Activating Hauora Kaupapa:

Realising Māori Aspirations and Disrupting Racism through

Māori Health Workforce Transformation

Haidee Rēnata

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Abstract

The mobilisation of mana motuhake – the autonomous authority inherent to whānau, hapū, Māori, and their communities to determine their destiny, is at the heart of this thesis. Grounded in te ao Māori – the world of Māori, this study offers hauora kaupapa as a foundational concept for realising Māori health and wellbeing aspirations. Within this study I argue that it is a pathway to asserting aspirations and disrupting racism through Māori health workforce transformation. Severe health inequities experienced by Māori, the Indigenous peoples of Aotearoa – New Zealand, are a consequence of institutional racism entrenched in Western-dominated health and health education systems. The Crown continues to compound these inequities with ongoing breaches of te Tiriti o Waitangi. Importantly, with regard to this thesis, advocacy for developing the Māori health workforce has been ongoing since the 1880s. In the last three decades, research has further highlighted the continued critical importance of such advocacy. This study employed kaupapa Māori methodology to explore the visions and values of Māori for health workforce development while simultaneously addressing racism that hinders its progress. Within this rangahau – Māori-led research, I worked alongside a rōpū rangahau – comprising of Māori and Pākehā researchers as critical allies who were committed to developing a Māori-specific theory of anti-racism within the health sector. Within this qualitative study, I completed secondary analysis of data comprising seventeen Māori health professionals with known expertise in transformative praxis and disrupting racism. This study provides insights into how to challenge and interrupt systems which entrench inequities, advocating for the assertions of Māori and Indigenous-led solutions. This rangahau affirms the whakapapa of hauora – embedded in te ao Māori, honouring the inseparable connections between tāngata, whenua, taiao (people, land, environment), and the celestial realms to the health and wellbeing of an individual. These relationships are key to developing the Māori health workforce while empowering the leadership of whānau, hapū, Māori, and communities. This rangahau asserts hauora and the critical intent of kaupapa Māori, alongside critical allyship, as key solutions to strengthening workforce development for transformative change.

Ngā Mihi Aroha Nui

To the many who have supported me throughout this rangahau, I give my deepest appreciation and mihi aroha. In particular, I name and thank the following:

This thesis is dedicated to Ellia, Naia, Jordan, and my mother, Fay. I acknowledge the sacrifices you all made to complete this rangahau. While you did not choose this waka rangahau, you had no choice but to journey its rough and relentless sea. May these sacrifices and the sharing of mātauranga from my pāpā Fred and uncle Evan contribute to a body of work to honour our ancestors and empower our descendants in future generations.

Professor Jacquie Kidd, my primary supervisor, for embracing me into your wahine toa korowai in 2021 and continuing to do so into 2025. As I frequently failed to follow the lead of your helm, you continued with unwavering consistency to navigate the deep ocean with me. Dr Zoë Tipa, my secondary supervisor, for bringing the lightness of your wairuatanga, an exceptional PhD thesis from which to learn, and for last-minute revisions!

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Kia whakatōmuri te haere whakamua –

I walk backward into the future with my eyes fixed on my past.

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Attestation of Authorship

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

Haidee Rēnata, 16 February 2025

Ethics Approval

Auckland University of Technology Ethics Committee approved ethical application 22/58 for this research on 31 March 2022; further evidence was requested and satisfied on 04 September 2023.

Opening Karakia

Whakataka tō hau ki te uru,
Whakataka tō hau ki te tonga.
Kia makinakina ki uta,
Kia mataratara ki tai.
E hi ake ana te ata kura,
he tio, he huka, he hauhunga –

The wind swings to the west, settles
then turns to the south, settles down.
Making it prickly cold inland,
Making it piercingly cold at sea.
The glowing morning will rise,
on ice, on snow, on frost.

Preamble

Throughout this thesis, both English and te reo Māori – the language of Māori, are used in a style that can be referred to as 'language switching' (Gumperz, 1982). While I have used English predominantly, I have included te reo Māori as able, as I aspire as a kairangahau – Māori researcher, to learn my reo. Te reo Māori is deeply interwoven with mātauranga – Māori knowledge, wisdom, and understanding, inherently connected to the world of Māori (Aldrige, 2012; Walker et al., 2006).

The te reo Māori glossary was explicitly developed for this thesis with input from the wider research network, providing basic translations from Māori to English. The first time te reo Māori terms are used is typically followed by a lengthened dash – with an English interpretation ending with a comma, or full stop to indicate where the translation ends. These extended translation aims to convey the meaning and significance within the study. More straightforward translations may occasionally appear in (brackets), and footnotes are used sparingly, primarily in poetry or when presenting participant quotes in the findings wāhanga (chapter) four. Overall, these approaches acknowledge that English translations cannot fully capture the richness, depth, or cultural nuances of te reo Māori terms, and thus pose a risk of misinterpretation (Aldrige, 2012; Walker et al., 2006).

This thesis also uses footnotes to offer additional information or clarity, ensuring the main text's flow remains uninterrupted.

Te Reo Māori Glossary

Āe	Yes
Aotearoa	New Zealand
Hapū	Community/s, subtribe/s, a section of a large kinship group, primary political unit in traditional Māori society
Hauora	The interconnected relationship between the health and wellbeing of the individual to the collective people, environment and celestial realm is innate to Māori and embedded in the world of Māori
He Wakaputanga/ Whakaputanga	Declaration of Independence/Contemporary spelling
Hui	Assemble, gather, meet
Iwi	Nation/s, tribe/s often refers to a large group of people descended from a common ancestor and associated with a distinct territory
Kaiāwhina	Māori non-regulated health workforce
Kaimahi	Māori employer, worker
Kairangahau	Māori researcher doing Māori research
Kaitiaki	Māori guardian, advisory
Kaitiakitanga	Guardianship
Kaitiaki rōpū	Māori advisory group for this study
Karakia	Ritual, prayer - embedded in Māori knowledge, wisdom and understanding
Kaumātua	Respected Māori elder
Kaupapa	The Māori way, incorporating the knowledge, skills, attitudes, and values of Māori society embedded in the world of Māori
Kōhanga reo	Māori language immersion preschool
Koro	Māori grandfather

Kuia	Māori grandmother/respected female elder
Māmā	Māori mother
Māhaki	Respectful conduct
Mahi	Work, accomplishment
Mana	Māori power and authority
Mana motuhake	Māori power and authority with the autonomy to assert and determine their own destiny and identity as Māori, embedded in the world of Māori
Mana whakahaere	Māori power and authority within governance, jurisdiction, management, research
Marae	Meeting house, a place
Mātauranga	Māori knowledge, wisdom, and understanding are embedded in the world of Māori
Matike Mai	Aotearoa independent working group on constitutional transformation
Mauri	Life force, vital essence, source of emotions - the essential quality and vitality of a being
Nēhi	Māori nurse
Pākehā	New Zealander of European descent
Pakeke	Māori mature adult
Pāpā	Māori father
Papatūānuku	Earth Mother and wife of Ranginui – all living things originate from them
Pēpē	Baby
Pūrākau	Māori storytelling is a way of teaching and learning, embedded in Māori knowledge, wisdom and understanding
Rangahau	Research led by Māori/research
Rangatira	Māori chief(s)/to be or become of high rank
Ranginui	Sky Father and husband of Papatūanuku – all things originate from them

Rongoā	Māori traditional healing system, plant-based remedies, massage, and prayer - embedded in Māori knowledge, wisdom and understanding
Rōpū	Group
Rōpū rangahau	A group of Māori and European researchers from the wider study that supported this study
Taitamaiti	Māori child/singular
Tāmaki Makaurau	Auckland
Tamariki	Māori children
Tāne/Tane	Māori men, male/man
Tāngata/Tangata whaiora	Māori people seeking wellness/person
Tāngata whenua	People of the land, Māori Indigenous to New Zealand
Tāngata Tiriti	People are committed to a Treaty-based future, which may be through the practice of critical allyship
Tangi	Funeral, to cry
Taonga	Something of great value to Māori and the Māori world
Tauira	Māori student
Tautoko	Support
Te ao Māori/Te ao	The world of Māori/the world
Te ao Mārama	The world of light through the creation of the physical world of Māori, through the separation of Sky Father and Earth Mother
Te Ara Tika	Ethical guidelines for research involving Māori
Te reo Māori/te reo	The language of Māori - embedded in the world of Māori knowledge, wisdom, and understanding/the language
Te taiao/taiao	The environment/environment
Tika	The right way

Tikanga	Māori customs and protocol, embedded in Māori knowledge, wisdom and understanding, are unique between family, communities, regions, and nations
Tino rangatiratanga	Māori absolute authority
Te Tiriti o Waitangi/ te Tiriti	Māori language version of The Treaty of Waitangi/the Treaty
Tūpuna	Māori ancestors and or grandparents
Ūkaipō	Source of substance, nurturing, home, often originating from the mother or a feminine source
Wāhanga	Chapter/chapters of this thesis
Wāhine/Wahine	Māori women, female plural/singular
Wāhine toa	Strong Māori women female
Wairua	Spiritual aspect and integrity, the spirit of a person, which exists beyond death
Waiū	Breastmilk
Wānanga	Meet, discuss, negotiate
Whakapapa	Descent, origin, genealogy of which includes the relational and interconnected of people, nature of all living things, and the celestial realms
Whakataukī/ Whakatauākī	Māori proverb, a significant saying embedded in Māori knowledge, wisdom and understanding, author unknown/known
Whakawhanaungatanga	The process of building and maintaining relationships
Whakawhiti korēro	Idea negotiation through conversation
Whānau	Family, a close group
Whānau rangahau	The collective recognition of the researchers, participants, and advisory group of this study
Whanaunga	Relative, relation
Whanaungatanga	Relationships, a sense of family connection and belonging through shared experiences and working together through a reciprocal relationship that serves to strengthen each member

Whare	House, home, meeting place, Māori space
Whenua	Land, nation, territory, New Zealand, placenta

Wāhanga 1: Background and Overview

1.1 Introduction

Aotearoa – New Zealand, was first inhabited by my tūpuna, hapū, and iwi – ancestors, communities, and nations Māori, the Indigenous peoples of Aotearoa (Hemara, 2000; King, 2023). Tino rangatiratanga – Māori absolute authority, and the health and wellbeing of Māori were upheld through hauora – a sophisticated, values-based system embedded in te ao Māori – the world of Māori (Durie, 1998; Graham & Masters-Awatere, 2020; Ratima, 2001; Salmond, 1991; Wenn, 2007).

In 1840, an agreement was established between two sovereign nations: Rangatira – Māori Chiefs, and the British Crown (Berghan et al., 2017; Moewaka Barnes & McCreanor, 2019; Waitangi Tribunal, 2014). This agreement permitted British settlement while ensuring tino rangatiratanga over all significant to Māori remained. However, the Crown rapidly and frequently breached the terms of this agreement, resulting in the colonisation of Aotearoa and, as a consequence, severe Māori health inequities arose, especially compared to what became the dominant population (Mutu, 2019; Waitangi Tribunal, 2023).

Māori are not alone in experiencing these effects. Globally, the colonisation of Indigenous peoples has had a devastating impact on health and education (Bond et al., 2019; Ratima et al., 2007; Wilkie et al., 2023). A critical factor underpinning these disparities is institutional racism, which limits access to quality healthcare and drives significant health disparities (Came, 2012; Kidd et al., 2022; Mutu, 2019; Paradies, 2016). Internationally, researchers argue that institutional racism significantly drives health inequity (Harris et al., 2011; Paradies, 2016) by influencing the accessibility and quality of healthcare services, thereby exacerbating health disparities (Came, 2012; Kidd et al., 2022; Mutu, 2019). Furthermore, it has been found to increase risk factors for premature death, co-morbidity, and poorer mental and physical health outcomes (Harris et al., 2011; Paradies, 2016).

Internationally, Māori and Indigenous health workforce development is recognised as crucial to addressing health inequities and countering racism (Bond et al., 2019; Ratima et al., 2007; Russell et al., 2022; Waitangi Tribunal, 2023; Wilkie et al., 2023). Indigenous-

led care has been shown to be culturally responsive, effectively addressing and improving health and wellbeing outcomes. However, despite Māori health workforce advocacy dating back to the 1880s and three decades of recent research and rangahau emphasising its urgency, progress in development has remained slow and limited in scope (Durie, 1998; Health Workforce Advisory Board, 2022; Lange, 1999).

This thesis argues that Western-dominated health systems and their policies are entrenched in institutional racism, which has caused and continues to exacerbate challenges for developing the Māori health workforce (Kidd et al., 2022; Russell et al., 2022; Waitangi Tribunal, 2023). This study aims to explore the aspirations of Māori for developing a health workforce addressing health inequities and disrupting racism that hinders progress. It centres on the vision and values derived from Māori perspectives as pathways to genuine solutions. This approach establishes a foundation for advocating for and developing a workforce aligned with such aspirations.

This wāhanga provides my whakapapa (descent) and positionality as the kairangahau for this study. It offers a historical background and a contemporary overview, including the beginnings of Māori health workforce development, the health, hauora and tino rangatiratanga of Māori. Te Tiriti o Waitangi is central to this thesis and to Māori, providing historical and contemporary perspectives. The thesis highlights Crown's breaches of te Tiriti have caused and continue to cause severe health inequities for Māori while forming barriers to Māori health workforce development.

This background and overview conclude by acknowledging the wider group of researchers who contributed to this study. It then poses the thesis question and outlines the five subsequent wāhanga.

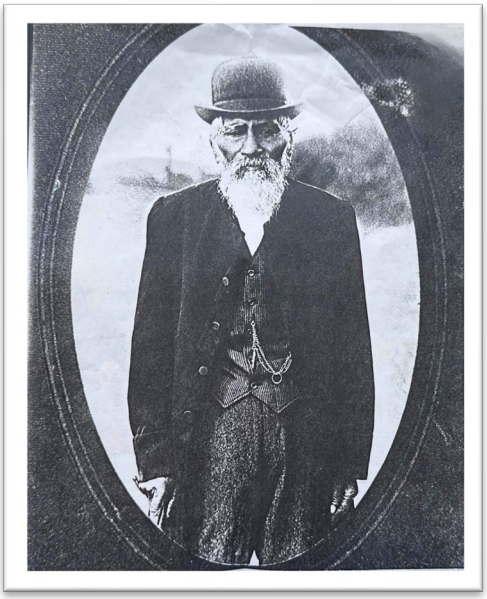
1.1.1 My Whakapapa

As the kairangahau of this qualitative study, it is imperative to recognise my whakapapa and positionality and the influence on this rangahau (Braun & Clarke, 2019; hooks, 1989; Smith, G. et al., 2017).

Table 1. My Ngāpuhi Whakapapa, direct male line, and the origin of my Hapū

Tūpuna	**Hapū**
Rēhia[1]	Ngāti Rēhia
Kakiroa	
Tuaka	
Titore[2]	
Ngāhuru	
Rēnata Te Ngāhuru	Ngāti Rēnata
Hapeta Rēnata	
Wetere Rēnata	
Ernest Rēnata	
Frederick Rēnata	

Figure 1. Photograph of Rēnata Te Ngāhuru, My 3rd Great-Grandfather



I whakapapa from Ngāpuhi iwi, from my tūpuna Rēhia and Irakau (8th great-grandfather and grandmother), of Ngāti Rēhia hapū. I whakapapa from my tūpuna Rēnata Te Ngāhuru and Mere Te Mārihi (3rd great-grandfather and grandmother), of Ngāti Rēnata hapū. Ernest Rēnata is my koro (grandfather), and Venus Rēnata[3] (née Hall) is my kuia (grandmother). Frederick Rēnata is my pāpā (father). Our meeting places are in te Tai Tokerau — the Northland of Aotearoa, Mangōnui Waiaua (Hihi), Whangaroa Kaeo, and Mangatūroto.

[1] Macrons added for known pronunciation; historically not included.
[2] Titore - the brother of Toko. Not to be confused with the grandson of Toko, known as (Titore Tākiri).
[3] Still learning, however, known as Ngāpuhi iwi from her mother and New Zealand European descent from her father (Hall).

I descend from my great-grandparents, who emigrated from London, Yorkshire, and the Southwest of England to Aotearoa between the 1900s and 1920s. James Lusty is my grandfather, and Lorraine Lusty (née Lawrence) is my grandmother. They are both of Pākehā (New Zealanders of European descent). Fay Rēnata (née Lusty) is my mother. Ko Haidee Rēnata tōku ingoa — my name is Haidee Rēnata.

1.1.2 My Positionality

In 1984, a beachfront property in Mangawhai Heads was purchased by my Pākehā grandparents, who had previously owned a farm. They built a large and beautiful home on the land. While they worked hard, their status reflected the systemic and social structures of Pākehā privilege (Came, 2012; Nixon, 2019). This privilege can be understood as unfair advantages, benefits, or rights, and in this case, afforded to those of European descent. One such advantage was the unequal access to bank loans. My great-grandparents and, thus, my grandparents were able to secure bank loans with relative ease. For Māori generally, however, this was not the case, as highlighted in the 1961 Report on Māori Affairs, which demonstrates systemic barriers preventing Māori from accessing the same opportunities (Hunn, 1961). From the 1980s to the late 1990s, our whānau, which consisted of my mother and two of my siblings, would travel from the Waikato to spend Christmas with our grandparents in Mangawhai and visit our koro and kuia in Mangatūroto.

The whare (home) of our koro and kuia, considered an exception in Māori home ownership for the region (Hunn, 1961; Rēnata, F., 2024), was located 30 minutes inland. Despite this distinction, their whare was small, humble, situated down a steep gravel driveway, and housed eight children growing up. My koro and kuia endured profound loss, violence, and racism stemming from the enduring impacts of colonisation (Rēnata, F., 2024; Renét, 2024; Walker, 1996). For them, being Māori was a sensitive and painful reality. They were forced to give up key aspects of their identity, beaten in school for speaking te reo Māori and pressured to act Pākehā to survive. This systemic and systematic discrimination denied them the opportunity to build the monetary wealth needed to thrive in a rapidly changing society. These legacies continue to affect our whānau, hapū, and iwi today and are validated by the evidence presented throughout this study. However, here I must acknowledge that my descent from my grandparents has afforded me unearned Pākehā privileges through these social structures that I have

benefited from. In particular, these have placed me in a position to be able to attend schooling, university, and complete this rangahau.

My journey as a tauira nēhi (Māori student nurse) began in 2008, following the birth of my first child. I took a different path from my pāpā, a cinematographer (McAlpine, 2018) and my siblings who were engaged in the music and film industries. Initially, I enrolled in a paramedicine programme at AUT due to my interest in health and physical exercise. Meaning I could build on my certificates in sport and recreation and in physical therapy. However, on the first day, I noticed a much smaller group, mainly comprising Pākehā men. In the recognition, there was a broader mix of diversity and increased opportunity within the nursing programme, promptly requested a transfer.

During a clinical nursing placement at Auckland City Hospital, I cared for a patient who made a serious suicide attempt. I found myself more drawn to understanding his mind, reason, life essence, and that of his family who would visit, rather than learning how to fix his maxillofacial fractures and how to dress his large, open, and gaping physical wounds. The emphasis on treating his physical body as separate from his whole bothered me.

Soon after, and since becoming a nēhi, I have spent 14 years working in adult mental health services across the Tāmaki Makaurau – Auckland region. My experience spans acute inpatient units, community and crisis services, and forensic mental health settings under government agencies, and in the last 5 years, a range of nēhi education with AUT.

1.1.3 Poem of Tama and Final Remarks on Positionality

I wrote this poem, a pūrākau (story, way of teaching), for a critical reflection contributing to a postgraduate assignment in 2021. Dedicated to Tama,[1] a young tāne and tangata whaiora – Māori man and service user seeking wellness.

A Young Tāne

You came to us broken.
Alone and homeless.
Stripped and raped.
Physically, emotionally, and spiritually.
In our 'better, best, brilliant' DHB hospital,
straight to high-care,
under the Mental Health Act.
You were left in dirty clothing,
without shoes,
for six days.

We judged you by this daily.
Your notes said you were:
'Intimidating,'
'Difficult to engage,'
'Dishevelled and malodorous,'
'Wearing the same clothing as yesterday'
(and the day before that, and the day before that).
Had anyone thought, why might this be?
No critical lens, no kaupapa[2] Māori, no te Tiriti.
I was then allocated to be your nurse,
I, too, Māori.

You came up to the glass screen that separated us.
You asked for a hug.
I came outside the 'safety' of the nursing station.
You stood over me, six and a half feet tall,
looked down at me with your piercing eyes.
You were used to being intimidating.
You thought I would flinch;
I did not.
I hugged you, and
you were shocked.

1 Tama is a pseudonym to maintain privacy.
2 The Māori way, incorporating the knowledge, skills, attitudes, and values of Māori society embedded in the world of Māori.

Whakawhanaungatanga, pepeha, whakapapa.[1]
To me, a brother, cousin, whānau.
We were no different,
yet I was the nurse, and
you were the patient.
You did not fit our 'one size fits all' hospital pj's.
You were larger than your average Pākehā.
No WINZ application, no special needs grant.
No money, no access, no mana.[2]
I took you to the Ware Whare.[3]
It was a bargain.
Respect, confidence, mana.
One hundred and twenty dollars:
shoes, socks, clothing.

You walked around with a sparkle in your eye,
a smile on your face.
A simple act, yet
outside of professional boundaries
and ethical code.

But soon, you were discharged,
nothing really addressed.
Racism, inequity,
dishonour of te Tiriti—
still blatantly the oppressed.

Then I got the news that
your body lay cold.
I attended your tangi.[4]
Whānau mourned, and
it fucken dawned.

[1] Māori custom and protocol involving the building of relationships through connection and conversation of mutual descent.
[2] Māori power and authority.
[3] Idiomatic term for The Warehouse, a retail store in New Zealand.
[4] Funeral, to cry.

Through the pūrākau of Tama, I sought to reflect upon and critique his experience as a tangata whaiora and expose institutional racism. He came into our care traumatised, however, rather than receiving the tautoko (support) needed for wellness, his trauma was further perpetuated within the Western-dominated health system, a common thread found in rangahau (Harris et al., 2011; Kidd et al., 2020). This failure to protect him inevitably led to his early death. This reflects the reality in which tāne have an overall mortality rate 1.7 times higher and a suicide rate double that of non-Māori men (Health NZ, 2024c, 2024d).

I also sought to reflect on my struggles as a nēhi, similarly found and experienced by Māori working in the health sector (Cowles, 2024; Rawson, 2020). In order to meet his basic needs as a nēhi, I was required to question the nursing code and professional boundaries, which were seen as contradicting each other. This poem aimed to reflect on my personal and professional resistance and advocacy for social justice, as explained by (hooks, 1989; Smith, L., 2021), while highlighting the marginalisation of Tama. I wish his story were a single one, but I would not be here if it were the case. Over a decade, I have witnessed countless similar cases treated as standard practice and rarely questioned. This reality is further explained by Came (2012) who outlines that those in privileged positions often fail to recognise institutional racism.

I wanted to do better for my tāngata (people) and was desperate to find others who felt the same. Rather than confronting the daily realities of a broken and racist health system alongside tāngata whaiora and their whānau, I returned to AUT, several years on, but this time as a clinical nēhi educator. Nonetheless, I supported tauira Māori within the equally problematic Western health education system. Struggling to prepare them for the onslaught they would further experience working in the health system. Naturally, I was drawn to advocate for tauira success and to address institutional barriers. Working at AUT quickly led to me becoming a postgraduate tauira (again). My passion for the health and hauora of Māori, tauira and education became the foundation for this rangahau. While I whakapapa Māori and Pākehā, I am driven by the certainty that Māori deserve and are entitled to equitable health, education, and wellbeing outcomes. Within this study, I assert my whakapapa and identity as Māori, while mindful of the Pākehā privileges I have been afforded.

