Understanding the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa

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Abstract

There are persistent life expectancy differentials among Pacific people in Aotearoa compared to non-Pacific (Came et al., 2019; Curtis et al., 2015; Health Quality & Safety Commission, 2021; Walsh & Grey, 2019). There are consistently low numbers of Pacific allied health professionals in Aotearoa, and there is an urgent need to prioritise more Pacific health professionals across the healthcare sector.

This qualitative study explored the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa. The research provides insight into the perspectives of five Pacific allied health professionals utilising Talanoa methodology and thematic analysis. The four main themes and 13 sub-themes are identified and discussed. The collective voice of the research participants details the opportunities for allied health staff to achieve culturally responsive care.

This study identified three key overarching meta-themes of cultural isolation, cultural intelligence, and cultural load. Cultural knowledge and expertise are crucial in helping non-Pacific allied health clinicians to recognise, acknowledge and embrace culturally responsive healthcare. This current study contributes to the gap in the literature identified by highlighting the challenges and opportunities. The research provides a platform that allows my colleagues to build further, more specific research exploring Pacific allied health professionals' experiences across Aotearoa.

Attestation of Authorship

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

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Acknowledgments

Glossary

A'u tonu (Tongan):	face to face
Fakafehokotaki (Tongan):	engagement
Hui (Māori):	meeting
Kainga (Tongan):	extended family
Kainga Lotu (Tongan):	church family
Mihimihi (Māori):	acknowledgements
Pākehā (Māori):	New Zealander of European descent
Tauiwi (Māori):	foreigner, European, non-Māori, colonist
Teina (Māori):	younger/less experienced sibling
Tuakana (Māori):	older/most experienced sibling
Vā:	a relational space that connects social, physical, spiritual, cultural, and environmental elements, people, places, and objects
Wānanga (Māori):	indigenous seminar, conference, forum
Whānau (Māori):	extended family

Chapter 1: Introduction and Overview

Introduction

There are persistent life expectancy differentials among Pacific people in Aotearoa when compared with non-Pacific (Came et al., 2019; Curtis et al., 2015; Health Quality & Safety Commission, 2021; Walsh & Grey, 2019). Health inequities continue to exist among groups with similar characteristics, including gender, race, and ethnicity (Curtis et al., 2015; Ioane et al., 2021; Kurtz et al., 2018). Governmental, organisational, and local leadership attempts to reduce healthcare inequities must empower the groups experiencing systemic inequities and develop a workforce representative of the population it serves (Curtis et al., 2015; Walsh & Grey, 2019). Pacific people are under-represented in the health and helping professions (Ministry of Health & Le Va., 2012). This current study concurs with Harwood et al.'s (2022) study that highlights the urgent need to prioritise more Pacific allied health professionals in Aotearoa. This dissertation utilises a qualitative approach to understand the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa. This chapter provides the introduction and background to the study, including the aim and research question. Additionally, this chapter presents an overview of the key concepts and the organisation of the report chapters.

Pacific peoples in Aotearoa, formed by a collective of distinct cultures from a range of diverse Pacific Islands, make up 382,000 or 8% of the total population (Stats NZ, 2018). A collective worldview is fundamental to the traditional existence of Pacific people (Ioane et al., 2021; Smith et al., 2021; Taylor et al., 2019). Secondary to a labour crisis in Aotearoa in the 1950s, Pacific people immigrated to work until the recession in the 1970s when Pacific people were subjected to discrimination and racism at the hands of the government and police (Anae et al., 2015; Smith et al., 2021). At the Dawn Raids apology, the government admitted that "inequities that stem from direct and indirect discrimination continue to exist" (Ardern, 2021 "New Zealand's human rights commitments", para. 2) and "lives on in the disruption of trust and faith in authorities" (Ardern, 2021 "Apology statement", para. 2). Colonial structures continue to keep Pacific people out of tertiary education and in low-paid labour leading to further disparities in the healthcare workforce (Waiari et al., 2021). Pacific people in Aotearoa

continue to be challenged by socioeconomic hardship and increasing health needs due to generational hardships, including respiratory illness, mental ill health, and diabetes (Health Quality & Safety Commission, 2021; Ioane et al., 2021).

