This discussion will form the basis of the study's contribution to practical knowing and will inform the conclusions and recommendations outlined this chapter.

1.11 Conclusion

Transgender people in Aotearoa are members of a population group that is growing in visibility. Transgender people experience significant disparities in health and healthcare access. Nurses are well positioned to influence their patients' healthcare experience and advocate for inclusivity, and subsequently reduce barriers to accessing healthcare for transgender people. However, anecdotal evidence would suggest there is limited discussion about transgender healthcare within nursing programmes in Aotearoa

despite these programmes being mandated to ensure nursing students can provide inclusive and culturally safe care. Culturally safe care is defined by the recipients of the care, yet nursing programmes are not mandated to include members of minority population groups in the development of course content. This study used an AR project to enable authentic engagement with members of the transgender community. It contributes to knowledge by demonstrating how engagement with a marginalised community, using an AR approach, can influence nurse education and nursing practice.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

The research question for this study is: How can engagement with the community influence an existing nurse education programme, with regards the provision of quality care for people who are transgender? The significant role that nurses can play in improving healthcare encounters for transgender people and the importance of preparing nursing students for such a role was discussed in chapter one. This chapter will discuss findings published by tertiary education researchers who instigated initiatives aimed at enhancing nurse education programmes to better support nursing students in their future provision of culturally safe care for transgender patients.

The review focused on the degree to which the respective pedagogical strategies used engaged with people from the transgender community to inform their actions and how the level of engagement influenced change. It is framed by the view that respecting the expertise of members of marginalised communities is important to the determination of culturally safe care. Culturally safe healthcare professionals are competent in the delivery of safe care for marginalised communities and are able adapt to safely meet the needs of patients from diverse cultural groups. Cultural safety is care that is defined as safe by those who receive it (Nursing Council of New Zealand [NCNZ], 2011). It is a social construct that acknowledges patients come from diverse backgrounds and are experts of their healthcare needs. It presupposes that nursing education enables educator and student engagement with members of minority communities to enable respective communities to define what safe care means for them. The review found that few of the studies reviewed engaged transgender community members in the design and implementation of action, and even fewer studies considered wider institutional initiatives.

2.2 Search strategy

The search for literature was undertaken using three electronic databases. These were EBSCO Health (that included CINAHL Complete, and MEDLINE), Google Scholar, and Scopus. The search strategy aimed to find published articles that discussed studies from within educational institutes of initiatives aimed at improving nursing students' cultural competency, humility, or safety with regard their future care of transgender patients. The following search terms were used: nurse OR nurses OR nursing AND education OR program OR programme OR curriculum OR train OR training AND transgender OR transsexual OR transsexual OR 'gender variant' OR 'gender non-

conforming' OR 'gender non-binary' or 'gender diverse' or 'LGBT'. No date range was used to limit the search.

From the EBSCO health database, the search found 720 articles, a further 261 were retrieved from the Scopus database. Google Scholar brought up 71,000 results which were far too many to review. However, narrowing the search terms subsequently resulted in too few articles from the EBSCO and Scopus databases. Thus, the original search terms were retained and the first 500 results in Google Scholar were reviewed. This number was selected as it was the average number of articles from the other two databases, and at this point there appeared to be no further articles which closely met the criteria. 'Google Scholar' and 'EBSCO Host' alerts were set up to capture literature published after the initial review in December 2021.

Studies were included if they occurred within nursing education/training institutes, participants were predominantly nursing students, including advanced practice nursing students, and the studies included a focus on transgender healthcare. Conference abstracts, magazine articles that did not provide methodological detail, and articles that did not have an English translation were not reviewed. The results of the search are discussed next.

2.3 Results

From the EBSCO search, 36 articles met the selection criteria. Thirty-two of these articles were also found in the Google Scholar search alongside an additional two articles. Twenty-eight of the articles from the EBSCO search were also in the Scopus database, and one additional article was retrieved from the Scopus search. A manual search using the references of included published literature revealed an additional three articles. An email alert was set up to retrieve articles published after the first search, from which a further five acceptable articles were included in this review. In total, 47 articles, based on 42 studies were reviewed. These 42 studies are discussed in this review. Most of the studies reported on pedagogical strategies that added one-off learning sessions related to LGBT or transgender healthcare. Few initiatives led to changes that expanded to wider organisational transformation.

The findings from the literature review will discuss the pedagogical strategies used to support transgender education. The findings will be presented in four sections. The first section will present pedagogical strategies that did not involve transgender people in the learning session. The second will discuss pedagogical strategies where the learning sessions provided students with an opportunity to engage with transgender

people. The third section will discuss the few initiatives that enabled transgender people to inform the development of new content, and the fourth will review the few initiatives that sought cultural change within the wider organisation. This chapter is premised on a view that culturally safe healthcare should be defined by the recipients of care, learning occurs through discursive interaction, and that change needs to be supported by a cultural shift within the wider organisation. This review will use the acronyms/gender terms used by the respective authors. A glossary of these terms was provided prior to chapter one.

Most studies did not involve the transgender community in delivery.

Most studies reported on learning sessions that did not involve transgender community members in delivery. While a few studies reported their initiatives were reviewed by content experts, most were not clear as to what they meant by subject experts. This section, therefore, discusses studies that did not explicitly involve transgender people in delivery, and in most cases did not involve them in the review of content. These learning sessions were mostly not impactful. For example, many of the studies discussed in this section reported no significant or lasting gains in attitudes, skills or knowledge or self-reported confidence with regards transgender affirming care. Some of the studies that reported gains, found students expressed a desire to know more. These findings suggest students would have benefitted from the opportunity to engage with transgender people, an approach which would have enabled students to ask questions. Involving community members in learning sessions enables students to construct new knowledge by allowing them to ask questions as they process new information.

Learning sessions that did not involve community members included role-play or manikin simulations, brief lectures or workshops, case studies, or outside of class learning. In some of these studies, students received a learning session prior to the initiative. Seven studies used simulations which involved students in role playing scenarios, or the use of manikins, or virtual simulation. Six initiatives used lectures or workshops, and two used a case study approach. The two case studies enabled students to engage in facilitator supported discussion about ways to assist a patient and their family in a real-life scenario, and in a professional and unbiased way (Henriquez et al., 2019), both were transgender case studies. Four studies set students an assignment or online learning module related to transgender or LGBT health disparities/health care. These approaches were cost-effective ways to enhance student

knowledge and required little preparation and cost. The 19 one-off initiatives that did not involve transgender people in delivery are discussed next.

Role plays, manikins, or virtual simulations.

The initiative in Englund et al.'s study (2019), required 77 students, following a learning session developed from literature, to role play patient/nurse sexual history taking scenarios. While one researcher in this study was described as an expert in LGBTQ healthcare, it was not clear in what capacity they were an expert. This initiative reported an increased number of students reporting feeling 'somewhat confident' about providing culturally competent care to LGBTQ adults but a reduction in the number of students reporting feeling 'very confident'. A shift from feeling 'very confident' to 'somewhat confident', might indicate that some students reflected on their learning experience and realised they knew less than they initially thought about LGBTQ healthcare. One of the scenarios used in the Englund et al.'s study (2019) was based on a transgender patient. None of the students involved in this scenario were able to correctly diagnose the transgender patient's condition, yet over 93% of students correctly diagnosed the condition that the non-transgender patient presented with. This suggests that students were ill-prepared for sexual history taking with transgender patients, and the students had less awareness of non-binary gender identities. An understanding likely influenced by the dominant constructions of gender as normatively binary.

The evaluation of Englund et al.'s study (2019) study appeared to be heavily focussed on culturally competent sexual history taking for non-transgender patients. For example, the outcomes were assessed using a scale that assessed gay/lesbian affirming practice (Crisp, 2006). This gay/lesbian affirming practice tool, initially designed for social workers, enabled the assessment of practitioner's knowledge, attitudes, skills, and subsequent cultural competency regarding gay and lesbian affirming practice. The tool does not mention transgender affirming care. Transgender people have healthcare needs outside of gay/lesbian/bisexual affirmative practice. Conversely, the evaluation of the impact of the intervention in McEwing (2020), discussed next, incorporated transgender cultural competency questions. Transgender cultural competence cannot be fully assessed using a gay/lesbian affirming practice framework.

McEwing (2020) used a version of the Sexual Orientation Counsellor Competency Scale put forward by Bidell (2015), which was designed to enable assessment of practitioner skills, knowledge, and attitudes about LGBT healthcare provision. This

scale included a transgender clinical competency assessment component. The 124 senior public health nursing students in this study completed a series of three online learning modules prior to their simulation exercise. The simulation exercise was based on an emergency evacuation scenario, where students played one of several roles including: health officials, transgender people, or their partners. Pre and post test results were analysed in relation to LGB and Transgender competencies separately. The students showed improvements in overall LGB and transgender cultural competency scores which did not decline by the one-month post intervention survey. The improvement in score was more significant for LGB competency than transgender competency. A result that is further indicative of how a constructed dominant view of gender as being normatively binary impacts on students' cultural competence in relation to transgender healthcare. This result suggests transgender healthcare initiatives require consideration of specific healthcare needs beyond LGB inclusivity.

The simulation in Koch et al. (2021) specifically sought to enhance nurses' skills for communicating with transgender patients. It required students to role play a scripted scenario of a couple, one of whom was a transgender person, experiencing a negative healthcare encounter, followed by a script of the same couple experiencing gender affirming care. The learning activity was followed by a debriefing session. The authors' awareness of the basics of transgender communication was evident in this report. For example, the authors used a non-binary pronoun of 'they' when referring to a singular gender non-binary person and provided correct examples of inappropriate communication with transgender patients. Most students in this study found the simulation helpful, with some reporting an increased empathy for transgender people and a greater understanding of how families may differ. Students also reported an increased confidence in promoting awareness to other providers and a desire to learn more. This study was also unique in that it focussed on the role nurses could play as advocates for transgender people within a healthcare setting.

Alongside role playing, another option for simulation is the use of a manikin. Three articles reported on their study that used a manikin (Diaz et al., 2017; Stockmann et al., 2017; Maruca et al., 2018). The content in this study was informally validated by transgender people and other experts. A trained simulation facilitator led the manikin simulation. Participation in the simulation was compulsory. Prior to this simulation, 170 nursing students received information related to LGBT people within a lecture. Students were provided with readings related to the management of patients presenting with mental health issues and were also informed of resources/services available for transgender people in the local community. This study, as did Englund et

al. (2019) also used a ‘gay/lesbian affirmative practice’ (GAP) measure to assess changes in practice, behaviours, and beliefs/attitudes towards transgender patients. GAP scores for students in this study improved significantly but only minimal gains were seen in students’ belief/attitude scores. Engagement with transgender people directly, and with their lived experiences, might have better supported changes in beliefs and attitudes. Following the simulation, students expressed a desire for more simulations involving LGBTQ people. Students’ desire to know more following this manikin simulation was a positive outcome of the study. It suggests that raising awareness in nursing students of genders beyond the prevailing dominant constructions of gender as binary, led to internal questioning of constructed normativity regarding gender.

Two other studies also used a manikin for their simulation. The transgender patient, in Pittiglio and Lidtke (2021), presented with chest wounds which were self-inflicted to hasten access to gender affirming healthcare. The 91 nursing students in this study undertook a pre-simulation module and a debrief session. These authors also used a GAP scale, although adapted to include to transgender healthcare questions, to assess changes in understanding, before and after the simulation. From the results, the authors reported that the simulation improved student cultural competency regarding transgender healthcare. The Muckler et al. study (2019) involved 30 post-graduate nursing students and focussed on supporting students in gender affirmative practice. The scenario activity was reviewed by a transgender content expert; however, it was not made clear in what capacity they were an expert. Students were briefed prior to the scenario activity. From this intervention, most students reported still feeling unconfident about transgender healthcare. This might suggest that students reflected on the learning experience and realised they needed more knowledge and practice to enable them to provide gender affirmative care. Involvement of transgender people in the delivery of this learning session would have provided an opportunity for unanswered questions and areas of uncertainty to be addressed.

A novel approach to simulations is virtual patient simulation (VPS). Altmiller et al. (2022) developed VPSs which included a transgender person. This study did not explicitly collaborate with its community when developing their respective learning session. From those, of the 126 nursing students in the study who undertook the pre and post-test, using a Transgender Attitudes and Belief scale (Kanamori et al. 2017), the authors found there were no significant gains in total scores however, mean scores increased in the human value subscale. While, VPSs modules might become more common as the world’s digital capability grows, the lack of significant gains from a VPS

approach demonstrates the value of an approach which enables engagement with real people.

Brief lectures or workshops.

One large study involving 1398 students, evaluated the impact of a two-hour advocacy teaching session presented by the researchers Tartavoulle and Landry (2021). The researchers used validated scales (Hill & Willougby, 2005; Morrison et al., 1999) to measure attitudes and knowledge of disparities, terminology and care related to gender and sexual minorities. Similarly, Strong and Folse (2015) used a validated scale (Herek & McLemore, 2011) modified to include questions about bisexual and transgender people, to assess the impact of their brief education session. While this session was only 45 minutes, it was reviewed by students who were members of the organisation's LGBT body. In both initiatives, the results from pre-and post-tests indicated that students made significant gains in knowledge and attitudes.

Braun et al. (2017) studied the impact of 10 x one hour lunchtime elective teaching sessions. These sessions were developed by student leaders and guided by a faculty member (the study author). The sessions were delivered by faculty staff members and were modified in light of student feedback. Impacts were reportedly assessed using a validated transphobia scale; however, I was unable to find this scale from their reference. Post-elective assessment results indicated an increase, relative to pre-elective assessment, in knowledge in three categories of cultural competence without decline after three months. However, there was some drop off in the number of students completing the second and, more so, the third survey which may have skewed these results. Those who completed the follow-up surveys may have found more positive results from the initiative than those who dropped off. Furthermore, this programme was an elective, which may also have skewed results and, may have meant it did not attract the students who would have benefitted most from the initiative.

No funds were available for Braun et al. (2017) to support the development of a module or the involvement of an expert advisor from the community. This is an example of the invisibility of transgender healthcare within nursing curricula, and a lack of respect for the expertise that members of the community would bring to learning experiences for nursing students. It is a credit to Braun that this learning module produced positive outcomes, even though it was developed and offered on the proverbial 'smell of an oily rag'. This study demonstrates the potential effectiveness of collaborative action. It is likely the students who assisted with the development of the module and the teaching

staff who delivered it would have gained significant knowledge about transgender healthcare through this project.

Similarly, Smith et al. (2021) introduced a learning session aimed at enhancing cultural competence with older LGBT adults for nursing and social work students. The session was based on an existing resource (Grubb et al., 2013). It included a video, film clips, and discussion points, alongside terminology related to LGBT healthcare, education, and a question-and-answer session. Notable outcomes reported in this study included statistical gains in attitudes and knowledge, and students indicating a desire to know more about LGBT healthcare. Opportunities for discussion may have supported the construction of knowledge for students. The desire to know more demonstrated that when presented with alternative perspectives to existing gender and sexual normativity, students felt challenged in a positive way. Their curiosity and desire for equity for all people was invoked.

In contrast, the study by Klotzbaugh et al. (2020) specifically focussed on gender minorities. The students in this qualitative study participated in a lecture and set readings that included critical information related to gender affirming care, such as disparities in health, pronoun use, inclusive intake forms, gender-neutral toilets and education about cross-sex hormone therapies. Content was reportedly developed from relevant literature. The learning session also included an open dialogue session between students and lecturers. The initiative led to significant improvement in attitudes and beliefs. It was assessed using a validated transphobia scale (Nagoshi et al., 2008). There was also a significant increase in students' perceived comfort levels towards providing care for transgender patients. Outcomes were likely supported by the opportunities for students to discuss content and collaboratively construct new understandings.

Similarly, the 'Positive Space Training', adopted by Haghiri-Vijeh et al. (2020), also enabled discussion. 'Positive Space Training' was a three-hour workshop which included a range of activities including: a presentation, discussions, case studies, role-plays, and reflection exercises. It was delivered by an equity advisor and two faculty staff. It was not explicitly inclusive of community members in planning. While this workshop was principled on constructivism, described as students building on what they knew, again opportunities for discussion likely supported the collaborative construction of knowledge. The outcomes revealed that most students, following the training, reported feeling more knowledgeable, and comfortable with communicating with LGBTTQ+ patients. Feedback indicated a ripple effect of knowledge transmission

to friends and family of participants regarding communication with gender and sexual minority patients. The use of multiple learning approaches and the drawing on established resources may have supported positive outcomes from this approach. Another approach which might support knowledge development about transgender healthcare is through the use of case studies.

Case studies.

The approach in Henriquez et al. (2019), used case studies, and focussed on nursing students' future care of LGBT older adults, and analysed qualitative feedback. Their programme of learning included preliminary readings and collaborative problem solving, based on a family case study. It was a process that enabled active discussion. The feedback from the 42 students involved in this study was positive. For example, "students noted how the class content combined with the case study not only increased their preparation for practice but also increased their empathy when working with this population and development of critical thinking" (p. 521). Similarly, the case study in Yingling et al. (2017) also included pre learning and opportunities for discussion. In this initiative, after a week of self-paced study which included a case study of transgender woman accessing primary healthcare, family nurse practitioner students reconvened to discuss their learnings. The authors did not consult with their LGBT community when designing the initiative and they did not consistently delineate between LGB and T patients. For example, they stated "to increase knowledge of the day-to-day lives of LGBT people, students view (sic) videos of personal stories from LGBT people describing their experiences of being sexual minorities" (p.11). Students' evaluations of this learning experience were also positive.

Case studies help students to critically analyse and evaluate situations, particularly when they are discussed in groups (Mahdi et al., 2020). The use of multiple approaches within one session appears to support students' comfortableness with LGBTQ+ healthcare, as does the opportunity to discuss cases. When collaboratively discussed, case studies support students' social construction of knowledge.

Assignments or online learning modules.

The 61 associated nursing students in Maley and Gross (2019), were required to complete a reflective essay as part of a core nursing course. From a content analysis of students' essays, the authors concluded the assignment led to students going through a revelatory process. Comments within students' essays affirmed this view. For example, one student wrote "communication with LGBT+ patients, is the most

important part of fixing health disparities" (p. 201). Another echoed this sentiment. "I'm going to consciously think how I address all patients…" (p. 201). The authors also reported some students sought out faculty members to thank them for including such an "important assignment" (p. 202). This assignment inspired students to reflect on their perceived cultural competences and to construct a different view on LGBT healthcare.

Similarly, students' assignments in the study by Carabez et al. (2015) were also analysed. This assignment required students enrolled in a particular course, to interview two practising nurses. Additionally, students were given readings, and a two-hour lecture related to LGBT health issues prior to undertaking their scripted interviews. Following their interviews students summarised their data. The post assignment survey revealed nearly 40% of students felt ill-prepared to provide healthcare to members of transgender communities. As suggested earlier, this might indicate their respective reflections on the information and a realisation that there are genders beyond their constructed normativity. Data from the 129 practising nurses interviewed were analysed by the researchers and the findings were later published (Carabez et al., 2016). The authors noted many of the open-ended comments made by the practising nurses interviewed, revealed many practicing nurses were ill prepared for transgender patient healthcare.

The assignment in Kroning (2018), following a pre-test of 15 questions, required students to read the author's own article related to transgender youth healthcare. This was followed by a post-test of the same questions. The author reported students gained an increased understanding of LGBT health disparities. The initiative also promoted student engagement with journal articles. Questions in the pre-test might have prompted students towards attending to particular information in the article and this may have skewed results. An alternative to an assignment is the use of an online learning module. In their doctoral study, O'Gorman (2022) developed a one-hour virtual learning session for 67 advanced practice nurses. The session was developed from literature and particularly emphasised the transgender population. It included short vignettes from real patients. O'Gorman's study did not lead to any significant gains in knowledge, attitudes, or beliefs, based on pre and post-test scores on two validated tools (Kanamori et al., 2017; Strong & Folse, 2015) which included questions related to transgender people. A reason for the lack of gains may have been because the pre-test scores of the participants were already particularly high. An approach which enabled students to discuss their understandings with others may have supported improved outcomes.

The studies discussed in this section, indicate that there are numerous ways to enhance students' knowledge about LGBT health issues and culturally safe care. The use of multiple teaching approaches supported learning. For example, a combination of case studies, role plays or assignments, particularly initiatives that included opportunities for students to discuss content and collaboratively come to new understandings were most impactful. Studies that focussed specifically on transgender healthcare had better outcomes with regards transgender competencies. That said, most of the studies discussed in this section reported little or temporary gains, from pre to post initiative evaluations. Some of the studies reporting positive results also reported students requesting more content, an outcome which suggests, that students once presented with something some may not considered before realised their own deficits in knowledge on the topic. Involvement of transgender people in the learning sessions, also led to positive results, likely because, this would have enabled questions to be answered and confusions to be addressed. Safe communication with transgender patients requires practice and engagement. Constructions of gender as binary and fixed, based on sex at birth, is so pervasive within western societies that for some students engaging with the lived experiences of transgender people is critical to supporting a shift in thinking. Studies which have enabled students to engage with transgender community members are discussed next.

Studies that engaged transgender people in delivery were impactful.

The 14 studies discussed in this section provided students with an opportunity to engage with transgender people or members of the wider LGBT community. Generally, these studies reported positive results, a finding that demonstrates involving the community in learning sessions is beneficial to students learning experiences. None of the studies discussed involved the community in the planning of the initiative but some had members of the community review aspects of the learning session or engaged a community education group which had previously developed their own content for delivery. These initiatives included simulations, guest speakers, speaker panels, or placements. Some of these interactions included a prior teaching session or pre-readings.

Simulations enabled students to practice communication skills for their future engagement with patients. They were useful in supporting students' communication skills with members of marginalised population groups, people they might not otherwise have the opportunity to engage with in a healthcare context. Seven studies, in this review, employed 'standardised patients' (SPs) in simulations. SPs are people who

have lived experiences of receiving healthcare as gender or sexual minority people, or people who have been trained to represent gender or sexual minority people in scenario education. SPs are remunerated for their time. Four studies involved guest speakers or speaker panels, an approach that enables students to actively engage with members of the LGBT community. Unlike simulations, these learning activities enable students to ask questions. In such initiatives, questions can be presented live as new knowledge is constructed based on previous questions and answers. Only one study reported on the use of a video. Placements enabled students to learn about their practice while in practice. Two studies reported on enabling students to undertake placements with providers of healthcare to transgender patients. These 14 studies are discussed next.

Simulations

The simulation in Hickerson et al.'s study (2018), involving 230 nursing students, followed a 90-minute lecture related to terminology and competent care for LGBT patients. It was based on a young gay male, simulated by gay males, presenting with symptoms of a sexually transmitted infection. While this simulation was not about a transgender person, the pre scenario education session included education about gender non-binary children and adults. Similarly, the study by Kuzma et al. (2019), involving 99 advanced practice student nurses, was also not specifically about transgender people. The simulation was with one of the five SPs appointed, which included gay, bisexual, and transgender patients. Students in this study were required to read, and participate in a lecture about cultural humility, and then experienced a history taking exercise prior to their SP simulation. Cultural humility means being humble when communicating with others and being aware of power imbalances within one's interactions. Both simulations included debriefing sessions. The results of both studies were positive. A finding that highlights the value of discussion and the benefits of adopting multiple learning strategies within an initiative.

Similarly, Karlin and Nickasch (2022), enabled 21-nurse practitioner doctoral student participants to complete an online learning module before they participated in one of five live simulations, one of which was with a male with transgender experience who played himself. While this study used a resource developed by a national LGBT health centre (Fenway Health, Boston), it did not explicitly engage with the transgender community in the planning of its initiative. Simulations were based on gender and sexual minority patients. Following the simulations, students participated in an

extensive online debrief of all simulations. Anecdotal student feedback was positive. Learning was enhanced by the opportunity to collaboratively debrief the scenarios.

Four simulations specifically focussed on transgender patient care. The simulation, in Rodriguez (2022), for example, enabled Bachelor of Science Nursing students to engage with transgender SPs. It followed a virtual simulation learning session. Participation was voluntary but engagement was credit bearing. Results, based on a 'Queer Youth Cultural Competency Scale' (Gandy-Guedes, 2018), from 36 students, indicated significant increases in overall cultural competence scores. In Ozkara's study (2020), two transwomen SPs and an understudy were employed as standardised patients. This initiative included a pre-brief, observation, debrief, and a reflection. Analysis of pre and post-test results, based on 41 matching intervention and control pairs, revealed the intervention resulted in a statistically significant improvement in student's knowledge, attitudes, and skills. Almost all students rated this simulation as enriching and thought the experience would enable more inclusive language with LGBT patients. Neither study explicitly engaged with members of the community in the planning of their initiatives, however opportunities to engage with transgender people likely supported the reported positive outcomes.

The 60 students in the Quinlan and Carino (2021) study, prior to their simulation, first participated in a 'contact seminar', a transgender education session which included presentations by transgender people about their lived experiences. Statistical gains, based on the 'Transgender Attitudes and Belief' scale (Kanamori et al., 2017), were only found in students who participated in the contact seminar and the simulation. An outcome which demonstrates that both contact, and simulations are needed to support nursing students in the provision of culturally safe care. In Waxman et al. (2020), the learning scenarios were simulated using transgender, and gender non-conforming SPs: i.e. not conforming to the dominant construction of gender as binary and fixed on sex assigned at birth. The testers of the scenarios in this initiative were doctoral students, (number not provided). Faculty members and students involved in this trial reported the learning experience was extremely beneficial for them and they considered the session would better prepare nursing students and other healthcare students for their future care of transgender patients. Again, opportunities to engage with transgender people likely supported positive outcomes.

Panel/speaker discussions.

The panel discussion in McNeil and Elertson (2018), included a lecture, a reflexive exercise, and students' role-playing scenarios. The panel involved four wider campus

students who identified as LGBT. Although the training was stated as being collaborative, it was not clear if members of the LGBT community were involved in the planning or just the presentation component of this initiative. Panel member safety was supported by the campus equity facilitator asking the questions which were written on cards by student participants. The intervention resulted in the small number of respondents (n=13) reporting a perceived improvement in skills and knowledge. Several students, in their reflexive journals, also reported an increased confidence in advocating for change regarding LGBT healthcare. The participants in Rowniak and Ong-Flaherty (2015) also valued the opportunity to participate in a panel discussion. This study was located within a Jesuit institution based on the principles of Catholicism. The panel discussion involved three transgender people and a gay male Jesuit priest. The feedback, regarding the quality of the presentation, timeliness and the value of the information provided was “overwhelmingly positive” (p. 75). However, attendance at this panel discussion event was voluntary and was only attended by 80 members of the institution. As such, results may have been somewhat skewed in favour of a positive response.

The speaker in Cornelius and Whitaker-Brown (2015) was able to prepare their presentation and responses to student questions in advance. This study assessed the impact of 38 undergraduate nursing students engaging with an African American transgender woman as a guest speaker. Prior to the learning session, students received a PowerPoint presentation on LGBT health concerns which had been pre-reviewed by a transgender female and two nurses. Results showed a significant increase in knowledge and a non-significant increase in attitudes related to LGBT healthcare. As noted by the authors, “students expressed appreciation for the opportunity to openly discuss health care concerns with a transgender individual” (p. 2).

The previous three studies demonstrate that discursive engagement with members of population groups outside of dominant constructions of sexuality and gender minority population groups, support new understandings. Conversely, Garcia-Acosta et al. (2019) did not conclude that students gained from the opportunity to engage with the transgender community, however, a gain could be inferred from the results. Their study involved transgender people and other experts in transgender healthcare in a workshop delivered to students. Students then participated in one of two learning activities. One learning activity, with 31 students, was a film forum. The other was problem-based learning with 28 students. Both approaches were reported as being significantly more effective in enhancing knowledge compared to a control group consisting of 57 students who did not receive either of the two interventions or the initial

workshop. The authors suggested that neither of the two intervention approaches were significantly better than the other. However, that “both interventions shared a discussion forum with experts” (p. 3) suggests that the pre-session panel discussion with experts which included transgender people was a factor which led to a significant gain in knowledge for students. An alternative approach to physical engagement, the use of video lectures, is discussed next.

Video lectures.

One study, McCave et al. (2019), reported on the use of a video, developed by the authors, and reviewed for authenticity by two transgender advisors. The video portrayed a transgender male’s experience of presenting at an emergency department following a physical assault. Prior to this simulation, the 494 graduate health science students, including nursing students, attended a question-and-answer session with ‘Stonewall’ speakers, members of the LGBT community, who presented on their experiences accessing healthcare. Following this, the students watched the video, participated in a small group discussion with the SP, and then undertook a 25-minute discharge planning meeting followed by a debriefing session. Unfortunately, due to a lack of availability, the SP in this study was not transgender. However, the involvement of transgender people on the panel and the wider LGBT community in the delivery of this learning experience reportedly enhanced perceived competency. The study reported 93% of the responses “identified the addition of transgender individuals sharing their personal experiences as useful or very useful.” (p. 4). This study demonstrates that simulations where LGBT community members reviewed content, and group discussion between students and transgender people was enabled, resulted in highly valued learning sessions.

Placements.

Two studies used placements as a means of enabling students to engage with transgender people. The placement setting in Rowniak and Selix (2016), involved 30 learners and focussed on sexual healthcare, and differed from the placement setting in Vance et al. (2017), which involved 18 learners and focussed on young people and their gender affirming care needs. Rowniak and Selix (2016) reported informal positive feedback. Vance et al. (2017) reported statistically significant improvements with regards knowledge and awareness, and participants reported a high satisfaction rating for the learning experience. However, within Aotearoa, sexual healthcare and paediatric gender affirming care are specialised services with few agencies providing this sort of care. This means there are limited slots for this sort of placement. The logistics of

timetabling all students around a few placements might be challenging for some institutes and it might also be too burdensome for the small number of providers within each region. That said, based on these studies, if possible, placements provide valuable engagement opportunities.

This section focussed on initiatives that engaged LGBT community members in the delivery of new content on LGBT or transgender healthcare. The results of these studies indicate that nursing students considered opportunities to engage with members of the transgender community to be beneficial to their understanding and subsequent culturally safe healthcare provision. That said, many of the studies involved voluntary participation which may have skewed results. Outcomes were enhanced by initiatives which included pre- engagement learning, and discursive interaction between students or between students and community members. Some of the initiatives were reviewed or authenticated by transgender people. However, a lack of engagement with community members in the planning stages of these initiatives means there is the potential for cultural competency and safety in transgender healthcare to be inaccurately defined.

Few initiatives engaged the community in designing change.

Approaches that differ from the studies discussed previously are the seven studies that engaged experts by experience, transgender people, with the lived experiences of accessing healthcare, in the planning and delivery of the learning initiative. While not a pedagogical strategy, per se, engaging with the community is an approach that better allows transgender people to determine what will support nurses in their provision of culturally safe care and enables them to define the care that is safe for them. It respects transgender people as experts. The few studies, in the current review, that engaged the community in the design of new content, used the following pedagogical strategies: videos, online learning sessions, participatory theatre intervention, and simulation. Few initiatives engaged the community in designing change.

Videos and online learning sessions.

In the study by Martin et al. (2022), the researchers collaborated with transgender community members to develop a learning session. The collaboration involved one of the authors and a transgender woman working with transgender adolescents to develop videos related to their lived experiences. The researchers also developed a didactic educational session which included opportunities for questions and answers. One of the student groups had the content delivered by a transgender woman, and

another had a cis gender woman presenting using the videos. A second group had the learning session without the videos but with the same cis gender woman presenting the session, and a control group had neither. From their 457 pre-and post-tests on knowledge, attitudes and beliefs about transgender people, the video groups had higher scores post intervention than the non- video groups. The researchers were surprised to find that there was little score difference between those educated by a transgender woman and those educated by a cis woman. The researchers proposed that sessions could successfully be delivered by cis gender people. However, the cis-gender woman in this study had been involved in the development of the videos and had 15 years' experience in transgender healthcare. The researchers acknowledge that the same conclusion may not have been drawn had the cis gender person been new to the topic.

Similarly, Du Mont et al. (2021) also consulted with the transgender community when developing their seven-session e-learning tool. This consultation occurred through the development of an advisory group of transgender people and their allies. Responses from the 47 forensic nurses who completed this training indicated a perceived and demonstrable increase in competency in working with transgender victims of violence with a 92.3% satisfaction rate with the e-learning curriculum. The positive outcomes of this, and the previous study, demonstrate the value of collaboration when developing new content related to a marginalised population group. The initiatives enabled the constructed norms of those without lived experiences of being a gender minority to be challenged. Another, somewhat unique approach, to enabling people with lived experiences of LGBT in the planning is a participatory theatre intervention (PTI).

Participatory theatre intervention.

Based in Lesotho and Swaziland, Logie et al. (2019) had four audiences which included nursing students. Audiences were required to co-construct alternative endings to three performed skits depicting negative events for LGBT people including a transgender person. The skits were developed in consultation with LGBT people and members of a theatre company. This study was based on a participatory approach. "Participatory approaches recognize that stigma reduction initiatives should build on community understanding of forms and causes of stigma and that persons who are targets of stigma should be actively engaged to develop solutions (Campbell et al., 2005; Freire, 1973)" (as cited in Logie et al., 2019, p.147). Following the PTI, audiences participated in focus group meetings, 12 meetings which involved 106 participants. The data from these meetings were analysed. The authors concluded

exposure to the lived experiences of LGBT people supported a better understanding of the impact of stigma for those population groups. This study also highlighted how the opportunity to co-construct solutions supported the development of new knowledge for the audiences.

Scenario based activities

The scenario activity developed by Ruud et al. (2021), for health care students, mostly nurse practitioner students, focussed on sexual health history taking. This study partnered university staff, sexual health professionals and transgender people to develop the session. They presented two common scenarios, as determined by the group. This study enabled members of the transgender community to work as patient-teachers in the simulation. The 33 students were provided with pre-simulation readings on providing gender affirming care, and a pre-simulation briefing session. While the students and the community participants' feedback indicated improvements could be made regarding pre-learning activities, student surveys indicated the simulation led to significant gains in skills and comfort in providing transgender patient care. Student feedback demonstrated they particularly appreciated their patient-teachers who were members of the transgender community. The community engagement process used in this study was also noted as being beneficial for transgender consultants.

> "... the community partnership was critical to developing an authentic and relevant simulation where patient-teachers from a community experiencing harms in health care settings gave positive feedback about their experience contributing to education of future health professionals" (Ruud et al., 2021, p. 7)

While this study focussed on Midwifery and Nurse Practitioner students, its outcomes demonstrated such collaboration is valuable for interventions within nursing education.

In Rogers et al. (2013), the simulation training was developed and managed by a group of older LGBT facilitators who were trained in delivery. This was a large-scale study that analysed the responses from 605 participants across several sites which were mostly tertiary institutions. Feedback indicated participants felt they gained a greater understanding of issues facing LGBT adults and of their own biases in this area. 94.2% of participants rated the panel discussion aspect of the initiative as very good or excellent. Similarly, Corrigan et al. (2022) using a co-production approach, involved members of the transgender community in the development and delivery of an online training session. This session was delivered three times to students, to staff, and then to staff or students who could not attend the initial training session offered. All, bar one

of the 84 respondents to a feedback survey were positive. These two studies demonstrate that students valued the opportunity to engage with members of the LGBT community and the value of community collaboration in developing content.

One study, Ziegler et al. (2021), used a 'design jam' approach to create an online educational tool kit for nursing students. Design jam is an approach where community members and other professionals collaborate to develop a plan to address an identified issue. This study enabled 'content experts', members of the LGBTQI2S (2S means two-spirit) community, and other specialists, such as technology and simulation experts, to collaborate in the design of the toolkit. This toolkit included four virtual scenarios, two of which were based on transgender people, and vignette mini games related to non-heterosexual and non-cisgender people. The resource was not formally evaluated but it was amended following informal feedback. This study demonstrated authentic collaboration with the community. Authentic in that community members were recognised as being the content experts and they were involved in the planning from the onset.

The studies discussed in this section demonstrate how the involvement of community experts in the planning and delivery, led to meaningful learning sessions. The opportunity for students to engage with lived experiences supported a greater understanding of the impact of living outside of socially constructed gendered norms. However, these one-off learning sessions may not be enough to support future nurses' cultural competence, safety, or humility, regarding transgender healthcare. The gains may be fleeting if delivered within a programme that is based on gender binary norms and does not have any further content related to transgender healthcare. Studies which sought change beyond a one-off learning session are discussed next.

Even fewer initiatives sought wider programme change.