1.2 Background

1.2.1 Tino Rangatiratanga, Hauora, and the Health of Māori

Contextualising the background of tino rangatiratanga and hauora is essential to the foundations of this study. Aotearoa was first inhabited by hapū, and iwi Māori, recognised as tāngata whenua – people of the land, and Indigenous to Aotearoa (Hemara, 2000; King, 2023). Tino rangatiratanga was intact, hapū Māori had authority and control over all that was significant to them (Healy et al., 2012; Moewaka Barnes & McCreanor, 2019; Salmond, 1991). Similarly, the sophisticated values-based system of hauora that was developed for the wellbeing and survival of hapū Māori was intact. Hauora acknowledges the intrinsic connection between tāngata, taiao (environment), and the celestial realm, Ranginui (Sky Father) and Papatūānuku (Earth Mother), as fundamental to an individual's health and wellbeing (Durie, 1998; Reilly et al., 2018; Roberts, 2013; Wenn, 2007). Indeed, the health of Māori was comparable to that of Europeans or, as Salmond argues, better (Healy et al., 2012; Moewaka Barnes & McCreanor, 2019; Salmond, 1991). Early reports described Māori as strong, active, and in a good state of health (Cook, 2005; Pember Reeves, 1899). In 1810, the population of Māori was approximately 95,000, similar to Cook's earlier estimate of 100,000 (Pool, 2015; Pool & Kukutai, 2018).

1.2.2 He Whakaputanga and te Tiriti o Waitangi

He Whakaputanga o te Rangatiratanga o Nu Tireni – Declaration of the Independence of New Zealand, asserting tino rangatiratanga, was signed by 34 northern Rangatira – Māori chiefs at Waitangi on the 28th of October 1835 (Healy et al., 2012; Moewaka Barnes & McCreanor, 2019; Waitangi Tribunal, 2023). Tāreha (the nephew of my 5th great-grandfather Titore)[1] signed on behalf of our hapū of Ngāti Rēhia on this date (Henare, 2012; Rēnata, F., 2024). This signing was "recognised by the Crown of England" and occurred in the presence of British Resident James Busby, under Te Whakaminenga o ngā Hapū o Nū Tireni – the Confederation of United Tribes (Mutu et al., 2022, p. 36).

Furthermore, tino rangatiratanga was acknowledged through the signing of te Tiriti o Waitangi by Rangatira and the British Crown at Waitangi on the 6th of February 1840

[1] Tāreha the nephew of Titore. Not to be confused with Tāreha's nephew (Titore Tākiri).

(Healy et al., 2012; Moewaka Barnes & McCreanor, 2019). Confirmed by Berghan et al. (2017) that this agreement between two sovereign nations permitted British settlement while ensuring that Māori retained "absolute authority over lands, settlements, and all that was and is valuable" to them (p. 26). Furthermore, Walker (1996) asserts that the first Rangatira Hone Heke to sign te Tiriti in 1840 he "was not participating in the demise of his Reo nor his Tikanga.[1] For him, for Māori, our Tino Rangatiratanga was never in dispute. For Māori today, our vision for Te Tiriti is no different" (p. 7).

1.2.3 Crown Breaches and the Impact on Māori

Te Tiriti o Waitangi, although signed between two sovereign nations, was quickly undermined by the British Crown, whose representatives here engaged in corruption and breaches of the agreements "before the ink was dry" (Moewaka Barnes & McCreanor, 2019, p. 19). This disregard for tino rangatiratanga, Māori ownership, authority, and leadership has been well-documented (Moewaka Barnes & McCreanor, 2019; Waitangi Tribunal, 2014). Much later, the Treaty of Waitangi Act 1975 facilitated inquiries into claimants' grievances and sought to determine the "meaning and effect" of te Tiriti (Waitangi Tribunal, 2014, p. 527). The report on stage One of the Te Paparahi o Te Raki Inquiry (Wai 1040) concluded that "Rangatira did not cede… their authority to make and enforce law over their people and within their territories" (p. 527). Furthermore, te Tiriti o Waitangi, the te reo Māori text, was formally recognised as the *legally* binding document (Berghan et al., 2017). This text is distinctly different from the English-language version of the 'Treaty of Waitangi', which the Crown sought to misapply (Berghan et al., 2017; Waitangi Tribunal, 2014) as an "act of cession" in an attempt to claim Māori had submitted to British sovereignty (Waitangi Tribunal, 2014, p. 527).

The colonisation of Aotearoa and the dishonouring of te Tiriti o Waitangi rapidly subjected Māori to severe loss, trauma, and land confiscation (Moewaka Barnes & McCreanor, 2019). By the 1890s, 40% of wahine (female Māori) born did not survive their first year of life (Pool & Kukutai, 2018) by 1896, the total Māori population had declined by more than half, with a mortality rate more than double that of Pākehā (Moewaka Barnes & McCreanor, 2019).

[1] Māori customs and protocol, embedded in Māori knowledge, wisdom and understanding, unique between whānau, hapū, iwi.

1.2.4 Nineteenth Century: Young Māori Party and into the Twentieth

Against the backdrop of a rapid decline of half the Māori population by 1896 (Moewaka Barnes & McCreanor, 2019; Pool & Kukutai, 2018), before the 1900s, the government stated that there was no need for any concerted or formal action for Māori health workforce development (Lange, 1999). Nonetheless, the development of a Māori health workforce was first promoted as early as the 1880s (Gillies, 2006; Lange, 1999; McKegg, 1992). This was predominantly by young tāne, the first to engage with and graduate from Western universities, primarily tauira from Te Aute College in Hawke's Bay. In 1897, the Te Aute College Students' Association was formed, later known as the Young Māori Party (Gillies, 2006; Lange, 1999; McKegg, 1992).

However, while this party wished to see the health of Māori improve, they represented the first generation of Māori leaders schooled and influenced by the Pākehā health system (Hill, 2004). Many held the view that full tribal autonomy was neither practical nor desirable. Some members of the Young Māori Party became interested in upskilling Māori into the Pākehā health system (Hill, 2004). They reasoned that this was preferable as opposed to advocating for a system based on Māori perspectives and autonomy. In 1907, Māori practices critical to mātauranga were outlawed through the Tohunga Suppression Act 1907, authored primarily by one of its members, James Carroll (Hill, 2004; Ward, 1993). Carroll viewed these practices as regressive and believed they discouraged Māori from engaging with and training in modern medicine (Dow, 2001; Hill, 2004).

Durie (1998) reports on Māori health leadership between the 1900s and 1930s. Despite concerns about the actions of some Young Māori Party members, as shown by Cram et al. (2019) many had a positive influence. They recognised and promoted the value of wāhine (Māori women) providing care within their communities in ways which exceeded the skills of Pākehā nurses (McKegg, 1992). Tāne Āpirana Ngata, the first Māori graduate at a university in Aotearoa, advocated for training wāhine in Western health practices (Lange, 1999; McKegg, 1992). Concurrently, tāne Hamiora Hei proposed a scheme to train wāhine in Western hospitals, intending for them to return to their communities to provide culturally relevant care (Lange, 1999; McKegg, 1992).

This initiative was supported by tāne Māui Pōmare, the first Māori doctor who graduated from an American medical college in Chicago, and undergraduate medical student Te Rangihīroa (also known as Peter Buck). Discussions around this initiative continued between Hamiora Hei and a Pākehā man, James Pope, who served as the Inspector of Native Schools (Gillies, 2006; McKegg, 1992).

This advocacy resulted in the first Māori Health Nursing Scheme scholarships introduced by the Education Department (Gillies, 2006; McKegg, 1992). Wahine Akenehe Hei, sister of Hamiora Hei, became the first nēhi to register through this scheme in 1908. Although the scheme was initially successful and met its goals, the government soon abandoned these efforts (Gillies, 2006). In 1911, the Public Health Department replaced the original Māori Health Nursing Scheme with the Native Health Nursing Scheme, where nēhi frequently experienced training refusals and racial segregation (McKegg, 1992; McKillop, 1998). Most of the appointed nurses were Pākehā, and the scheme was used to assimilate Māori into Pākehā practices, focusing on hygiene and sanitation.

In 1920, the Māori Health Act was established, and Te Rangihīroa created a Māori Advisory Committee to provide advice to the Department of Health (Durie, 2023). However, Te Rangihīroa resigned in 1927 due to obstructions to his efforts to provide a Māori voice, and a few years later, the Committee was disestablished. During the same decade, the advocacy of Māori Princess Te Puea Herangi for a hospital at Tūrangawaewae Marae was declined (Durie, 2023; Ramsden, E., 1952). Despite numerous challenges and ongoing experiences of racism, these young Māori leaders laid the foundation for advancing Māori health initiatives and workforce development (McKegg, 1992; McKillop, 1998).

1.2.5 Women's Health League and the Māori Women’s Welfare League

In 1937, the Women's Health League was established at Tūnohopū marae (meeting house) in Rotorua (Else & Internal Affairs, 1993). This first Māori health organisation soon became associated with the Department of Health and was dedicated to improving the health and welfare of wāhine. Nurse Ruby Cameron served as its first president from 1937 to 1971 (Else & Department of Internal Affairs, 1993). The initiative fostered unity between Māori and Pākehā through a range of initiatives, including supporting youth, promoting agriculture, and assisting marae committees.

By 1951, the Women's Health League had 165 branches, expanding to ten sub-branches with over 400 Māori and Pākehā members working together (Else & Internal Affairs, 1993). Following the league's success, the Department of Māori Affairs initiated women's welfare committees throughout the country (Else & Internal Affairs, 1993). These committees sought to merge with the Women's Health League to form a national organisation. However, they collectively declined the request, with Nurse Cameron personally travelling to Parliament to convey their decision to remain an independent organisation (Else & Internal Affairs, 1993).

In 1951, the Māori Women's Welfare League was formed within the women's welfare committees, becoming the first Māori organisation to have a national voice (Gillies, 2006; Metge, 1967). The league advocated nationally for culturally relevant and accessible health services for Māori. In 1961, formal recognition of Māori health inequity was shown with the release of the Report on the Department of Māori Affairs (Hunn, 1961). However, the report was highly racialised, aiming to assimilate Māori into Western normalities and suppressing Māori ways of being embedded in te ao Māori (Cram et al., 2019).

1.2.6 Hui Taumata 1984 and into the Twenty-First Century

In 1982, the Māori Women's Welfare League conducted a survey of wāhine, anchoring it within a holistic model for Māori health formulated by Mason Durie Te Whare Tapa Whā (Durie, 2005a, 2021). The survey gained momentum and recognition, particularly for its emphasis on wairua and the environment as essential components of Māori health.

The first national hui of contemporary times, a Māori health hui was launched in 1984 at the Hui Taumata, Hui Whakaoranga, marking the beginning of what Durie (2021) referred to as the "Decade of Positive Māori Development" (p. 307). This summit validated the importance of Māori health workforce development, social equity, and cultural affirmation, recognising Māori development as crucial (Durie, 1998, 2005a, 2021). It also provided a platform from which it was feasible to advocate for Māori health initiatives during a period when te Tiriti o Waitangi was being re-established as a founding document.

Amid this leadership, significant progress was made in developing the Māori health workforce (Durie, 1998, 2005a, 2021). In 1984, this included Māori health becoming recognised by the Ministry of Health and identified as a priority (Ministry of Health, 2017). Before 1980, there were only a handful of Māori providers, and they often faced assumptions that all people of Aotearoa shared the same cultural values, aspirations, and histories (Durie, 2005b). In 1988, Hui Waimanawa, led by the National Council of Māori Nurses, championed Kawa Whakaruruhau (cultural safety) and advocated for structural changes in the health system beyond transcultural nursing (Ramsden, I., 1990). These efforts marked key milestones in Māori health workforce development (Ministry of Health, 2017).

By 1993, the Health Research Council supported two Māori research units (Ministry of Health, 2017). It established a Māori Health Committee alongside funding for Rongoā services (traditional Māori healing practices) within primary health care. Within two years, Māori organisations such as Ngā Ringa Whakahaere o te Iwi Māori (Traditional Practitioners) and associations like Te Ohu Rata o Aotearoa (Medical Practitioners) and Te Ao Mārama (Dentists and Oral Health) were formed (Ministry of Health, 2017). Additionally, Māori Health Scholarships (now known as Te Pitomata Grants) were introduced to encourage a Māori health workforce (Health NZ, 2024b; Ministry of Health, 2017, p. 6). The Māori Provider Development Scheme, introduced in 1997, aimed to increase the number of qualified Māori health professionals (Delamare, 1997; Ministry of Health, 2017, p. 6).

With an expanding Māori health workforce embedded within Māori communities, a greater focus was placed on health promotion, primary health care, and disability support, thereby prioritising improved health outcomes for Māori (Durie, 2021). By the late twentieth century, Māori health providers delivered services across hospitals, state agencies, and community centres (Durie, 2005b). In 2002, the Ministry of Health established a Kaupapa Māori Public Health Leadership Programme to strengthen Māori leadership, foster collaboration, and promote kaupapa approaches for better public health outcomes (Lovell et al., 2015).

The Hui Taumata 2005 reflected on the long history of Māori development, shaped by external forces and Māori leadership. This reflection on history brought both significant

benefits and severe challenges, particularly during times when the survival of Māori as an iwi, a nation, into the early twentieth century seemed uncertain (Durie, 2005b). By 2007, Māori health providers had grown to nearly 300. However, despite ongoing advocacy, achieving equitable health outcomes for Māori, as promised in te Tiriti o Waitangi, particularly through Ōritetanga (equality), remained a challenge (Durie, 2021; Wyeth et al., 2010). Māori now, as then, continue to drive advocacy and workforce development to address these disparities. Critically, the assertion of Māori and health workforce development is at the heart of this rangahau.

1.3 Overview

1.3.1 Workforce Development

An overview of the general foundations of workforce development is essential to the context of this study. Workforce development includes various components, such as education, training, knowledge, attitudes, skills, support, policies, guidelines, and supervision (Roche, 2001).

While these elements are vital, educationalists have long debated the distinction between training and education (Marshall, 1981; Peters, 1967). Unlike training, which focuses on developing specific skills, education reflects a broader approach to learning that encompasses critical thinking and adaptability. From an educationalist perspective, the narrow focus on skill deficiencies and individual training has often neglected the organisational context in which individuals operate and overlooked the broader systemic framework (Bawden et al., 1984; Marshall, 1981; Peters, 1967; Roche, 2001). Therefore, a broader systems approach to workforce development is crucial (Roche, 2001). Such an approach favours learner-centred methods over teacher-centred ones, encourages organisational flexibility, and moves away from rigid discipline-based departmental structures (Bawden et al., 1984; Roche, 2001).

In light of these educational perspectives on workforce development, this rangahau aims to prioritise strategies led by Māori and Indigenous communities. It advocates for flexibility instead of strict organisational structures, which acknowledge the interconnections between various organisational and structural systems.

1.3.2 Developing the Māori Health Workforce and Institutional Racism

The Māori health workforce is critical in addressing Māori health inequities and driving systemic change. Over the past two decades, Māori representation in the health sector has increased by only 1–2% (Health Workforce Advisory Board, 2022; Statistics NZ, 2019). Currently, Māori make up just 5% of medical practitioners and 7.3% of registered nēhi (Health NZ & Te Aka Whai Ora, 2023; Infometrics & Te Rau Ora, 2022). These modest gains have been driven by kaupapa – the Māori way, incorporating the knowledge, skills, attitudes and values of Māori society, leadership embedded in te ao Māori, particularly through community-led initiatives (Health Workforce Advisory Board, 2022; Savage et al., 2020). However, system-wide changes at the national level remain absent, leaving the Māori health workforce underrepresented within the sector.

Pre-colonisation of Aotearoa, hauora Māori was intact, and the health of Māori was on par with European (Healy et al., 2012; Moewaka Barnes & McCreanor, 2019; Salmond, 1991) and argued by Salmond, potentially better (1991). However, today Māori comprise 17% of Aotearoa's population (Infometrics & Te Rau Ora, 2022) but face severe health inequities, including a 7-year gap in life expectancy, higher rates of co-morbidities, greater physical and mental distress, and up to 2.6 times the risk of suicide (Came et al., 2022; Health NZ, 2024d; Waitangi Tribunal, 2023). These inequities highlight the pressing need for systemic change and advocacy for Māori-led health workforce development.

Institutional racism within the health and health education systems significantly impacts Māori health workforce development. This systemic racism is evident in government functions, procurement, policy, recruitment, retention, and remuneration, and the impact on workplace satisfaction and success (Rawson, 2020; Waitangi Tribunal, 2014). Addressing institutional racism is essential to reducing Māori health inequity and ensuring equitable representation within the workforce (Russell et al., 2022; Waitangi Tribunal, 2023).

Despite efforts to combat racism, the Māori health workforce continues to face discrimination. Employment data reveals a pay gap of up to 25% between nēhi Māori and their non-Māori nursing counterparts (Came et al., 2019; Kidd et al., 2020; Waitangi Tribunal, 2023). This reflects the Crown's failure to achieve pay equity or meet te Tiriti

o Waitangi obligations. The Wai 2713 Māori Nurses' Claim has called for urgent action, with the Waitangi Tribunal recommending targeted measures to support Māori health workforce development (Waitangi Tribunal, 2023).

In 2022, Te Aka Whai Ora – The Māori Health Authority, was established to "drive and support change" for Māori health (2024, p. 1). Te Aka Whai Ora, advocated by Māori, and seen as a positive step and implemented to "remedy some of the contemporary breaches of te Tiriti o Waitangi" following the Waitangi Tribunal's Health Service and Outcomes Inquiry Wai 2575 (Came et al., 2024, p. 1; Waitangi Tribunal, 2023). However, only 18 months later, with a change of governments, the National-led ACT and New Zealand First coalition government disestablished Te Aka Whai Ora in 2024, despite strong support and thus opposition to that move from Māori, Pākehā, and Indigenous, including the Aotearoa health workforce (Aspin, 2024; Health NZ, 2024a; RNZ, 2024).

Further, undermining of tino rangatiratanga, in 2024, the ACT Party spearheaded the New Zealand Treaty Principles Bill passed its first reading in parliament (Came & Harris, 2024; NZ Government, 2024; OneNews NZ, 2024). Again, this was despite significant opposition from Māori, tāngata Tiriti – people committed to a Treaty-based future, and members of parliament (Came & Harris, 2024; OneNews NZ, 2024). Members of Parliament described the Bill as "divisive, a wrecking ball" to the Māori-Crown relationship, accusing it of rewriting the Treaty and dismantling decades of partnership efforts (OneNews NZ, 2024, p. 1). While Prime Minister Luxon described the bill as "simplistic and divisive," dismissing "184 years of debate and discussion", he still approved the Bill's first reading (OneNews NZ, 2024, p. 1).

The ongoing breaches highlighted above, particularly as found in the Wai 2575 report, demonstrate a continued disregard for the Crown's obligations under te Tiriti o Waitangi for Māori (Waitangi Tribunal, 2023). The report acknowledges that "the Māori health experience remains inequitable and, therefore, unacceptable." (p. 11). Furthermore, it confirms the profound impact of racism in driving and exacerbating disparities in Māori health outcomes and workforce development.

Racism is underpinned by the European legacy of invasion and exploitation, rooted in power and injustice, and perpetuated through actions and inactions, whether intentional or unintentional (Came, 2012; Kidd et al., 2020). Institutional racism, as

explained by Came (2012) is often less visible to the layperson or those benefiting from Pākehā privilege, yet it enables a more “insidious violation” (p. 1). This form of racism operates through the hierarchical ranking of ethnic groups and is further entrenched by personal racism, which manifests in attitudes, beliefs, and behaviours (Came, 2012; Kidd et al., 2022).

1.3.3 Disrupting Racism

Despite the challenges of institutional racism and developing the Māori health workforce, it is essential to consider how to actively challenge this status quo. Disrupting racism, similarly to anti-racism, is a strategy that actively challenges and interrupts systems, policies, practices, and attitudes that perpetuate racial inequities (Griffith & Came, 2022; Kidd et al., 2020; Kidd et al., 2022). This involves directly addressing institutional and systemic racism by advocating for transformative change in organisational structures, amplifying marginalised voices, and ensuring accountability in upholding equity and justice. Disruptors of racism not only expose entrenched injustices within the systems but also actively work to dismantle oppressive structures and rebuild them in ways which promote fairness and inclusion (Griffith & Came, 2022; Kidd et al., 2020; Kidd et al., 2022). Their efforts go beyond recognising racism to initiating and sustaining actions which create equitable outcomes, particularly for those disproportionately affected by systemic inequities.

Nixon (2019) and Rae (2024) discuss the importance of those in positions of unearned privilege and power engaging in critical reflection. Explained later in the discussion and outcomes wāhanga, is how this reflective practice can enable action to disrupt and address these inequities. Cultivating disruptors of racism is a transformative solution. Disruptors amplify Māori and Indigenous voices, advocate for equity, and work to dismantle oppressive frameworks. Thus, rebuilding systems which reflect fairness, inclusion, and te ao Māori. Disrupting racism is pivotal in creating sustainable change within the development of the Māori health workforce and addressing the root causes of inequity.

1.3.4 Whānau Rangahau and Thesis Question

In 2021, I was invited to join the whānau rangahau of an existing project. The whānau consisted of a Māori participant rōpū (group), a Māori kaitiaki (advisory) rōpū and the rōpū rangahau – a group of Māori researchers and Pākehā researchers as critical allies. The whānau rangahau originates from a Marsden project to develop, specific to Māori, a 'theory of anti-racism' for the health sector between 2021 to 2024. The Marsden project is led by Professor Jacquie Kidd and Associate Professor Heather Came, with further members including Professor Tim McCreanor, Dr Zoë Tipa, Ph.D. candidate Ngaire Rae, and Garrick Rigby. The Marsden project is based on kaupapa Māori, Matike Mai, and Western change theories.

My involvement was in a kaupapa Māori-led qualitative study (the Māori caucus stream of the Marsden project), which involved seventeen Māori health professionals, as a participant rōpū. These highly experienced participants brought expertise in transformative praxis and disrupting racism within the health system.

Working with the whānau rangahau gave me a valuable opportunity to formulate a question for this thesis and conduct a secondary analysis of data from this qualitative study. Building on this opportunity and recognising the high level of expertise and experience demonstrated by the participant rōpū.

The question posed for this rangahau is:

How can the visions and values of experienced Māori health professionals be leveraged to assert Māori aspirations for health workforce development and disrupt racism?

1.3.5 Thesis Outline

Wāhanga 1: Overview and Background. I identified my whakapapa and positionality, including a historical background and a current overview of Māori health workforce development. I also discussed the associated challenges, providing a rationale for this rangahau and the thesis question posed.

Wāhanga 2: Literature Review. I review, analyse, and critique literature on Māori and Indigenous health workforce development.

Wāhanga 3: Kaupapa Māori Methodology and Methods. I detail the methodology, methods, and ethics relevant to the study.

Wāhanga 4: Findings. I present the findings from the participant rōpū, exploring the visions and values for developing the Māori health workforce.

Wāhanga 5: Discussion and Outcomes. I analyse, critique, and reflect upon the findings and literature pertaining to Māori and Indigenous health workforce development, presenting the discussion, outcomes, and recommendations for the study.

Wāhanga 6: Looking Back and Moving Forward. I present an overall summary, review the thesis question, strengths, and limitations, propose future studies, and conclude with a personal reflection.