The Covid-19 pandemic further highlighted areas of inequity in Pacific communities known to have a history of generally poorer health (Ioane et al., 2021; Smith et al., 2021). During the pandemic, the loss of in-person healthcare, support, church, and education significantly impacted vulnerable Pacific communities (Ioane et al., 2021). During the height of the pandemic, Pacific people experienced racism via social media due to an outbreak associated with a Pacific church gathering (Smith et al., 2021). Steyn et al. (2021) found that Pacific people were more likely to require hospitalisation due to Covid-19. Their research supported a targeted vaccination campaign to avoid large-scale inequities from a Pacific community outbreak (Steyn et al., 2021). Pacific health professionals were heavily relied upon to reach Pacific community groups and churches to support the vaccination campaign (Kai Tiaki Editors, 2021).

Institutional bias and racism in all its forms are present across the healthcare system (Steyn et al., 2021). The lack of ethnic diversity in the workforce providing healthcare to vulnerable populations further reveals the effects of biases and institutional, interpersonal, and individual racism (Health Quality & Safety Commission, 2021; Smith et al., 2021; Snyder & Schwartz, 2019; Taylor et al., 2019). In Aotearoa, racism is one of the critical determinants of the long-standing ethnic health inequities that have failed to narrow in the last 20 years (Steyn et al., 2021; Te Whatu Ora., 2022a).

There are consistently low numbers of Pacific allied health professionals in Aotearoa. Based on the current 4118 pharmacists, there would need to be 329 Pacific pharmacists to accurately represent the population of Aotearoa. In 2022 there were only 33, a reduction from 48 in 2021 (Pharmacy Council, 2021, 2022). The reports published by individual professional bodies for the identified allied health professions detail the following percentages of the profession to identify as Pacific. The percentages range between 0.8% Pacific pharmacists, 1% Pacific speech-language therapists, dietitians, physiotherapists, and psychologists, to 2.5% of occupational therapists and 7% of social

work professionals identify as Pacific (Dietitians Board of New Zealand, 2021; New Zealand Speech-language Therapists' Association [NZSTA], 2021; Occupational Therapy Board of New Zealand, 2022; Pharmacy Council, 2022; Physiotherapy Board of New Zealand, 2022; Psychology Workforce Task Group, 2016; Social Workers Registration Board, 2021).

In Aotearoa, Pacific peoples have been identified as a priority group targeted to improve health equity (Te Whatu Ora., 2022b). Ola Manuia is the interim Pacific health plan detailing health priorities for Pacific well-being alongside Te Pae Tata, the interim New Zealand health plan 2022. Ola Manuia documents Pacific workforce development as one of six Pacific health enablers, supporting and developing the Pacific health workforce to ensure Pacific people are represented equitably across health (Te Whatu Ora., 2022a). In 2019, the 20 district health boards' workforce strategy group published a People Force Vision 2025, aiming for our communities to live well, stay well and get well. One of the statements within this vision was for Workforce Diversity, a culturally responsive workforce reflective of the community (Technical Advisory Services [TAS], 2019). According to the 2018 census, 8% of New Zealand's population and 15.5% of Auckland's population identify as Pacific (Stats NZ, 2018). Pacific allied health professionals comprise only 3% of the healthcare workforce nationally (Technical Advisory Services [TAS], 2021). The percentages in this data are made up of Pacific staff from workforces with a specific focus on targeted recruitment, retention and support. The tertiary education providers who purposefully educate and support doctors and nurses have particular strategies for recruitment and pastoral care of undergraduates in a targeted methodology, such as the Māori and Pacific Admission Scheme (MAPAS) at the University of Auckland (Curtis et al., 2015).