Only three initiatives sought to have content weaved throughout a whole nursing curriculum or wider organisational change. While initiatives aimed at supporting changes beyond the classroom setting are not pedagogical strategies, the inclusion of transgender specific healthcare throughout the curriculum helps to normalise the variety of genders that exist beyond socially constructed binary norms. The 'Transgender Health Curriculum Integration Project' developed by McDowell and Bower (2016) and reported on by Sherman et al. (2021) aimed to improve transgender and gender diverse (TGD) health related knowledge amongst accelerated nursing students. Content based on literature was integrated into five nurse education papers. This study engaged a graduate expert in content development. It was not clear how nurse

educators were trained for the delivery of this new content. Student evaluations indicated the initiative led to small, yet positive, gains in attitudes and knowledge. In the free response section, some students expressed their appreciation of the TGD content and suggested there should be more of such content included, and it should be mandatory. This feedback indicates firstly a need to consider that a voluntary approach may mean that those who choose not to attend may be the ones that would benefit most from participation and secondly that there is a need to consider training for lecturers when new content related minority groups is introduced. Generally, however, the study found that an integrated approach that resulted in the weaving content throughout the curriculum was positive for students.

Similarly, Saini et al. (2022) were also able to weave content throughout their nursing curriculum. This study used an AR approach which engaged LGBTQI+ experts, to include content in six semesters across all three years of their nursing programme. Their study differs from the previous studies discussed as it addressed the need to train nurse educators to deliver the new content. That said, some students noted not all nursing staff in the faculty were LGBTQI+ competent. To improve the effectiveness of content delivery, they may need to make educator training mandatory. In this study, formative, qualitative feedback, from 87 final semester students, concluded most students found the content relevant, useful, and reported feeling better prepared for practice. Some students suggested content should be delivered by people who are part of the LGBT+ community. A further example of nurse education programmes in Aotearoa being constructed to have nurse educators deliver all content even when students might be better served by having community expert involvement in delivery.

A study that considered the wider nursing team is Whitney et al. (2020). Their project sought to develop a tool (AQUERY) to support nurse educators if they mistakenly misgendered a transgender nursing student. They engaged students who had experienced being misgendered alongside nursing educators, in the development of the tool. The tool has not yet been formally evaluated but is currently publicly available for use. Transgender nursing care would be enhanced by having more transgender nurses. For transgender students, correct pronoun use is critical to wellbeing as they engage in learning. Supporting correct pronoun use supports transgender people's success in their healthcare qualification and the subsequent upstream effects of having more transgender healthcare providers. The importance of incorporating content throughout a nursing curriculum and the need to address gender binary normativity within the program is emphasised by Levesque (2015):

> Nursing faculty are charged with the responsibility of crafting a curriculum that is inclusive of the gender (and sexual) minority. In keeping with this culturally congruent curriculum, educators have the responsibility of creating a nursing education unit where those in the gender minority can learn safely and become the next generation of professional nurses, free from harm and prejudice (p. 247).

Studies in this section demonstrated the value of community engagement with regards influencing wider change within existing nursing programmes. Initiatives supported new content across the whole curriculum. Wider organisational change is needed if the binary normativity that pervades is to be challenged. Institutions reflect dominant constructions that are reflected in the attitudes of staff, which may be particularly damaging if these staff are delivering new content related to transgender healthcare. An institution that is not inviting for transgender people may present barriers to success. If the culture within the organisation is not inclusive, change is needed for gender minority students to learn safely.

2.4 Relevance of literature to current study

The research question for this study is: 'How can engagement with the community influence an existing nurse education programme, with regards the provision of quality care for people who are transgender?' The literature review was positioned around seeking to better understand how the level of engagement with the community, in the development of initiatives which sought to enhance nursing education in relation to transgender healthcare, influenced outcomes. The review found that while almost all studies reported positive results**,** the level of community engagement influenced outcomes. Best outcomes were achieved from initiatives designed and delivered by community members, particularly when initiatives enabled student discussion, more so their discussion with transgender people. The value of involving transgender people in delivery and design of content, and the importance of wider organisational change is discussed next. This discussion will also consider the value, based on the review, of supporting discursive interaction when delivering content that challenges normative perspectives of reality. This section will then link the findings of the literature review to the methodological approach adopted for this study.

Why is contact in learning sessions important?

The studies reviewed showed that initiatives that provided opportunities for students to engage with transgender people and hear about their lived experiences, were

particularly impactful and valued by learners. In a mostly gender binary world, many gender-binary students may not have considered what it might be like to access healthcare as a transgender person. Being confronted with the personal lived experiences of transgender people generally, and their experiences of accessing healthcare, may have led to questions for some students. Having a person or people available to answer questions as they arose for students processing new information supported knowledge.

Stigma and discrimination present barriers for nurses in their provision of gender affirming, culturally safe care. Direct engagement with people's lived experiences supports culturally safe practice. This is a view supported by Moran et al. (2024) who stated, "learning from lived experiences encourages students to build critically informed understandings and develop unique insights that challenge negative and prejudicial attitudes and facilitates skill development" (p. 82). Moran et al.'s view is supported from the findings of a literature review undertaken by McBride (2015) who advised that contact improved attitudes through having misconceptions and stereotypical beliefs challenged. Less than half of the studies in the review discussed in this chapter, engaged members of the LGBT community in the delivery of learning sessions. Logistics, availability, and finances may have led to barriers for the respective researchers' engagement of community experts in the delivery of their new learning sessions. Barriers that are indicative of the value western nurse education providers place on lived experience as an important educational resource.

The value of engaging community members in planning.

Few of the studies reviewed explicitly involved members of the transgender community in the design of their initiatives. Studies that did, reported positive outcomes. Transgender people are experts in the determination of what is safe healthcare for them. Within nursing education in Aotearoa, the dominant view is that nurse educators are the most appropriate people to determine content. This view undermines the experiential knowledge that exists within local communities. The key to culturally safe care is that it is care defined as 'safe' by those who receive it. To leave out transgender community members in defining culturally safe care, means it is inherently inaccurate. Transgender people need to be able to determine what safe care is for them and the appropriate ways that this knowledge can be presented to students.

Transgender people were involved in some of the studies reviewed, and in the delivery of pre-determined scenarios or learning sessions. However, there was a power imbalance at play between nursing educators and community members facilitating

these simulations. Transgender people, mostly, were not considered ‘experts’ in these situations, but rather facilitators of pre-planned content. The inclusion of community members in facilitation may make the content appear ‘authentic’ to nursing students, when it may not be, potentially skewing the results of the studies discussed. This view is supported by Postelnik, et al. (2021) who suggested authentic education is a socially constructed concept, used to indicate the degree to which the learning session(s) align to professional practice and that presenting a learning session as authentic might discourage student’s critical scrutiny of its content. Transgender community members should be involved, from the onset, in informing nurse educators about their personal barriers to accessing healthcare and their perspective of what transgender inclusive healthcare could look like. They should be involved in every stage of development, not just at the last hurdle.

Why wider organisational transformation is needed.

Supporting gender affirmative practice in nursing requires wider organisational transformation within nursing education provider organisations. This again speaks to authentic delivery. Nurse educators purporting the importance of practice and action to support transgender patient outcomes, whilst also not pushing for change to support outcomes for transgender students in their own organisation, is somewhat disingenuous. Only three of the studies discussed in this literature review moved beyond one-off teaching sessions to wider curricula initiatives to address institutional barriers to transgender student success. While teaching sessions were shown to enhance students’ knowledge, attitudes, skills, and reflection of practice, in the short term, lasting knowledge or attitude changes need initiatives beyond one off learning sessions. Organisational culture and structures shape what is possible to do and be within them. They themselves are products of social norms.

It is important that education at a programme level demonstrates that the wider programme is gender inclusive. According to Levesque (2015), nursing educators need to be supported in their competent delivery of transgender related content and the wider team needs to create of a programme which is welcoming and safe for transgender nursing students. Education delivered within a programme that does not demonstrate inclusiveness would quickly be forgotten by most and for students with a more critical lens would appear insincere. Initiatives need to consider the transgender cultural competence of the nurse educators delivering new content, and the wider nursing team.

If we really want to improve transgender patient care outcomes, nursing education programmes must also consider initiatives that extend beyond their respective programmes to those that seek to create a transgender inclusive tertiary education organisation and subsequently support increased enrolments of transgender nursing students. According to Kellett and Fitton (2017), nurses educated in gender inclusive settings would be more conscious of gender issues and better able to challenge practices which lead to transgender and gender non-binary invisibility. Kellett and Fitton (2016) provided several suggestions for how institutions might better support transgender students. Unless an institution itself is welcoming and safe for transgender students, barriers to enrolment or completion may mean nursing healthcare will miss out on the upstream benefits of transgender nursing graduates. Inclusive educational institutions support transgender nursing students' enrolment, successful completion, and subsequent enhancement of the nursing pool.

An organisation that professes to be inclusive with regards LGBTQ people must be authentic when making this claim. Authenticity requires the organisation demonstrates an integrated and sustained commitment to addressing the issues faced by LGBTQ people and not just a superficial flying of the 'Rainbow' flag (Ciszek & Lim, 2021). This requires meaningful engagement with the community; meaningful in that it must enable members of the LGBTQ community to determine actions that will address issues experienced by gender and sexual minorities and actions which will support a more inclusive organisation moving forward.

The value of discursive interaction.

The literature discussed in this chapter found that studies which enabled students to interact with other students reported positive results. Studies which enabled students to engage with transgender community members were particularly impactful. These findings support a learning position which aligns with the world view that underpins the current study discussed in this thesis, knowledge is socially constructed. In this world view, discussion between students would support better understanding of unfamiliar content as students collaboratively construct new knowledge. Discussion between students and transgender facilitators enables confusions to be addressed and discussed as the respective student processes new information. Globally, post learning discussion opportunities are believed to support reflective thinking and subsequent improvements in practice (Vanassche, 2023). The findings of this literature review support initiatives that provide opportunities for students to discuss and process unfamiliar content.

Identifying the gaps and linking to the methodological approach.

This literature review identified the benefit of involving the respective minority group in the collaborative determination of actions aimed at improving the healthcare outcomes for members of the group. Few of the studies had done this. An approach that is designed to deliberately foster a collaborative approach to action is action research (AR). An AR approach engages members of the respective community to be involved from the onset, in a project which seeks to bring about a change. AR is an approach that supports an equal voice for all involved and changes that reflect the needs of those the study seeks to support.

An AR study that engaged members from six minority groups (including LGBTQ community members) as guest speakers within a participatory AR was undertaken by Bristol et al. (2020). In this study six guest speakers presented their experiences as a student and/or nurse to two nursing education conferences involving 531 participants. After the presentations, participants at the conference worked in small groups, facilitated by the speakers, to develop strategies to support inclusivity in nursing education and clinical settings. In this study the speakers and facilitators were positioned as experts. Engagement with lived experiences supported knowledge and drove action. Four themes and several strategies were determined demonstrating the capacity of AR to support understanding and drive change. This finding reflects the findings of the literature review presented in this chapter, engagement with the community and positioning marginalised community members as experts in their field, alongside enabling discursive interaction, supports knowledge and inspires a desire for change.

Other studies that used an AR approach to support inclusiveness for minority population groups, also found engagement supported knowledge and a desire for action, for example, Hafford-Letchfield et al. (2018) and Neville et al. (2022). Hafford-Letchfield et al. (2018) sought to improve healthcare for LGBT older adults. In this US study, six aged care homes collaborated with ‘community advisors’ and academics to develop and implement structured activities to promote LGBT inclusion. Their study reported gains in awareness and changes in centre staff attitudes. An output attributed to a participation approach that enabled the organisation to draw on the goodwill of individuals to develop a strategic resource to support LGBT inclusiveness. Neville et al. (2022) used a participatory AR approach to better understand older Pacific people’s engagement with healthcare in Aotearoa. This study involved 104 Pacific people as co-researchers. An important finding from this study was that an AR process, that

positioned the participants as experts, empowered older Pacific people to take leadership roles with regards healthcare engagement for Pacific people.

The study discussed in this thesis used an AR approach underpinned by social constructionism. Only one study, Saini et al. (2022), in this chapter's literature review, used an AR approach. There is a dearth of literature about AR that involves minority communities, let alone transgender communities, to bring about change in nursing education. The study discussed in this thesis contributes to knowledge about how an AR approach can support change within an existing nursing education programme. The current study is underpinned by a social constructionist world view, a view that considers how knowledge at a social level, such as gender being normatively binary, is constructed; and a view that considers knowledge at a local level is constructed through discursive interaction.

2.5 Conclusion

In total, 47 articles, based on 42 studies of initiatives that sought to enhance nursing education to better support transgender health care, were retrieved from the initial search. These initiatives tended to be one-off and nurse educator driven, an approach that is indicative of how research responds to constructed norms and further contributes to the construction of nurse educators as being experts when it comes to designing and delivering content related to the nursing care. Some initiatives enabled students to engage with transgender people, these studies supported compassion, discursive interaction, and the construction of new understandings for students. Few initiatives included transgender community members in all stages of initiative development and even fewer studies moved beyond one-off teaching sessions to influence the whole nursing programme or the wider organisation. An inclusive wider organisation supports transgender student enrolment and more transgender nursing graduates. It also supports more positive attitudes, with regards gender minorities, for all graduates of the organisation. The findings from this literature review support a need to better understand how participatory approaches can influence nurse education programmes in relation to transgender healthcare.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

Chapter one provided a rationale for this study and the context of transgender healthcare as it relates to nursing education in Aotearoa. The rationale for this study was that transgender people experience significant disparities in health outcomes, and barriers to accessing healthcare. It suggested in chapter one that nurses are well positioned to influence the healthcare experiences for transgender people, however, the literature related to this found few studies sought to investigate how nursing education can support nurses in their provision of care for transgender people. Chapter two presented the literature associated with interventions within nursing education that aimed to support nursing students' future provision of transgender healthcare. This review found that studies that enabled students to discuss issues with each other and/or with transgender people, supported learning. This finding supported a social constructionist approach. The review also found that studies that engaged transgender community members in the planning and delivery of initiatives were most impactful. This finding supported an action research (AR)/community engagement approach. There is limited research about how engagement can influence an existing nursing programme. This further supported an AR approach.

The findings from the literature review supported a social constructionist epistemology. Findings suggested knowledge is supported through engagement with multiple perspectives and realities. A social constructionist epistemology brings to light that gender is socially constructed. The ways in which people position themselves and are positioned by gender can shape both possibilities and constraints for social life and wellness. The view of gender as being binary and fixed from birth is strongly constructed as normative in Aotearoa, as it is elsewhere. This means it is difficult to imagine alternatives, let alone live them. Understanding how gender came to be so strongly constructed as normatively binary and alternatives to this view is critical to this current study. This chapter will present this study's epistemology, its research approach and the philosophy that underpins the study. The current study assumed a social constructionist epistemology and used an AR approach. It is underpinned by a philosophy of 'practical knowing' that describes a perspective of knowledge that occurs through AR.

3.2 Social constructionism

What is social constructionism?

Social constructionism is an epistemological position. Epistemology is the position a researcher takes in relation to how we come to know what we know (Crotty, 1998). Social constructionism considers knowledge is constructed through social interaction; and that such constructions are influenced by the context of interactions; that is, the cultural norms of the society within which the interactions are taking place, and the language and meaning systems available to the respective participants within these interactions. Social constructionists seek to understand how interpersonal processes, within particular settings and broader societal structures, influence the formation of societal constructs, the ideas, concepts and practices that are normalised within particular societies. They might also seek to understand how socially constructed norms maintain inequalities (Burr, 2015). Some social constructionists might consider how socially constructed norms make possible, celebrate, promote particular social identities while shutting down, constraining, or excluding others. Social constructionists challenge attempts to identify an objective truth, and instead invite alternative approaches to knowledge production (Gergen & Gergen, 2014). How social constructs are expressed and shaped through language and discourse is discussed next.

Social constructs, language, and discourse.

Constructs are shared understandings of objects or ideas that are adopted by people inhabiting a particular group which become widely accepted as typical (normal) by those in that group (Schutz, 1962). Shared understandings, held within a group, are developed, and maintained through social interactions (Lock & Strong, 2010). People interact with others in ways that are intelligible, based on their perspectives of reality, these behaviours in turn reinforce common understandings. Social constructionists seek to unpack and make visible how common understandings come into being. A core tenet of social constructionism is that how the world is understood does not necessarily reflect the material world but is a product of how it is represented and produced through language (Burr & Dick, 2017).

Language makes possible the construction and transmission of thoughts. It is a means through which social interactions and thus social constructions of reality can occur. Language is necessary for, and gains meaning within, social interactions (Gergen & Thatchenkery, 2004). Language is more than vocabulary and syntax. There are aspects of language that are not readily understood, if literally translated, by those not

orientated to a particular group (Schutz, 1962). Thus, a stranger to a cultural group, even if aware of the history and language of the group, might be confused by particular terms that are normalised within that group (Schutz, 1944). For example, a common request within Aotearoa that guests ‘bring a plate’ to an event, might be confused by some from other cultures as meaning the guest literally brings a plate, rather than a food item. New language terms are developed and understood through existing terminology, shaped by the events of a particular culture at a particular point in time.

According to (Gadamer, 1970) language is critical to the process of constructing and reconstructing understandings of ourselves and the world. For Gadamer, “reaching an understanding is a process that succeeds or fails in the medium of language” (p. 13). However, as Gadamer argues, it is not just the dialogue that occurs between people that supports new understandings, but also the dialogue with oneself and the moments we are speechless with wonder, that moves us to new knowledge. With regards gender, language has become particularly pertinent, as existing language is used for the construction and reconstruction of gender identities. For example, non-binary and genderqueer are new language terms based on existing terms. New language terms demonstrate the social reconstruction of gender.

Discourse relates to language; it refers to written or verbal communication. However, discourse is more than spoken or written words, it encompasses societal or institutional norms and makes understandings of terminology possible. According to Burr and Dick, (2017), discourse is the meaning system through which people make sense of their world. It determines the boundaries of thought and communication within a particular society at a particular point in time (Baumgarten & Ullrich, 2012). While, for example, terms related to genders which are not male or female have existed for a long time, they have only come into common use, within western societies, over recent decades. Gender binary dominant discourse has shaped and limited how some societies can think about or discuss genders outside of a dimorphic view. Foucault (1969) suggests discourse is the set of statements pertaining to a particular system, be it general statements, or a group of statements related to an aspect of the system, or regulations of practice. So, for example, gender discourse includes general statements related to expected behaviours and presentations of genders, the groups of statements pertaining to gender within particular social domains, and the informal or legal rules that permit or constrain actions based on gender.

Discursive influences operate through normative pressures that infuse social interactions and expectations of behaviour (Elder-Vass, 2011). Normative pressures

are a sum of the admonishments of people who do not conform, and the rewards for those who are willing and able to comply with socially constructed norms. Discourse influences how people shape reality and conventions of practice at an interpersonal (micro) level and at an institutional or social (macro) level. Burr (2015) warned against a strict division between macro and micro social constructionist approaches to research because it is possible to synthesise both approaches. The study of this current thesis assumed that knowledge is socially constructed at a micro level when individuals discursively interact with others and at a macro level through the social processes that lead to accepted norms or standards. These forms of social constructionism are discussed next.

Micro and macro social constructionism.

Micro social constructionists explore how particular discourses function within social interactions. A social interaction being two or more people communicating with each other. People draw on discourse to speak and to make sense of the communication. These interactions occur through means, such as language, that pre-exist the person (Schutz, 1962) and are also influenced by the context of the interaction. Each individual brings to the interaction their own subjectivities, cultural norms, and language terms enabled by discourse. Gergen, (1996) gave credit, for the emergence of micro social constructionism, to Gadamer (1975). Gadamer sought to understand how a person who approaches an interaction with a framework of understanding, shaped by their past experiences, moves, because of the interaction, to a ‘new horizon’ of understanding. Within AR projects, micro social constructionists seek to explore how the discursive interaction of group members influences respective subjectivities that bring about action or change.

Macro social constructionists seek to understand how societal discourses function to shape ideologies and beliefs, and how such dominant discourses relate to societal power. That is, they seek to expose how sociocultural processes work to privilege some discourses over others and influence the construction of knowledge, social norms, identities, and subsequent perspectives of reality. Gergen, (1989) discussed the notion of ‘voice’ in social interactions and suggested that those with a greater capacity to present appropriately, in relation to the dominant discourse of the moment, are better able to influence the construction of knowledge. The understanding that power influences the construction of knowledge is relevant in this current study because nurse education content and how it is delivered within Aotearoa is largely influenced by people who have a degree of social power. That is, as argued in chapter one and two,

nurse educators are positioned as experts in their respective fields, and little credence is given to the lived experiences of the recipients of particular aspects of care.

Power and knowledge production are inextricably linked: one implies the other (Foucault, 1977a). Research available to be drawn on to construct best practice and curricula is influenced by power structures which determine what research projects might be funded and disseminated, and the existing realities of the researchers and the sociocultural context within which the research takes place. The perspectives of marginalised people, such as transgender people, have been less likely to influence the production of research knowledge, and this subsequently influences what is considered relevant within health care education.

Macro social constructionists seek to understand how prevailing discourses contribute to marginalisation, the positioning of some identities as less significant, and thus less eligible of social recognition and support, than others (Burr, 2015). Making the discursive practices of marginalisation more visible has the potential to contribute to social change, by opening the possibility of others, such as nurse educators, disrupting marginalising discourses and the practices and systems they give rise to. Transgender people are a marginalised population group in Aotearoa. They experience gender-based violence, victimisation, discrimination, and exclusion. They also experience significant disparities in health and healthcare access, and reduced access to housing and employment opportunities. Social constructionists do not consider an individual's identity as an essential aspect of them, but rather something that is shaped by their sociocultural context (Lock & Strong, 2010). While discourses and social cultural context might impose identities onto individuals, they may also provide multiple options and possibilities which individuals can negotiate, take, or resist.

People are born into particular social contexts; their identities are shaped through their interactions and the discourses available to them. The process through which individuals are classified and defined within a discursive system is, what Foucault referred to as subjectification (Lock & Strong, 2010). Subjectification is a continuous social process of attributing cultural typing to particular social positions. An individual can influence the discourse that defines their identity. That is, not all identities are absorbed unwittingly, and individuals are capable of resisting the dominant ideologies which constrain them. However, the agency that enables subversion is part of the constituted character of the subject (Butler, 1990). The practices available for such are constructed within the respective culture, society, or social group (Foucault, 1997b). Therefore, the capacities to challenge the constraints of identities are themselves

socially constructed. The study discussed in this thesis sought to make visible the multiple constraints and opportunities operating around transgender identities in healthcare, so that NEs are able to critically engage with them and find improvement possibilities.

The social construction of gender.

> "There is no such thing as gender other than what we say it is"
>
> (Bornstein [in Bell], 1994, para 3).

This current study holds a view that gender is socially constructed. It sought to draw attention to how western societies have strongly held constructs of gender as binary and fixed, based on sex assigned at birth, and how these constructs oppress some individuals and impact on their access to healthcare. Furthermore, the study sought to better understand and subsequently address these constructs as they exist within nursing education in Aotearoa. From a social constructionist perspective, people attribute a gender to a person based on socially determined elements (physical traits, clothing etc.) that vary over time and across cultures (Kessler & McKenna, 2006). Some social constructionists, for example (Lorber, 1994) seek to understand how and why the dichotomous view of gender, based on genetics or physical presentation at birth, a view that prevails within western societies, is produced, and maintained. Others for example DuBois and Shattuck-Heidorn (2021) have sought to challenge the view that there are two biological sexes, upon which gender is constructed.

Feminist writer Lorber, (1994) suggested, gender construction begins from when a child is assigned a sex category (boy or girl) at birth. This sex category, Lorber argued, becomes a gender status through the application of socially normalised gender markers such as names and dress. This gender status influences the child's perception of self, how they behave and interact with others, and how others behave and interact with them. Gender is a primary cultural frame which enables individuals to define self and others in social interactions and biases the expectations of behaviours of self and others (Ridgeway, 2009). What could be considered as normal presentation and behaviour for a particular sex is, Butler (1990) posited, constructed through the repeated, over time and space, expressions of acts, postures and gestures which have been socially constructed to correlate with a biological sex and serve to construct over time, gendered bodies. Thus, Butler argued gender is both a performance and performative; through the repeated performances of gender, gender becomes performative (representative of that which it is constructed to be). Gendered behaviour

follows through to family, work, and organisational practices, and through this process gender expectations and binary normativity become embedded into the institutions that make up the fabric of societies (Lorber, 1994).

Within the hegemonic discursive model of gender, for our bodies to be intelligible (make sense to others) there must be two stable genders based on heterosexual practices (Butler, 1990). That is, our understanding of heterosexual and homosexual desire is based on the notion that there are two sexes - male and female. Within this model, recognition of same sex or other, through individuals' embodiment of socially constructed gender signifiers, has been constructed as necessary to maintain reproduction. However, Kessler and McKenna (2006), argue if such were true, dimorphism would only be necessary for the reproductive years, not for a lifetime. Lorber (1994) suggested dimorphism, with regards gender, is maintained to enable a reliable division of higher paid (usually male) and lower paid/voluntary workers (usually female), through power, if necessary, but mainly voluntarily, through the norms and expectations being built into the individuals' sense of identity and worth. While gendered expectations change over time, there are punitive consequences such as social exclusion, abuse, and disparities in healthcare access and/or economic status for those who significantly diverge such as transgender or gender non-binary people, from the socially constructed norms of gender as binary and fixed at birth. However, given that gender is enacted/performed, socially constructed scripts of gender can be interpreted and enacted differently, opening the potential for norms to be challenged (Butler, 1998).

Critiques of social constructionism.

The main criticisms of social constructionism are centred around the view that social constructionism is based on relativism (Andrews, 2012). Relativists consider all perspectives of reality are to be accepted and considered equally valid. If such were true, the critics suggested, then a research finding is but one view that is no more valid than another, and thus the relevance of any research could be questioned (Andrews, 2012). Walker (2015) argued, such criticisms are based on a misunderstanding, because social constructionism is an epistemology, how we come to know what we know, and does not seek to make ontological claims.

Relativism, Burr (2015) posited, has also been critiqued with regards its capacity to challenge oppressive structures, as challenge infers one particular moral stance is superior and thus more valid than another. As relativism supports multiple perspectives of what is 'right' or 'wrong' any action or perspective, within such a world view, would be

considered valid. However, from a social constructionist perspective, values are determined through interaction with others, within particular contexts. What is considered valued is constituted by discourse and can change over time. For example, children's ability to rote learn in education was valued when discourses of education as a kind of 'mental training' were dominant. More recently, however, the capacity to problem solve has been considered more relevant. Thus, while there are multiple perspectives of what is right and wrong, from a social constructionist view, they must be considered relative to the context of their construction.

Social constructionists accept multiple views of reality but seek to understand how some perspectives become reified and others subsumed within particular societies. Social constructionists consider realities to be constructed through the medium of language and the respective social structures that enable or constrain particular perspectives of reality. With regards research, social constructionism might complement realist perspectives by encouraging researchers to critically reflect on their own biases and seek alternative ways of framing their existing realities (Romaioli & McNamee, 2021).

Social constructionism's alignment with action research.

> "Social constructionism is central in how action researchers work"
>
> (Bradbury, 2020, p.46).

A social constructionist lens aligns with AR methodology. Researchers who assume a social constructionist epistemology hold a view that what we take to be true is the result of the social processes that take place within particular historical and cultural contexts. From this perspective, it is important to bring multiple views of reality to the fore, and value collaboration to engage with a broader range of possibilities (Camargo-Borges & Rasera, 2013). AR is an approach that necessitates collaboration and is dependent on the multiple perspectives that group members bring to the project.

Both micro and macro social constructionism are relevant to AR. Social constructionism, at a micro level, is a worldview that assumes the importance of discursive interaction in the production of knowledge, a worldview in common with AR. An AR process is dependent on the knowledge that is produced within group member interaction. Social constructionism, at a macro level, acknowledges that power structures influence the societal norms that subsequently marginalise particular population groups. AR enables members of marginalised groups to have a voice in the

collective determination of action to address the issues they see as impacting on their lives.

Influenced by a social constructionist world view, this current study sought to enable discursive interaction between transgender community members, and nurse educators, to support the collaborative construction of action. This required a process that would give voice to members of a marginalised population group and a purpose that sought to upset socially constructed norms that have previously led to inequities in healthcare access for transgender people. An AR methodology supported the requirement of the study discussed in this thesis.

3.3 Action research

AR is a research approach where the researchers work together to bring about change, within a particular context. The change needed is ascertained by the researchers. Change occurs through the repeated cycles of the collaborative understanding of the issues, determination of actions, the undertaking of actions, and the reviewing of actions. AR, Newton and Burgess, (2016) suggested, could be considered to have its origins in the research work of Lewin (1946). It was subsequently taken up within educational and critical sociology research. While there are numerous approaches that action researchers can take, Coghlan & Brydon-Miller (2014) suggest all are based around the integration of theory and action, in order to address, with those affected, an organisational or social issue.

History of action research.

AR emerged in the 1940s from a growing interest in the development of alternatives, to positivist approaches to studying sociology and education. Lewin (1946) has often been credited with establishing AR, and the development of a method to enable the application and trialling of theories in practice (Carr, 2007). Lewin was a Jewish psychologist who sought refuge in the United States from Nazi Germany. He worked with the Tavistock Institute that was contracted to support the redevelopment of British industries following the war. In 1946, Lewin wrote an article that described an ‘action research’ process aimed at improving inter-group relations within an organisation. The process of his AR, described in his article, was repeated cycles of planning action, executing action, and evaluating action. This work set the stage for AR in Europe (Levin & Martin, 2007). However, the positivist epistemology that prevailed at that time, led to a lack of uptake of AR within social science research (Carr, 2007).

The 1960s saw a resurgence of AR within education and critical orientated research. The work of Elliott and his subsequent publication: 'What is action research in schools?' (Elliott, 1978) was influential in the shift from positivist educational research to self-reflective examinations of practice (Carr, 1989). Positivist research assumes there is a single reality that is understood through observation. This is an approach Carr (1989) suggested, where educational research was preserved for the academic elite and not something that could be undertaken by teachers in the classroom. Elliott, however, described educational research as a process by which teachers examined the tacit theories of their practice (Carr, 1989). Within education, AR became a method by which teachers could make radical changes to the way curricula were structured and delivered (Elliott, 1993). Prior to his 1978 publication, Elliott spent over a decade, in the United Kingdom (UK), facilitating projects that sought to reform curricula through AR methodology. The uptake of this approach was significant, not just within the UK, but within educational institutes within Europe, USA, and Australia (Carr, 1989).

Freire, whilst also focussing on education, provided a critical orientation to AR in his eminent work *Pedagogy of the Oppressed* (Freire, 1970). For Freire, education that supports the development of a critical consciousness of the structures that oppress, or empower people to take action to change conditions, is liberating. His work provided a model for research that engages with the knowledge and experiences of people in order to confront inequalities and bring about social change (Brydon-Miller, 1997). Freire (1972) did not consider education practices to be neutral. He suggested when curriculum content is developed, or educational policies are drawn up and processes are planned, educators are making ideological choices. According to Freire (1972), education might perpetuate alienation as the values of the dominant class, who organise education, and determine the aims incorporated into and maintained within the system. In this domesticating praxis, the educator merely transfers existing knowledge, based on a dominantly constructed norms and perspectives to the 'ignorant' student. However, a liberating teaching praxis is possible, Freire (1972) suggested, where there is no absolute knowledge to be passed on but "a knowledgeable object which mediates the educator and student as subjects in the knowing process" (p. 180).

Freire made popular 'participatory action research', an approach that engages marginalised or under privileged participants in an AR project that will change systems and processes to enhance their lives (MacDonald, 2012). Within critical research, AR is seen as an approach that supports the emancipation of underprivileged groups by enabling the challenge of dominant ideologies and coercive structures (Johansson &

Lindhult, 2008). Thus, Freire's approach could be considered to be critical AR. Participatory and critical AR are two of a number of approaches to AR that are discussed next.

Types of action research.

There are several ways action researchers could approach their study. The approach selected is influenced by the worldview of the main researcher and the context of the study. Common approaches to AR are: 'Participatory Action Research' (PAR) and 'Critical Action Research' (CAR). PAR, made popular through the education research undertaken by Freire (1970/1972), is an approach that involves the community and is focussed on action that addresses issues for members of a particular group. Another approach, similar to PAR is CAR. This approach supports a collaborative approach to addressing a problem of practice; but, in addition to engagement with others, it also requires a critical consideration of the social, political, and contextual factors that contribute to inequities (Kemmis, 2006). CAR seeks transformative change through education and social justice approaches (Walker & Loots, 2018).

Other approaches to AR include action science, and appreciative inquiry. Action science is the application of knowledge to action that subsequently contributes to theories of action (Argryis et al., 1985). It draws on the principles of PAR and focusses on the theories that help the researcher understand participants' behaviours, such as controlling or defensive behaviours. Appreciative inquiry "adopts a positive and strengths-based approach to identify what is going well' within a situation" (Sandars & Murdoch-Eaton, 2017, p. 3). While appreciative inquiry is an approach that could be criticised for not acknowledging the issues of the context of the study, Hung et al. (2018) argued it does address the issues by appreciating and reframing the issues into constructive action. Action science's emphasises theorising behaviour over instigating change, and appreciative inquiry's focus on what is working well, were not suitable approaches for a study that was primarily seeking to influence change in a programme that currently has no content related to transgender healthcare.

The study discussed in this thesis aligned with some of the key principles of PAR and CAR in that the study was participatory and was critical of the hegemonic structures that impact on marginalised population groups. However, because this study needed to be explicitly mindful of the internal politics associated with undertaking research within the researcher's own organisation, the approach developed by Coghlan (2019) 'Undertaking AR within your own organisation' was adopted. The method outlined by Coghlan was adapted to meet the needs of the current study. This is discussed more in

the methods chapter of this thesis. Coghlan's approach acknowledges the contextual nature of AR and how it might influence the process. For example, it discusses the challenges the researcher might face due to the politics of the organisation. It is an approach that emphasises the importance of relationships over rigidity of process and understands that the researcher must continue to work in the organisation following the research project. An overview of this approach is presented later in this chapter.

Action research is concerned with practical knowing.

There are many ways of knowing. For example, Indigenous Corporate Training Inc. (2018) discussed indigenous knowledge as the skills, philosophies, and understandings gained through people's historical engagement with their natural environment. Heron and Reason (2008) described four ways of knowing: propositional, experiential, presentational and practical. Propositional knowledge is knowledge that includes ideas and theories borne out of procedures or trials designed to establish facts. Experiential knowledge is knowing what something is like through having experienced it, gained by the individual as they engage with others and the world. Presentational knowing is gained through the expression of action aimed at keeping a respective audience engaged. Practical knowing is knowing how to behave in a particular context to achieve a particular outcome. AR is concerned with the development of practical knowing (Reason & Bradbury, 2001) a knowing that incorporates other ways of knowing. The philosophy of practical knowing is discussed next.

Characteristics of 'practical knowing'.

Practical knowing is the knowledge that supports competence when participating in day-to-day living. It is knowing how to behave, respond, and interact with others and the environment when the responses of others and the environment are not predictable, and each situation is unique. This type of knowing has been explored by several distinguished philosophers including Aristotle, Dewey, Gadamer and more recently, Eikeland (2006), Carr (2007), and Coghlan (2016). Coghlan (2016), identified four characteristics of practical knowing, these are listed below. A discussion that draws on historical and more recent philosophers of practical knowing will then be presented.

1) Practical knowing is focused on the everyday concerns of human living.
2) Practical knowing is socially derived and constructed.
3) Practical knowing requires attentiveness to the uniqueness in each situation.
4) Practical action is driven by values and is fundamentally ethical.

(Coghlan, 2016, p. 92).

Reflection is also critical to the development of practical knowledge. The importance of reflection will also be discussed.

Practical knowing is focused on the everyday concerns of human living.

Practical knowledge, otherwise termed common sense, is not the knowledge which is taught but what is learnt through everyday experiences (Sternberg et al., 2000). Practical knowing occurs when people work together to resolve a problem or complete a task that is important to them. In so doing they gain insight through finding solutions or new ways of doing things. This knowledge is developed through the building up of clusters of insights into everyday living (Coghlan, 2016). The person who is formed through actions that seek to serve their community is fuller and broader than the person who acts against the needs and purposes of others (Dewey, 1910/1996).

AR seeks to address the concerns of the people involved in the research project. While other research approaches might also be concerned with issues impacting on the day to day lives of people, practical knowing is specifically dependant on the collaborative deliberation of action which seeks to resolve issues that impact on people's lives. For example, accessing healthcare presents significant issues in the day to day lives of many transgender people. The current study, discussed in this thesis, sought to address barriers to accessing healthcare for transgender people, through enhancing nurses' provision of quality care for this population group. AR enables people to work together to better understand individual concerns and identify actions that will address these concerns.

Practical knowing is socially derived and constructed.

When faced with a concrete project, we draw on knowledge gained from experiences and on what we have learnt from our parents, teachers, and other members of society (Coghlan, 2016). This type of knowledge is socially constructed. It is knowledge that includes socially constructed norms, expectations, and perspectives of what is real and true (macro social construction). Individuals bring to the research process their own perspectives of what is real and true. The AR process enables people to be open to different ways of viewing the world and the possibilities for enhancing other people's wellbeing through changing practice.

