Planting seeds for reflection:

Utilising design thinking methods for learning about equity

Attestation of authorship

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

이예은 Phoebe Lee

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Ngā mihi

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- 사랑하는 우리 엄마 아빠, 정말 감사합니다. 나를 키워줘서, 나를 사랑해줘서. 엄마 아빠, 자랑스럽게 하고 싶어요! ♡

Kuputaka

An effort was made to weave te reo Māori within this exegesis. As with all languages, words do not have singular meaning, and there can be no direct translation from one to another. There may be different meanings depending on the context and circumstance. In te reo Māori, kupu have mana and whakapapa, and Māori worldview is expressed throughout the language. I have included this glossary with some definitions, but this list is non-exhaustive, and further knowledge-seeking is encouraged.

Aotearoa: is a generally accepted term for New Zealand but, depending on the context, can mean specifically New Zealand through a Māori lens

Aroha: compassion, love, kindness

Awhi: to surround, embrace,

Āwhina: to support, uplift

Hapū: subtribe, kinship group, clan, part of a larger group, also: pregnant, expectant, with a child conceived in the womb

Hauora: to be fit, well, healthy, vigorous, in good spirits, health

He Whakaputanga o te Rangatiratanga o Niu Tīreni: The Declaration of Sovereignty of New Zealand

Hui: meeting, gathering, assembly, seminar, conference, to congregate

Iwi: extended kinship group, tribe, often associated with a distinct area and descendants of a common ancestor

Kaiako: teacher, instructor

Karakia: secular recital of incantation, chant, or words to begin an activity

Kaupapa: topic, matter for discussion, plan, purpose, agenda, subject, theme, issue, initiative

Kāwanatanga: governance

Koha: gift, donation, reciprocity

Kōwhiringa: option(s)

Kūmara: sweet potato, Ipomoea batatas

Kupu: word

Kuputaka: glossary

Māhaki: to be inoffensive, humble, modest, unassuming
Mahi: to do, work
Mana: prestige, power, authority, ability
Mana motuhake: autonomy, independence, authority, agency, sovereignty, self-determination
Mana taurite: equity
Māori: an indigenous person of Aotearoa
Motu: land
Ngā hau e whā: the four winds, 1. colonisation, 2. racism, 3. migration, and 4. marginalisation
Ngā mihi: acknowledgements, thank you
Niu Tīreni: transliteration of New Zealand
Ō Tautahi: placename of Christchurch
Pākehā: New Zealander of European descent, a foreigner, originating from a foreign place
Papatūānuku: earth, earth mother, wife of Rangi-nui – they are the parents of all living things
Patuitanga: partnership
Pono: honesty, truth
Rangatira: chief, noble, esteemed, to be/become of high rank, revered, leader
Ratonga hauora: services that provide support for patients and whānau within the health context
Reo Māori: Māori language
Taha hinengaro: mental
Taha tinana: physical
Taha wairua: spiritual
Taha whānau: familial
Taiao: the physical, natural environment and world
Taku: my, possessive pronoun used when referring to a single thing, this is the neutral form

Tāmaki Makaurau: placename of Auckland

Tamariki: children

Tangata Tiriti: citizens of Aotearoa by virtue of te Tiriti o Waitangi

Tangata whenua: people of the land, Māori peoples

Taonga: precious, treasure

Tau: at peace

Tauiwi: non-Māori, a person from afar, foreigner, outsider

Tauiwitanga: a colloquial term, tanga is used as a suffix to describe the qualities of the base noun, tauiwi

Tautoko: to support, prop up, verify, advocate, agree

Te ao: the world, life, realm, context

Te reo: the language, voice, sound

Te reo Māori: the Māori language

Te Tiriti o Waitangi: this name is used interchangeably with the Treaty of Waitangi, but it is essential to distinguish between te Tiriti o Waitangi as the Māori version of this text and the Treaty of Waitangi as the English version, which is different in parts between the two documents

Te Whanganui a Tara: placename of Wellington

Tika: to be correct, genuine, right, just, fair, valid, lawful, accurate, proper, appropriate, direct

Tino rangatiratanga: self-determination, self-governance

Tōku: my, mine, I have, I own, referring to a single thing

Waka hourua: double-hulled canoe

Wānanga: to meet and discuss, deliberate, consider, educational seminar, a place of higher learning

Whakamarumarutia: actively protect

Whakapapa: genealogy, lineage, descent

Whakataukī: proverb, significant saying of unknown origin

Whakawhanaungatanga: relationship-building process, positively relating to others, creating connections

Whānau: family, family group, to be born, give birth, modern usage as a familial term for members who may not be blood-related, to address a group of people

Wharenui: a traditional meeting house

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1 Abstract

This design research endeavoured to challenge persistent negative narratives about Māori health inequity. I acknowledged the limitations of the scope for this research. It aspired to be one of many seeds planted towards imagining and transforming an equitable healthcare system.

I utilised design frameworks such as human-centred and participatory design to evaluate their effectiveness in enhancing reflection on the meaning of health equity. This investigation engaged keen members of a quality improvement and innovation unit situated within a large public hospital. To assist this organisation with recognising their responsibility and capability for honouring te Tiriti o Waitangi. Therefore, it was essential to collaborate with Māori to maintain an authentic and reciprocal partnership.

This research tested the effectiveness of using design methods for learning about the meaning of equity. The findings from this study revealed that personal action and transformation were more significant than using design methods to enhance reflection with others. Furthermore, the research journey affirmed my positioning and confidence in myself as a tangata Tiriti.

2 Introduction

On the 21st of April 2021, Health Minister Andrew Little announced a significant reform to the public health system of Aotearoa. A singular national health organisation, Health New Zealand, would replace all twenty District Health Boards in conjunction with establishing a Māori Health Authority.[1] This announcement met a polarised reaction, including tautoko from the New Zealand Medical Association[2] and the Human Rights Commission[3] and aspersion from then National Party leader Judith Collins. She labelled the move separatist and called for further debate on this change.[4] Critical discourse should be encouraged among citizens of Aotearoa. But how might we navigate these conversations in a culturally safe manner?

On the 6th of February 1840, representatives from the British Crown and Māori rangatira signed te Tiriti o Waitangi[5] (also referred to as te Tiriti). This document is often regarded as our founding national constitution. Yet, there remains contention over the Māori and English texts.[6] The cause for which include enormous and ongoing breaches to te Tiriti.[7] Namely, the consequence of inequity between Māori and Pākehā.[8] Even the continual responses to Covid-19 are another example of Crown imposition on Māori governance.[9]

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[1] Andrew Little, Peeni Henare and Ayesha Verrall, "Major reforms will make healthcare accessible for all NZers," Beehive, April 21, 2021, https://www.beehive.govt.nz/release/major-reforms-will-make-healthcare-accessible-all-nzers.
[2] Madeleine Boles de Boer and Liz Brown, "Doctors Back A Fully Empowered Māori Health Authority," New Zealand Medical Association, accessed May 29, 2021, https://www.nzma.org.nz/media-releases/doctors-back-a-fully-empowered-maori-health-authority.
[3] New Zealand Human Rights Commission, "Māori Health Authority welcomed by Human Rights Commission," April 21, 2021, https://www.hrc.co.nz/news/maori-health-authority-welcomed-human-rights-commission/.
[4] One News, "'It cannot be separate' - Collins says Māori health inequities can be solved without dedicated authority," April 21, 2021, https://www.tvnz.co.nz/one-news/new-zealand/cannot-separate-collins-says-m-ori-health-inequities-can-solved-without-dedicated-authority.
[5] Mathew Palmer, *The Treaty of Waitangi in New Zealand Law and Constitution* (Wellington: Victoria University Press, 2008), 54.
[6] Claudia Orange, *The Treaty of Waitangi* (Wellington: Bridget Williams Books, 2015), 92.
[7] Veronica Tawhai and Katarina Gray-Sharp. *Always Speaking: The Treaty of Waitangi and Public Policy* (Wellington, Huia, 2011), 208.
[8] Andrew Coleman, Sylvia Dixon, and David Maré. *Māori economic development – Glimpses from statistical sources* (Wellington: Motu Economic and Public Policy Research Trust, 2005), http://motu-www.motu.org.nz/wpapers/05_13.pdf.
[9] Moana Jackson, "Moana Jackson: Covid and the pandemic of colonisation," *E-Tangata*, December 12, 2021, https://e-tangata.co.nz/coment-and-analysis/moana-jackson-covid-and-the-pandemic-of-colonisation/.

Equity formed the cornerstone of this design research kaupapa. Health inequity is inextricably bound to the legacy of colonisation.[10] Such historical, deeply embedded determinants of health require varied approaches to dismantle and transform these unfair systems. Through existing relationships within the health system, an opportunity to implement design methods to galvanise health practitioners' commitment to achieving health equity arose. This design research was just one initiative of a large public hospital's quality improvement and innovation unit to meet their responsibility to te Tiriti o Waitangi.

[10] Fiona Cram, et al., *Oranga and Māori health inequities, 1769-1992* (Wellington: New Zealand Ministry of Justice, 2019), accessed 29 May, 2021. https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152096130/Wai%202575%2C%20B025.pdf.

2.1 Position statement

Te Tiriti o Waitangi is an integral constitution to the formation of this nation. Fundamental to this contract is the agreement that those who wish to call Aotearoa their home must be in partnership with tangata whenua. As tangata Tiriti, it is our responsibility to honour te Tiriti in congruity with our entrance onto this motu.[11]

My journey to pursue research into racial health equity initially emerged as a pathway to reconcile with my experience as a Korean person living in Aotearoa.[12] I have since learned that anti-Asian racism moreover racial justice cannot be achieved without tino rangatiratanga.[13]

I spent close to a decade in my healthcare career before pursuing design. Since embarking on this new adventure, my worldview has exploded in ways I had never imagined were possible. Through my design studies (and *not* my healthcare education), I have sharply discerned this nation's history. I am grateful to be able to bring my previous healthcare experience and newfound design knowledge to this research.

Throughout my learning journey, I have grappled with my position and intention. I feel frequently overwhelmed by the entrenchment of injustice, rendering myself desolate and despairing. Paradoxically, the privilege of having this consciousness compels me to continue. A personal goal in undertaking this research has been navigating how to manage this commitment to a responsible learning journey in a thriving yet sustainable manner.

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[11] Tina Ngata, "What's required from Tangata Tiriti," Tina Ngata: Dismantling Frameworks of Domination, Rematriating Ways of Being (blog), December 20, 2020, https://tinangata.com/2020/12/20/whats-required-from-tangata-tiriti/.
[12] Anisha Sankar, "Whanaungatanga: Tauiwi learners of te reo Māori," *RNZ*, September 13, 2017, https://www.rnz.co.nz/news/the-wireless/374856/whanaungatanga-tauiwi-learners-of-te-reo-maori.
[13] Asians Supporting Tino Rangatiratanga (@asians4tinorangatiratanga), "ASTR statement on Anti-Asian Racism In solidarity with the victims of the Atlanta shooting," Instagram carousel, March 28, 2021, https://www.instagram.com/p/CM8Jmg-sEuR/.

“..racial justice cannot
be achieved without
tino rangatiratanga.”

3 Research question

Throughout this study, the research question was constantly evolving. These changes were reflective of the continual learning undertaken on this journey. They also demonstrate the iterative nature of this design research approach. Changes will be signalled within the exegesis (in the Documentation chapter) to explain the influences that led to learning and how thinking was transformed.

How might design methods be applied to enhance **reflection**, with members of a quality improvement and innovation unit, at a large public hospital on the meaning of **equity**, as practitioners, colleagues, and **tangata Tiriti?**

4 Contextual review

4.1 Addressing inequity in Aotearoa

This design research is primarily focused on ethnic health inequity. But it is imperative that we unpack the historical causes of inequity before we can begin to comprehend an equitable healthcare system or nation. "This is not us" is a rhetorical statement overheard in Aotearoa. This sentiment stems from the 2019 Ō Tautahi terrorist attack,[14] an act of seemingly[15] unprecedented violence. However, tragedy and terrorism are not new here.

Polynesians first inhabited this land in the 14th century and formed a distinct Māori culture.[16] They voyaged an incredible distance across Oceania. Traversed over the two islands, formed different iwi and hapū, and were prospering.[17] Several centuries later, in 1769 James Cook claimed the 'discovery' of New Zealand for the British Empire. Following this, throughout the early 19th century, Pākehā migration steadily increased.[18] Tensions arose due to the behaviour of lawless British subjects, and a document was called for to maintain control of its citizens. He Whakaputanga o te Rangatiratanga o Niu Tīreni was the first such document, signed in 1835.[19] Often referred to as He Whakaputanga, meaning an emergence. It was signed by representatives of the British Crown and Northern rangatira, and declared Niu Tīreni, a sovereign land and independent state.[20]

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[14] Waikaremoana Waitoki, "This is not us": But actually, it is. Talking about when to raise the issue of colonisation," *New Zealand Journal of Psychology* 48, 1 (2019): 140-145, https://hdl.handle.net/10289/12680.
[15] RNZ, "Alice Snedden's Bad News #8 Treaty Partnership," September 2, 2020, video, 10:57, https://youtu.be/-0TMZmdpXME.
[16] Ross Clark, "Moriori and Māori: the linguistic evidence," in *The Origins of the First New Zealanders*, ed. Douglas G. Sutton (Auckland: Auckland University Press), 123-135.
[17] Janet M. Wilmshurst et al., "High-precision radiocarbon dating shows recent and rapid initial human colonization of East Polynesia," *Proceedings of the National Academy of Sciences of the United States of America* 108, no. 5 (2011): 1815-1820, doi: 10.1073/pnas.1015876108.
[18] Palmer, *The Treaty of Waitangi*, 35.
[19] Vincent O'Malley, *He Whakaputanga: The Declaration of Independence, 1835* (Wellington: Bridget Williams Books, 2017), 8.
[20] Susan Healy, "He Whakaputanga o te Rangatiratanga o Nu Tireni: The Key to Understanding Te Tiriti o Waitangi," (Zoom seminar, New Lynn Community Hub, Auckland, March 15, 2022).

He Whakaputanga sets the foundation for understanding te Tiriti. The frequently referred to constitution, the Treaty of Waitangi is distinct from te Tiriti o Waitangi.[21] It was signed five years after He Whakaputanga and brought Aotearoa into the British Empire.[22] Around 530 rangatira signed the Māori text, te Tiriti o Waitangi, and only 39 signed the English text, the Treaty of Waitangi.[23] Te Tiriti and the Treaty are conspicuously different in several select phrases. Te Tiriti uses the term kāwanatanga, transliteration for governance. In contrast, the Treaty states that rangatira gave "all the rights and powers of sovereignty" to the Queen. The rangatira who signed did not and could not cede that authority. **Māori never ceded sovereignty**.

What they had agreed was to share authority with Britain so their Governor could maintain their subjects and have peace with Māori.[24] Single-title land ownership for property and sale is unfathomable and implausible. Rangatira did not cede this authority as it cannot be transferred or possessed.[25]

However, signing these documents marked only the beginning of disputes due to continual breaches by the Crown. From 1845 to 1872, the Land Wars took place due to the mistranslation of te Tiriti and an estimated 2,100 Māori lives were lost over this time.[26] In the aftermath, the Crown confiscated large land areas as punishment for retaliation, the loss of this significant resource base has led to impoverishment for Māori.[27]

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[21] Asians Supporting Tino Rangatiratanga, "Commentary on Aotearoa NZ's Histories Draft Curriculum," Issuu, May 25, 2021, https://issuu.com/asianssupportingtinorangatiratanga/docs/astr_commentary_on_aotearoa_nz_histories_draft_cur/1?ff.
[22] O'Malley, *He Whakaputanga*, 8.
[23] Palmer, *The Treaty of Waitangi*, 54.
[24] Hori Parata et al, *Ngāpuhi Speaks* (Whangārei: Network Waitangi Whangārei, 2012), 148.
[25] Mason Durie, *Whaiora: Māori Health Development* (Melbourne: Oxford University Press: 1998), 36.
[26] Mark Hickford and Carwyn Jones, eds., *Indigenous Peoples and the State: International Perspectives on the Treaty of Waitangi* (Oxfordshire: Taylor & Francis, 2018), 30.
[27] Durie, *Whaiora*, 148.

4.2 Design for health and hauora

Hauora is distinct from health as defined and understood from a Eurocentric context. Frequently referred to as meaning health or wellbeing. Māori worldview of these concepts is vastly different. Te whare tapa whā and the Meihana model are frameworks developed to better understand and deliver healthcare services for Māori.[28] Sir Mason Durie introduced te whare tapa whā in 1982.[29] His metaphor of hauora as an interconnected wharenui explains the necessity of a holistic approach (Figure 1).[30]

Each of the four walls of the wharenui represents the dimensions of hauora, taha tinana, taha wairua, taha whānau, and taha hinengaro.[31] If any of these walls are affected, the whare is unbalanced, meaning the person is unwell.[32]

Figure 1. Our Hauora, *The 4 Pillars of Our Hauora*, 2021, infographic, Ō Tautahi, https://www.ourhauora.nz/blog/te-whare-tapa-wha.

[29] Suzanne Pitama et al., "Meihana Model: A Clinical Assessment Framework," *New Zealand Journal of Psychology* 36, 3 (2007): 118-125, https://www.psychology.org.nz/journal-archive/Pitamaetal_NZJP36-3_pg118.pdf.
[30] Durie, *Whaiora*, 71.
[31] Ibid., 69.
[32] Ibid., 69 - 71.

The Meihana model uses an analogy of a waka hourua (Figure 2).[33] This framework expands upon the components of te whare tapa whā with taiao and ratonga hauora. It also includes contextual factors to be acknowledged when assessing Māori patients and whānau. These factors are ngā hau e whā: 1. colonisation, 2. racism, 3. migration, and 4. marginalisation.[34] Understanding how these winds impact Māori health encourages health practitioners to reflect on how these winds may influence their perception of Māori patients and whānau.

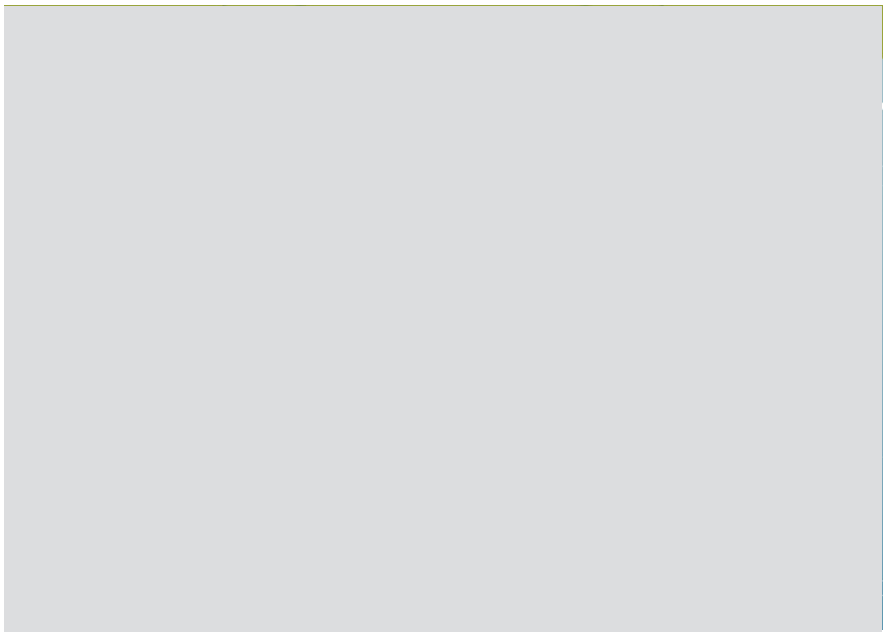

Figure 2. Emma McCleary, *The Meihana Model*, 2021, infographic, The Royal New Zealand College of General Practitioners, Te Whanganui a Tara, https://www.rnzcgp.org.nz/GPPulse/Equity_news/2021/The_Meihana_Model.aspx?WebsiteKey=5d6ca365-aa40-4574-8861-3f40caea2dce.

[33] Arama Rata, Jessica Hutchings, and James H. Liu, "The Waka Hourua Research Framework: A dynamic approach to research with urban Māori communities," *The Australian Community Psychologist* 24, 1 (2012): 64-75, https://psychology.org.au/aps/media/acp/rata-et-al-acp-24(1)64-75.pdf.

[34] Suzanne Pitama, Tania Huria, and Cameron Lacey, "Improving Māori health through clinical assessment: Waikare o te Waka o Meihana," *Journal of the New Zealand Medical Association* 127, 1393 (2014): 107-119, https://wharaurau.org.nz/sites/default/files/Projects/Foundations-ICAMH/Event-Documents/Presentation/2020/20201014-Meihana-model-a-clinical-assessment-framework.pdf.

Like our healthcare system, design cannot cure the world of wicked problems. But design can facilitate us to imagine a world without them. Across industries, design is becoming recognised for its ability to challenge the status quo. Healthcare design or health design is an emerging practice worldwide,[35] with successful case studies winning prestigious awards[36] and positively affecting livelihoods. Our pandemic response was commended internationally, gaining recognition from the World Health Organisation (WHO) for outstanding public health messaging.[37]

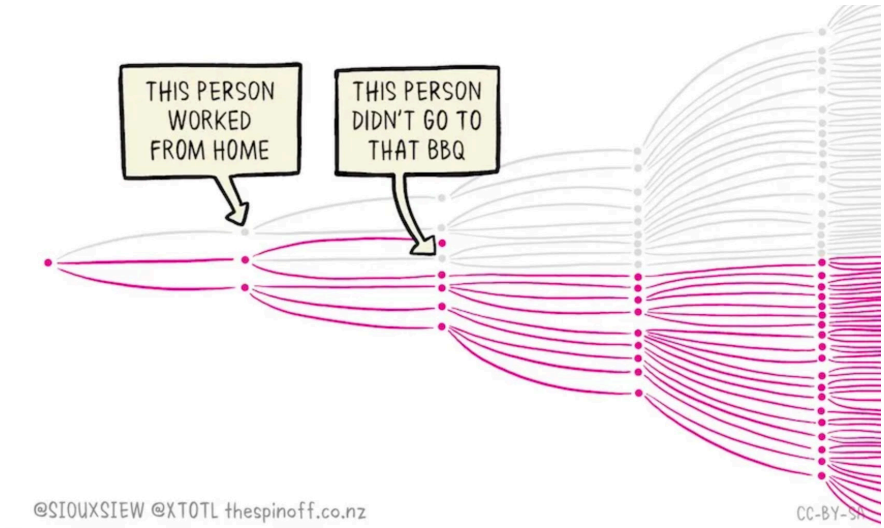

Figure 3. Siouxsie Wiles and Toby Morris, *How you can break the Covid-19 chain*, 2020, gif, The Spinoff, Tāmaki Makaurau, https://thespinoff.co.nz/politics/22-03-2020/siouxsie-wiles-toby-morris-what-does-level-two-mean-and-why-does-it-matter.