The specific focus on data and the reporting of raw numbers from a district level through to the Ministry of Health, as well as the preferential recruitment of Pacific allied health staff, may have a detrimental impact on the staff employed in these roles. This is due to institutional racism by non-Pacific staff that Pacific allied health staff have only been employed to make up the numbers or only getting the job because they identify as Pacific. This negatively held perception is worsened by having so few Pacific staff employed in a large organisation serving a large Pacific population. Tokenistic consultation or representation is often requested of these few staff. Being

asked to represent or speak on behalf of all Pacific is very difficult and emotionally heavy, especially for new and recent graduates (Came et al., 2019).

Most allied health staff providing care to Pacific populations are non-Pacific and need more exposure to understanding their biases. The focus on in-house training options is about 'Enhancing Pacific Engagement', formally known as 'Pacific Cultural Competence in Health Care' or 'Cultural and Linguistic Diversity' programmes (Counties Manukau Health, n.d.; Waitematā District Health Board, 2022). This leads to allied health staff and leadership not always acknowledging the actual value and authenticity of Pacific allied health clinicians, other than perhaps helping with the translation of language or resources or helping to de-escalate a situation when an offence has been caused (Kurtz et al., 2018).

Pacific health staff often have additional kainga (extended family), community and kainga lotu (church) commitments. This experience with additional responsibilities and leadership skills means Pacific people may be perceived as leaders, even if somewhat reluctantly (O'Connor, 2008; O'Connor, 2018). In a Western health system, there is a risk for these individuals, where the overall representation of ethnic diversity within the allied health professions is already incredibly low. Therefore, Pacific allied health may face additional challenges, including being culturally isolated, lacking cultural safety, and overt or covert racism and discrimination (Harwood et al., 2022).

The ongoing need to debate if institutional racism exists within the healthcare system in Aotearoa has recently been resolved. Not only is there agreement that it exists, but it has been identified as the leading cause of health inequities in Aotearoa (Came, O'Sullivan, et al., 2020). Bula Sautu states, "We must address the unacceptable racism of our system, that is a driver of inequitable health care processes and outcomes and is enabled by the structure of the system" (Health Quality & Safety Commission, 2021). Racism can be defined and understood using three levels; institutionalised, personally mediated and internalised racism (Jones, 2000). Institutionalised racism can be perceived as the systemic factors that limit access based on race and demonstrated as the significant differences between races and long-standing socioeconomic disadvantages. No one is directly responsible for this type of racism, but instead, it is

represented in large systems and processes such as health, education and justice (Ahuriri-Driscoll, 2022; Jones, 2000). Personally mediated racism can be defined as the individual biases, assumptions and prejudices held against minority racial groups. A healthcare professional can have racist beliefs or biases, which go largely unnoticed as they often present subtly (Jones, 2000; Snyder & Schwartz, 2019). Internalised racism presents as self-depreciation, individuals not believing they are worthy of being acknowledged for their hard work or considered for a pay rise, for example. Their experience of the systems and the things that society values leads to acceptance of the negative messages (Ahuriri-Driscoll, 2022; Jones, 2000).

Long-standing health inequities and marginalisation in the form of colonisation are experienced by Pacific people living in Aotearoa (Anae et al., 2015; Health & Disability System Review, 2020). The ongoing impacts of marginalisation and colonisation concern and test Pacific allied health professionals working with the Western health system. Systemic racism is documented in the Hauora report (Ministry of Health, 2019) and Bula Sautu (Health Quality & Safety Commission, 2021). There is almost no literature explicitly related to the Pacific allied health workforce concerning racism faced by staff. In the context of health in Aotearoa, institutional or systemic racism is experienced alongside personally mediated racism and tokenistic inclusion of ethnic minority groups within health advisory groups (Came et al., 2019) and ethnic pay disparities are documented in public sector leadership in Aotearoa (Came, Badu, et al., 2020).

Researcher's interest in the study

Interest in this topic originated from my experience working as a physiotherapist for five years and my subsequent years as an allied health educator. While working in my clinical role, I noticed that things were different for Pacific allied health in being the 'other'. I observed challenges with upholding their Pacific value system while working in a Western biomedical health system. When I moved into a professional development role and learned more about health inequities, biases, and racism, I saw a new perspective on these challenges for Pacific allied health.