At a micro social constructionist level, the process of interpreting and understanding another's perspective is described in Gadamer's hermeneutics (Clark, 2008). Gadamer's hermeneutics refers to the back-and-forth interpretation, of parts to whole to parts etc., which occurs for an individual within an interaction with a text or with

discussions with another (Austgard, 2012). Hermeneutics is the process through which a person moves to a new understanding through the reconciliation of their existing prejudices (perspectives, that have been influenced by their social and cultural history), with the new information within the text or conversation. Thus, within a collaborative, discursive interaction, as occurs in AR, if all are receptive to others' ideas, practical knowledge is advanced (Carr, 2007).

> …practical knowledge and understanding can only be developed and advanced by practitioners engaging in the kind of dialogue and conversation through which the tradition-embedded nature of the assumptions implicit in their practice can be made explicit and their collective understanding of their praxis can be transformed (Carr, 2007, p. 433).

Practical knowing requires attentiveness to the uniqueness in each situation.

> "What should experiences be but the future implicated in the present"
>
> (Dewey, 1917, p. 5).

Practical knowing requires a reflexive attentiveness to what is happening in the here and now (Coghlan, 2016). Attending to the moment generates insight. Within each new situation we draw on these insights and, if we are attending to them, these situations provide new insight. Attending to the uniqueness of the situation is an important aspect of the AR model adopted for this current study. To be attentive as a researcher means, closely observing and considering internal and external experiences (Bova et al., 2018). It also requires the researcher attend to the uniqueness of the research context.

Attending to internal experiences ensures the researcher considers what is happening for them, at the moment in time, as they engage with others. That is, they attend to what they are experiencing, what they feel, and what they understand about what they are feeling (first person inquiry). Attending to external experiences asks the researcher to question what they observe to be happening for those they are engaging with. Attending, when engaging with others, directs researchers to actively listen to others, to reflect on what they say, in relation to what others say, and to observe and consider people's expressions, behaviours, and silences, as they interact with others. Researchers contribute to practical knowing through being explicit about their train of thought, and how they think and feel as they engage with others to bring about change.

Researchers must also be attentive to the uniqueness of each situation. AR unfolds in real time, in a unique context, where end points are unpredictable. This current study

engaged with members of a marginalised community through an AR process. This was a unique research process for the organisation where I worked. In AR the group needs to reflect on their current knowledge, challenge what has happened before, and through action and reflection, improve the organisation's future (Austin, 2017). Through this process group members gain practical knowing. Attentiveness to the uniqueness of a particular context is critical to practical knowing.

Practical action is driven by values and is fundamentally ethical.

According to Gadamer (1975), ethical practice is an essential aspect of practical knowing. It requires researchers reflect on their prejudices and seek to address them to support moral decision making. The purpose of action must be well intentioned, because skill without good intention could lead to self-serving action that does not build practical wisdom (Schwartz, 2011). Practical knowing draws on the Aristotelian ethical virtues of *phronesis* (Coghlan, 2016) and *praxis* (Carr, 2007). *Phronesis* is the capacity to deliberate towards the right course of action in a situation (Friesen, 2000). Aristotle considered *phronesis* to be both an intellectual and ethical virtue (Eikeland, 2006). *Phronesis* differs from other Aristotelian virtues, such as *techne* and *episteme,* because it cannot be applied universally. Knowing what is right in a particular situation, cannot be determined independent of that situation (Gadamer, 1975).

Praxis is action orientated towards understanding human good. It is a form of action where the means and ends are not known in advance but are realised through action and reflection (Carr, 2007). The current study aimed to address health disparities for transgender people. It was ethical in intent because it sought to understand human good through wider engagement with a marginalised population group to determine actions. *Praxis* and *phronesis* relate to moral knowledge that, according to Gadamer (1975), requires deliberation with oneself and cannot be taught or forgotten. It is gained when acting within a concrete situation with ethical intent. That is to say, the end, moral knowledge, is only achieved through moral action, which can only occur within a situation that cannot be determined ahead of that situation. Yet, determining the moral action requires moral consciousness which is only gained through encounters that require moral decisions. Thus, the means determines the end, and the end determines the means.

Moral consciousness, Gadamer suggested, is influenced by the prejudices embedded in one's effective history and cultural traditions (Carr, 2007). Prejudices and traditions cannot be understood by an existing theory but can be rationally revised through the reflection of one's own understanding of the historical and cultural situations that shape

prejudices (Carr, 2007). Ethical practice (*praxis* and *phronesis*) requires the practitioner reflect on their moral decision making and they have a capacity to be sympathetic of others (Gadamer, 1975). The understanding of another, Gadamer suggested, requires a consciousness of one's prejudices and openness to new understandings. This current study sought to raise the consciousness of non-transgender/nurse educator members' own personal biases with regard transgender people. The AR process was reliant on authentic reflection. The approach adopted (Coghlan, 2019) supported the researchers' attentiveness to, and reflection of, their own assumptions.

Importance of reflection in practical knowing.

A contribution to practical knowing, based on the characteristics discussed in this section, is heavily dependent on the researchers' commitment to reflection. Reflection is the critical link between attending to the moment and taking responsible action (Coghlan, 2019). One of the earliest writers on reflection, with regards improving practice was Dewey (1910). For Dewey reflection is the:

> Active, persistent, and careful consideration of any belief or supposed form of knowledge in the light of the grounds that support it, and the further conclusions to which it tends, a process of being uncertain, when drawing on past experiences and prior knowledge; inquiry into possible alternatives and testing to determine a way forwards, with regards improving practice (Dewey, 1910, p. 6).

Later, Schön (1983), in relation to teaching practice, described reflection as a process by which the practitioner critiques their own initial understandings of practice in order to make sense of new (unique) situations and construct new theories. Reflection with regards actionable knowledge has been emphasised in Coghlan (2019), Kemmis (2006), and Wicks and Reason (2009).

The cycles of action and reflection can take many forms. They might be introspective solitary self-dialogue, intersubjective (pertaining to relations with others) or a mutually collaborative (a participatory dialogic) approach (Finlay, 2008). Some AR approaches emphasise the importance of reflection as solitary processes that support their personal understanding of practice. Coghlan (2019), suggested, in addition to the collaborative reflective AR cycles, the researcher must also incorporate their own reflection cycle as their contribution to actionable knowledge.

> A useful guideline in my experience, is that if the report contains extensive reflection on the personal learning of the author-researcher as agent of the

> action in the story … then the first-person narrative adds a considerable strength to the published report (Coghlan, 2019, p. 232).

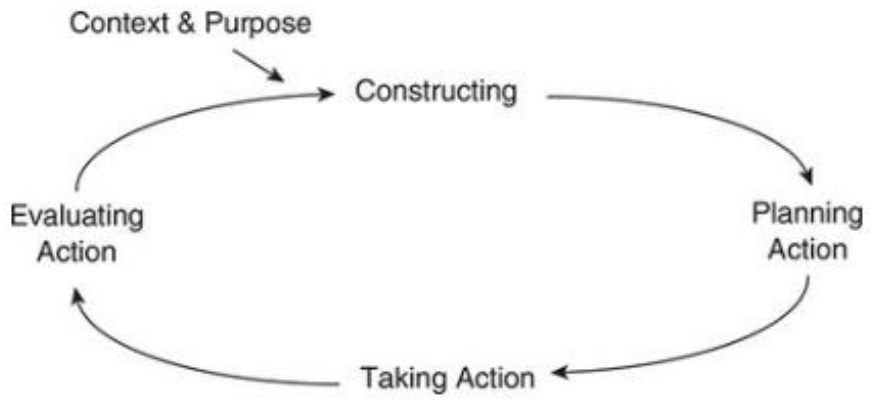
Solitary process reflection requires practice, practice which might include habitual meditation and journaling (Reason & Torbert, 2001). Kemmis (2006) considered both self-reflection and collective reflection as occurring within an established communicative space. A communicative space supports democratic expression of differing perspectives with the aim of reaching a consensus on action (Wicks & Reason, 2009).

Reflection is a critical aspect of practical knowing and other aspects of knowledge gained through AR. The study discussed in this thesis drew on both solitary reflection and collective reflection. Solitary reflection occurred through reflective journaling and explicit reporting of the learning cycles, as presented in chapters five and six of the current thesis chapters of this thesis. This study also presents the collective reflections that occurred as group members sought to understand the experiences of others in the group space.

Doing action research in your own organisation.

Doing action research in your own organisation is an approach to AR developed by Coghlan (2019). The first edition of this method was published in 2001 (Coghlan & Brannick, 2001). It was subsequently modified and republished. The 2019 publication was the fifth edition of the method. At the time of this thesis, Coghlan was a Professor and Fellow of the Trinity College, at the University of Dublin, Ireland. How his method was adapted for the current study will be discussed in the methods chapter of this thesis. Coghlan's method firstly outlines the repeated cycles of four phases: constructing, planning action, taking action, and evaluating action as shown in Figure 1. These phases occur in collaboration with others in the AR group, influenced by the context and purpose of the current study (Coghlan, 2019). Coghlan suggested there may be several cycles running concurrently.

Figure 1 *The action-research cycle*



(Coghlan, 2019, p. 29, [used with permission])

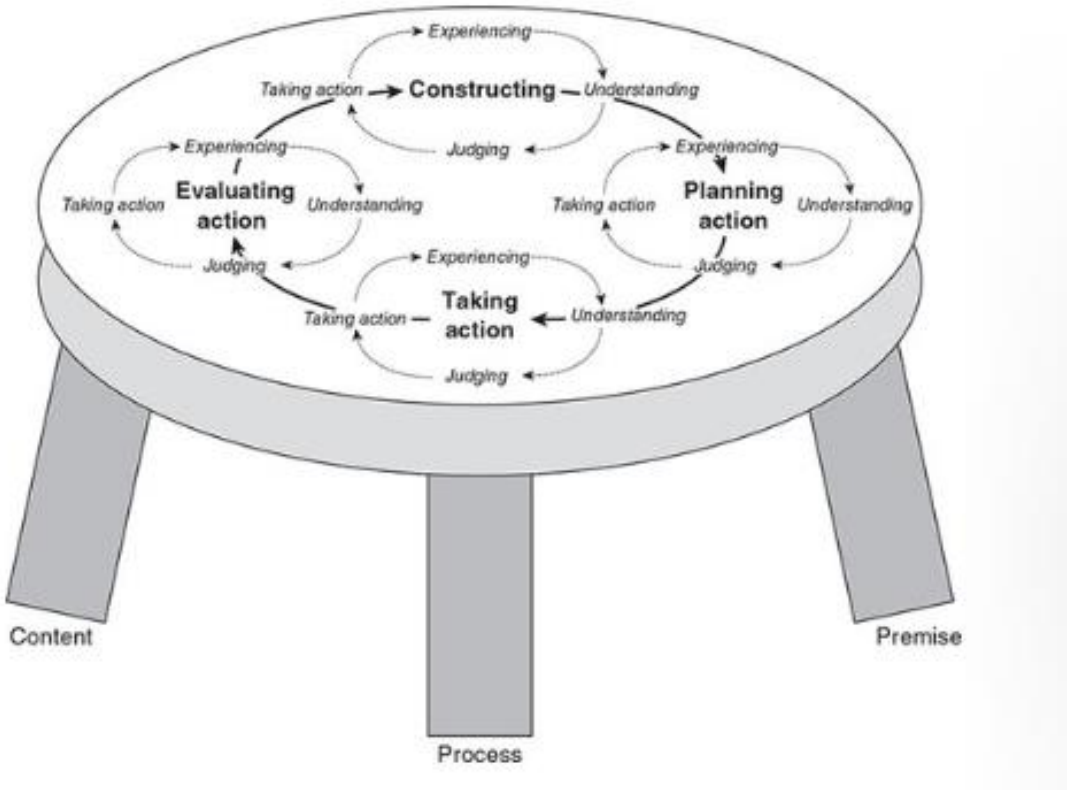
The four phases of an action research cycle:

- Constructing: the group collaboratively ascertains the issues of concern for them. These issues will form the basis for action.
- Planning action: the group identify actions or interventions that align with the purpose and address the collaboratively ascertained issues to be addressed.
- Taking action: planned actions are collaboratively implemented.
- Evaluating action: intended and unintended outcomes of the actions are reviewed to determine: if the construction of issues was correct; the actions addressed these constructions; the actions were carried out appropriately; and what will feed into the next cycle.

The meta-cycle of inquiry.

The meta-cycle of inquiry, as shown in the lower part of Figure 2 (Coghlan, 2019, p. 76), requires the researcher reflect on: content (the main issue being addressed); the process (the strategies adopted and how they occurred) and the premises (their underlying assumptions and perspectives). In the current study the issue addressed was outlined in the introduction chapter; the underlying assumptions were presented in this chapter, and the methods adopted are outlined in the next chapter.

Figure 2 *The meta-cycle of inquiry*



(Coghlan, 2019, p. 76, [used with permission])

The general empirical method.

In the model adopted for this study, as shown in Figure 2, the researcher must be explicit about the learning that occurs for those engaged in the AR project. In Coghlan (2019) these learning cycles are described in his 'General Empirical Method'. This method discusses four steps of learning. These steps are 'experiencing', 'understanding', 'judging' and 'taking action'. These steps occur within each of the main phases of the AR cycles. Coghlan indicated that learning occurs at three person levels. At the first-person level, the researcher outlines their own learning. At the second person level, group members' learnings are discussed. At the third person level, learnings of the wider organisation and beyond are also considered. While the image appears to depict the process as occurring once within each phase of an AR cycle phase, this is not the case. Coghlan (2019) advised, learning is the ongoing repetition of these cycles, throughout the phases.

In first person inquiry, the researcher reflects on the research as it unfolds in the present tense. It requires the main researcher attends to their experiences, that is, they attend to what they think, and emotionally and physically feel. The researcher reflects on these experiences by deliberately trying to make sense of them, and then draws on

theories and constructs to support their sense making (understanding) of these experiences. This process Coghlan refers to as interiority, “the cutting edge of theory and practice” (2010, p. 299). This process contributes to research knowledge through which the learner will determine what action they might take. This may include deciding to do things differently when faced with a similar situation.

As the researcher is also engaged in second person inquiry, they must also reflect on the observed, or reported, learning cycles that occur for group members as the AR progresses. The integration of first and second person voices supports scholarship that improves practice and contributes to knowledge through the development of generalisable conclusions which are disseminated to the third person, the wider community (Reason & Torbert, 2001). How this AR project influenced learning beyond the group involved in the project is discussed in the ‘findings’ chapters of this thesis.

3.4 Critiques of action research

AR is an emergent process which occurs within a specific context. AR has been criticised for appearing to be unscientific (Krumsvik, 2012) and thus lacking rigour. Rigour requires research validity so that findings can be trusted. One reason for questioning the validity of AR is low researcher control, as the researcher cannot control for external factors that might influence outcomes. AR is unpredictable. It occurs in real time in sometimes complex situations. This unpredictable aspect of AR may create a vulnerability for the researcher who may experience unexpected changes to the topic or method or may have to abandon their project altogether (Kock, 2004). However, AR does not seek to contribute to scientific knowledge. AR contributes to practical knowing, a knowing how rather than a knowing that. That is, understanding how practice was changed is more important than knowing what has changed.

AR validity could also be questioned because of a potential for bias in analysis and reporting due to a strong personal involvement of the participants/co-researchers (Burns, 2005; Kock 2004), or researchers needing to report findings in a way that reflects well on the organisation. The concern about bias in reporting, is based on a view that the focus of the research is the outcomes. Practical knowing occurs in the doing and is not reliant on successful outcomes. AR avoids misrepresentation of findings through its dependence on authentic reflection of the events of the research as they occur. The necessity for transparency with regards process, analysis, and findings, with group members, also supports validity.

AR might also be criticised for its low generalisability. Reasons for low generalisability include the commonly small scale of AR projects (Burn, 2005) and that the findings could only be considered to be relevant to the particular context of the study (Kock, 2004). However, it could be argued, that because AR contributes to practical knowing, the 'knowing how rather than knowing that' it contributes to knowledge which is generalisable. Just as other practical skills, such as trades, that are usually transferable to other contexts.

AR has also been criticised for not always meeting its purpose of addressing the needs or issues that are identified collaboratively by the group. The thought being that the researcher could be influenced by organisational pressures to push a focus on issues that might not have otherwise been collaboratively identified as important by the group. AR uses a methodical process which includes the group's collaborative determination of the issues to be addressed and subsequent actions. AR requires authentic reflection on how actions are determined and undertaken. Because AR is collaborative, transparent, and authentically presented means it is less likely than other methodologies to be influenced by organisational aims or to be misrepresented by the researcher. How rigour was maintained in the current study is discussed in the methods chapter of this thesis.

3.5 Conclusion

The current study sought to understand how engagement with the community could influence an existing nurse education programme with regards to provision of quality care for transgender people. This study was underpinned by a social constructionist epistemology. This world view acknowledges that the concept of gender and gender expectations are, at a macro level, socially constructed and that knowledge is supported, at a micro level, by opportunities for people to interact with others. The study's aim and epistemology necessitated an approach that enabled discursive interaction, a requirement supported by an AR methodology.

The AR approach, 'Doing Action Research in Your Own Organisation' (Coghlan, 2019) was adopted because the current study was based in the researcher's own organisation. The approach adopted outlines the phases of each AR cycle; the meta-cycle/thesis component of inquiry; and the 'General Empirical Method' of learning which occurs for the researchers as they engage in the AR process. There are numerous ways of knowing but this chapter has argued that this study's aim, epistemology, and research approach would support a contribution to practical knowing.

Coghlan (2016) presented a philosophy of practical knowing. In this philosophy, practical knowing occurs when research "… focusses on the everyday concerns of human living; … is socially derived and constructed; … attends to the uniqueness in each situation; … its actions are fundamentally ethical" (p. 9). Reflection is a critical aspect of many AR approaches and is particularly important for researchers seeking to contribute academically to practical knowing. How this study aligns to this philosophy is discussed in the methods, results, and conclusions of this study.

CHAPTER FOUR: METHOD

4.1 Introduction

This study used an action research (AR) method developed by Coghlan (2019) that can be used in your own organisation. It sought to contribute to practical knowing through its adoption of an approach that is underpinned by a philosophy of practical knowing, an approach principled on social constructionism (Coghlan, 2016). How the current study aligned to the characteristics of practical knowing is outlined next. The context of the study will then be discussed. The ethical considerations, in particular how member safety was maintained, will also be presented. This chapter will then provide a detailed outline of the research process, including how the method was adapted to meet the needs of the study, alongside a discussion of how rigour was maintained, and data analysis was undertaken.

4.2 Practical knowing

Our AR study sought to contribute to practical knowing through its adherence to the four characteristics of practical knowing as outlined by Coghlan (2016). These characteristics and how they were adhered to are listed below:

1) *Practical knowing is socially derived and constructed*. This study is underpinned by a world view that knowledge is socially constructed.

2) *Practical knowing is driven by values and is fundamentally ethical*. The aim of this study was to improve healthcare experiences for transgender people, an aim that is ethical in intent.

3) *Practical knowing is focused on the everyday concerns of human living*. In the current study initial actions, determined by the group, supported education for nursing students. Further actions addressed group members concerns about how content should be designed, and subsequently delivered, and their view that wider organisational change was needed.

4) *Practical knowing requires attentiveness to the uniqueness in each situation*. Chapters five and six of the current thesis focus on the group members' and the main researcher's explicit attendance to the uniqueness of each situation.

4.3 Understanding the context

Prior to this study, and several times during the study, I consulted with Māori/tangata whenua, people of the land/indigenous population (Te ara Māori dictionary, 2024) and with transgender support groups. How these consultations were undertaken and why they were important, for the study is discussed next.

Consultation with tangata whenua.

Prior to the first group meeting, I met with Matua Mike (matua is a term of respect for an older male [Te Tāhū Hauora, 2024]). Matua Mike is the kaumatua, meaning the respected elder, (Te ara Māori dictionary, 2024), of the local iwi, meaning tribe (Te ara Māori dictionary, 2024) of the region, of the organisation where I work. I had already discussed with Matua Mike my initial thoughts for a study and asked if he would be willing to culturally support me, on my doctoral journey. He enthusiastically agreed to do this. This consultation was the right thing to do when researching within an Aotearoa context. It also supported the creation of a safe place for engagement and a personal critical awareness, about western versus indigenous constructions of gender. AR has much synergy with kaupapa (meaning ways of doing [Te ara Māori dictionary, 2024]) Māori research. The importance of engagement with a local kaumatua is discussed next.

Consultation was the right thing to do.

AR is fundamentally ethical, and practical knowing is hinged on researchers working with ethical intent. While consultation with tangata whenua (Māori) is common practice when undertaking research in Aotearoa, it was particularly important in this study because Māori experience significant disparities in health. Health disparities are a consequence of colonisation which led to a loss of land, culture, and resources, and a subsequent reduced access to determinants of good health (National Ethics Advisory Committee [NEAC], 2022). “Under the principle of Manaakitanga, all health researchers should engage in consultation” (NEAC, 2022, para. 6). Manaakitanga means being kind and respecting of others. It draws on the concepts of hospitality, respect, and care for others (Moorfileld, 2024)

Consultation is also a requirement of this study’s national treaty (Te Tiriti o Waitangi). Te Tiriti o Waitangi is a treaty between Māori and the crown that was signed in 1840 in Aotearoa. It affirmed a commitment to partnership in decision making and equity of outcomes (Orange, 2023). It is ethically important that health research, within Aotearoa,

is informed by tangata whenua (people of the land). Both AR and practical knowing are essentially ethical in intent and process.

Consultation supported the creation of a safe place for engagement.

Consultation was also important because it supported the creation of a safe space for research participants within an Aotearoa context. A space that supports whanuangatanga (a family like atmosphere) enables participants to safely connect with others and express their personal experiences and perspectives. As a non-Māori researcher, I needed to better understand how I could support safe meetings within a bi-cultural context. In our first meeting, Matua Mike prioritised preparing me for my first group meeting. While I was quite familiar with protocols for meetings within the Aotearoa context, I appreciated the opportunity to get this aspect of our meetings correct. In our meeting, Matua Mike and I wrote my pepeha (personal connections to the land) and a karakia (an opening prayer or greeting commonly used in Aotearoa to establish an intent of goodwill) and discussed actions that might also support positive group connections.

Actions suggested by Matua Mike to support a safe space for participants included starting the meeting with a karakia, introducing myself with my pepeha and inviting members to introduce themselves ‘in ways that felt comfortable for them’. Alongside this, Matua Mike suggested I provide a substantive group lunch, to enable group members to make connections with others, in relation to each persons’ roles and positions within the community in a more relax meeting setting. This adherence to Māori meeting protocol supported the development of a communicative space - a physical and conceptual place that enables participants to safely engage in discursive interactions (Bevan, 2013).

I met with Matua Mike again during the action phase of our project. I informed him of our progress, and mentioned that group members, when delivering a workshop developed by the group, expressed nervousness about the karakia (an opening, an appropriate way to start a meeting). I asked Mike, with permission from the presenters, if I could voice record a karakia for this workshop, he agreed to this. The words and their English translation were put up on the screen at the start of our workshops, his recording introduced the session. His voice and his mana (the respect afforded to people of significance) led to a spiritually rich recording of a karakia that supported culturally respectful openings to our workshops.

Conversations shaped my thinking about western constructions of gender.

Alongside the discussions about safe spaces, Matua Mike and I also discussed Māori perspectives of gender. These discussions led me to think about how cultural practices are socially constructed, and how what is considered to be gendered cultural norms came to be reconstructed through the influence of social hegemony. For example, we discussed how what is now considered to be traditional gendered practices, for Māori, may have been influenced by colonial norms. Matua Mike suggested, for example, that different expectations of behaviour, based on gender, at a pōwhiri (an event where hosts welcome visitors) may have changed. Matua Mike suggested that in our region, there were some strong wāhine (women) leaders, who were unlikely to have taken a back seat in pre-colonial meetings. Yet, Matua Mike suggested, even respected elders have come to accept certain practices such as wāhine sitting behind men in meetings as being protocol. Collaboratively we came to a view that colonial norms, where women were less expected to be engaged in political matters, were adhered to out of respect for European colonisers, led to new constructions of protocol, in relation to wāhine roles within pōwhiri.

In later meetings, Matua Mike and I had more discussions related to Māori constructions of gender and how they differed from western norms. In pre-colonial times, for example, gay and/or transgender people were accepted members of communities. There was no word for them because a word was not needed. Takatāpui, is a recently constructed Māori word for gay and/or transgender people. These discussions with Matua Mike supported personal reflections of how different contexts shape language and constructions of meanings and led to my critical consideration of indigenous verses western constructions of gender. Had traditional practices continued, I believe life would have been significantly easier for gay and transgender people in Aotearoa.

Kaupapa Māori approaches to engagement align well with action research.

AR has much synergy with indigenous ways of knowing. Kaupapa Māori research, for example, supports insider research, and empowerment for those involved in the research project (Tiakiwai, 2001). Kaupapa Māori research seeks to address the everyday concerns of the community, it views knowledge to be socially constructed, and is based on a social justice intent. These principles align well with the characteristics of ‘practical knowing’ that inform the current study. Engagement with kaumatua enabled a better personal understanding of the similarities between ‘practical knowing’ and indigenous ways of knowing, and approaches that support both types of

knowledge production. While both approaches are action orientated and emphasise collaborative decision making, understanding the synergies led me to drawing on aspects important to kaupapa Māori approaches to action in the current study. For example, I sought to build positive relationships (whanaugatanga) with group members and provided good hospitality and care (manaakitanga) within meetings.

Prior networking with transgender communities.

To further support my understanding of the context of this study, prior to the first meeting and during this study, I also connected with transgender community organisations. This was important because 'practical knowing' requires the researchers address people's everyday concerns. As such, I needed to be informed about the healthcare concerns of transgender people in the wider community. As a cis-gender person these consultations were necessary to support my understanding, and the subsequent provision of a research process that was culturally safe for transgender group members. Consultations were also important because they supported networking with transgender communities, networking is an important aspect of the AR process. The importance of prior networking in AR is discussed next.

Understanding the everyday healthcare concerns of transgender people.

As discussed in chapter one, prior to determining this study's research question I met with a young transgender male. We discussed his concerns about an upcoming hospital procedure, and his views of the changes that were needed with regards transgender people's healthcare. This meeting affirmed my earlier discussed understanding that there are significant barriers to accessing healthcare for transgender people. I later attended the inaugural 'Professional Association for Transgender Healthcare Aotearoa' (PATHA) conference alongside a preconference workshop presented by Pearce, the author of 'Understanding Trans Health' (2018). I became an inaugural member of this association. This membership allowed me to participate in the email discussions largely related to healthcare concerns discussed between members of this group.

I applied, and was accepted, to be part of two Aotearoa transgender Facebook sites. These sites were 'Genderbridge NZ' and 'NZ Transgender News Share'. These memberships further supported my understanding of the minority stresses regularly experienced by transgender people. Around this time, I had an online meeting with Oliphant, primary author of 'Guidelines for gender affirming care…' (Oliphant et al., 2018). Here, I presented my potential study. She advised that this study would be very useful with regards supporting future transgender healthcare. These connections

supported my pre-study journey to better understanding the everyday health concerns of transgender people.

Supporting safe engagement for transgender people.

Early into my doctoral journey, I connected and spent time with 'Gender Minorities Aotearoa', an organisation that supports and advocates for transgender people. In this meeting we focussed on terminology and correct pronoun use. Correct pronoun use is critical to safe engagement with transgender people. We discussed the term 'transgender people', and I was informed this was the most appropriate term for the members of the population group I was working with. We also discussed their organisation's role and how it operates. Other topics, too complex to delve into here, were also discussed. The meeting was important because it was ethical in intent and supported safer engagement with the transgender people involved in the current study.

Networking was critical to the AR process.

In the model adopted for this study, Coghlan (2019) suggested that the early establishment of relationships with those invested in the study's purpose is critical to the process. Pre-study networking supported early engagement with people who might become involved in the study. Prior to starting this study, I attended PATHA's inaugural conference. At this conference I met a nursing student who was studying within the organisation where I worked. I discussed my research interest and they advised that they would be keen to be involved in my impending study. Advocacy for transgender people and challenging the status quo was important to them. With ethical approval they became a member of the group and subsequently a good friend. They co-presented, with me, at PATHA's first national conference in 2022.

Around this time, I also attended a community workshop about gender and sexual minority inclusiveness. I learnt much about the Rainbow groups in the community workshop and made valuable connections with the facilitators. Networking undertaken prior to this research enabled potential participants to get to know me, and subsequently led to their willingness to be involved in the project. A co-researcher advised when I was struggling for words for this section, "they knew you and trusted you as a researcher and an ally". The co-researcher's comment suggested that networking with community groups supported relationships with community members, an aspect of AR, highlighted by Matua Mike, when he advised of the importance of establishing whanaugatanga (kinship).

I also presented my research aims to nurse educators (NEs) in an organisational research meeting. This led to a number of NEs offering support to the current study, as participants or educators keen to see inclusiveness within our existing programme. All NEs at my organisation were invited to participate in the current research project. My presentation, and subsequent discussions, spurred some to become participants, and others to support the current study's actions. Networking supported connections and the gaining of trust within the local transgender community.

4.4 Study location

This study was located at a tertiary education institute, a subsidiary of Te Pūkenga, in Aotearoa. This subsidiary, in 2022, had almost 6000 students, with 506 Bachelor of Nursing students and 46 Enrolled Nursing students across three of its four campuses. Although I work at one of the smaller campuses, this study was based in the largest of four campuses in a city with a population of over 90,000 people. At the time of the study there were no active 'Rainbow' (LGBTIQ,) support groups in the regions of three of the four campuses, but there were several support groups in the region of the larger campus, where this study was undertaken.

4.5 Ethical considerations

Ethical approval for this research was gained from Auckland University of Technology Ethics Committee (AUTEC) on the 5/11/2019 (see Appendix 1). The reference number for this consent is 19/366. I also submitted an application to the Health and Disability Ethics Committee (HDEC) and was informed that the current study did not require a HDEC review (see Appendix 2). A request to undertake action within the organisation, where the study was undertaken, was submitted to the organisation's own ethics committee and was subsequently approved (see Appendix 3). The aspects of these consents, discussed in this section, are participant recruitment and group member safety/privacy. Two amendments (April 2020 and July 2021) to this ethical approval were sought, and subsequently approved (see Appendices 4 & 5). These amendments are also discussed in this section. Furthermore, approval to conduct a survey with people from the organisation, outside of the AR group, was also granted (see Appendix 6).

Participant recruitment.

To reduce group member selection bias, invitations to participate in this study were sent to all members of the respective groups that the study hoped to gain representation from (see Appendix 7). The respective groups were nurse educators,

and ‘student support’ team members (staff of the organisation who support students to succeed in their studies and work to create an inclusive, inviting, learning environment) at the institution across all campuses. Members of transgender community groups and regional providers of transgender healthcare were also invited. I selected the larger campus as a base for the study, as this was the only campus of the four that was based in a community that had transgender support groups and transgender specific healthcare support providers. The AR intent behind this selection process was aimed at meeting ethical requirements of inviting all that met inclusion criteria, alongside enabling people who were needed to inform change, or people who could enable change to participate.

The inclusion criteria for participation in this study were that participants were one of the following: nurse educators within the organisation; student support team members of the organisation; members of a community who identify as transgender; or members of a community that support health and wellbeing for transgender people. There were no exclusion criteria, but participants needed to be able to attend daytime meetings. I did not offer online meetings at this time as I thought such would be challenging in the building of trust and comfortable interaction in early meetings. However, I did not state that face to face was a requirement of participation. If a potential group member requested online participation this would have been accommodated. As it was, two meetings were moved to an online platform during the Covid 19 pandemic.

An invitation to participate in the AR project, alongside information about the study (see Appendix 8) was sent to all nurse educators and student support team members across all campuses of the organisation. This invitation was sent from the organisation’s staff capabilities leader, a person whose main role was to enhance staff member capability with regards academic delivery. I chose this staff member to be the person who sent the invites to reduce the potential of any sense of coercion, as she was not a manager of any of the prospective participants. An invitation was sent to a gender non-binary nursing student (with ethical consent) who had previously expressed an interest in participating in the project and had verbalised a desire to engage in advocacy for gender minorities. An invitation was also sent to all local community groups and healthcare providers who identified as promoting wellbeing for people who identify as ‘Rainbow’ (LGBTQI,) or gender diverse. A list of these groups was attained from the facilitator of a community workshop I had attended prior to the start of this project.

Eleven people (four nurse educators, two student success team members, the aforementioned nursing student, and four community members) expressed an interest in participating in the study. All prospective members consented to participate (see Appendix 9) and completed the Confidentiality Agreement (see Appendix 10). The initial AR group had representation from the following LGBTIQ, population groups: gay male, transgender male (for the sake of the study, but identifies as male usually), transgender female, gender non-binary, Takatāpui, and cis gender people. The group later collectively decided to invite an additional, younger, transgender male who was very active in the local transgender community, and also another nurse educator. This is typical of an AR process where group members sought to assure that, moving forward, the right people were at the table as we sought to influence change.

We started with a large group of 12 participants. However, the research project took longer than anticipated (two and a half years as opposed to the anticipated one year) and there was some group member attrition. This could be anticipated with such a lengthy study. Most members who left the group did so to support their respective career pathways, outside of the organisation. In AR people are more important than a perfect process, and flexibility is intrinsic to the process. That said, we still had seven active group members by our last formal meeting.

Participant privacy and safety.

The determination of processes to ensure group member confidentiality and safety in AR should be collaborative. In this study I was not as collaborative as I should have been. In the first meeting, for example, I should have ascertained group members' understandings of privacy and safety and their views on what was needed beyond my own ethical consent considerations. Coghlan (2019) provided an example of how shared values might be discussed in a first meeting. However, in my first meeting, I was more focussed on making sure we met bi-cultural obligations, that all the required forms were signed, and affirmed, and that the AR process was presented and opened up for discussion. As it was, no privacy or personal safety issues occurred in this study. Indeed, all members who fed back their reflections of the study reported feeling particularly safe throughout the research process. Privacy and safety processes that were put in place, were in alignment with ethical approval. These are discussed next.

Prior to the first meeting all participants signed a consent form and a confidentiality agreement (Appendices 9 and 10). New members who joined later also signed these forms. Participants were reminded of these agreements and the importance of confidentiality prior to the group's first discussion. Our signing and agreeing to

confidentiality, could not guarantee such, particularly when using a research approach that would lead to actions that would filter out to the wider organisation, and potential co-authorship of future articles. However, I was mindful of participants' privacy throughout the entire project. For example, I never used group members' names outside of the meetings, in relation to actions being undertaken, without explicitly gaining their permission first. Maintaining privacy presented challenges. Privacy in the context of participatory research may not always be possible or even desirable given the nature of this type of research (Kalsem et al., 2018). This raises the question of the suitability of current ethical processes when undertaking AR projects.

In relation to participant safety, group members were advised, in the first meeting, that there were people from a diverse range of backgrounds in the group, and as such all members needed to be respectful of the potentially differing perspectives that members brought to the discussion. I asked the group if they agreed to this and checked that each member agreed. When reflecting on my own process, I should also have asked the group if there was anything more we could do to support group member safety. This is because AR is underpinned by collaborative decision making and this really needed to be demonstrated from the start of the project. Furthermore, as I have emphasised in this study, cultural safety is defined by the recipients of care, as such, I really needed to have given group members the opportunity to define what safe meant for them.

The information sheet provided to participants (Appendix 8) included the contact details for free counselling, which was made possible by a counsellor involved in the study. This was a requirement for ethical approval. Furthermore, in the interest of safety, group members were advised that if when personally reflecting on a meeting, they wanted something they had said to not be included in the transcript they could let me know and I would not include it. This was a safety step listed in my ethics application. Participants could also request the removal of statements they had made after viewing a meeting transcript. These steps enabled participants to remove comments that they, on reflection, were concerned, may have repercussions for them personally if publicly available.

Repercussions from statements made in meetings might include, for example, a chastisement from management for criticising organisational practice. It was important to me, and to the methodology of this study, that participants felt safe to chat freely, and that no member would experience a negative repercussion because of something they had said in a flowing conversation. These processes further supported the formation of a communicative space. Additionally, I personally contacted members when I came

across a statement in a transcript that I thought might have negative consequences for that member if sent out. These statements included, for example a criticism of a colleague or family member. This practice enabled group members, if they desired, to have their comment removed. This step was not part of my ethics requirements, and was based on a personal judgement, that ‘it doesn’t hurt to check’. I am pleased I put these safety processes in place as they were occasionally used by group members in this study.

Ethical amendments.

Two ethical amendments were sought and approved. The first was a request to hold a meeting via a video conference, during the COVID 19 lockdown period. Only auditory data was saved, and subsequently transcribed. This amendment was approved on 15/4/2020 (see Appendix 4). The second amendment sought approval to recruit participants and collect data related to the evaluation of the actions of the group. This amendment requested permission to survey staff at the organisation to gain their perspectives of the impact of the actions of the group and potential improvements that could be taken into the next AR cycle. This amendment was approved on 9/7/2021 (see Appendix 5). The participants who participated in the survey completed a different Consent Form – Survey Participants (see Appendix 11).