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[35] Bon Ku and Ellen Lupton, *Health Design Thinking* (New York: Cooper Hewitt, 2020), 216.
[36] "Covid 19 - Siouxsie and Toby," Designer's Institute of New Zealand Best Design Awards, accessed June 4, 2021, https://bestawards.co.nz/public-good-award/public-good-award/the-spinoff/covid-19-siouxsie-and-toby-1/.
[37] Toby Morris and Siouxsie Wiles, "How you can break the Covid-19 chain" (gif), *The Spinoff*, March 22, 2020, https://thespinoff.co.nz/politics/22-03-2020/siouxsie-wiles-toby-morris-what-does-level-two-mean-and-why-does-it-matter/.

A design approach can help reimagine solutions within the healthcare context. For example, the Design for Health and Wellbeing Lab was situated inside Auckland City Hospital from 2013 to 2018.[38] They faced many challenges during their venture.[39] Such as being answerable to competing concerns, including budgets, the immediacy of healthcare, roles about managing things instead of engaging with cultural change, and a biomedical rather than holistic orientation to health in hospital settings. In contrast, design can rapidly prototype and test solutions (within certain limits of risk-averse healthcare institutions) to iterate for best meeting the human-user needs.

For almost three decades, design thinking has been examined and defined into a practice pioneered by Innovation Design Engineering Organization (IDEO) consultancy and d.school at Stanford University.[40] There are numerous ways in which the process of this practice has been mapped out. This methodology has two primary principles in Dr Bon Ku's book, Health Design Thinking.[41] First is the ethos that design must be human-centred.[42] It begins with the user's needs rather than a designer's hunch or business proposal.[43] Second, all that is required is a creative mindset.[44] Everyone can practice creativity, not just designers.[45]

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[38] "Home," Design for Health and Wellbeing Lab, accessed May 24, 2022, https://www.dhwlab.com/.
[39] Helen Cunningham and Stephen Reay, "Co-creating design for health in a city hospital: perceptions of value, opportunity and limitations from 'Designing Together' symposium," *Design for Health* 3, 1 (2019): 119-113, https://doi.org/10.1080/24735132.2019.1575658.
[40] Ku and Lupton, 10.
[41] Ibid.
[42] Ibid.
[43] Ibid.
[44] Ibid.
[45] Ibid.

In the wake of the pandemic, the significance of health design has been thrust into the spotlight. Common examples include the design of personal protective equipment, advertising campaigns,[46] and the built environment to encourage social distancing. The significance of design for health is indisputable, demonstrated recently by our nation's Covid-19 public health messaging.[47] Covid-19 has also brought critical attention to the stark inequities of our healthcare system. It has also shown how well Māori and Pasifika leaders can address the needs of their communities when given the agency to do so.[48]

Figure 4. Clemenger BBDO, *Patuerohia ka uru ana koe*, 2020, Poster, New Zealand Government, Te Whanganui a Tara, https://www.clemengerbbdo.co.nz/the-work/unite-against-covid-19.

Figure 5. Clemenger BBDO, *Sanitise on your way in*, 2020, Poster, New Zealand Government, Te Whanganui a Tara, https://www.clemengerbbdo.co.nz/the-work/unite-against-covid-19.

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[46] "Kowheori-19 / Covid-19: Posters," Te Papa, accessed May 24, 2022, https://collections.tepapa.govt.nz/topic/11014.
[47] Duncan Grieve, "The epic story of NZ's communications-led fight against Covid-19," *The Spinoff*, May 11, 2020, https://thespinoff.co.nz/politics/11-05-2020/a-masterclass-in-mass-communication-and-control.
[48] Api Talemaitoga, "Unfounded assumptions and 'come from behind' wins," *E-Tangata*, February 20, 2022, https://e-tangata.co.nz/comment-and-analysis/unfounded-assumptions-and-come-from-behind-wins/.

Clever design has assisted in better healthcare delivery. But it has also exposed how systems do not meet equitable health outcomes.[49] How might we redesign the future of healthcare by blending a creative pedagogy and scientific method? We can use design to plan, prepare, and produce the next generation of healthcare professionals. To resource and equip a workforce who cares deeply about health equity.[50]

Figure 6. Toby Morris, *Two New Zealands: The 2,700 Day Gap*, 2021, Web Comic, The Side Eye, Tāmaki Makaurau, https://thespinoff.co.nz/society/15-01-2022/the-side-eyes-two-new-zealands-the-2700-day-gap-2.

[49] Toby Morris, "Two New Zealands: The 2,700 Day Gap," The Side Eye, January 15, 2022, https://thespinoff.co.nz/society/15-01-2022/the-side-eyes-two-new-zealands-the-2700-day-gap-2.
[50] Jarret Fuller, hosts, "Scratching the Surface" 158. Bon Ku (podcast), July 22, 2020, accessed June 4, 2021, https://scratchingthesurface.fm/158-bon-ku.

4.3 Participatory design

Participatory design was founded in Scandinavia in the 1970s and was initially called cooperative design.[51] It is also popularly known as co-design or co-creation.[52] Participatory design is an invaluable approach to engaging participants throughout a problem-solving process.[53] This approach involves all the relevant stakeholders from project beginnings to end.[54] By doing so, solutions are developed that will best meet the needs of human users.[55] All participants are viewed equally and as rightful experts of their knowledge.[56]

There are numerous instances of participatory design being used within the healthcare industry[57] and is gaining popularity globally. In part due to its ability to shift approaches, methods, and thinking for better patient experiences. Local examples in Aotearoa have seen improved public health outcomes. In a recent case study from Tauranga, Chadwick Healthcare saw a 17% increase in Māori patient enrolment at their practice.[58]

The equity team launched a co-design project at the start of 2020 to improve engagement with their Māori community. They recognised their 11% enrolled population of Māori did not reflect the overall 16% of the area. By undergoing a co-design approach, several changes were made from the feedback. Participatory design methods, such as a hui and surveys, were undertaken to gather insights. The team were appreciative in their reflection of the participatory design experience. They expressed surprise at the specificity of suggestions in the surveys. Such as extra space to disclose multiple iwi affiliations on their enrolment forms, which has now been implemented.[59]

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[51] Sussane Bødker, "Creating conditions for participation: Conflicts and resources in systems design," *Human Computer Interaction* 11, 3 (1996): 215-236, https://doi.org/10.1207/s15327051hci1103_2.
[52] Elizabeth B.-N Sanders and Pieter Jan Stappers, "Co-creation and the new landscapes of design," *CoDesign* 4, 1 (2008): 5-18, doi:10.1080/15710880701875068.
[53] Kelly Ann McKercher, *Beyond Sticky Notes* (Sydney: Inscope Books, 2020), 14-15.
[54] Ibid.
[55] Ibid.
[56] Monica Weiler, Anthony Weiler and David McKenzie, "Co-design: A Powerful Force for Creativity and Collaboration," Medium, accessed June 7, 2021, https://medium.com/@thestratosgroup/co-design-a-powerful-force-for-creativity-and-collaboration-bed1e0f13d46#:~:text=Co%2Ddesign%20is%20the%20act,often%20within%20the%20design%20community.
[57] Chris Walsh, "'Authentic' co-design - what is it and how do we do it?" Health Quality & Safety Commission, November 13, 2019, https://www.hqsc.govt.nz/blog/authentic-co-design-what-is-it-and-how-do-we-do-it/.
[58] Health Quality & Safety Commission, "He waka eke noa – We are all in this together," June 2021, https://www.hqsc.govt.nz/assets/Consumer-Engagement/Publications/Case_Study_He_Waka_Eke_Noa_Chadwick_Healthcare_June_2021.pdf.
[59] Ibid.

Participatory design is well placed alongside Tiriti-based practice as they share some similar values. In **Wai 2575** health services and outcomes inquiry by the **Waitangi Tribunal**, the principles of te Tiriti are listed as tino rangatiratanga, mana taurite, whakamarumarutia, kōwhiringa, and patuitanga.[60]

The main kaupapa of this participatory design research was centred around the principle of equity. As mandated by the government, healthcare institutions have committed to achieving equitable health outcomes for Māori. The equity team leaders of this design research partner foresaw reluctance in disseminating teaching to all healthcare workers on understanding why promoting health equity had been mandated. Using te Tiriti to inform the development of this participatory design, it hoped to contribute to the cultural safety of this team and thus a part of our healthcare system. [61] In an endeavour to achieve māhaki that is, culturally best practice.[62]

Wai 2575: is a programme intended to provide a procedure for hearing nationally significant claims concerning grievances impacting Māori related to health services and outcomes.

Waitangi Tribunal: is an active commission of inquiry. The panel make recommendations on claims made by Māori for actions, policies, legislation, or omissions of the Crown that breach te Tiriti o Waitangi.

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[60] Waitangi Tribunal, *Hauora: Report on Stage One of the Health Services and Outcomes Kaupapa Inquiry* (Wellington: Waitangi Tribunal, 2019), 163-164, accessed June 7, 2021, https://forms.justice.govt.nz/search/Documents/WT/wt_DOC_152801817/Hauora%20W.pdf.

[61] Grant Berghan, Heather Came, Nicole Coupe, Claire Doole, Jonathan Fay, Tim McCreanor, and Trevor Simpson, *Te Tiriti o Waitangi based practice in Health Promotion*, Tāmaki Makaurau: STIR Stop Institutional Racism, 2017, accessed May 31, 2021, https://trc.org.nz/sites/trc.org.nz/files/ToW%20practice%20in%20HP%20online.pdf.

[62] Maui Hudson, et al., *Te Ara Tika: Guidelines for Māori research ethics: A framework for researchers and ethics committee Members*, (Auckland, New Zealand: Health Research Council of New Zealand on behalf of the Pūtaiora Writing Group, 2010), 12, accessed June 9, 2021, https://www.hrc.govt.nz/sites/default/files/2019-06/Resource%20Library%20PDF%20-%20Te%20Ara%20Tika%20Guidelines%20for%20Maori%20Research%20Ethics_0.pdf.

4.3 Cultural safety

Like health equity, cultural safety can mean different things to different people. Nevertheless, in Aotearoa, people have differences in their health and hauora that cannot be dismissed. These differences are needless and inordinately unfair. Health equity recognises that different approaches and resources are necessary to achieve the same, that is equitable health outcomes for people with differing levels of advantage.[63]

Cultural safety emerged as a nursing term in 1989 to describe the delivery of best practices for patients.[64] It represents a framework of delivery for culturally appropriate, and thus the provision of safe healthcare services for Māori. It is now a widely recognised concept by many practitioners to deliver healthcare services for Māori and whānau but also non-Māori patients and clients.[65]

Robyn Williams defines cultural safety as:

> "An environment that is spiritually, socially, and emotionally safe, as well as physically safe for people, where there is no assault, challenge, or denial of their identity, of who they are and what they need. It is about shared respect, shared meaning, shared knowledge, and experience of learning together."[66]

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[63] "Achieving Equity," Ministry of Health, accessed May 24, 2022, https://www.health.govt.nz/about-ministry/what-we-do/work-programme-2019-20/achieving-equity.
[64] "Kawa Whakaruruhau: Cultural Safety," Treaty Resource Centre – He Puna Mātauranga o Te Tiriti, accessed May 24, 2022, https://trc.org.nz/sites/trc.org.nz/files/Cultural%20Safety.pdf.
[65] Elaine Papps and Irihapeti Ramsden, "Cultural Safety in Nursing: the New Zealand Experience," *International Journal for Quality in Health Care* 8, 5 (1996): 491–497, https://doi.org/10.1093/intqhc/8.5.491.
[66] Robyn Williams, "Cultural safety – what does it mean for our work practice?," *Australian and New Zealand Journal of Public Health* 23, 2 (1999): 213-214, https://doi.org/10.1111/j.1467-842X.1999.tb01240.x.

What the practice entails must be defined by the patient. The concept emphasises the responsibility of the healthcare professional[67] to acknowledge embedded power imbalances and systemic biases inherent to the services they provide.[68] Integral to this concept is shifting the onus onto the healthcare practitioner.[69] Moving the focus away from any specific culture but instead assessing our own.[70] The practice demands reflecting on our cultural identity, viewpoint, and beliefs and being open to adapting our approach toward people of differing cultures.[71] Observing and reacting to differences is easy — perhaps English is not their mother tongue, or they practice customs dissimilar to yours.[72] It is much more challenging to interrogate our culture and how it impacts our stance and response.[73]

This practice involves actions that acknowledge and honour cultural identities different to our own.[74] To provide a culturally safe health service whilst meeting a practitioner's responsibilities of fulfilling patient rights, expectations, and care.[75] These actions include 1. jargon-free, non-judgemental, transparent, and considerate communication, 2. identifying and overcoming stereotypes, 3. engaging in a reciprocal exchange of knowledge, and most importantly, 4. reflecting on one's culture and its impact on our views and opinions.[76]

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[67] Frances I. Richardson, "Cultural Safety in Nursing Education and Practice in Aotearoa New Zealand" (PhD thesis, Massey University, 2010), 12-13, https://mro.massey.ac.nz/bitstream/handle/10179/2411/02_whole.pdf.
[68] "Learning and education modules on understanding bias in health care," Health Quality & Safety Commission, November 15, 2021, https://www.hqsc.govt.nz/our-programmes/patient-safety-day/publications-and-resources/publication/3866.
[69] Williams, *Cultural safety*, 213-214.
[70] Ibid.
[71] Richardson, *Cultural Safety in Nursing*, 12-13.
[72] Ibid.
[73] Ibid.
[74] Nursing Council of New Zealand, *Guidelines for Cultural Safety, the Treaty of Waitangi, and Māori Health in Nursing Education and Practice*, (Wellington: Nursing Council of New Zealand, 2002), 9, accessed May 24, 2022, https://www.nursingcouncil.org.nz/Public/Nursing/Standards_and_guidelines/NCNZ/nursing-section/Standards_and_guidelines_for_nurses.aspx.
[75] Ibid.
[76] Ibid.

4.5 Summary

Poor health statistics are tied to public narratives about Māori. Poor health is often perceived as the outcome of individual behaviour and is not attributed to the wider social determinants of health.[77] For Māori, these social determinants are inextricably linked to the ongoing impacts of colonisation.[78] This research was an endeavour of how design could be used to affect not only people's minds but also their hearts. Equity teaching is about increasing awareness and knowledge of colonial history.[79] But on closer inspection, it is about fostering compassion which leads to advocacy and restoration.[80]

The pandemic has amplified the evolution and brought the role of design in healthcare to mainstream attention. By utilising design thinking, "not just to design a new leaflet."[81] But using radical imagination to redesign a new healthcare system. Design alone cannot solve the world of wicked problems, especially within the healthcare context, which requires a high-level, multi-faceted approach, including legislation, education, and economics.

What design does allow us is to challenge pre-existing ways of being, thinking, and doing by providing alternative solutions within the limitations of institutional bureaucracy. Design offers the ability to rapidly prototype and user test solutions. In contrast to the risk-averse health profession. Instead of fragmented and siloed education systems like healthcare institutions. We should apply design to health thinking and vice versa.

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[77] National Health Committee, "The Social, Cultural and Economic Determinants of Health in New Zealand: Action to Improve Health," June, 1998, https://www.health.govt.nz/system/files/documents/publications/det-health.pdf.
[78] Durie, *Whaiora*, 27.
[79] Came, Heather, et al., "He hokinga ki te mauri: strengthening te Tiriti o Waitangi public health education in tertiary education settings," *Teaching in Higher Education: Critical Perspectives* 25, 8 (2020): 926-941, doi:10.1080/13562517.2019.1613357.
[80] Fuller, *Scratching the Surface*.

It is undeniable that colonial structures have perpetuated health inequity since the 19th century. Healthcare institutions have made public declarations to honour te Tiriti o Waitangi. One of the methods employed by these systems is to affect change at an employee level. If the system encourages individual behaviour, the intention is to bring about systemic change.

There has been a type of paralysis described by non-Māori when learning about structural and institutional racism. A questioning of how non-Māori can conduct meaningful research without being offensive or tokenistic.[82] In tandem with this, Māori should not be expected to carry the mental and spiritual burden of educating others. We, as tauiwi or Pākehā, must educate ourselves and converse with fellow tauiwi or Pākehā.[83] We must recognise that pathways to multiculturalism cannot occur without a commitment to biculturalism.

[81] Came, et al., *He hokinga ki te mauri*, 926 -941.
[82] Max Harris, "Racism and White Defensiveness in Aotearoa: A Pākehā Perspective," *E-Tangata*, June 10, 2018, https://e-tangata.co.nz/comment-and-analysis/racism-and-white-defensiveness-in-aotearoa-a-pakeha-perspective/

5 Methodology

5.1 Introduction
5.2 Human-centred design
5.3 Participatory design
5.4 Ethical considerations
5.5 Research timeline

5.1 Introduction

This design research, including consultation with Māori advisors, bears a responsibility to te Tiriti o Waitangi and is informed by this. All research undertaken in Aotearoa must engage with te Tiriti principles. As all research conducted in Aotearoa is and should be of relevance to Māori.[84]

This design research strived to be conducted in a culturally appropriate manner. Several preliminary meetings were undertaken to establish a reciprocal and mutually beneficial partnership between myself and the research partner hosts, a quality improvement and innovation unit at a large public hospital.

Much of this research was qualitative and based on a reflexive process. It used participatory design theory and practice methods to explore how reflection and discussion can galvanise our professional as well as personal commitment to achieving health equity. To be responsive to the responsibilities of this design research and promote cultural safety, the methodology was situated within the human centred design framework and employed a participatory design approach.

There was an opportunity to reflect on the meaning of health equity with keen team members of the partner host organisation. We tend to depend on our Māori health experts to educate us. Therefore, this research was about practising our responsibility and recognising our capabilities in becoming better tangata Tiriti.

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[84] Health Research Council of New Zealand, *Guidelines for Researchers on Health Research Involving Māori* (Auckland: Health Research Council of New Zealand, 2010), 2, accessed June 2, 2022, https://gateway.hrc.govt.nz/funding/downloads/Guidelines_for_researchers_on_health_research_involving_M%C4%81ori.pdf.

5.2 Human-centred design

This research proposed using a human-centred design (HCD) framework. HCD is an established method of practice. As its' name implies, HCD places the human user at the centre of the design process.[85] It expands upon participatory action research as it involves participants in the problem solving process.[86]

There are five main stages to HCD. The first is an investigation into the human user known as empathy building. Various methods can be employed to assist with insight generation. After this divergent thinking step has been explored and collated, it is essential to converge these ideas to articulate and prioritise the main pain points to be addressed. Once the problem or opportunity is defined, viable solutions can then be ideated, by once again employing divergent thinking. These ideas can then be rapidly prototyped to test the potential of these solutions with the human user. The user offers their feedback to iterate these prototypes. Empathic methods can be used to identify any shortfalls to define what needs addressing or improving. Thus the process begins again and it can be repeated as many times as necessary or capable for best meeting the human user's needs.

Figure 7. d. school, Design Thinking Process, 2014, Diagram, Stanford University, Stanford, https://dschool.stanford.edu/.

[85] Don Norman, *The Design of Everyday Things*, Rev. ed. (New York: Basic Books, 2013), 8.
[86] Lisa M. Vaughn and Farrah Jacquez, "Participatory Research Methods – Choice Points in the Research Process," *Journal of Participatory Research Methods* 1, 1 (2020): 1-13, https://doi.org/10.35844/001c.13244.

HCD was born at the intersection of several industries, engineering, psychology, anthropology, and the arts. Its' founding is attributed to John Edward Arnold at Stanford University's d.school in 1958.[87] This birth coincided with a growing movement throughout the 1960s and 70s, utilising creative methods and participatory design approaches. HCD gained popularity in the 90s as a lucrative process for businesses, spurring the term design thinking.[88] HCD is usually concerned with the methodology and methods used to interact with users to facilitate insight generation directly or indirectly to the design team.[89]

As a designer, it is paramount that our practice places our users at the forefront to enable solution development that best meets the needs of the user. However, critics have argued that this methodology stifles innovation and perpetuates design for obsolescence,[90] as this thinking is only concerned with existing problems. Solutions using this approach are based on insights which may become irrelevant, and thus the product becomes obsolete.

This brand of design has also been heavily capitalised.[91] Small and large companies peddle various online courses, workshops, and boot camps. They claim to customers that with these 10 simple steps, you too, can become a DeSigNEr. Despite these concerns, the HCD methodology provided a valuable framework for this research process. It assisted with creating a timeline, employing the HCD process as a framework that enabled the use of specific methods and thinking. This becomes relevant whenever uncertainty inevitably strikes. It offered a sense of direction and structure. I enjoy HCD because of its' capability and promotion of collaboration.

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[90] Massimo Garbuio and Mortiz Dressel, "6 Building Blocks for Successful Innovation," Brandsome, July 24, 2019, http://www. 6buildingblocksbook.com/.