In 2014, my family and I visited Tonga, we visited the small village and attended a service at the church my Grandma grew up going to. This trip helped me to

understand just how difficult it must have been for Grandma moving from such a tiny little village to Aotearoa, the culture shock and the associated challenges. It is not surprising that when Grandma came to Aotearoa with intentions to study nursing, she did not gain her qualification due to her family commitments. She fulfilled her desire to care for others by working as a healthcare assistant in a rest home. This enabled her to maintain her family responsibilities and role as Grandma to her grandchildren as her children returned to work. Understanding and acknowledging these challenges as part of this trip to Tonga was a key factor in the initiation of this research with Pacific allied health.

Anecdotally, as a physiotherapist with Tongan whakapapa and ten years of experience working in mainstream healthcare provision and professional development, the professional development opportunities around culture and cultural learnings are 'light touch'. The current professional development tends more towards developing cultural awareness only. The cultural and professional development opportunities lean towards an enhanced understanding of another culture and their way of doing things. The intent of the existing professional development is to better understand that cultures have specific traits that may lead to a perceived way of engaging and, therefore, how to provide targeted healthcare. This can act as a further barrier as professional development may result in 'othering' different cultures and individuals while not taking any personal responsibility for our own cultures, values, and biases held (Curtis et al., 2019).

There is limited research that has been conducted in Aotearoa detailing the experiences of Pacific healthcare professionals, let alone Pacific allied health professionals. As a novice researcher, I am passionate about the opportunity for Pacific allied health to have their experiences heard and documented in a safe and informative way that contributes to evidence-based practice.

Aim of the Study and Research Question

Aim of the study

- This study aims to explore the challenges and opportunities for Pacific allied health staff in providing culturally responsive care.

- What are the challenges and opportunities for Pacific allied health staff to enable care in a culturally aligned way?

Key Concepts and Definitions

The following key concepts are utilised throughout this dissertation, *allied health, culturally responsive care* and the *Western healthcare system.* The terms have been defined below as they relate to their application in this small-scale research project.

For the purposes of this study, the term *Allied Health* refers to the healthcare professionals that fall outside of medicine, nursing and midwifery. It is important to note that there are a few ways in which the allied health professions can be regulated, including the national approach under the Health Practitioners Competence Assurance [HPCA] Act 2003 or the Social Workers Registration Legislation Act 2019, or professions may be self-regulated by their own professional body (Ministry of Health, 2021). Allied health in the context of this research is defined as dietitians, occupational therapy, pharmacy, physiotherapy, psychology, social work, and speech-language therapy.

Culturally responsive care requires healthcare professionals to have an open mind and be self-aware of any biases, attitudes, or beliefs they may carry about cultures. It is the capability to deliver safe, respectful, and culturally relevant care. Cultural responsiveness is a skill that is expected in healthcare practice. It is a journey that all healthcare practitioners must continue through personal and professional development throughout their careers (Te et al., 2019).

The *Western healthcare system* focuses on a biomedical approach in relation to disease and healing through scientific models and an evidence-based approach to physical and mental health. In a Western approach to healthcare, the emotional, cultural, and spiritual aspects of an individual's health are not always adequately addressed within healthcare delivery. Within the Western biomedical model, the social determinants of health are often dealt with outside of the mainstream healthcare system. Culture determines how one views illness and, thus, their choice of healing to

seek treatment for disease processes (Pulotu-Endemann & Faleafa, 2017; Tuisano, 2021).

Chapter Overview

The following section outlines an overview of the chapters.

Chapter One: Introduction and Overview

This chapter provides an overview of the rationale for this research and the researcher's personal interest in the study. The aims of the study and the research questions are outlined. Key concepts and definitions related to the research are presented.

Chapter Two: Literature Review

This chapter presents the review of the literature, including the search strategy and themes drawn from the literature review. It presents a critical overview of the literature that informs the challenges and opportunities to provide culturally responsive care in an Aotearoa context.