4.6 Action research process

The model adopted for this study has a pre-step process and four repeating phases of constructing, planning, taking action, and evaluating action. The model also incorporates a ‘Meta-cycle of inquiry’ and a ‘General Empirical Method’ of human learning. How the model adopted, reflects the social constructionist lens that underpins this study is discussed next. The pre step process, ‘Meta-cycle of inquiry’ and the General Empirical Method’ are then discussed. This is followed by an overview of the events that occurred for us as a group within each of phases of one AR cycles. This study merged the ‘constructing’ and ‘planning action’ phases, and group actions were initiated during the constructing and planning phase.

A social constructionist lens.

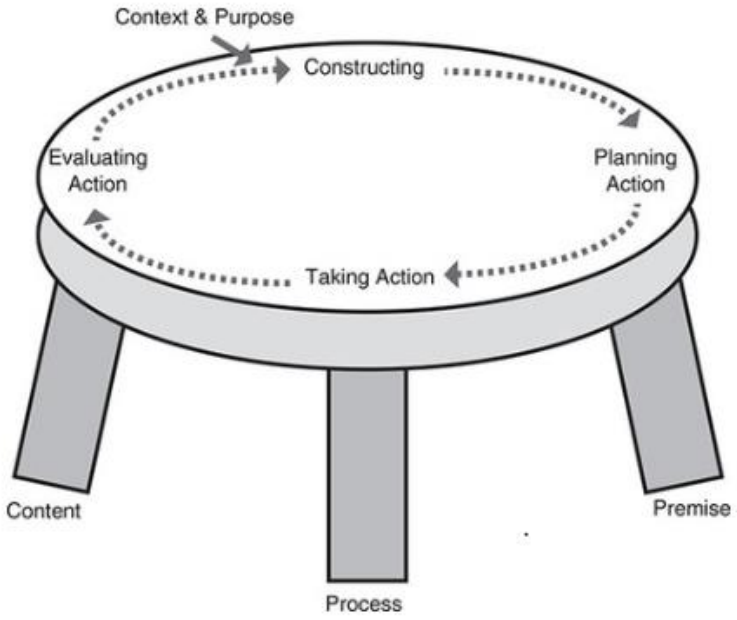
A social constructionist approach, at a micro level, suggests knowledge production occurs when discursive interaction is enabled. The model adopted for the current study, enabled supported discussion between NEs, student support staff, transgender community members, and transgender allies. Discussions supported new understandings for group members regarding the minority stresses regularly

experienced by transgender people. Macro social constructionism focusses on the collective questioning of socially constructed norms, develop over time that have positioned some ways of being as more socially acceptable than others and have led to social inequities. The model adopted for this study enabled action that challenged social norms that impact on the wellbeing on transgender people when accessing healthcare.

The meta-cycle of enquiry.

The meta-cycle of enquiry refers to the researchers' reflection on the content, process, and premises of the study as shown in the Figure 3. Coghlan (2019), presented this as the 'thesis' component of the study. Content refers to the researcher's reflection of the issues. Chapter one outlined my understanding of transgender barriers to healthcare access and disparities in healthcare outcomes. How these issues were experienced by transgender members of the group are further reflected on in chapters five and six of the current study. The 'process' refers to the reflection of the strategies and procedures of the project. The process is outlined next. This study assumed that knowledge is socially constructed and is premised on a view that AR supports 'practical knowing' and practical knowing is developed when the four characteristics as outlined by Coghlan (2016), occur. How our AR process aligned with the characteristics of PK was outlined earlier in this chapter and is reflected on in the next three chapters of the current thesis. Content, process, and premises are explicitly reflected on throughout this thesis.

Figure 3 Meta-cycle on action research



(Coghlan, 2019, p. 35, [used with permission])

The action research cycle.

As shown in Figure 3, the AR model adopted for this study, has a pre-step process (context and purpose), alongside four repeating phases. These four phases are constructing, planning action, taking action, and evaluating action. In this study we undertook one AR cycle. Our study merged the 'constructing' and 'planning action' phases, and group actions were initiated during the constructing and planning phase. The pre-step process is discussed next. Each of the main phases in the cycle also has a learning in action process, described as the 'General Empirical Method'. This method is discussed followed by an outline of the phases of the AR cycle undertaken in this study.

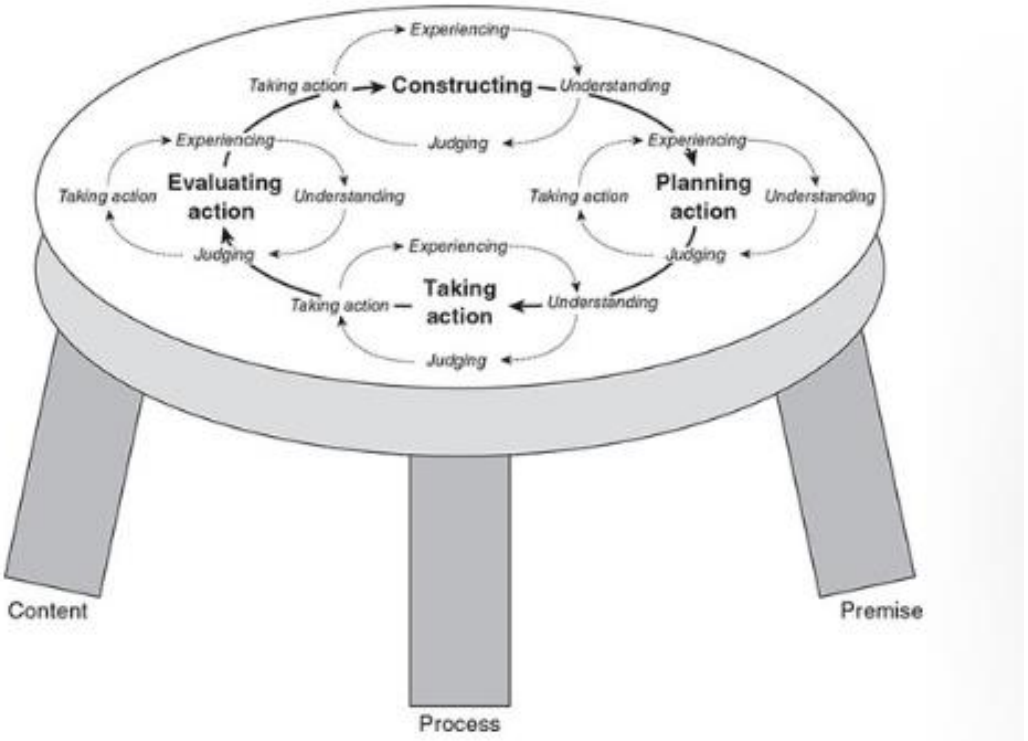
The pre step process.

The pre-step process refers to the context and purpose of the study. Understanding the context is important for action researchers, it supports a better understanding of the experiences of those the study seeks to support and the establishment of networks that will enable the recruitment of people relevant to the study purpose. Chapter one provided a clear rationale and subsequent purpose, based on the literature for the current study. Chapter one also outlined the socio-cultural context of the study. Chapter four of this study outlined the actions I undertook to better understand the local socio-cultural context of the current study.

The general empirical method.

AR contributes to knowledge through focussing on the learning that occurs, throughout the research process, irrespective of the tangible outcomes or challenges that may have impeded on progress, with regards the research aim. It is the learning that occurs for the researchers as they engage in first (their own), second (the group) and third (the organisation) person inquiry. In the 'General Empirical Method', adopted for this study, Coghlan (2019), advises, learning in action involves four steps: experiencing, understanding, judging, and taking action (EUJT). This process, as shown in the Figure 4, occurs throughout the phases of the AR cycle. The 'learning in action' process includes an explanation of what was experienced and reflected on, how the researchers understood and judge these reflections and the actions that were undertaken in light of reflection.

Figure 4 The general empirical method



(Coghlan, 2019, p. 76, [used with permission])

At a first-person level, I regularly undertook a learning in action process throughout the phases of the study. Examples of my learning in action are presented in chapters five and six of this thesis. As a group, we did not explicitly step out the learning in action process. Rather, I let the conversations flow and reported retrospectively on my interpretation of how we collectively understood group members' experiences, judged our understanding of these experiences, and subsequently determined action.

The 'learning in action' cycles are change cycles. They demonstrate how understanding an experience, and making a judgement based on the understanding leads to action at all levels of inquiry. A specific example of how second-person 'learning in action' led to change is included in the outline of the events of each phase of the AR cycle presented in the next section. The EUJT discussions and how they led to change were analysed thematically and are discussed in chapters five and six of the current thesis. Learning in action not only supports organisational change it also brings about change for those involved in the AR project. At a first-person level, in the current

study, the learning in action supported self-awareness and practical knowing about how to behave in new, and often challenging, situations. At a second person level, it fostered critical thinking and supported new perspectives for people in the group. Examples of people gaining new perspectives are discussed in chapter five. First person learning in action cycles were not analysed but are presented as personal reflections within the chapters five and six, an approach recommended in the method (Coghlan 2019) adopted for this study.

Constructing and planning.

'Constructing' requires the identification of issues. This is a process undertaken collaboratively with relevant others. The constructing phase is not the same as social constructionism, the worldview that underpins this research, however, they are linked. Social construction at a micro level refers to the collaborative determination of knowledge which occurs when people discursively interact with others. Coghlan (2019) suggested the constructing phase involves the collaborative framing of the issues and determination of a future state - what the organisation could look like if issues were addressed. This is a fluid and dynamic process. Interpretations of issues are revised as the process progresses.

In the current study, the issues, based on group members' experiences were collectively understood and judged over several meetings. In response, we subsequently planned actions as these issues were constructed and discussed. Thus, the 'constructing' and 'planning action' phases were merged. This merging has occurred in other studies, such as Austin (2017) and Ferkins (2007). Coghlan (2019) suggested phases should not be followed too rigidly, as the politics of the organisation might influence the process. Coghlan emphasised relationships with people are more important than rigidity of process. Constructing of issues and planning of actions occurred over several meetings, as shown in Table 1.

Table 1 *Events of the constructing and planning action phase*

Date	**Members involved**	**Purpose**
Dec 2019	Whole group	The context and proposed purpose, alongside the approach adopted were presented. The group went on to construct the issues and determine the 'future state'
Feb 2020	R, four TG (sub-group meeting)	To develop a collective understanding of experiences of transgender people accessing health and their perspectives of the future state

April 2020	Whole group	To further discuss some of the issues raised within the first and the subgroup meeting. Additional potential actions were planned (EUJT).
Aug 2020	Whole group	Our construction of the issues and the 'future state' that had been determined by the group were affirmed, and the plans for action were revised in light of this discussion.

R=researcher; TG=transgender members; EUJT = experience, understanding, judging, taking action (discussed in the next section).

Our constructing and planning phase occurred over several meetings, demonstrating the iterative nature of AR. Our understanding and judgements of the issues, related to transgender healthcare, developed as the meetings progressed, as did our awareness of how the cultural norms within the nursing programme and the wider organisation might present barriers for progressing nurse education in this space.

Learning in action: experience, understanding, judging, and taking action.

In the constructing and planning phase, one example of the EUJT process was our discussion about an experience of a transgender group member, raised in a sub-group meeting. The group member, who was a nursing student, raised a concern that there was no content related to transgender wellbeing in the mental health course of the nursing programme they were currently studying. We discussed their concern in the next whole group meeting. To support our understanding of their concern, they presented to the group some statistics that showed transgender people experience significant disparities in mental health in Aotearoa. These statistics alongside our growing awareness, from other group discussions, of the ongoing minority stresses experienced by transgender led to a collective judgement. We judged that content related to transgender people was needed in the programme's mental health course. As an action, a nurse educator offered to work with the respective course co-ordinator to find space in their course for such content. We agreed to this action as a group.

Taking action.

Taking action, Coghlan (2019) advised, is when the actions planned are collaboratively implemented. In taking action, the group moves the organisation towards what the group ascertained to be their desired future state. It requires the group members to draw on the skills and experiences of each other and their organisational capacities. In the current study, many actions agreed to in the constructing and planning phase, were implemented, instantaneously within the first phase, by subgroups working together on agreed actions. As such, 'taking action' was not a distinct phase but rather a series of agreed to actions, instigated by group members that spanned across the

constructing/planning phase of the project, For example, in the first meeting, NEs offered space within their respective courses for new content and, as agreed by the group, transgender group members made a plan to meet to discuss and design the new content.

As the project progressed actions moved beyond the nursing education programme to bringing about change within the wider organisation and within the Nursing Council of New Zealand (NCNZ). How this occurred is discussed in chapter six of this thesis. The actions, and what members were involved in the actions are presented in Table 2. Taking action led to more actions, emphasising the iterative nature of AR. Further actions were driven by group members' collective reflections on actions previously undertaken, and their desire, driven by engagement, for more change.

Learning in action: experience, understanding, judging, and taking action.

One example of an EUJT process in the 'taking action' phase of the research cycle was when we formally reflected on facilitators' (who were group members) first experience of delivering our developed workshop. This occurred in a reflection meeting, following the workshop. The reported experience of the facilitators was that they ran out of time. This meant they were not able to complete all the planned activities. We collectively understood, based on our discussions about the times that each activity took, that too much time was spent on preliminary discussions. For example, participants were asked to indicate where they ranked their knowledge, from one to five, of gender and sexual minorities. They were then asked, to explain why they ranked their knowledge at that level. This took more time than originally planned. As a group we discussed the relevance of this activity compared to later activities that involved real life scenarios of gender and sexual minorities. We judged that engaging with lived experiences was more important. Our planned action was to rethink the initial activities, cut them back somewhat, and enable more time for the activities we judged to be more important. For example, we chose not to ask participants to present their reasoning for their initial ranking but rather, at the end of the workshop, to present their reason for a change or no change in their ranking.

Table 2 *The events of the taking action phase*

Date	Action	Members involved	
Jan 2020	a) Content focussed on improving transgender healthcare competencies developed by the group	R, one NE, five TG	Developed a three-hour session for a BN 1 Communication paper
		R, one NE, one TG	Inclusion of a consideration of a typical urethra in catheterisations in BN2 Skills
		R, one NE, one community member	Inclusion of a sex v gender explanation and an example of intersex caused by alterations to chromosomes into a biology paper
		Two NE, two community members	Development of a profile of a patient who identifies as gender diverse for clinical assessment (later moved to a primary health paper)
		R, One NE	Inclusion of content into 700 level Primary Health Care
		R, one NE (non-group), one TG	Inclusion of content into year two mental health paper
Jan 2020 – Jan 2021	b) Nurse educator attitudes and skills are enhanced	R, 4 TG, one CA	Nursing/healthcare educator workshop, alongside group member facilitation training
		R, one NE, 3 TG, one student success, one CA	Reflected on our experiences of the above workshop and planned for future workshops. (EUJT)
		All members (online)	Development of a resource site for nurse educators
March 2020 – March 2021	c) The organisation has an inclusive learning environment for gender and sexual minorities	R, two SS, five TG	Seek an amendment to the enrolment form. Some other forms were subsequently amended
		Whole group	Expand the resource site out to all staff
		R, one SS, 4 TG, one CP/A	Expand the workshop out to all staff, whilst also enhancing group member capabilities to deliver this workshop.
		R, 2 TG	Two more workshops delivered to members of all departments
		R, one SS, 4 TG	Sought funding and planned events for ‘Pride Day’
Nov 2021	Change beyond the organisation	R, one TG	Facilitation of workshops to NCNZ

R=researcher; TG=transgender; SS= student success; CA= community provider/ally; EUJT = experience, understanding, judging, taking action (discussed in the next section).

Evaluating action.

In the ‘evaluating action’ phase, the actions undertaken by the group, were then evaluated. The evaluation sought to understand whether the actions moved us towards the desired future state, and whether they were carried out appropriately. This evaluation also identified what needed to be taken into the next AR cycle, a process that supported the iterative nature of AR. In this study we undertook an evaluation, with ethical approval, of the perspectives of organisational staff members who participated in the major initiatives instigated by the group.

We would have liked to have evaluated students’ perspectives of the new content. However, the process of gaining ethical consent to survey students from one tertiary institute when the current study was being undertaken in another tertiary institute, required two full and interdependent ethical consent processes. This was time prohibitive. Thus, we agreed to the evaluation of staff member feedback, a decision supported by my research supervision team. The research group and the supervision team assisted with the development of the evaluation survey questions (see Appendix 13 Evaluation Questions). Staff member feedback was critical and informative. We were able to reflect on feedback, and, in particular, staff criticisms. This enabled us to better understand the experiences of staff, and their understanding, and judgements of our actions and their perspectives of further action that was needed. This process provided a third person learning in action process of experience, understanding, judgement, and taking action.

In the first evaluation meeting, as shown in Table 3, we explicitly reflected on the feedback from those attending the workshops we had delivered, those engaging with our online resource, and those delivering our new content. That is, we sought to understand feedback from our actions. We judged the feedback from workshop attendees to be positive, except for one comment which suggested we needed a more advanced workshop. Our action, from this third person judgement was to move towards the development of an advanced training session. The feedback from our online learning platform was almost entirely positive except for one participant who personally emailed a comment that suggested the use of the term ‘cis-woman’ was offensive for them. We had not used this term on this learning site. I reflected on this feedback and group members’ responses in chapter five. In the first evaluation meeting we also collectively reflected on the research process. Participant responses to the process were very positive and is discussed in chapter six.

Three non-group nurse educators, with permission from the group, attended some of the first evaluation meeting to discuss their experiences of delivering the new content, specifically the year one learning session. This supported a collaborative reflection of the major learning session we had developed. It was a major session because it was a full, stand-alone teaching session rather than an inclusion within an existing session. These three were the only nurse educators that had delivered the session and so their perspectives of the major session were valuable to us as a group. Their inclusion and the subsequent discussions with the group enabled a third person learning in action process.

Learning in action: experience, understanding, judging, and taking action.

The nurse educators who attended the meeting indicated that they experienced discomfort when planning and delivering the first-year session. Their verbalised experience reflected the survey feedback that indicated some nurse educators felt there was not enough information provided to support them in the delivery of the session. To understand the learning session, the non-group nurse educators who were in the meeting, advised they had undertaken some background reading. However, they verbalised their judgement that without knowledge of personal lived experiences of being transgender they were ill equipped to deliver this session. These non-group nurse educators took the opportunity, in our meeting, to engage with transgender community members to better understand transgender terminology and transgender healthcare experiences. Their planned actions were to either attend one of our educator workshops, or seek in-class support from a community expert for the delivery of this session. Our action was to update the educators' version of the presentation, so that it had more notes. Also, we made a note for nurse educators presenting this session that if they felt uncomfortable, we could arrange a co-presenter to support them in this session. From our collective understanding and judgement of their experiences, additional actions were put in place to support the future delivery of this session.

In the evaluation phase we also had a meeting to review and amend my coding and potential themes. This was a collaborative process and is discussed in the analysis section of this chapter. The events in this phase are presented Table 3.

Table 3 *Summary of events during the evaluation phase*

Date	Members involved	Purpose
Dec 2021	R, one NE, 3 TG, one SS, three non-group NEs	To review the evaluation responses and determine actions for the next AR cycle (EUJT)
April 2022	R, 3 TG, one SS	To review and amend the researcher's coding and potential themes

R=researcher; TG=transgender; SS= student success; EUJT = experience, understanding, judging, taking action

4.7 Research quality

Quality in AR requires attending to authenticity, rigour, reflection, and relevance. These aspects of research quality, and how this study sought to ensure these aspects of quality were attended to, is discussed next.

Authenticity.

Authenticity is an important aspect of quality within AR (Coghlan, 2008). While authenticity is defined differently for each research context, it generally refers to the truthful reporting of the research process and outcomes (Newman & Smith, 2016). Authentic researchers try to be just and truthful throughout the research process. In this study authenticity was assured through the sharing of transcripts and transparency of process with group members and research supervisors. The data analysis process was transparent and is discussed in the data analysis section of this chapter. Truthful reporting also requires the researcher reports on aspects of the study that did not go so well. Aspects of the process that I came to understand I should have done differently have been reported on in this chapter as a demonstration of authenticity. I also discussed the challenges I experienced, as the main researcher, within the personal learning in action processes presented in chapters five and six.

In the method adopted for this study, Coghlan (2019) suggested, authenticity in relation to the 'General empirical method' requires the following: attentiveness, intelligence, reasonableness, and responsibility. In the current study, our attending to group members' and third-party experiences, is evident, it was critical to our determination of action. How we were intelligent when understanding, reasonable when judging and responsible when determining action is demonstrated in chapters five and six.

Rigour.

Attending to rigour might be considered an aspect of quality related to quantitative research. However, Coghlan & Shani, (2014) consider it to be an important aspect of quality in AR. Rigour supports the validity of research findings. According to Melrose (2001) validity in AR requires the researchers demonstrate that: a) outcomes were a result of the process; b) the findings are generalisable to other communities; and c) the method aligned with the research paradigm and methodology. In the current study, chapters five and six outline how the process supported outcomes (point a). Chapter seven includes a discussion about how the findings are generalisable to other tertiary provider organisations seeking to be more inclusive of gender minorities specifically, and other minority population groups (point b). In writing this thesis I have endeavoured to demonstrate a clear and strong alignment across method, to methodology and philosophical underpinnings (point c). The study discussed in the current thesis has consistently demonstrated rigour.

Reflection.

Reflection is the main researcher's consideration of how the processes and context influenced the gaining of new insight/theories. It is the inclusion, within the research, of an explicit acknowledgement of how the researcher's situatedness influenced the study. Reflection supports research credibility and makes evident that an ethical process was followed (Berger, 2015). In the method adopted for this study, reflection was critical to the meta-cycle of inquiry, discussed in this chapter, the thesis component of the project (Coghlan 2019). It is demonstrated through first person reporting, supported by their reflective journal (Coghlan, 2019). My reflective journal supported the first person reporting of the current thesis. It also supported first-person learning in action, examples of which are presented in chapters five and six.

Relevance.

Relevance is established through ongoing consideration of how outcomes support a change in practice (Alfaro-Tanco & Mediavilla, 2023). How this study led to a change in practice is discussed in chapters five and six of the current thesis. How the practical knowing associated with our changes is transferable to other nursing educator providers and other minority population groups is discussed in chapter seven.

4.8 Data analysis

AR supports practical knowing through capturing the learning that occurs for the researchers. The main data analysed were the group (second person) 'learning in

action' (EUJT). That is, our collective experience, understanding, judging and determination of action within each phase. Discussions captured in meetings were recorded and transcribed. A transcriber 'Confidentiality Agreement' (see Appendix 12) was signed. These were the main data because practical knowing in AR is about how change happens. Third person EUJT discussed in group meetings were also considered data. Transcripts of group meetings were analysed using reflexive thematic analysis. The process of reflexive thematic analysis is discussed next. It includes an outline of how data were analysed, and how the respective themes were developed.

Analytical method.

This study used thematic analysis (TA) as its main analytical method. I chose to use TA because I considered it to be an approach that would allow the consideration of all viewpoints, rather than an aggregated or consensus of responses that did not look at outliers. This approach is theoretically coherent with AR because everyone's opinion is relevant. A TA approach can be used within a range of methodologies to analyse data, and within a wide range of fields (Boyatzis, 1998). Clarke and Braun (2018), distinguished between three approaches to TA. These three approaches are: i) a positivist 'coding reliability' approach; ii) the use of a codebook; and iii) an organic qualitative process of analysis. The current study adopted an organic, qualitative process to analysis. Specifically, it used 'Reflexive' TA (Terry et al., 2017). Reflexive TA aligns well with AR methodologies because it is hinged on the view that researchers' reflections are critical data. How reflexive TA was used in the current study is discussed in this section. The six steps of reflexive TA are presented next.

Step one and two: familiarising with the data and generating codes.

The first step of reflexive TA involves reading and rereading the texts, actively thinking about the meaning, and making notes of points that may be of interest (Braun & Clarke, 2019). The next step, 'coding', is the process of assigning identifiers to features of data that may be relevant to answering the research question. It is an iterative and flexible process (Braun & Clarke, 2012). Codes lie on a continuum between being semantic codes that capture what is said by the participants, and latent codes that express a more implicit or abstract understanding of the data (Braun & Clarke, 2019). Terry et al. (2017) suggest a move to more latent codes comes with experience of TA. In the current study, I, with support from my supervisors, moved from semantic coding to latent coding. Coding was supported by NVivo a computer programme that enables a digital assigning of codes to sections of text and supports the storage and movement of codes and text as the analysis progresses (Academic Consulting, n.d.).

Coding is influenced by the researcher's epistemological position, and the context of the study (Braun & Clarke, 2021). In reflexive TA, the researcher must also be explicit about their ideological commitments; an example of which is giving voice to marginalised people (Braun & Clarke, 2019). Our study drew on the characteristics of practical knowing and was principled on being ethical in intent, and the importance of marginalised voices influencing process and action. Examples of how this study's methodology, context, and ideological commitment influenced the coding are included in the discussion of our coding process. Our coding process across each of the research phases is discussed next. After each phase previous coding was reviewed in light of new codes, a process that demonstrates the iterative nature of AR.

In the first phase, where we constructed and planned actions, the voices of those representing the marginalised, with regards gender identity, were critical to understanding how teaching environments are spaces where gender normative discourses are constructed and enforced through the rituals and interactions between students and teachers, and the curriculum. Codes in this phase focussed on the comments made by those who identified as transgender within the group. That is, their personal experiences of accessing healthcare, and how they subsequently influenced group members' understanding of the impact of societal gender binary normativity on wellbeing (see Appendix 14). For example, 'GPs are ill prepared' was a code that represented participants' experiences of general practitioners/doctors in primary practice being unable or unwilling to support them. Other codes such as 'misgendering significantly impacts on wellbeing' and 'minority stress impacts on mental health' also represented the expressed impacts on wellbeing due to abuse, discrimination, or restrictions, that were regularly experienced by transgender group members. Codes that indicated our construction phase supported new understandings that led to action being planned included, for example, 'engagement leads to an increased understanding' which contained comments where a group member had verbalised that they were surprised, or the information was something they had not previously thought about. Influenced by new understandings, actions to support change were suggested. Comments that included examples of this were coded as 'engagement leads to enthusiasm for change'.

In the second phase of this study, where we undertook actions, coding was influenced by a macro social construction lens. The codes focussed on barriers to action that arose due to the influence of hegemonic structures within our organisation that maintained a perspective of gender as being normatively binary. For example, one code 'challenging the system' highlighted that gender binary normativity was so

strongly constructed within the organisation that transformation was not easy. Several factors, at a micro level, that influenced the group's capacity to bring about change were also coded. One such code, for example, 'drawing on group member expertise' was used to code data where members gave advice on particular actions, informed by their personal experience. Another code, 'bottom up, top down' captured data related to our growing understanding that we needed to undertake actions at a lecturer level, whilst also engaging with the executive level to support organisational wide changes.

In the final phase, we evaluated staff member feedback on our actions and reflected on these actions. The codes of this phase focussed on our understanding and judgement of what we needed to take into the next AR cycle, based on non-group nurse educators' reported experiences of some of our actions. The code 'educators need upskilling and support', for example, included text related to nurse educators reporting a need for support in the delivery of new content. Another code 'finding ways to make changes sustainable' included data where participants expressed a concern about payment for transgender community members when co-teaching classes, and discussions related to participant feedback that indicated a more advanced, next level, staff workshop would be appreciated. The codes of this phase also acknowledged that tertiary education processes present barriers to change. For example: 'education is socially constructed' and 'organisational stated values differ from practice'.

As discussed earlier in this chapter, AR is not just about external actions but also about change for the individuals that occurs through participation. Examples of codes that reflect this include 'engagement led to an increased understanding' and 'members gain from participation'. There was a significant amount of data within these codes, as such, these codes, with amended wording became themes. They are discussed in chapters five and six.

The codes and potential themes were discussed, reviewed, and amended by group members. I met with group members during the action phase of this project, firstly to discuss our respective progress on actions, and secondly to discuss the codes and candidate themes that I had developed by this point. The codes and candidate themes discussion part of the meeting was awkward. While group members expressed satisfaction with the analysis to date, they were unsure as to what they could add. I reflected on this awkwardness. In this study, I needed to do the hard graft, the time-consuming process of coding data, and I was the only one with access to NVivo. However, I needed to find a way to recognise group members as valuable co-researchers. I reflected on this and devised a way to be collaborative in the analysis

whilst acknowledging the constraints associated with involving volunteers, who had no experience of coding data, and who did not have access to the data analysis programme.

In our last group meeting, I gave group members, in written form, the codes and the candidate themes I had developed from my analysis. In this meeting I presented a verbal explanation of what I thought each code meant and provided examples from the data. Group members were then given time to collectively reflect on these codes. They were invited to highlight the codes that they felt were important, or codes that needed rewording, removal, or merging with other codes. Each member then fed back their thoughts on the codes and we collectively amended them accordingly. Amendments suggested by the group are explicitly noted in the list of codes (see Appendix 14). This approach to involving group members in the analysis, was similar to Neville et al. (2022) who presented their codes from their data analysis back to the participants of their PAR group for their participants to review.

Steps three to five: Theme development, review and defining.

In the next step of reflective TA, codes are used to identify candidate themes. This step builds on previous steps and is guided by the research question. Theme construction might involve the collation of codes, or the promotion of a code to a theme. In this study, both approaches were used to develop themes. In reflexive TA, themes would be reviewed, revised, and defined. When reviewing ‘candidate’ themes the researcher seeks to ensure the themes tell a “distinctive and meaningful story that answers the research question” (Terry et al., 2017, p.29).

Step six: The production of the report.

This step will help ascertain the usefulness of the themes in telling the story of the data in relation to the research question (Braun & Clarke, 2019). In this step the findings are interwoven with the literature. In the current study this process was supported by a full-day co-construction meeting with my supervisors. In the meeting, themes were discussed and further developed. The themes are linked to the literature in chapters five and six and are further linked to literature in the conclusion chapter of this thesis. The themes are organised into two chapters that describe the change that occurred in the programme and changes that rippled out to the wider organisation and nationally. These two chapters and their respective themes are outlined below:

Chapter five: Engagement led to a reconstruction of how education could be designed and delivered:

- Engagement made visible the impact of binary normativity.
- The programme was understood to be lacking in diversity content.
- Transgender group members were repositioned as experts in their field.
- Organisational barriers to community engagement became visible.

Chapter six: Engagement led to transformation beyond the nursing programme:

- Collective concern around NE's understanding of non-binary genders.
- Challenging organisational norms to support transgender engagement.
- Opportunities were created that empowered transgender community members.
- Reconstructing the curriculum through influencing change at a national level.

4.9 Conclusion

This chapter discussed the methods of a social constructionist AR project, that drew on a model presented by Coghlan (2019) focussed on AR within the researcher's own organisation. Cultural consultation, with Māori and transgender groups occurred within each phase of the study. This study merged the first and second phase of the model, and so the phases of the current study were: constructing (the issues) and planning action; taking action; and evaluating action. The learning in action process that occurred for the group and the primary researcher was: experiencing, understanding, judging, and taking action. The steps in this process occurred within each phase of the AR project, as such, data were analysed across phases and the analysis was developed iteratively throughout the study. Data were analysed using reflexive TA. The eight themes determined from the analysis are discussed in the following two chapters. These reflect changes within the programme and the ripple out impact of the AR project.

CHAPTER FIVE:

Engagement led to a reconstruction of how nursing education could be designed and delivered.

5.1 Introduction

The research question for this study was: How can engagement with the community influence an existing nurse education programme with regards the provision of quality care for people who are transgender? This chapter will present the themes that reflect changes within the programme. It will be presented as an explanation of how the action research (AR) process led to NEs repositioning community members as invaluable in the development and delivery of new content. The explanation will include quotes from participants, and my own personal 'learning in action' reflections (presented in grey boxes). The abbreviations used in the quotes are, nurse educator (NE), transgender community member (TG), student support (SS), community ally/provider (CA) and researcher (R).

The four themes, determined from the reflexive thematic analysis of data, that describe shifts or changes within the programme, are discussed in this chapter are:

- Engagement made visible the impact of binary normativity.
- The programme was understood to be lacking in diversity content.
- Transgender group members were repositioned as experts in their field.
- Organisational barriers to community engagement became visible.

The themes are ordered to demonstrate the iterative nature of AR and how knowledge is reconstructed over time. They are discussed next.

5.2 Engagement made visible the impact of binary normativity

The AR process enabled group members to engage with the lived experiences of transgender people. This process enabled them to gain greater insight into the impact of binary normativity on transgender group members' health and wellbeing. Hearing about these experiences influenced the group's collective construction of the issues to be addressed and the determination of action. One example of how binary normativity impacted on transgender peoples' lives was provided by a transgender group member who explained how the gender on their passport led to problems when travelling:

> TG: … when changing passports, you can tick male or female or other, if you tick other it's great on your passport, for here, but if you go to other countries,

certain countries, then you might get stopped and they ask questions and you might get nailed because they don't recognise other, they only recognise male and female…

NE: Wow, these are things that I have never thought about…

TG: So, it's one thing people get caught on, they go oh yes and tick this and then they go and get stopped, and they need to be prepared for a 3-to-4-hour delay.

(Stunned silence)

This group member advised that being able to tick 'other' as opposed to male or female on their passport was 'great' for them. This example demonstrated how systems that enable a person to socially affirm their gender reduces stress and promotes wellbeing. It also highlighted how different countries provide different possibilities and constraints on being able to live as one's gender. While 'othering' (positioning a group of people as outside of the constructed norms) has commonly been constructed as marginalising, they appeared to view 'other' as a much-preferred option than officially aligning to a gender they did not associate themselves with. However, being 'other' in some spaces, they suggested, might be unsafe. For example, in some countries one might get 'nailed'. In this case the person was held up for many hours at immigration for being 'other'. This is but one example of the potential harsh consequences for those who step outside of constructed gender binary normativity. These ongoing stresses significantly impact on the health and wellbeing of transgender and gender non-binary people (Testa et al., 2015).

The relaying of a personal experience led to a nurse educator's expression of shock and her admitting that these examples of minority stress were not things she had "thought about". There was a noted collective stunned silence as group members sought to understand and judge this experience. From their silence I judged they viewed that a transgender woman needing to travel with a passport which identified her as male would be particularly traumatic. Their experience and other relayed negative experiences were drivers of action. Binary normativity is a pervasive issue for transgender people when accessing healthcare, for example:

TG: There are a lot of people who make assumptions and then they move forward and then it becomes embarrassing for the person asking and the person being treated. I recall an incident where I was misgendered by a health professional time and time again, its awkward when you have to explain, hey this is what I would like. In this case I was misgendered again… doctors are the

> ones mainly that don't use pronouns correctly; they go off on a tangent…there should be something in there to help nurses advocate to doctors.

The group member advised "there are a lot of people who make assumptions", with specific reference to their healthcare experiences. Their comment suggested healthcare providers making gender assumptions is a common experience for transgender people. It highlighted how the social construction of gender leads to normative expectations of appearance and that some healthcare professionals struggle to use gender pronouns which differ from their expectations of physical appearance. It is awkward in an encounter when one person in the discussion has made assumptions about the other, and the other person needs to correct them. Such an experience must be incredibly distressing when health outcomes might be influenced by the healthcare professional's understanding of a patient's gender. The patient cannot just bear with the provider's gender confusion or, as may have happened in this case, deliberate misgendering.

The example provided demonstrated how the dominance of gender normativity in practice can make it the patient's responsibility to challenge, in the moment, or be 'outed' at a later stage of medical investigation. Challenging is not always easy, given the power imbalance inherent within doctor-patient interactions. This group member demonstrated assertiveness. Such assertiveness may have been difficult for younger or less resilient transgender or gender non-binary patients. Their experience demonstrated to the group the myriad of ways gender normativity constrains the wellbeing of transgender individuals. It led, as shown next, to a construction of gender responsiveness and advocacy for gender non-binary and transgender patients as a core nursing competency, akin to cultural safety.

Group members sought to understand reported lived experiences and interpret them in ways that relate to nursing education. For example, one NE suggested a need for nurses to gain skills in advocacy, to enable nurses to advocate for their patients:

> NE: … in nursing training, the Nursing Council has something in there for nurses, to advocate to doctors, to say hey, because it is much nicer when somebody else does your advocating for you, so you don't have to do it yourself.

The NE understood the negative healthcare experience raised by the transgender group member was less than optimal. This was an understanding that supported a judgement that nurses, if educated, are well positioned to advocate for their patients when they are placed in uncomfortable situations. While gender affirming advocacy

would be seen as a natural fit within a cultural safety model, gender minority status is not, as yet, stated as a 'cultural competence' by Nursing Council of New Zealand (NCNZ).