1.4 Conclusion

This overview and background reflect the strength, health, and hauora of my tūpuna, hapū, and iwi Māori as Indigenous people of Aotearoa. Tino rangatiratanga empowered Māori to uphold a hauora-based system central to te ao Māori and our collective wellbeing, where the health of my tūpuna and Māori was intact. However, despite the assertion in He Whakaputanga and the agreement of te Tiriti o Waitangi, established between Māori Rangatira and the Crown, these agreements were rapidly and consistently breached. This led to the impacts of colonisation on Māori health inequity and the institutional inequities within Aotearoa's health system. My whakapapa and experience as a nēhi within a Western-dominated health and education system further reveal the institutional challenges faced by nēhi, tāngata whaiora, and whānau Māori.

Globally, the value for a Māori and Indigenous health workforce in reducing health inequities is well evidenced. In Aotearoa, despite efforts dating back to the nineteenth century, significant health inequities persist, and the Māori health workforce remains underrepresented in the sector. These inequities highlight the pressing need for strengthening Māori health workforce development to address disparities and disrupt institutional racism for and within the Māori health workforce.

Engaging as a tauira with the rōpū rangahau has given me the privilege of conducting a secondary analysis of rich qualitative data. This analysis explores how the visions and values for developing the Māori health workforce can be used to disrupt racism within and for the Māori health workforce and improve Māori health equity.

This wāhanga transitions to the literature review to identify existing knowledge, gaps, and rationale for this study.

Wāhanga 2: Literature Review

2.1 Introduction

This wāhanga presents my review, analysis, and critique of literature on Māori and Indigenous health workforce development. While this rangahau is specific to Māori, the scope of this literature reviewed acknowledges the parallel challenges faced by Indigenous peoples globally regarding health inequity (Reid et al., 2019; United Nations, 2009; WHO, 2002). Acknowledging that, "Indigenous peoples have the right" to enhance health and education, as well as to establish and implement priorities and strategies for exercising this development (United Nations, 2007, p. 7). Relevant international Indigenous literature has been included to provide context, but that is not the primary focus. That focus is specifically Māori health workforce development. However, it is acknowledged that globally, Indigenous health workforce development is recognised as essential for addressing health inequities (Bailey et al., 2021; Ratima et al., 2007; Wilkie et al., 2023).

In Aotearoa, a substantial body of literature has shown consistent advocacy for Māori health workforce development over the last three decades, reflecting various rangahau, research, and policy (Health NZ & Te Aka Whai Ora, 2023; Komene et al., 2023; Te Rau Matatini, 2018). However, despite numerous workforce plans and strategies being implemented, the Health Workforce Advisory Board's report to the Minister shows that the progress of Māori health workforce development has been slow and, thus, insufficient to change the landscape for Māori health inequity (2022). The Waitangi Tribunal has consistently highlighted the Crown's shortfall in addressing persistent health inequity (2023). Within this, it was reported that the Māori Nurses' Claim 2713 emphasised the critical need for a sustainable and adequately compensated Māori nursing and health workforce to mitigate health disparities.

This wāhanga outlines the search strategies used to source, review literature, and offer critique. It is organised into three categories and concludes with a summary that highlights the rationale for framing the rangahau question underpinning this thesis while also identifying a gap in the existing literature.

2.1.1 Search Strategies

The literature review employed a range of search strategies to identify resources focusing on Māori and Indigenous health workforce development. The initial search began in 2023, using AUT library databases Scopus and EBSCO/host, which included MEDLINE, CINAHL Complete, Australia/New Zealand Reference Centre, OpenDissertations, and e-Book Collection. One search included 1994 – 2013 to offer a brief historical context specific to Māori health workforce development, with the primary searches completed in 2023 between 2018 - 2023. Following this search again in early 2024 ensured all of 2023 was included. This five-year focus warranted that contemporary developments and workforce plans were prioritised.

The primary search in 2023 yielded over 2,000 results via Scopus and hundreds of thousands in EBSCO/host. Supported by AUT library staff, further refinement using Boolean operators were utilised to refine the searches using terms deemed most relevant: *Māori* OR *Maori* OR *Indigenous* AND *health* OR *hauora* AND *workforce* AND *develop** OR *improv** OR *strength** OR *strateg** OR initiativ*. For Scopus, all source types and subjects were included; for EBSCO, an *advanced search* under the subject of *health* was conducted, with no further refinement thereafter. The inclusion criteria specified English and te reo Māori. Thus, all other languages were excluded.

Through ongoing refinement completed through the Boolean operators, the searches produced results under one thousand, making it possible to review each abstract to assess alignment with the study topic. All results were in English; no literature was identified in (full) te reo Māori. Priority was given to literature led by Māori or that was explicitly focused on Indigenous-led approaches to workforce development initiatives and strategies. Literature was included that had a direct impact on Māori health workforce development, such as government plans and policy.

A significant number of exclusions were made, particularly with results often about the (positive) impact of Indigenous health workforces on patient outcomes rather than the development of the workforce itself. Through these search strategies, a total of seven articles were selected between the 2018 – 2023 searches and two articles were selected from the 1994 – 2013 search.

Acknowledging the argument by A. Rolleston et al. (2020) that rigorous Indigenous research often faces barriers to publication and recognition within Western knowledge systems, the search extended beyond traditional academic databases. Additional sources were identified through my Māori and Aboriginal Torres Strait Islander health, education, and research networks. This included consultation with two Māori colleagues completing PhDs on Māori health workforce development. Through this process, 15 pieces of literature that were offered were added to the review. The filtering process involved the literature highly relevant to Māori or Indigenous health workforce development.

Thus, the final selection consisted of nine from the library database searches and 15 from my research networks. This totalled 24 pieces of literature, encompassing Māori-led, Indigenous-led, and Western-led. These included peer-reviewed journal articles, government documents, workforce plans, strategies, reports, and grey literature. While intentionally prioritising Māori-led studies, the selected documents reflected diverse views and contexts, with materials sourced from Indigenous perspectives, with twelve from Aotearoa, four from Australia, and one from the United States of America.

The literature reviewed prioritised recent work with the intention of providing a valid and reliable overview of workforce development strategies with kaupapa Māori relevance and alignment to the rangahau intent. The categories examined in depth were identified by focusing on patterns and insights related to Māori and Indigenous health workforce development. Key considerations included the extent to which the literature centred Indigenous perspectives, addressed systemic barriers, and proposed transformative workforce strategies.

Table 2. Final Pieces of Literature for Review

	Literature (Shortened/amended description titles)	**Māori-led**	**Indigenous-led**	**Western-led**	**Workforce Plan or Policy**
1	Strengthening Māori participation in the health and disability workforce (Ratima et al., 2007).	Yes	Yes	--	-
2	A literature review exploring 'best' practice for recruitment into tertiary health programmes (Curtis et al., 2012).	Yes	Yes	-	-
3	Earn as you learn, a workforce initiative to increase Māori nurses in primary health care (Wiapo et al., 2023).	Yes	Yes	-	Yes
4	A qualitative study into the realities of Indigenous Māori registered nurses (Komene et al., 2023).	Yes	Yes	-	-
5	Kaupapa Māori Health Workforce Plan 2018 -2021 (Te Rau Matatini, 2018).	Yes	Yes	-	Yes
6	Enacting mana motuhake Māori health workforce responses to COVID-19 (Russell et al., 2023).	Yes	Yes	-	-
7	Indigenising our future (Russell et al., 2022).	Yes	Yes	-	-
8	Health Workforce Evaluation Report of Kia Ora Hauora (Savage et al., 2020).	Yes	Yes	-	-
9	Ngā Manukura o Āpōpō, kaupapa Māori leadership development programme (Pipi et al., 2021).	Yes	Yes	-	Yes
10	A report on the experiences of Māori nurse educators and their impact on recruitment and retention (Barton & Wilson, 2021).	Yes	Yes	-	-
11	Thesis on the experiences of Māori health practitioners (Rawson, 2020).	Yes	Yes	-	-

	Literature (Shortened/amended description titles)	**Māori-led**	**Indigenous-led**	**Western-led**	**Workforce Plan or Policy**
12	The Health Services and Outcomes Kaupapa Inquiry (Wai 2575), concerning the Treaty of Waitangi Act 1975 (Waitangi Tribunal, 2023).	Yes	Yes	-	-
13	Statistics on Māori workforces employed in the Health and Social Care workforces (Infometrics & Te Rau Ora, 2022).	Yes	Yes	-	-
14	Niganawenimaanaanig, Indigenous model to support nursing student success (Wilkie et al., 2023).	-	Yes	-	Yes
15	A literature review on the discourse surrounding the development of an Indigenous primary healthcare workforce (Bond et al., 2019).	-	Yes	-	-
16	Growing our rural and remote Aboriginal health workforce (Naden et al., 2023).	-	Yes	-	-
17	Qualitative, multisector study on the barriers and enablers to Aboriginal and Torres Strait Island-led careers in health (Bailey et al., 2021).	-	Yes	-	-
18	A Report on Growing and Strengthening the Aboriginal and Torres Strait Islander Health Workforce (Bailey et al., 2020).	-	Yes	-	-
19	Health workforce webinar series: Issues and opportunities for the Māori health workforce (Ministry of Health, 2022a).	Input	-	Yes	-
20	Māori Health Workforce Webinar dialogue (Ministry of Health, 2022a).	Input	-	Yes	-

	Literature (Shortened/amended description titles)	**Māori-led**	**Indigenous-led**	**Western-led**	**Workforce Plan or Policy**
21	Whakamaua: Māori health action plan 2020 – 2025 (Ministry of Health, 2020).	Input	-	Yes	Yes
22	Health Workforce Plan 2023/24 (Health NZ & Te Aka Whai Ora, 2023).	Input	-	Yes	Yes
23	Report to the Minister of Health (Health Workforce Advisory Board, 2022)	-	-	Yes	-
24	National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework (Australian Government, 2022).	-	-	Yes	Yes

2.2 Three Categories

Three categories emerged from the critique of the reviewed literature. They have been categorised as **Institutional Racism in the Development of the Health Workforce** which identified factors contributing to consistent barriers to Māori and Indigenous health workforce development; **The Pipeline of the Health Workforce** critiques the predominant focus on the development of this workforce under Western-led constructs; and finally, **Māori and Indigenous-Led Workforce Success** that reinforces the significance, success, and value of Māori and Indigenous health workforce development.

2.2.1 Institutional Racism in the Development of the Workforce

Institutional racism within health, health education systems, and funding structures profoundly impacts Māori and other Indigenous communities, perpetuating acute and systemic inequities in health workforce development (Bailey et al., 2021; Barton & Wilson, 2021; Bond et al., 2019; Russell et al., 2022; Savage et al., 2020; Wilkie et al., 2023). The Wai 2575 Māori Nurses Claim to the Waitangi Tribunal stresses significant economic disparities, highlighting a pay parity gap "of up to approximately 25%" between Māori working within iwi providers and their counterparts who are employed within District Health Boards (Waitangi Tribunal, 2023, p. 150).

This gap forces many Māori health professionals to choose between financially supporting their whānau or working in culturally aligned spaces. Further, nēhi who pursue Māori-specific training, such as a Bachelor of Nursing – Māori, are frequently destined to face discrepancies in both recognition and remuneration in their subsequent employment (Waitangi Tribunal, 2023). Despite possessing the same qualifications and passing the same examinations as their peers, they are often deemed to be less qualified.

Although efforts have been made to make health services culturally safe, many of these initiatives result in tokenistic gestures which fail to challenge the underlying structures of power (Komene et al., 2023; Rawson, 2020; Savage et al., 2020). Institutional practices often sideline Māori professionals from leadership roles, boxing them into culturally specific positions without genuine authority or influence. The literature documents instances of deep-seated biases, including disturbing remarks from education professionals questioning Māori tauira capability to aspire beyond roles such as hospital

orderlies (Savage et al., 2020). Such as “we don’t have any Māori tauira who could be doctors or medical professionals, but do you organise sessions for hospital orderlies?” (Savage et al., 2020, p. 18).

Institutional racism was evidenced, too, by notable omissions of the topic itself, that is, an evident lack of mentions of how Western-led health workforce development plans sought to address institutional racism effectively. The Health Workforce Plan (2023/24) refers to ‘racism’ in relation to focusing on continuing to promote “equitable recruitment practices to further reduce racism and bias in hiring and promotion” (Health NZ & Te Aka Whai Ora, 2023, p. 33). However, its single usage in the 41-page plan was not located under the section relating to Māori or Indigenous, but under a broader section on supporting and retaining the workforce (Health NZ & Te Aka Whai Ora, 2023). The document did not discuss how the plan would address racism in the first place; it did not relate it to those who are more likely to experience racism (Health NZ & Te Aka Whai Ora, 2023). Nor did it offer what such equitable recruitment practices would look like, whether newly implemented or continuing. Furthermore, in 2022, several hui were held to gather whānau Māori and their community aspirations for health workforce development (Ministry of Health, 2022a, 2022b). These hui offered valuable insights on Māori values and priorities, including mana motuhake – the autonomous authority inherent to whānau, hapū, Māori to determine their destiny, tino rangatiratanga, kaupapa Māori entities and leadership. It is worth mentioning that these insights were not seen to feature in the final Health Workforce Plan (Health NZ & Te Aka Whai Ora, 2023).

The literature, however, shows the persistent failures of the health system in attracting and retaining a Māori health workforce (Rawson, 2020). It is apparent within the literature that this is further aggravated by issues in the mainstream health education sector, which similarly struggles to recruit, support, and graduate tauira and Indigenous peoples (Barton & Wilson, 2021; Wilkie et al., 2023). The literature calls for a paradigm shift that not only addresses but actively confronts racist structures which limit the growth and effectiveness of the Indigenous health workforce (Bond et al., 2019; Russell et al., 2022). The entrenched nature of institutional racism within the health and health education sectors continues to harm Indigenous peoples significantly, necessitating a transformative approach to workforce development. To truly improve health and

wellbeing outcomes for Māori and similarly Indigenous populations, policies and practices must not only include but also be led by Indigenous worldviews, thereby ensuring that workforce development is equitable and in alignment with Indigenous aspirations.

2.2.2 The Pipeline of the Workforce

Indigenous-led literature by Bond et al. (2019) and Russell et al. (2022) offers a critical examination of health workforce development strategies targeted at their relevant Indigenous populations. Bond scrutinises over two decades of such initiatives in Australia, which have predominantly focused on increasing and retaining the Indigenous Aboriginal and Torres Strait Islander health workforce 'pipeline', into Western-dominated services (2019). Similarly, Russell et al. criticise Western-led deficit-focused plans for developing the workforce (2022). According to each of these researchers, while the strategies are well-intentioned, the authors argue that they often miss the mark by diverting attention from the root causes of health inequities and imposing expectations on Indigenous people to conform to Western-dominated paradigms (Bond et al., 2019; Russell et al., 2022). This suggests that Western models risk failure when they neglect Indigenous approaches.

The critique centres on the notion that while the presence of Indigenous professionals within the health sector is undoubtedly essential, overemphasising this aspect often misguides and surpasses the need for a more transformative approach. As Russell et al. stated, "Simply adding more Māori health professionals trained within a paradigm which steadfastly resists Indigenous worldviews and solutions is not the answer" (2022, p. 11). This statement highlights the fundamental flaw in current approaches, which usually fail to challenge and change the structures perpetuating health inequities. The prevailing strategies reinforce the idea that Indigenous health can only be improved by adapting to Western systems and theories rather than by providing space for Indigenous-led worldviews and solutions. Significant gains for Māori health and workforce development require more than traditional professional networks (Russell et al., 2022). The expectation should be for Western workforce development plans to honour Indigenous-led paradigms.

2.2.3 Māori and Indigenous-Led Workforce Success

Australasian and United States research highlights the desirability of an Indigenous health workforce reflecting the relevant countries' population demographics (Australian Government, 2022; Health NZ & Te Aka Whai Ora, 2023; Wilkie et al., 2023). Retaining Māori and Indigenous staff is a key focus in workforce development (Australian Government, 2022; Barton & Wilson, 2021). Specifically, the Health Workforce Advisory Board (2022) report to the Minister emphasised the urgent need to expand the Māori health workforce across all levels. Similarly, Australia's National Workforce Plan targets increasing Aboriginal and Torres Strait Islander representation to "3.43% of the national health workforce" by 2031, aligning with their overall population proportion (Australian Government, 2022, p. 11).

These policy backings align with evidence which consistently shows that Indigenous health outcomes are most equitable when health services are led by the relevant population (Ministry of Health, 2020; Naden et al., 2023; Te Rau Matatini, 2018; Wilkie et al., 2023). In other words, this emphasises the effectiveness of Indigenous-led approaches, which align culturally and have the capacity to catalyse positive change in health workforce development.

In Aotearoa, literature advocates for community-driven and kaupapa Māori-led approaches, which are supported by equitable funding (Health Workforce Advisory Board, 2022; Waitangi Tribunal, 2023). However, as mentioned in the first category, funding structures have not aligned (Waitangi Tribunal, 2023). Kaupapa Māori strategies, grounded in te ao Māori, have demonstrated success in incorporating collective vision and culturally rooted values to improve Māori health outcomes (Barton & Wilson, 2021; Pipi et al., 2021; Russell et al., 2023; Savage et al., 2020; Wiapo et al., 2023). Moreover, these authors emphasise that te ao Māori knowledge and skills are critical for improving health outcomes.

Incremental advancements described by the Health Workforce Advisory (2022) in workforce development, which are driven by kaupapa Māori strategies, highlight their significance. These initiatives, rooted in Māori worldviews and values, excel in developing a health workforce prioritising relationships, collectivising care, and upholding tika (the right way) (Russell et al., 2023; Savage et al., 2020). Many Māori are

choosing qualifications in traditional Māori health practices rather than regulated professions, reflecting an increasing interest in mātaurangaa and te ao Māori-led pathways (Infometrics & Te Rau Ora, 2022).

Initiatives such as Ngā Manukura o Āpōpō, Earn As You Learn, Kia Ora Hauora, and Te Rau Matatini (now named Te Rau Ora), demonstrate the effectiveness of Māori worldviews in workforce development (Pipi et al., 2021; Savage et al., 2020; Te Rau Matatini, 2018; Wiapo et al., 2023). Similar success is observed in other Indigenous initiatives, such as Niganawenimaanaanig, an Indigenous nursing education model from the United States (Wilkie et al., 2023).

The COVID-19 pandemic highlighted the strength of kaupapa Māori approaches, as whānau Māori, hapū, iwi, and organisations mobilised to address community health and wellbeing (Russell et al., 2023). Efforts included upskilling staff in vaccination and testing while focusing on long-term workforce sustainability. The pandemic also saw a rapid increase in the Māori kaiāwhina workforce, that was critical in meeting immediate and ongoing community health needs (Russell et al., 2023). A fundamental Māori understanding that hauora is collective, further strengthened the effectiveness of these interventions; they are firmly rooted in kaupapa Māori values.

The broader literature highlighted the profound impact of culturally grounded strategies on Māori health outcomes. The success of kaupapa Māori approaches was centred on Indigenous knowledge, values, and leadership as essential to health improvement. Similarly, this was shown internationally when strategies prioritised Indigenous leadership and cultural competence (Bailey et al., 2020; Wilkie et al., 2023). Like kaupapa Māori, these approaches centred on the validity of traditional knowledge, reflecting the universal applicability of Indigenous-led solutions across Indigenous populations. Evidence supports that approaches grounded in cultural values and knowledge systems are essential for developing a responsive health workforce that aligns with the aspirations of Indigenous communities.

Overwhelmingly, literature from this category demonstrated the critical need for Māori and Indigenous-led strategies in health workforce development. It clearly highlighted their proven effectiveness in addressing systemic barriers in order to advance equitable health and wellbeing outcomes. The literature strongly advocated for approaches which

prioritise Indigenous worldviews, cultural values, and leadership as fundamental to transformative change. It is very apparent that these strategies are not only relevant but are in fact essential for addressing entrenched inequities within health systems.

2.3 Conclusion

This tightly focused review of literature highlighted three critical areas in Māori and Indigenous health workforce development, namely: *Institutional Racism in the Development of the Workforce*, critiques of the *Pipeline of the Workforce*, and *Māori and Indigenous-Led Workforce Success*. Each category has illustrated the complex interplay of historical inequities, systemic barriers, and the transformative potential of Indigenous-led strategies.

Institutional racism, however, remains a pervasive barrier, stalling progress, and marginalising Indigenous professionals. Addressing structural inequities requires a paradigm shift that actively dismantles entrenched biases while prioritising equitable practices. The analysis of the workforce pipeline proposed that there are limitations within Western-dominated frameworks which overlook Indigenous worldviews. The literature demonstrated that while increasing representation within these systems remains important, true progress demands that transformative approaches be devised which respect and incorporate Indigenous paradigms into workforce development.

Literature critiqued within this wāhanga has shown that Māori and Indigenous-led workforce solutions repeatedly emphasise the necessity of culturally aligned and community-driven approaches. These strategies have been found to be most effective when they centre on Indigenous knowledge, values, and leadership.

Overall, this review has demonstrated that sustained and meaningful improvements in Māori health outcomes require strategies which are culturally grounded, adequately funded, and led by Indigenous communities. Findings within the literature repeatedly advocated for a commitment to systemic change, ensuring that workforce development policies and practices are not only inclusive, but also equitable, and align with the aspirations of Māori and other Indigenous peoples.

Overall, the literature revealed a critical gap in current Māori health workforce development research, workforce plans, strategies, and initiatives led by Māori. While

increasing the number of Māori professionals in health was identified as essential, this review has highlighted the importance of challenging the underlying assumptions of Western-dominated paradigms. It has pointedly and repeatedly highlighted that Māori-led strategies for health workforce development are demonstrably the most successful. However, the literature also shows a significant lack of focus within existing rangahau and research on their implementation and broader application. That gap clearly establishes a rationale for further study to explore how Māori aspirations and approaches can be supported in order to achieve transformative outcomes for the Māori health workforce and, ultimately, Māori health equity.

This wāhanga now transitions to the methodology that provides the foundation to the study and underpins the methods and procedures.

Wāhanga 3: Kaupapa Māori Methodology and Methods

3.1 Introduction

This wāhanga introduces my intentional use of kaupapa Māori as the methodology underpinning this study. Grounded in kaupapa Māori theory, this methodology informs the chosen methods and provides the foundational framework for this rangahau. The ontological reality is explored and explained through whakapapa, while the epistemological framework is understood through mātauranga (Henry & Pene, 2001; Roberts, 2013). This study seeks to recognise and assert our whakapapa through hauora and te reo Māori which are weaves of mātauranga. At the core of kaupapa Māori methodology, is the critical intent to activate tino rangatiratanga (Smith, G. et al., 2012; Walker, 1996). Central to tino rangatiratanga and the aspirations of Māori is that decisions are made by Māori, for Māori (Matike Mai, 2016).

This wāhanga then details the associated methods which are interwoven with relevant ethical considerations. These include the whānau rangahau process, recruitment, consent, and data collection via wānanga. Details of my ethics approval, granted to conduct a secondary analysis of the original data, are also included. Finally, the process of reflective thematic analysis is outlined, highlighting how the themes of this study's findings were developed.

3.1.1 Kaupapa Māori Theory

Kaupapa Māori can be understood as the way of Māori that incorporates knowledge, skills, attitudes, and values of Māori society embedded in te ao Māori. Kaupapa Māori, as a theory developed from the aspirations of Māori and the long and constant struggle to revitalise te reo Māori (Smith, G., 1997; Smith, G. et al., 2017). The struggles and aspirations of whānau, hapū, and community leaders for their tamariki (children) to be educated in te reo Māori and immersed in te ao Māori (Ratapu & Hohepa, 1991; Smith, G., 1997) gave rise to the revolutionary movement in the 1980s, which culminated in the establishment of kōhanga reo – early childhood te reo Māori immersion. This was soon followed by the first immersion te reo Māori kura (school) named – "Te Kura Kaupapa Māori o Hoana Waititi" (Ratapu & Hohepa, 1991, p. 1). Soon afterwards, Graham Smith (1997), a Māori doctoral candidate and teacher, began writing

extensively on ‘kaupapa Māori’ in conjunction with his Ph.D. study, cementing the term in academic pursuits to advance Māori aspirations.