[91] Darin Buzon, "Design Thinking is a Rebrand for White Supremacy," Medium, March 2, 2020, https://dabuzon.medium.com/design-thinking-is-a-rebrand-for-white-supremacy-b3d31aa55831.

For this design research, I applied some but not all aspects of HCD. This project is centred on a wicked problem, and design has limited scope for solving such issues. However, the intention and aspiration were that design thinking could foster shared imagination with keen team members. This was to allow dreaming and, hopefully, inspire doing. As I will continue to discuss in this exegesis, equity does not have a destination or a checklist for competency. Instead, it is a continual journey that requires constant updating and monitoring. Although this research was situated in an HCD framework, it acknowledges its' limitations whilst providing a foundation to platform this research for potential future iterations.

5.3 Participatory design

This research draws from methods of a participatory design approach. This approach involves relevant stakeholders from the earliest design stages and through all process phases. This involvement allows the development of a solution that best meets the users' needs. This design research aimed to assist in 1. enhancing reflective practice and 2. discovering how I could apply design to imagine new ways of thinking about and doing health equity discussion and learning.

Participatory design methods such as expert interviews, workshops, iterative prototyping, and user testing were planned. To investigate the potential of using these methods with the research question — How might design methods be applied to enhance reflection amongst members of a quality improvement and innovation unit, at a large public hospital, on the meaning of equity, as practitioners, colleagues, and tangata Tiriti?

This research used participatory design methods to investigate navigating conversations about health equity. It was essential to employ a participatory design approach to involve team members in these conversations, hoping they would align with the values of a user-centric study and purpose-driven research. The next chapter will discuss each method used in this research (including the participatory design methods, expert interviews and workshops).

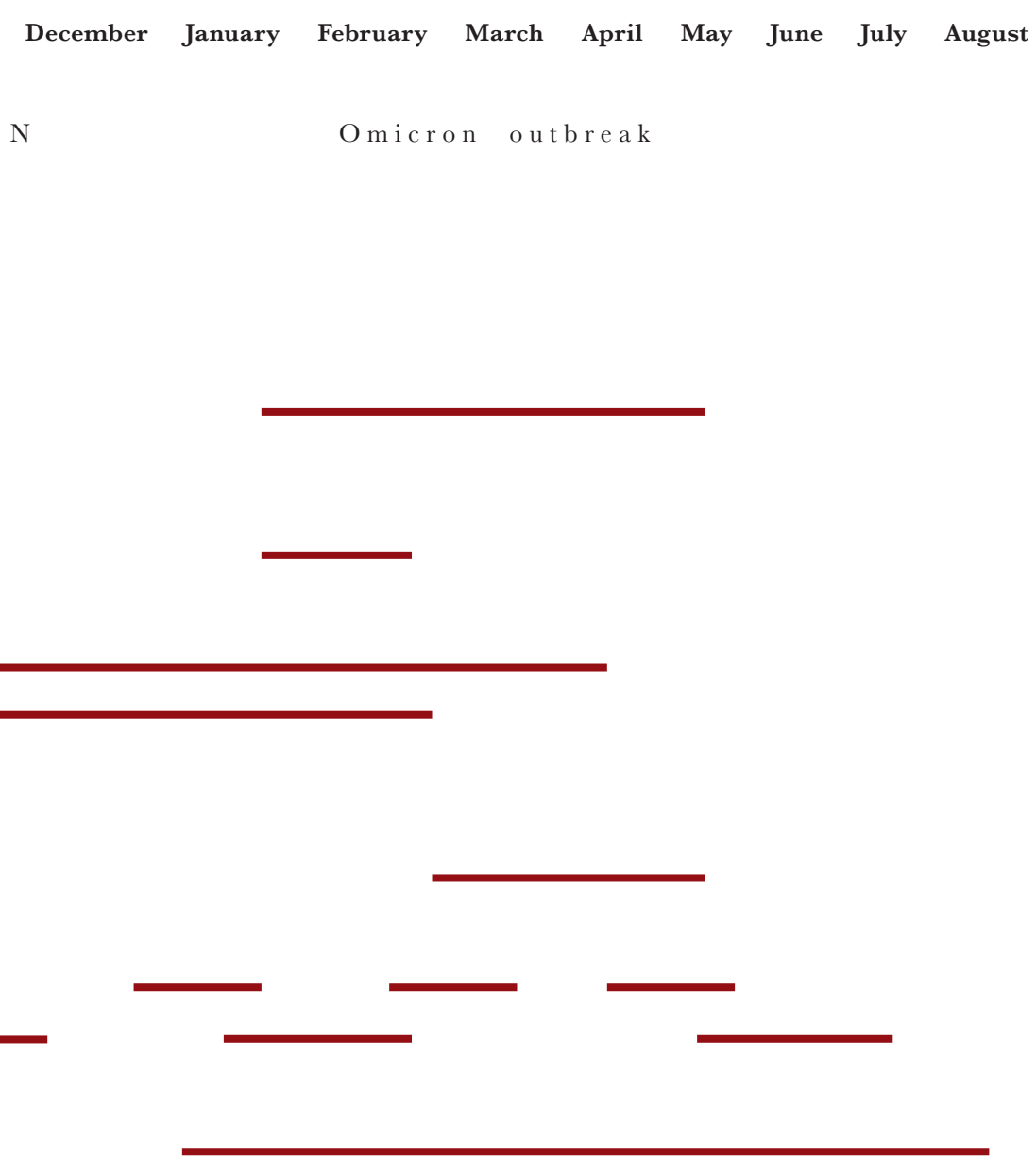
5.4 Ethical considerations

Ethics approval for this research was granted by the Auckland University of Technology Ethics Committee (AUTEC) on the 1st of September 2021 (21/284) for the expert interviews and focus groups (workshops). AUTEC approved ethics amendments on the 28th of October 2021 for adapting to an online focus group (workshop) due to the disruption of Covid-19 lockdowns on in-person data collection. See Appendix 1 for ethics-related documents.

Research involving people requires a framework to ensure safe practice. Ethics boards serve to safeguard that good practice will occur. Ethical approval was necessary since this research drew from a participatory design approach, where working with people was fundamental. Expert interviews and workshop participation were pivotal in the design and development of this research. Ethics approval for this research was sought for both project phases: 1. to interview experts in health equity promotion to inform the design of this research, and 2. to undertake workshops with keen team members of a quality improvement and innovation unit. These workshops were conducted to understand the team's needs and opportunities better to galvanise their commitment to achieving health equity. Practices that were engaged with to ensure ethical practice included — maintain confidentiality using pseudonyms and frequent check-ins, including rigorous discussion with the supervisory team to protect anonymity when any risks were identified. These will be explained further in the Documentation chapter. From this point of the exegesis onwards, all mentions of people use pseudonyms.

The expert interviewees and workshop participants were informed throughout the research process that they could withdraw their participation at any time. Their right to privacy and confidentiality was evident in their invitation, participant information sheet, and consent form. Where there were multiple participants, there was a mutual agreement that the information shared during the workshops would remain confidential. Confidentiality could not be guaranteed between participants at the workshop, but every effort was made to remind participants to be respectful and protect one another's privacy.

5.5 Research timeline


December
January
February
March
April
May
June
July
August
N
Omicron outbreak

6 Research methods

6.1 Consultation

Consultation is a method or, rather, a process of investigating and listening to the experiences of those involved[92] to clarify and analyse problems to enact and implement plans.[93] This method acknowledges the tendency to speculate without input or intervention from the people directly impacted by the issue attempted to be solved.[94] Essentially, it is about making the unseen seen.[95] This research would not have been possible without input from Māori advisors during this learning journey. I was fortunate to receive some specific guidance from a few mentors, along with my own wisdom seeking from a scholarship of tiriti educators, tangata Tiriti groups, and scholarly rangatira.

Several meetings were undertaken to establish a reciprocal and mutually beneficial partnership with the host partner of this research. Keen members from this team were the users of this design research. This organisation initially had two equity team co-leads, Deborah and Mikaere, who were the liaisons for this project and was co-created with them. An initial meeting was undertaken with Āwhina to pursue an opportunity to develop a design research project in conjunction with their mahi. She also gave an expert interview on the research design once it had been established with the eventual research hosts. The purpose of having these conversations was to discuss the potential relevance and appropriateness of the initial ideas for this research. This guidance was invaluable in further progressing personal learning and developing the direction and framing of this investigation. Additional advice was also sought through connections with the supervisory team to ensure the research was being planned appropriately.

The use of te reo Māori within the participant information sheet for workshop participants was checked with a kaiako Reo Māori. The reo Māori within this exegesis was proofread by a licensed translator. It was integral to the values this research attempted to instil that translation was resourced.

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[92] Terry B. Gutkin and Michael J. Curtis, "School-based consultation: The science and practice of indirect service delivery," in *Handbook of school psychology*, 4th ed., eds. Terry B. Gutkin and Cecil R. Reynolds (New York: Wiley, 2009), 591-635.
[93] John R. Bergan and Martin L. Tombari, "Consultant skill and efficiency and the implementation and outcomes of consultation," *Journal of School Psychology* 14, 1 (1976): 3-14, https://doi.org/10.1016/0022-4405(76)90057-1.
[94] Ibid.
[95] Mary M. Clare, "Qualitative Research Methods Render and Advance Consultation Practice: Here's Why that Matters," *Journal of Educational and Psychological Consultation* 32, 1 (2022): 9-21, doi: 10.1080/10474412.2020.1768859.

6.2 Contextual review

A contextual review is a mapping and evaluation of scholarship related to a research focus. It cultivates a foundation of knowledge and a framework of understanding,[96] equipping the researcher with the necessary expertise to conduct a meaningful inquiry.[97] It allows the researcher to position themselves amongst relevant and aspirational contexts whilst acknowledging the influence of existing research and seeking validity for prospective yet worthwhile future contributions.[98] Establishing and reviewing contexts that would inform this design research was essential. This provided a baseline for situating the project whilst sharing my understanding with audiences for potential future iterations.

I initiated the contextual review through the exploration of literature. I conducted the literature review by searching online libraries using the keywords: design, healthcare, health equity, te Tiriti o Waitangi, and Aotearoa. Although the exegesis writing began with the contextual review, it was constantly evaluated and iterated throughout the research process. This meant there was a continual engagement with new literature and critical topic findings were added throughout the learning journey.

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[96] David E. Gray, *Doing Research in the Real World* (Los Angeles: SAGE Publications, 2017), 35.
[97] Carole Gray and Julian Malins, *Visualizing Research: A Guide to the Research Process in Art and Design* (Farnham: Ashgate Publishing, 2013), 12.
[98] Ibid.

6.2.1 Active learning

Active learning is a method of learning involving an experiential engagement in the process.[99] There are various levels and techniques, its' distinguishing feature is any action involving more than passively listening.[100] The literature demonstrates that this higher level of engagement is necessary to learn effectively.[101]

Attendance of workplace meetings, continuing professional development sessions, beginner Māori language courses, Tiriti-based educational seminars, and a He Whakaputanga workshop, amongst other actions, was done to actively engage with a breadth of resources to better understand the many different contexts.

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[99] Charles C. Bonwell and James A. Eison, *Active Learning: Creating Excitement in the Classroom AEHE-ERIC Higher Education Report No. 1*., (Washington: Jossey-Bass, 1991), iii, https://archive.org/details/activelearningcr0000bonw.
[100] Ibid.
[101] Michael Prince, "Does Active Learning Work? A Review of the Research," *Journal of Engineering Education* 93, 3 (2004): 223–231, doi:10.1002/j.2168-9830.2004.tb00809.x.

6.3 Expert interview

Key Informants (KI) are specific people who are specialists, operating at the leadership level either formally or informally.[102] The value of KI interviews was critical to developing this design research question. Expert interviews are a form of qualitative data collection and KI interviews.[103] They are an organised discussion on a particular topic between the researcher and a person who is an expert in a specific topic or field.[104] Interviews were conducted to gain insights from several experts on how this design research and workshops should be conducted. It was essential to investigate experts' perspectives and experiences to understand and inform this design research.[105]

Three experts were interviewed. These individuals are professionally involved with health equity efforts from various backgrounds and relevant experience. Their data were pivotal to the development of this project. Their input radically informed the progression of this investigation, workshops, and my positioning. They profoundly affected the ongoing direction of this research and transformed my thinking.

During the KI interviews, recordings were taken with the expert's verbal and written consent. Notation was also used to record data. A semi-structured approach was undertaken, questions were open-ended and related to the expert's area of expertise related to the design research. (See Appendix 2 for the list of interview questions and notes). These interviews were conducted online over Zoom due to the disruption of Covid-19 lockdowns. Online interviewing offers a unique opportunity for researchers to broaden their scope, as travel and location are no longer restrictions.[106]

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[102] Gareth Terry, Key informants, in *Wiley-Blackwell Encyclopaedia of Sociology*, eds., George Ritzer and Chris Rojeck (New Jersey: John Wiley & Sons, 2021), 2.
[103] "The Field Guide to Human-Centered Design," IDEO, 2015, https://d1r3w4d5z5a88i.cloudfront.net/assets/guide/Field%20Guide%20to%20Human-Centered%20Design_IDEOorg_English-0f60d33bce6b870e7d80f9cc1642c8e7.pdf.
[104] Alexander Bogner, Beate Littig, and Wolfgang Menz, *Interviewing Experts* (London: Palgrave Macmillan, 2009), 17.
[105] Stefanie Döringer, "The problem-centred expert interview'. Combining qualitative interviewing approaches for investigating implicit expert knowledge," *International Journal of Social Research Methodology* 24, 3 (2020): 265-278, doi: 10.1080/13645579.2020.1766777.
[106] Paul Hanna and Shadreck Mwale, "I'm not with you...Yet I am": Virtual face to face interviews," in *Collecting qualitative data: A practical guide to textual and virtual techniques*, eds. Virginia Braun, Victoria Clarke, and Debra Gray, (Cambridge: Cambridge University Press, 2017), 235-255.

6.4 Workshops

Workshops are also a method of qualitative data collection.[107] They are not dissimilar to focus groups. Both involve gathering participants together to engage in activity and discussion on a particular topic or research focus. They may or may not be facilitated by the researcher, who is gathering data on the workshops whilst it is occurring.[108]

Workshops are usually employed in participatory design approaches. They were a necessity for this research to centre problem-solving around participants. Workshops effectively generate insights that would not otherwise be known to the researcher via more passive methods, such as ethnographic observation or surveys.[109]

Workshops were planned to be facilitated at the quality improvement and innovation unit. The design of the project was initially built around a series of workshops. These workshops were intended to generate qualitative data to help identify opportunities for improvement with the research participants on how successful discussion and learning of health equity might occur.

Concurrently, the potential of using participatory design methods to enhance health equity discussion was tested. The workshops had planned to involve a series of participatory design activities, such as mind mapping, drawing, model making, user testing, and iterative prototyping.

There were a total of four workshops planned and prepared. They were booked to be held onsite at the unit. Data were to be gathered from these workshops through reflective notation and any artefacts produced from the participatory design activities. These would then be further analysed for insight generation.

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[107] Paul Gill, Kate F. Stewart, Elizabeth T. Treasure and Barbara Lesley Chadwick, "Methods of data collection in qualitative research: interviews and focus groups," *British Dental Journal* 204, 6 (2008): 291-295, http://dx.doi.org/10.1038/bdj.2008.192.
[108] Ibid.
[109] Alexander Bogner, Beate Littig, and Wolfgang Menz, *Interviewing Experts* (London: Palgrave Macmillan, 2009), 2.

Due to the disruption of Covid-19 lockdowns and responding to the data generated from the expert interviews, the initial plans had to be reframed and were altered. I eventually conducted two workshops. The first was held online over Zoom due to gathering restrictions during the Covid-19 lockdown. I ran the second workshop in person, on-site at the unit. Data generated from these workshops will be discussed in the next chapter, including the challenges and obstacles that changed the direction of this research.

Figure 8. Phoebe Lee, *Set up*, 2021, Photograph, Tāmaki Makaurau.

6.5 Reflective journal

A reflective journal is a means to practice analysing one's thoughts, beliefs, and attitudes.[110] Reflective journaling is an essential professional skill that health practitioners readily encourage.[111] Studies demonstrate that reflective practice enhances critical thinking and decision-making skills by drawing on previous experiences to inform judgements.[112] Reflective journaling is also valuable for researchers to expand their knowledge and drive research further.[113]

Reflective journaling has been an enriching and essential tool for insight generation, learning, and well-being management throughout this research journey. Frequently, I was overwhelmed by thoughts and emotions. Through journaling, I could process these to better articulate the impacts of doing this kind of research. Later, these entries underwent reflection again and iteration.

I initially began journaling to document notes for and from supervision meetings. I recorded these historically on a Google Doc. I updated it semi-regularly to track the progress of our fortnightly discussions, hoping they would serve as a helpful tool for future exegesis writing. As is often an occurrence in life, consistency waned, and notes were scattered everywhere. Musings were hastily scribbled in notebooks, the notes app on my phone, random voice notes, and scrap pieces of paper. I tried to update the document whenever possible and keep it in a chronological format.

As the research began to delve deeper into personal territory, I turned off sharing this document with my supervisors. I wanted to be honest and transparent but could not do so without privacy. There is some irony here, I failed to be open and vulnerable, which people often struggle with in these teaching and learning topics. How can we learn if we cannot share our raw thoughts and feelings?

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[110] Michelle Ortlipp, "Keeping and Using Reflective Journals in the Qualitative Research Process," *The Qualitative Report* 13, 4 (2008): 695–705. https://doi.org/10.46743/2160-3715/2008.1579.

[111] Ramesh Walpola and Cherie Lucas, "Reflective practice: the essential competency for health systems and healthcare practitioners during the COVID-19 pandemic," *Reflective Practice International and Multidisciplinary Perspectives* 22, 2 (2021): 143-146, https://doi.org/10.1080/14623943.2020.1860925.

[112] Cherie Tsingos-Lucas, et al., "The Effect of Reflective Activities on Reflective Thinking Ability in an Undergraduate Pharmacy Curriculum," *American Journal of Pharmaceutical Education* 50, 4 (2016): 65, doi: https://doi.org/10.5688/ajpe80465.

[113] Ortlipp, *Using Reflective Journals*, 695–705.

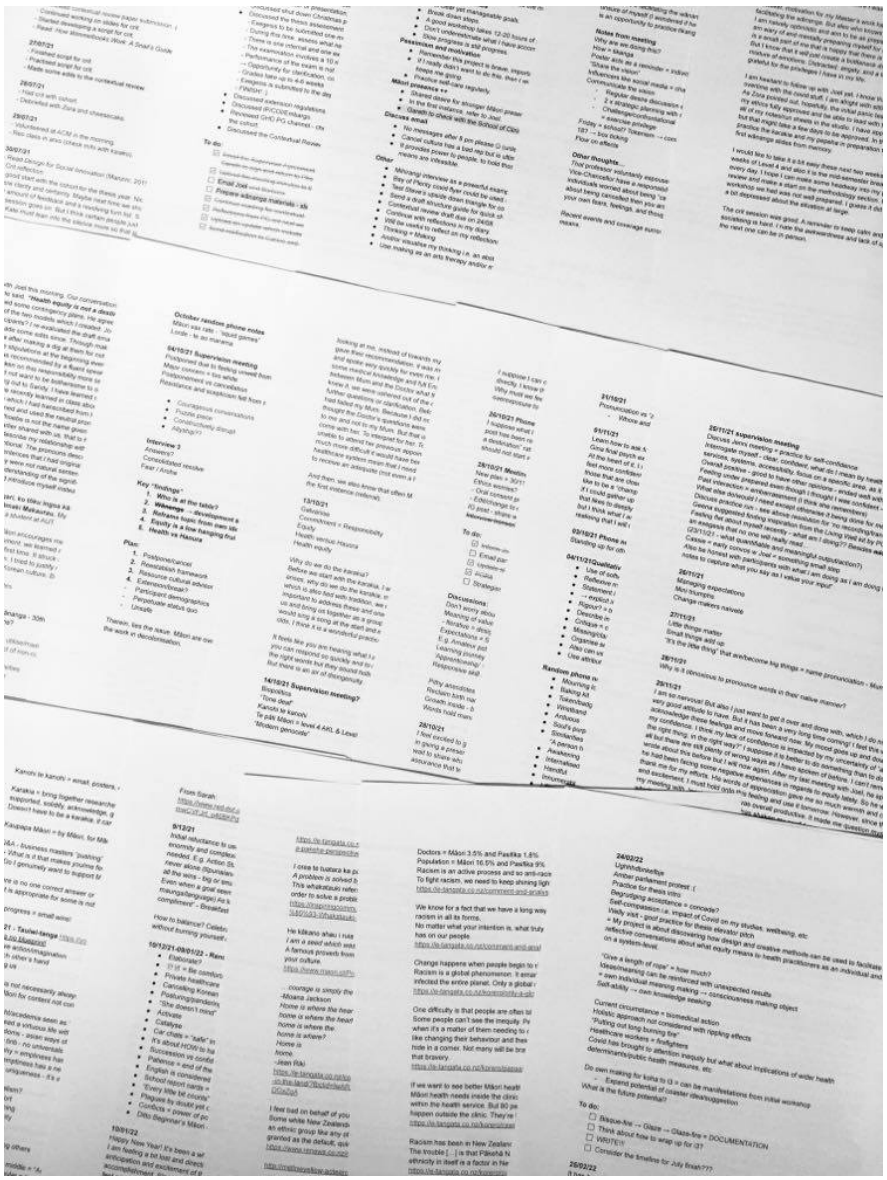

Figure 9. Phoebe Lee, *Digital journal*, 2022, Photograph, Tāmaki Makaurau.

6.6 Design methods

Several design methods were used throughout this research process, including mind mapping, critiquing, iterating, and prototyping. Research methods which are also design methods include interviews, workshops (focus groups), and reflection. I believe the distinguishing difference between these would be the mindset attached by the researcher when analysing the data.