There were numerous discussions throughout the study that positioned doctors or general practitioners as gender normative or insensitive to their transgender patients. One response to this emerging construction within the group was provided:

> NE: It just angers me so much because all the things we are seeing, not doctors, but nurses are not upholding the very competencies of the nursing council. When we ask them to reflect on it, they say, well we don't know what to do …

From the NE's understanding, it was nurses who were not demonstrating culturally safe practice for transgender patients. It was not made clear here, whether the nurse educator had observed nurses being culturally unsafe. The NE went on to suggest that nurses or nursing students "did not know what to do". A comment which suggested a positioning of nurses as ill prepared for transgender healthcare. This highlights that action, with regards transgender healthcare competencies, was needed within nurse education in Aotearoa. Another example that demonstrated how negative healthcare encounters, experienced and relayed by a transgender group member, influenced the perceptions of NEs in the group was discussed:

> TG: You find that for most transgender people, especially our Trans feminine and Trans masculine, when they get misgendered they'll correct but if it keeps on going, if they get a doctor that is not supportive in that respect, they don't rock the boat by going away and complaining because they don't want to upset their progress through the system. We know there are people within hospitals that are very anti-trans and will not deal with this and when we stir the pot it is going to stir things with the DHB (District Health Board, [now merged into 'Te Whatu Ora']) so they have a tendency to just try and cruise around it.
>
> R: And I guess one way to address that is to educate our nurses so it is not just about educating them but also teaching them to be advocates, people who will challenge systems.

This example demonstrated the precarious position the current healthcare system in Aotearoa positions transgender people. Access to gender affirming healthcare in Aotearoa is quite a stringent process. It requires multiple levels of consent from various healthcare professionals. That a person would choose not to complain about their unsafe healthcare experiences, rather than disrupt their progress towards gender

affirming care, demonstrated how socially constructed normativities are maintained. Those in power determine the norms. Those without power conform rather than risk losing something that is important to them. My response affirmed earlier comments that emphasised the potential role of nurses, if informed, as advocates and drivers of change. It was not discussed further during this session because a transgender group member then advised they had been invited to deliver a learning session to trainee doctors, the following year. They explained that involvement of transgender people in learning sessions would model enabling people to speak for themselves about their expectations of healthcare. This is discussed further in another section of this thesis.

The AR process supported cis gender group members' understandings of a need for reform and the need to support nurses to be advocates for change. Although, it could be argued if the system was more inclusive, we would not need nurses to advocate for transgender people in their care. The experiences presented so far, supported our collective understanding of the impact of socially constructed binary normativity for transgender people accessing healthcare, and led to a number of actions. At the start of my doctoral journey, I did not appreciate how valuable engagement with marginalised people's narratives would be to our collective understanding of the impact on wellbeing of binary normativity and how engagement could be a driver of change.

In the philosophy of practical knowing (Coghlan, 2016), knowledge is socially constructed. This section has demonstrated how the social construction of knowledge was enabled at a micro and macro level. At the micro level, engagement with transgender people led to new understandings, for group members, of the significant impact of gender binary normativity on transgender peoples' wellbeing and healthcare experiences. This led to the research group considering how nursing education, particularly in the areas of cultural safety and advocacy, might support change. At the macro level, transgender participants' experiences also highlighted how the social construction of gender, as being normatively binary, has significantly impacted on the wellbeing of transgender people. The next section discusses how these new understandings led to the provision of space for new content related to transgender healthcare.

Table 4 *Researcher's reflection 1*

Experience (E), understanding (U), judging (J), 'taking action' **(T)**
E: There were moments in the first meeting where I felt individuals' (in particular transgender community participants) relaying of personal experiences were taking too much time. I was conflicted, I knew that community voice was important, but I still wanted to capture the enthusiasm of the nurse educators, while I had them in the room committing to action. U: Reviewing the transcript, I realised that personal stories were informative and led to new understandings of the minority stresses experienced by transgender people. These understandings were transformed by the group into something that informed NE action. I wondered if my desire to identify actions detracted from the AR process. According to Bradbury et al. (2019) transformation occurs through the creation of a "relational space in which people share their experiences, stakeholders can then discover relevant/useful concepts together" (p. 7). J: Thus, I judged, discussions helped us, as a group, determine intelligent action. I realised that engagement with members' challenging lived experiences was critical to the process, because it supported an understanding and invoked a judgement that the current situation was not, in a societal sense, fair. A judgement that led to a barrage of suggestions for action and opportunities for change. T: I decided that, moving forward, I needed to be more trusting of the AR process as a means of bringing about change. My action was to commit to valuing the personal narratives, within meetings, as these narratives were critical in the social construction of knowledge and to the AR process.

5.3 The programme was understood to be lacking in diversity content

This section describes how the AR process led to more space being enabled for transgender related healthcare education within a NE led programme of delivery. A nurse educator interrupted a discussion related to culturally safe transgender communication. Her enthusiasm was motivated by the stories of negative healthcare experiences presented by transgender group members. Prior to the first AR meeting, influenced by our impending study, a nurse educator had already provisioned time within a year one communication paper for a two-hour teaching session related to transgender healthcare.

NE: They just need to learn, sorry to interrupt, but yes, you could have a two-hour session on it but you need to pull it through.

NE: Originally it was planned as a two-hour session, in a communication paper, but I have actually got space now to make it a whole session, add in the self-directed prior to that which would increase it to a five-hour session really.

The NE here, was thinking from within a traditional construction of nurse education as being about imparting clinical knowledge or content. A construction based on dominant discourse and practices within nursing education in Aotearoa. Content in this context refers to pre-planned information which would be presented to the class. This differs from learning that is developed by students through interactive discussion. The NEs positioned themselves as capable of determining and delivering new content that would enable students to learn about trans-affirming healthcare. In the first AR meeting the initial time allowance was extended, but we did not discuss how it would be developed. The nurse educator suggested that one two-hour session would not suffice, indicating she felt that changing attitudes or building competence needed more than a brief, one-off session.

Another NE suggested that “you need to pull it through” indicating that she was beginning to understand that ongoing ‘content’ would be necessary to instil knowledge and skills for students and the normalising of the diversity of genders beyond the dominant construction of gender binaries. There were nods of agreement from the group to this suggestion. Two group members picked up on the suggestion content should be pulled through curriculum.

SS: Yes, it needs a follow through.

NE: We need to keep weaving it through the curriculum…

These group members agreed to the importance of repeated exposure to transgender related healthcare content, to support the skills, knowledge, and attitudes needed for gender affirming care. The suggestions that ongoing education was needed, rather than a one-off teaching session demonstrated a growing understanding within the group that teaching students once, and them returning to a society that is so normatively binary, may not be effective. In response, influenced by a growing understanding of the importance of nurses as advocates for their transgender patients, one NE suggested:

NE: … we get them to reflect on gender diversity as a whole and then present them with a scenario of when you were faced with a person who is being

> disempowered. That is the link to cultural safety, because of terminology and incorrect pronouns that are being used, and how can they advocate for that person.

The NE here gave quite specific examples of what might be included in the previously discussed, first year communication session. Their suggestions were informed by our group discussions related to negative healthcare experiences. Misgendering and incorrect pronouns, were noted and became important aspects of the year one communication learning session. These were aspects of cultural safety that had previously been highlighted by transgender group members as important aspects of wellbeing. The 'importance of correct pronouns and advocacy' were codes which resonated throughout this study.

Another example that demonstrated a shared view that content space could be added to an existing curriculum, was the possibility of additional content being included within a year one genetics session:

> NE: I have written down a note here that there is this idea in genetics that all cells have all genes and a lot of them are switched off, but I haven't got it clear enough to um…I will try and get it a little bit sharper in my head before I say more…

Here, the NE indicated a desire to better understand, before determining new content, genetics, and sexual characteristics at birth. Their coming up against the limits of their professional and personal knowledge was evident. The NE was not sure of how to verbalise such but could see a need for additional content that challenges nursing students' current constructions of sex as binary and fixed at birth. A need driven by an awareness of the complexity of the construct of gender made possible through engagement. The NEs sought to understand gender more deeply and subsequently pass this information onto students.

Another example that demonstrated our collective judgement, that education for nurses beyond a one-off teaching session was needed is presented next:

> NE: There is also profile, where we teach them to do health history, and get them to be OK to explore 'how do I ask the questions?'

The inclusion of a transgender patient profile, within our patient scenarios, would be a significant divergence from our usual practice. The NEs in the group came to an understanding that heteronormative patient profiles contribute to the sustainment of normativities within societies. Schools at all levels, sustain dominant social practices

through their legitimising of knowledge that aligns with the dominant culture and interests (Giroux, 1997; Freire, 2021).

Taking a health history commonly occurs in the early part of a healthcare encounter. It requires the nurse to ask many personal questions to gain an understanding of the influences on the patients' health. The NE here suggested some of these questions might be uncomfortable for transgender patients. For example, questions may relate to 'name' and 'gender', depending on how the health history form is designed. The NE suggested some of the questions might be difficult. This view may have been based on their experience of history taking or their awareness of the organisation's existing form and linking this to being incompatible with her growing understanding of non-binary genders. The form is another example of the socially constructed binary normativity that currently existed within many of our major institutions. The quote demonstrated how engagement led to a shift in understanding for this nurse educator with regards the need to be responsive to the needs of transgender patients.

Nurse educators went on to consider other aspects of the curriculum where content might be needed. For example:

> NE: … you need to take it into year three too, into the primary health care paper, which also involves acute scenarios

This comment suggested a need for students to discuss scenarios, particularly acute scenarios (when the patient presents with an urgent medical need), in primary (first point of call) settings. It affirmed earlier suggestions of a need for opportunities that enable students to practice culturally safe communication with transgender patients. It is in acute healthcare scenarios that patients may feel particularly vulnerable and culturally safe care becomes more important. The two comments, discussed prior, and this comment, demonstrated how content space was enabled within all three years of our programme. This flow of ideas, where suggestions built on earlier suggestions, demonstrated how actions were proposed through a discursive process that was enabled through AR. These proposals addressed earlier group understandings that content needs to be weaved throughout the curriculum, and scenarios were important to support cultural competencies with regards transgender healthcare.

All bar one of the NEs in the group enabled space for new content within their respective areas of influence. However, one NE was initially not supportive of the creation of space for new content related to transgender healthcare. Their reason for this and my response are discussed in my personal reflection in Table 5.

Table 5 *Researcher's reflection 2*

Experience (E), understanding (U), judging (J), 'taking action' (T)

E: There were several moments, during the project, where I met resistance to change. Some of these moments were quite challenging for me. These moments were coded as 'challenging conversations.' For example, one member expressed concern about the actions, determined in a meeting. They suggested that our AR process would enable, "a minority few to have undue influence over our programme" and that our actions detracted from our nursing education's strongly held construct, within Aotearoa, that cultural safety is primarily focused on seeking to ensure equitable outcomes for members of tangata whenua (indigenous population). My initial experience to this email was a sense of panic, would this mean the end of this project?

U: The concept of cultural safety within nursing education was initiated out of a necessity to improve healthcare outcomes for Māori. It was expanded to include other aspects of culture (Richardson, 2004). This expansion demonstrates that 'cultural safety' is a socially constructed and contested term. Richardson's view, I understood to mean, is that as society progresses other aspects of culture that impact on wellbeing and healthcare outcomes must also be considered within nursing education in order to support culturally safe care for all.

J: I respected and could not disagree with the dominant construct that Māori, with regards cultural competency, were a priority group, but this group member's concern points to a view that in nursing education there is one objective truth of what constitutes nursing best practice, irrespective of patient identity and circumstance. Within Aotearoa, Māori continue to experience significant disparities in health and healthcare access despite a treaty that legislates equity (Brown & Bryder, 2023). Gender minorities are also a population group that experience significant disparities in health. However, gender identity is not yet listed as an example of culture within NCNZ cultural safety guidelines. I judged this to be something that needed to be challenged.

T: My action was to personally respond to this group member and acknowledge that cultural safety for tangata whenua is a priority, and an area that I hoped we would continue to grow in. I also suggested, that making a difference for another population group (transgender people) that is so marginalised would require content, content that might support growth for nursing students through its emphasis on reflection and subsequent challenging of powerful social normativity that impact on patient outcomes. The group member that raised her

concerns, discussed here, continued to be a member of the group and contribute towards influencing change.

The creation of space for content demonstrated another characteristic of practical knowing: that researchers attend to the uniqueness of each situation. A “reflexive attentiveness to unfolding contextual dynamics is central to both understanding and action. AR’s emphasis on cycles of action and reflection as they unfold in the present tense is paramount” (Coghlan, 2019, p. 86). The above reflection was an example of the main researcher’s reflexive attentiveness to the group dynamics. As a group, it was also unique for NEs and SS staff to engage with the community on an issue of concern. We collectively attended to this situation, having realised as a group that the needs of transgender people required education, through the provision of space for transgender healthcare related content within respective nursing courses. New content included: a communication session and content within the genetics section in year one papers; a transgender patient profile; content related to sensitivity when needing to insert a catheter; content in the mental health paper in year two papers; and content within the primary healthcare paper in year three. While group members were unsure of the details of what should be delivered and how, it was clear their intent for change was driven by a need to attend to the concerns raised.

This section has outlined how engagement with the community led to the creation of space for content related to transgender healthcare across all three years of a nursing education programme. The allowance of space was motivated by an access to, and a greater understanding of, transgender group members’ negative life and healthcare experiences and a subsequent judgement that new educational content was needed. The NEs in the group subsequently barrelled ahead with space and ideas for content, influenced by a collective judgement that to make a difference content needed to be weaved throughout our curriculum. The next section discusses how TG group members became the developers of learning sessions.

5.4 Transgender group members were repositioned as experts in their field

The NEs appeared to assume a primacy that they, as clinical experts, would be developing transgender healthcare content in response to the experiences relayed. As the study progressed, the AR process led to group members understanding that transgender group members’ experiences positioned them as transgender healthcare content experts. The group conversations produced a significant shift from societal norms that position NEs as the experts of the content they deliver. The comments below, that followed a nurse educator’s allowance of space for new content, are an

example of how the AR process led to a reconstruction of how course content could be developed.

> R. So how is that content going to be informed, how is the best way?
>
> [Slight pause]
>
> NE: How am I going to write it? Where am I usually just … gosh uhm
>
> R. I wonder whether you could get people who have more experience of gender diversity to review it.
>
> NE: Yes, absolutely, totally … so that is where you guys could be really helpful.

My comments were 'in the moment' responses aimed at nudging the NE towards considering the involvement of transgender people in the development of content. This NE subsequently acknowledged the experiential authority of transgender group members. The NE's slight pause was noted to demonstrate their shift in thinking as they took time to understand and judge my comment, and relate it to their prior experiences and our group's discussions. Their normative view that nurse educators develop new content, shaped by institutional norms, was being challenged. This NE was taken aback at being positioned as a non-expert, but they enthusiastically conceded to the transgender experts in the room.

The NEs in the organisation where I work when developing content, do not normally engage with members of marginalised communities. A shift in thinking was made possible by the AR process that brought organisational members into contact with experts by experience. The NE's response to my interjection demonstrated how my questioning, as Gadamer (1970) suggested, would lead to a shift to a new understanding as one horizon merges with another. In this case, the NE came to a new appreciation of the importance of engaging with members of TG communities when determining content that relates to TG people. Contact made visible the NEs' limitations about educational content on this topic. The emerging group construction that transgender related content should be developed by transgender group members is further demonstrated:

> SS: Yes, from a wellbeing perspective and diverse education, it is obviously important that those who the content is about are also looked after, and also, they are involved in it, you know, they are given the opportunity to be involved in it. It's the nothing about us, without us kind of mentality.
>
> NE: It is representation within the group itself

SS: Yes, and the option to be involved. Not just be involved in the presentation but also the creation of the content.

The SS team member's perspective that there should be "nothing about us without us" may have been driven by his extensive work with HIV positive people. 'Nothing about us without us' has been referred to many times in literature. This term was first used in the 1990s within the campaigns for disability rights in decision making processes. It suggests that decisions should not be made without input from those that the decision will impact on. This SS member was an out gay male. His passion for inclusion in decision making for minorities was evident. For him, obviously, transgender group members would inform content. The NE, in this discussion, readily agreed with this, even though engagement with marginalised communities is not standard practice in nursing education. The SS group member suggested that transgender group members be given the opportunity to participate in the delivery of sessions. A perspective that is discussed in the next section of this chapter.

One of the project's significant contributions to the nursing programme was the development of a year one, three-hour teaching session plus two hours of self-directed activities. This learning session was placed within a communication course and was aimed at supporting culturally safe communication with transgender patients. The specifics of the content were not made clear in the first meeting because, as previously discussed, we collectively came to a judgement that transgender group members should develop the session. An excerpt from the sub-group meeting, involving transgender group members and me, as the facilitator, when we were developing the session, is presented next. This example demonstrated a view of the potential for nurses to support their patients in uncomfortable situations.

TG: When I was in hospital here, I had a hysto [hysterectomy] 3 years ago. A discussion came up with the surgeon about afterwards, about which ward am I going in because it's technically split by gender. They said, well obviously you will make people uncomfortable if you are in the women's ward but if you are in the men's ward, they won't know how to treat you if anything goes wrong…

TG: (in response to the participant's comment above), well, if for some reason for safety, you had to go into the women's ward even if the nurse could find a way to say out loud, "I'm so sorry we can't get you a bed, you shouldn't be in here" as if to make it clear to the other people that this was just an irregularity.

TG: Well first I was taken to the women's ward because there wasn't space in the men's ward, and the lady next to me was like, "Why are you in this ward?" (Group members chuckled in a supportive way).

The hospital experience, presented here, was clearly not as positive as it should have been. The surgeon had not ahead of time, determined a safe post-operative space for their patient. This further demonstrated how healthcare systems in Aotearoa are not yet constructed to support culturally safe healthcare access for transgender patients. The patient was consulted, which was positive, but they were not offered an acceptable option for their post-operative care. The problem was given to the patient to solve. This experience influenced the session development. For example, the importance of nurses advocating for their patients in uncomfortable situations was emphasised.

In response to the discussion, a group member offered a rationale for the situation; a perspective which demonstrated a view that sometimes healthcare situations are not perfect. However, if there is an acceptable reason, then such a situation might be tolerated. In their view, the nurse could have made the situation better. This highlighted the importance placed on the value of nurses as influencers of the healthcare experience for transgender people. The role of nurses as advocates for their patients then became a central focus of the teaching session we were developing.

The TG group member was comfortable relaying the surgeon's view that he, the TG person would "obviously" make people uncomfortable if placed in a women's ward post-surgery and the ward patient's view that it was odd the TG person was in a woman's ward. This was a somewhat surreal way to have one's gender affirmed. However, the reiterations of these gender affirmations, when discussing a negative healthcare encounter, suggested that these affirmations made the encounter less traumatic. The supportive, chuckles of group members, demonstrated a shared understanding of having one's gender affirmed even in difficult situations was a take-away positive from the situation.

Table 6 *Researcher's reflection 3*

Experience (E), understanding (U), judging (J), 'taking action' (T)
E: In the transgender subgroup meeting I felt a sense that transgender group members were very willing to share their negative healthcare experiences with others in the group. I reflected on this and noted that transgender group members often arrived early to meetings and would then share their positive news related to gender affirming access to care or would ask transgender group members questions related to access to care.

U: While the negative healthcare experience discussed and others also discussed in this meeting, helped us prepare for the development of a learning session, the relaying of these experiences also appeared to be a) somewhat cathartic, and b) demonstrative of how this process of engagement supported comradery amongst the transgender group members.

J: My initial intent, when embarking on this study, was about transforming an existing nurse education programme, with regards transgender healthcare. However, as the study progressed, I began to see how AR supports individuals to feel they had a voice, not just with regards informing about their personal healthcare experiences, but also through seeing their experiences being translated into nursing education. This judgement was affirmed as the study progressed.

T: My action from this reflection was to commit to supporting opportunities for group members to benefit from their experiential knowledge and their involvement in this AR study.

In the philosophy of practical knowing (Coghlan, 2016), practical knowing occurs when action researchers are ethical in intent. The above reflection demonstrates my own ethical intent for the project. Other co-researchers participated in this research with an initial understanding that we were seeking to improve healthcare outcomes for transgender people, through influencing nursing education. Their participation was also ethical in intent. NEs, agreed with the suggested ethical stance that there should be 'nothing about us without us.' Their understanding was influenced by the exposure to a viewpoint that was persuasive because it was argued passionately and based on lived experience. From quotes presented in this chapter, it is clear that ethical intent was an important influencer of our collective judgements and subsequent actions.

This section has demonstrated how, as an AR group, we collectively came to understand and judge that transgender group members should design the content which NE group members had enabled space for. Our action from this judgement was to commit to involving transgender group members in the development of new content. This was a diversion from the norm, community members are not normally called on to design nurse education content. The evaluation of the new learning sessions led to concerns that nurse educators were not confident in delivering the new content, and our rethinking of how content is delivered. How this occurred is discussed next.

5.5 Organisational barriers to community engagement became visible

In the first meeting all transgender group members expressed an interest in participating in education sessions for nursing students. For example, when discussing the importance of involving transgender group members in the development of learning sessions, one group member advised:

> TG: I could help, I would be happy to do a talk.

The enthusiasm by TG group members to be involved in delivery, resonated throughout the study. For example, one participant, later in the study, in a personal email (used with permission) said:

> TG: For so long I didn't have a voice, now I have a voice, and although it is hard, I want to use it to help others.

These TG group members' comments suggested that it would be empowering for them to be able to influence change through their involvement in the learning sessions. The comment "I didn't have a voice" demonstrated the impact of marginalisation that occurs for minority population groups, due to dominant social constructions which position some perspectives as more relevant than others. The comment suggested current systems of healthcare render transgender people as invisible with regards being able to relay their personal experiences. Both responses highlighted how binary normativities constrain the possibilities of transgender people defining culturally safe care. Constraints, which occur through the constructed norms in nursing education with regards marginalised peoples' healthcare, have positioned nurse educators or other academics as the experts.

All transgender group members, despite how uncomfortable it might have been for them, were willing to facilitate learning sessions. Their willingness to work through this discomfort, or as one transgender member stated "to walk across some rocks" to bring about change, epitomised how important change was for these group members. In response to these comments a community ally advised:

> CA: We always co-facilitate so an ally and a Rainbow person
> SS: That's really nice pairing
> CA: Yes again, it is not putting everything on a minority population to have to do all that work, it's kind of anyone can be involved but you do need to work with a Rainbow person
> SS: Its good when you use that word ally, it's kind of like a coming together.

The support of a co-facilitation model, presented here, demonstrated group members' concern about transgender group members' personal safety. It demonstrated a collective understanding that a teaching approach which involved both transgender group members and a nurse educator, or other ally, was optimal because it positioned transgender people as experts, whilst also supporting their personal safety. I was fully supportive of a transgender/ally approach; however, I had a personal concern about how this might occur within our nurse education teaching programme.

My early assumption, there would be barriers to involving community members in the delivery of teaching sessions, influenced how transgender group members developed new content. For example, the aforementioned three-hour teaching session for the year one communication paper was developed with a view that transgender community members would not be guest speakers or facilitators of the session. In the organisation of this study, learning sessions are normally developed to be delivered by NEs. Thus, we developed the session for nurse educators to solely deliver. As the project progressed, however, engagement led to increased involvement of community members in the delivery of learning sessions, through a new understanding, discussed next, that nurse education related to transgender healthcare would be very challenging without co-facilitation.

Table 7 *Researcher's reflection 4*

Experience (E), understanding (U), judging (J), taking action (T)
E: At this point I was quite nervous. I was aware, from my personal experience, as an educator within a nursing programme, that it was not easy to respect the time and experience of community experts within teaching sessions.
U: To gain funding to appropriately recompense a speaker for their time, and travel, requires an incredible amount of administration. Any payment or gift beyond a box of chocolates needed a formal contract that required a detailed justification, and management signoff. Engaging transgender people as instructors within learning sessions would require an ongoing commitment, from me, to apply for funding for every session across all campuses ad infinitum, or my personally paying transgender group members for the sessions they deliver. The process undervalued the expertise of marginalised people and the benefit of engaging with their lived experiences in learning sessions.
J: I judged it to be too hard for this content to be co-delivered in the long term. I openly iterated this as a concern. This reflection highlights barriers to involving community experts within nursing education. It demonstrates how institutions

such as nursing education within Aotearoa are not constructed to enable marginalised community members to be involved in the delivery of healthcare content.

T: My action was to push for content, with significant notes, that could be delivered by nurse educators, whilst also seeking to find ways to involve community people in the delivery of sessions and investigating how we can appropriately financially compensate them for their time and expertise.

Three events led us, as a group, to understanding some NEs were not confident about delivering the major communication session we had developed. The first was that all the NEs who delivered the main session we had developed, subsequently attended one of our staff training workshops related to gender and sexual minorities. This will be discussed later. The second was the evaluation of this learning session indicated NEs were supportive of the content, but they expressed a lack confidence in the delivery. For example, one NE advised:

> NE (non-group): Resources were not well explained for someone who had not presented the topic previously.

Delivering the learning session raised an awareness, for the non-group NEs, of how little they knew about non-binary genders. This is a further confirmation of how pervasive binary normativity in Aotearoa is.

Feedback about the main learning session from our non-group nurse educators, was discussed in our evaluation meeting. Three non-group NEs requested to attend this meeting, and with permission from the group, attended some of it. These non-group NEs reiterated a finding from our evaluation that they did not feel confident in the delivery of the newly developed year one session. The non-group NEs considered the topic of culturally safe communication in relation to non-binary genders as a specialised topic that required practice and more support for delivery.

> NE (non-group): Yeah, I haven't heard that before. I haven't heard non-binary masculine, non-binary feminine.
>
> NE (non-group): Nor have I
>
> TG: Like, I identify as Trans masculine, non-binary…

The NEs admitted to not knowing some of the basic terminology of transgender and gender non-binary people. Transgender group members, following these comments,

educated the NEs about the terms. After the discussion, the NEs took the opportunity to ask numerous questions related to transgender terminology and transgender healthcare. Another example of an NE admitting that involving transgender people in delivery would be beneficial was:

> NE (non-group): And therefore, I would have wanted personal journeys, personal thoughts, personal beliefs, because I feel like that has a bit more of an emotive layering. So, for me, the only thing, with this, other than the fact that I have no idea and there it is, you've got three hours, go away, and do something with it.

The NE, when given a three-hour session to deliver, admits to having "no idea". They considered themselves to be positioned in a situation of being somewhat out on a limb. The NE emphasised the importance of experts being involved in the delivery of the new content, because they considered personal journeys, thoughts, and beliefs were critical to student nurses' understanding of this topic. A point previously made by NEs in the AR group, a point that demonstrated the power of contact. Engaging with the lived experiences, it was suggested, supports an "emotive layering". Meaning that hearing first-hand about the minority stresses of transgender people supports a development of empathy and increases nursing students' desire to provide culturally safe care for this population group. The NE's comments demonstrated what can be made possible, when the limits of clinical expertise are acknowledged, and experiential authority is recognised. My response to this comment, reflected my ongoing concern about how transgender community members would be recompensed for their time:

> R: One of the issues with actually getting people in as guest speakers, which is ideal, is that you have to fund that person … for me it's going cap in hand constantly and asking and they're like "hmmm" and it's just becomes too hard for the nurse educator to try and get the particular funding, that's why it ended up being more like this (designed to be delivered by nurse educators).

This comment made transparent my previously discussed concern about securing funding to recompense guest speakers, for their time and expertise, and was based on personal experiences of seeking funding for guest speakers. From my experience, NEs would generally self-fund a small gift for their guest speaker, which is acceptable as these guest speakers would usually be a representative of a healthcare provider and would be paid by their organisation for their time. However, a community expert should not be expected to give up three hours of their personal time for a box of chocolates. In response to my comment, a non-group NE, advised that she would request funding for

transgender group members to be involved in the delivery of the major learning session. This was an example of good intent, in the moment, driven by engagement, but it was not actioned. Enabling funding for community experts continues to be a struggle within my organisation.

A transgender group member offered to support, without payment, a NE in their first delivery of a learning session. The transgender support person arrived early for the session but was asked to leave the teaching room, while a senior lecturer discussed the session with the NE. Both lecturers participated, as students, in the three-hour teaching session which was, in whole, delivered by the transgender community member. Being asked to leave the room while the 'experts' discussed the session, was disrespectful to the community member as the main presenter of the learning session. This reflected the dominant positioning of NEs as the experts in the provision of nurse education. This session, as evidenced by the feedback, was well received by the class. An NE provided feedback of the learning session, sent in an email (used with permission):

> NE (non-group): Yesterday I was able to speak to the class in some detail regarding the session and got really great feedback. They were very grateful that a transgender community person was able to speak to them and they found it particularly useful that they were able to engage with an individual who is actually part of the community being discussed. They enjoyed the activities and felt that they learnt a great deal from the session.

The feedback indicated students valued having a community member deliver this session. Their feedback reflected a quote by a NE, discussed earlier, that personal stories add an emotional layering for students. The stirring of emotion helps keep students engaged in the learning session and evokes a desire to support social change for the respective population group (Keehn, 2015). This view is supported by Postelnik et al. (2021) who found using a co-facilitation model involving a clinical expert and a community mental health expert, and the "sharing of personal stories brings the training content to life and makes it more meaningful for participants" (p. 300). The value students placed on learning from the lived experiences of transgender people, and the interactive activities within the session, highlights the benefits for learners when community people are able to design and deliver learning session. That the community member was not paid for the delivery of the session and was excluded from pre-session discussions by the senior lecturer, demonstrates how educational institutes are

not structured to value community involvement in education. This is discussed and elaborated on in the next chapter of this thesis.

According to Coghlan (2016), practical knowing requires the researchers address the everyday concerns of people. The involvement of the non-group NEs into our evaluation discussion meeting demonstrated how our AR study engaged with and addressed the non-group NE everyday concerns. These concerns were that NEs were not confident about delivering the learning session we had developed. In the meeting the NEs attended, we sought to collectively answer their questions. We also provided training for all staff, which is discussed in the next chapter, and enabled the co-delivery of learning sessions so they could learn from community members how to deliver the session they were concerned about.

Table 8 *Researcher's reflection 5*

Experience (E), understanding (U), judging (J), taking action (T)
E: During the study, I experienced delivering the major year one learning session alone and alongside a transgender group member. I found it much easier to co-deliver the session. U: It felt safer for me to have a more experienced co-facilitator alongside me who could confidently answer tricky questions. Also, the involvement of a person with lived experiences of minority stresses appeared to evoke a certain degree of compassion that may have influenced how some questions were posited by students. When teaching alone, for example, I experienced in one session, questions that came from, what I had judged to be, a position of transphobia. Despite my many years of studying and engaging with transgender people, my answers did not satisfy this student. J: It was suggested in the first meeting of this study, that if nurse educators delivered the session, it might enable students to ask difficult questions, without fear of causing offense to a community member. However, having reflected on the sessions I delivered; my judgement is that the students overall are better served by having a trained community member deliver the session. T: My action from this reflection was to continue to advocate that trained community members deliver this session and they be recompensed for their time

This section outlined how the AR process enabled non-group NEs to discursively interact with transgender community members and gain new knowledge about gender terminology and the regular stresses experienced by gender minority people. The

section demonstrated how transgender community members came to be positioned as experts and how they came to be delivering nursing education sessions. NEs could see how beneficial it was for students to have people with lived experiences delivering sessions. However, the system was unwilling or ill-prepared for community experts to be involved in content delivery. This demonstrated how powerful the social construction of clinical expertise is in healthcare education.

5.6 Conclusion

This chapter provided specific examples of how the study aligned with the characteristics of practical knowing. The process demonstrated how knowledge is socially constructed at a micro and macro level. Our making space for new content demonstrated our attending to the uniqueness of the situation. Attending to the uniqueness was further demonstrated at a main researcher (first person) level, through the personal reflection cycles. Group members demonstrated their ethical intent through collectively determining that content related to transgender healthcare should be designed by those the care is about. The positioning of community members as appropriate designers of new content was contra to how nursing education is normally designed in Aotearoa. We addressed the everyday concerns of transgender people in the group through the provision of space for content which sought to address their concerns related to healthcare provision. We attended to the concerns of non-group NEs through enabling processes whereby their questions could be answered, and they could be supported in their delivery of new education related transgender healthcare.

The AR process, through enabling discursive engagement with transgender community members, supported a greater understanding for NEs and support staff of the impact of binary normativity on people's lives. We collectively judged nurses as healthcare providers, could positively influence the healthcare experiences for transgender people. Motivated by new understandings NEs jumped into action mode. Multiple opportunities for new content were offered. Cultural safety, patient advocacy, and content being more than a one-off session, were topics commonly discussed as important aspects of transgender healthcare education, and codes within the thematic analysis.

While space for new content was provided, as a group we sought to understand how new content could be developed. Through discussion we came to understand and subsequently judge transgender group members should design new content. Thus, we positioned transgender group members, as content experts. As the study progressed, we learnt from NEs' feedback that these experts were also needed by some to support their delivery of new content; something that is not the norm within the nursing

programme that I work in. The next chapter discusses how the AR process led to transformation beyond the nursing education programme. It further demonstrated the transformative capacity of AR.

CHAPTER SIX:

Engagement led to transformation beyond the nursing programme.

6.1 Introduction

The research question for this study was: How can engagement with the community influence an existing nurse education programme, with regards the provision of quality care for people who are transgender? This chapter will discuss how engagement led to transformation beyond the nursing programme. It will present an explanation of how the action research (AR) process led to wider organisational change, empowered community group members, and led to change at a national level. Four themes determined from a reflexive thematic analysis of data demonstrated how engagement led to transformation beyond the nursing programme. These themes were:

- Collective concern around NE's understanding of non-binary genders.
- Challenging organisational norms to better support transgender engagement.
- Opportunities were created that empowered transgender community members.
- Reconstructing the 'hidden curriculum' through influencing change at a national level.

The themes are ordered to demonstrate the ripple out effect of change that can be attributed to the adoption of an AR approach.

6.2 Collective concern around NE's understanding of non-binary genders

As outlined in chapter five, engagement influenced the provision of space for new content related to transgender healthcare education, within the existing programme. Furthermore, we agreed as a group that transgender group members would inform this new content. However, in one meeting there was a concern raised that some NEs may not be confident in delivering this new content:

> NE: I think it is all very well to talk about educating the nursing students, but you also have to educate the people that are part of the education system, that are actually delivering.
>
> SS: Receptionists?
>
> R: So, are you meaning our nurse educators or our administrators?
>
> NE: Our nurse educators

The NE, based on her experience, understood, and judged that other nurse educators may not be confident in the delivery of content related to transgender healthcare. The NE considered such content may present challenges for delivery. This demonstrated how our society is strongly constructed as normatively gender binary. Within our nursing programme we would not generally consider NEs would need educating before delivering particular content. The term 'educating', used here, I understood to mean NEs may need to attend a training workshop which would better support their sensitive delivery of new content related to culturally safe care for transgender people. The NE's view turned out to be an accurate understanding of the situation. As outlined in chapter five, our evaluation process revealed non group NEs were not confident delivering transgender related healthcare content.

The view that some NEs may not embrace teaching about transgender health was raised again in the next whole group meeting:

> NE: But it is the culture within a school that is critically important too, isn't it? It's the same I guess that we talked about in our last meeting, about the fact that even though we are doing this within our programme and we are enhancing our programme as we are, ultimately, we are still, you know, if people are carrying attitudes and biases, our nurse educators are carrying attitudes and biases, that still might, uh, come through, so it is something to be mindful of.

This was the first time we collectively considered how the culture of the school might impact on the delivery of content related to transgender healthcare. This demonstrated a shift from considering content to context.

Context reflects how dominant social norms influence curriculum content and the organisational backdrop to content delivery. It reflects the hidden curriculum within which values and expectations, not made explicit, serve to perpetuate dominant social norms. The NE here understood that nurse educators' attitudes and biases might present challenges for some when delivering the content we developed. They judged that if NEs held biases against transgender people, it might be reflected in their delivery. An important principle of nursing in Aotearoa is that nurses "respect the dignity and individuality of health consumers" (NCNZ, 'Code of Conduct', p. 4). While NEs might seek to adhere to this principle, genders which are not male or female, might for some, be outside of their cultural norms or religious beliefs. As such some NEs may not understand genders outside of socially constructed binary norms. My response was to suggest an action that we develop an online training programme for nurse educators. The response to this suggestion was:

> NE: I mean online would be easy, but I personally think, we do need somewhere where it is face-to-face, because in some ways, like happened here, because those of us who are really open are going to embrace it… people perhaps who are not going to embrace it as much are going to pick up a lot in that discussion… It is a really an important issue and we need to make sure that when we are teaching it, that it is being taught genuinely and with the passion and the emphasis it needs and the respect and everything so it's not a tick box.