3.1.2 Kaupapa Māori Methodology

Kaupapa Māori is a methodology derived from kaupapa Māori theory, and thus, highlights Māori aspirations (Smith, G., 1997; Smith, G. et al., 2017; Smith, L. & Reid, 2000; Walker et al., 2006). Linda Smith asserts that kaupapa Māori methodology, derived from the struggle, resistance, and emancipation of Māori (2021). This methodology provides a pathway for the reawakening, preservation, and protection of te ao Māori through kaupapa Māori rangahau (Smith, G. et al., 2012; Smith, L., 2021; Walker et al., 2006). Through the activation of tino rangatiratanga, it aims to ensure that aspirations nominated and determined by Māori are realised. Kaupapa Māori methodology and thus rangahau, seeks to disrupt the foundations and expose the underlying assumptions which conceal and sustain existing power relations, structures, and societal inequities experienced by Māori (Pihama, 2015; Smith, L., 2021). It aims to function as a platform for affirming and normalising kaupapa Māori ways of being, doing, and knowing (Cram, 2019; Smith, G. et al., 2017).

3.1.3 Whakapapa

Kaupapa Māori methodology, explained by Henry and Pene (2001), is “a set of methods and procedures…” that “is shaped by our assumptions about what is ‘real’ and what is ‘true’ ” (p. 238). As discussed in the first wāhanga, I asserted my whakapapa as Māori. While Māori are not all the same (Opai, 2021), there are some shared understandings (Tipa, 2021). Whakapapa embodies an ontological reality deeply intertwining Māori identities and relationships within te ao Māori (Henry & Pene, 2001; Rawnsley, 1998). An ontology reality, as stated by Studer et al. (1998), can be explained as “a formal, explicit specification of a shared conceptualisation” (1998, p. 184). Whakapapa provides a foundation for understanding the origins and interconnectedness of te ao Māori, tracing all existence back to primary tūpuna (Henry & Pene, 2001; Roberts, 2013; Tau, 1999; Te Huia, 2015). Mātauranga is grounded in the structured framework of whakapapa, which offers “an epistemological basis for a Māori… way of knowing about the world” (Roberts, 2013, p. 93). Mātauranga enables us to understand te ao Māori, how both tikanga and te reo Māori are generated and sustained by whakapapa (Pihama,

2015; Tau, 1999). This whakataukī – proverb, a significant saying embedded in Māori knowledge, wisdom and understanding, exemplifies our connection and relationship through whakapapa and our reciprocal responsibilities of caring for one another.

Ka ora te whenua, ka ora te tāngata –
The land, Mother Earth, is the source of all life; she is our mother.

Papatūānuku, referred to as our mother and "the elemental womb to which we must all return." (Te Awekōtuku, 1991, p. 139), demonstrates our connections through the whakapapa. This study recognises our whakapapa, and that of hauora, is central to our collective health and wellbeing (Durie, 1998; Moewaka Barnes & McCreanor, 2019)The tikanga of returning whenua (placenta) from māmā to pēpē (baby) following the birth of new life acknowledges this. This study sought to honour our innate connections through whakapapa to hauora and is thus highly relevant to the Māori health workforce and its development, which is intended to improve the health and wellbeing of Māori.

My primary supervisor shared Te Punga Somerville's *Always Italicise: How to Write While Colonised* (Te Punga Somerville, 2022), which further influenced my approach. The author's poetry critiques the colonial practice of italicising certain words, which mark them as foreign or of less importance. Te reo Māori, historically subjected to this practice, deserves rightful recognition and centrality within our mahi (work) and narratives (Te Punga Somerville, 2022). In this thesis, italics have not been used to distinguish between languages, but instead used sparingly for the purpose of visual presentation and formatting. However, I recognised that to honour te reo Māori truly, this thesis would be written entirely in te reo Māori. However, as discussed, my whānau were forced to give up our reo; thus, I am not fluent. Instead, the gradual inclusion of te reo Māori into the thesis demonstrates my resistance to the prioritisation of English and my struggle to learn our te reo (Smith, G., 1997; Smith, G. et al., 2012)This study seeks to assert Māori aspirations for the revitalisation and legitimisation of te reo Māori, contributing to the progression and normalisation of its space within rangahau.

3.1.4 By Māori, For Māori

Critical to kaupapa Māori methodology is the active use of tino rangatiratanga, and at the core of tino rangatiratanga is "the right for Māori to make decisions for Māori" (Matike Mai, 2016, p. 8). Throughout this thesis, I acknowledge the aspirations of Māori

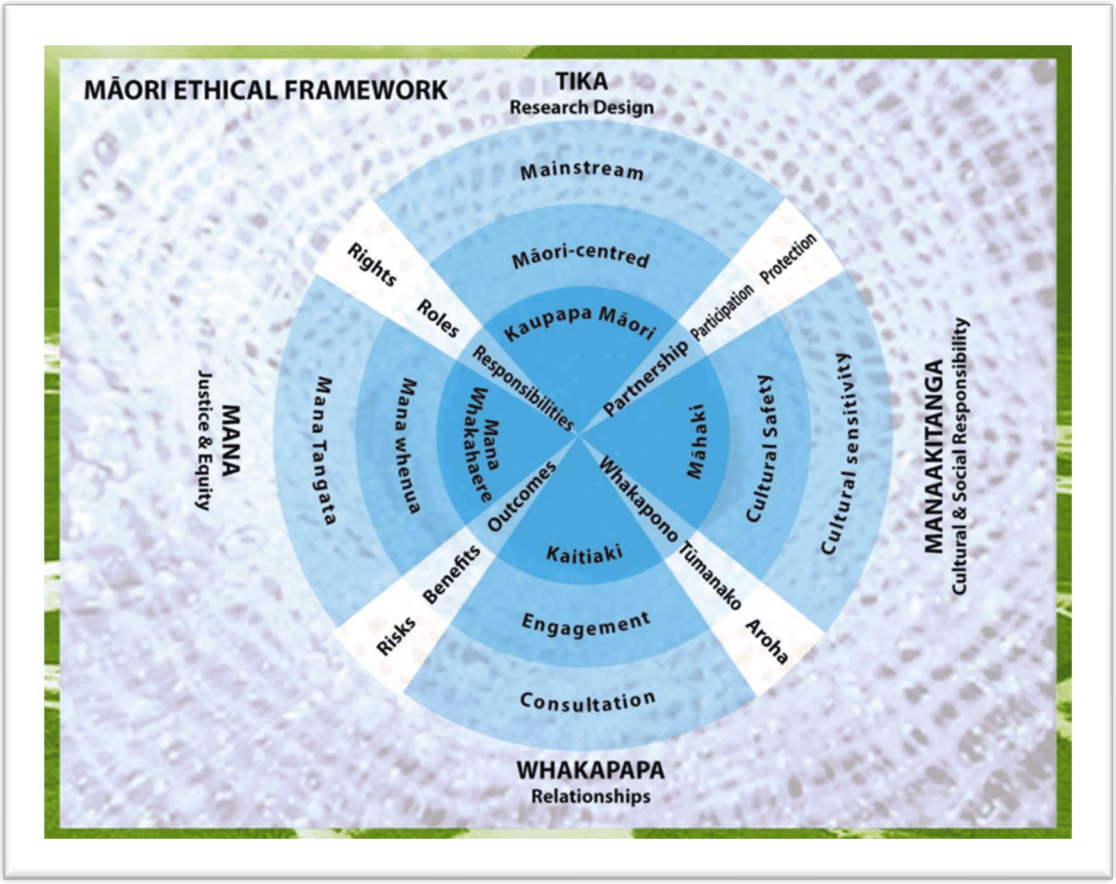
for tino rangatiratanga, while recognising the challenges for its full realisation within a Western-dominated society, health, and education systems. As a tauira seeking to gain a Master of Health Science, I am navigating a system that undermines tino rangatiratanga. However, throughout this rangahau, my engagement with the rōpū rangahau, participant and kaitiaki rōpū – collectively referred to as the whānau rangahau, and through the courageous leadership of Māori and Pākehā as tāngata Tiriti critical allies, the space was created. This rangahau and its methodology were led by Māori, for Māori, with the whānau rangahau able to offer tautoko and critical advice to ensure outcomes align with the aspirations of Māori. However, as stated, "Māori are not a homogenous people" (Opai, 2021, p. 10), and thus, critical to this study is that kairangahau cannot speak for any Māori and most certainly not for all. Instead, as whānau and hapū, Māori have the right to determine who can speak and make decisions on their behalf.

Furthermore, kaupapa Māori rangahau is viewed exclusively as by Māori, for Māori. Bishop (2011) argues that other researchers who have a legitimate wish to support their Māori colleagues and rangahau may be included. While I am the sole kairangahau of this study, the whānau rangahau provided advice and critical feedback. While some of the members within the rōpū rangahau were of Pākehā descent, they were recognised as tāngata Tiriti, through the ongoing reflective practice and action of critical allyship with Māori. Thus, they were advocates and supporters of the rangahau intent; however, they did not, nor did they want to, make decisions on behalf of Māori.

3.2 Methods and Ethics

In this section, the chosen methods are interwoven with ethical considerations through the Te Ara Tika (Hudson et al., 2010). It is an ethical framework collaboratively designed by the Pūtaora Writing Group for research involving Māori. Underpinned by kaupapa Māori methodology, Te Ara Tika ensured that this rangahau would result in positive outcomes for Māori and that no harm would be caused in the process.

Figure 2. Te Ara Tika Māori Ethical Framework for Research involving Māori



Te Ara Tika framework by Hudson et al. (2010) utilised for this rangahau

The study sought the four best practice guidelines represented within the inner circle of this figure. As shown, kaupapa Māori, Māhaki, Kaitiaki and Mana Whakahaere within the frameworks of Tika, Manaakitanga, Whakapapa and Mana (Hudson et al., 2010). This study was purposefully led by kaupapa Māori methodology, and thus, this rangahau was conducted by Māori for Māori. This study recognised our collective whakapapa through the whānau rangahau and, within this, the kaitiaki rōpū. While I am identified as the kairangahau, collectively, these relationships ensured that power and control were held by Māori. Therefore, spiritual integrity remains embedded in te ao Māori and thus, aspirations as determined by Māori were realised.

3.2.1 Whānau Rangahau

The whānau rangahau consisted of the rōpū rangahau, the participant rōpū and the kaitiaki rōpū. The kaitiaki rōpū provided advice and guidance for this study, in alignment with the best practice of Te Ara Tika (Hudson et al., 2010). Alongside the rōpū rangahau, I presented to this kaitiaki rōpū several times between 2022 and 2024, receiving advice,

critique, and approval for my ongoing rangahau. My presentation slides were sent out once for further opportunity to review, but I did not receive additional feedback. While the kaitiaki rōpū consisted of many members, the following, in particular, provided advice and tautoko: Maria Baker, Grant Berghan, TerryAnn Clark, Hayley Arnet, and Brian Rodgers.

3.2.2 Participant Recruitment, Rōpū and Consent

As discussed, this study involved the secondary analysis of data, and thus, data recruitment and collection were completed by the rōpū rangahau. Relevant to this study, based on kaupapa Māori theory, the rōpū rangahau recruitment process involved purposive recruitment from their professional networks via email, phone, and in-person. Purposive sampling was used to gather diverse and information-rich data relevant to support the development of a Māori-specific theory of anti-racism for the health system. Requirements included having whakapapa and identity as Māori. Participants were required to have at least seven years of experience as health professionals and have expertise in anti-racism/disrupting racism and or transformative praxis.

The participant rōpū involved seventeen Māori health professionals. They were kaumātua, kuia – respected male and female elders, and several pakeke (mature adults) who demonstrated a high level of experience and expertise in the field of inquiry, consisting of two tāne and fifteen wāhine. The participants worked in a wide range of services currently and throughout their time, including workforce development, population and public health, mental health and addiction services, universities, research and rangahau organisations, government and non-government organisations within rural and urban areas of Aotearoa. They were leaders, managers, deans, iwi chairs, and Māori representatives. Health backgrounds included nursing, public health, psychology, and occupational therapy. Each participant had expertise in transformative praxis in the health, health education sector and/or their associated policies.

The participants were provided with a written information sheet (see Appendix C) and made aware of what the study consisted of, including but not limited to proposed dates, hours, criteria, consent process, wānanga and the contact details for the rōpū rangahau, to contact the members at any point. If they chose to participate, they received a consent form; however, if they attended the wānanga online, it was also explained, and

their attendance was recognised as informed consent. To ensure accessibility, participants were offered three days and times to attend any or all of the three wānanga. Each participant attended a single session. They were informed that they could withdraw from the study, although no participants withdrew at any point.

3.2.3 Data Collection: Wānanga

Three kaupapa Māori caucused wānanga – to meet, discuss and negotiate online were led by Professor Jacquie Kidd and supported by the rōpū rangahau, of which Pākehā members supported from the background, that is, they attended online wānanga, and engaged in whakawhanautanga, but did not engage further in the kōrero. I attended each of the three wānanga in October 2021. Within each of these, I shared my whakapapa and my positionality as a Master's tauira, hoping to complete a thesis alongside the rōpū rangahau,[1] focusing on Māori health workforce development. While traditionally, wānanga would emphasise in-person interactions (Mahuika & Mahuika, 2020) the COVID-19 pandemic and logistical constraints required adaptation, leading to the facilitation of three wānanga in virtual spaces.

With consent from all present, each wānanga was video and audio recorded and transcribed. Each wānanga was opened with a karakia (prayer, saying), and an overview of the study and ethics was provided. This was followed by whakawhanaungatanga – the process of building and maintaining relationships between the participants and the rōpū rangahau. This created a safe interpersonal space for a collective process of whakawhiti kōrero – ideas negotiated through conversation. The participants were asked to 're-imagine a health system that wasn't racist' (Māori specific), with the question, 'What is your vision of the health system? If the health system wasn't racist, what would you see, hear, and feel?' Having Māori caucused wānanga and building relationships allowed a safe space for normalised emotional responses of the rōpū, including feelings of hurt, anger, and experiences of racism (Kidd et al., 2025; Mahuika & Mahuika, 2020). This approach allowed for in-depth and detailed discussions.

[1]At the time of the wānanga, through ethics I was yet to be added as a research member, thus I signed as the 118th participant.

3.2.4 Reflective Approach to Thematic Analysis

My ethics application 22/58 was approved for secondary data analysis on 31 March 2022, while further evidence was requested and satisfied on 04 September 2023 (Appendices A and B).

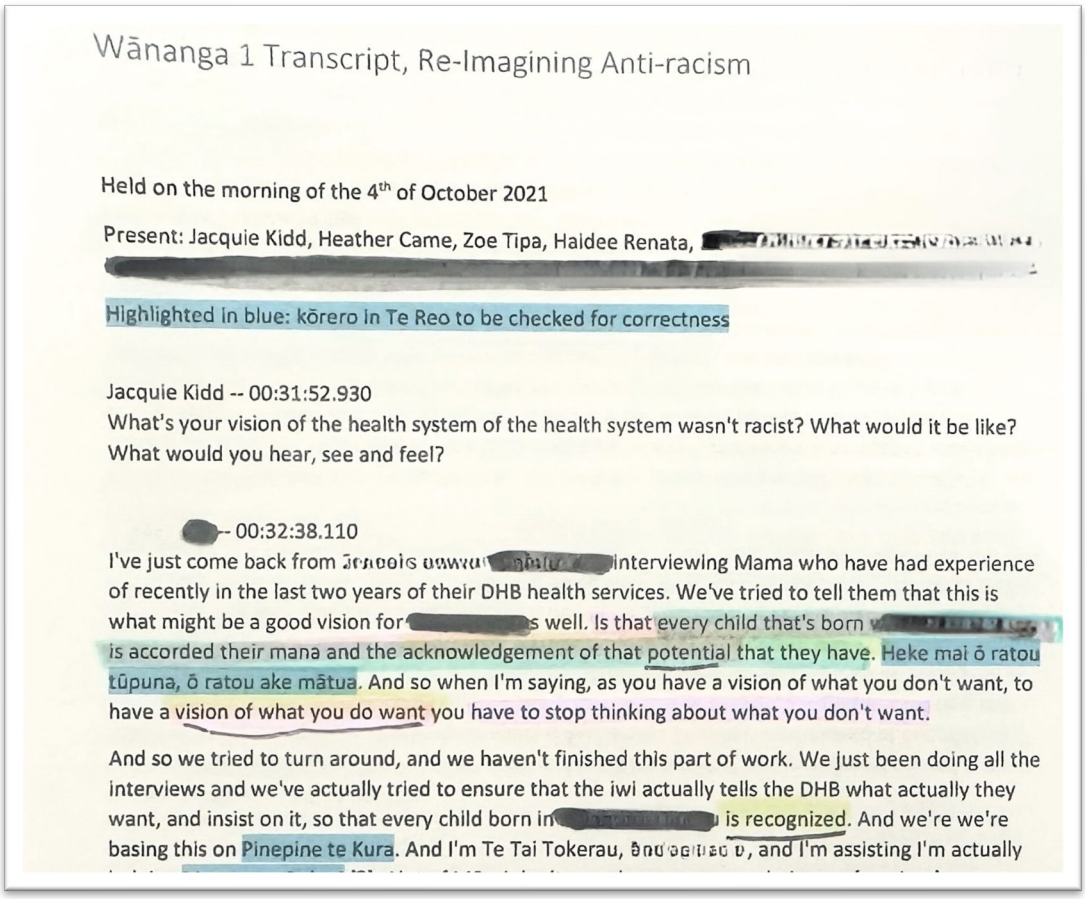
Thematic analysis is a method used to engage and analyse qualitative data, which is helpful for engaging deeply with the material and doing justice to the participants' voices (Terry & Hayfield, 2021). The reflective approach to thematic analysis involved and emphasises the importance of critically engaging with my positionality as the kairangahau, recognising that my role is central to producing mātauranga (Braun & Clarke, 2019). This method and approach allow for reflective and contextual analysis with the ability to prioritise kaupapa Māori (Kidd et al., 2025; Terry & Hayfield, 2021). The process of this analysis is inherently reflective and non-linear, requiring continuous back-and-forth engagement to ensure the analysis remains meaningful and grounded (Braun & Clarke, 2019; Terry & Hayfield, 2021). Key components of this approach included familiarisation, coding, theme development, reviewing, and refining, culminating in the final naming of themes.

The following subheadings have been included to offer structure to the reader. However, they do not convey the iterative and reflective nature of thematic analysis as expected within a reflexive thematic analysis process (Braun & Clarke, 2019; Terry & Hayfield, 2021).

3.2.5 Data Familiarisation

Familiarisation is an active engagement process with the intent of becoming fully immersed in the "data as data" (Terry & Hayfield, 2021, p. 30). Having been in attendance in the three wānanga, for me, these data analysis process of familiarisation had already begun. However, while I knew that my area of focus was within Māori health workforce development, my specific question was yet to be formulated. Starting with the transcripts transcribed by the rōpū rangahau, I thoroughly engaged with these data and the familiarisation process through the lens of the 'visions and values for Māori health workforce development.'

Figure 3. Data Familiarisation



Wānanga 1 Transcript, Re-Imagining Anti-racism

Held on the morning of the 4th of October 2021

Present: Jacquie Kidd, Heather Came, Zoe Tipa, Haidee Renata, [redacted]

Highlighted in blue: kōrero in Te Reo to be checked for correctness

Jacquie Kidd -- 00:31:52.930
What's your vision of the health system of the health system wasn't racist? What would it be like? What would you hear, see and feel?

[redacted] -- 00:32:38.110
I've just come back from [redacted] interviewing Mama who have had experience of recently in the last two years of their DHB health services. We've tried to tell them that this is what might be a good vision for [redacted]s well. Is that every child that's born [redacted] is accorded their mana and the acknowledgement of that potential that they have. Heke mai ō ratou tūpuna, ō ratou ake mātua. And so when I'm saying, as you have a vision of what you don't want, to have a vision of what you do want you have to stop thinking about what you don't want.

And so we tried to turn around, and we haven't finished this part of work. We just been doing all the interviews and we've actually tried to ensure that the iwi actually tells the DHB what actually they want, and insist on it, so that every child born in [redacted] is recognized. And we're we're basing this on Pinepine te Kura. And I'm Te Tai Tokerau, [redacted], and I'm assisting I'm actually

Process of Thematic Analysis – Hard Copy (with sections blurred to maintain privacy)

I first read each of the transcripts in full. As shown in the figure above, I started by highlighting areas of interest to question, reflect or discuss further. This was followed by watching the audio-video recordings alongside the transcripts twice. During this process, I paused frequently to write notes, including questions and reflections for personal consideration and discussion with my supervisors. Furthermore, I extracted quotes relevant to the question for the study. Regular meetings with my supervisors allowed me to discuss and refine the analysis. This demonstrated the reflective and iterative nature of the process (Braun & Clarke, 2019).

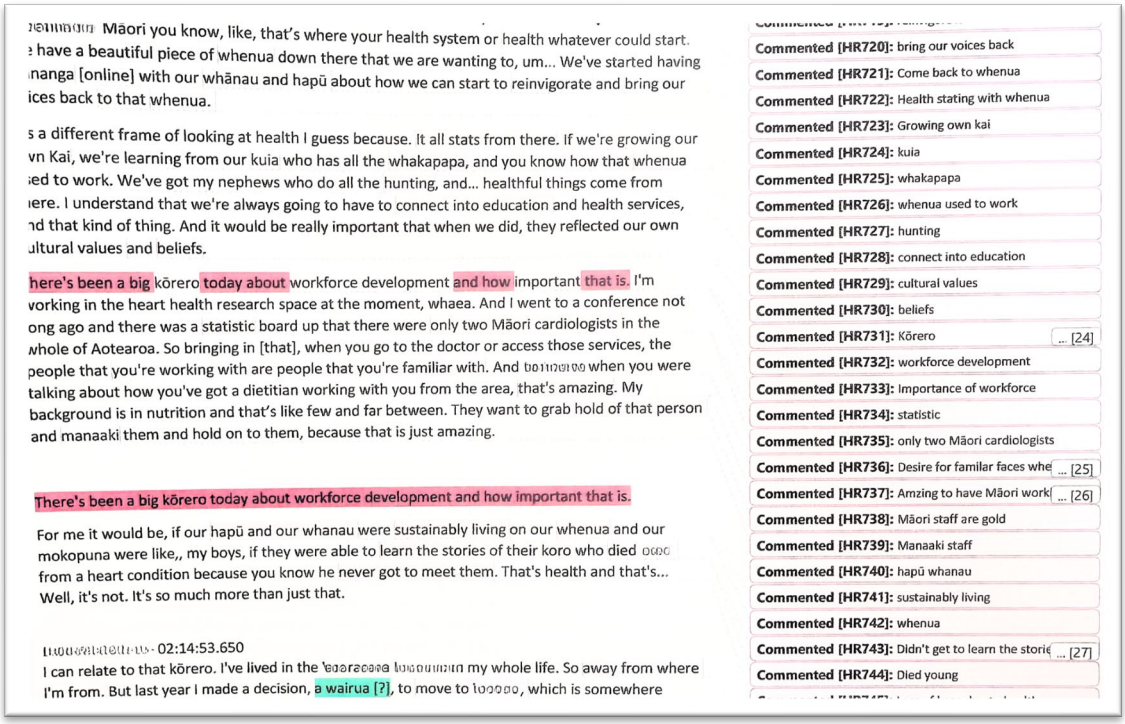
Within each wānanga, te reo Māori was spoken freely, often gaining momentum as discussions progressed. Those fluent in both languages provided translations into English, ensuring that all participants could engage in whakawhiti kōrero and contribute to fostering collective insights. Recognising the critical importance of te reo Māori to this study (Walker et al., 2006) and acknowledging my current stage as a learner of my reo, I sought further clarification with my supervisors for some of the kōrero. This ensured

that all kōrero in te reo Māori were fully understood and included relevant to the study. As shown above in Figure 3. Data Familiarisation: The blue highlighting represents text that needed further translation or clarification.