As part of a practice-oriented thesis, I employed a creative perspective to gather insights and reflect on my thinking. Design thinking methods were also tested, including whether they were an effective means of conducting this type of study. The main design methods used for this research will each be explained.

6.6.1 Mind mapping

Mind mapping is a method of writing down ideas, contexts, and information; and arranging them into categories that stem from a central theme or focus.[114] This helps with organising ideas by identifying connections between them.[115] Before beginning the research, I utilised this method to help define what the project could and should involve. It also helped identify significant influences, key concepts, practitioners, and previous bodies of work. I also used mind maps to explore different research opportunities altogether.

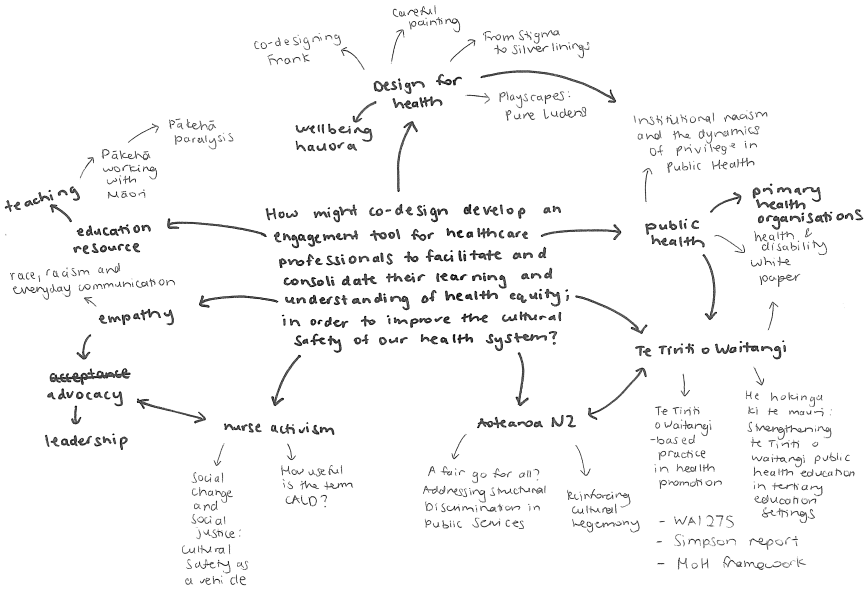

Figure 10. Phoebe Lee, *Mind map*, 2022, Scanned image, Tāmaki Makaurau.

[114] Silvina P. Hillar, *Mind Mapping with FreeMind* (Birmingham: Packt Publishing, 2012), 23.
[115] Florian Rustler, *Mind Mapping for Dummies* (New York: John Wiley & Sons, 2012), 47.

6.6.2 Prototyping

Prototyping is a method of rapidly creating and testing ideas through an interactable concept model.[116] Prototypes help provide instantaneous feedback to generate insights on them[117] by evaluating and defining what works or does not.[118] The prototypes can then be developed through cyclical iteration for improvement.[119]

This method was planned to be used extensively during the workshops, with participants assisting with generating a tangible design outcome. These prototypes were intended to be tested at the workshops and beyond to produce constructive critiques for improvement. However, because of findings from the research, prototyping did not end up being an appropriate method (this will be explained in the next chapter).

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[116] IDEO, *Field Guide to HCD*, 119-120.
[117] Ibid.
[118] Ibid.
[119] Todd Zaki Warfel, *Prototyping: A Practitioner's Guide* (New York: Rosenfeld Media, 2009), 26-27.

6.6.3 Critiquing

Critiquing, also called feedback, is vital for the design process.[120] This method involves the inclusion of varied viewpoints and opinions on the progress of the design.[121] Critiquing was crucial for this design research, this method helped evolve and enhance ideas through a reflection of the critique.

Semi-regular meetings were held with Deborah and Mikaere to ensure a reciprocal and mutually beneficial project was established. Several meetings were conducted to initiate this design research. These meetings were primarily concerned with providing updates on the progression of the research design. It also allowed these laisons to contribute feedback on thinking and ideas and advise on the appropriateness of the approach and method. Critique was planned to feature heavily during the workshops and be incorporated into the scheduling. Although it was not used with the initial intent, there was still an opportunity for participants to give feedback during the eventual workshops. I prompted participants to respond to a list of questions to evaluate their workshop experience. This feedback provided measurable input for analysis and discussion in the research. Monthly critique sessions were conducted with other designers from the Master of Design (MDes) cohort. These were friendly check-ins and an opportunity to ask for assistance where and when required.

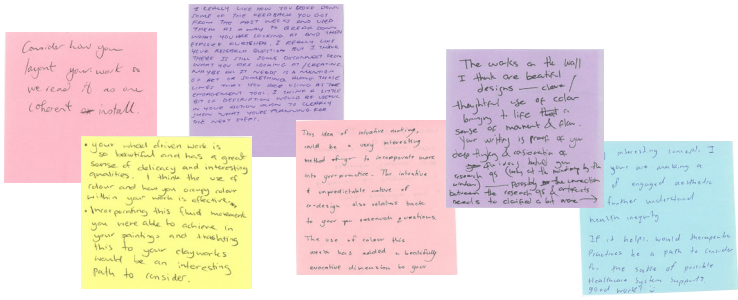

Figure 11. Phoebe Lee, *Sticky note feedback*, 2022, Scanned image, Tāmaki Makaurau.

[120] IDEO, *Field Guide to HCD*, 126-127.
[121] Ibid.

6.6.4 Refining

Refining is the 'last' stage in the design process that develops a selected concept further.[122] This method usually involves resolving the details of a design solution, which may only be minor or aesthetic.[123] This method may be lengthy as it can take several iterations to develop the final refined design.[124] Feedback from users, clients, or stakeholders often influences refinement, primarily when using HCD and participatory approaches.[125]

Several iterations of workshop materials were iterated, critiqued, and refined. To test whether they were appropriate yet effective before being used. Many changes were made in this planning, which reflected the learning undergone throughout this research process.

Refinement was undertaken while creating the final design output. Several critique sessions were undertaken with the supervisory team and MDes cohort to develop the design further. In particular, the framing of the design process. And how it might be presented to the research participants. There was also discussion and suggestions about specific details, which will be explained in the next chapter.

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[122] IDEO, *Field Guide to HCD*, 126-127.
[123] Terry Lee Stone, *Managing the Design Process Concept Development: An Essential Manual for the Working Designer* (Massachusetts: Rockport Publishers, 2010), 154.
[124] IDEO, *Field Guide to HCD*, 148.
[125] Ibid.

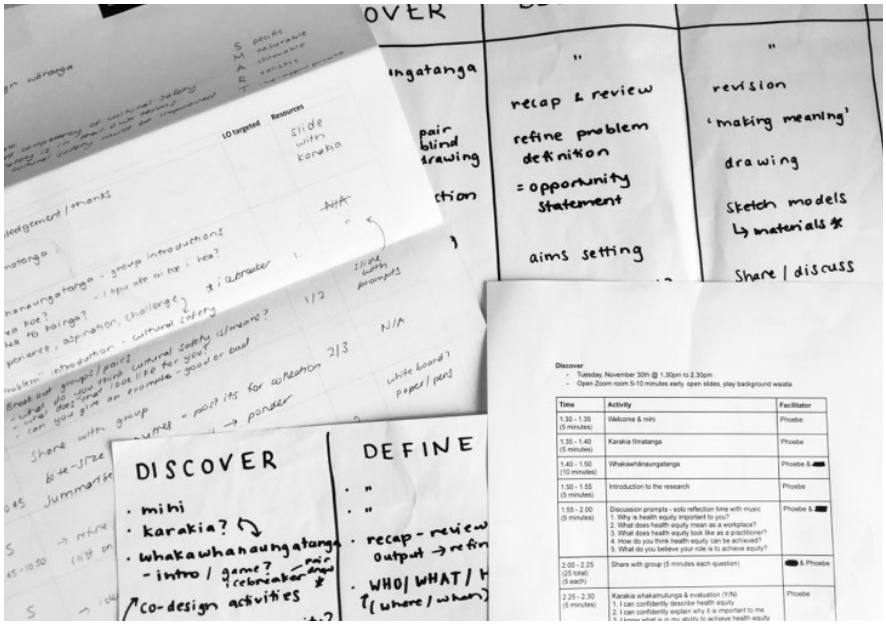

Figure 12. Phoebe Lee, *Planning*, 2021, Photograph, Tāmaki Makaurau.

7 Documentation of research

7.1 Project beginnings

This Documentation of research chapter encompasses the evolution of my thinking and learning throughout this study. There are descriptions of thoughts that I regrettably later identify as mistaken. However, it would be inaccurate and dishonest not to include them as part of this research journey. Descriptions of discussions and reflections have mostly been recorded chronologically to explain how they influenced the direction of this study. Iterations of the research question are positioned alongside these writings to demonstrate the changes in learning being made.

Beginnings
How might design encourage, facilitate, and mediate anti-racist discourse?

Before the thesis study began, I sought guidance from Āwhina, she was the Māori patient and whānau experience lead at a public hospital. I was feeling hesitant whether to proceed with my research hunch. I had previously attended a workshop she facilitated —"How to engage with Māori effectively." I wondered if I might be able to offer her my design skills to assist in her facilitation, maybe in the form of a post-event, self-directed learning kit. However, she kindly declined this idea. She likened her mahi to planting seeds for people to start asking their own questions. She intentionally chose not to use slides for attendants to be fully present and engaged. If she provides resources, Āwhina believes these limit the mana within us to look beyond them. After reflecting on this meeting including discussion with my peers and supervisors, I was unsure whether to proceed with my studies. I explored alternative research topics using several mind maps and discussions with other designers. I felt dubious about my position as a researcher and as a designer.

New meetings

How might healthcare professionals share their education on health equity with friends and whānau?

Through connection with my supervisor, I met with Deborah and Mikaere. They were the equity co-leads of their organisation and would later become the liaisons for the host of this eventual research. They had recently launched an in-house cultural safety training initiative, organising monthly events and workshops for their team. They were keen to discuss how we might work together to develop a method of engagement. Deborah asked for, "Something to take the conversation home to family." I reiterated Āwhina's perspective on resource provision as being mana limiting. They also work with Āwhina. Mikaere suggested, "Ploughing the field is necessary before sowing the seeds." I enjoyed this analogy at the time, but I later wondered if it was dismissive of Āwhina's earlier misgivings.

Making decisions

I attended a monthly health equity meeting at the research partner organisation, where Nigel, a Māori Emergency Department (ED) Doctor, gave a presentation. He talked about the historical causes of racism and inequity in Aotearoa, how causes of ethnic inequities are attitudinal, and Pākehā guilt. Nigel referred to the quote — "The opposite of love is not hate, it's indifference." He suggested encouraging dialogue was one step towards realising equity through unpacking entrenched deficit thinking about Māori health. However, Nigel believed that one-on-one conversations with loved ones risked alienation and were unworthwhile. It was better to go straight to the leadership of organisations because systems change instigates personal action. Systems are, albeit, made up of individuals, and at some point, it is an individual or a small group making decisions for the institution. Nigel explained our primary healthcare system as the main barrier to achieving health equity. He described it as a dispirited, unorganised, fractured system that values profit over patients' wellbeing. They should instead be a collaborative, active group as part of an integrated government body. One pathway towards realising this that Nigel recommended was the auditors' approach. They are outliers to the overall health system, but they monitor institutions and can demand accountability.

After the presentation, there was some time for feedback and questions. One attendant said, "We want to believe that we are doing the best for *all* our patients." This comment struck me because I realised that best for all does not mean the same for all, that is equal treatment versus equitable treatment. For example, when a Māori child from a low socioeconomic area presents at the ED, they should immediately be admitted. Whereas a Pākehā child from an affluent neighbourhood, you could send them home after attending to them. These two courses may seem 'unequal,' but ethnicity and socioeconomic status are inextricably linked. Both must be considered by practitioners' when assessing patients. It is much more likely that a Māori child will have severe disease and fewer resources to access healthcare.[126] Another attendant asked, "How do we challenge or have these conversations at home?" Nigel responded, "It's not worth it. It's more trouble than it's worth." After this presentation, I felt a bit hopeless but not helpless. I felt my desire to fulfil this mahi and duty grow.

Second-guessing

How might co-design facilitate equity training and consolidate this learning for healthcare workers?

In the next monthly health equity meeting, Judy, the Director of this research partner organisation, shared a case study from the Radiology department. This departments did-not-attend appointment rates for Māori and Pasifika clients were too high. One step to counter this was meeting with the reception staff, who expressed concern that taking extra measures for Māori and Pasifika clients was 'reverse racism.' This reiteration mortified me, but even more so by my impression that Judy and Deborah condoned these comments. They were congratulatory that measures could now be implemented as staff felt comfortable enough to voice and share their opinions. When someone asked what was being done next. Judy responded that this was just the first step.

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[126] Dale Husband, "Owen Sinclair: Fighting the racism in our health system," *E-Tangata*, February 17, 2019, https://e-tangata.co.nz/korero/owen-sinclair-fighting-the-racism-in-our-health-system/.

In our Te Reo Māori class, our kaiako shared, "Patua te whakamā, nau mai te hapa" — To overcome shyness and shame, welcome the mistake. It shares similarity to the common phrase, "Feel the fear and do it anyway." This applies to our language learning journey because making mistakes is the only way we can learn. I thought it would be essential to instil this mentality within potential research participants. Feel brave enough to share their stories honestly and be open to learning. However, I did not want to condone racist comments without reproach.

Counsel

How can I co-design a conversation tool with members of a large public hospital's quality improvement and innovation unit to galvanise their commitment to achieving health equity and improving cultural safety?

Once ethics was approved, Deborah left her position to return to her country of citizenship. At this point, Mikaere explained to me how the project should not depend on particular individuals. The essence and intention of this mahi could and should be continued by anyone and everyone. It is much bigger than a single person. It is not, and should not, be any individual's responsibility. It must be a continuous, collective effort. I often sought guidance from Mikaere to ensure I planned the research design appropriately. Reassurance from having his endorsement alleviated my anxiety and bolstered my confidence in undertaking research in this field.

'Champions'

Mikaere invited me to a meeting with the leadership team of the ED. He thought my being privy to these conversations would add to my insights. Honestly, I did not understand much of the meeting. But I remember Mikaere saying, "We are working with the willing who are the 'champions' at the expense of everyone else." I did not fully realise what this meant then, but I understand better now. Everyone must be on board with equity work for it to be successful. By relying on specific individuals to drive change, it permits the rest to remain indifferent.

Our meeting and discussion were the motivation I needed. I shared some of my trepidations about the research, such as facing apathy. Mikaere acknowledged that apathy was a valid risk and he asked how I could turn that into an opportunity, perhaps measuring this amongst participants after the workshops. Since the opportunity was the research itself, the process was the purpose and a seed for future research. I can only fail if I do not learn anything. If the outcome does not galvanise healthcare workers' commitment to achieving health equity, I can discover what did not work to inform the next iteration. I must remind myself of my scope as a researcher that I alone cannot attempt to solve institutional racism.

We discussed some concerns expressed to me during the monthly MDes cohort critique session. These included how I might create a 'safe' environment, to ensure participants felt comfortable enough to share, amidst aversion in our current 'cancel culture' climate. However, this feedback did not sit right with me. I felt like this in some way concurs and validates racist remarks. Mikaere contemplated this and recommended that I should embrace any silence and acknowledge 'cancel culture,' white privilege, et cetera. He likened it to the values of pono, tika, and aroha. Pono meaning honesty, allowing participants to be open about their thoughts and feelings. Tika meaning integrity and doing the right thing, enabling people to reach conclusions and trusting them to do the right thing. And aroha meaning compassion, treating people with the benefit of the doubt and then going back to pono and tika, do the right thing if or when needed, for example, calling out racist behaviour.

Mikaere asked if my facilitation of the workshops was a requirement of the MDes. This question made me unsure of myself, and I wondered if he was sceptical of my capability. I explained that facilitating was an opportunity for me to gain experience and build my confidence. I later recognised that he might have just been expressing concern for my safety.

Two approaches

During the meeting with the ED leads, Mikaere discussed two differing approaches to addressing health equity. I later abstracted these concepts into the visual diagrams below, which Mikaere also validated. The first option is derived from existing models and based on a linear approach. Whereas the second option is based on a cyclical and holistic-based approach, which is what we should be adopting.

Figure 13. Phoebe Lee, *Option 1: Linear result-driven model*, 2021, Diagram, Tāmaki Makaurau.

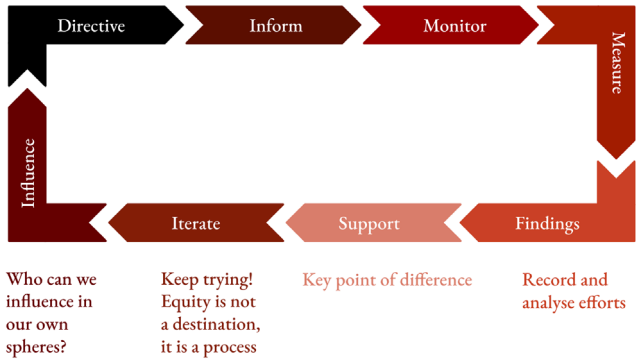

Figure 14. Phoebe Lee, *Option 2: Holistic cyclical approach*, 2021, Diagram, Tāmaki Makaurau.

Delta lockdown

Soon after the meeting with the ED leads came the announcement of another lockdown. However, online meetings with Mikaere, did not deter from the motivation and inspiration I gained from having our discussions. A memorable quote from Mikaere during one of our Zoom meetings was, "Health equity is not a destination. It is a process." This statement seemed profound to me at the time, but I now realise it to be essential learning.

We discussed some workshop contingency plans since in-person data collection could no longer commence. I asked if Mikaere would co-facilitate the workshops, to which he agreed. He recommended I consider how I would entice participants. This led me to re-evaluate the email I drafted for the ethics application, and the realisation of stipulations in the ethics approval. A fluent reo Māori speaker on the ethics committee advised me to carefully check the use of te reo Māori in the participant information sheets. I had not taken on this responsibility seriously enough. I mistakenly thought what I provided, 'Ko Phoebe taku ingoa,' was sufficient. After consulting our kaiako Reo Māori, I learned some new kupu and sentence structure. We had recently learned possessive pronouns. At the beginner level, we used the neutral pronoun taku. Taku felt appropriate as Phoebe is *not* my birth name. I did not think that tōku, meaning belonging to, was suitable. I love the intentionality of each kupu, adding such richness to the language. Pronouns describe your relationality and connection to everything which surrounds you. Our kaiako was understanding of the significance of my birth name and provided this alternative:

> Ko 이예은 tōku ingoa, engari, ko tōku ingoa kārangaranga ko Phoebe.
>
> My name is 이예은, but the name I am commonly known as is Phoebe.

All these discussions and reflections described in this section (amongst others) were instrumental to developing my learning and growth as a researcher and designer. Every conversation, including consideration of the ideas discussed and later iterations of these reflections, contributed to my own development on this research journey. The following section covers the next stage of the design process and the first data collection method, expert interviews.

7.2 Interviweing

How can I co-design a conversation tool with members of a large public hospital's quality improvement and innovation unit to galvanise their commitment to achieving health equity and improving cultural safety?

Ethical considerations
I identified potential experts and contacted them through publicly available information. They were contacted via email, inviting them to participate in the research. After an expert responded with their interest, I sent them an information sheet and consent form. Due to travel and gathering restrictions at the time, we had to arrange online video meetings.

1. Daley
I conducted the first interview with a general practitioner who works with rural Māori communities. Daley emphasised their likening of the term equity to fairness. They described this concept as approachable and accessible for even young audiences to grasp, including their tamariki.

Midway through this interview, I worried that this research was in jeopardy. Daley expressed that a spectrum of participants would be essential for this project, which would need to include 1. Māori and Pasifika patients with lived experience of health inequity, 2. Māori providers and organisations, and 3. non-Māori providers. They also recommended recording the demographics of providers, including their gender, where and when they had their training, and whether English was their first or subsequent language.

Although there had been a brief discussion with the liaisons about shoulder tapping participants for the research, this idea did not eventuate. As a non-Māori researcher, it would be inappropriate for me to investigate Māori. I knew that the scope for this research and the demographics of this research partner host would not allow for the spectrum of diversity viewed as essential by Daley.

2. Morgan
Next, I interviewed an academic and educator on public health and equity. From this interview, it was apparent that this research needed to be revised. I felt embarrassed and ashamed that I had been blind to this before these interviews. When I reflect on that conversation with Āwhina before commencing the study, it seems like I should have known better than to pursue the creation of a conversational tool.

3. Āwhina
Finally, I interviewed Āwhina. This interview was pivotal for me to validate my concerns and to seek guidance on how I might be able to progress. I thought of this conversation as a way of seeking answers and finding resolve for how to continue the design research. I felt a lot of fear that I was doing the wrong thing. However, I felt so much aroha from Āwhina, who advised me to reframe the opportunity.

I recognise now and acknowledge that it was unfair to place so much emphasis on receiving direction from solely Āwhina's advice. She should not be the single bearer of that responsibility. It was my ultimately my responsibility to do self-reflection and learning. Similarly, it was not Mikaere's role to be the sole champion of health equity for his team.

Key findings

From the expert interviews, it was clear that the framing of this research was inappropriate and should not progress without reflection and re-evaluation. The key insights from these data which informed the next iteration of this design research were:

1. Who is at the table?

Team members of this research host do not reflect the diversity of ethnicity, socioeconomic status, et cetera, necessary to inform the development of this design research. The homogeneity of the participant demographics would only perpetuate the status quo. Essentially, the majority of staff from this organisation were of European descent. It would be unsafe for everyone to be involved.