This NE placed considerable value on face-to-face engagement. Their "like happened here" comment affirmed this study's epistemology that the construction of new knowledge occurs through discursive interaction. The comment demonstrated how the AR process, which enabled NEs to engage with the experiences of transgender people, was judged to support a better understanding about transgender people and their healthcare needs. The suggestion that action could be to provide education that would enable NEs to engage with transgender community members was vehemently supported through nods and expressions of agreement. The group recognised that interactive engagement supported a better understanding of the impacts of binary normativity on health and wellbeing. Furthermore, contact is critical to ensuring transgender healthcare is delivered in a sensitive and appropriate manner. 'Not just a tick box', demonstrated the NE's judgement that educating nursing students about transgender people is more than the inclusion of content; how the content will be delivered, also needs to be considered. 'Not just a tick box' became a code which resonated throughout the project. In response a CA advised:

> CA: Sometimes you offer something and people attend but I think sometimes it is the ones who aren't there that should be attending.
>
> TG: Yes, they just avoid it.
>
> CA: Then policy becomes very important. If you have people that are misgendering, using the wrong pronouns, even after being corrected, then you have policy to go back to that says this is how we do things in our organisation…

The CA and TG community people understood, based on their experiences that some people may choose not to attend non-compulsory workshops related to transgender inclusiveness, even though people who hold strong heteronormative and gender binary normative perspectives might gain from having their views challenged. The CA's suggested action, from this judgement, was to refer to policy. This CA was talking about a policy of their own organisation, which was not a policy in the organisation where I

worked. Addressing policy was not raised as an action for the group to discuss. Perhaps, because we collectively understood, although not verbalised, that to get anywhere near discussions about such a policy at the executive level, would require a significant cultural shift within the wider organisation. Seeking policy change was something much bigger than action to influence an existing nursing programme, the initial aim of the project. My reflections on the notion of us discussing policy change, alongside how compulsory workshops might be funded are discussed next.

Table 9 *Researcher's reflection 6*

Experience (E), ***understanding (U), judging (J), taking action (T)***
E: My 'in the moment reflection' here was that changing organisational policy to such a degree would not be something that could not be realistically actioned within our AR project. I did not interject and mention that the organisation did not have a policy that required people who were consistently misgendering people attend an in-house gender inclusiveness workshop. **U:** I reflected on why I did not start a discussion on organisational policy and came to a view that I did not want to lead us into discussions which would detract from feasible actions. In seeking to understand my 'in the moment' decision, I reviewed the literature related to what would be needed to bring about a policy change, and what would be needed to challenge dominant social constructions within an organisation. The literature related to organisational change with regards LGBT inclusion, for example, Eckstrand et al. (2017) and Everly and Schwarz (2015), primarily focussed on how change occurs once a wider organisation has committed to organisational change to support LGBT inclusiveness. **J**: I judged that policy change would be much easier within an organisation that had identified a need for change. As we were a small AR group seeking to bring about change within a very large organisation, I judged we would struggle to influence wider organisational policy. This would require a significant culture change within the organisation. A culture change would, I judged, require a push from the top by someone at the executive level who was willing to support such a change, alongside a push from the bottom where people in the organisation indicated a need for change. I coded data related to this judgement as 'top down/bottom up'. **T:** The CA comment that inspired this reflection, did not, in my view, require action at this point. However, as the project progressed, I became more aware that to progress some actions we would need some top-down support.

Experience, ***understanding, judging, taking action***

E: Another in the moment reflection during this time, based on experience, was that the nursing programme I worked in rarely funded training workshops. Workshops offered were generally those delivered for free by nurse educators in the programme or those provided by people from the wider organisation.

U: This caused me to think how gender minority inclusiveness training would be positioned within the school's professional development agenda. The groups' collective understanding of 'nothing about us without us', would require our transgender competency workshops to be co-delivered by external facilitators, who would need to be appropriately recompensed for their time.

J: I judged a gender and sexual minority workshop would be unlikely to receive funding, from the respective programme managers, and certainly not receive ongoing funding.

T: My action from this reflection was to see if we could draw on the resources of the people in the room. This is discussed next.

The CA understood their own face-to-face training, usually provided to new nurses and community groups, would be beneficial for the NEs in the organisation. They also saw value in offering the training to other 'teachers' within the organisation, this is discussed in the next section. Their training used a Rainbow and ally partnership model for delivery, an approach that was discussed in the chapter five and was judged as an appropriate and safe way of education delivery for community members. The next quote is added again to emphasise why the approach adopted used such a partnership approach for their workshops.

> SS: That's really nice pairing
>
> CA: Yes, again it is not putting everything on a minority population to have to do all that work, it's kind of anyone can be involved but you do need to work with a rainbow person
>
> TG: Its good when you use that word ally, it's kind of like a coming together.

Allies are people from a socially constructed dominant population group, with regards a particular social characteristic such as race, sexuality, or gender, who seek to address social inequities. They are people who support the challenging of behaviours or systems that marginalise particular population groups, such as transgender people. By now, the group had already come to understand from the reported experiences of transgender people in the group, that challenging behaviours or systems was

exhausting, so the CA's "all that work" comment aligned with these earlier discussions. The "nice pairing" comment reiterated the same member's earlier comment that there should be "nothing about us without us". Both the SS and the TG group members judged working together would be the most effective mechanism for preparing NEs to deliver education to support transgender health equity. Our action was to organise a 'train the trainer' workshop, for NEs. This workshop would use a Rainbow/ally partnership approach, involving, primarily a person who identifies as transgender with an ally, a person who does not necessarily identify as gay or gender diverse, but who openly works to support members of the 'Rainbow' community. My view of such an approach to delivery is discussed next.

Table 10 *Researcher's reflection 7*

Experience (E), ***understanding (U), judging (j), taking action (T)***
E: With regards the partnership model discussed above. I reflected on earlier discussions, outlined in chapter five, where transgender community members enthusiastically expressed a willingness to be involved in educating others. I began to think that an educational role might not only be positive but might also be empowering for transgender group members. **U:** Other studies affirmed this perspective. A study by Riggle et al. (2011), for example, found activism through the education of others was a positive aspect of transgender self-identification. A finding echoed in a study by McFadden et al. (2013) who suggested educating others about the transgender community was a source of resilience for some transgender people. **J**: Enabling some group members to develop facilitation skills, through being coached, using a 'train the trainer' approach, in the delivery of a workshop, aligned well with my values of social justice and with the ethical intent of this study. A train the trainer approach would be empowering for the new facilitators, I judged, such an approach would also provide a valuable resource for the organisation. **T:** As a training workshop using an ally model had been agreed to by the group, my action was to email group members to ascertain who wanted to be involved and trained as facilitators.

While the events discussed demonstrated most of the characteristics of practical knowing as outlined by Coghlan (2016), they particularly demonstrated how the group attended to the concerns, based on their everyday experiences. Their concern was NEs may not have the experience or understanding to enable them to sensitively

deliver content related to transgender healthcare. We collectively attended to this concern by enabling a training workshop for nursing, and other healthcare educators.

This section has demonstrated how we came to understand as a group, NEs may need further educating. We judged training for NEs was important in order to ensure the new content would be delivered in a way which supported student nurses in their provision of culturally safe care for transfer people. Our 'taking action' was to enable the provision of training for NEs. This action was based on a view the workshop would use a train the trainer and ally/Rainbow model of delivery. Some of the quotes used to illustrate this theme also demonstrated how we as a group began to move towards an understanding that change was needed within the wider organisation.

6.3 Challenging organisational norms to support transgender engagement

Engagement with the community moved us as a group towards an understanding that transgender representation in health education is a key part of transgender health equity. That is, transgender people's enrolment and success in health education supports the reconstruction of social norms through their presence in education and healthcare systems. This shift in understanding was a gradual process, influenced by the involvement of people in the research group whose focus for change was more on the organisation than the programme. It led us to focus on actions that would influence wider organisational change. Transgender representation in health education was hinted as being important several times, for example:

> CA: We are making sure that [student] nurses, who start the nursing programme are being tutored from the beginning towards the whole classes, and they are aware of the language we use. They are on a journey too, how are they supported so we ensure we actually get gender diverse students coming into the nursing programme and out into nursing, you know we want our nurses to be reflective or our community.

This comment was made in the first meeting, but it took us, as a group, several meetings to collectively come to understand that to make a difference, change was needed within the wider organisation. A key to this shift in understanding was a collective deepening recognition of how organisational norms, which led to uncritical approaches to education, support inequities - a shift brought about by contact with transgender community members and their allies. We came to understand organisational practice is largely influenced by dominant norms in ways that are taken for granted.

An organisation that is inclusive of minority population groups, including gender minorities, would support the diversity of students and subsequently increase the diversity of qualified nurses. Extrapolating this out, an inclusive organisation would also increase the number of gender diverse people qualified in the provision of other types of healthcare and other social services. Increasing the diversity of providers within health and social institutions, given their importance in society, would support the wider reconstruction of gender social norms. While the CA affirmed our initial aim was to enable and subsequently develop new content related to transgender nursing healthcare within the programme, they judged wider organisational change would be more impactful.

The view presented was not contested. There were nods of agreement from all in the group. We understood that a transgender nurse would provide culturally safe healthcare for transgender patients and the transgender nurse would be able to empower transgender patients and advocate for change within their respective healthcare provider organisation and the wider healthcare system. The CA went on to provide some examples of actions that needed to happen to support inclusiveness within the organisation.

> CA: It is right through all that you do like your application forms, your templates and so on so that intersect with anybody coming in.

Forms based on a dominant social construction of gender as binary present barriers to access for gender non-binary and transgender people and further reproduces binary genders as normative in society. Templates and learning resources that are not inclusive of diverse population groups marginalise minority groups by making them feel invisible. This comment led to a discussion about my organisation's enrolment form. One member advised that our enrolment form had been updated. However, in a later sub-group meeting a group member advised it had not been changed, or if it had been changed, it was still not acceptable:

> TG: Well, the way they changed it I thought an A for effort but, well they took the name thing, legal name preferred name and applied that to gender
>
> TG: What!
>
> TG: Yes, they had preferred gender and legal gender…
>
> TG: Well anyway an A for effort but that is culturally not safe, it doesn't translate to me …
>
> TG: Some other polytecs just have Gender Diverse …

This is a snippet from a lengthy discussion where we collectively came to understand the use of terms such as ‘legal gender’ and ‘preferred gender’ on a form was offensive to transgender group members. One member, for example, made it quite clear in a personal email, when he introduced himself, “male was his gender, not his preferred gender”. Preferred implies of all the possible genders, a person likes being one gender more than others. People do not prefer a gender; they are a gender. “It doesn’t translate to me” indicated that the person would not be able to complete the enrolment form. The form in its current state was judged to be culturally unsafe by the transgender people in the group. This judgement further demonstrated the movement of the group towards constructing education, from a transgender health equity perspective, as being so much more than 'content' to also being able to demonstrate that organisational practice was safe. This was a view so different from where the project started. A view made possible through the whanaungatanga (respectful relationships formed within the group), enabled through an AR process.

Another group member advised other tertiary providers had already moved towards inclusive enrolments forms, albeit through enabling a tick in a very generic box of ‘gender diverse’. A move, nevertheless, that indicated a societal shift, within tertiary education generally in Aotearoa towards recognising transgender and other genders. Our organisation was still using culturally unsafe enrolment forms which demonstrated there was room for improvement. This was an understanding made visible through the AR process that enabled transgender group members to see their voices were relevant because they could see they were influencing change within a programme. They saw a need for change within the wider organisation, and being part of a process bringing about change empowered them to push for more.

My personal action, with permission from the group, was to enquire into how we might get the enrolment form changed. When enquiring about the form, I asked a member of the organisation’s executive leadership team why we needed a student’s gender for their enrolment. I was advised this was for statistical purposes. The notion that we need to have data related to gender for those participating in educational programmes, highlights the socially constructed significance of gender in western societies. Those designing the form had given consideration to transgender or gender non-binary people but did not appear to have consulted with members of the respective community. The process of getting the form changed was quite challenging and involved most group members, a process that is reflected on below.

Table 11 *Researcher's reflection 8*

Experience (E), ***understanding (U), judging (j), taking action (T)***

E: After making an enquiry about the form, to a member of the executive leadership team, I was advised that the enrolment form could be changed and that the AR group would be consulted on the wording of the change. After waiting several months and then enquiring again, I was sent the amended form. I knew it would not be agreeable to the group. While it now included a 'gender diverse' option, in line with other tertiary providers (this alignment was the means by which I got agreement at the executive level for an amendment), it still asked for 'preferred gender'. When I spoke with the person responsible for the change, their response was quite aggressive, and they advised it was too late to amend the form as it was about to go to print. I experienced significant discomfort at this point. To challenge decisions already made would require assertiveness and diplomacy. I needed to buy us some time. I did not consider myself to be a comfortable negotiator, but I had to try.

I was given two hours to determine the wording for the 'gender' aspect of the form, and this had to be agreed to by the manager of our student support team. I was able to contact transgender group members to find an acceptable wording (it was a back-and-forth process), seek agreement from others in the group, and gain sign off from the manager of student support in the time given. These conversations were not easy for me. Meanwhile a SS group member assisted the process by taking the form to another executive leader, advising them as to why it was not acceptable. This escalated the issue and led to us to being able to get the form amended to something that was agreeable to all in the group.

U: To understand this experience, I drew on Aristotle's intellectual virtue of phronesis. Phronesis (practical wisdom) relates to knowing what to do in praxis (in practice) with others, when the events are unpredictable. Phronesis is gained from moments that are unpredictable, provided one is acting with virtuous intent.

J: I judged that the outcome of challenging constructed institutional norms, predicated on gender binary expectations, was unpredictable, but was ethical in intent. This experience led me to a view that challenging organisational norms, particularly in relation to strongly held normativities and socially unjust practices was uncomfortable. I also came to a judgement that people, in organisations, pass on tasks and do not always make clear what is expected. My practical

knowing from this encounter was that advocating for organisational change takes time, persistence, and often comes at personal cost. It is crucial that all members are empowered to take some of this load to avoid main researcher burnout. I also learnt how to diplomatically negotiate for time. I did this by presenting a view that consultation with the group, was agreed to by an executive officer, and ethically needed to be undertaken.

T: This learning cycle occurred through action. My action to follow this was to verbally acknowledge, in the next meeting, the work of all involved in bringing about the change.

Another action, which further demonstrated a shift toward considering the wider organisation, was that the previously discussed training for NEs was expanded to include all staff at the organisation.

> CA: … as well [in addition to nurse educators] as those teachers that feel like they want the training
>
> SS … so maybe it could be a workshop that is included in the staff on boarding process …
>
> CA: How many staff do you have?

These comments demonstrated an almost instantaneous move from us considering that NEs may need training, to including all staff. Two factors supported a shift towards considering the wider organisation. Firstly, the SS group member had a focus on the wider organisation, the work team he was part of was concerned with enhancing success for all students. Secondly, this CA referred to the wider organisation in an earlier meeting, and at the time group members agreed with her views. Over time these perspectives influenced group member's thinking. This demonstrated a social construction of knowledge at a micro level that occurred as people reflected on discussions, in the moment, and then drew on these understandings in future interactions. A layering occurred of what was being understood, onto what was previously discussed and understood. The process described by Gadamer (1975) as a 'shifting of horizons'.

The suggestion that wider organisational teaching staff be considered led to a discussion about how action might support wider organisational change. That is, the logistics of expanding the training out to the wider organisation. I suggested:

> R: We are just talking about building the in-house capacity to deliver the workshop [wider] … and how we can build our capacity to do that… the issue is then about the money because if we are using a partnership model then we have to pay a person who comes from the community, they can't just keep giving their time for free really.

I made this comment because of my own ongoing concern about how external facilitators would be funded. I had reflected on this concern earlier when we discussed training for NEs. My raising it here not only demonstrated my ongoing commitment to ensuring that the transgender community members were respected for their expertise, but it also indicated a shift for me as an action researcher. This shift was from feeling personally responsible for the actions determined by the group to involving the group in addressing issues which may present barriers to action. This shift is discussed in the next learning cycle.

Table 12 *Researcher's reflection 9*

E *Experience (E)*, *understanding (U), judging (j), taking action (T)*
E: As meetings progressed, I experienced a sense of burden. I felt, as a group, we were determining actions, I considered, that were not realistically actionable. This view was based on my perception of where the organisation was positioned regarding gender minority inclusiveness. In regards the provision of staff training, having already enquired, I had been advised "there was a very limited budget".
U: In seeking to understand this I drew on Coghlan (2019) who advised that political dynamics may be an obstacle to the project and may put the researcher off. At this point I was also trying to understand myself as an action researcher and the difference between consultation/stakeholder engagement and collaboration. In a consultation mind set, I judged that I was gaining an impossible wish list for change which I felt obliged to try to follow through on to maintain the enthusiasm of the group. I needed to be more collaborative, I needed to share the load. Collaboration to support AR for organisational change is emphasised in Brydon-Millar and Coghlan (2014) and Coghlan (2019).
J: I judged that in a collaborative way of thinking I needed to be more transparent about my concerns related to the barriers to action.

T: The action I took was to raise my concern about funding with the group. The outcome of my action is discussed below. It demonstrated the value of collaboration over consultation when undertaking action research.

In response to my concern about funding, and my stating that I had, unsuccessfully, tried through our usual 'funds for professional development' to gain funding, a group member offered a solution:

> SS: I'm surprised that X hasn't got behind it. Because there is definitely money. When we developed the strategies, there was money set aside in the budget for this kind of stuff. I might do an e-introduction about it with X. Say "hey, what about that fund?"

This group member had, in an earlier meeting, emphasised the importance of there being "nothing about us without us". His commitment to involving marginalised people in action that related to them was evident throughout the project. His experience within the organisation meant he understood what funding was available. He judged that he was able to influence some financial decisions and suggested an action. He did follow up on his agreed action and successfully sourced funding for two workshops per year for the wider organisation with all our anticipated costs covered. This outcome demonstrated how actions within organisations are themselves products of social constructionism. That is, funding is determined by the respective power one holds within an organisation. A deepening understanding of procurement sat behind and made so many actions thinkable.

Organisations are microcosms of their respective societies. The previous example demonstrated how positional power influenced the reconstruction of a constructed norm. When funding is scarce people allocate funds to events that are socially constructed to be more important. However, when people have the power to influence funding, a reallocation becomes possible. Following the discussion about expanding the workshop out to the wider organisation we went on to discuss the timings of these trainings. I sought to clarify the details:

> R: If we can get that [funding] and then we are going to go there [location of next training], I can put that PowerPoint together, and [TG group member, who agreed to facilitate] is going to come. It looks like we have got a plan, that's awesome. Is that alright?
>
> TG: Yup, it just depends on when next year because pride months are February/March so I'm all over the place.

R: I actually thought ‘Pride Month’ would be a good time, as it also ticks the other box of doing something for Pride Day. To just do something to say, ‘hey it’s this, so we thought we’d offer this. But if you’re busy?

The importance of celebrating ‘Pride’ had been raised in an earlier meeting. In the above discussion, I suggested merging the two actions, thinking this would make things financially easier for us. However, the proposed TG facilitator of the workshop, based on his experiences, advised that his time was limited around ‘Pride’ celebration time. In the end we found a time that worked for him, and the session was subsequently delivered. I raised the possibility of celebrating a ‘Pride’ day again in a later meeting:

R: … that brings me to the notion that I was going to ask the student support, whether they could be the ones who could assist financially and time wise with the Pride Day.

SS: That’s on their calendar

R: Student success calendar

SS: Yup.

Again here, I was expressing my personal concerns about the funding of actions. That the organisation had for the first time put the celebration of Pride formally into the organisation’s calendar was evidence of a cultural shift in the organisation. This was likely influenced by the AR project and the two group members, who were part of student support teams, who pushed for action on the two campuses that went on to celebrate Pride Day. The decision to support Pride Day may also have been influenced by my discussions, in relation to project actions, with the manager of ‘student support’, and through non group members of ‘student support” team attending one of the training workshops we provided. My learning from reflecting on this is discussed below.

Table 13 *Researcher’s reflection 10*

Experience (E)**, **understanding (U), judging (j), taking action (T)
E: I was relieved that the student support team was now supporting Pride Day celebrations. A first-time celebration of Pride, and a continued commitment to this, alongside permanent transgender flags being erected on campuses, felt to me to be a huge achievement for the group. At the same time, I experienced a small sense of disappointment that the SS team had not sought involvement from the group when making these decisions. **U:** Trying to understand this was more of a self-reflective process than seeking to find answers in the literature. I was disappointed but drew on the words of a

friend who was also studying AR: “Just giving something legs, and it taking a life of its own, is an achievement” (C. Williams [personal correspondence, used with permission] 2022). Our project had supported transformation within the organisation, and I needed to feel proud that we as a group had influenced change. I also wondered, if not an action directly instigated by the group, what factors had also supported change? I reflected here on where we were as a society and whether social change, alongside the group’s actions, influenced wider organisational change.

J: I judged that as other tertiary education providers were already celebrating Pride Day, and as a society, gender and sexual minorities were becoming more visible and had a stronger voice, that social norms, alongside our actions, influenced change. I also judged that the student support team that is focussed on student achievement wanted to demonstrate to the wider organisation its own recognition of a need for change in this space. Two members of our research group were part of the wider student success team.

T: My action, with agreement from the group, was to offer our support to the day. This was readily accepted. The event was actioned on two campuses, supported by group members. This event was well received by students and became a regular activity in the students’ event calendar.

As previously discussed, an online resource site was also suggested as an idea for action. It was mentioned again by the group’s community ally:

> CA: Could we do an online learning module which would be like a brief introduction and then you can add the resources on to that and then people would look at it… It is where we are kind of hoping people will go before they even come to the workshop, just to have the basics… It’s like a brief introduction just to get the basics around the difference between sex, sexuality and gender and different terminologies and where to go for more information. And then come to the face-to-face workshops to do more of the interactive, value-based activities. That’s where we landed after all of the discussion.

This CA understood, based on her experience of facilitating training workshops, and her personal understanding of what is needed to be effective, that a resource site would be beneficial. It would enable workshop participants to gain the basics and enable more time for the interactive, value-based activities. This group member’s comments highlighted that heteronormativity and gender binary are so strongly constructed within western societies that some people may need educating about non

heterosexual and non-binary identities prior to attending a workshop. Her comment indicated that she understood more time in the training to focus on interactive activities would support changes in attitudes. The CA viewed interaction would enable participants to reflect on and consider personal responses to incidences of discrimination and to socially interact with others to construct, with them, new understandings.

The development of a gender and sexual minority resource site was a real group effort. Most members sent me articles or resources they thought were useful. One member set up the site and I loaded the resources and presented the final site to the group. It was well received by them. One CA asked if they could have the resource site for their organisation. The site was promoted as part of our organisation's Pride celebrations. More than 10% of the large organisation accessed the resource site. We formally evaluated participants' views of this resource.

All evaluation responses were positive. However, one staff member, emailed me directly to advise that while she thought the site was great, she felt that transgender communities' use of the term 'cis woman' was offensive because she considered herself to be a woman, not a cis woman. I responded with a polite email and advised that the site, and we as a group, did not use this term, but I appreciated her view and would bear it in mind moving forward. She thanked me for my response. We later discussed the comment as a group. I learnt that cis gender was derived from Latin, meaning 'on the side of'. With regards gender, it was later constructed to mean people whose gender is the same as their sex assigned at birth. It appears to be losing favour in transgender discourse, perhaps because it is a word that is contentious for some. As a group we decided that this person wanted to express a view and have it acknowledged. We agreed there was no need for further action.

Two other events demonstrated how engagement influenced a cultural shift within the wider organisation. Firstly, the establishment of a support group for 'Rainbow' students, now promoted to all students in their 'orientation week'. Secondly, the provision of an annual grant for a 'Rainbow' student at the organisation. Evidence of the first event is the quote below:

> SS: Yeah, the other thing X is doing is they've got funding to have an on-campus support group for gender diverse, or however people fit under the rainbow group.
>
> R: Wow

SS: Yeah, starting next year, every second week on a Wednesday, lunch time, I think.

R: This is your TG support group?

TG: Yup.

While not a direct action from the group, the establishment of a support group for 'Rainbow' students was likely influenced by the transformative actions of the project. One group member was employed to lead this support group. The organisation authorised a support group for sexual and gender minority students to support their sense of belonging to the organisation. It provided a point of connection with others and demonstrated the organisation's recognition and valuing of 'Rainbow' students. The importance of enhancing a sense of belonging for non-binary students in tertiary education was stressed by Budge et al. (2020). Other tertiary education providers within Aotearoa already had similar supports groups. This was being socially constructed as the norm. So, in addition to group action influence, social factors also supported this change. That a group member was contracted to lead this group, further indicated that the AR project in some way influenced this transformative action within the organisation.

The other example which also demonstrated a cultural shift in the organisation, is its partnering with the regional branch of 'Te Whatu Ora' (our national healthcare provider) to provide an annual study grant for a 'Rainbow' nursing student to study at the organisation. This action was driven by two group members, one a TG student and the other an employee of Te Whatu Ora. They got to know each other through the project and worked together after the project to organise the grant. The organisation was open to discussing this grant and formally celebrated the grant at a public event. This further demonstrated that the AR project led to a reconstruction of practice, with regards transgender inclusivity within the organisation.

While the actions discussed in this section demonstrated aspects of all four characteristics of practical knowing (Coghlan, 2016), they particularly highlight that action was underpinned by a view that knowledge is socially constructed. For example, group members emphasised the importance of face-to-face interaction in our training workshops. They judged based on their respective experiences and understandings, that knowledge is supported when participants are given the opportunity to problem solve with each other and to discursively interact with people with lived experiences of the topic. As a group we also came to understand that a cultural shift was needed within the organisation if we were to achieve greater representation of transgender

people in healthcare. Our actions supported a reconstruction within the organisation of how we value and support transgender students.

This section has outlined how the group constructed a need for change beyond the nursing education programme. Changes included enabling the ongoing delivery of a training workshop for all staff, amending the enrolment form, developing an online resource site for staff, and supporting the first and ongoing celebration of Pride Day. This section also discussed changes which occurred within the wider organisation that were not planned by the group, such as, the establishment of a support group for 'Rainbow' students and an annual scholarship for a 'Rainbow' nursing student. It was suggested in this section that these changes occurred due to group actions influencing a cultural shift within the organisation that supported change, and through the connections made between group members.

6.4 Opportunities were created that empowered community members

Group members participated in the project to support transformative action in relation to transgender nursing care. Much was achieved in this regard. Furthermore, actions which supported transgender inclusiveness within the wider organisation were also planned and actioned. Beyond these actions the research project also benefitted group members in other ways. This is an important principle of many AR approaches, as suggested by Dupont (2008) "…community psychologists and critical sociologists have long embraced participatory research and co-operative inquiry approaches—where the empowerment of research participants is as important as the contribution to knowledge and policy development …" (p.197). It was important to me that group members, in particular transgender group members, personally benefitted from their participation. How the AR project benefitted group members is discussed in this section.

Non transgender group members, in addition to gaining a personal satisfaction from actively influencing a positive organisational transformation, benefitted from their involvement in the AR in other ways. For example, NEs, in the organisation, are required to be actively involved in research and this project enabled them to achieve that whilst also participating in a project they considered important. The two SS people, both active members of the 'Rainbow' community were able to bring about organisational change in ways that were important to them. The CA, whose personal work position was to promote sexual and gender minority health amongst healthcare providers and within the community, was able to participate in a project that supported change in relation to her role.

The project was also reportedly rewarding for transgender group members beyond the transformation that occurred within the nursing programme, and its wider organisation. These benefits include members being able to draw on their new learnings within their workplace; gaining work opportunities; and for one member, presenting at both the NCNZ and at a national conference. One participant for example, when asked what she gained from involvement in the group, advised:

> TG: Well, little things I'm picking up from here, I'm bringing into there and trying to instigate those, and I had a good meeting with a regional manager two weeks ago, and she informed me about a webinar [related to transgender wellbeing] thing coming up, so we're going to do it together.

This group member, who works in disability support, was happy to share that they were taking their experiences from being part of the group, and new understandings gained, into their workplace management role. Her recent 'good meeting' with the regional manager suggested the research project empowered her to make changes in her organisation and to discuss these changes with her manager.

Another group member, a nursing student, who was trained through a group action to be a facilitator of our training workshop, went on to gain a part time position as a community training facilitator, working for another member of the group. A position gained through connections made within the group. This member also delivered the workshop to NCNZ, discussed in the next section, and presented the actions of the group at a national conference. This person went on to be a trainer and an activist in this space after the project.

A third group member, during the research project, as previously discussed, gained a contract with the research organisation to lead a 'Rainbow' support group. He also gained a position as a transgender peer support worker through the regional branch of Te Whetu Ora. It is acknowledged, while he was encouraged to apply for this position, by others in the group, gaining this role cannot be directly attributed to their participation in the research.

One transgender group member was just pleased to be part of a project where they were able to influence change:

> TG: I think there's definitely lots of times where gender diverse people in general are caught out like "what's your perspective on this?" and we're like "it's terrible" and they're like "okay cool", that's it, not doing anything more about it.
>
> R: We consulted!

> TG: Yeah so, I think kind of yeah actually seeing that action and how that can empower people as well is quite good.

From this feedback it is clear that this person had experienced numerous ‘tick box’ consultations that did not result in action. Their experience of our AR process was one of collaborative action occurring as a process of engagement. Our process, they understood, was also empowering for people in the group, an experience they judged be a positive aspect of an AR approach.

Another transgender group member affirmed his appreciation of our AR approach:

> TG: I really enjoyed how the process was ‘organic’ and how the project lead was willing to ‘flex’ and ‘stretch’ within the scope of the project, for example [numerous examples provided].

I flexed and stretched because this is how AR works. The group determined actions, based on their experiences and judgement of what needed to change. Then we collectively sought to undertake these actions. These last two people presented their experiences and understanding of the AR process. Both participants explicitly stated that the AR process was positive for them. This study has described how a ‘stretch and flex’ approach, enabled through an AR methodology, was particularly transformative. It was also an approach that allowed us as a group to meet the needs of group members, which supported ethical practice. Working with ethical intent is another characteristic of practical knowledge.

This section has focussed on how the AR process benefitted group members. It described how transgender group members valued the process or benefitted in a tangible way through the connections made. Our support, as a group, of actions which benefitted transgender group members demonstrated our ethical intent, another characteristic of practical knowing.

6.5 Reconstructing the curriculum though influencing national level change

As discussed, the curriculum reflects and perpetuates dominant social norms. The nursing curricula in Aotearoa is influenced by the national body ‘Nursing Council of New Zealand’ (NCNZ) which governs nursing programmes in Aotearoa. Amongst many things, NCNZ works to ensure nursing competency and ethical practice, alongside determining the code of conduct for nursing practice. An important way NCNZ influences curricula content is through its emphasis on nursing graduates being culturally competent in a specified set of cultural competences. These competences do not yet include gender or sexual minorities.

In the first group meeting we discussed the role of NCNZ. This was an informative discussion for those of us in the group who were not nurses. Following this discussion one member advised:

> TG: I did email the nursing council at the beginning of the year, saying I was a first-year nursing student, and wondered if the nursing council were thinking of adding gender identity within its documentation amongst a range of identities. They said it is something they have been thinking about. I plan to email them at the start of next year (year two) and say “Hi it’s me again I am a second-year nursing student”
>
> [Group laughter], SS: That’s awesome
>
> TG: And then, it’s just me again, in third year (group laughter again).

This TG group member’s comments demonstrated their understanding of a need for change with regards what was considered cultural competencies. The NCNZ’s response that gender identity was something they had been thinking about, but clearly, they were not committing to at that point in time, provided an example of how dominant constructs are maintained. Thinking about it suggested that gender minority inclusiveness was something they were aware needed to be considered, due to the increased visibility and voice of transgender people. However, there was not a dominant driver of action within their organisation to bring about a revision of existing competencies. The AR group’s support for the member’s personal action is demonstrated by their supportive laughter and positive comments. The group member did contact NCNZ in their second year, but they received a similar non-committal response. They tried again in their third year but contacted me beforehand and I made a few suggestions for change in their email. They received a more positive response to the third email and reported this back to the group:

> TG: Trish (R) recommended that we offer them, free of charge, the diversity training if they want it so I offered that to them, and, as well if they wanted Trish can also give a summary of the research project and what we’ve been doing at [organisation], because I also asked about content being put into all institutions about gender diversity and stuff. It’s the most positive response I’ve had, I’ve sent one every year for the last three years, and it was much more positive.

While this was an individual action, undertaken based on a suggestion I made, they shared the response with the group because they had previously discussed their quest to gain traction with the NCNZ. Also, it was shared, because we would be using a resource developed by the group (with permission) in this education session we were

offering. With agreement from the group, this person and I delivered the training workshop to NCNZ twice, with almost all staff at NCNZ attending the training. The training led to changes within NCNZ. These changes are discussed next.

As a consequence of our delivery of a training workshop to NCNZ, they advised us of their planned changes. One change was that NCNZ staff insisted that at least one toilet in their multi storey building be gender neutral. More importantly, we were advised, they had subsequently included the importance of enhancing diversity, specifically with regard gender and sexual minorities within their 2020 to 2025 strategic plan. Their priority five (of five) advised they would seek to "promote diversity, equity, and inclusion within systems of nursing practice, education and regulation" (p.5). Within this priority area they stated:

> "It is critical that the nursing profession can meet the needs of all people and communities within Aotearoa New Zealand. This includes respect and safe care for people of different ethnicities and cultures, with diverse gender identities and sexualities, who have differing experiences of disability, and with a range of ages and social backgrounds." (p. 12).

To have the NCNZ, the main authorising body of nursing education and practice in Aotearoa, following our workshop, commit to actions which would support safe care for people of diverse gender identities and sexualities, was a great outcome for the project. As discussed in chapter one, while gender was already considered to be an aspect of culture within NCNZ cultural competencies, nurse education providers viewed this from a binary perspective of gender. NCNZ's inclusion of the statement 'diverse gender identities' made explicit that they are referring to genders beyond binary norms.

NCNZ highlighting a focus on safe care for gender and sexual minorities will influence nursing education and the future nursing healthcare of transgender patients. Given the critical importance of nurses and the respect afforded them within Aotearoa, actions at a national level which influence nurses' knowledge and attitudes about transgender people would support the reconstruction of gender norms in Aotearoa. The shift in thinking by the nursing council was influenced by them having the opportunity to engage with the lived experiences of a transgender person. The presentation we did also included examples of healthcare experiences the transgender facilitator had gained from people in a private Facebook group they were part of. These experiences were confronting and shocked some workshop participants. It was an impactful presentation made possible through involvement of a transgender facilitator who had gained confidence through our AR facilitator training action.

NCNZ included within the strategic plan document (NCNZ, 2022a), its actions already undertaken towards its prioritising diversity, equity, and inclusion. An action stated was the provision of “internal staff training on diversity in gender identity and sexuality” (p. 10). This was the training provided by members of this study’s AR group. Another action, not related to our AR project, although influenced by our work, was NCNZ publicly announcing, as a major banner on their website, their making of a ‘Pride Pledge’. This pledge makes explicit NCNZ’s commitment to making sure members of the ‘Rainbow’ community feel welcome in their workplace, and that members of the ‘Rainbow’ community feel understood, respected, and supported, when receiving nursing healthcare.

Our involvement with NCNZ was largely influenced by the persistence of one group member. I coded data, related to their comments in meetings, as ‘quiet activist’. They needed group action to get their quest over the line. This highlights the significance of AR in bringing about transformative change. The group member occasionally mentioned other actions they were doing individually to bring about change. One particular action mentioned, in a meeting, was to challenge the New Zealand Nurses Organisation (NZNO) membership application:

> TG: They [NZNO] are pretty good, when I registered with them, they had gender diverse as an option, but it didn’t let me proceed as it needed a title, but they didn’t have a gender non-binary title.
>
> Group: [shocked laughter]

The group thought it laughable that the NZNO had taken steps to being more gender inclusive, yet people who did not have a binary (such as Mr or Miss) title still could not join their organisation. The transgender person contacted the NZNO directly to advise them of their barriers to registering. Their system was, after some time, altered to enable non-binary people to join the organisation. This example demonstrated that as a society we are very much at a point of socially reconstructing gender norms. In many organisations there appears to be, once triggered, an understanding of a need for change and a willingness to instigate action towards transgender inclusivity. However organisational change is complex and needs to be informed by those who will be affected by the changes. Factors that support change within the organisation where I work, influenced by an AR process are discussed in the next chapter. The group member’s action discussed here is reflected on in the next learning cycle.

Table 14 *Researcher's reflection 11*

Experience (E), understanding (U), judging (J), taking action (T):
E: It was surprising for me that this person was not able to join the NZNO because its online system did not enable them to proceed. Why take one step without thinking about the next. Not being able to apply for something, because of my gender, was not something I had not previously considered. **U:** To understand this, I attempted to register with numerous organisations as if I were a transgender person. I came to understand that many organisations in Aotearoa were not set up to enable registration by non-binary people. Some did however, and this affirmed my view that we really are at a pivotal point of social reconstruction with regards gender minority inclusiveness in Aotearoa. **J:** I judged that barriers to applying for something or to registering with a particular organisation would significantly contribute to minority stress. Minority stress is the additional stress, beyond usual life stresses, experienced because of being a gender or sexual minority (Frost & Meyer, 2023). **T**: My personal action from this reflection was to commit to emailing my dissatisfaction, to organisations, that I noticed, when personally applying for something, would not allow the application to proceed if I were gender non-binary.