3.2.6 Data Coding

The coding process involved the kōrero of the seventeen participants exclusively, meaning that no codes were formulated from members of the rōpū rangahau; they were shaded in grey. These data coding followed the reflective approach to thematic analysis by identifying and recording codes within the transcripts (Braun & Clarke, 2019; Terry & Hayfield, 2021).

Figure 4. Initial Coding

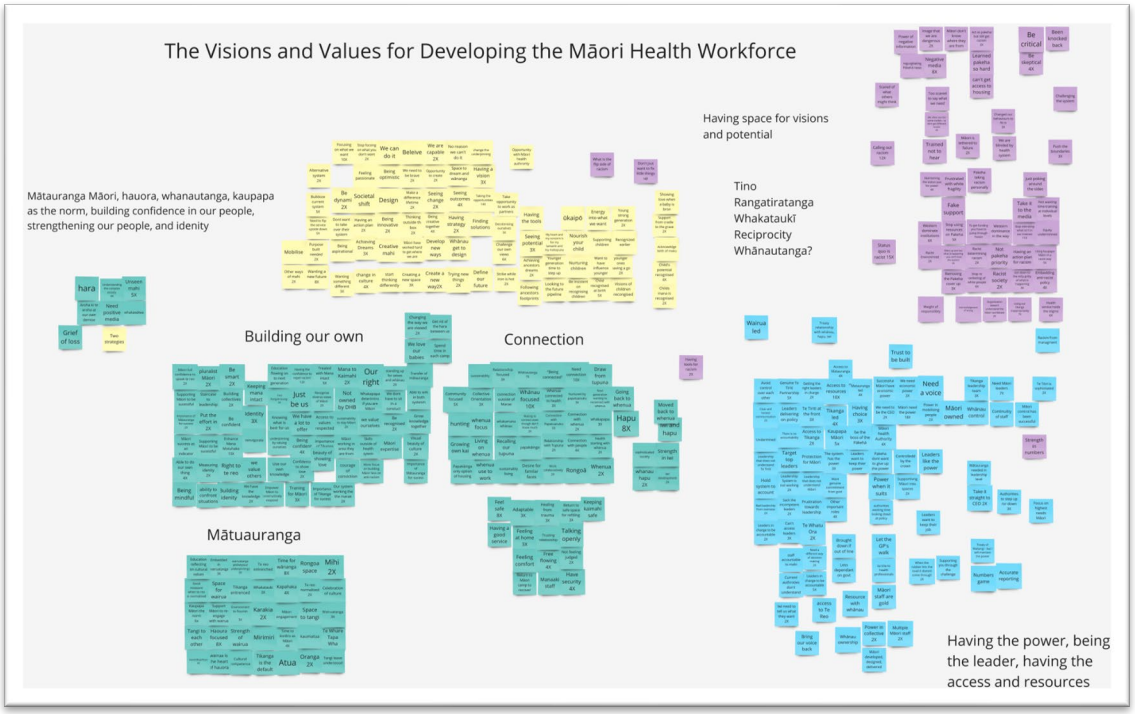


Process of Thematic Analysis - Electronic version on Microsoft Word

This initial phase involved 874 comments in the first transcript and 520 codes by the end of the third transcript. Further refinement of coding was required, as I was inexperienced in coding, meaning there was a crossover of similar terms or their semantic meanings. Thus, they were reviewed, double-coded to capture both semantic explicit level coding and latent codes which involved underlying notions and meanings from my assumptions (Braun & Clarke, 2019; Byrne, 2022). Through this process, they were decreased to approximately 400 codes.

3.2.7 Initial Themes

Figure 5. Initial Theme Workings



Transferring the Codes onto an Electronic Miro Board

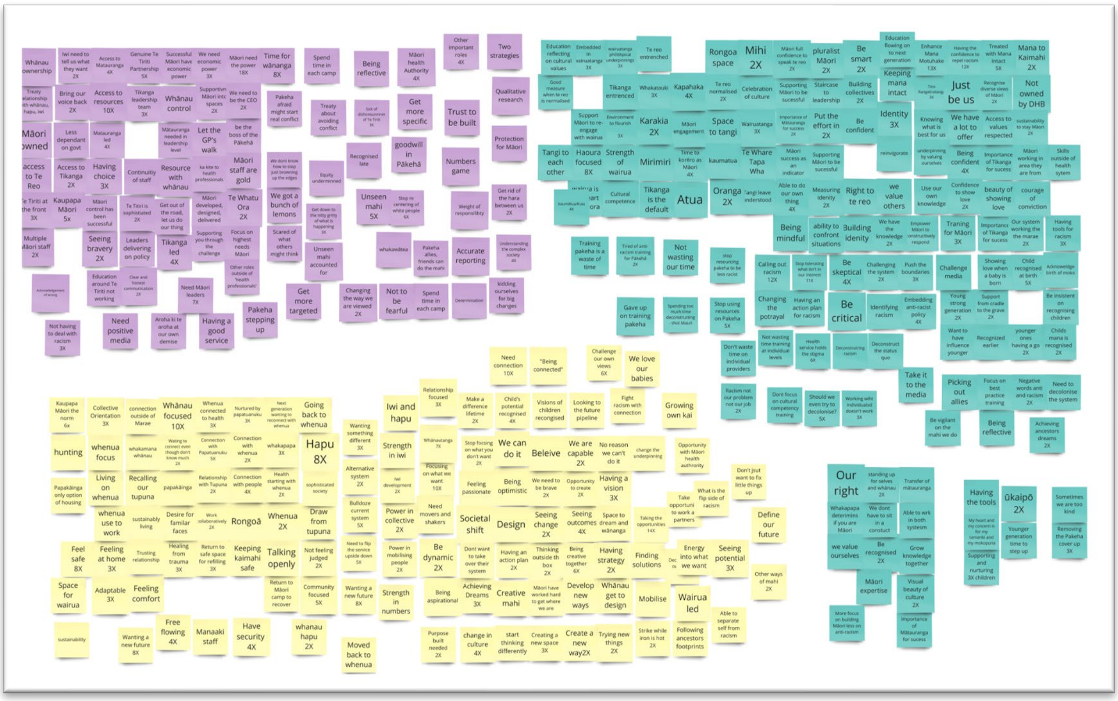
My supervisors were given shared access to the online Miro board, allowing them to oversee the process and discuss it further during supervisory sessions, which was essential to my reflective process (Braun & Clarke, 2019). Initial theme development commenced. The codes located on the Miro whiteboard were moved around and colour-coded to start the process of initial theme development (Braun & Clarke, 2006; Terry & Hayfield, 2021). Through this process, four loose themes were named: Mātauranga, Strengthening Whānau, Access to Power and Resources, and the challenges of Racism and the Status Quo. These were presented to members of the rōpū rangahau and the kaitiaki rōpū in 2023 (Kidd et al., 2023). Through collective whakawhiti kōrero and the advanced knowledge and research completed by these rōpū (Berghan et al., 2017; Came et al., 2020; Kidd et al., 2020; Rae, 2024; Rēnata, H et al., 2025), there was a collective consensus to ensure the focus remains on the 'visions and values' of the participants rather than the challenges. Additionally, this was guided by a well-respected kuia and participant in the first wānanga, providing further instruction. "To have a vision of what you do want, you have to stop thinking about what you don't want" (Wānanga One/W1, Kuia). The returned focus to the vision and values, created space for the

aspirations of Māori, symbolised as the ‘ngahere’ (native forest), to come to the forefront rather than getting entangled in the ‘gorse’ (of racism) as explained by members of the rōpū rangahau (Came et al., 2020; Kidd et al., 2023).

3.2.8 Theme Development

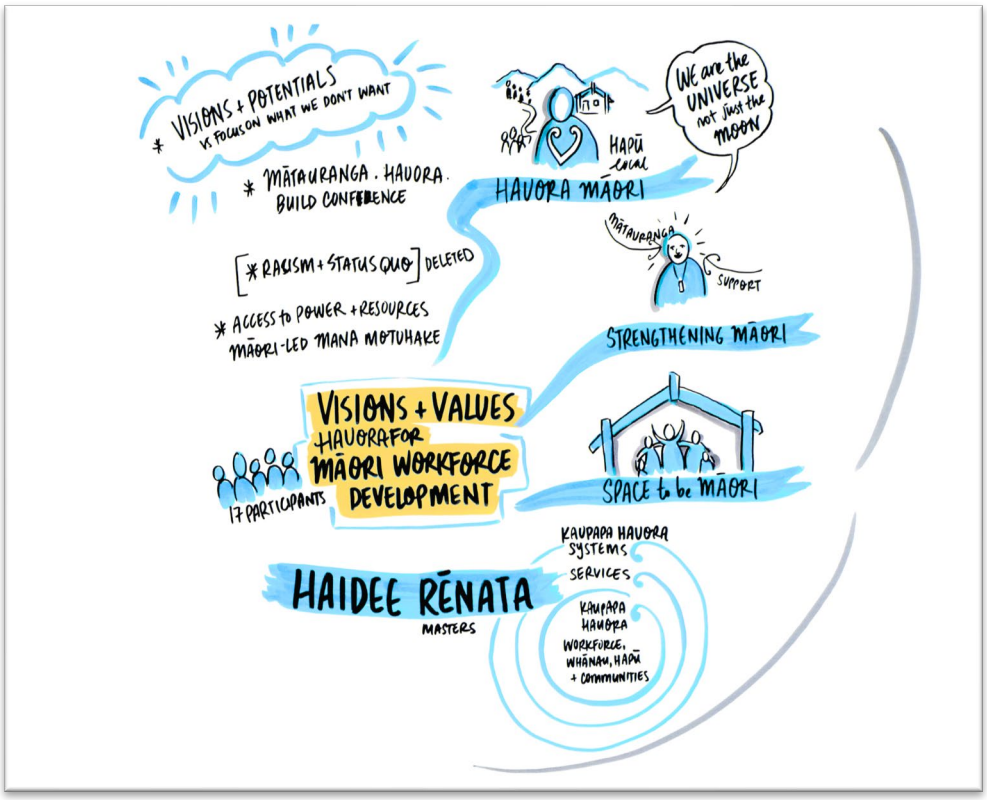
As I refined the themes further, it became clear that the initial theme of Mātauranga Māori encompassed far more than a single theme could manage. Furthermore, revisiting and rearranging the codes on the Miro board, the vision of Māori was progressing and found to be more of an overarching idea. Again, as previously done, quotes were extracted from the transcripts, printed, cut out, grouped by similarity, and further refined, with some quotes being removed and replaced with others as the process was expected to be non-linear (Braun & Clarke, 2019). Over several months, I continued to work with the online whiteboard tool, redefining and renaming the themes. My supervisors reviewed the findings, offering critique and guidance to challenge rational reflection on my decisions.

Figure 6. Returning to the Codes



Rearranging of Codes on the Miro Board

Figure 7. Presenting Working Themes



Sketch drawn by Jacqui Chan[1] during an the in-person whānau rangahau wānanga 2024

The next phase of theme development resulted in working towards Hauora Māori, Strengthening Whānau Māori, and Space to be Māori. As shown above in Figure 7, three themes were presented to whānau rangahau wānanga, including wider project stakeholders, in early 2024. Further feedback was provided, including how to appropriately discuss mana motuhake as *the inherent* autonomy and authority of Māori to determine their destiny. This resulted in further tweaking within the naming of the themes, but not within the core of the findings.

3.2.9 Final Themes and Write-Up

Finally, the three themes were confirmed: *Hauora-Led Systems, The Potential and Strength of Mana Whānau* and *Spaces to Be Māori.* It was evident throughout the first two wānanga that the participant rōpū notably respected the voices of kaumātua and kuia. This meant that their wisdom and mātauranga frequently guided the whakawhiti kōrero. Therefore, while the quotes presented in the findings include the wānanga in

[1] Jacquichan.com drawing for change = drawing and listening in service to collective change making.

which the quote was spoken, a special notation is added alongside the wānanga in brackets if spoken by these kaumātua or kuia.

3.3 Conclusion

This wāhanga has outlined the intentional use of kaupapa Māori methodology and the alignment of methods underpinning this rangahau. By employing this approach, the study was firmly grounded in te ao Māori, asserting Māori aspirations and challenging systemic inequities that undermine them. Within this study, I sought to affirm and normalise Māori ways of knowing, being, and doing, while acknowledging the critical importance of tino rangatiratanga.

Guided by Te Ara Tika, this rangahau prioritised whakapapa, mana, and kaitiakitanga, ensuring ethical engagement and positive outcomes. The whānau rangahau structure provided collective guidance, while participant recruitment and wānanga-based data collection fostered safe and transformative discussions on Māori health workforce development. This process reinforced the mana of Māori as essential to shaping equitable and anti-racist health systems.

The reflective thematic analysis used in this study enabled a comprehensive and iterative engagement with the participant rōpū centring kaupapa Māori. Through familiarisation, coding, and theme development, the rangahau shifted from challenges to aspirations, guided by collective whakawhiti kōrero and the wisdom of kaumātua and kuia. These themes reflect a future-focused, strength-based approach that centres Māori aspirations in health workforce development. Hauora-led systems, the potential and strength of mana whānau, and spaces to be Māori reflect a future-focused, strength-based approach that centres Māori aspirations in health workforce development.

The study now moves on to present the vision and values of these findings of the participant rōpū.

Wāhanga 4: Findings

4.1 Introduction

This wāhanga presents the findings from the participant rōpū. As outlined within the kaupapa Māori methodology and methods wāhanga, these findings were developed via secondary analysis of these data through a reflective approach to thematic analysis.

These data comprised of the participant rōpū,[1] which consisted of seventeen experienced Māori health professionals with expertise in transformative praxis and disrupting racism. Each participant attended one of three Māori caucused wānanga from the original Marsden project in developing a Māori-specific theory for anti-racism, within the health sector of Aotearoa. In each of the three wānanga, the first question to start the whakawhiti kōrero was: 'If the health system wasn't racist, what would you see, feel and hear?'

Within this study, the experience and expertise of these participants were recognised. Thus, it sought to explore and answer the question:

How can the visions and values of experienced Māori health professionals be leveraged to assert Māori aspirations for health workforce development and disrupt racism?

As discussed in the methodology wāhanga, the voices of kaumātua and kuia were notably respected by the rōpū of their relevant wānanga. Therefore, the quotes presented in the findings include the wānanga in which the quote was spoken, and if spoken by these particular kuia or kaumātua, are included. To open this wāhanga, I have used a quote from Wānanga One (W1) spoken by one kuia that I have acknowledged as a whakatauākī (Known author presented in English). As explored in the findings, it became a central thread to the realisations of Māori.

To have a vision of what you want –
Stop thinking about what you don't want.

[1] Solely within this chapter. 'rōpū' refers in specific reference to 'participant rōpū' to avoid excessive repetition.

The findings present three interconnected themes. The first theme, **Hauora-Led Systems**, centres on systems led by hauora and the whānau, hapū and their communities for which the Māori health workforce is intended and generated. The second theme, **The Potential and Strength of Mana Whānau**, highlights the capability and strength of whānau, hapū, and Māori to lead hauora systems. When mana – Māori power and authority, and thus resources, is entrusted directly to whānau, hapū, and Māori, they are empowered to realise whānau Māori aspirations, which the health workforce is intended to serve. The final theme, **Spaces to Be Māori**, emphasises the importance of creating environments that reflect te ao Māori vision and values, where being Māori is normalised, fully embraced and free from racism, where Māori can thrive. These spaces would contribute to developing a strong hauora-led health workforce.

4.2 Three Themes: Vision and Values

4.2.1 Hauora-Led Systems

Throughout the wānanga, the rōpū envisioned hauora-led systems which are innate to te ao Māori. In this sense, hauora was understood as the holistic wellbeing of the collective, Papatūānuku, the connection to their tūpuna, and all that lies between. This is consistent with our intrinsic connection through whakapapa (Roberts, 2013). During the wānanga, hauora was recognised as encompassing Māori ways of doing, being, and knowing, focusing on maintaining balance within te ao Māori. Having “a hauora system for our people would be there at the forefront” (W2). There was a need for the health system to operate at the opposite end of the continuum, “our effort should be at the other end of the continuum… at the hands of whānau” (W2). Emphasising the health system and workforce development should primarily focus resources within primary health care and communities.

Hauora-led systems would signify transformative shifts towards prioritising whānau and hapū at the grassroots level. This approach centres on empowering whānau Māori while also embracing hapū, iwi, and their surrounding communities. As the rōpū asserted, “Whānau are the key... I would go whānau, hapū, then iwi” (W2). This highlights the foundational role of whānau leading hauora systems, ensuring they align with whānau Māori aspirations.

While hauora-led systems would restore hauora when necessary, their more significant and frequent purpose would be to maintain hauora, reflecting a proactive and preventative focus. “The fundamental shift to a hauora focus is central, moving away from this model or this notion of illness... We know it's so much more than that” (W2). This shift emphasises the need for systems which prioritise and are embedded in te ao Māori.

The rōpū refuted that the notion of ‘hauora’ and that of the ‘health system’ could be used interchangeably, as these were seen as incompatible. The rōpū viewed the current health system and its focus as more of an ‘illness system’, finding it restrictive and inadequate in understanding the concept of hauora and its integral role in te ao Māori. One kaumātua highlighted how whānau often avoid engaging with the current health system in its present form. For instance: “I'm only there because I'm sick, I'm not there to stay healthy. I'm only going to come to you when I've got one foot in the grave, and you're the last call” (W1, Kaumātua). This distinction emphasises the need for a system grounded in hauora that embraces proactive engagement and supports holistic wellbeing rather than solely addressing illness.

The rōpū envisioned systems of hauora where whānau are at the core of decision-making, empowering whānau to make choices which are tika and relevant to their needs, overtly recognising whānau and hapū Māori as the genuine experts; fully aware of what is best for them. “So, if we were looking at a vision of the health system... it would be a wellness-hauora focus. We have whānau at the centre and whānau are in control... whānau determine which part they want” (W2). This vision would ensure that health workforce development solutions would foster mana, thus aligning with whānau, hapū, Māori and their community aspirations and reality.

Throughout the whakawhiti kōrero, the rōpū asserted that developing the Māori health workforce required the flexibility to work with and for whānau in systems which genuinely supported whānau visions and values. The rōpū envisioned whānau Māori succeeding and understood that for this to happen, the system must adapt to serve whānau rather than expecting whānau to conform to the system. “Wouldn't it be great if the health system did a massive pivot... going to where whānau are” (W3). The rōpū envisioned and sought to do mahi in acceptable and meaningful ways to the whānau

they served. “Whānau-centric... collective, focused and designed... So, if you rock up for an oral health appointment, koro and the mokopuna (grandchildren) can be seen at the same time or whatever is convenient for the whānau” (W2).

> The health system... would fit in with whānau. That whānau don't have to contort themselves into different shapes to fit in with the health system and be what the health system defines them as. But the health system would be able to bend, adapt, adjust, and respond to whatever whānau wanted and needed from them. Including where they want to receive the service, how they want it, and who they want to receive it from. (W3).

The rōpū envisioned whānau Māori taking charge of their own wellbeing through their inherent capability, knowledge, and skills. They saw whānau becoming integral to a hauora-led Māori health workforce, and this hauora-led Māori health workforce becoming a natural extension of whānau.

> It would be that the health system... resides with whānau [and] that we don’t need to go outside anywhere else to reclaim and reignite the healing that we already have through our tūpuna and ourselves. So, I would see my own whānau doing the healing, my own whānau supporting each other... That’s sort of our inherent responsibility to each other, and I'd feel empowered about them... So, if we could flip that and it was just something that existed and resided amongst us [as just] a part of life. (W2).

Participants recalled the practices of their tūpuna, where healing and wellness were community-driven efforts.

> When I think of my nannies... if we got sick, then whether it be karakia or getting Rongoā out of the garden or the bush, there would be things we would do to keep healthy... It’s about the whānau taking control and sharing those things that keep us well... Everyone has a responsibility... You have your informed whānau so that whānau are in control and they work together. But also, you inform the communities that are around them.” (W2).

The participant rōpū envisioned opportunities to encourage thinking and practising outside the box, embracing new ideas, change, and what they already know works.

> I'm encouraging us not to be fearful of what we have to offer... We've got some amazing tikanga and knowledge. And it might be your auntie down the road who just says, 'eh you fullas, why don't you do such and such?'... And hearing those guys talking, I'm going, 'Why didn't I think

> of that?' Wow, you know, mātauranga Māori is alive and well if you just listen with different ears... I want to talk about that brand new world. (W1, Kuia).

Furthermore, the rōpū valued the opportunity and choice for a Māori health workforce to do mahi within their own whānau, hapū, iwi, and surrounding communities.

> I just got my Ph.D. [and a] postdoctoral fellowship... And I just thought, well, I don't have to sit in a university. I don't have to be in a particular construct. I love iwi development and... I thought, we can do it.” (W1, Kuia).

The theme of hauora-led systems highlights the vision and values underpinning Māori health workforce development approaches that prioritise hauora and place whānau at the centre. It emphasises a workforce grounded in te ao Māori and aligned with the specific values of whānau, hapū, and their communities. Such systems would therefore recognise, uphold, and be guided by the aspirations and strengths of these communities, ensuring they remain relevant and responsive.

4.2.2 The Potential and Strength of Mana Whānau

The participant rōpū reiterated the potential and strength of whānau, hapū, Māori and their communities to assert their hauora. They emphasised that, if given the opportunity, and their mana recognised, they have the potential to lead systems of hauora appropriate to their communities. "Let’s start talking about our iwi and our hapū with more mana, recognising that they are complex societies that have been thriving for centuries" (W1, Kaumātua). The rōpū emphasised that whānau need to be directly entrusted with the power and authority for whom the Māori health workforce is intended and generated. When the mana of whānau is activated, whānau have the potential to build confidence, they can be proud to be Māori, and thus, are able to thrive. The rōpū envisioned that “every child born to whānau Māori is honoured and recognised for the potential that they bring to achieve the dreams of their ancestors” (W1, Kuia).

Wairua was recognised as the primary element and a source of strength inherent to te ao Māori. The rōpū emphasised that wairua should lead the way, acknowledging it as a priority to ensure hauora can flow. “We talk about wairua as our first being” (W3), and further was added, “basically before anything else” (W2). This highlights the centrality of wairua, positioning it as foundational to all aspects of life and wellbeing. “I do really

tautoko that conversation that wairua is the heart of hauora… that keeps us well" (W2). The rōpū reiterated that "We are wairua... our bodies are a total manifestation of what Te Ao Mārama[1] between Rangi and Papa at the moment look like" (W3). The rōpū emphasised the importance of honouring wairua as the core of hauora, contrasting with current approaches that overlook its significance. The systemic undermining of wairua within the current health system was noted: "We're dealing with wairua problems in physical ways in their health system all the time" (W2).