2. ~~Wānanga~~ → Development session

Was this an appropriate naming convention? What makes an event a wānanga? I had changed the naming of the workshop to wānanga after a suggestion by Mikaere. I adopted this change without hesitation. However, after questioning by Āwhina about what makes this event precisely a wānanga, I could not answer. By 'culture-fying' in name only, it is insufficient and offensive. In this comment and analysis by Dr Elana Curtis, she writes, "I love my culture, but it's not the answer to Māori health inequities."[127] Being more culturally aware and incorporating different cultures does not solve the wickedness of racism.[128] The problem is *not* any one specific culture. But rather, it needs to be addressed through a constant and critical self-reflection of culture itself.[129]

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[127] Elana Curtis, "I love my culture, but it's not the answer to Māori health inequities," *E-Tangata*, March 8, 2020, https://e-tangata.co.nz/comment-and-analysis/i-love-my-culture-but-its-not-the-answer-to-maori-health-inequities/.
[128] Ibid.
[129] Ibid.

3. Reframe the topic from my own identity and experience
Why do *I* personally want to achieve health equity? What does health equity look like and mean for me? Language access was one suggestion made by Āwhina. It is a thought that crosses and troubles my mind, worrying about my parents' lack of agency in navigating our health system due to limitations in their English comprehension. This insight informed the development of my recognition of the role tauiwi must have in health equity conversations that is not burdensome for Māori. Coming to the Tiriti table means equipping people with the necessary tools and creating a secure environment where everyone feels empowered to participate.

4. Equity is a low-hanging fruit
Equity is only a starting point and it is only the baseline. The goal posts will constantly be moving, as there is no end destination. Fairness and equity are basic human privileges, but it is only the beginning of this continual journey.

5. Health versus Hauora
These are two distinct concepts. Patients and whānau are the rightful experts on their health or hauora. Similarly, the term health equity acknowledges that differences in practice and treatment are necessary. There are no universalities within healthcare. Fair and equitable treatment does not mean the same treatment for all. For example, in the ED, triaging recognises and responds to the perceived urgency for care.

7.3 Reframing the opportunity

What initially began as an opportunity to leverage my design skills to tackle the wicked problem of health inequity, the research revealed that creating a conversation tool did not align with the (eventual) research question. However, it was essential to acknowledge that this initial thinking was part of my journey, learning, and growth. I could frame that making intended to gather and expand knowledge,[130] combined with the subsequent realisation that a designed product would be inappropriate, tested the potential of using design thinking methods to produce critical learning within the researcher. In addition, to an attempt to bring other people onto this learning journey in a mutually beneficial, reciprocal, and mana-enhancing way.

A plan was made and enacted to honour the findings from the data gathered to reassess how I might resume and move forward with the design research. I attempted to define a problem needing to be solved using design, but the expert interviews revealed that I needed to restart and try again. This stage exemplifies the iterative nature of the HCD process.

1. Cancel or postpone workshops
Firstly, the workshops needed to be cancelled or postponed

2. Re-establish framework
Pause. Take a break and step back from the research altogether. Dedicate some time to evaluate what I am aiming to achieve and why. Position myself in a way that framed new opportunities for design research.

3. Resource a cultural advisor
If possible, there needs to be someone at the University who can guide the cultural appropriateness of whatever progresses.

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[130] Nigel Cross, *Designerly Ways of Knowing* (New York: Springer, 2006), 22-24.

Reflection of the expert interviews

I felt a mixture of emotions throughout this period, including fear, guilt, and shame. It seemed so evident that I had made such a huge oversight. I was unsure how to progress with the design research and if I should continue. After speaking with my supervisors and friends, I spent some time reflecting on myself. To understand why I wanted to achieve health equity and deem it necessary, I wrote the diary entry below.

Upon reflection of this entry, I recalled that often Māori do not get offered a referral for a specialist appointment in the first instance.[131] Although it was emotionally draining to think and write through these thoughts, it was essential to establish a foundation and framework of understanding from my own lived experience. That is the only thing anyone has, can, or should do.

> Why do I want health equity in Aotearoa? So that I do not need to attend my Mum's health appointments with her. I want to feel confident that my Mum will receive a high quality healthcare service without my presence. I trust the healthcare worker nearing the end of their twelve hour shift of an eight-day working week to treat my Mum with as much care as they would their own. Because I know that does not always happen, I have seen that the system does not allow for this to happen. But I want to know that I did everything possible to ensure the healthcare system can be equitable for her.
>
> My Mum broke her ankle in 2015. She has had a long recovery journey with ongoing problems to this day. Earlier this year, she asked me to go to a specialist orthopaedic appointment with her. While waiting at the clinic, I witnessed the Doctor walk their elderly White patient to the front door and patiently answer their last-minute questions.

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[131] Donna Cormack, et al, "Ethnic bias amongst medical students in Aotearoa/New Zealand: Findings from the Bias and Decision Making in Medicine (BDMM) study," *PLoS ONE* 13, 8 (2018): 1-19, https://doi.org/10.1371/journal.pone.0201168.

Shortly later, the Doctor called us in. The Doctor began with a few generic questions for Mum. She replied by describing the swelling in her ankle. The Doctor could not understand Mum's pronunciation of swollen and they turned their head towards me for translation. I obliged. Later, Mum misinterpreted some of the Doctor's questions. But I let her answer without translating for either party. I felt the Doctor increasingly look towards me instead of Mum.

Once the Doctor was finished with the assessment and gave their recommendations, it was my turn to communicate. Although I have full English comprehension and some medical knowledge, the Doctor spoke swiftly and in medical jargon that even I could not fully understand. I was trying to translate for my Mum and the Doctor, what each wanted to convey to one another. But before we knew it, Mum and I were ushered out of the consultation room without getting a chance to ask any further questions or clarification.

After this experience, I felt like I had failed my Mum. I did not want to answer for her, so I let her answer the Doctor. I also did not want the Doctor to only look and talk with me. But this is what my Mum had wanted. For me to interpret, translate, and advocate for her. I could not attend her previous appointments because I lived in another country. How much more difficult it would have been for her then? I want health equity because that means I am able to trust our healthcare system to provide an equitable service for my Mum.

"Who am I?"

After this necessary reflection time, I wanted to share this thinking with Mikaere. I explained I needed to reframe the research and decided to postpone the workshops. The lockdown provided an easy scapegoat but it was to provide buffer time to figure out how I could proceed. I acknowledge the similarity here to the design process where iteration is a natural part. Mikaere was supportive and understanding that I was experiencing internal conflict. But he also seemed disappointed and frustrated that the project was on hold indefinitely. He interpreted my analysis of the expert interview data as "This research is inappropriate because the potential participant recruitment pool is too white." But he questioned whether that was not the point of the research. After this meeting, I made some decisions and changes. The main change was the research question, which had transformed to:

> How can I learn alongside members of a large public hospital's quality improvement and innovation unit to recognise and practice our responsibilities and capabilities for achieving health equity?

Another Zoom, another lesson

After making these changes to the research question and workshop planning, I prepared them for another discussion with Mikaere. He asked what my expectations for the outcome and success were. For me, my goal was to gain confidence through experience and practice. Together with Mikaere, we developed this reasoning for the research project, I am leveraging support from the quality improvement and innovation unit to propagate learning. The learning from this study will be a seed for planting future iterations of understanding and knowledge.

Seeking additional Māori counsel

Māori, moreover any ethnicity, are not a homogenous people. One cannot be expected to speak for all. I had received counsel from Mikaere and Āwhina, who are tremendous and whom I deeply admire. But I acknowledge that one or two endorsements do not make rigorous consultation with Māori. Their advice has been invaluable, but I cannot expect Mikaere and Āwhina to provide answers for all Māori.

Through my supervisor, I organised a meeting with Mia to incorporate more Māori views into this research. From our conversation, Mia questioned what I meant by equity, as it means different things to different people. Did she mean the accessibility of services or the system or something else? Mia encouraged me to be specific. She appreciated that I was speaking with her now, not later or after. Mia also talked about kaupapa Māori research practice. Since it is embedded in the psyche, it is therefore unteachable and unlearnable.

The meeting with Mia was necessary and informative. But it did make me question myself again. I did not confidently deliver my elevator pitch. As I was unsure what I was designing. The process was the design, but I felt lost without a specific intention for a tangible outcome. From our conversation, I had many more questions than answers. Some of these were:

- How are tauiwi responsible for decolonisation praxis?
- How can non-Māori be cognisant of kaupapa Māori research?
- How can tangata Tiriti bolster indigenisation in an authentic, respectful way?

7.4 Workshop 1

Ethical considerations

Deborah and Mikaere announced that this research would occur during their weekly team meeting. An invitation with an attached participant information sheet was forwarded to the team via email, asking for expressions of interest. In the information sheet, I advised participants that anyone who was disruptive and put others at risk would be removed and excluded from the study to ensure the safety of the researcher and other research participants. I excluded managerial members from participating as their involvement would have created a power imbalance. Potential participants had more than two weeks to consider their invitation and those interested then contacted me directly via email. I asked these respondents to sign and return a consent form before the workshop commenced.

Initial plans

As previously mentioned in the Methods chapter, four workshops were initially planned. They were titled, discover, define, design, and deliver, akin to the double diamond design process model.[132] The plan for the workshops was:

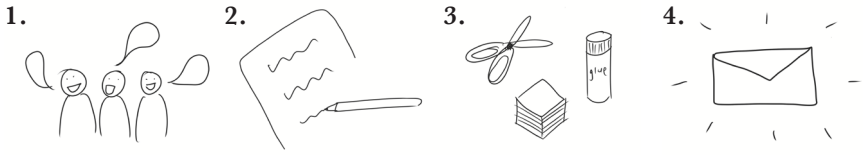

Figure 15. Phoebe Lee, *Workshop process illustration*, 2021, Digital drawing, Tāmaki Makaurau.

[132] What is the framework for innovation? Design Council's evolved Double Diamond," Design Council, accessed July 15, 2021, https://www.designcouncil.org.uk/news-opinion/what- framework-innovation-design-councils-evolved-double-diamond.

1. Discover
Whakawhanaungatanga would be established with the participants. An overview of the workshop plan would be outlined. Then depending on the group size, participants would break into pairs or small groups to discuss their assumptions and brainstorm any initial ideas. The group would then come back together to discuss their findings, generate feedback, to further drive insights and identify a problem to be solved.

2. Define
A summary of the previous workshop would be discussed. The problem would be refined into an opportunity statement and aims set for the potential design output. An activity would be used for facilitation. If time allowed, prototyping could be started by drawing or sketch models using provided materials.

3. Design
A summary of the previous workshop would be discussed. Prototyping may be continued depending on progress from the last workshop. There will be a focus on sharing and discussing ideas and concepts. Other participatory design activities such as role-playing, storyboarding, or personas can be used test these ideas and concepts. Participants may test their prototypes outside the workshop if they wish to do so.

4. Deliver
A summary of the previous workshop would be discussed. There will be a focus on sharing and discussing their feedback on the ideas and concepts generated in the previous workshop. Participants are invited to provide constructive criticism. Once these steps have been undertaken, the process can be reiterated to refine these concepts and prototypes further.

Refinement

The workshop materials, such as the slides and run sheets for the workshops underwent several evolutions, using critique and refinement. (See Appendix 3 for the final slides used for the online workshop). Several iterations were developed to incorporate feedback from my supervisors, Mikaere, and the MDes cohort. I will explain their comments and how each developed the outcome of the final slides.

1. Supervisors

I initially sought advice on the slide content and its' design from my supervisors. We discussed their feedback during our supervision meeting. Their critique was high-level, included suggesting practising the workshop with the MDes cohort.

2. Mikaere

The feedback from Mikaere was pragmatic and affirming. We discussed the meaning of karakia and why we should practise karakia. We open and end meetings with karakia to give respect to Māori culture. To acknowledge our kaupapa and the whakapapa of knowledge before us. It brings the group together, helps us focus our attention, to be intentional and engaged.

Some practical suggestions from Mikaere included opening the online meeting room early for participants, a title page with the message, "The session will start soon," and have background music playing. To create a positive environment and put participants at ease. He suggested pre-sending as much information as possible, such as the housekeeping questions (such as consent forms and their choice of pseudonym) and the prompt questions. Mikaere suggested using the colours red, black, and white. To make the slides visually appealing and represent the theme of the kaupapa, that is tino rangatiratanga. He suggested including "What is your role?" during the whakawhanaungatanga. However, I declined this suggestion as I did not want to bring any hierarchical labels into the discussion.

3. MDes cohort

As suggested by my supervisors, I organised a practice run with those keen from the cohort. A peer asked if I would be recording the session for analysis, as there may be bias in my interpretation of the discussion. I contemplated their suggestion but felt that recording would make participants feel less at ease, which would be counterproductive for the data collection. I discussed this comment with my supervisors, who explained interpretation is grounded in my recall of the discussion. My analysis would then be an interpretation of an interpretation. I cannot eliminate bias regardless of the measures I take. It is more useful to acknowledge that bias exists and understand how it informs my thinking for reflection.

Pre-workshop reflection

During our previous meeting, Mikaere explained he had recently had some negative experiences in his equity work. So, he wanted to thank me for my efforts. It was affecting to hear of his struggles. But his words of appreciation provided much affirmation, confidence, and excitement for the workshop. I was incredibly nervous on the day. My mood fluctuated, as did my confidence. My confidence (or lack thereof) was due to my uncertainty surrounding, "Am I doing the right thing?"

Workshop 1 findings

During the workshop, the participant's shared their thoughts on five prompt questions, which I had forwarded to them before the meeting. I used these questions to facilitate reflection with the participants:

1. Why is health equity important to you?
2. What does health equity mean in a workplace?
3. What does health equity look like as a practitioner?
4. How do you think health equity can be achieved?
5. What do you believe is your role in achieving health equity?

Using my notes from the workshop, I have included some quotes and answers from each question. I have also created word maps of common words and phrases mentioned for each prompt discussion.

1. Why is health equity important to you?
Sharon L said, "It is part of the clinician's oath not to harm. It's the right thing to do." Kate added, "We must aim to build a fairer world for everybody." Mikaere also added, "It's our personal, human value."

Figure 16. Phoebe Lee, *Word map 1*, 2021, Diagram, Tāmaki Makaurau.

2. What does health equity mean in a workplace?

Sharon T started the discussion by saying, "It's not personal. We need to be able to talk openly." I believe she meant that it is not about an individual's personality or character but rather a calling out of behaviour and actions. Jordan offered that there needs to be a top-down approach reflected by the organisation and filtered at every workplace level. Erica shared that we must embrace equity efforts by showing a genuine interest and support, not just on a superficial level. Sharon L suggested that there should be equal voices at the table, but some need more volume than others. And it is our role to amplify those voices.

Figure 17. Phoebe Lee, *Word map 2*, 2021, Diagram, Tāmaki Makaurau.

3. What does health equity look like as a practitioner?

Sharon T started the conversation with "…leave behind assumptions and bias." Sharon L countered that it was essential to acknowledge bias and recognise where it affects care provision. She recommended self-auditing practice as self-awareness has limits. Winona offered that we should see how we can support colleagues working in smaller communities. Mikaere added we should identify what is working and celebrate those for it to become a reality and 'the norm.'

Figure 18. Phoebe Lee, *Word map 3*, 2021, Diagram, Tāmaki Makaurau.

4. How do you think health equity can be achieved?

Erica started with, "We should have more conversations like these." Winona offered that we must speak up and use our privilege for good. Sharon T pointed out that there are different answers, just as the definition of health equity suggests. Mikaere said that co-leadership and persistence are critical. "We must overcome fears of achievability." Do the small things. Stay vulnerable, keep doing, trying, and making mistakes. Sharon L also said we should highlight their milestones, such as speaking te reo Māori during weekly huddle meetings.

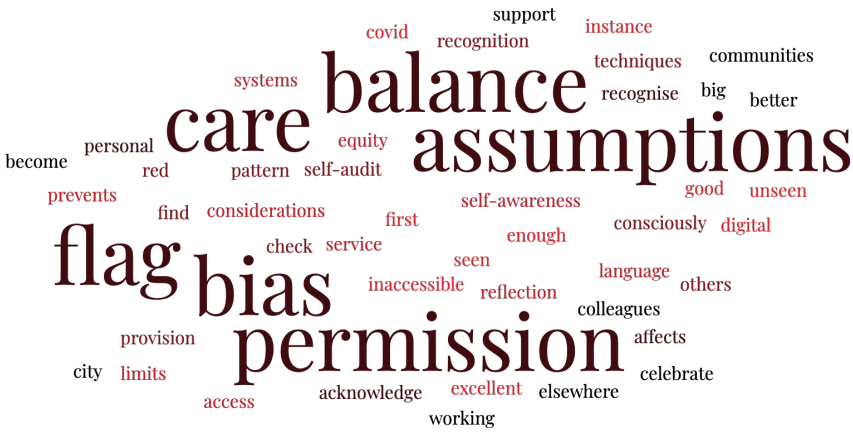

Figure 19. Phoebe Lee, *Word map 4*, 2021, Diagram, Tāmaki Makaurau.

5. What do you believe is your role in achieving health equity?
Sharon T said she inserts herself into uncomfortable situations and is open to correction so that she may learn and grow. Sharon L added, questioning others who may be saying inappropriate things and "nipping it in the bud." Jordan said they believe it is about helping create safe spaces and giving a platform to others. Mary continued the theme of highlighting and communicating success for it to become contagious. Mikaere said he believes his role is to uplift others' mana through celebration and praise. One cannot boast of their achievements, but it is the role of others to praise one another. I was reminded of the whakataukī, "Kāore te kūmara e kōrero mō tōna ake reka" — The kūmara does not speak of its own sweetness.

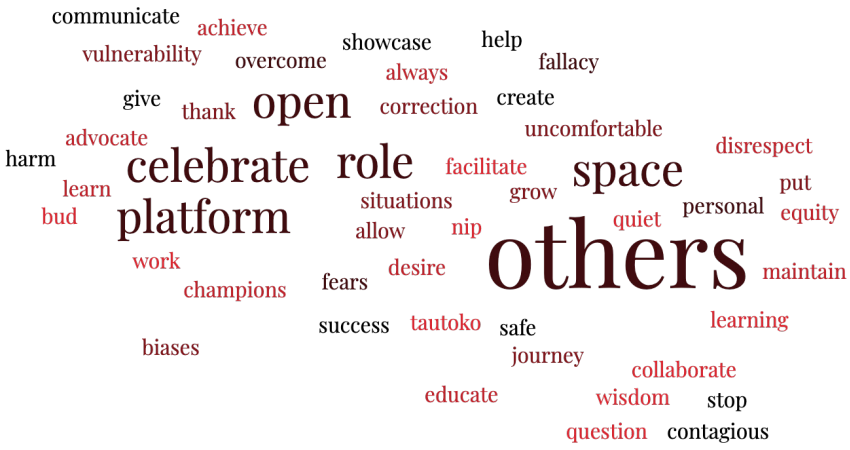

Figure 20. Phoebe Lee, *Word map 5*, 2021, Diagram, Tāmaki Makaurau.

I incorporated some self-evaluation questions at the end of the slides. I asked three questions to generate qualitative feedback on the workshop's effectiveness. Participants responded via the chat function on Zoom before they left the meeting. Some participants gave a single response to all three questions. I have recorded this under the first question for conciseness.

1. I can confidently describe health equity
Four respondents replied yes, and four said they were yet unsure.

2. I can confidently explain why it is important to me
Of all five respondents, they all replied yes.

3. I know what is in my ability to achieve health equity
Again, all five respondents said yes. In the words of Sharon T and Erica, "forever learning." A common theme amongst the replies was,"I am still learning, and I can always do better!"

I felt the atmosphere of the workshop was kind and supportive. Everyone shared in several instances and comfortably gave their input. (Except for one participant who left after the whakawhanaungatanga for reasons unknown). I am appreciative of the sincerity and willingness of everyone's contribution. The workshop was very insightful, and I hope everyone learned as much as I did from the session. I would like to acknowledge my thanks to Sharon T for starting off many of the discussions.

7.5 Supercharge your tauiwitanga

How can design be used to galvanise healthcare practitioners' commitment to achieving health equity?

I realised I needed to include design within the research question. The question — How can design be used to galvanise healthcare practitioners' commitment to achieving health equity? was used as a placeholder to review until after the summer holiday period.

Shortly after the first workshop, I attended an online seminar facilitated by ActionStation titled "Supercharge your tauiwitanga." The descriptor for the event read — "Everything you've always wanted to know about honouring te Tiriti without hassling (your) Māori (friends),"[133] which seemed apt for my design research. It was awesome to hear there were over six hundred viewers in attendance. I felt inspired and motivated by this fact. Pursuing research in this field can sometimes feel isolating and joyless. It was reassuring to know that others were feeling similarly, and we can help each other not to feel this way. This feeling of community was what I wanted to encapsulate in the eventual design output. The central learning I took from this seminar was the knowledge that there is no blueprint or roadmap for this kind of mahi. It was comforting to know that so many people were beginning their own learning journey. A helpful reminder to keep collaborating, imagine together and tautoko one another.

There was a Chinese speaker on the panel who provided wisdom specific to their third culture perspective. They recommended us to challenge ideas within our spheres of influence, such as our own families. By utilising the principles of collectivist Asian culture, which are concerned with putting others before yourself. The philosophical question stemming from Asian thought — "How do we lead a virtuous life with others?," bears some similarity to the latter part of this quote from Doctor Te Kawehau Hoskins, "Māori do not want you to be Māori. They want you to think positively about how you can have productive relationships with Māori."[134]

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[133] ActionStation, "Supercharge your tauiwi-tanga," December 3, 2021, Facebook live recording, 1:41:42, https://youtu.be/jHJgG2FISYg.

[134] "Te Kawehau Hoskins: building relationships with Māori is a win-win for all," The University of Auckland, August 2, 2021, https://www.auckland.ac.nz/en/news/2021/08/02/te-kawehau-hoskins-building-relationships-vital.html.