This section provided an example of how we as a group demonstrated another aspect of practical knowing – attending to the uniqueness of a situation. We applauded the transgender group member's respective requests for change within NCNZ and NZNO. We collectively jumped at the opportunity to present a training workshop at NCNZ. This was a somewhat unique opportunity that led to an important positive outcome. The main researcher's attentiveness to the uniqueness of the events as they unfolded was also demonstrated through their personal learning cycles included in this chapter.

The emphasis in this section has been on demonstrating how AR within your own organisation can lead to change at a level beyond the organisation. It demonstrated how socially constructed norms can be challenged and changed over time. This section has described how we as a group brought about change beyond the wider organisation. Our actions led to changes at an NCNZ level and changes within NZNO.

6.6 Conclusion

Chapter six discussed how:' Engagement led to transformation beyond the nursing programme'. These changes included the provision of NE training, aimed at addressing an identified need that nurse educators might need educating, and actions supporting wider organisational inclusiveness such as training workshops, and amending the enrolment form. These actions supported a culture change within the organisation and led to further changes such as the celebration of Pride Day and the setting up of a support group for 'Rainbow' students. Also discussed, was how group members benefitted from the AR process and how we as a group supported change at the national level.

CHAPTER SEVEN: CONCLUSION

7.1 Introduction

I embarked on the current study after identifying an issue in health related to transgender people's healthcare outcomes. I came to a view that nurses are well positioned, if educated, to make a difference in this space. The literature reviewed in chapter two showed involvement of transgender people in learning sessions, and enabling discursive interaction between students and facilitators, was beneficial to the students. The literature review identified two important gaps. Firstly, few studies engaged transgender community members in the planning of their respective learning initiatives. Secondly, even fewer studies considered the need for wider organisational change. These gaps were addressed in our study and are discussed next.

Involving transgender people in the planning of initiatives was important in this study for several reasons. Firstly, as identified in chapter one, culturally safe care is defined by the recipients of the care. I have argued throughout this thesis that the quality of community engagement to define safe care increases when people from a particular social group are positioned as experts by experience. Drawing on the work of Freire (1970), education related to marginalised people needs to be positioned within an equity and empowerment lens. Within this lens people from marginalised communities are empowered to determine change. As a group we also quickly came to an agreement when discussing how we would design new content, that there would be 'nothing about us without us.' That is, new content would be designed by transgender community members. Adopting an AR methodology meant for us that all participants would be involved in all stages of the planning and action of the initiatives.

Adopting an AR methodology also led to wider organisational change. The group collectively constructed a view that nurse educators delivering content, related to transgender wellbeing, who were not themselves demonstrating trans- inclusive attitudes would be problematic. This led to us collectively reaching a view that wider organisational change was needed. We subsequently undertook action to support transformation, beyond the nursing programme.

The research question was: How can engagement with the community influence an existing nurse education programme with regards the provision of quality care for people who are transgender? This chapter will start with a summary and will then address the research question, through an explanation of what was changed, and what was reconstructed, within an existing nurse education programme, as an outcome of engagement with the community. The conditions that made change possible, as

practical knowledge that might be extrapolated to other tertiary education providers, programmes or population groups, will then be discussed. Limitations of the study, recommendations, and an executive summary will also be presented.

7.2 Summary

The previous two chapters discussed how engagement led to programme change and change beyond the nursing programme. Eight themes, derived from a thematic analysis of data provided the building blocks for each of these two chapters. The two chapters and their respective themes are presented next.

Chapter five: Finding One '*Engagement led to a reconstruction of how nursing education could be designed and delivered'* was based on the following four themes:

- Engagement made visible the impact of binary normativity.
- The programme was understood to be lacking in diversity content.
- Transgender group members were repositioned as experts by experience.
- Organisational barriers to community engagement became visible.

Three of the four themes listed above demonstrate how, as the project progressed, other ways of designing and delivering new content were accepted. After gaining a better understanding of how binary normativity impacted on the healthcare experiences of transgender people, space for new content was enabled. As a group we quickly agreed that this new content should be designed by transgender people. The involvement of community people in content design was not normal practice in the programme I worked in. While non-group nurse educators were supportive of the new content, they admitted they were not confident in its delivery. This led to transgender community members supporting the delivery of new content. Again, this was not normal practice where I worked.

The fourth theme highlighted challenges with engaging the community in the design and delivery of the new content. Mostly this was because the 'lived experience' was not valued as much as qualifications and clinical expertise. As such, there was no budget allowance for community involvement. It was our shifts in thinking as we attempted to bring about change that made these challenges visible and able to be discussed and addressed.

Chapter six: Finding two '*Engagement led to transformation beyond the nursing programme'* was based on the following four themes:

- Collective concern around NEs' understanding of non-binary genders.
- Challenging organisational norms to better support transgender outcomes.
- Opportunities were created that empowered community members.
- Reconstructing the curriculum through influencing change at a national level.

Wider organisational change occurred due to a ripple out of concern, from the group, that some nurse educators may need educating about gender and sexual minorities. This led to training being offered for all staff in the organisation and other practices and procedures within the organisation with regards gender and sexual minority inclusiveness being challenged. The facilitation workshop training we undertook supported some transgender group members to gain positions in the field of transgender advocacy and training. One group member pushed us, as a group, to seek change within the national regulatory authority for nursing in Aotearoa, Nursing Council of New Zealand (NCNZ). Our facilitation training supported action in that space, and subsequently this push, led to change at a national level.

7.3 What was changed?

Our AR project led to new content, related to transgender healthcare, being developed and included in all years of an existing nurse education programme. Furthermore, the new content was designed and mostly delivered by group members. We provided training opportunities for nurse educators to support the delivery of the new content. The AR project also led to changes that extended beyond the nursing programme. For example, we developed an online learning LGBTQI+ resource for all staff and enabled opportunities for staff to attend training about gender and sexual minority inclusiveness. We also successfully sought to make the enrolment process within our institution more inclusive of gender minorities, and we celebrated Pride Day across the organisation for the first time.

Our study also influenced change within the national regulatory body, Nursing Council of New Zealand. This resulted in the inclusion of the priority of supporting diversity within nursing as part of their five-year strategic plan, with their specific reference to gender and sexual minorities (Nursing Council of New Zealand, 2022a). Following the project, two group members worked together to enable the regional health provider to provide an annual grant to support a Rainbow nursing student to study at the organisation, and one group member went on to be the facilitator of a support group for Rainbow students in the organisation (Manawatu Gaurdian, 2023).

7.4 What was reconstructed?

The study, discussed in this thesis, was underpinned by a social constructionist worldview; a worldview that influenced the choice of methodology, the methods, and the study's analysis. AR aligns well with a social constructionist world view (Gergen & Gergen, 2008). The AR methodological approach adopted for the study philosophically considered practical knowledge to be socially constructed. This section will discuss what was reconstructed in the process of change.

Chapter five discussed how: *Engagement led to a reconstruction of how nursing education could be designed and delivered.* Change, from a social constructionist perspective occurred because:

- Marginalised communities, as key stakeholders, were made visible.
- Clinical expertise was productively challenged by trans lived experience.
- Empowerment and advocacy were constructed as central to nurse education.

Chapter six discussed how: *Engagement led to transformation beyond the nursing programme*. Change, from a social constructionist perspective occurred because:

- Norms that limited the freedom and engagement of transgender people within an organisation were challenged.
- Cultural safety as a socially constructed concept was contested and expanded.

These reconstructions are discussed next. How change was practically enabled will be discussed after this section.

Marginalised communities as key stakeholders were made visible.

Despite critical commentary (for example, Gill et al., 2015, and Craddock, 2022) and explicit policy (Ministry of Health, 2020), that supports service user involvement, there is still disconnect between service users and providers of healthcare (Shaw et al., 2023).

The current study created the conditions of possibility for educators to critically consider where marginalised community members and users of healthcare generally are positioned when considering stakeholder engagement. Gill et al. (2015) criticised the lack of healthcare consumer input in the development of competency frameworks for critical care in nurse education in the UK, Europe, and the US. Conversely, with regard mental health, in Aotearoa, consumers have had an increasing role in informing health care practice and research. For example, a government inquiry into mental health and addiction (He Ara Oranga, 2018) was heavily focused on hearing the voices

of those with lived experiences of mental health and addiction problems. However, based on a lack of Aotearoa based literature, and my observations, there does not appear to have been the same progress with regards service user involvement in nursing education in Aotearoa.

Where I work, a small amount of input from students is gained through programme evaluation processes. Input from our other 'relevant' stakeholders, such as local healthcare managers, and providers involved in students' placements, is gained through regular stakeholder meetings. In these meetings placement providers are priority stakeholders because nursing students are required to undertake a minimum number of hours in healthcare to complete their qualification. It is often a challenge for education providers to find and retain placement opportunities (Macintosh, 2023). Ensuring our programme meets the needs of placement providers takes priority over other aspects of stakeholder engagement. Marginalised community members are not generally positioned as stakeholders.

The importance of giving voice to marginalised people has been acknowledged (Craddock, 2022). However, Craddock suggested there are challenges to ensuring "authentic direct participation of marginalised groups and the practical reality of engaging with these groups and communities" (p. 18). A view supported by De Abreu Lourenço, (2021). The New Zealand study (Maher et al., 2017), using a co-design approach to 'patient' engagement in healthcare service design, also highlighted the importance of involving 'patients' in healthcare initiatives. They too found challenges to engagement. Co-design in health research, has become increasingly popular over recent years. It originates from participatory AR and incorporates a range of approaches, where providers and 'end-users' collaborate to find ways to address a persistent problem (Butler et al., 2022). It differs from the AR approach adopted for this study through its predetermination of the problem to be addressed and having less emphasis on participant reflection.

The study discussed in the current thesis demonstrated that respecting transgender community members as important stakeholders is critical to enhancing the nursing programme. This was made possible through an AR process. Our AR project enabled nurse educators in the group to gain a greater understanding through social construction at a micro level of the healthcare challenges faced by many transgender people. This new understanding drove programme level changes and wider organisational change. It also provided an important resource of knowledge to support educational content and delivery. This is discussed further in the next section.

Clinical expertise was productively challenged by people with lived experience.

Most nursing education in Aotearoa is delivered by registered nurses. Their experience in the field is considered critical to supporting student nurses' knowledge and nursing practice. Registered nurses are constructed as experts in particular aspects of nursing based on their clinical experiences. This view is supported by Brand and Dart (2022) who suggested that healthcare research positions the expertise of clinicians, researchers, and educators, as more relevant than that of people with lived experiences. However, it was the nurse educators in our AR group, because of engagement with the study, who conceded they were not 'experts' in transgender healthcare and that they would need to draw on the expertise of people 'in the room' for the development of new content.

Some non-group nurse educators also admitted that culturally safe transgender communication was outside of their level of expertise. This led to transgender community members supporting NEs in their session delivery. NEs and staff within the wider organisation were offered training workshops, using an ally and community member model, where transgender community members were positioned as the experts. We successfully gained funding, for the training session, to respect their expertise.

The literature review, presented in chapter two, of the current thesis, found that initiatives, for example Karlin and Nickasch (2022) and Rodriguez (2022), that enabled nursing students to engage with transgender community members in learning sessions, were positively received by students and led to demonstratively improved knowledge, attitudes, and skills. These findings highlight the importance of involving transgender community members in the delivery of learning sessions about them. Involving people from transgender communities as educators in learning sessions, supports an understanding, for students, of the impacts of everyday social structures and practices on the wellbeing of transgender people. It is beneficial knowledge for nursing students and supports their future culturally safe practice.

The finding that engagement with the community is positively received by students, is supported by the integrated literature review undertaken by Orgel (2017). Their review of initiatives aimed at supporting LGBT cultural competence in nursing students found that "attitudes have been improved by cultural competence education, especially when students have opportunities for face-to-face encounters with members of cultural groups through interventions such as panel discussions, guest speakers, and community outreach" (p.18). Engagement with the community in training is not only positively received by students, but it also supports their future practice (Kline et al.,

2020). Kline et al. in their study found that enabling medical students to authentically engage with autonomous ‘patient’ educators/mentors supported their later patient centred practice.

While many of the studies reviewed in chapter two, involved transgender people in the delivery of content, only seven studies, for example Martin (2022) and Rudd et al. (2021) involved community members in the design of learning initiatives. In most of the studies discussed in chapter two the transgender person was engaged as a guest speaker, rather than an expert facilitator of the learning session.

The current study created the conditions of possibility for positioning transgender community members as experts in their field. They were valued as expert consultants and paid accordingly. From this perspective, involvement in teaching sessions, not initially planned and determined by the respective transgender community member, denigrates the guest speaker to a tokenistic representation of engagement. Not involving transgender people from the start of an initiative becomes inauthentic and disrespectful of their significant value as critical to the process of determining what and how educational transgender healthcare content is delivered. Brand et al. (2023) suggested that such an approach “negates the authentic and experiential knowledge derived from human experience” (p. 2). Authenticity with regards community engagement is discussed next.

Authentic engagement

The need for authentic community engagement in healthcare has been discussed much in recent years, particularly in relation to the COVID-19 response. For example, Schiavo (2021) and Gilmore et al. (2020) suggested that in the time of a health crisis, authentic community engagement is more important than ever. Both studies argued that engagement with marginalised communities, who were disproportionately affected by the pandemic, is needed to support an understanding of the national health response. Studies that have discussed how authentic engagement is supported are discussed next.

Authentic engagement in health research is when stakeholders are involved in all stages of the research process, from design to dissemination of results (Woolf at al., 2016). Authentic engagement is engagement “built on trust, inclusion, a willingness to listen and an openness on how research will be used, communicated and shared.” (De Abreu Lourenço, 2021, p. 9). Burgess et al. (2021) offered one mechanism for meaningful engagement - community co-design forums. Brand et al. (2023) supported this view. They suggest that a co-design research approach involving people with lived

experience can disrupt academic power imbalances by enabling a shared ownership of knowledge. There is the possibility, however, that co-design has become popularist, with the risk of superficial consumer engagement (Mark & Hagan, 2020). AR provides a structured approach to ensure authentic engagement when co-designing.

Group members in the current study, co-constructed meaningful engagement as being "more than a tick box process". A tick box process of engagement, for example, is a one-off focus group meeting or an invitation to a stakeholder meeting that does not influence change. Community participants in the current study expressed the view that our engagement was authentic. They appreciated that they were not just being consulted but they could see their views were respected and influenced transformative action. Our project considered all group members to be co-researchers, and decision makers, in all phases of the research. They were involved from the onset in the design and in most cases the delivery of new content. They were also instrumental in the determination and implementation of action that led to wider organisational change. Our study positioned transgender people at the forefront of action in the design and delivery of content, and showed how this can significantly influence nursing education and lead to wider organisational and national level changes.

Empowerment and advocacy constructed as central to nurse education.

At a health consumer and health provider level, nurse education programmes seek to enable nurses to empower those they are caring for to make informed decisions about their healthcare and to advocate for them when prejudice is apparent (Nursing Council of New Zealand, 2016). Education is needed to support such quality care for transgender people (Roosevelt et al., 2021). Within healthcare, non-affirmative practice causes minority stress and creates barriers to access for transgender people (McCann et al., 2021). As advocates, nurses can push for organisational change when systems or processes are not conducive to wellbeing for a particular population group (Nursing and Midwifery Council, 2015, Myers, 2020; Scott & Scott, 2021). That is,

> … if one takes the role of patient advocacy seriously, as core to the nursing role, two things are required of nurses: We must (a) broaden the conceptualisation of patient advocacy beyond the individual patient to the system of healthcare resourcing and provision and (b) see systemic change as important as change at the bedside.
>
> (Scott & Scott, 2021, p. 723).

Healthcare systems are reconstructed over time to adapt to the needs of society, a process influenced by changing social and political environments (Goh & Loh, 2019). Likewise, as society interacts with healthcare, given its relevance to people's lives, changes within healthcare will influence social norms. Education that supports empowerment and advocacy for transgender people, or other marginalised groups, that subsequently leads to systemic changes in healthcare practice will likely have wider social impacts.

The current study has demonstrated how our working with staff to support their advocacy for LGBT students and co-workers led to wider organisational change. At a nursing level, wider organisation action enabled NEs, from the group, and other NEs who engaged with our actions, to walk the talk. Engaging in action provided them with examples of how to empower and advocate for clients and co-workers when practices are not inclusive. An example of how the current study had a wider social impact is the previously discussed partnership, between Te Whatu Ora (Health New Zealand) and the organisation of the current study that enabled an annual grant for a Rainbow student to study nursing at the organisation. This outcome was published in the local paper. Given that media is an important influencer of social norms (Arias, 2019) and the relevance of the two organisations, in the region of this event, would likely have been socially impactful.

Only one of the studies (Tartavoulle & Landry, 2021) discussed in the literature review of the current thesis explicitly focussed on advocacy. These authors included content related to culturally competent care for LGBTQI+ people into an advocacy programme. They recommend advocacy education to support outcomes for particular population groups. In the nurse education programme of the current study, prior to the study, content related to empowerment and advocacy was embedded throughout the curriculum. However, it was generally not specific to any population group, with the exception of Māori. Students, in the programme, were taught how to enable Māori patients to voice their healthcare needs and desired healthcare outcomes. Students were also taught how to advocate for Māori patients within the wider healthcare team when healthcare provision was not meeting their cultural and healthcare needs. Now, as an outcome of our study, students will be taught how to empower and advocate for transgender people in their care.

Being able to empower and advocate for transgender people specifically, is important because transgender people often have negative healthcare experiences. For example, they may experience disrespectful communication or an environment that is not inclusive of all genders. Because gender binary is so normalised in Western

societies, some cis-gender nurses may need educating on how to advocate, in the moment, for a patient who is not being treated respectfully and how to recognise and challenge environments that communicate exclusion for transgender people (Paradiso & Lally, 2018).

'Empowerment and advocacy' for transgender people was a common code within the data analysis of the current study, which highlighted that the group collectively constructed a view that enabling students to empower and advocate for transgender people specifically, was important. This was because we came to understand people who are transgender have unique healthcare needs that many nurses or other healthcare providers may not be familiar with. Some transgender people experience healthcare providers who demonstrated transphobic attitudes or systems and processes that make their healthcare experience less than optimal. Until all providers are familiar with transgender healthcare needs and organisational barriers to access are addressed, specific education related to empowerment and advocacy for transgender people is needed to equip nurses with the knowledge and skills to challenge disrespectful or non-inclusive care.

Norms that limited the freedom and engagement of the transgender people within the organisation were challenged.

The constructed norms within the organisation of our study were such that it was not welcoming of students who identified as anything but gender binary. As a direct consequence of our actions there was a cultural shift within the organisation which led to significant changes to adopted practices. The wider organisational changes were aimed at supporting increased enrolment and successful completion for transgender students. Only two of the studies discussed in the literature review of the current thesis (Kellett & Fitton, 2017; Saini et al. 2022), focused on wider organisational change. Group members, in our study, suggested that organisational barriers to enrolment or completion may mean nursing healthcare will miss out on the upstream benefits of transgender nursing graduates. Our study emphasised the importance of learning institutions creating a welcoming and safe learning environment for transgender students.

The importance of addressing wider organisational barriers to success, for transgender students was highlighted in some studies, for example McKendry and Lawrence (2018) and Knutson et al. (2022). McKendry & Lawrence, in an earlier study, found there were barriers to success for transgender students and staff within the higher education organisation where they worked. Their subsequent actions, in their 2018 study, supported wider organisational change. The authors went on to develop a free, open-

access, support website, with resources, for other higher education institutes seeking to support transgender people. Knutson et al. used a socio-ecological model to better understand sources of stress for transgender students. They used this information to provide recommendations for change at a structural, interpersonal, and individual level. At a structural level Knutson et al. suggested that organisational policies and paperwork, alongside recruitment and access processes needed to be reviewed to support more inclusive learning environments.

The actions of our study supported a cultural shift within the organisation with regard gender and sexual minority inclusiveness. For example, a training and an education resource site related to gender and sexual minority inclusiveness was developed and made available to all staff, and 'Pride' day was celebrated for the first time (see Appendix 15) and became a regular event at two of the three campuses. Organisational changes occurred as a direct outcome of this study's AR process. Actions related to wider organisational change were informed by the transgender students who were part of the group and other transgender community members.

Cultural safety as a socially constructed concept was contested and expanded.

'Cultural safety' was an important code and influencer of the themes and subsequent findings of the current thesis. NCNZ mandates that nursing programmes integrate the principle of the 'Code of Conduct', which includes cultural safety (NCNZ, 2021 [updated, 2022]). Culturally safe nurses "will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action which diminishes, demeans, or disempowers the cultural identity and wellbeing of an individual." (Nursing Council New Zealand, 2011. P. 7). Cultural safety is a social construct. How it is defined and who it refers to has been reconstructed many times.

Cultural safety has its origins in cultural competence, a concept, as previously discussed, originating from the work of Cross et al. (1989). It was premised on the importance of having knowledge of others. A view that positions white people as the norm and 'others' being non-whites (Reid et al., 2018). Māori have long contested for changes in healthcare, through an equity lens. In that space, it was the eminent work of Irihapiti Ramsden that shifted us as a society towards the concept of cultural safety (Cox 2016). "A key difference between the concepts of cultural competency and cultural safety is the notion of power" (Curtis et al., 2019, p. 12). Cultural safety requires providers to reflect on their own biases, cultural assumptions, and potential power imbalances of their healthcare interactions (Curtis et al., 2019).

The NCNZ (2022b) defined cultural safety as the “effective nursing practice of a person or family/whanau from another culture and is determined by that person or family” (p. 13). The NCNZ is not clear about how the recipients of care are able to determine what safe care is for them. The current research suggests that culturally safe care should not be defined within a patient-provider interaction. An interaction, for example, when the patient is in a situation of being significantly unwell, or in a healthcare emergency, or in a post-operative vulnerable state. It must be defined when people from particular cultural groups are in an equal position with providers. An example of where members of a particular population group are engaged in the defining of what cultural safety means for them, outside of a healthcare context, is seen in Urbanoski et al. (2020). This study enabled 75 people who ‘use substances’ to participate in focus group meetings. The analysis of data from these meetings was used to develop a model of safe primary care. In their study, Urbanoski et al. (2020) used a model of cultural safety to enable a marginalised group to define culturally safe care for them.

In the current study, it became evident to the group, after NEs acknowledged they would need to ‘draw on the expertise in the room’, that transgender group members would be involved in the design of new content. There was a realisation that transgender peoples’ determination of culturally safe healthcare requires their active involvement in the process of defining what is safe healthcare for them. For this to be an authentic process, it must occur when recipients of the care are in a position of equity with providers. Together there can be co-construction of what safe care for transgender population groups looks like. An AR methodology, within a social constructionist lens as undertaken in the current study, respected participants’ experiential authority and enabled transgender community members, through their designing and delivery of course content, to define culturally safe care for transgender people.

7.5 Practical knowing

As discussed, there are numerous types of knowledge. The most understood is propositional/factual knowledge, a knowing ‘that’. Another type of knowledge is practical knowledge, a knowing ‘how’ (Wiggins, 2012). The current study was based on practical knowing. This section will focus on how, from a practical viewpoint, we as a group were able to bring about transformative change within the organisation. Coghlan (2016), determined four characteristics of practical knowing:

1) Practical knowing is focused on the everyday concerns of human living.

2) Practical knowing is socially derived and constructed.

3) Practical knowing requires attentiveness to the uniqueness of each situation.

4) Practical action is driven by values that are fundamentally ethical.

(Coghlan, 2016, p. 92).

How our AR process aligned to these characteristics was discussed in the methods chapter and in chapters five and six. Our study demonstrated that an AR process that adheres to these characteristics supports practical knowing. The practical knowing presented in the current thesis is how we were able to bring about change.

A safe space for communication was established.

In our study, establishing a communicative space was critical to transformative action. According to Bevan (2013) the "concept of the communicative space in action research was developed from the critical social theorist Jürgen Habermas (1970, 1971, 1981, 1987)" (p.14). It is a space where people can participate as equal partners in the AR process (Bevan, 2013, Kemmis et al., 2014). Our established space enabled group members to speak freely about their experiences, which supported a collective understanding of the issues being addressed and the action needed to support change. Establishing a communicative space for AR is necessary to realise the emancipatory interests of marginalised people in an AR project (Kolenic, 2021).

Creating a safe space for community participation requires a consideration of the venue and the timing of the project (Warrington, 2020). Warrington suggested, finding an easily accessible location that is not stigmatising is important, whilst also ensuring the timing works around participants' childcare and work arrangements. Our study was based at a location that was easily accessible for all participants, and access to the venue was made easy for anyone outside of the group. For example, all external group members were met at the door of the organisation, and the research rooms were always next to an all-access toilet. The timing of our meetings was designed to work around group members' work schedules, and childcare arrangements.

Also critical to creating a safe space for communication is ensuring all voices are heard and respected. From Dewey (1916) to Habermas (1987) to Kemmis (2014) the importance of equal partnerships in AR has been emphasised (Edwards-Groves & Rönnerman, 2022). An initial action, on my part, to support the voices of transgender community members was to ask, in the first meeting, if we as a group agreed to

respecting the voices of people outside of the community. Group members agreed to this. In retrospect, as previously discussed, I could have been more collaborative in the determination of how all voices in the group would be heard and respected. Establishing a shared commitment to ways of working together was emphasised in the eminent work by Kemmis and McTaggart (2014).

In the current study, a safe space for communication was also supported in part by me being an experienced facilitator, but mostly by there being a trained counsellor/group facilitator within the group. My actions as a facilitator were to ask questions that demonstrated an inquisitiveness of transgender group members' experience of healthcare. I believe my interest led to these members wanting to disclose more. I also sought to involve the less vocal group members by directing questions that came to mind related to their expertise, to them when the opportunity arose. The counsellor in the group, I believe, had a presence. He demonstrated active listening to the marginalised voice, which, I observed, was mirrored by others in the group. Warrington (2020) emphasised the importance of facilitators, when creating a safe space for participatory group work, having facilitation skills supported a safe space for the current study. An additional action towards establishing a communicative space was enabling group members to retract comments after a meeting or after they had viewed the transcript. This enabled group members to speak freely without fear of saying something they might later regret and not be able to retract.

Critical to establishing a communicative space, within an Aotearoa context, is drawing on indigenous ways of knowing. Tipene-Matua et al. (2009) advised that cultural protocols in research ensure the dignity of people in the group is maintained by enabling space for people to have their say. These authors suggested that an AR approach aligns to kaupapa Māori (indigenous) research. Our actions to establish a communicative space, were similar to those presented by Tipene-Matua et al. (2009) and were approved by my cultural advisor, a highly respected elder of the region of the study. The recommendation from our study is that further research is needed to better understand how drawing on indigenous practices, alongside published guidelines, and literature, can support communicative spaces in AR so that all group members can be safely included and feel valued in all stages of the AR process.

Community members were valued as experts.

Positioning community members as experts in their field was ethical in intent. Thurber et al. (2020) concluded, from their study, that engaging community people as experts in their aged care related AR process "amplified residents' self-determination and provided greater congruence between the researchers' social justice values and our

research methods" (p. 414). Valuing community members as 'experts by experience' was also critical to the transformative outcomes of our study. The skills and desire for change of transgender group members, and community allies, supported new understandings for nurse educators and student success members, and drove transformative action. 'Experts by experience' is a term that has been commonly used recently within healthcare, mental health, and social work research. It includes a diverse range of population groups. For example, experts by experience include community service users and their carers (Cabiati & Levi, 2021); people who experience daily living challenges (Howlett et al., 2023) and people living with a particular healthcare experience (Hollins, 2019). In our study experts by experience were transgender people whose experiences of discrimination in their day-to-day living, and when accessing healthcare, were particularly informative to our determination of actions.

While not an AR project, Hollins (2019) provided suggestions about respectful and successful co-working with 'experts by experience'. The author suggested that researchers have clear expected outcomes and that barriers to engagement are minimised. For example, they suggest recompensing participants for their time and making reasonable adjustments to accommodate participation. Hollins also argued that progress should be regularly evaluated, and plans adjusted accordingly. These suggestions appear to be more about supporting participation than recognising people as experts by experience. Our AR process aligned with these suggestions, with additional considerations. For example, community group members were not just recompensed for their time, they were recompensed at a consultant rate. This was a tangible way to position community members as experts, and likely elevated their mana (prestige) through demonstrating that their experiential knowledge was valuable to the project. As discussed in the last section, participation was made easy, and our AR process meant we regularly, collaboratively reviewed and adjusted our plans.

Other ways that the current study supported the positioning of those with lived experience as experts included our acknowledging and respecting the expertise of community people in meetings. This occurred through our being attentive to their stories and often referring to them as the 'expertise in the room'. This way of engaging may have been supported by my questions. Such questions included asking how particular new content would be informed or designed, which led to some in the group 'in the moment reflecting' and then advising they would need to draw on the 'expertise in the room'. Secondly, a community ally group member, insisted the workshops we delivered to the health educators and then to all staff, were delivered in a partnership model (a transgender person and an ally). We agreed to this as a group. This meant

we would not run a workshop without a transgender facilitator as they were the experts. Thirdly, we as a group, were particularly responsive to suggestions made by transgender people and community allies in the determination of actions. Indeed, one transgender group member described our AR project as refreshingly different to other types of 'consultations' they had been involved in because community members' suggestions were actioned.

A particular mix of people supported action.

Transformative action, in the current study, was supported by having a particular mix of people who collectively enabled the micro social construction of new knowledge and transformative action. This view is supported by Hollins (2019) who suggested the success of a project is determined by the qualities that those involved bring to the whole research process. In the study discussed in the current thesis, the involvement of transgender community members, community allies, NEs, and student support was a particularly salient mix with regards supporting change within the organisation that this study was based.

While our study was based on a model of 'Doing Action Research in Your Own Organisation' (Coghlan 2019), the involvement of people from outside of the organisation was invaluable to our collaborative construction, planning, and implementation of the actions. For example, engagement with non-organisation transgender people's personal healthcare experiences supported an understanding for NEs and student support team members of the need to improve access to safe healthcare and a more inclusive education environment for transgender people. Inviting a community ally who worked in the area of transgender and sexual minority healthcare was also a propitious move. This ally enabled our 'train the trainer approach' to organisational staff training, through her experience of regularly delivering training sessions within the community.

Within the organisation where I work, the involvement of NEs and members of the student support team was also a critical move for the project. NEs were able to influence change within the papers they had leverage over. Student support members drove wider organisational change. Furthermore, the involvement of a transgender nursing student was particularly fortuitous for the project as they were able to provide a transgender view of accessing healthcare and a nursing student's perspective of the actions related to new content within the nursing programme. Two studies reviewed in chapter two also had a particular mix of people who were collectively impactful with regards transformative action. One such study, Saini et al. (2022), involved researchers, nurses, educators, and community members in their AR group. Another

study, McDowell and Bower (2016), also engaged NEs and community members in their project. Both studies were able to get content woven throughout their respective nursing curricula. In both studies, content was well received by students.

The mix of people in our group did not happen by chance. It was supported by prior networking. Networking was important in this study as it supported engagement with prospective group members, and a better understanding of the social context of the study. It also, as one group member commented, demonstrated to the community my personal commitment to change and supported the trust of the 'Rainbow' people and 'Rainbow' allies who went on to become group members. The current study found prior networking was important in AR. It supported a greater understanding of the study context, the gaining of trust of prospective group members, and subsequent participation from group members that can inform and influence change.

Few retrievable recent studies have emphasised the importance of prior networking to AR. However, Cornish et al. (2023) suggested that PAR researchers, if new to a particular community, must earn their trust by, for example, attending public events and informal meetings. Our study found that prior networking supported the recruitment of the appropriate people to the project and a better understanding of the issues to be addressed. In the context of our study, prior networking included my attendance at a national conference and a community training, meetings with community groups, and presenting my research ideas to the nurse education team at the organisation. Prior networking, in the current study, supported my own understanding of the issues faced by transgender people accessing healthcare. It also supported the engagement of a particular mix of people who collaboratively enabled transformative action.

A bottom-up/top-down approach supported change.

The project discussed in this thesis was undertaken by a small group of people, small that is, relative to the number of people within the organisation. The study was undertaken by community members and people from the organisation who did not hold management roles. As such, it was very much a 'bottom-up' project. A bottom-up approach is not a novel approach to research. James and Buffel (2022), for example, undertook a systematic review of studies that engaged older people as co-researchers. Their review discussed 27 studies that enabled older people to be actively involved in determining change. The authors concluded that it is important to involve the respective population group in the determination of action that will impact on their lives and the communities where they live.

Our study found that a bottom-up approach was supported by the involvement of 'champions.' Champions are people internal to the organisation who have a personal interest in implementing change and are willing to work tirelessly without recompense or formal recognition (Miech et al., 2018). The successful engagement of champions to overcome organisational barriers in healthcare settings and support the implementation of evidence-based practice, is well documented (e.g. Cullen et al., 2020; Miech et al., 2018; Wood et al., 2020). Effective champions can advocate for change, motivate others, and use their influence to plan and facilitate practice change. In our study, one person particularly aligned with the Miech et al definition of a 'champion'. They were a nursing student and a transgender community member. I coded my thoughts on their drive for action as 'quiet activist'. They were instrumental in wider organisational change, and they now continue to push for change at a national level.

Establishing a 'Community of Practice' (CoP) is also an example of how a bottom-up approach can influence change within an existing education programme. A CoP is similar to an AR group. It is a group of people within a particular context who are working together, and collectively reflecting on their respective practices, to co-construct new ways of working. A literature review of 11 qualitative studies of CoP initiatives, related to supporting indigenous health education, undertaken by Wynn et al. (2023), found that CoPs can support the development of culturally appropriate responses to health education and strategies for learning that may play a role in improving health and education outcomes for indigenous population groups.

Another study that demonstrated the potential of CoPs was undertaken by Johnson (2023) who studied the experiences of members of a CoP which sought to create more inclusive primary school learning environments for LGBTQI+ students. While their group members faced challenges, over time they were able to make cultural shifts within their respective organisations. During their challenging times members of the CoP discussed needing the support of their wider organisation, which included their respective leadership teams. In the current study, a bottom-up approach enabled change at the nursing programme level, however, we too needed the support of the organisation's leadership team to bring about wider organisational change.

The 'safe and brave spaces' method discussed by Ladwig (2022) promoted a multi-level approach to organisational change. Ladwig's study sought organisational change to support gender non-binary inclusiveness in the organisation of their study. The author suggested that a bottom-up approach supports attitude and behaviour change at an individual level, but a top-down approach is needed to support wider organisational change, such as structures and policy changes. The need for a bottom-

up, top-down approach to bring about individual and wider organisational change was an important finding of the current study.

If both bottom-up and top-down approaches are needed for transformative action, as argued in this current thesis, then what enables the bottom-up to influence a top-down approach? Ladwig (2022) suggested the research method facilitates the connection between the two levels to support enduring positive change. Our current study demonstrated that our research method, AR, led to a bottom-up, top-down approach to transformative action. The participants in Johnson (2023) "…described developing key alliances within the school leadership team to drive organizational change …" (p. 551). In the current study, the position of some members in the group, due to their length of time in the organisation and previously established connections, enabled them to gain support from the members of the executive leadership team who were able to authorise actions related to wider organisational change. The findings of Johnson (2023) and our study suggest the skills, experiences, and connections of people in an AR group combine to bring about wider organisational change.

An increased visibility of gender minorities supported action.

The current study was undertaken at a time of increased visibility of transgender identities within Aotearoa and internationally. For example, as stated in chapter one, the transgender community, globally, appeared to be on the brink of what the Times Magazine headline as a 'transgender tipping point' (Steinmetz, 2014). Within Aotearoa, Delahunt et al. (2018) acknowledged that the increased recognition of gender minority identities, indicates a need for high quality research in the gender minority space. In nursing, the New Zealand Nurses Organisation (2016) has acknowledged a need for a response from the profession to ensure culturally safe care for gender and sexual minorities; and 'Emerge', one of largest mental health providers in Aotearoa has launched a Rainbow network (He Muka Tāngata) for its staff and the people who use their services (College of Nurses Aotearoa, 2022). One reason why the study discussed in the current thesis led to wider organisational change, despite none of the group members being in a formal position to make wider organisational decisions, is that our study aligned with social movements, within Aotearoa, that were focussed on transgender inclusiveness.

An increased social awareness of transgender people supported the involvement of people into the AR group. It supported engagement, for example, from some NEs who saw a need for change within the nursing programme and participation from members of the student support team who also saw a need for change within the wider

organisation. An increased number of recently formed transgender support groups, within the local community, alongside the recently developed community education workshops, provided access points for inviting community transgender people and their allies to be involved in the project. Social change, with regards transgender visibility, made networking and recruitment easier.