Furthermore, the rōpū identified the potential of mana whānau through the connection to the values of whenua and whakapapa, which are deeply embedded in mātauranga. Their vision emphasised "supporting Māori to be successful from the cradle to the grave" (W1, Kaumātua), asserting the importance of uninterrupted transmission of mātauranga across generations. This was seen as essential to achieving the vision of mana whānau acknowledged, providing a strong foundation for reclaiming the right to be Māori, and ensuring the asserting of hauora for future generations.

The rōpū recognised the potential when the mana of whānau, hapū, and communities is activated, enabling them to thrive with confidence and strength. These values were seen as essential for fostering positive whānau identity, creating opportunities, and ensuring choice, and these, critical to building resilience, particularly when navigating or engaging with the health system. "Right now, the opportunities to facilitate mana motuhake [are about] absolutely shifting resource and power and control into Māori spaces" (W2).

> So my mana motuhake and my baby's mana motuhake is so important and powerful... We are confident enough to repel any little comment or any large comment or any systemic racist act that happens to them [and] it is not going to change my course or my trajectory in life for my whakapapa... Having the confidence to say [recognise] my baby's mana motuhake, that's what I'm about... We want to build our own resilience in our own mana around how we determine our destination. (W1, Kaumātua).

> We should focus on training our own people to resist and constructively confront situations rather than withdrawing into themselves. Feeling stink, you know, having their own mana diminished by experiencing racism… empower them to respond

[1] The creation of the physical world of Māori through the separation of Sky Father and Earth Mother.

> constructively to it, knowing the institutional factors that are shaping their experience separating it from them. (W1).

The need for authority and resources was also highlighted, ensuring that whānau Māori can make their own decisions and establish partnerships on their terms. We must "invest and distribute power and control at the other end of the continuum" (W2).

> We need authority, and we need resources to do our own thing. And to do that, it can be in partnership with whoever we want, but it's our choice. Our decisions... you know there are not enough people, brown people making bloody decisions in this institution. You need to give them some authority, and you need to give resources to re-align services. (W1, Kuia).

The rōpū identified that focused investment, including time, attention, and financial resources, was seen as essential for systems of hauora, and that of a hauora-focused workforce. The participant rōpū saw the potential and strength of mana whānau in leadership positions, recognising the critical need for focused investment to build and develop a strong, assured hauora-led workforce. "I think that we need in our dream world to have good staircases to leadership for Māori across all the different health disciplines. We need more Māori in leadership and decision-making" (W3). "What we need to do is put all that money, workforce development money, into Māori workforce development... It's about training our own workforce to be the leaders of things. Because that makes a lot more sense to me" (W1). The rōpū emphasised the importance of channelling resources directly into Māori health workforce development, understanding that nurturing the mana of whānau and its health workforce as standard practice.

> It's important to invest in our own. When we've got skill shortages, we look at importing from overseas. When we're looking at solving a problem, we look at importing a model from overseas. It hasn't even worked with the Indigenous peoples. So, we've got to start making investments in our own and ourselves. (W2).

Throughout the wānanga, the rōpū saw the potential and valued the bravery, assertiveness, and success of whānau, tauira, and the Māori health workforce. Sharing positive stories of strength provided resilience and motivation for the rōpū to persevere in their mahi. "In terms of our hauora stories, let's get good at sharing those" (W2).

Participants found inspiration in seeing the younger generation take on challenges and mana with courage and enthusiasm.

> One thing I've loved that has given me some good energy for my job has been seeing the students take on some of the fights. And some of their bravery, I'm like, 'Go you!'... they get out there. I find their energy just so cool, and it's so incredible to see them getting amongst it. (W3).

The rōpū saw the potential for mana whānau reclaiming confidence through mātauranga. Participants highlighted the importance of ūkaipō – source of sustenance, home, often connected to a maternal origin. They emphasised returning to traditional nurturing and caring for our homes, communities, and "sustainably living on our whenua" (W1). The concept of ūkaipō serves as both a practical and spiritual guide for whānau, reconnecting them to traditional practices that promote self-sufficiency, environmental stewardship, and collective wellbeing. Embedding this into workforce development priorities was seen to nurture relationships, foster resilience, and strengthen the capacity of whānau to lead and sustain systems of hauora that are reflective of te ao Māori.

> How do we fill another with mana in every interaction that we go into?... Thinking about all those constructs we know kept our people well pre-colonisation, I think they need to come back with force... My nanny would say to me, the most important thing that you do is give your waiū (breastmilk) to your pēpē (baby)... because that's how our pūrākau and all that mātauranga gets transferred. (W2).

Furthermore, through deliberately focusing on mana whānau, hapū, physical locations, and whenua, "We could re-empower ourselves with the knowledge that we already have, that we really can reclaim, and build that capacity back in confidence with ourselves" (W2), and to "start to reinvigorate and bring our voices back to the whenua" (W1), highlighting the potential, strength and importance of mana whānau in order to reinstate traditional ways of knowing, being, and doing.

4.2.3 Spaces to Be Māori

The participant rōpū envisioned spaces where it would be normal to be Māori, to rest and recover in environments free from racism, and be able to thrive. There was an inherent understanding that shifting towards Māori cultural norms, values, beliefs, and mātauranga as everyday practices was essential. "We have to be thinking about how we

facilitate that shift to Māori cultural norms and values, beliefs and mātauranga being our everyday norm" (W2).

The rōpū then discussed two whare – spaces, one where they could be creative and be free to engage in wānanga, and the other, a less desirable space of the mainstream health system in which they needed to transform practices and thereby disrupt racism.

> [We are] talking about two whare... we have to decolonise [the mainstream] one… and the other one we get to be totally creative and wānanga, just literally wānanga, and that is our space... Some of us choose, and some have to go between. (W2).

Whether whānau work in one or both spaces, "we need to create the spaces for wānanga so we can work this out... get [the obstacles] out of the road so we can do the wānanga" (W1, Kuia), where whānau could freely wānanga without hindrance.

> How often do we get an opportunity just ki te noho tahi, ki te kōrero tahi, te wānanga ki ngā kuia me ngā kaumātua? Te kōrero, he aha te tino ngakau o te whakatupu ngā uri o a muri ake nei, uri o a muri ake nei – just to sit, talk, and explore things with our elders? These conversations are at the heart of raising up our future generations. (W1, Kuia).

The rōpū found there was need to balance working in Māori-led services and spaces with mainstream health services. Doing mahi within Māori-led services was considered valuable and provided a safer space for rest and recovery to recharge.

> I know for me, if I spend too much in this deconstructing and fighting-with-racists spaces, my mauri[1] is shot. But it also opens me up for my wairua to be attacked. It's open season... So, actually, I have to go into this space intentionally and deliberately with you guys, with whānau Māori and wānanga... so my wairua remembers, and I remember why I'm here. (W2).

> I notice for myself and my practice, I flip. Sometimes, I'm over at the Iwi health service because I just need a rest. I need to get nourished again and then 'voom', back out to the DHB or whatever it is. (W2).

From the wānanga, it became apparent that Māori-led services and spaces provided the opportunity for creativity and allowed people within the health workforce to do mahi in

[1] Life force, vital essence, source of emotions - the essential quality and vitality of a being.

ways known to bring success and benefit Māori. Hearing about the success of normalising Māori celebrations was uplifting.

> Māori-led services are pretty amazing, the way that they have to develop new ways of doing things... Trying new things out because this is what works. And when you've got people's buy-in, and you can see people enjoying it, you can see a whole lot of benefits that weren't previously explored. (W3).

The vision for these spaces to be Māori would be led by mātauranga and tikanga, where there is the space is available to "ki te whakaaro nui mō te mātauranga Māori" – share important thoughts about Māori knowledge. (W1, Kuia). These spaces were recognised as the ultimate aspiration, "having... ways to access our reality and our cultural practices." (W3). Where te ao Māori is validated, whānau feel safe, empowered, and able to thrive.

> Like with blue sky thinking, it would be mātauranga, tikanga led in that space. So, Māori coming into those environments feel very at home, can flourish in those contexts because they have access to those deep underpinning values and that worldview, rather than having to feel that it gets left to one side. (W1).

Spending time in whanaungatanga was seen as invaluable for working, collaborating, and negotiating with each other. The participant rōpū envisioned whanaungatanga as a space within which it became possible. Indeed, realistic to develop and sustain relationships with colleagues, tāngata whaiora, whānau, hapū, iwi, and the community.

> Taking the time to build relationships... Respect for me and my whānau... Taking the time to get in and breaking down the professional walls a bit. Like, I'm giving all this stuff to you. How about you introduce yourself a bit more thoroughly just break it down a bit... breaking down that wall and getting to know each other. (W3).

The rōpū valued that investing in relationships was fundamental to building trust with whānau and walking alongside them through whatever challenges they faced.

> Yeah, it's about relationships. It's about investing in relationships. So, relationship building, no matter what the service is, is fundamental to building trust with whānau to walk alongside them through whatever they're going through at that time... If we're going to create a cultural shift, then we need to invest in relationships. And get to know each other. And our differences. And celebrate that, not be afraid of

> difference. Because that's fundamentally what it's about. We've got to celebrate diversity and difference. (W3).

Through whanaungatanga, the mauri, skills, and strength of whānau would be understood, ensuring that whānau are working in spaces that are right for them and those they support.

> The dynamics of whanaungatanga are pretty cool. In terms of having different role players. And with a focus on the mana, the tapu, the mauri of the people. And there can be role players that might be service providers, but they might actually be whānau as well... Having the right people who can make them feel comfortable, make them feel like it's home. It's OK, they're trustworthy. So yes, I think it's the environments and having the right people in place. (W3).

The rōpū vision for spaces to be Māori showed the value of a hauora-led workforce that embraces and normalises being Māori. They dreamt of a time when they could fully be themselves again. The rōpū demonstrated a yearning for environments where being Māori is not only accepted but celebrated, fostering a sense of identity, confidence, and connection. This is significant in the context of workforce development, where such spaces can empower both the workforce and whānau to engage in hauora without the constraints of cultural alienation or the pressures of assimilation. "Let's just be us… for any culture, just be you" (W1, Kamātua). It was important for whānau Māori to see others holding the space to be Māori.

The rōpū highlighted the societal impact of colonisation, where traditional expressions of emotion and identity, such as crying at tangihanga (funeral), have been suppressed.

> A lot of Māori don't cry at tangis now or they look around before they cry because society has knocked us back so much that we can't. You look around the whares now. They look around like who's watching before they get caught up in it and then release [wail]. (W1, Kaumātua).

"Yes, we've modified our behaviours about what's normal" (W1, Kuia). This shows the loss of cultural expression and the internalised hesitance that Māori experience in expressing themselves. However, the enduring practices of kuia, who continue to cry publicly and unapologetically, reflect the resilience and continuity of tikanga Māori. In the health workforce, creating spaces where such cultural expressions are normalised

would contribute to reclaiming power and authority, enabling practitioners and patients to connect more deeply with their cultural identity.

> Heoi [however lucky], we still have our kuia. They still walk into the whare and cry from the doorway, just wail. It's a whole other thing, and they will do that in public. (W1, Kaumātua).

Examples such as Te Matatini kapa haka festival and being able to attend wānanga further demonstrate the transformative potential of culturally safe spaces. These environments allow Māori to thrive without explaining or justifying their practices.

> We go to the Matatini and my God, isn't that magnificent to be in?... Nobody asked you to explain what you're doing or how you're doing it, or when. It just is. (W1, Kuia).

Similarly, they expressed a vision of a bilingual Aotearoa, where Māori confidently speak te reo in public, much like within each of the wānanga where te reo Māori was freely spoken and embraced. It would be normal to be Māori, speak te reo and be bilingual, while those on their journey to fluency in te reo Māori would feel welcomed and safe.

> I think that's a good measure when a Māori can walk onto that bus, and she has other Māori whanaunga[1] in there, or just another Māori, and just bust out their language with confidence. That's the Aotearoa that I want to see. (W1, Kaumātua).

These spaces reflect a future where cultural confidence is nurtured, empowering a Māori health workforce to operate authentically with whānau, hapū, and iwi Māori. The rōpū vision emphasises the importance of recognising and creating environments where being Māori is the norm. This means enabling a hauora-led workforce to freely reclaim and express their identity, supported by access to mātauranga, tikanga, and te reo Māori. In doing so, the workforce becomes a vehicle for cultural revitalisation, supporting intergenerational knowledge transfer and enabling Māori and the health workforce to thrive. This transformation strengthens the effectiveness of hauora systems and contributes to broader societal shifts that normalise Māori ways of being, doing, and knowing.

[1] Relations.

4.3 Conclusion

This wāhanga explored the collective vision of the participant rōpū, identifying aspirations for a transformative approach to workforce development that is hauora-led. A system and workforce were envisioned that empowered whānau, hapū, and iwi by entrusting them with the authority and resources to make decisions best suited to their communities. This system was described as flexible, grounded in mātauranga and tikanga, and responsive to the mana of whānau, fostering resilience, confidence, and connection to wairua, whenua, and whakapapa.

These elements were seen as critical for reclaiming cultural identity, resisting racism, and ensuring intergenerational knowledge transfer. The rōpū highlighted the potential and strength of mana whānau, enabling them to build mātauranga, confidence, and mobilise their mana motuhake. Central to this vision was creating spaces where being Māori was normalised and celebrated, fostering hauora-led workforce systems that reflect Māori aspirations. This vision focused on creating environments where Māori could thrive, free from the constraints of the current health system, and where being Māori was fully embraced.

The participant rōpū vision holds the potential to transform Māori health workforce development. It fosters a system where the strength of mana whānau enables Māori to flourish in reciprocal relationships, as both contributors to and recipients of the hauora of their communities.

This wāhanga now transitions to the discussion to formulate the outcomes and to provide the recommendations from this study.

Wāhanga 5: Discussion and Outcomes

5.1 Introduction

Grounded in kaupapa Māori methodology, this wāhanga analyses, critiques, and reflects on the findings and relevant literature pertaining to this rangahau and in relation to Māori and Indigenous health workforce development and transformation.

As identified in the literature review, the first two categories, *Institutional Racism in Workforce Development* and *The Pipeline of the Workforce,* highlighted critical issues and gaps in Māori and Indigenous health workforce development. It acknowledged the global challenges of entrenched institutional racism and the impact on health inequity. The third category, identified as *Māori and Indigenous-Led Workforce Success*, involved approaches centred on kaupapa Māori and Indigenous ways of being, doing, and knowing. These were shown to be most effective in developing a Māori health workforce, thus addressing, but not necessarily resolving, Māori health inequity. Despite decades of targeted strategies, developing a Māori health workforce was shown to still be slow and incremental.

As previously described in the kaupapa Māori methodology and methods wāhanga, the findings of this rangahau were generated by conducting a secondary analysis of these data, initially collected by the rōpū rangahau. This participant rōpū consisted of seventeen experienced Māori health professionals with expertise in disrupting racism and transformative praxis. From these wānanga, three key themes were developed using a reflective analysis approach of these data, to explore the question for this rangahau:

How can the visions and values of experienced Māori health professionals be leveraged to assert Māori aspirations for health workforce development and disrupt racism?

As detailed in the findings wānanga, the three developed included, first, *Hauora-Led Systems*, which are led by whānau, hapū, Māori and their communities. These are rooted in their inseparable connections to the health and wellbeing of the collective, that is embedded in te ao Māori. Second, *The Potential and Strength of Mana Whānau*

highlighted the significance of Māori power and authority in the hands of whānau Māori. This would see Māori build confidence, assert their mana motuhake, and reclaim their identity as Māori. It was found that centralising the values embedded in te ao Māori, including mātauranga, whenua, and tikanga, was fundamental to the vision for Māori health workforce transformation. Third, the vision encompassed *Spaces to Be Māori* in which it is normal and celebrated to be Māori, able to speak te reo, be free from the constraints of racism, and, thus, able to thrive.

This discussion and outcomes wāhanga are presented in three sections, each collectively answering the question of this rangahau, as posed above. The first section presents the vision embedded in values, more accurately described as taonga. These are offered through the interconnected vision for **Hauora and Mana Motuhake: Led by Whānau, Hapū, Māori, and Communities**. These reflect the exploration of Māori aspirations within the development and transformation of the Māori health workforce.

The second section, titled **The Slippery Construct***,* examines the challenges of asserting Māori and Indigenous health workforce development aspirations, where Crown agencies hold the predominant authority in shaping their development. I argue that current Western-led health and health education systems hinder this development through institutional racism, which seeks to maintain the status quo, as evidenced by the dominance of the Western-led paradigm.

In the third section, I explore solutions that include **Critical Allyship**, which involves critically reflecting on one's position and power and acting on this to disrupt racism and support equity. I then present **Hauora Kaupapa Māori** as a foundational concept to achieve the vision and assert the aspirations of Māori, which simultaneously disrupts racism. Finally, I provide practical **Recommendations** that prioritise Māori and Indigenous-led health workforce transformation within the health and health education sectors.

5.2 Vision: Embedded in Taonga

This discussion proposes the values for developing the Māori health workforce are more accurately described as taonga. This study asserts the taonga of hauora is central to both the development of the Māori health workforce and to the health and wellbeing of

Māori. Te ao Māori acknowledges tāngata whenua as originating from the pūrākau of our tūpuna, Ranginui and Papatūānuku (Reilly et al., 2018; Roberts, 2013), emphasising the whakapapa of hauora and our inherent interconnection with all living beings, te taiao, whenua, and the celestial realms (Durie, 1998; Moewaka Barnes & McCreanor, 2019; Ngatae, 2020). Tāmati Kruger provides an example of the whakapapa and the fundamental connection of tāngata whenua to the whenua (2019). He further references his own Tūhoe iwi from the Te Urewera area, describing Ngāi Tūhoe as "descendants of the mist maiden… Hine-pūkohu-rangi" and her union with te Maunga (mountain) (4:37 - 34:52 mins).

This discussion aims to recognise the broader factors at play at the system level for workforce development (Bawden et al., 1984; Roche, 2001). It adopts a broad perspective, recognising the interconnected systems and wider orientation crucial to workforce development for Māori and Indigenous. It does so by acknowledging whānau-centred approaches, determined by those the workforce development is intended. It emphasises the whakapapa of hauora, highlighting the inseparability of te ao Māori and its centrality to the vision for Māori health workforce development.

5.2.1 Hauora: Led by Whānau, Hapū, Māori, and Communities

This study demonstrates that achieving hauora requires acknowledging and valuing our intrinsic connections to the collective whānau, hapū, and communities. The literature review shows that hauora is best achieved when it is collectively sought for all. This rangahau has shown that the taonga of hauora is embedded in mātauranga, tikanga, te reo, and the whenua, which are fundamental to te ao Māori.

It is important, however, to recognise that while hauora originates from the same collective whakapapa, tikanga varies between each whānau and hapū and is grounded in the whenua. As stated by Opai (2021) practices and protocols vary between whānau and regions, "Māori are not a homogenous people"; they each have "distinct attitudes, perspectives and tikanga" (Opai, 2021, p. 10). Furthermore, Durie asserts that whānau are the key agents of change (2021). Given these findings, this rangahau argues that whānau and hapū are best positioned to serve the communities within which they live and operate, because they hold, the expertise in the hauora of their communities. Therefore, clearly they are best placed to lead Māori health workforce development.

An example of whānau and hapū-led workforce development is found in the mahi of Māori community workers, who are connected to local networks, centre tikanga, and are well-positioned to align with community aspirations (Boulton, 2005; Durie, 2021; Durie et al., 2009). The pivotal role that whānau and flax-root communities play in developing effective health workforce solutions is crucial (Kaiwai et al., 2024; Russell et al., 2023). Furthermore, Māori-centred approaches delivered by local Māori services can provide practical solutions to local community challenges (Boulton, 2005). The importance of structuring health services around specific communities cannot be understated.

This approach was recently supported by the Health Workforce Advisory Board (2022), which advocates for flexible community resourcing and highlights the proven capability of Māori and iwi providers to engage with their communities. During the COVID-19 pandemic, whānau, hapū, and iwi demonstrated cohesive leadership and success through their collective orientation, grassroots knowledge, and networks (Health Workforce Advisory Board, 2022; Kaiwai et al., 2024; Russell et al., 2023; Te One & Clifford, 2021). Russell et al. (2023) asserts Māori community services have demonstrated their ability to mobilise resources in alignment with the health and wellbeing of the community.

Simultaneously, whānau, hapū, and communities focused on collective health and wellbeing, rapidly developed a dedicated Māori health workforce (Kaiwai et al., 2024; Russell et al., 2023). This process involved sharing resources, knowledge, and skills relevant to their communities. Crucially, the success of this Māori health workforce was that it was “based on mātauranga Māori…” which resulted in them being “singularly more successful” in, for instance, boosting vaccination rates more than what was achieved by the primary health sector (Health Workforce Advisory Board, 2022, p. 13).

This study also clearly shows that developing the Māori health workforce is most effective when led by whānau, hapū, and the wider community, as they are better able to meet the needs of their local communities. As consistently emphasised in the literature, this aligns with whānau-led workforce development (Bawden et al., 1984; Roche, 2001). This positioning logically makes whānau and hapū best placed to assert Māori aspirations while simultaneously addressing health inequities.

Māori-centred approaches embedded in te ao Māori ways of being, doing, and understanding are fundamental to Māori health workforce development (Pipi et al., 2021; Russell et al., 2023; Savage et al., 2020; Te Rau Matatini, 2018; Wiapo et al., 2023). This study indicates the need to embrace the innate connection through whakapapa to whenua to restore and maintain hauora. Moewaka Barnes and McCreanor (2019) argued that whenua is critical to hauora, describing it as “the key determinate of health and wellbeing”, stating that tāngata whenua are "not separate but operate as an ecosystem with visible and invisible, tangible and intangible dimensions” (p. 26). Similarly, the whenua and our environment are described as parents to be cared for rather than owned, sold, commodified, or extracted (Kruger, 2017; Walker, 1996). Whakapapa pūrākau such as this affirm our deep connection to whenua and emphasise the importance in the restoring and maintaining of hauora. Building on this, this rangahau asserts that our whakapapa to whenua is essential for developing the Māori health workforce.

Mātauranga and te ao Māori provide a strong foundation for Māori health workforce development (Health Workforce Advisory Board, 2022; Pipi et al., 2021; Russell et al., 2023; Savage et al., 2020; Te Rau Matatini, 2018; Wiapo et al., 2023). Te reo, embedded within mātauranga, is critical to te ao Māori, as discussed in the methodology wāhanga. Access to, and the use of te reo Māori, normalises being Māori, as highlighted in the findings wāhanga. Te reo Māori is an essential component of mātauranga and has been established as both a fundamental and determining factor of hauora (Durie, 1998; Nepia, 1994). Te reo provides a mechanism that weaves together our ways of knowing, being, and doing (Smith, L. & Reid, 2000; Walker et al., 2006).

Māori health workforce development aspirations can be realised through the inherent interconnections in te ao Māori. Hauora is rooted in whakapapa and whenua and can be expressed through te reo Māori. This fosters and normalises mātauranga, affirming Māori identity. The normalisation and uninterrupted intergenerational transmission of te reo Māori, of which is embedded in mātauranga, is essential to asserting Māori health workforce development aspirations. Therefore, this requires long-term investment in mātauranga, which is critical for reclaiming and sustaining hauora. This study has affirmed and demonstrated the unique capability of whānau, hapū, and their

communities to best and meaningfully respond to those for whom the Māori health workforce is intended and developed.

5.2.2 Mana Motuhake: Led by Whānau, Hapū, Māori, and Communities

This rangahau supports the argument that mobilising the mana motuhake of whānau, hapū, Māori, and their communities is integral to developing the Māori health workforce. The findings reinforce that resources should ideally go directly to the whānau and community for whom the workforce is intended. Furthermore, this study affirms that whānau power and authority in determining their destiny and identity as Māori, embedded in te ao Māori, is critical to workforce development. Clearly, hapū and the community are central to the initiative this workforce aims to serve.