I arranged my notes and reflections from the seminar of these into a few themes:

1. "Anti-racism is a verb, not a feeling"

- "If you can feel overwhelmed, you are privileged enough to feel that way."
- Wanting to know before acting is not enough, thinking is not a surrogate for action.
- Lack of resilience is due to a lack of challenge and practice, it is a muscle that needs exercising.

2. Try, learn, and try again

- Stay involved, find other people, have conversations and keep going.
- Support one another. Do not attack one another for taking on differing roles.
- Keep making mistakes, apologising, reflecting, and carrying on.
- Help each other not to centre ourselves. Tauiwi and Pākehā are not the ones with a crucial relationship with Papatūānuku. Learn to follow, not lead. Get behind, listen, and act.

3. Keep reading the room

- Speak only for yourself, no one else.
- Te reo Māori is political. The language cannot be divorced from its violent history and the context of power and control in the colonisation of Aotearoa.
- Learning what is appropriate requires constant reflection and is full of contradictions. But they can have positive value, not just negative. In Asian philosophy, emptiness has value, for example, a cup has space to hold tea. I analogise this to my journey of this research learning. Through making mistakes, I have gained increased clarity and confidence in my position as a tangata Tiriti.

4. Be true to yourself and keep it real

- It is OKAY for non-Māori to advocate for Māori issues.
- Practise your commitment, and it will affect others. Tenacity is essential.
- Persistent calling out. It is not Māori responsibility to educate non-Māori.

5. What does solidarity mean?

- Find opportunities to be visible and supportive near you and practical ways to show up.
- Resources — time and money. Move money you will notice, for example six percent of your income.
- Publicly align yourself with tangata whenua issues and make yourself a target instead of letting Māori "take the blame."

7.6 Workshop 2

How might design thinking and creative methods be used to exercise reflection with members of a large public hospital's quality improvement and innovation unit on the meaning of equity as a practitioner, workplace, and individual?

After the first workshop, Mikaere left his role. I was reminded and felt emboldened by his earlier lesson and message — the onus of achieving health equity is not on any one individual. It is a collective, continual responsibility.

Reflecting on Workshop 1

During the first workshop, there was discussion about using an appreciative inquiry lens to frame this design research. I was aware of appreciative inquiry but had been reluctant to utilise this approach as it seemed tone-deaf in the context of the enormity and complexity of health inequity. However, insights from the data and reflection on these made me realise that some naïveté is needed. Some additional notes from my reflection included:

- Even if you have just started, you have made some progress.
- We must celebrate all the wins, whether big or small.
- How can we find a balance? Celebrate the wins yet acknowledge that the mahi is ongoing without burning out.

I combined this desire to "celebrate the small wins" with concepts discussed at the workshop, which were championing, accountability, and resilience. These led me to the idea of mug making as a symbol of these. A mug is a small, humble object, yet some might say vital, as the vessel that holds your morning coffee. My intention for the next workshop was to provide a comfortable environment and an opportunity for reflection. My hope for the mugs, once in use, was that they would be a reminder of the discussions had. A reminder to take a moment of reflection over a hot drink and chat with your colleague. A reminder to support and uplift one another. A reminder to keep doing better.

Reflecting on Workshop 2

As this was during peak Omicron with the **Covid Protection Framework** in place, one participant Jordan, attended the workshop. I expected but was still disappointed by the reduced participant engagement. Understandably, priorities shifted during this time, but equity initiatives should be viewed with as much urgency as Covid-19. I decided to move forward with the workshop despite the circumstances because I knew that waiting would only maintain inaction. Also, my priority was to complete the MDes within the timeline.

> **Covid Protection Framework:** is a guideline established by the New Zealand government for managing living with Omicron to lessen the impact of outbreaks.

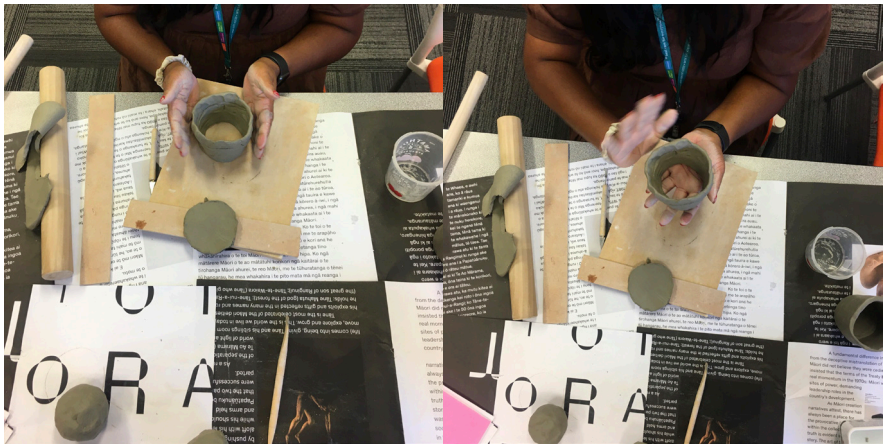

Figure 21. Phoebe Lee, *Workshop 2 making*, 2022, Photograph, Tāmaki Makaurau.

I demonstrated a few hand-building methods, a metaphor for the many approaches required, striving for equity. Once I had shown the hand-building techniques and Jordan was engaged in the process, I prompted them with some questions. I started with, "Did you have any worries about the creative aspect?" This initial inquiry led to a natural flow in conversation. These were some of the insights generated from our discussion:

- It is nice to have something to focus on, but I am aware that I am thinking of the outcome when I should be paying attention to the process.
- It makes me feel relaxed while having the conversation. I am more open minded and less focused on answering 'correctly' or over-thinking.
- The mug represents fulfilment and pouring from the self onto others. The topic of equity can leave you feeling depleted. There are positive values such as filling your cup to achieve fulfilment and satisfaction. But also the emotional cost required.

During the workshop, I observed Jordan struggling with handling the clay. I was thinking, "How can I support without taking control?" Instead of bringing attention to it, I thought it better to ask, "What can I help you with?" From their response, I suggested trying another tool or adjusting their manoeuvering to help with their issue. I now see the similarity of this mindset with the abstractions I created from the discussion between Mikaere and the ED leads. It is much more effective to offer support than attempt to control.

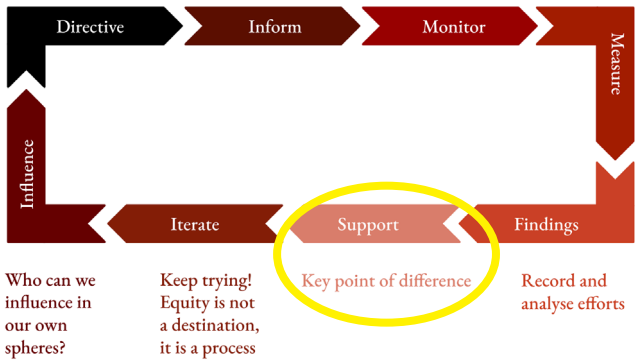

Figure 13. Phoebe Lee, *Option 2: Holistic cyclical approach*, 2021, Diagram, Tāmaki Makaurau.

Intuitive making

The idea for mug-making felt full circle that my journey had led me here. Throughout my studies, clay-making has been a calming remedy for me. I once believed that design alone could not change the world, but if design can change the world for one person, then that difference is all that matters. However, this thinking felt unaligned with my desire to encapsulate the feeling of community and shared aspirations. I decided to make nine mugs to represent the participants from the first workshop. I inscribed their initials on the bottom, similar to a potter's signature. However, this posed a confidentiality risk. As the mugs were not intended for individual use but as a koha for the organisation as a whole team.

Figure 22. Phoebe Lee, *Making*, 2022, Photograph, Tāmaki Makaurau.

Integrating feedback

The intention behind the mugs is ambiguous allowing opportunity for interpretation and meaning-making. However, my peer from the MDes cohort asked how I could make the concepts more accessible. Some suggestions included accompanying coasters with messaging or inscribing words onto the handles using glaze. I had planned to glaze them all the same, as I thought each mug would be created by an individual and the glaze would be unifying.

After a monthly MDes cohort critique session, I made some executive decisions. 1. I decided to gift the making from the workshop directly to Jordan. They had inscribed their initials on the underside of the mug, which had already been bisque fired and would not be able to be anonymised. 2. I made another mug to represent their contribution to include with the set, and 3. I anonymised the participant initials using an overlapping script to be hidden in plain sight. This was an idea from one of my peers during the critique session, I enjoyed this technique as it still imbued the participants' input yet acknowledge their contribution.

Anonymity assessment

I contemplated the usage of the photos taken from the second workshop where Jordan could be identified by their colleagues from their skin tone. As there were only two possible candidates within the team at the time of this writing. I believe this demonstrates a lack of diversity and is representative of a systemic issue. After discussion with my Supervisors and with Jordan, I have decided to include the images as well as this refelction.

Final recipe

I underwent the firing process in several phases to test different glazing techniques. I was keen to replicate the glazing technique from a previous batch (Figure 24). However, like a recipe there are always uncontrollable factors for example, the weather, which makes consistency irreplicable. A metaphor for the workshop attendance, no matter how much I prepare, there are no guarantees and I must always anticipate curveballs.

Figure 23. Phoebe Lee, *Test batch*, 2022, Photograph, Tāmaki Makaurau.

Figure 24. Phoebe Lee, *Glazing*, 2022, Photograph, Tāmaki Makaurau.

Figure 25. Phoebe Lee, *Mug set*, 2022, Photograph, Tāmaki Makaurau.

Presentation plan

This research attempted to investigate how design could be used to support and uplift members of an organisation with recognising their responsibility and capability striving for health equity. The initial intention to co-design a conversation tool was found to be in dissonance with the data. There is no final competency for health equity. A designed product would be inappropriate, instead the 'outcome' will be a presentation of this research and learning journey. By using a design process including critiquing, failing, iterating, and testing, it allowed me to be adaptable and responsive to the participatory nature of this design research. We need to co-exist with the cyclical design process, as we are designing within our humanity as well as with human-centred design. It is messy because we are messy, it needs to have flexibility because life is not contaminable. I plan to present this research and learning journey at the quality improvement and innovation unit. I will also gift the mugs to them. As of August 2022, there has been no replacement for the equity team leaders since November 2021. After Deborah resigned, management did not refill her position. Mikaere's role has also been left unfilled. This inaction demonstrates a lack of prioritisation perceived by their management. I hope the mugs will plant the seeds for team members to realise that their equity initiatives require a sustainable revitalisation plan.

Checking the use of te reo Māori

From discussion with my peer in the MDes cohort, they suggested I resource someone to check the reo Māori within this exegesis. I am grateful for their recommendation, as it provided another learning opportunity. I referred to Te Taura Whiri i Te Reo Māori website, which has a registry list of available translators. The Māori Language Act 2016 permits Te Taura Whiri i Te Reo Māori to accredit professional translators and interpreters.[135] Taurapa has provided me and this writing with essential recommendations and learnings.

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[135] Te Taura Whiri i Te Reo Māori, "Te Rēhita Kaiwhakamāori," accessed July 18, 2022, https://www.tetaurawhiri.govt.nz/.

7.7 Tiriti-based futures

How might design methods be applied to enhance reflection with members of a large public hospital's quality improvement and innovation unit on the meaning of equity as practitioners, colleagues, and tangata Tiriti?

I attended the online symposium, "Te Tiriti-based futures."[136] This event took place over ten days, with various local and international speakers addressing issues including anti-racism and decolonisation.[137] I engaged with a handful of sessions from over a dozen on offer. I will explain key takeaways from some of the seminars I attended. The two main learnings I gathered from the symposium were:

1. Find your community
Connect with other like-minded, value-oriented, purpose-driven people to support and uplift one another.

2. Do it only for yourself
Do not try to bring anyone else with you on the journey. If you are willing and open to change, the transformation will be visible for others to notice and be inspired.

[136] "Home," Te Tiriti-based futures, accessed July 5, 2022, https://www.tiritibasedfutures.info/.
[137] "Te Tiriti-Based Futures: Aotearoa decolonisation event set to enlighten, educate and create change," *The Lovepost*, March 17, 2022, https://www.thelovepost.global/perspective/articles/te-tiriti-based-futures-aotearoa-decolonisation-event-set-enlighten-educate-and.

Racism in the health sector in Aotearoa - whose responsibility is it?[138]
I thought the title of this seminar was pertinent to this design research. The panel included leaders in Māori health research, Lady Tureiti Moxon, Professor Papaarangi Reid, and Professor David Tipene-Leach. They discussed several questions such as:

- Will the current reforms deliver the transformation that needs to occur?
- What needs to be in place for the Māori Health Authority to succeed?
- What does mana motuhake look like in this space?

The key message I learned from this session was that equity is only the monitoring framework. Equity does not mean te Tiriti compliance, which requires constant updating and accountability. Professor Papaarangi Reid explained how they believe shame should be a motivator for systems change. But it is permitted in our society for example, the pushback from the right wing on earlier Covid vaccinations for Māori and Pasifika.[139] Professor Reid also explained that adverse deficit health statistics should be framed as system and Crown failings, "The data does not speak for itself. Māori speak for their data." Some other messages I took away from this panel included:

- Make the space to change your practice.
- Know how to ask and engage, find underlying issues, and change.
- Acknowledge your ignorance, make the space to learn how to do better, and love Māori!

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[138] Papaarangi Reid, David Tipene-Leach, Tureiti Moxon, and Joanna Lambert, "Racism in the health sector in Aotearoa - whose responsibility is it?" (panel at Te Tiriti-based futures, Zoom, Tāmaki Makaurau, March 21, 2022).
[139] Ibid.

Figure 26. @tetiritibasedfutures, *Racism in the health sector in Aotearoa - whose responsibility is it?*, Instagram post, Te Tiriti-based Futures, Tāmaki Makaurau, https://www.instagram.com/p/CbV7ZN-hnzo/.

Perspectives on power, change, and the State for Chinese in Aotearoa[140]
This seminar was centred around the question — How have Chinese in Aotearoa supported tino rangatiratanga and their self-determination? The panel examined previous paths taken, their role and its' effects on their communities, and potential future directions to transform Aotearoa into an equitable, harmonious, and Tiriti-based society. It was fantastic to see faces who look similar to mine represented on the panel. They are role models for how I wish to practice. One of the panel members is part of the group, Asians Supporting Tino Rangatiratanga (ASTR) and their contact information was provided. The key message from this seminar is summarised in the quote (Figure 28) which was similar to the lesson from the "Supercharge your tauiwitanga" webinar about influencing those within our existing spheres.

[140] Bev Tso Hong, Kirsten Wong, Tze Ming Mok, Mengzhu Fu, and Valance Smith, "Perspectives on power, change, and the State for Chinese in Aotearoa," (panel at Te Tiriti-based futures, Zoom, Tāmaki Makaurau, March 22, 2022).

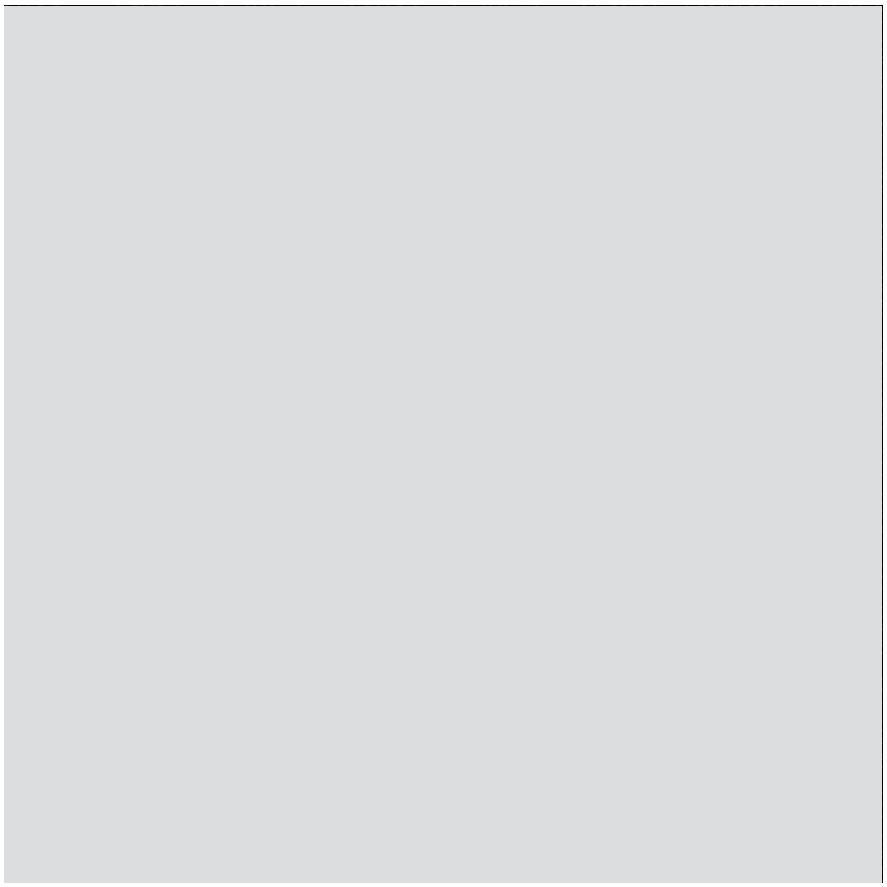

Figure 27. @tetiritibasedfutures, *Perspectives on power, change, and the State for Chinese in Aotearoa*, Instagram post, Te Tiriti-based Futures, Tāmaki Makaurau, https://www.instagram.com/p/CbY01xfJtwx/.

An Indigenous perspective on modernity and decolonial futures[141]
In this seminar, the key message I took was the latter of the two main learnings mentioned earlier about doing it only for yourself. The speaker, Yin explained using the quote, "Be the change you want to see in the world." He described when an audience is asked the rhetorical question, "Who wants the world to change?" Many hands are raised, alongside head nodding. But when the following question, "Who wants to change themselves?" is asked, often the response is less enthusiastic.

This speaker positively influenced my mindset, and his talk gave me solace, affirmation, and validation. His presentation was highly academic, and I am unsure if I understood most of it. But his intention was clear. We must return to indigenous ways of living with the natural world before we meet the extinction of our planet. Yet, in somewhat of a contradiction, all we can concern ourselves with is focussing on our capacity for learning, change, and transformation. It is all we can or should try to do. Do not concern yourself with others by trying to change their minds. We can only keep trying to best live our values, which may spur others to see the positive effect it has on us and desire to do the same.

From attendance of these events about anti-racism and decolonisation, my practice, as does my determination grows. These deliberate actions, attending seminars and symposia searching for knowledge have contributed to this design research, which for me has been learning about and becoming a tangata Tiriti.

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[141] Yin Paradies and Grant Berghan, "An Indigenous perspective on modernity and decolonial futures," (panel at Te Tiriti-based futures, Zoom, Tāmaki Makaurau, March 24, 2022).

Figure 28. @tetiritibasedfutures, *An Indigenous perspective on modernity and decolonial futures*, Instagram post, Te Tiriti-based Futures, Tāmaki Makaurau, https://www.instagram.com/p/CbezsFELxqK/.

8 Discussion

8.1 Research in a pandemic

This design research commenced before the introduction of the Delta strain of the Covid-19 virus into Aotearoa. The arrival of Delta was inevitable, yet the lengthy lockdown which ensued felt unforeseen. The impact of the Covid Protection Framework in Tāmaki Makaurau (amongst other regions) had evident effects on the planned data collection for this study. However, it was the mental toll that was most significant. The feeling of hopelessness grew as the weeks progressed into months, then over a third of a year.

Once most Covid Framework Protections were lifted, and seeming 'normalcy' returned, Omicron arrived on our shores. A rhetoric often espoused since the pandemic is, "We must learn to live with the virus."[142] Yet it would be remiss not to acknowledge the feelings of demotivation and apathy during this research process. Pandemic fatigue is a proven phenomenon occurring amongst many of us.[143] The WHO defines this phenomenon as the stress, exhaustion, and despair caused by everyday challenges of living in a pandemic.[144] These challenges include the loss of routine activities, social connections, and constantly preparing for change. Culminating in intense emotional reactions including panic, anger, loneliness, and grief.[145] Conducting this research has been a lesson and practice in patience and self-compassion. I had to continually remind myself to be as compassionate to myself as I am to others about the circumstances we are all in and still facing.

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[142] BBC News, "WHO's Nabarro: We must learn to live with Covid-19," April 21, 2020, https://www.bbc.com/news/av/health-52369969.

[143] Fiona Cassie, "COVID fatigue anybody?" *New Zealand Doctor*, March 30, 2022, https://www.nzdoctor.co.nz/article/opinion/columns/covid-fatigue-anybody?fbclid=IwAR2_zG3-4jttseZz69gVvM1RNoZfgEGNFkZp8FcrEHlJZPDgHfvxUJPG7F4.

[144] World Health Organisation, *Pandemic fatigue – reinvigorating the public to prevent COVID-19. Policy framework for supporting pandemic prevention and management* (Copenhagen: WHO Regional Office for Europe, 2020), 7-8, accessed July 18, 2022, https://apps.who.int/iris/bitstream/handle/10665/335820/WHO-EURO-2020-1160-40906-55390-eng.pdf.

[145] Ibid.

Research often takes a back seat in times like this, though some, such as vaccine trials, were expedited. What defines a crisis, and why is health equity not treated as such? Covid-19 has heightened the visibility of longstanding health disparities, yet health inequity does not qualify for emergency status. People working within the healthcare system face a multitude of interconnected challenges. I recognise and acknowledge the significant pressure of working in this environment and how care provision must take precedence. Working with liaisons and participants from a hospital context meant navigating their heightened workloads responding to the pandemic. These additional roles and tasks added to the strain they already faced. The liaison and potential participants' priorities were mainly concerned with preparation for delivering care and services in our Covid-19 response. This situation meant I delayed some communication to respect their circumstances but this also gave them the best opportunity to participate in this research.