An increased social awareness of transgender people also supported our actions. For example, NEs, who were not part of the AR group, readily accepted new content related to transgender healthcare being included in the papers they taught. Furthermore, these NEs participated in the diversity training offered by the group. Other actions, such as the institution's first celebration of 'Pride Day' being well supported by students and staff, alongside many staff accessing our resource site and/or attending the diversity training, further demonstrated a growing social awareness of gender minority inclusiveness.

Wider organisational participation in the actions developed by the group, supported their continuance, because higher management influenced by the popularity of these actions financially supported the continuance of the actions. The ongoing resourcing of actions by the higher management team, in response to actions being well received by staff and students, indicated a growing sense of social responsibility. Wider organisational participation in actions made the management team more aware of their need to respond to staff and student support of gender and sexual minorities.

The link between AR methodology and social movements has been discussed. AR is commonly rooted in an activism/social change or organisational learning (Pettit, 2010). Eminent action researcher Freire (1970) considered participatory AR in education as a means of challenging oppression, and linked AR to educational change and activism. More recently, Comas-Dias and Rivera (2019) also highlighted the potential of AR to support social action and social justice.

The current study agrees that AR within education can support social action and social justice. However, our study sought to contribute to practical knowledge by discussing how our AR project was able to bring about transformative action. Our study was posited within a sociocultural context where the notion of transgender identities had much social and political attention. It is suggested here that AR within your own organisation is more likely to be transformative if it aligns to a social awareness of a need for change influenced by a social change or activism within the social/political context of the study.

7.6 Extrapolation to broader context

Professional doctoral research seeks to contribute to practice as well as academic knowledge (Creaton & Anderson, 2021). The current study has outlined how engagement with the community, using an AR methodology, was able to influence a change in practice within an existing nursing education programme, within the organisation and at a national level. AR leads to practical knowing, that is, knowing how to determine and carry out virtuous and wise action (Cohoe, 2022). The practical knowledge gained from our study is transferable to other contexts. Eminent action researchers including Gustaven (2008) and Coghlan (2021) suggest that AR should draw on and contribute to theory. This study drew on Transgender theory and contributes to theory through connecting the work of transgender theorists to nursing practice.

Contribution to practice

The practical knowledge, gained from our using an AR methodology which engaged the community with a nursing programme is transferable to other education programmes seeking to enhance students' future provision of quality care for transgender people. Enhancing the capabilities of healthcare and other service providers, to meet the healthcare needs of transgender people in our communities, will subsequently support more equitable health and social outcomes.

While not the initial purpose, our AR project brought about wider organisational change; change that would support transgender student enrolment and successful completion of programmes outside of nursing. Enhancing the learning environment for other health, allied health and social work programmes will support successful completion of these programmes by transgender students and the flow on impact of having more transgender health, allied health, and social work providers of care. Obstacles to transgender people's successful completion of health or social work programmes, excludes them from professional practice and further perpetuates gender binary in the particular health or wellbeing sector (Austin et al., 2019).

Being a gender minority is but one aspect of a person's identity that may lead to marginalisation, subsequent minority stress, and poor health outcomes (Tan et al., 2019). The practical knowing discussed in the current study is also transferable to action researchers seeking to enhance a nursing or other health programmes to support the provision of quality care for members of other marginalised groups, such as indigenous groups, sexuality minorities, refugees and people with disabilities.

Theoretical contribution

The current study drew on and also contributes to transgender theory. This theory supports an understanding of people who identity as transgender. It is a theory that has its origins in feminist and queer studies but particularly, it takes a social constructionist approach and questions essentialists' perspectives of gender and sexuality (Nagoshi & Brzuxy, 2010). While transgender people have been supported by some feminist and queer theorists, gaps for this population group, within these theoretical perspectives, influenced the emergence of transgender studies towards transgender theory. Transgender theorists seek to understand how identities within multiple minority population groups intersect to support or oppress individuals (intersectionality). They also highlight the importance of drawing on (and appreciating) the narratives of the lived experiences of those who identify as transgender.

Inadequacies with other theoretical approaches made clear that there was a need for a theory that supported both a fluid self-embodiment and a self-construction of gender identity. What was needed was a dynamic theory that sought to understand self-embodiment within the context of social expectations and an individual's lived experiences (Nagoshi & Brzuxy, 2010). Both Roen (2001) and Nagoshi and Brzuxy, (2010) highlight the importance of self-embodiment, self-identification beyond the confines of socially constructed identities. I have demonstrated how action research can facilitate, within nurse education, an understanding of transgender identity as the interaction of that which is embodied, that which is self-constructed, and that which is socially constructed.

Also critical to transgender theory is intersectionality. The term 'intersectionality' is accredited to the work of Crenshaw (1989), who discussed how the discrimination experienced by black women, was greater than the sum of the discrimination experienced by women and the discrimination experienced by black people. "It is a useful 'catchall' phrase that aims to make visible the multiple positioning that constitute everyday life and the power relations that are central to it" (Phoenix & Pattynama, 2006, p. 187). Intersectionality supports an understanding of how membership of multiple disadvantaged groups influences wellbeing. It questions how the experiences of occupying a particular social category are shaped by the other social categories that they simultaneously occupy. It moves beyond the assumption that there is an additive effect of the respective minority stresses associated with a person's social identities. The current study demonstrated the need to consider the compounding experiences of disadvantage.

Engaging with the lived experiences of transgender people is also key tenet of transgender theory (Roen, 2001; Nagoshi & Brzuxy, 2010)). It was a critical aspect of the current study. We pushed as a group to support the provision of opportunities, within our workshops and major class teaching session, for participants to gain a greater understanding of the lived realities of transgender people. The study found such engagement was impactful for participants.

More recently Breaux and Thyer (2021) stated that “The principles of transgender theory are relatively simple - you are who you say you are, you exist, you are not invisible, you should not be subjected to the emotional labour of educating others, and you are the expert on your own body and life’s experience.” (p. 74). While Nagoshi and Brzuxy, (2010) and Breaux and Thyer (2021) presented from a social work practice perspectives, their views align with the findings of the current study as it relates to nursing education and practice. That is:

- Self-embodiment and self-identification are important, ‘you are who you say you are’.
- Educating others is emotionally challenging, an ally/gender minority partnership model is needed
- Transgender people should be able to make decisions about the healthcare they need
- Experiential expertise (experts by experience) should be appropriately recognised

This study contributes to practical knowing through its discussion on how change was supported. It contributes to theory by drawing on and linking Transgender theory to nursing education and practice.

7.7 Recommendations

In alignment with this study’s method (Coghlan, 2019), the recommendations presented next, relate to three audiences. These audiences are: first person (the individual or main researcher); second person (the group); and third person (the wider organisation, researchers outside of the organisation and national bodies). Recommendations to these three voices or audiences are presented next.

At a first-person level, for others intending to undertake an AR project in their own organisation, the analysis and findings of our study led to a number of practical suggestions. Firstly, our study was undertaken at a time of social change concerning the visibility of the population group of concern. The increased social awareness of the disparities faced by transgender people supported engagement with the actions from

people in the wider organisation. It is recommended that action researchers seeking change within an organisation align their projects to social change movements. Secondly, for me, a personal commitment to regular, purposeful reflection using the learning cycles presented by Coghlan (2019) supported practical knowing at a first-person level. Action researchers should not underestimate the value of a structured reflection process.

Also, at a first-person level, prior networking, when undertaking a project related to a marginalised community group, is recommended. It supports a greater understanding, for the main researcher, of the issues faced by members of the community, alongside engagement of people who could support transformative action within the organisation of the study. It also helps build the trust of perspective group members. I suggest action researchers actively participate in relevant conferences, consultations with community organisations, community workshops, and internal research workshops prior to their study. The current study was based on a 'Research within your own organisation' model (Coghlan, 2019), however half of the group were from outside the organisation. More research is needed in understanding the impact of action researchers bringing community people into organisational models of AR.

At the second person, group level, I found that creating a communicative space, recognising experiential expertise, and drawing on a bottom-up top-down approach, supported transformative action. The current study found that establishing a communicative space was important. Many studies have discussed how a communicative space can be established, however more research is needed to better understand how indigenous practices can be drawn on to support communicative spaces so that all group members can be safely included and feel valued in all stages of the AR process. The current study needed both bottom-up and top-down to bring about a change in practice. It was the make-up of the group that enabled support at both levels. There is a need for more organisational AR studies that have attempted organisational transformation from a position of not having a prior executive leadership decision, and subsequent funding allocation for change.

At the third person level, within the context of tertiary nursing education, the current study found that an AR methodology enabled community members, as subject matter experts, to work alongside NEs in the co-design of new content. This was important because NEs in the group, and subsequently NEs in the wider organisation, admitted to not feeling confident about the development or delivery of such content. Engagement led to training opportunities and classroom support for nurse educators to assist them in their delivery of new content.

A recommendation of the current study is that nursing and other health related programmes adopt more learner centric pedagogies. Richards et al. (2020) suggest that nursing education in Aotearoa is based on learner-centric pedagogies. Learner centric pedagogies seek to meet the individual learning needs of students (Oermann et al., 2017). From my experience, nursing education in Aotearoa is based on teacher centric pedagogies. From this study, it is recommended that nursing education considers pedagogies that have a social justice intent, such as critical and transformative learning pedagogies. Such pedagogies would consider members of population groups that experience disparities in health or healthcare access as important subject matter experts and co-designers of content. Approaches that better enable members of population groups that experience disparities in health and healthcare access to define culturally safe care for them.

Throughout the current study I argued that if cultural safety, is care defined as safe by the recipients of the care, then for people from cultural groups that experience disparities in health, or healthcare access, we need to consider how they get to define safe care. This study contributes to academic work related to 'Cultural Safety' through related discussions that were weaved throughout the entire thesis. Bresnahan and Zhuang (2024) undertook a scoping literature review about culturally safe healthcare. Their study led to five themes. These themes and how they relate to the current study are presented next:

> Theme one suggests that provider communications with marginalised patients were less than optimal. They suggested that trusting communication was supported by providers who showed warmth, inclusiveness, and being responsive to patients' needs. Our study led to the development of a learning session specifically focussed on culturally safe communication for nurses when caring for transgender patients.
>
> Theme two advises that providers need to be aware of the history of racial inequity, institutional racism, and the deep causes of racial inequities. The current study links to this, it found that providers of care need to be made aware of the history of inequality with regards transgender health and the need for students to understand the impact of societal normalisation of binary genders and how this impacts on transgender people's wellbeing.
>
> Theme three relates to patient mistrust of providers of care. The current study affirms a deep mistrust for marginalised people to accessing healthcare. Transgender participants of the current study outlined how previous negative healthcare experiences led to a mistrust of healthcare provision.

Theme four states that there are issues for cultural minorities with regard the dominant biomedical model of health. From our study, I have come to understand that the biomedical model of health does not work well transgender people accessing healthcare. In particular, this study has helped me understand that the pathologising of genders that differ from binary norms and the need for psychiatric approval before gender affirming care can proceed, impedes on the process and negatively impacts on wellbeing.

Theme five focusses on patient care and provider alllyship. This theme highlights the importance of building allyship between patients and providers of care. Allyship was critical to the current study, actions were based on an allyship model.

In Aotearoa culturally safe care is care that is deemed safe by its recipients, however, NCNZ is not clear about how the recipients of care are able to define what safe care is for them. A recommendation from the current study is that NCNZ, and governing bodies of other health, wellbeing, or social qualifications, mandate content related to marginalised population groups is designed through a process of authentic engagement with people from that group.

7.8 Limitations of this study

The current study adopted an AR model within the main researcher's own organisation. It was located within one organisation, which was positioned within a unique community. While the knowledge gained from the process is useful to other tertiary providers seeking wider organisational change, with regard outcomes for a marginalised population group, it is acknowledged that an organisation, with different systems and processes and different management structures, using the same methods, may reach quite different findings. The community context also influenced our findings. The current study, for example, took place within a community that had 'Rainbow' support groups and a 'Rainbow' community health promoter. Involvement of people from these groups supported change. The generalisability of its findings is reduced as the current study was undertaken in one organisation within a unique community context.

The current study was also limited by its involvement of only five transgender community members, and two wider 'Rainbow' community members. These members were established advocates and presented their healthcare and personal experiences with confidence. However, transgender and 'Rainbow' communities are very diverse communities that encompass people from a broad range of personal experiences of accessing healthcare. The views of group members may not be representative of the

wider transgender or Rainbow communities and so may not be generalisable to nursing programmes in other institutions. Other nursing programmes seeking change with regards quality care for people who are transgender are advised to authentically engage with their respective transgender community.

The current AR study was not initiated from a management desire to instigate change in relation to organisational practice. As such, there was no funding for our project. Staff involved in the AR group were not given time release for the project, nor was there any funding to recompense community members for their time or, initially, to instigate the actions aimed at supporting wider organisational change. If we had more time as a group, and more funding for actions, we may have achieved more. Other studies that have focussed on organisational change, mostly discuss models of changed based on an established wider organisational/leadership team commitment to a particular change. The study by Doherty et al. (2022), for example, sought to implement “lasting change in health systems and experts working to advance health equity through organizational change” (p. 263). In their model of organisational change, four of the six factors needed were dependant on a prior organisational commitment to change. The current study was limited by it not being a study initiated out of management decision for a particular change.

This study was also limited by me, the researcher, not being transgender, or even a member of the Rainbow community (other than being an ally). I do not know what it is like to be a gender that differs from the sex assigned to me at birth and how this might impact on day-to-day living and healthcare experiences. I have not experienced the ongoing minority stress that is felt by transgender, gender non-binary people or sexual minority people. This limitation, however, enabled this study to provide useful guidance about being an effective and authentic ally. Allyship, during the current study, at a group level and personal level is discussed next.

Examples of group allyship that were demonstrated throughout our study included: our collective genuine interest in the lived experiences, and being empathetic when made aware, of the gender norm related negative experiences of the transgender people in the group, alongside our workplace actions to support wider organisational change. Fletcher and Marvell (2023) supported these suggestions, based on their study that looked into allyship in regard to enhancing workplace inclusion for transgender people. From their study they concluded that, for them, three areas of allyship within the workplace needed to be studied more. These are “understanding perspectives of different stakeholders, examine both individual and contextual factors together, focus

on the lived experience of minoritised groups" (p. 1750). Our study might contribute to knowledge in these areas.

Based on personal reflections, during the current study, I came to understand that at an individual level, allies are involved with the work of support organisations, are activists for change, are passionately mindful of correct pronouns, and are there to support their transgender friends during difficult times. Gender minorities Aotearoa (n.d.) support both my individual understandings and actions related to the group level/workplace allyship discussed in the previous paragraph. In addition, in relation to being a friend or co-worker, Gender Minorities Aotearoa, also suggest allies challenge biological essentialism, and examine own biases. These were actions that were critical to the current study. Our study aligns well with Fletcher and Marvell (2023) and Gender Minorities (n.d.) models of allyship. It is suggested here that our knowledge gains related to allyship in a workplace, AR, or individual level, that also align with literature, supports study related to transgender wellbeing.

7.9 Conclusion

The study discussed in this thesis sought to understand how community engagement might influence an existing nursing education programme with regards the provision of quality care for transgender people. Its rationale was based on my preliminary research and community discussions where I learnt that transgender people experience significant disparities in health and barriers to healthcare access. This drove my desire for action in this space. The study used a methodology underpinned by a philosophy of 'practical knowing' and a social constructionist world view. As discussed in chapter one, in Aotearoa there appears to be a fundamental mismatch between the construct that culturally safe care is defined by the recipients of care and what happens in practice. The study used an approach that demonstrated how authentic engagement can lead to a reconstruction of how nursing education could be designed and delivered to enable transgender community members to define safe care for them. Engagement also led to transformation beyond the nursing programme to the wider organisation.

The study found that because our AR initial purpose did not specifically align to the study's organisation's strategic plan and was not a project of focus for the organisation, there were barriers to action. For example, internal group members were not given a time allowance for their involvement in the study, and we struggled to get funding for actions. However, the study was undertaken at a time of increased visibility of transgender/gender non-binary identities which supported transformative action. Establishing a communicative space, valuing transgender community members as

experts, and having a particular mix of influential people in the group that could bring about action or gain policy and financial support at a management level were critical factors that drove wider organisational change.

The knowledge gained from the study is transferable to other nursing education programmes, or other healthcare or social services programmes who are considering educating about cultural safety for a particular marginalised group. It is also transferable to other tertiary education providers seeking to be more inclusive for people from minority population groups. It is acknowledged, however, that this study's findings are limited by the fact that it involved people from one organisation and externally engaged with people from one geographical community. The study recommends that nursing programmes position members of population groups who experience disparities in health or healthcare access as important stakeholders and that they authentically involve them in determining content design and its delivery. It also recommends wider organisational actions are needed to support their enrolment and successful completion of nursing qualifications. From a practical knowing perspective, more research into how to establish a communicative space within a particular cultural context is needed. Additionally, it is suggested that there is a need for more research into better understanding how AR supports an organisation's sense of social responsibility, and active allyship, how this links to a growing social awareness of a need for change, and the subsequent support of action aimed at addressing social inequities.

In summary, engagement with the community enabled those that could influence change in the nursing programme to gain a greater understanding of the lived experiences of transgender people. This drove action at a nursing programme level and led to a partnering with the community to design and deliver trans-affirming nursing education. Engagement also supported critical consciousness that led to actions that rippled out beyond the nursing programme to organisational change. Wider organisational change was supported by the organisation's leadership team, likely influenced by staff and students of the organisation and their enthusiastic participation in actions, and some members of the group having connections to this leadership team.

The main researcher admitted that she was new to both AR and transgender people's research and has been open, in the current study, about her journey of understanding in both of these areas. From a practical knowing perspective, this study found that change within your own organisation, when seeking action that supports equity for a

particular minority population group, is supported by an AR approach underpinned by a social constructionist epistemology.

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Appendices

Appendix 1 AUT Ethics Committee Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

5 November 2019

Katie Palmer du Preez
Faculty of Health and Environmental Sciences

Dear Katie

Re Ethics Application: **19/366 Enhancing nurse education to support the provision of quality of care for gender diverse people**

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

Your ethics application has been approved in stages for three years until 29 October 2022.

This approval is for the initial Action Group stage of the study. No participants may be recruited, and no data collected for the interviews, focus groups, action implementation and evaluation stages of the study before full information about each stage has been submitted to and approved by AUTEC

Standard Conditions of Approval

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

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

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

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

Yours sincerely,

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

Cc: t.morison@xtra.co.nz; Diana Austin; Stephen Neville

Appendix 2 Health and Disability Ethics Committee

Health and Disability Ethics Committees

Health and Disability Ethics Committees
Ministry of Health
133 Molesworth Street
PO Box 5013
Wellington
6011
0800 4 ETHICS
hdecs@moh.govt.nz

15 May 2019

Ms Trish Morison
Auckland Institute of Technology
t.morison@ucol.ac.nz

Dear Ms Morison,

Study title:	How can nurse education support the provision of quality care for gender diverse patients

Thank you for emailing HDEC a completed scope of review form on 14 May 2019. The Secretariat has assessed the information provided in your form and supporting documents against the Standard Operating Procedures.

Your study will not require submission to HDEC as, on the basis of the information you have submitted, it does not appear to be within the scope of HDEC review. This scope is described in section three of the Standard Operating Procedures for Health and Disability Ethics Committees.

An observational study requires HDEC review only if the study involves more than minimal risk (that is, potential participants could reasonably be expected to regard the probability and magnitude of possible harms resulting from their participation in the study to be greater than those encountered in those aspects of their everyday life that relate to the study).

For the avoidance of doubt, an observational study always involves more than minimal risk if it involves one or more of the following:

- one or more participants who will not have given informed consent to participate, or
- one or more participants who are vulnerable (that is, who have restricted capability to make independent decisions about their participation in the study), or
- standard treatment being withheld from one or more participants, or
- the storage, preservation or use of human tissue without consent, or
- the disclosure of health information without authorisation.

If you consider that our advice on your project being out of scope is incorrect please contact us as soon as possible giving reasons for this.

This letter does not constitute ethical approval or endorsement for the activity described in your application, but may be used as evidence that HDEC review is not required for it.

Please note, your locality may have additional ethical review policies, please check with your locality. If your study involves a DHB, you must contact the DHB's research office before you begin. If your study involves a university or polytechnic, you must contact its institutional ethics committee before you begin.

Please don't hesitate to contact us for further information.

Yours sincerely,

Joel Tyrie
Assistant Advisor
Health and Disability Ethics Committees
hdecs@moh.govt.nz

Appendix 3 Universal College of Learning Approval

13 September 2019

Trish Morison
Health and Science
UCOL Wairarapa Campus

Dear Trish,

RE: Enhancing nurse education to support the provision of quality care for gender diverse people.

The UCOL Research and Ethics Sub-committee have completed their review of your research application, including your request to both recruit subjects through UCOL and undertake this research at UCOL. I have the pleasure to Inform you the above project has been approved, subject to receiving ethical approval from Auckland University of Technology {AUT).

We wish you all the best for your project, and if you have any questions please do not hesitate to contact me.

Yours sincerely,

Dean Rankin
Chair- Research and Knowledge Transfer Committee
UCOL

Appendix 4 AUT Ethics Committee Amendments Approval

Auckland University of Technology Ethics Committee (AUTEC)

Auckland University of Technology
D-88, Private Bag 92006, Auckland 1142, NZ
T: +64 9 921 9999 ext. 8316
E: ethics@aut.ac.nz
www.aut.ac.nz/researchethics

15 April 2020

Katie Palmer du Preez
Faculty of Health and Environmental Sciences

Dear Katie

Re: Ethics Application: **19/366 Enhancing nurse education to support the provision of quality of care for gender diverse people**

Thank you for your request for approval of amendments to your ethics application.

The amendment to the data collection protocol (online platform) is approved.

Non-Standard Conditions of Approval

1. Update the Executive Secretary to Dr Carina Meares

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

I remind you of the **Standard Conditions of Approval**.

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

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

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

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

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

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: t.morison@ucol.ac.nz; diana.austin@vuw.ac.nz; Stephen Neville

Appendix 5 AUT Ethics Committee Amendment Approval 2

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

9 July 2021

Katie Palmer du Preez
Faculty of Health and Environmental Sciences

Dear Katie

Re: Ethics Application: **19/366 Enhancing nurse education to support the provision of quality of care for gender diverse people**

Thank you for submitting your responses to the conditions for the amendment to your ethics application.

The amendment to the data collection protocol has been approved.

I remind you of the **Standard Conditions of Approval**.

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

AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted. When the research is undertaken outside New Zealand, you need to meet all ethical, legal, and locality obligations or requirements for those jurisdictions.

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

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

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

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: t.morison@ucol.ac.nz; diana.austin@vuw.ac.nz; Stephen Neville

Appendix 6 UCOL Approval to Conduct Survey

UCOL
Te Pae Mātauranga ki te Ao
Universal College of Learning

26 May 2021

Trish Morison
Nurse Education Team
UCOL Wairarapa Campus

Dear Trish,

RE: "'Enhancing nurse education to support the provision of quality care for gender diverse people.'

I have the pleasure to inform you that our Research and Knowledge Transfer Committee has approved your request to survey UCOL staff for your above project subject to gaining ethical approval from AUT and considering the below feedback from the committee:

- Intellectual property should be held by both UCOL and AUT if the project will be carried out during UCOL time. Please refer to the updated UCOL Intellectual Property Policy which discusses a formal contract between the two organisations.
- The definitive responses on the questions make them closed. Could a different method be used to gain qualitative insights?

We wish you all the best for your project, and if you have any questions please do not hesitate to contact me anytime.

Yours sincerely,

Dean Rankin
Chair- Research & Knowledge Transfer Committee

Appendix 7 Invitation to Participate Email

Email to staff:
Kia ora koutou

I am part of an action research project that consists of 6 UCOL staff and 6 community members. The aim of this project is to investigate how engaging with the community might support enhancement of an existing nurse education programme with regards the provision of quality care for transgender people.

You have been sent this request to participate in a brief survey, because you may have been impacted by changes within the organisation that were triggered by the project. The survey asks about the influence of the changes on your awareness of the issues for gender minorities, examples where you have applied this new knowledge, and how the particular resource you accessed could be improved.

Before participating in this survey you will be asked to agree that you have read and understood the information sheet and agree to the conditions of the consent form. These documents are attached to this email. All responses will be anonymous. Your thoughts would be very much appreciated.
Please click on one or more of the links to surveys below.
Changes that you may have been impacted by are:

- Delivering new content to students that focused on the provision of quality care for transgender people. (survey one link)
- Attending a "Gender and Sexual Minorities @ Work" workshop. (survey two link)
- Accessing the Moodle site of resources related to Gender and Sexual Minorities (survey three link)

Appendix 8 Participant Information Sheet

Participant Information Sheet

This information sheet is intended for staff at the Universal College of Learning (UCOL) who have accessed resources related to the action research project: Enhancing Nurse Education to support the provision of quality care for transgender people.

Date Information Sheet Produced:

25th June 2021

Project Title

Enhancing Nurse Education to support the provision of quality care for transgender people

An Invitation

My name is Trish Morison. I am a nursing lecturer at UCOL. This is an invitation to participate in a survey about the impact of changes that have occurred at UCOL in relation to above project. This research project will contribute towards a Doctorate of Health Science qualification. This survey is voluntary and you will not be advantaged nor disadvantaged by participating or not participating.

What is the purpose of this research?

The purpose of the initial research project was to investigate how engagement with the community could influence an existing nurse education programme (or the context in which it is located) with regards supporting nurses in their future provision of care for transgender people. This aspect of the research project will seek to evaluate the impact of changes, within papers or the wider organisation that were triggered by the action research project. The findings of the entire project may be used for academic publications and/or presentations.

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

You have been identified and invited to participate in this phase of the research as you are part of the nursing education programme or a member of a team that supports this programme that may have been impacted by changes triggered by the action research project. All staff who accessed a resource developed by group members have been invited to participate in part of the study.

How do I agree to participate in this research?

A consent form is attached to the email you have been sent. Your responding to the survey indicates you have read this information sheet and the consent form and you consent to participate. 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, however, as the survey will be anonymous, the removal of your data may not be possible.

What will happen in this research?

Your participation in this part of the project involves responding to a survey. Your responses will be anonymous. All responses will be collated and thematically analysed (themes will be developed to tell a story of the data). Quotes from respondents may be used to illustrate themes but any potentially identifying information would be removed beforehand. The findings, including respondents' quotes, may be included in my research thesis, a publication or a conference presentation.

What are the discomforts and risks?

I anticipate the survey will take about 15 minutes to complete. It may be that you decide to do a longer than expected response to a question, or you take more time than anticipated to respond to a particular question. As such, the survey may take more than 15 minutes of your time. You will be able to skip any questions that you don't feel comfortable answering and continue with the survey.

How will these discomforts and risks be alleviated?

You do not need to answer all the questions, indeed you might start the survey and decide you do not want answer any questions. This will be fine, you will be able to click 'submit' and whatever you have answered, if anything, will

be submitted. If you need time to think about a particular question you will be able to submit the questions answered already and repeat the survey at a later date and answer any further questions.

What are the benefits?

Your responses will support existing or future actions in relation to inclusiveness for gender and sexual minorities at UCOL or in relation to transgender healthcare. As this research will assist me in gaining a Doctorate of Health Science it may benefit UCOL through the advancement of a staff member's qualifications. If the findings are published or used in a conference presentation it may benefit UCOL through contributing to research outputs.

How will my privacy be protected?

The survey will be anonymous, that is, I will not know who has responded. As such, no findings or quotes could be attributed to a person. It is possible, however, that a person may be identifiable by a particular comment made. Comments that I believe might enable a respondent to be identified will not be included in the data that will be analysed or included in the findings.

What are the costs of participating in this research?

I believe the survey will take about 15 minutes to complete.

What opportunity do I have to consider this invitation?

The survey will be available for one month from when you received this invitation. You will be send another request to participate two weeks before the survey closes.

Will I receive feedback on the results of this research?

A summary of the findings, with any identifying information removed, will be available on the Moodle site established for this project. The URL for this site is https://moodle.ucol.ac.nz/course/view.php?id=43435 and the enrolment key is 'purple'.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Stephen Neville; email: Stephen.neville@aut.ac.nz; phone 021995689

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

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Trish Morison, email; t.morison@ucol.ac.nz; phone: 06 952 7001 ext. 72031

Project Supervisor Contact Details:

Stephen Neville; email: Stephen.neville@aut.ac.nz; phone 021995689

Approved by the Auckland University of Technology Ethics Committee on *type the date final ethics approval was granted*, AUTEC Reference number *type the reference number*.

Appendix 9 Consent Form – Action Group

Consent Form – Action Group

Project title: ***Enhancing nurse education to support the provision of quality care for gender diverse people***

Project Supervisor: ***Katie Palmer Du Preez***

Researcher: ***Trish Morison***

- ○ I have read and understood the information provided about this research project in the Information Sheet dated 21st July 2019.
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our discussions in the action group is confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the action group meetings and will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the action group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ I agree to take part in this research.
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature : .....

Participant's name: .....

Participant's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

Note: The Participant should retain a copy

Appendix 10 Confidentiality Agreement

Confidentiality Agreement

Action group participants

Project title: *Enhancing nurse education to support the provision of quality care for gender diverse people*

Project Supervisor: ***Katie Palmer Du Preez***

Researcher: ***Trish Morison***

- I understand that all the material I will be asked to review from action group meetings is confidential.
- I understand that the contents of the Consent Forms, tapes, or interview notes can only be discussed with the researchers.
- I will not keep any copies of the information nor allow third parties access to them.

Signature : .....

Name : .....

Approved by the Auckland University of Technology Ethics Committee on the 5th November 2019; AUTEC Reference number 19/366

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

Appendix 11 Consent Form - Survey Participants

Consent Form

Project title: **Enhancing Nurse Education to support the provision of quality care for transgender people**

Project Supervisor: **Stephen Neville**

Researcher: **Trish Morison**

- I have read and understood the information provided about this research project in the Information Sheet dated 25th June 2021
- I understand that responses to the survey may be used in a thesis, publication or conference presentation
- I understand that taking part in this study is voluntary (my choice)
- I understand that, as the survey is anonymous, if I choose to withdraw from the study it will not be possible to remove my data from the findings
- I agree to take part in this research.
- I have been advised as to where I will be able to access a summary of the findings

***Approved by the Auckland University of Technology Ethics Committee on** type the date on which the final approval was granted **AUTEC Reference number** type the AUTEC reference number*

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

Appendix 12 Confidentiality Agreement – Transcriber

[redacted] **Confidentiality Agreement (transcriber)**

Project title: ***Enhancing nurse education to support the provision of quality care for gender diverse people***

Project Supervisor: ***Katie Palmer Du Preez***

Researcher: ***Trish Morison***

- O I understand that all the material I will be asked to transcribe is confidential.
- O I understand that the contents of the tapes or recordings can only be discussed with the researchers.
- O I will not keep any copies of the transcripts nor allow third parties access to them.

Transcriber's signature: .....

Transcriber's name: .....

Transcriber's Contact Details (if appropriate):

.....

.....

.....

.....

Date:

Approved by the Auckland University of Technology Ethics Committee on type the date on which the final approval was granted AUTEC Reference number type the AUTEC reference number

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

Appendix 13 Evaluation Questions

Evaluation surveys were undertaken using Qualtrics

Consent to participate was required before the participant could access the survey

Survey One:

Delivering new content to students that focused on the provision of quality care for transgender people.

1. How (if at all) did delivering this session *enhance your knowledge* of transgender people or the provision of care for transgender people?
2. How did delivering this session *influence or change your views* about transgender people or the provision of care for transgender people?
3. How have you applied a new understanding of this topic at work or in your social life?
4. What examples (if any) do you have of how this session enhanced student competences or influenced their views with regards their future provision of care for transgender people?
5. What suggestions do you have as to how the structure, content, or activities of the session you delivered might be improved to increase student engagement or understanding?
6. What ideas do you have for other actions that might support health students in their future provision of care for transgender people?

Survey Two

Attending a "Gender and Sexual Minorities @ Work" workshop

1. How (if at all) did attending this workshop *enhance your knowledge* of gender and sexual minorities?
2. How did atttending this workshop *influence or change your views* of gender and sexual minorities?
3. What examples do you have of where you have applied a new understanding of this topic at work or in your social life?
4. What suggestions do you have as to how the structure, content, or activities of the workshop might be improved to increase staff engagement or understanding of this topic?
5. What ideas do you have for actions that might support inclusiveness at UCOL for 'rainbow' staff or students?

Survey Three

Accessing the Moodle site of resources related to Gender and Sexual Minorities

1. How (if at all) did the resources on the Moodle site *enhance your knowledge* of gender and sexual minorities?
2. How did the resources on the Moodle site *influence or change your views* of gender and sexual minorities?

3. What examples do you have of where you have applied a new understanding of this topic at work or in your social life?
4. What suggestions do you have as to how the structure, content, or activities might be improved to increase staff engagement or understanding of this topic?
5. What ideas do you have for actions that might support inclusiveness at UCOL for ‘rainbow’ staff or students?

Appendix 14 Collation of Codes After Group Suggested Amendments

Constructing and planning	Taking (added) Action	Evaluation
AR process • Different constructions presented • Encouraging group member reflection • Engagement led to an increased understanding. • Engagement led to enthusiasm for change • Group member safety considered • Group members determine content and actions • Misunderstandings quickly resolved? • Needing to drive change • TG group members experts in their field • Importance of community engagement • Intention is everything • ~~NE enthusiasm for change~~ (repeated)	**Action research process** • Actions not actioned • Affirming the need for action • Drawing on group member expertise • Group members determine content and actions • High expectations of group (empowered by process added) • Learning from others • Misunderstandings in group • Quiet activist • Sharing the load or building capacity • Using technology • Valuing community input	**Action Research Process** • Action research can present ethical challenges • Engagement drives change • Members construct content • Seeking group members perspectives • Researcher seeks clarification • Valuing groups feedback and reflections • Members gain from participation • Knowledge for others socially constructed • Researcher acknowledges their own lack of process

Constructing and planning	Taking (added) Action	Evaluation
Binary normativity, particularly in health, constructed as unsafe • GPs constructed as ill prepared for transgender • Lack of access to GA care • Systems and processes do not meet the needs of TG	**Binary normativity particularly in health constructed as unsafe** • HC providers may make incorrect assumptions • Lack of access to GA care	**Binary normativity particularly in health, constructed as unsafe** • Discrimination in healthcare settings • Expectation of unsafe care • Barriers to access to GA therapy • Challenging transphobia
Cultural safety • Encouraging student nurse reflection • Nurses as advocates • Nursing education is a social construction	**Cultural safety** • Educating about intersex (in catheterisation session) • Self-determination or identification • The importance of sensitivity	**Cultural safety** • Challenging student's gender binary normativity Content support students • social construction of knowledge • Enabling nurses as advocates • Nursing competencies
Impact of binary normativity on mental health • Gender minority status intersects with other minority identities • Minority stress and mental health • Misgendering significantly impacts on well being	**Education is a social construction** • Challenging the system or facing barriers • Educators need educating • Organisational stated values differ from practice • Organisational willingness to change	**Education is a social construction** • Change is not without challenges • Maintaining the momentum of change • Need to ensure actions are maintained • Finding ways to make to changes sustainable Reality contradicts policy • Ripple out effect • Celebrating Pride

Constructing and planning	Taking (added) Action	Evaluation
• Educating others constructed as challenging • Resilience of our TG folk	• Top down/bottom up needed (moved to here)	
	Impact of binary normativity on MH • Minority stress • Lower socio economic related to GD status Educating others constructed as challenging	**Impact of binary normativity** Educating others constructed as challenging
Making sense of terminology and pronouns • Gender vs sexuality • The importance of correct pronouns and names	**Making sense of terminology and pronouns** • Gender diverse as an identity • Gender identity vs. sex • Takatāpui	**Making sense of terminology and pronouns** • Terminology confusing for some
Not just a one off! • Change needed beyond the programme • Institutional support needed to reconstruct norms • International students ~~need educating~~	**Not just a one off** • From programme to organisation • International students need educating • ~~Needing a top down and a bottom up~~ (moved down) • Rainbow as well as GD	**Not just a one off session** • Educators may need upskilling and support • It is more than nursing students • Value of including transgender people in sessions realised

Constructing and planning	Taking (added) Action	Evaluation
• Nurse educators (add may here) need educating and support		
Society reconstructing gender norms • Growing awareness within some DHBs (How do we preserve this?)	**Society reconstructing gender norms**	**Gender as a social construction** • Ludicrous gender binary normativity • Perceptions of identities are socially constructed
		Evaluating the impact • Actions were impactful • Difficult to determine a shift in attitudes or confidence • Concern of biased responses • They don't know what they don't know (relates to self-reported confidence about knowledge and skills) • Social desirability bias • Staff report increased knowledge and empathy

Key to table: **** amended by group; ⟷ group suggested merging; **** highlighted as important by the group

Appendix 15 Pride Day Posters