The literature review highlighted the importance of Māori authority and leadership in developing a health workforce that is responsive to Māori (Pipi et al., 2021; Russell et al., 2023; Savage et al., 2020; Te Rau Matatini, 2018; Wiapo et al., 2023). It plays a critical role in addressing inequity experienced by this workforce. Russell et al. (2023) assert, "mana motuhake lies at the heart of health and wellbeing for Māori" (Russell et al., p. 14) and involves the authority to determine the meaning and effect of hauora (Russell et al., 2022).

The Wai 2575 report stressed that the Crown must “empower mana Māori motuhake” within the primary Māori health workforce sector in order to address Māori health inequity (Waitangi Tribunal, 2023, p. 9). The enactment of mana motuhake in Māori communities and its local workforce has demonstrated the ability to develop a relevant Māori health workforce (Russell et al., 2023). Furthermore, this autonomy and self-determination have enabled local and collective leadership to provide positive health outcomes for whānau, hapū, and their communities. This rangahau argues that mobilising the mana motuhake of whānau, hapū, Māori, and their communities can drive meaningful advancements essential to developing the Māori health workforce. It further asserts that this is crucial for the long-term sustainability of both hauora Māori and workforce development.

The interconnections between whakapapa and whenua, mana motuhake and hauora have been illustrated by Ngāi Tūhoe. The mana of Ngāi Tūhoe iwi was reclaimed in 2014 in relation to their whenua, reinstating their role as kaitiaki (guardians) of the region

(Kruger, 2019). This milestone marked the unprecedented legal recognition of Te Urewera as a person. Reclaiming the mana of their whenua has initiated the process of restoring hauora, and contributing to a sense of belonging, safety, and connection to their people not previously experienced in their lifetime (Kerr, 2021; Kruger, 2017; Taumatua, 2022). Furthermore, kaitiakitanga (guardianship) has fostered collaboration and sustainable practices to restore hauora and ensure its protection and preservation for future generations. Such legal personhood of natural features and recognition of their iwi guardians was subsequently recognised for te Awa Tupua (Whanganui River) in 2017 and te Kāhui Tupua (Taranaki mountain) in 2023 (Forbes, 2023).

These iwi and hapū activations are important examples to draw on when considering strengthening and sustaining Māori health workforce development. Mobilising mana motuhake of whānau, hapū Māori is an essential step for reclaiming and sustaining hauora and addressing persistent Māori health inequities. The findings of this study have affirmed the unique capability of whānau and their communities to respond most effectively to those for whom the workforce is intended and, thus, where it should be developed. This study has proven that long-term investment in mātauranga, tikanga, and te reo Māori is critical for reclaiming and sustaining hauora. It also plays a key role in creating a Māori health workforce that addresses systemic inequities while prioritising the hauora of Māori and their communities. I argue that the collective strength of whānau, hapū, Māori, and their communities is essential to developing a health workforce that reflects and asserts Māori aspirations.

5.3 Challenges: The Slippery Construct

One of the significant challenges to effective Māori health workforce development is its historical entrenchment within the shifting frameworks of Western health and health education paradigms. In this rangahau, I have conceptualised this as ‘The Slippery Construct of Māori and Indigenous Health Workforce Development’.

The slippery construct reflects the deceptive and shifting nature of Western-dominated health and health education systems, which remain established in colonial ideologies (Barton & Wilson, 2021; Came et al., 2021; Russell et al., 2022; Waitangi Tribunal, 2023). The literature review demonstrated significant concern for the predominant focus on developing the Māori and Indigenous health workforce within Western-led structures

(Bond et al., 2019; Russell et al., 2022). In defining this as a slippery construct, I have sought to highlight that although the current health sector appears to offer pathways for transformative change, it remains deeply entrenched in institutional racism that aims to maintain the status quo (Came, 2012). The full impacts of these processes and their potential remedies are often elusive and difficult for those who are privileged to be able to grasp (Came, 2012). What is portrayed as progress and opportunities for Indigenous health workforce development is often incompatible with Indigenous worldviews. These systems actively deny aspirations for reasserting Indigenous authority and relative to Māori, our hauora, and mana motuhake.

This rangahau has been purposefully aligned with existing literature that highlights the racism experienced by Māori health professionals, tauira and tāngata whaiora within the health and health education systems (Barton & Wilson, 2021; Russell et al., 2022; Savage et al., 2020). Indeed, this rangahau has exposed the constant struggle and exhaustion of Māori working and navigating mainstream health and health education services. It described the undermining of whakapapa and highlighted the prevention of Māori from accessing mātauranga that keeps us well.

Recent rangahau has consistently shown the inability of the health system to meet the needs of whānau Māori and their communities during critical periods of the recent COVID-19 pandemic by "either reducing their capacity or closing their doors" (Russell et al., 2022, p. 7; Russell et al., 2023). This study, further verified by the literature, confirms that Western-led systems are not the experts concerning the hauora, health and wellbeing of Māori. Notably, it reinforces that these health and education systems lack whānau, hapū, and Māori expertise. Nixon highlights the contradiction that while these systems hold power, they do not hold the expertise or capability, which makes these systems inherently flawed (2019).

In the Wai 2575 report, the Crown admitted that a "one-size-fits-all" system fails to address the needs of Māori (Waitangi Tribunal, 2023, p. 155). Likewise, it recognised the deeply flawed nature of its health policies, frameworks, and practices and the probability of these exacerbating existing health inequities. The Crown also acknowledged that institutional racism has resulted in the failure to embed mātauranga within these strategies (Waitangi Tribunal, 2023). Despite this recognition, the

development of a Māori health workforce continues to be primarily framed within the Crown's Western-dominated health systems (Health NZ & Te Aka Whai Ora, 2023; Rēnata, H et al., 2025). This approach continues to limit opportunities for equitable outcomes for Māori and restricts transformative advancements in workforce development critical to achieving health equity.

The Health Workforce Plan (2023/24) was developed under Crown agency Health NZ, the largest employer in the public healthcare system (Health NZ & Te Aka Whai Ora, 2023; Rēnata, H et al., 2025). In the absence of a dedicated Māori health workforce plan, it is considered to be the de facto plan for the entire health sector. This is of significant concern considering that the majority of the Māori health workforce is employed outside of Health NZ (Health NZ & Te Aka Whai Ora, 2023) and is instead working in the chronically underfunded Māori health primary sector. Pay disparities between Māori health providers and Crown agencies are significant (Kaiwai et al., 2024; Waitangi Tribunal, 2023) and provide undeniable evidence of Western structures undermining Māori aspirations. The Health Workforce Plan, holding the majority of resources and serving as the authority for the entire health system, highlights entrenched and systemic issues. While appearing collaborative, the foundations reflect Crown aspirations, which contrast with the aspirations of Māori.

Furthermore, while the Health Workforce Plan was reportedly developed in partnership with Te Aka Whai Ora, which purports that there was an equitable collaboration, the final document suggests otherwise (Rēnata, H et al., 2025). Before the final preparation of this plan, Te Aka Whai Ora and the Ministry of Health hosted several hui to formulate a Māori health workforce action plan aligned with the aspirations of whānau Māori and communities (Ministry of Health, 2022a, 2022b). In October 2021, a Māori health workforce webinar series was held to gather insights. Extensive mahi and aroha were involved (Irving & Baker, 2024). Māori contributed valuable perspectives on essential topics, including mana motuhake, tino rangatiratanga, and enabling kaupapa Māori entities to lead the workforce (Ministry of Health, 2022a, 2022b). However, these contributions were notably excluded from the final policy document (Health NZ & Te Aka Whai Ora, 2023). These exclusions demonstrate a continued inability and reluctance to genuinely include whānau Māori and community perspectives. This study has found the excluded content and contributions to be crucial for workforce development.

Moreover, such exclusions contradict the recommendations for whānau-centred workforce development (Bawden et al., 1984; Roche, 2001).

The first of the six actions in the Health Workforce Plan aims to "ensure that Māori are supported to see themselves in health careers" (Health NZ & Te Aka Whai Ora, 2023, p. 64). On the surface, this appears to be a reasonable step. However, when critically reviewed alongside the literature and findings from this study, it reveals the underlying aspirations of the Crown. This approach does not reflect the aspirations for hauora, led by whānau, Māori and their communities. This is a further example of the slippery construct and nature of Māori health workforce development within a Crown structure, given that the aspirations of each party do not align. The subsequent goal in the Health Workforce Plan seeks for Māori to "cultivate the skills they need to succeed in health" (Health NZ & Te Aka Whai Ora, 2023, p. 64), demonstrating the Crown's authority to determine that the skills and qualifications Māori require inevitably involve conformity. This thesis argues that such an accord will not lead to the required Māori health workforce transformation.

While the establishment of Te Aka Whai Ora in 2022 was a response to the recommendations of the Wai 2575 report, aimed at addressing some of the long-standing injustices (Came et al., 2024), it was too confined by a restrictive structure and limited resourcing. Despite strong "support from whānau, hapū, and iwi" for the entity's potential to strengthen and develop a responsive Māori health workforce (Aspin, 2024, p. 1), Te Aka Wha Ora was systematically undermined as demonstrated in this study. Furthermore, despite the backing of Wai 2575, widespread whānau Māori support, and opposition from non-Māori, particularly within the health sector (Moxon, 2024; RNZ, 2024) the tenure of Te Aka Whai Ora was abruptly ended in 2024 by the incoming National-led coalition government (Health NZ, 2024a).

This rangahau confirms that the health and health education sectors, along with the development of the Māori health workforce, are entrenched in institutional racism and colonial ideologies. It demonstrates that authority, power, and resources remain firmly within the government and Western-led agencies, undermining Māori health and wellbeing aspirations. Clearly, these sectors have been adversely impacted by recent changes under the National coalition-led government. These biased structures hinder

transformative Māori health workforce development. Despite this recognition, the development of a Māori health workforce continues to be primarily framed within the Crown's Western-dominated health and education systems. This approach limits opportunities for equitable outcomes for Māori and restricts advancements critical to achieving health equity. These structures perpetuate the status quo and remain fundamentally incompatible with the vision articulated in this study.

These discussions and outcomes are primarily situated within the context of hauora and its relevance to Māori health workforce development. However, I also acknowledge the parallel struggles faced by other Indigenous peoples in relation to health, wellbeing, and workforce advancement. Furthermore, struggles that similarly arise from systemic barriers entrenched in colonial structures. This study argues for urgent action prioritising and centring Indigenous worldviews, health, wellbeing, and workforce development aspirations as essential drivers of transformative change.

5.4 Solutions: Embedded in Hauora Kaupapa

5.4.1 Critical Allyship

This study has highlighted the systemic challenges that exist within Western-dominated health and education systems and which fuel and maintain systemic racism. It also highlights how systemic racism negatively impacts the subtle but slippery construct of Māori and Indigenous health workforce development. In other words, the health and health education systems, as they are, perpetuate the status quo of health inequity by reinforcing the existing power dynamics (Came, 2012; Nixon, 2019). Hence, this thesis contends that it is vital to support and assert Māori and Indigenous aspirations and to actively disrupt racism so that transformative change may occur.

This study argues which as Nixon (2019) describes, "practising critical allyship" is imperative for those in privileged positions of power to critically reflect on their unearned privileges (p. 2). I suggest within this thesis, this study has demonstrated that the solutions, actions, or inactions pursued are impacted by how inequity is framed and understood. This study recognises that their broader impacts become clear when Māori health disparities and workforce development are understood within a broader systemic context rather than seen as Māori and Indigenous issues. With critical reflection, those

in privileged positions can take meaningful and assertive action to address the social structures which sustain these disparities. Such reflection and recognition of unearned privilege and power are essential for advancing Māori and Indigenous aspirations and driving transformative change. Therefore, this thesis argues that practical actions through critical allyship, as described by Nixon (2019), can play a vital role in supporting the realisation of Māori and Indigenous aspirations.

Within the specific context of Aotearoa, this study highlights “Pākehā critical allyship” as described by Rae (2024) as a crucial framework for addressing systemic inequities within Māori health and its workforce development (p. 216). This rangahau argues that Pākehā allyship requires both critical reflection and practical action. Together, these elements acknowledge and begin to dismantle systemic barriers within the health and education systems. Furthermore, it aligns with existing scholarship emphasising that non-Māori must actively acknowledge and confront their own biases to genuinely support Māori aspirations and deconstruct inequitable health structures (Wilson et al., 2022). This study asserts that practising critical allyship is essential for driving transformative change in Māori and Indigenous health inequities, its workforce, and development (Nixon, 2019; Rae, 2024).

Furthermore, Rae (2024) Introduces the concept of "becoming consciously Pākehā" as a necessary process for Pākehā engaging in critical allyship (p. 216). This study argues that this concept is useful to individuals within the health and education systems, arguing that such allyship demands an ongoing commitment to confronting systemic racism to support hauora and Māori aspirations. Additionally, Rae’s “ethic of service” provides a valuable lens for understanding how Pākehā, and similarly those of colonial advantage, can meaningfully contribute to Māori and Indigenous health equity (2024, p. 216)This requires deliberate, sustained action to challenge and transform racist structures within health workforce development. Pivotally, there must be a normative acceptance of Māori as tāngata whenua and have the right to tino rangatiratanga.

5.4.2 Hauora Kaupapa Māori

The critical intent of kaupapa Māori theory evolved from whānau, hapū, and their communities' aspirations to ensure the survival of te reo Māori through the revitalisation (Ratapu & Hohepa, 1991; Smith, G., 1997). These efforts involved the long struggle and resistance of Māori to the Western-dominated education sector.

This rangahau argues that the critical intent of kaupapa Māori theory is crucial to asserting and defending the taonga of hauora. Thus, the reciprocal embeddedness of hauora and te ao Māori can draw on kaupapa Māori to activate tino rangatiratanga and assert Māori aspirations. This study proposes that these struggles for the revitalisation of te reo Māori closely align with this study's vision for hauora. As whānau, hapū, and communities resisted and continue to resist the Western-dominated education systems that undermine te reo Māori, this study seeks to challenge and resist the Western-led health and health education systems. These systems undermine hauora, whānau, hapū, Māori, which restricts the development of a Māori health workforce.

In this study, I propose the phrase 'Hauora Kaupapa', which is innately 'Hauora Kaupapa Māori', as a means of developing a health workforce that aligns with Māori aspirations and thus can disrupt racism. While this phrase (in this particular order) appears to be new to academia, the concept itself is not and is deeply rooted in te ao Māori.

In alignment with workforce development considerations discussed in this thesis, I suggest adopting a broad approach to developing the Māori health workforce. Rather than treating workforce development as a separate yet related concern of the health and education sectors, the foundational concept of a hauora kaupapa embraces a broader, systemic approach. Hauora kaupapa contends that developing the Māori health workforce should focus on creating health and education services, systems, and workforces that are generated within and by whānau, hapū, and Māori communities, where whānau work, study, live, and play.

Figure 8. Hauora Kaupapa

This figure illustrates the Whakapapa of Hauora and Mobilising Mana Motuhake as the two interconnecting concepts that form the foundations of Hauora Kaupapa—copyright 2025 of the author Haidee Rēnata (2025) in collaboration with, and much gratitude to Jacqui Chan (2025) for illustrating.

Figure 8, as illustrated above **Hauora Kaupapa** represents two interconnected concepts forming the study's conceptual foundation: **Whakapapa of Hauora** and **Mobilising Mana Motuhake**. This study argues that these integral and interwoven concepts are essential for developing a Māori health workforce, disrupting racism, and realising Māori aspirations. Within this figure, the Whakapapa of Hauora highlights the inseparable connections between the tangata to the health and wellbeing and the collective tāngata, taiao, to the celestial realm. It reinforces whānau, hapū, Māori, and their communities as the experts in their hauora. The interwoven kōwhaiwhai patterns visually emphasise the critical importance and relationship between hauora and Mobilising Mana Motuhake. This of which enables whānau, hapū, Māori, and their communities to exercise their inherent autonomy and authority to determine their destiny.

Furthermore, in Figure 8, several small figures illustrate the many taonga of hauora kaupapa embedded in te ao Māori. This addition aims to depict whānau, hapū, Māori, and communities engaging in teaching, learning, and sharing of mātauranga through kōrero and practices intergenerationally. Included are kai gathering, rongoā, and the tikanga of returning whenua to Papatūānuku, symbolising the reciprocal relationship of care and respect for both the whenua and Papatūānuku.

This study argues that contextualising hauora within kaupapa Māori is pivotal to activating tino rangatiratanga and thus to ultimately achieving meaningful progress for Māori health workforce development. Hauora kaupapa reflects both the breadth and depth of hauora (Wenn, 2007), and the critical intent of kaupapa Māori to activate tino rangatiratanga (Smith, G., 1997).

> Tino rangatiratanga: mō tātou, ā, mō kā uri ā muri ake nei –
> The ability to create and control our destiny for generations to come.

I have drawn parallels between the revitalisation of te reo Māori and the vision for hauora, recognising both as taonga which are central to Māori aspirations and, further, the parallel struggles and resistance of Western-led systems. My findings have enabled me to argue that prioritising the whakapapa and taonga of hauora while recognising the connections to whenua, mātauranga, and the tikanga specific to each whānau, hapū, and Māori is essential. Recognising and respecting this uniqueness is critical to Māori health workforce development. In alignment with community-led aspirations, hauora kaupapa prioritises the specific aspirations of those it serves, as depicted below in Figure 9. The visual depiction of the aspirations of Māori as determined by the relevant whānau and community for whom the health workforce is intended and generated.

Figure 9. Aspirations Bubble

I argue that the foundations of hauora kaupapa are critical to effectively understanding and thus promoting the development of a robust and responsive Māori health workforce. This approach aligns with Māori aspirations and offers a pathway to transformative change. Hauora kaupapa is, therefore, a way to strengthen the Māori health workforce by calling for transformative change that empowers whānau, hapū, and their communities to succeed. For this reason, the whakapapa of hauora and the mobilisation of mana motuhake are essential to transform the Māori health workforce and its development effectively. By prioritising these, Māori aspirations can be fulfilled, generating positive change within the communities it is intended to serve.

5.4.3 Recommendations

These recommendations are intended to shape a unified approach towards hauora kaupapa, capable of fulfilling Māori aspirations and disrupting racism. This, in turn, drives systemic transformation. Furthermore, the following recommendations assert the significance of Māori and Indigenous authority and leadership, strengthened by critical allyship relationships. These which may include individuals in government, management, workforces, academia, education, and student bodies. The following recommendations promote actions for change and serve as starting points for future studies.

It is recommended that the health and health education policies, systems, sectors, and workforces, along with those in positions of power and individuals with Pākehā or colonial privilege who study, work, or educate within these sectors, take action to remove systemic inequities by actively and collaboratively addressing each of the following:

- Engaging in critical reflection by actively reflecting on status, power, and Pākehā or colonial privilege to develop an understanding and thus acknowledge that the health and health education systems are Western-dominated, exacerbating Māori and Indigenous health disparities and restricting workforce development.
- Recognising that Western-dominated health and education systems for Māori and Indigenous peoples are fundamentally flawed and, therefore, lack the expertise to adequately address Māori and Indigenous health inequities and workforce development unless concerted systemic change is implemented.

- Increasing awareness of status and engaging with all stakeholders to encourage critical awareness of the consequences of inequities in privilege and power. Such awareness can foster improved understanding, promoting constructive Māori and Indigenous health and workforce development.
- Practising critical allyship through honouring Māori and Indigenous rights to authority and autonomy, upholding Māori tino rangatiratanga as tāngata whenua of Aotearoa. This includes taking active action in confronting systemic racism within the health and education systems and supporting Māori and Indigenous aspirations.
- Prioritising Māori and Indigenous leadership, authority, and autonomy by acknowledging whānau, hapū, Māori, Indigenous, and their communities as the experts and best placed to ensure positive health and wellbeing outcomes.
- Normalising hauora kaupapa Māori and Indigenous-led initiatives, programmes, systems, services, and paradigms by prioritising whānau, hapū, Māori, and their community aspirations so they become standard practice within health, education, and workforce development.
- Actively supporting and adequately resourcing whānau, hapū, Māori, and Indigenous-led initiatives, by establishing well-supported and well-resourced programmes to ensure their sustainability and effectiveness in addressing Māori and Indigenous health inequities and workforce challenges.
- Strengthening and expanding existing Māori and Indigenous-led programmes and services, including the Bachelor of Nursing Māori, Mātauranga, Te reo Māori, Rongoā, Whānau Ora, Iwi and Hapū-led services.
- Investing in existing Māori health workforce development organisations, programmes, and initiatives, by ensuring continued support for initiatives including Te Rau Ora, Ngā Manukura o Āpōpō, Earn As You Learn, and Kia Ora Hauora to build capacity and capability within the Māori health workforce.
- Advocating for Māori students and staff by providing the opportunity to discuss and gain access to study, education, and career pathways that align with their aspirations, while not assuming all will be embed in te ao Māori.
- Normalising te ao Māori by ensuring Māori students and staff have access to study, education, career, and workplace development opportunities that are embedded within te ao Māori ways of being, doing, and knowing, becoming standard within the health and education sectors, and workforce development.

- Providing access to culturally grounded spaces for Māori students and staff by recognising and including marae, whānau rooms, mātauranga, rongoā, and te reo Māori, as having an integral place within the health and education sectors, workforces, and development.
- Normalising tikanga Māori by allowing for regular wānanga, hui, kōrero, and relationships between Māori students, staff, whānau, hapū, communities, and critical allies seen as integral to the health and health education sectors, workforce, and its development.
- Valuing Māori students and staff by formally providing cultural supervision for Māori students and staff, and similarly recognising and compensating their supervisor contributions to students and colleagues.
- Respecting whānau and community commitments by providing flexible education and employment pathways that align with Māori students and staff responsibilities, enabling Māori to build and sustain health workforce careers.
- Normalising hauora kaupapa, Māori, and Indigenous-led aspirations by prioritising whānau, hapū, Māori, Indigenous and their community-led initiatives, programmes, systems, services, and paradigm so they become standard practice within health, education, and workforce development.
- Aligning policies by prioritising whānau, hapū, Māori, Indigenous, and community-led initiatives, programmes, systems, and services.
- Maintaining accountability whereby processes, monitoring and evaluations are directly led by the relevant whānau, hapū, Māori, and Indigenous, to align with their aspirations.

While these recommendations primarily assert Māori aspirations, they also champion Indigenous-aligned aspirations and initiatives while challenging institutional barriers and systemic inequities. Importantly, these recommendations recognise the role of those in positions of power and privilege who can become more conscious of fundamentally flawed systems which exacerbate Indigenous inequity through critical reflection and transformative action development. Fundamentally, it is argued that practising critical allyship through practical actions is a positive way to support and honour the rights of Indigenous people. It is a way to assert the aspirations and rights of Indigenous peoples towards equitable health and education.

5.5 Conclusion

This discussion and outcomes wāhanga has explored and articulated a vision for transforming the Māori health workforce which is embedded in taonga and deeply connected to te ao Māori. This vision has been informed by the rangahau I have undertaken for this thesis, and it prioritises the hauora and mana motuhake of whānau, hapū, Māori and their communities. The vision asserts that the Māori health workforce is intended to be at the forefront.

I emphasise the reclaiming and sustaining of hauora as a core focus, acknowledging its whakapapa and interconnectedness with te ao Māori. This connection is inseparable from whānau and community relationships. The tikanga of hauora recognises whānau and their communities as the true experts in their hauora, thus positioning them as the leaders in Māori health workforce development. Long-term investment is required to normalise, sustain, and transmit these taonga intergenerationally.