Although the pandemic has amplified the potential of using design to make positive changes within healthcare, there remain obstacles faced by designers and design researchers.[146] In a paper by Delft University, eight challenges were identified and categorised into three groups; 1. practice, 2. managerial, and 3. general.[147] Firstly, practice challenges include 1) fieldwork, 2) involving users, and 3) handling sensitive information.[148] Next, managerial challenges include 4) establishing mutuality, 5) relationship management, and 6) defining the value of design in healthcare.[149] And finally, general challenges include 7) creating rapport and 8) the time and financial constraints of the researcher and health organisation.[150] There is similarity with those observed within my own research. The main obstacle for me has been defining the value of design in the context of this investigation.

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[146] Bob Groeneveld, et al, "Challenges for design researchers in healthcare," *Design for Health* 2, 2 (2019): 305-326, https://doi.org/10.1080/24735132.2018.1541699.
[147] Ibid.
[148] Ibid.
[149] Ibid.
[150] Ibid.

8.2 What is design?

Through this research journey, I hoped to challenge and subvert what design is or should try to be. The research partner initially expected the design outcome for this research to be a tangible product such as a conversation tool. However, the findings and learning revealed that the result is not all design is about. Design is commonly viewed as mostly being concerned with aesthetics and problem-solving.[151] Historically, design started as a craft.[152] These days, design is centred on creating innovative solutions for human wellbeing.[153] Non-designers often perceive the value of design as a final output and outcome rather than the process.

Since this design research discovered that an outcome would be inappropriate and go against the findings, I reframed the project to emphasise the reflexive learning process instead. This cyclical iterative learning was similar to a 'typical' design thinking process, but instead of trying to justify and faithfully match the research journey to a design process. I instead recognised that utilising HCD and participatory design allowed me to be 1. adaptable, 2. resilient, and 3. reflexive. I believe these are the strengths, capability, and power of design. The ability to sit back, rethink problems, and occasionally adopt a radically new viewpoint.[154]

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[151] Donald A. Norman, "When You Come to a Fork in the Road, Take It: The Future of Design," *She Ji: The Journal of Design*, Economics, and Innovation 2, 4 (2017): 343-348. https://doi.org/10.1016/j.sheji.2017.07.003.
[152] Ibid.
[153] Ibid.
[154] Ibid.

1. Adaptable

Participatory design emphasises valuing and honouring participant input. This design research aimed to integrate the data and be responsive to the insights generated, for example, the findings from the expert interviews. A designed product would have been inappropriate given the context and prior framing of the project. The research intention was adapted, reframed, and shaped to incorporate these data as authentically and respectfully as possible.

2. Resilient

"Trust the process" is often quoted by designers.[155] Resilience is an essential trait for designers, where ambiguity is a given.[156] Designers must embrace fear, welcome the unknown, and become comfortable with uncertainty (like managing life in a pandemic). I needed to put my faith in the design process during (plenty of) times of confusion and anxiety during this research journey. Learning to be resilient enabled the completion of this study, to which I owe my increased confidence in my positioning for this type of research.

3. Reflexive

I have learned the necessity and value of reflexive practice from conducting this research during a pandemic. Reflective and reflexive practice are distinct from one another.[157] Reflective practise involves evaluating events that have transpired.[158] In comparison, the reflexive practitioner continually analyses themselves as well as their context.[159] They understand that inner and outer influences co-exist, and both must be reflected upon.[160] This reflexive practise has sometimes been overwhelming but reflexivity has enabled me to thoroughly interrogate my intentions by deeply understanding my thinking process.

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[155] Jon Kolko, "Trusting the design process," Interactions 20, 2 (2013): 80-81, https://doi.org/10.1145/2427076.2427093.
[156] Welby Ings, Disobedient Teaching: Surviving & Creating Change in Education, (Dunedin: Otago University Press), 29.
[157] Gillie Bolton and Russel Delderfield, Reflective Practice: Writing and Professional Development, 5th ed. (New York: SAGE, 2018), 3-10, https://uk.sagepub.com/sites/default/files/upm-binaries/32441_01_Bolton_3e_Ch_01.pdf.
[158] Ibid.
[159] Ibid.
[160] Ibid.

8.3 Personal learnings

It has been difficult to feel I have made significant progress on this research journey. But as I draw closer to the end of this study, I realise there have been many internal changes, such as learning, practice, experience, confidence, and growth. Education is valued highly and instilled from birth as part of my cultural heritage. Since there has been much civil unrest and uprooting in Korean history, this is why education is of utmost importance. You may not be able to take all your belongings with you, but you will always hold knowledge inside you.

I began with the hope I could assist others and myself by developing a resource to help have conversations on things that may be hard to discuss. I wanted to feel braver and be more confident. I have often felt a failure for not meeting my expectations. I have felt guilt for not measuring up whilst simultaneously doing something immeasurable. I have felt embarrassed that I was blind to so many mistakes I have made. I have felt shame that I could not deliver what I had initially intended to do. I have felt denial that everything will be okay in the end, but I have procrastinated due to my perfectionistic tendencies. From undertaking this research, I have discovered that there is no roadmap for equity and decolonisation. We must keep on failing, learning, and trying.

Although I have mapped this process mainly in chronological order, my journey has been anything but linear. It would be neat to be able to offer a tidy, tangible parcel of these research findings. But it would be a disservice to the learning I discovered. As the research uncovered (for me), there is no final competency or end destination for equity. It would be inappropriate to create a package of this investigation and call it a design 'solution.' The only personal action anyone can make is to open ourselves to learning, growth, and radical transformation.[161]

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[161] Yin Paradies and Grant Berghan, "An Indigenous perspective on modernity and decolonial futures," (panel at Te Tiriti-based futures, Zoom, Tāmaki Makaurau, March 24, 2022).

I have sometimes felt precious with my words whilst writing. I acknowledge the mahi never ceases, and the learning journey is forever. But I must remind myself that this exegesis was just a snapshot of my progress. I need to be generous with myself as well as with others, we are all on our own paths, at different stages of our journey. I overcame this preciosity by likening it to my tattoos. Some people may feel hesitant to permanently mark their bodies in case of regret. I view my tattoos as hallmarks of particular stages in my life, they allow me to reflect on my growth since I received them.

Admittedly, it has sometimes been hard to focus on this research topic as it is affecting to continuously learn about inequity. It can be easy to lose sight of the purpose and hold onto hope. I had felt regretful that I could have done more with this opportunity. But I realise it is a constant learning journey that was difficult to distil for this exegesis since it is a dynamic learning journey.

Similarly, no design project is ever truly finished and it takes years, if not decades, to reach mastery. I am reminded of the value of seconds. The term seconds is used for ceramic pieces that have imperfections and their sale is made with this disclaimer. However, these pieces may become a worthy investment when a potter reaches mastery, because of the seconds' rarity and uniqueness. This exegesis was a snippet of a lifelong journey, which will continue beyond the conclusion of this research. Ultimately, I will take forward the practise of humility whilst engaging in this space in future.

8.4 What being a tangata Tiriti means to me

From the gathering of contexts, I came across this essential reading by Tina Ngata, "What's required from tangata Tiriti?"[162] It has undoubtedly shaped and been paramount to my learning. She recalls a comment from her aunt when some researchers asked their community if they could do some work together, she responded "Stop trying to be Māori. I don't need you to be Māori. I've got that covered. I need you to be a good Treaty partner." Tina was spurred to compile and has generously shared a non-exhaustive list, which I have condensed below. She prefaces that this list does not shortcut our mahi as tangata Tiriti to identify and practice our responsibilities.[164] One, four, and seven resonated with me, which I will discuss.

1. **Be tau** (at peace) **with your position.**
2. Respect boundaries.
3. Be prepared to make sacrifices.
4. **There will be many spaces where your voice will be valued.**
5. Stand with us for our language, health, children's and women's rights.
6. Benchmark the discomfort of your decolonisation experience against our colonisation experience.
7. **Understand that learning our content and knowing our experience are two different things.**
8. Do not expect us to know everything about te ao Māori or have our identity journey sorted out.
9. Nothing is automatically a two-way street.
10. Do not expect back pats or thankyous.

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[162] Ngata, *What's required*.
[163] Ibid.
[164] Ibid.

1. Be tau with your position, sets an excellent precedent for the list that follows. We must be able to discuss the legacy of colonisation in Aotearoa candidly.[165] Learn and understand how that affects our own experience of class, gender, ability, or sexuality-based oppression.[166] These words allowed me to forgive my previous misgivings. Instead of stressing about everything I had done wrong, it was better to recognise and acknowledge the value of how far I have come since then.

4. There will be many spaces where your voice will be valued. Converse with other tauiwi and Pākehā about what it means to be tangata Tiriti. Māori spend far too much time educating non-Māori about their Tiriti responsibilities. Tangata Tiriti have a crucial place to engage with one another on how they can respond to the legacy of colonisation. This research initially began as a pathway to discover how I might have more courageous and confident conversations about race. I discovered from the findings that the journey I was navigating was how to better engage with anti-racism praxis and learn what it means for myself to be a tangata Tiriti. I realised that regardless of your ethnicity, everyone has a choice to be an advocate and develop their capability to do so.[167]

7. Understand that learning our content and knowing our experiences are two different things. We must learn and lead karakia and waiata but practising te reo Māori is not a free pass out of our Tiriti responsibilities.[168] Considering the comment by Tina's aunt ("Stop trying to be Māori…"), I was unsure of my role in 'normalising' tikanga Māori. But this lesson dispelled my second-guessing. I am cognisant of the privilege I have to even learn te reo Māori. When for many, what should be their birth-right, they may not have the same access to resources as I have.

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[165] Ngata, *What's required*.
[166] Ibid.
[167] Riki Nia, "Te Kete Rauemi | The Resource Kit," Australasian College for Emergency Medicine, accessed May 24, 2022, https://acem.org.au/Content-Sources/Advancing-Emergency-Medicine/Cultural-safety/Indigenous-Health-and-Cultural-Competency-Resource/Te-Kete-Rauemi-The-Resource-Kit.
[168] Ngata, *What's required*.

An ‘outcome’ for me from the Tiriti-based futures symposium was joining the community ASTR. At my first meeting, an online strategy hui, we shared our dreams and visions of a future, fairer Aotearoa. This group imagination session was a powerful yet relaxing experience. Although the meeting was lengthy, I felt lighter and recharged after the event.

Learning about te ao Māori has been affirming of my heritage and cultural identity. I feel prouder of my ethnicity, I speak my mother tongue louder with confidence and gratitude. I recognise and appreciate my upbringing as a first-generation immigrant and how this experience has influenced my values and worldview. I have the great privilege and pleasure of calling Aotearoa my home. This honour comes with the responsibility to uphold te Tiriti o Waitangi, which is essentially what allows me to be here.

8.5 What now?

In an interview with Professor Papaarangi Reid, she suggests that some people are blind to inequity, and it is only visible to them in an abstract form.[170] When self-reflection of their racist behaviour is required, most people will quit before they even begin.[171] Few are brave enough to change, but it also takes time to develop courage.[172] These latter words provided validation for my own learning journey where I felt a lot of uncertainty and hesitancy prior to the thesis year. Since undertaking this research, my position and ability to define what being a tangata Tiriti means for me with clarity and confidence has been solidified.

This research investigated how I could use design to affirm our sense of duty and commitment to te Tiriti o Waitangi. By working with keen members of a quality improvement and innovation unit situated within a large public hospital. Evaluating design thinking methods to enhance recognition of our responsibility and capability for achieving health equity. But it has mainly been a personal learing journey of what it means for me to be a tangata Tiriti.

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[170] Dale Husband, "Papaarangi Reid: Pushing for real change," *E-Tangata*, May 24, 2020, https://e-tangata.co.nz/korero/papaarangi-reid-pushing-for-real-change/.
[171] Ibid.
[172] Ibid.

From a recent paper examining current anti-racism interventions in Aotearoa, the authors found that most are focused on personal change.[173] In particular, student teaching and frontline worker training.[174] Health practitioners must complete training to meet certain 'requirements' of cultural safety.[175] Numerous initiatives exist to decolonise and indigenise health curricula.[176] However, increased financial or political support is required to sustain their continuation.[177] There is currently an overwhelming interest in anti-racism learning and although they are worthwhile contributions, the evidence does not suggest that they have made a significant impact on improving Māori health outcomes.[178] Decision-makers need to be uncompromising in their own anti-racism learning and equity efforts in order to address the signs and symptoms of structural and institutional racism.[179]

Several experts, managers, and staff were interviewed in a recent paper examining various gender and ethnic equity initiatives in public services across Aotearoa.[180] Participants reported that their company downsized aspects of their diversity efforts, demonstrating that business rationale was insufficient to secure equity initiatives from the demands of the pandemic.[181] For example, reduced resource allocation meant Māori and Pasifika recruitment programmes were made vulnerable.[182] While some equity efforts were curtailed, new initiatives focussed on longer equity goals had arisen, and some staff were even motivated to "step up." [183]

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[173] Heather Came, Jacquie Kidd, and Tim McCreanor, "Re-imaging anti-racist theory for the health sector," *New Zealand Medical Journal* 135, 1554 (2022): 105-110, https://journal.nzma.org.nz/issue-id/vol-135-no-1555-20-may-2022.
[174] Ibid.
[175] Deborah Heke, Denise Wilson, and Heather Came, "Shades of competence? A critical analysis of the cultural competencies of the regulated-health workforce in Aotearoa New Zealand," *International Journal for Quality in Health Care* 31, 8 (2019): 606-612, doi: 10.1093/intqhc/mzy227.
[176] Came et al., *Re-imaging anti-racist theory*, 105-110.
[177] Annabel Ahuriri-Driscoll, Vanessa Lee, and Heather Came, "Amplifying Indigenous voice and curriculum within the public health academy – the emergence of Indigenous sovereign leadership in public health education," *Higher Education Research & Development* 40, 1 (2021):146-61, https://doi.org/10.1080/07294360.2020.1857343.
[178] Elana Curtis, et al., "Why cultural safety rather than cultural competency is required to achieve health equity: a literature review and recommended definition," *International Journal for Equity in Health* 18, 174 (2019): 1-17, https://doi.org/10.1186/s12939-019-1082-3.
[179] Heather Came and Derek Griffith, "Tackling racism as a "wicked" public health problem: Enabling allies in anti-racism praxis," *Social Science and Medicine* 199, (2018): 181-888, https://doi.org/10.1016/j.socscimed.2017.03.028.
[180] Jane Parker, et al., "Gender and ethnic equity in Aotearoa New Zealand's public service: where is the progress amid the pandemic?," *Labour and Industry: A journal of the social and economic relations of work* 32, 2 (2022): 1-22, https://doi.org/10.1080/10301763.2022.2091198
[181] Ibid.
[182] Came et al., *Re-imaging anti-racist theory*, 105-110.
[183] Parker et al., *Gender and ethnic equity*, 1-22.

However, given the mainstream monoculture, several members still felt it challenging to bring their "full self" to work.[184] Also, these equity initiatives continue to depend on proactivity and endorsement by management.[185] Overall, staff and managers saw a need for additional agency-specific, contextually and culturally sensitive projects to advance gender and ethnic equity.[186] These paper findings share similarity with my own viewpoint and experience of the research partner from this study as mentioned in the Documentation chapter.

Māori have been generous in their teaching and guidance of tauiwi and Pākehā in decolonisation work.[187] Now, the government and keen tauiwi and Pākehā need to fulfil their duty and reciprocate their efforts.[188] Since racism is contextually specific, we cannot import equity 'solutions' from other nations.[189] We might support one another in our endeavours but anti-racism is not a static, one-size-fits-all endeavour.[190] It is an iterative process (similar to HCD) that requires trying something, reflecting on it, and trying something different each time, again and again.[191] The whakataukī, "I orea te tuatara ka patu ki waho" — A problem is solved by continuing to find solutions,[192] speaks to the importance of imagination, flexibility, and tenacity.[193] All these are necessary to address the wicked problem of inequity. In the words of Professor Pare Keiha, "If you *hope, dream and fight* for a miracle, **sometimes it happens**."[194]

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[184] Parker et al., *Gender and ethnic equity*, 1-22.
[185] Ibid.
[186] Ibid.
[187] Came et al., *Re-imaging anti-racist theory*, 105-110.
[188] Ibid.
[189] Ibid.
[190] Ibid.
[191] Ibid.
[192] "Whakataukī," Te Reo Kete - Whetū Kohara (blog), January 26, 2016, https://whetukohara.blogspot.com/2016/01/whakatauki.html.
[193] "Whakatauki information sheet," accessed July 18, 2022, https://inspiringcommunities.org.nz/wp-content/uploads/2018/09/Inspiring-Communities-%E2%80%93-Whakatauki-information-sheet.pdf.
[194] Charlie Gates, "Ōtautahi – the story behind Christchurch's informal te reo name," *Stuff*, September 19, 2020, https://www.stuff.co.nz/pou-tiaki/te-reo-maori/122813289/tautahi--the-story-behind-christchurchs-informal-te-reo-name.

Post script

During the examination, my examiners probed me on my research question. As part of the required amendments, I have revisited the question to give recommendations for further research opportunities.

"How might design methods be applied to enhance reflection with members of a large public hospital's quality improvement and innovation unit on the meaning of equity as practitioners, colleagues, and tangata Tiriti?"

This question has a high level of specificity which may be difficult for readers to understand. I explained to my examiners that the unit descriptor was provided to anonymise their involvement. However, I also shared some discussion I had with my supervisors where I questioned this action. I realised that anonymity was the deafult position which I did not question until it became too late. I believe that transparency may have led to necessary discomfort and therefore be an agent for change. Ultimately, this was not possible due to the limitations of ethics approval.

During the examination, we discussed the role and value of design in these types of research projects. We decided upon, design utilised as the facilitator of safe environments where conversation and learning could occur.

This type of study would benefit from a longer timeline than was feasible for a Master's project. I hope that the next iteration will be able to build upon this design research. As was the inital intention of this study, to plant seeds which will grow in the future...

‘Portfolio’

Presentation script

Tēnā koutou katoa. Nau mai haere mai ki tēnei hui. Ngā mihi nui ki a koutou katoa. Mōrena everyone! Thank you for attending this hui and the opportunity to share my design research with you. Today, I will be sharing an overview of my master's journey. I appreciate your attention and I hope you will enjoy.

Firstly, I will share a bit about myself and my motivations for pursuing this research. Then, I will explain the kaupapa of this project. I will briefly go over my process, giving an overview to explain some of the main insights, and how they influenced the direction of the research and my learning. Finally, I will discuss the research findings and outcome.

Nō Koria ōku tīpuna, engari i tipu ake ai ahau i Tāmaki Makaurau. Nō reira, ko Aotearoa te kāinga. Ko 예은 tōku ingoa, engari ko tōku ingoa kārangaranga ko Phoebe. He ākonga mahi hoahoa ahau i Te Wānanga Aronui o Tāmaki Makaurau, ā, kei te whai ahau i te tohu paerua.
I am of Korean heritage, but I grew up in Tāmaki Makaurau. Therefore, I call Aotearoa my home. My name is 예은, but the name I am commonly known as is Phoebe. I am a design student at AUT, and am pursuing my masters.

Before I began my design studies, I worked as a Radiographer and Mammographer here at [redacted] and [redacted] hospital and also in the UK. When I returned home after my OE, I decided to take the plunge and pursue my creative ambitions. I am so grateful and thankful I did this, because my worldview exploded in ways I never imagined were possible. It was through my design education that I came to critically understand our nation's history. This led me to utilising design methods for learning about anti-racism and equity. Personally, I pursued this path to reconcile with my experiences as a Korean person living in Aotearoa. But I have since come to learn that anti-Asian racism and multiculturalism in Aotearoa cannot exist without a commitment to biculturalism and tino rangatiratanga.

In the context of where we are, here in Aotearoa, when I refer to health equity, I am speaking about Māori health. This project was developed with Deborah and Mikaere and initially began with the idea of co-designing a conversation tool, to assist healthcare workers with discussing and learning about health equity. However, the data findings led to a reframing of the research opportunity, which I will explain.

The research question first began as — How can I co-design a conversation tool with team members to galvanise commitment to achieving health equity?

Around the time my ethics application had been approved, we entered the lengthy lockdown of last year. However, I was able to collect data through expert interviews. The main insight from these data were that since the majority of team members are of European descent, it would be inappropriate to co-design an equity tool. I was encouraged to do some reflection and try to reframe the opportunity in a culturally safe manner. This practice involves reflecting on one's own culture and its' influence on how we think, feel, and behave.

The question then evolved to — How can I learn alongside team members of to recognise and practice our responsibilities and capabilities for achieving health equity?

After much deliberation, I decided to conduct a Zoom workshop as an opportunity for reflection. I used several prompt questions to generate discussion and using my notes from the meeting, I created several mind maps.

After the workshop, I attended the online seminar, 'Supercharge your tauiwitanga' with the tagline: "Everything you've wanted to know about te Tiriti without hassling your Māori friends." There were over 600 people in attendance at the live recording. I felt affirmed by this fact and I learned there is no road map for equity work. We must keep working together and supporting one another on our learning journeys.

The question then finally became — How might design methods be applied to enhance reflection with team members on the meaning of equity as an organisation, practitioners, and tangata Tiriti?

After reflecting on these events, I decided to host another workshop. I wanted to imbue a sense of community and encourage small moments of reflection. I chose mug making as a symbol of these ideas. As well as some concepts that were discussed from the first workshop, such as celebrating the small wins and uplifting one another.

After this second workshop, I attended the online symposium, 'te Tiriti based futures.' I engaged with a handful of seminars ranging from talks about 'Whose responsibility is racism in Aotearoa's health sector?' and 'How have Chinese in Aotearoa supported tino rangatiratanga?'

For me, the main insight I gleaned from these talks was a presentation by Yin Paradies, 'An Indigenous perspective on modernity and decolonial futures.' They explained that personal transformation is all we are capable of concerning ourselves with. This gave me great comfort and reassurance that although design alone may not be able to change the status quo. It has certainly changed my worldview and as long as I remain open and tenacious in my efforts for learning, that is the best I can do.

I then decided to make mugs to represent each participant from the initial workshop. The intention behind the workshops was to provide an opportunity for discussion. I hope these mugs can serve as a reminder. A reminder to take a moment of reflection over a hot drink and chat with your colleague. A reminder to keep trying and do better everyday.

Looking at evolution of my research question, I see the essence and seed was there from the start but it was nourished and flourished over the course of my studies and learning.

I would like to emphasise that although these are the 'conclusions' of this design research, I must acknowledge that the learning is ongoing and the journey never ceases.

From undertaking my master of design, I would define my 'outcome' as a consolidation of my positioning as a tangata Tiriti. I have developed an increased sense of clarity, confidence and commitment for social justice mahi.

As a physical artefact of my learning, I would like to koha these mugs. Along with a wero. Since Deborah and Mikaere are no longer active in their roles, the equity team has remained dormant. Perhaps these mugs can inspire action, to coincide with mahuru Māori and te wiki o te reo Māori.

A personal observation I have made on this journey has been the perception of the value of design within healthcare. It is sometimes seen as a 'nice to have,' and given similar urgency as equity initiatives. Neither qualify for emergency status like Covid does.

I would like to thank you for enabling this opportunity. I hope this presentation can be a reminder to reinvigorate your equity team efforts and invest in the sustainability of its future.

Thank you all for listening. I hope you will enjoy these mugs.

Tēnā koutou, tēnā koutou, tēnā tatou katoa.

Figure 29. Phoebe Lee, *Koha*, 2022, Photograph, Tāmaki Makaurau.

Figure 30. Phoebe Lee, *Tea break*, 2022, Photograph, Tāmaki Makaurau.

Figure 31. Phoebe Lee, *Mug*, 2022, Photograph, Tāmaki Makaurau.

Presentation reflections

Firstly, how do those three-minute-thesis presenters do it? Trying to distil two years into ten minutes was tricky enough, yet alone three! It has been a great opportunity to reflect on the overall journey, as this master's research comes to a close. But I know, this is only the beginning of a lifelong commitment for social justice mahi.

I am beginning to realise that maybe feeling nervous is a good sign. It means I care deeply about what it is that I am nervous about. I used to think that confidence meant the absence of nervousness. But now I think that confidence is similar to courage, you feel the fear (or nerves) and do it anyway.

For almost two years, I had built up reservations for this presentation. I was aware of its inevitability from my previous studentship experience. Since then, I felt ambivalent as we witnessed a previous cohort student receive some tense feedback from the audience.

I also felt that today's presentation exemplified a culmination of my research, where I have experienced a lot of self doubt surrounding my efforts and intentions. I was weary about sharing these vulnerabilities with others. But through my learning journey, I have developed an appreciation for the necessity of discomfort for growth. As well as becoming friendlier with ambiguity and contradiction.

I prepared several contingencies in order to mitigate my anxiety. I sought and received kind encouragement from my supervisors, my cohort peers, and close friends. I attempted to convince my mindset into one of excitement and pride for the presentation. And, I think it worked! On that day, I felt a sense of calm. I was ready to stand tall, share my learning, and be accountable for my mahi.

It was a deliberate choice to present in person but I could not articulate why I felt compelled to do this. I initially described it as because I was delivering a physical artefact, it just made sense. But reflecting on this more, I realise that it felt more meaningful and respectful to be there in person. I wanted to show an effort on my behalf, as I was asking for reciprocity.

After the presentation, there were a few comments from the audience. The comments were kind and congratulatory. I felt humbled and my earlier worries were dissolved. After the 'formal' meeting had ended, I had a few follow up conversations with some of the team. Again, they were very lovely and wished me luck for my examination and future endeavours.

I received an email a week after the presentation with an update. Shortly after the meeting, a few team members gathered for coffee and conversation. They used the mugs and kindly sent through a few photos. I am delighted to hear they were well received. I hope they will continue to invite discussion and enjoyment.

I feel my studies have irrevocably altered my way of seeing and thinking about the world and myself. At the beginning of this master's journey, I had wished for increased confidence in speaking about anti-racism and decolonisation. But I am realising that perhaps the opposite is required. I must continuously and consistently practice humility. We are always learning, unlearning, and relearning.

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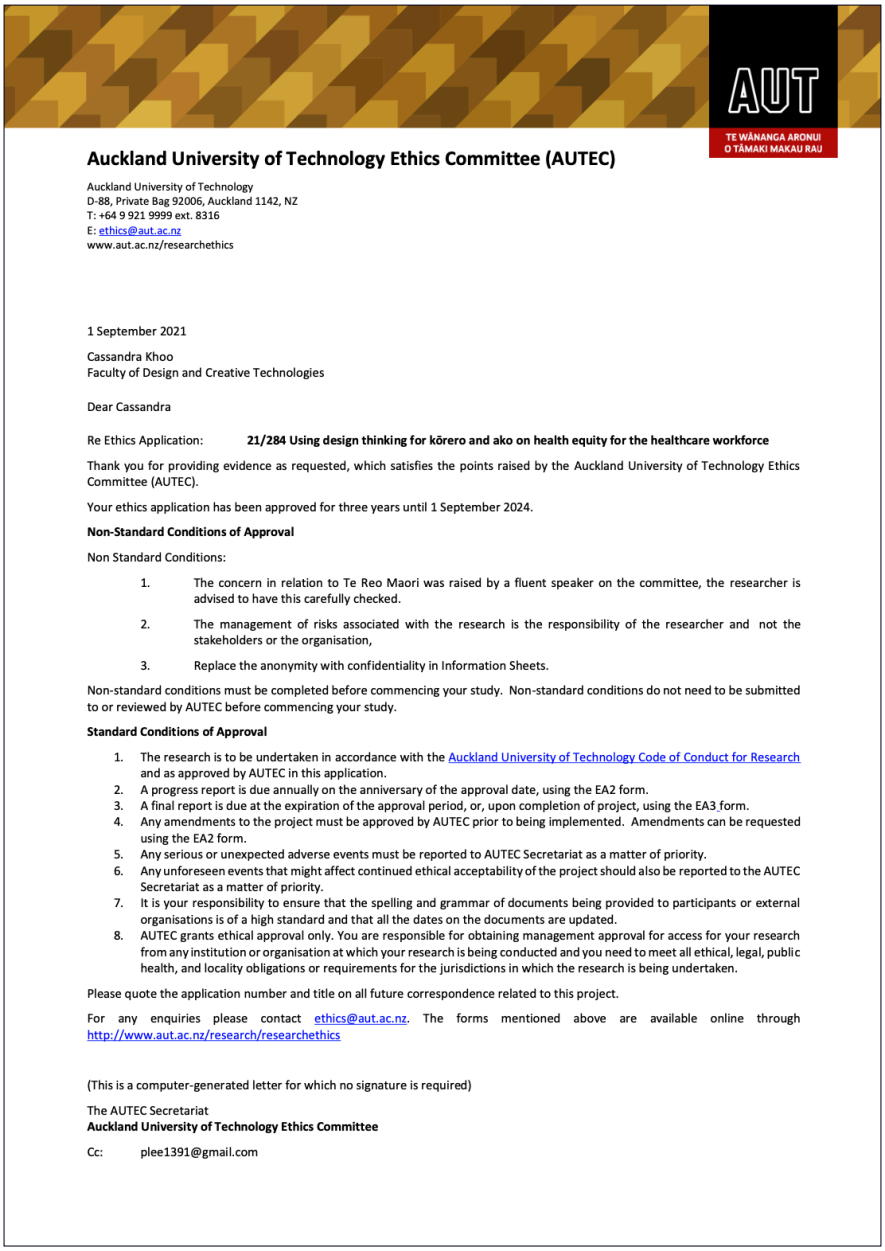
10 Appendices

Appendix 1 – Ethics-related documents
Appendix 2 – Expert interview questions
Appendix 3 – Workshop 1 materials

Appendix 1 – Ethics-related documents

Ethics approval



Auckland University of Technology Ethics Committee (AUTEC)

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

1 September 2021

Cassandra Khoo
Faculty of Design and Creative Technologies

Dear Cassandra

Re Ethics Application: **21/284 Using design thinking for kōrero and ako on health equity for the healthcare workforce**

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

Your ethics application has been approved for three years until 1 September 2024.

Non-Standard Conditions of Approval

Non Standard Conditions:

1. The concern in relation to Te Reo Maori was raised by a fluent speaker on the committee, the researcher is advised to have this carefully checked.
2. The management of risks associated with the research is the responsibility of the researcher and not the stakeholders or the organisation,
3. Replace the anonymity with confidentiality in Information Sheets.

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.

Standard Conditions of Approval

1. The research is to be undertaken in accordance with the Auckland University of Technology Code of Conduct for Research and as approved by AUTEC in this application.
2. A progress report is due annually on the anniversary of the approval date, using the EA2 form.
3. A final report is due at the expiration of the approval period, or, upon completion of project, using the EA3 form.
4. Any amendments to the project must be approved by AUTEC prior to being implemented. Amendments can be requested using the EA2 form.
5. Any serious or unexpected adverse events must be reported to AUTEC Secretariat as a matter of priority.
6. Any unforeseen events that might affect continued ethical acceptability of the project should also be reported to the AUTEC Secretariat as a matter of priority.
7. It is your responsibility to ensure that the spelling and grammar of documents being provided to participants or external organisations is of a high standard and that all the dates on the documents are updated.
8. AUTEC grants ethical approval only. You are responsible for obtaining management approval for access for your research from any institution or organisation at which your research is being conducted and you need to meet all ethical, legal, public health, and locality obligations or requirements for the jurisdictions in which the research is being undertaken.

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

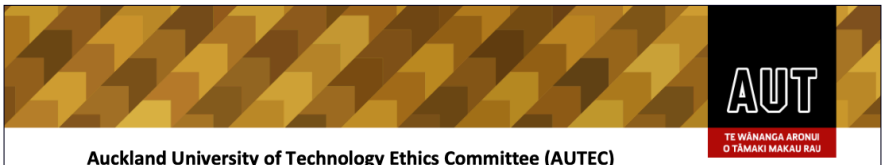
For any enquiries please contact ethics@aut.ac.nz. The forms mentioned above are available online through http://www.aut.ac.nz/research/researchethics

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

The AUTEC Secretariat
Auckland University of Technology Ethics Committee

Cc: plee1391@gmail.com

Ethics amendment approval



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28 October 2021

Cassandra Khoo
Faculty of Design and Creative Technologies

Dear Cassandra

Re: Ethics Application: **21/284 Using design thinking for kōrero and ako on health equity for the healthcare workforce**

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

The amendment to the data collection protocol has been approved.

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.
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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.
8. 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: plee1391@gmail.com

Locality approval

Application for Approval of Audit/ Observational Research

RM15142 **Using design thinking for kōrero and ako on health equity for the healthcare workforce**

[redacted] **Contact:** Cassandra Khoo External CI: Phoebe Lee, Masters Student, AUT

Department:

Project Type: Observational research

Duration: 19/10/2021 - 30/06/2022

Description: This project will use co-design methods to investigate navigating conversations around health equity. Several wānanga (focus group) will be facilitated at [redacted] with willing participants from their team to provide the qualitative information for this research. The aim of this design research is to investigate how using co-design methods, healthcare workers may galvanise their commitment to achieve health equity. The kaupapa of this project is to assist [redacted] with honouring te Tiriti o Waitangi and improving their cultural safety.
Four separate one-hour wānanga will be held over a period of six weeks. 30-60min interviews. Participants will be informed of the recording and consent will be sought to photograph and publish any drawings or notes taken by the participant.

Locality Review

The undersigned agree to the following:
- The study protocol and methodology has merit and aligns with departmental/service area interests.
- The local lead investigator is suitably qualified, experienced, registered and indemnified.
- Resources, facilities and staff are available to conduct this study, including access to interpreters if requested.
- Conducting this study will have no adverse effect on the provision of publicly funded healthcare.
- There is a stated intent that results will be disseminated & the findings translated into evidence-based care (where appropriate).

Before this study is granted approval to commence, the Research & Knowledge Centre on behalf of [redacted] will check:
- there has been the appropriate level of ethical review eg ethics committee approval if required.
- cultural consultations have occurred or will be undertaken, as appropriate.
- appropriate confidentiality provisions have been planned for.

Sent: Monday, September 20, 2021 12:43 PM

To: Phoebe Lee [redacted]

Cc: Cassie Khoo [redacted]

Subject: Notification of research - RM15142

Kia ora Phoebe

RM15142 Using design thinking for kōrero and ako on health equity for the healthcare workforce

Thank you for notifying us of your research which is now registered.

Appendix 2 – Expert interview questions

Question list:

- Nō hea koe? Where are you from?
- I whānau ake ai koe I hea? Where were you born?
- I tipu ake ai koe I hea? Where did you grow up?
- Kei hea tō kāinga? Where do you live?
- He aha koe? What do you do?
- Kei hea koe e mahi ana? Where do you work?
- What is your role?
- How did you become involved with health equity?
- Why is achieving health equity important/relevant?
- How do you think health equity can be achieved through the healthcare system?
- How do you think the best way is to approach this design research project?
- What do you think will be the biggest obstacle to achieving a successful outcome?
- What do you see as barriers for the healthcare workforce regarding achieving health equity?
- What do you struggle with personally when talking about health equity with others?
- Why do you think this is/how can this be improved?
- What do you think would be helpful to include in a 'tool-kit'?

Interview notes: Daley

How did you become involved with health equity?
GP 60% clinician, 30% research, health IT, care co-ordination.
Interest = rural health à Māori communities.
My understanding of equity became clearer when I began working as a teacher and researcher in 2019. Prior to that I had experiential understanding from working with rural and Māori communities as a GP. Also, working with rural African communities. I saw that these patients faced inequity. Growing up in multiple cultures (in Japan, US, France), I was interested in the concept of a "third culture." From this context, I attribute my understanding of disproportionate health inequity faced by rural Māori, an informal education."

Why is achieving health equity important?
Equity = "Fairness" – even children can understand the concept of unfair.
Basic human value and a breach of core, fundamental [innate, inherent].

How do you think health equity can be achieved through the healthcare system?
There is no fixed endpoint, always be striving for the goal.
Robust monitoring, explicit surveillance and definition of fairness/justice.
"Equity is a journey" = monitor, measure, drive solutions.
Constant refining and evaluation = must be defined by marginalised group.

What do you think is the best way to approach this design research?
Co-design = three groups.
• Māori & Pasifika patients with lived experience.
• Māori providers = experienced organisations.
• Non-Māori providers – record gender mix and where and when they had their training, also EFL or ESL.

What do you think will be the biggest obstacle to achieving a successful outcome?
Attendance, recruitment, endorsement.
Shoulder tap versus voluntary?
Sample strategy, implementation? Pilot = measure "success."
Education promotion – leverage existing CPD pathways.

What do you see as barriers for the healthcare workforce to achieving health equity?
Power control/sharing – public and private = Pākehā and tauiwi.
Enacting te Tiriti = leadership changes – authentic, genuine collaboration/ partnership.

What do you struggle with when talking about health equity with others?
Tension between unknown internal bias and making it visible/audible.
When to speak versus listen? Calling out deficit framing.

Why do you think this is/how can this be improved?
Humility – be open to critique. Willingness, desire, engagement.

What do you think would be helpful to include as a "tool-kit"?
Repository of resources – maintained and updated regularly.
Balance between tokenism and efficacy.
Ensure importance and relevance.
"Rapport" = value versus individual personal responsibility.

Miscellaneous notes:
Thought experiment = "fairness" = facts (physiological).
Myth = covid, genetics, homogenous, absurd.
"Acceptable difference" = juxtaposition.
Colonial past: hierarchy imposition = "sneaks in" = opinions become fact over time = infiltration.
"Genetic difference" = internal racism predisposition embedded/integrated.
"I feel comfortable with you" = red flag.
How Doctors think about health = multi-disciplinary.
Diagnosable disease = handbook.
Hui process = clinical consultation.

Key reflections
- Guilt versus scope limitations & ethics?
- Interesting side conversations
- Likeminded / kindred spirit

Interview notes: Morgan

How did you become involved with health equity?
As a teenager became involved with social justice activism.
Canterbury Masters – queer community.
AIDS epidemic / HIV prevention co-ordination.
Equity 'edge.'

Why is achieving health equity important?
Structural mechanism.
Public health practitioner/promoter.
Ethical requirements/mission.
Reduce inequity/improve health = bread and butter.
= competency robust – status quo.

How do you think health equity can be achieved through the healthcare system?
Wider determinants of health.
Redistribute wealth – wind back debt/uphold te Tiriti.
Tino rangatiratanga = macro level.
Opportunity / mandate / spheres of influence.
Governance – scope of practice.

What do you think is the best way to approach this design research?
Who is at the table? DHB staff...
Manifesting inequities.
Churning the existing pot.
Other thinkers/young activists/fresh ideas/outside member – retired, young.
Change agents.
Moving and then sense making.

What do you think will be the biggest obstacle to achieving a successful outcome?
TIME = context "too busy."
Wellbeing session.
How to reboot – 1. Ourself / yourself, 2. Others = skill.
Public artwork 1990's.

What do you see as barriers for the healthcare workforce to achieving health equity?
= Incentive / agency.
Permission – lack of autonomy
Critical thinking – community connection.
Repackaging the same ideas.
Reluctance to share power.

What do you struggle with when talking about health equity with others?
I don't! I love it, it's my favourite thing to talk about. I live, breathe anti-racism.
But I can be too impatient sometimes and with others.
Committed for life – how? Translate equity.

Why do you think this is/how can this be improved?
Chill out, solo practitioner < "it takes a village" = help/building up others.
PURPOSE - lifer – sustain – feeds soul.
Take rest and holidays, have balance .

What do you think would be helpful to include as a "tool-kit"?
Compelling stories.
Reflective practice – unpack.
Storytelling – powerful, elementary, connection.
= to learn what went well/badly.
Vulnerability = power.

Key reflections
• Shame/embarrassment
• Questioning resolve
• Inappropriate
• Tunnel vision

Interview notes: Āwhina

How did you become involved with health equity?
Whānau ora – started as an administrator, and then worked my way up to Lead Māori patient experience.
Journey to access, resources, and services for our whānau.
Develop staff.

Why is achieving health equity important?
Equity is a low hanging fruit.
Acceptable baseline for delivery and practice.
Aspirations = Māori health system has optional access for everyone (and not just for Māori).

How do you think health equity can be achieved through the healthcare system?
Start with and acknowledge history.
Be open and willing to learn.
Be sorry and courageous.
= Then "restart."
Accountability frameworks/pathway.
Altered tools e.g., contractors – setting up processes for assessing.

What do you think is the best way to approach this design research?
Whose experience is being centred?
List of priorities, reflective questions*
Interview procedure.
Hauora versus health.
Equity for different groups = development session.

What do you think will be the biggest obstacle to achieving a successful outcome?
*Reflective questions = narrow down = how I will approach as me?
Know where I sit – what is inequity for me?
Framework of own journey – keep it simple = within my own realm of influence.

What do you see as barriers for the healthcare workforce to achieving health equity?
Education – difference between equality and equity.
Practical to apply = policy = guide.

What do you struggle with when talking about health equity with others?
Patriarchal culture.
Lack of a formal qualification, impacting on others reputation and judgment of 'status'/prestige.

Why do you think this is/how can this be improved?
Remove titles altogether.
Champions model – celebrate/role model.

What do you think would be helpful to include as a "tool-kit"?
Checklist of questions for reflection.
= Are they using this resource effectively?

Key reflections
• Answers?
• Consolidated resolve
• Fear < Aroha

Appendix 3 – Workshop 1 materials

KŌRERO & AKO ON HEALTH EQUITY

Research question?

How can I learn alongside members of a health research group to recognise and practice our **responsibilities** and **capabilities** in honouring te Tiriti o Waitangi?

Karakia tīmatanga

Tukua taku wairua kia rere ki ngā taumata
Hei ārahi i a tātou mahi
Kia mau, kia ita, kia kore, ai e ngaro
Kia pupuri, kia whakamaua
Kia tina, tina!
Haumi e, hui e, tāiki e!

Kōrero

(verb) to tell, say, speak, read, **talk**, address.

(noun) speech, narrative, story, news, account, **discussion**, **conversation**, **discourse**, statement, information.

Māori Dictionary, 2021

Agenda

- Whakawhānaungatanga
- Research
- Prompts
- Kōrero
- Karakia whakamutunga
- Evaluation

Ako

(verb) to **learn**, study, instruct, teach, advise.

Reciprocity of knowledge between learner and teacher.

Ministry of Education, 2018

Whakawhānaungatanga

1. **Nō hea koe?** Where are you from?
2. **Ko wai tō ingoa?** What is your name?
3. **Kei hea tō kāinga?** Where do you live?

Health equity

In Aotearoa New Zealand, people have differences in health that are not only avoidable but **unfair** and unjust.

Equity recognises different people with different levels of advantage require **different approaches** and resources to get equitable health outcomes.

Ministry of Health, 2019

Discussion prompts

1. What/why is health equity important to you?
2. What does health equity mean as a workplace?
3. What does health equity look like as a practitioner?
4. How do you think health equity can be achieved?
5. What do you believe is your role to achieving this?

Ko tahi

1. Why is health equity important to you?

E rua

2. What does health equity mean as a workplace?

E toru

3. What does health equity look like as a practitioner?

E whā

4. How do you think health equity can be achieved?

E rima

5. What do you believe is your role to achieve equity?

Karakia whakamutunga

Kia tau ki a tātou katoa
Te atawhai o te runga rawa
Te aroha o tētahi ki tētahi
Me ngā manaakitanga o te wā
Haumi e, hui e, tāiki e!

Evaluation

1. I can confidently describe health equity
2. I can confidently explain why it is important to me
3. I know what is in my ability to achieve health equity