I have identified key challenges in developing the Māori and Indigenous health and health education workforce, highlighting the slippery construct of Māori and Indigenous health workforce development within a Western-led paradigm. That paradigm perpetuates institutional racism, maintains the status quo, and centralises authority, power, and resources within health and education systems. Collectively, these factors continue to undermine Māori rights and aspirations. Not prioritising Māori health workforce development under the Crown's authority continues to be disingenuous; therefore, not prioritising Māori health workforce development continues to marginalise Māori voices and sustain these health inequities.

To address these challenges, I have proposed hauora kaupapa as foundational to asserting Māori aspirations and developing a health workforce grounded in te ao Māori. Hauora kaupapa embodies the depth of hauora and the intent of kaupapa Māori to activate tino rangatiratanga. Activating hauora kaupapa is crucial for advancing Māori aspirations for Māori health workforce development.

This study contributes to a growing body of work advocating for hauora kaupapa-led solutions and offers practical pathways for transformation. It provides a cluster of broad, rather than specific, recommendations to address the interconnected aspirations,

challenges, and opportunities essential to advancing hauora kaupapa and its workforce development. Hence, although some recommendations focus on systemic change, they are all grounded in the goal of normalising hauora kaupapa, and Indigenous leadership as standard practice, ultimately contributing to transformative change.

This study now moves on to the final wāhanga to summarise this rangahau, review the thesis question, and move forward to identify future studies and conclude.

Wāhanga 6: Looking Back and Moving Forward

6.1 Introduction

This wāhanga looks back on the five preceding wāhanga and offers a summary, critique, and shares key insights for this rangahau. The thesis question is reviewed, and I reflect upon how it has been addressed. The strengths and limitations of the study are explored, and recommendations for ongoing rangahau are presented. Finally, this thesis concludes with a personal reflection on my journey throughout this thesis.

6.1.1 Summarising

The background and overview wāhanga reflected on the strength, health, and hauora of my tūpuna, hapū, and iwi Māori as Indigenous to Aotearoa. It highlighted tino rangatiratanga as foundational to sustaining a hauora system grounded in te ao Māori. However, it also pointed out that systemic injustices initiated by Crown breaches of He Whakaputanga and te Tiriti o Waitangi led to colonisation and entrenched institutional racism. These factors, I argued, resulted in health inequities for Māori. A recurring feature of this thesis has been commentary about how these issues persist in Aotearoa's health system today. This wāhanga presented evidence supporting Māori and Indigenous health workforce development as a critical mechanism to address these inequities, disrupt racism, and improve Indigenous health outcomes. By identifying and articulating the aspirations of Māori for health workforce development, this wāhanga provided a foundation for the study's exploration of solutions, thereby determining the potential for transformative change.

The literature review wāhanga emphasised that prioritising Māori and Indigenous worldviews and leadership is crucial for health workforce development. Within this wāhanga, I critiqued the dominance of Western paradigms and *Institutional Racism in the Development of the Workforce* and concluded that these perpetuate inequities and restrict Māori and Indigenous aspirations. In particular, I concluded that overemphasising *The Pipeline of the Workforce* hinders transformational progress. Significantly, and by contrast, evidence from *Māori and Indigenous-Led Workforce Success* demonstrated the capability of these Indigenous approaches. This wāhanga thus established the necessity of embedding Māori and Indigenous worldviews and strategies

into health workforce development, principally because these can disrupt systemic racism, thereby creating a platform for Māori and Indigenous solutions.

The methodology and methods wāhanga introduced the foundation of kaupapa Māori methodology rangahau, aligning the study with the aspirations of Māori. The core values of whakapapa, and by Māori, for Māori, guided the study. The methods used and accompanying ethical considerations were described, including the reflective approach to thematic analysis. That approach enabled three key themes to emerge, which were then developed as findings.

The findings wāhanga from the rōpū rangahau thus presented those three interconnected themes: *Hauora-Led Systems*, *The Potential and Strength of Mana Whānau*, and *Spaces to Be Māori*. The themes articulated aspirations for a health system grounded in hauora, where mana whānau is central, and spaces are created to normalise and celebrate being Māori. The participant rōpū envisioned a health system that upholds the mana of whānau, providing the authority and resources to make decisions best suited to their communities. Importantly, these findings highlighted the strength of whānau when mana motuhake is activated. Several values were identified, including mātauranga, whakapapa, te reo Māori, wairua, and whenua. These were identified as essential to fostering environments where Māori can thrive, free from the constraints of Western-dominated systems.

From the discussion and outcomes wāhanga, I explored the vision for Māori health workforce development through the vision embedded in taonga that is hauora-centred. I argued that an interconnected vision for *Hauora and Mana Motuhake, Led by Whānau, Hapū, Māori, and Communities,* is crucial for successful Māori workforce development. I emphasised the centrality of whānau, hapū, and Māori as leaders in hauora, recognising their authority to drive hauora-aligned and community-led health workforce strategies. The rangahau, therefore, highlighted the taonga of mātauranga, tikanga, and te reo Māori, which are connected to hauora. Sustained investment in these areas is essential for their normalisation and intergenerational transmission.

The Slippery Construct of Māori and Indigenous health workforce development highlighted systemic barriers and the dominance of Western paradigms as persistent challenges to transformation. The forming of *Critical Allyship* was seen as a way in which

those holding positions of privilege could support Māori and Indigenous health workforce development and health inequities. *Hauora Kaupapa* was proposed as a foundational concept and solution to assert Māori aspirations, disrupt racism, and thus address health inequities. The accompanying recommendations offered practical ways to transition and assert Māori and Indigenous aspirations, with the ideal of hauora kaupapa assertions becoming normative of the Aotearoa health system.

6.1.2 Review of the Thesis Question

The question posed for this study was:

How can the visions and values of experienced Māori health professionals be leveraged to assert Māori aspirations for health workforce development and disrupt racism?

This study was successful in its intent, which was to interpret these data and rangahau in identifying and asserting how the visions and values of experienced Māori health professionals contribute to the development of a health workforce that aligns with the health and wellbeing of the communities for which it is intended. This question was first explored through the perspectives of the participant rōpū. However, through the discussion, the perspectives from additional Māori and critical allies of Māori became appreciated, and these, therefore, contributed to the debate, outcomes and ultimately to the recommendations.

The vision identified was a hauora-centred workforce grounded in values recognised as taonga. This workforce is whānau and community-led, asserting mana motuhake for those it serves and from whom it is generated. This study highlighted and proposed challenges to achieving this vision, proposing hauora kaupapa as a foundational concept. In doing so, it asserts Māori aspirations, one of which is to disrupt racism and consequently address Māori health inequity. Hauora kaupapa thus demonstrates broad potential as a platform to disrupt racism for and within Māori health workforce development. This approach seeks to improve the health of Māori while asserting Māori aspirations.

6.1.3 Strengths and Limitations

My whakapapa as Māori, alongside my work in the health and education sectors, was a strength for this study, providing me with a broad insight into the challenges of developing the Māori health workforce. This study presented a unique opportunity to work alongside highly skilled and experienced kairangahau and researchers. These included Māori and Pākehā, Professors, Drs, academics, activist scholars, and tāngata Tiriti allies who were experienced in disrupting racism, decolonisation, and transformative change within the health and health education sectors and their associated policies.

The participant rōpū demonstrated particular strengths and wisdom and were able to navigate both te ao Māori and the Western world, reflecting their skill in grounding themselves in whakapapa Māori, collective orientation, and determination. Wānanga provided participants with an environment within which they could negotiate ideas and reach a consensus. Such a consensus would not have been feasible or practical if these data had been gathered across seventeen individual interviews.

It is essential to state that this study was based on a secondary analysis of these data, which were initially collected for a Marsden project on reimagining a health system in Aotearoa that wasn't racist. This broader project focus allowed for an expanded overview. Previously, much workforce development research and rangahau has been confined within the constraints of pre-determined Western health systems. Nonetheless, a limitation of that wider study was that the findings of the rangahau did not directly answer the specific question posed here. That question presented the challenge of relating the findings directly to workforce development.

Kaupapa Māori methodology emphasised my critical intent to activate tino rangatiratanga, which is central to the strength of this thesis. However, the study remains constrained within a Western-dominated structure, as I sought to be awarded a Master of Health Science. This process does not permit collective or shared authorship, which more appropriately aligns with kaupapa Māori. As discussed in my ethics section, to mitigate this, I presented my progress to the whānau rangahau and gained approval and critical guidance throughout the study. This limitation was therefore eased by the

strength of the kaitiaki rōpū and additional skilled Māori health professionals and academics, who offered valuable advice.

My kairangahau journey commenced in 2021, a slow, extended process allowing for reflection, integration of new knowledge, and in-depth critical thought into 2025. My discussion wāhanga took 12 months to develop, reflecting deep analysis and critique through multiple drafts and revisions. A limitation was that the Marsden project formally closed in June 2024, which reduced direct access to scheduled hui, which meant I could not present my final study outcomes. Nonetheless, I was supported by my primary supervisor, who was well-equipped to ensure that all which had previously been discussed remained true to the kaupapa in the final reporting of this thesis.

6.1.4 Future Studies

Future rangahau recommendations include pathways to strengthen the conceptual foundations of hauora kaupapa, building this into a theory that advances and asserts Māori aspirations and workforce development. These recommendations aim to address systemic challenges while aligning with the aspirations identified in this study.

Key focus areas included deepening the understanding of whānau-centred approaches, monitoring and evaluating policy development and implementation, expanding the scope of hauora kaupapa, fostering collaboration with Indigenous health and education systems and workforce, and exploring whānau and community-led health, education, and workforce development initiatives and models.

Opportunities for future rangahau include investigating the intergenerational impacts of whānau and community-led initiatives in building health systems which simultaneously develop a sustainable workforce centred on the hauora of whānau, hapū, and communities. Additionally, exploring the role of whakapapa and whenua in strengthening workforce strategies and improving health and wellbeing outcomes. Expanding the application of hauora kaupapa through longitudinal rangahau will enable a deeper assessment of its impact on hauora Māori, health, community wellbeing, and workforce development.

Rangahau which monitors and evaluates policy implementation, is crucial to ensuring the effective inclusion of hauora kaupapa. This includes assessing its influence on equity

and examining the broader impact of policy changes on Māori health outcomes and workforce sustainability. Insights from such evaluations can inform future strategies, ensuring policies remain responsive to Māori aspirations.

Collaborative Indigenous studies present a unique opportunity to partner with global Indigenous communities to share strategies for developing Indigenous-aligned workforce models. Such partnerships could enrich hauora kaupapa by gaining international insights and best practices, fostering a broader understanding of Indigenous-led health workforce development.

Innovation in workforce development, grounded in Indigenous worldviews, offers significant growth opportunities. Incorporating technology and contemporary practices can expand access to Indigenous-aligned education and services, particularly in remote areas, and there are many possibilities in that realm.

Future studies will play a critical role in building upon these foundations, ensuring that the vision outlined in this study continues to drive transformative and sustainable change in the health and education sectors. Continued rangahau is essential for promoting systemic transformation and achieving health and wellbeing equity for Māori and their communities.

6.2 Final Conclusion

This rangahau journey has been deeply personal and meaningful. Through this study, I have sought to articulate and assert a vision for Māori health workforce development, one that is hauora-centred, grounded in te ao Māori, and led by whānau, hapū, Māori, and their communities. The findings reaffirm the strength, resilience, and expertise of Māori and Indigenous people in shaping our futures while exposing the systemic barriers and colonial structures that continue to hinder transformative change.

Despite these challenges, this study offers practical pathways and recommendations to disrupt racism, assert tino rangatiratanga, and embed hauora kaupapa as the foundation for workforce development. The importance of critical allyship was also highlighted, recognising the role of those in privileged positions in supporting systemic change.

While this rangahau provides a strong foundation, it is just the beginning. The future of Māori health workforce development depends on sustained investment, Indigenous-led innovation, and the continued assertion of Māori and Indigenous rights and aspirations. I remain committed to this kaupapa and the ongoing mahi required to ensure that hauora kaupapa is normalised, valued, and implemented as a transformative solution.

This study was not just about identifying challenges but about amplifying solutions. The vision remains a Māori-led, whānau-centred, and hauora-driven health workforce that empowers Māori, restores balance, and ensures health equity for future generations. The journey ahead requires courage, commitment, and collective action. Still, the aspiration remains unwavering in a continued and collective effort for Māori and Indigenous rights for equitable health and education through the asserting of aspirations as determined by Māori and Indigenous communities.

6.2.1 Closing Personal Reflection and Karakia

Since beginning this study, my life and perspective have profoundly changed. As a rōpū rangahau member, I often questioned my mana within a space of highly experienced researchers and experts. Initially, much of the kōrero felt beyond my reach. However, I now see that my supervisors recognised my potential, even when I doubted my ability, particularly in completing this thesis.

He moana pukepuke e ekengia e te waka –

A choppy sea can be navigated.

This journey has not been without its challenges. As I submit this rangahau, I reflect on the two years since 13 February 2023, when Cyclone Gabrielle devastated our community. It reaffirmed the deep connection between hauora and Papatūānuku, yet also the profound loss, as the tears of Ranginui brought relentless rain that night, and Papatūānuku broke under the weight, causing landslides that led to the loss of loved ones and thousands of homes and livelihoods spanning over our whenua of Aotearoa.

Significantly, shortly after this difficult time, one of our tamariki started school, further impacting our hauora. During this time, we gained a deeper understanding of neurodivergent challenges faced in a society which marginalises neurodivergence, and

subsequent disability. Within our whānau, we navigated new diagnoses, alongside first-hand exclusions within health and education systems, and unhelpful society norms.

This rangahau has been an emotional journey filled with frustration, anger, and grief, not only for my own experiences but also for the inequities faced by Māori, Indigenous, and marginalised communities worldwide. Yet, amidst these struggles, it has also been a source of passion, new insights, and a rediscovery of ancestral pride. It has reinforced the strength and wisdom of our tūpuna and reaffirmed that disrupting racism and reclaiming the kaupapa of hauora is not only necessary but urgent.

As I close this wāhanga and this thesis, I accept that this rangahau chose me to tell its story. Furthermore, I acknowledge that it is imperfect, and minor errors may haunt me. However, I must now lay this down and look forward to spending time with my whānau and friends, which has been long overdue. This journey has been more than just a thesis; it is a legacy of resistance, resilience, and hope for future generations.

Kia hora te marino,
Kia whakapapa pounamu te moana,
Hei huarahi mā tātou i te rangi nei.
Aroha atu, aroha mai, tātou i ā tātou katoa.
Haumi e, hui ē, tāiki ē –

May peace be widespread,
The ocean be smooth like greenstone,
A pathway for us all this day.
Let us show love and compassion to one another, for we are all connected.
Together, we unite, together, we stand strong.

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Appendices

Appendix A Ethics Approval 2022

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

31 March 2022

Jacquie Kidd
Faculty of Health and Environmental Sciences

Dear Jacquie

Re Ethics Application: **22/58 Māori health professionals' anti-racism praxis and workforce development. Kaupapa Māori wānanga.**

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 31 March 2025.

Non-Standard Conditions of Approval

1. Please send through a data management plan. The plan is for the entire project, it will outline how the data is being managed, shared and who authorises it.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be reviewed by AUTEC before commencing your study, but leas send through for files.

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: haidee.renata@aut.ac.nz; zoe.tipa@wintec.ac.nz

Appendix B Evidence Requested and Verified 2023

Auckland University of Technology Ethics Committee (AUTEC)

7 September 2023

Jacquie Kidd
Faculty of Health and Environmental Sciences

Dear Jacquie

Ethics Application: **22/58 Māori health professionals' anti-racism praxis and workforce development. Kaupapa Māori wānanga.**

At their meeting of 4 September 2023, the Auckland University of Technology Ethics Committee (AUTEC) received the report on your ethics application. AUTEC noted your report and asked us to thank you.

On behalf of AUTEC, we congratulate the researchers on the project and look forward to reading more about it in future reports.

When communicating with us about this application, we ask that you use the application number and study title to enable us to provide you with prompt service. Should you have any further enquiries regarding this matter, you are welcome to contact me by email at ethics@aut.ac.nz or by telephone on 921 9999 at extension 6038.

(This is a computer-generated letter for which no signature is required)
The AUTEC Secretariat
Auckland University of Technology Ethics Committee
Cc: haidee.renata@aut.ac.nz; zoe.tipa@wintec.ac.nz

Appendix C Participant Information

Participant Information Sheet

Date Information Sheet Produced: November 2019

Project Title

Re-imagining anti-racism theory in the health sector: Stage 2

An Invitation

Kia ora, our research team of Associate Professor Jacquie Kidd, Ngāpuhi (AUT), Dr Heather Came (AUT), Garrick Rigby (Research Assistant), and Professor Tim McCreanor (Advisor, Massey University) would like to invite you to participate in stage 2 of our study to re-imagine anti-racism theory in the health sector.

Your decision to participate or not will neither advantage nor disadvantage you.

There will be six wānanga held over the next two months, followed by a final day when participants from all the wānanga come together to discuss the findings. You are free to attend any of these.

Date and time	Participants	Venue
	Tauiwi	
	Māori	
	Tauiwi	
	Māori	
	Tauiwi	
	Māori	
	All – final combined wānanga	

What is the purpose of this research?

Racism and dishonouring of te Tiriti o Waitangi are significant contributors to Māori health inequities in Aotearoa New Zealand. While there is growing acknowledgement of this situation and some improvement in individual practice within various disciplines, few initiatives have attempted to engage with racism in the health sector at an institutional level. We propose to develop a transformational theory and practice of anti-racism that is relevant to all levels of the health sector.

The current study draws on existing research by the team around cultural safety, health inequities and mapping racism that identifies the need for a cohesive approach to addressing racism in the health sector. The study is underpinned by Māori health aspirations, and focuses on the nexus of Māori and Tauiwi knowledges.

Our novel methodological approach is based on kaupapa Māori theory, Western change theories, Critical te Tiriti Analysis and informed by Te Ara Tika ethical principles. The study comprises four iterative stages over three years which will generate, refine, test, and disseminate a theory of anti-racism in collaboration with health sector partners.

Stage one is a scoping study of existing anti-racism praxis within Aotearoa New Zealand. In stage two we will work collaboratively with health professionals to examine and develop the theoretical work from stage one into a provisional theory of anti-racism. For stage three we will work with a health practice case (Mahitahi Hauora in Te Tai Tokerau) using an action research method to test the provisional theory and build knowledge of how it might work in situ. Stage four is a full day collaborative wānanga where convergent and contrasting experiences, insights and findings will be explored, and the new theory of anti-racism for the Aotearoa health sector will be articulated.

The purpose of the current stage of the study is to collaborate with Māori and non-Māori health professionals to examine and expand on the theoretical framework we have developed in stage one of the study to create a provisional theory of anti-racism which we will then test in the next stage of the study. The findings of this research may also be used for academic publications and presentations.

This research project has been funded by a Marsden grant, administered by the Royal Society of New Zealand.

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

You were identified to participate in this study through the existing professional networks of the research team and/or the research whānau (governance groups) of this study. You are being invited because you have been a health professional for seven or more years working in an Aotearoa New Zealand context; and you bring expertise and understanding of te Tiriti o Waitangi and anti-racism in the health sector.

How do I agree to participate in this research?

You were approached to participate in this study via email, phone or kanohi ki te kanohi. You agree to participate in the study by completing the consent form that was given to you directly by a member of the research team either electronically or kanohi ki te kanohi depending on how first contact was made. You will have two weeks to decide whether you want to participate in the study.

Your participation in this research is voluntary (it is your choice) and whether or not you choose to participate will neither advantage nor disadvantage you. You are able to withdraw from the study at any time. If you choose to withdraw from the study, then you will be offered the choice between having any data that is identifiable as belonging to you removed or allowing it to continue to be used. However, once the findings have been produced, removal of your data may not be possible.

What will happen in this research?

If you decide to participate, you will be invited to attend one of six wānanga with either Māori or non-Māori health professionals. During the wānanga we will analyse and critique through whakawhiti kōrero (idea negotiation) the provisional statements and their associated questions from stage one of our study. We will also ask you to describe your experiences of disrupting racism in your professional settings.

After the caucused groups are completed, you will be invited to a joint wānanga consisting of the members of each of the six groups coming together equitably to conduct a collaborative data analysis and reconcile the findings into a provisional theory of anti-racism. There will be the opportunity to contribute virtually to the final wānanga.

At the end of the overall study, you will also be invited to attend a full day collaborative wānanga (stage four of the study)

What are the discomforts and risks?

There are no probable discomforts or risks to you (tangible or psychological) while participating in this research. While discussing racism can be uncomfortable, your role as a participant is to draw on your professional experiences. The separation of Māori and non-Māori participants during the initial wānanga should also mitigate any discomfort you might experience.

What are the benefits?

Potential benefits for participants of this stage of the study include opportunities for you to engage in collaborative dialogue and share your stories around anti-racism praxis. Such engagement may lead to direct benefits such as feeling heard and contributing to a meaningful change process. It may also lead to greater awareness and improved understanding of best practice in relation to anti-racism within individual working roles. It is hoped that this process will also contribute to a collective will to enact positive change within individual workplaces.

The findings from this stage of the study will form the basis of an action research project with Mahitahi Hauora in Te Tai Tokerau to test the provisional theory and build knowledge of how it might work in situ. If the overall project is successful a key benefit will be constructive anti-racism changes within the Mahitahi clinical site.

How will my privacy be protected?

Participation in the wānanga will not be anonymous because you will be involved in discussion with researcher/s and other participants present. However participants will be advised of the confidentiality clause on the consent form, requiring that they do not disclose information obtained during the hui.

All identifying information, including names, will be removed from the raw collected data and replaced with code names with a master index stored in a password protected file using AUT secure storage. However, should you wish for your name and identifying information to remain, then, in the interests of upholding your mana we will ensure your true identity is appropriately acknowledged in any published findings and that you have had the opportunity to contribute to any such findings.

What are the costs of participating in this research?

It is expected that participation in the each of the two wānanga of this stage of the study will require three hours of your time. In addition, you will be invited to a full day wānanga at the end of the overall project.

What opportunity do I have to consider this invitation?

You will have two weeks to consider the invitation to participate in the study. If we have not heard from you within these two weeks, we will send you one reminder but will not contact you further.

Will I receive feedback on the results of this research?

At the end of the overall project, we will invite you to attend a full day wānanga where the results of the project will be discussed. You can also request to receive a summary of the research findings from this stage of the study.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisors, Associate Professor Jacquie Kidd (jacquie.kidd@aut.ac.nz, 09 921 9999) or Dr Heather Came (heather.came@aut.ac.nz, 09 921 9999 ext 7799)

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

Whom do I contact for further information about this research?

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

Researcher Team Contact Details:

Associate Professor Jacquie Kidd, jacquie.kidd@aut.ac.nz, 09 921 9999

Dr Heather Came, heather.came@aut.ac.nz, 09 921 9999 ext 7799

Garrick Rigby (Research Assistant), garrick.rigby@aut.ac.nz

Professor Tim McCreanor (Advisor), T.N.McCreanor@massey.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *18th August 2021*, AUTEC Reference number *21/187*.

Appendix D Artificial Intelligence Programme Usage

I hereby declare that Grammarly (2024) a writing assistant tool was used throughout this thesis to support grammar, spelling, and sentence structure. Automatic corrections were not applied indiscriminately; instead, suggestions were reviewed and implemented only when appropriate to ensure the accuracy and integrity of the text. OpenAI (2024) was utilised solely to enhance vocabulary and provide alternative ways for presenting short phrases I had already constructed. Its use was strictly limited to supporting the presentation of my work and did not influence the conceptual workings or interpretive content of this thesis.