Chapter Three: Research Design and Method

In Chapter Three, the methodology and rationale underpinning the study are presented. Recruitment and participant selection details are provided. Specific information outlining the measures to address ethical considerations and trustworthiness is identified and discussed. An overview of the data collection and thematic analysis are provided.

Chapter Four: Research Results

Chapter Four presents the key themes generated from the data. Verbatim quotes from Talanoa participants are included to outline and detail the meanings of the research themes.

Chapter Five: Discussion and Conclusion

The final chapter presents a critical discussion of the findings from the research in relation to the literature. The implications for further research are explored, and the limitations of the study are discussed.

Summary

This chapter has introduced the topic of research selected for this dissertation, highlighting the argument for the study, which is the importance of addressing Pacific health and a workforce able to carry out this work in culturally appropriate ways. This workforce includes allied health professionals, the focus of this study. The background information, including the researcher's interests in the topic of research, has been presented. The research question, aims, and definitions of key concepts are provided. Finally, an overview of the chapters has been included. Chapter two explores the literature that positions the research question.

Chapter 2: Literature Review

Introduction

This chapter provides an overview of the literature, including the search strategy and initial themes drawn from the literature review. The literature review aimed to identify what is currently known about Pacific allied health professionals' experiences of providing healthcare in a culturally aligned way. The literature review seeks to determine what is known in this area and identify the gaps within the literature. The key ideas from the literature include the importance of building meaningful relationships and connections with Pacific people. The emphasis on a Pacific collective worldview and the relational nature of Pacific people will be discussed as highlighted in the literature. The significant underrepresentation of Pacific people in allied health and broader health professions is evident in the literature review. The literature review was conducted between March 2022 and January 2023. It was updated throughout the study to include recently published studies and literature available in Aotearoa and internationally.

Search Strategy

The following search strategy was utilised to seek out relevant literature to help understand the specific challenges and opportunities for Pacific allied health staff to provide healthcare in a culturally aligned way. Multiple online database searches of AMED (Allied and Complementary Medicine), CINAHL Complete, MEDLINE, and Google Scholar were conducted individually in the first instance to identify relevant publications using the following terms: (i) "Pacific/Pasifika/Pacifica/Pasefika staff" OR "Samoan Staff", OR "Tongan Staff", OR "Fijian Staff", OR "Cook Islands Maori Staff", OR "Niuean Staff", OR "Tuvaluan Staff", OR "Kiribati staff"; (ii) "Allied Health" OR "Dieti*" OR "Occupational Therap* or OT" OR "Physiotherap*" OR "Social Work*" OR "Speech Language Therap*" OR "Speech Language Pathology*" OR "Pharmacy/Pharmacist/Pharmacists"; (iii) "experience" OR "impact" OR "staff experience" OR "cultural practice" OR "cultural responsiveness" OR "cultural alignment" OR "cultural competence" OR "cultural safety" OR "culturally safe practice or culturally safe care" OR "cultural values" OR "culturally responsive" OR "staff perceptions". The individual searches were then combined (i), (ii), and (iii), and a total of 371 articles were retrieved. The results were further refined by focusing on literature published within the

last ten years in English, and the full text was available. The articles were briefly reviewed according to their titles and abstracts. The search strategy included the searching of reference lists of the articles found, looking for related articles in a grey literature search to seek out unpublished research, theses, dissertations, and strategy documents.

There is scant literature pertaining to Pacific allied health in Aotearoa, or the individual Pacific allied health therapies. The literature identified three primary empirical articles related to Pacific allied health professionals' ability to provide culturally aligned care or culturally responsive care, including psychology services (Fa'alogo-Lilo & Cartwright, 2021), dietitians (Mullane et al., 2022) and a range of healthcare professionals working in a subspecialty of bariatric surgical care (Taylor et al., 2019). Another primary empirical article related to Pacific and Māori psychology student success (Waiari et al., 2021). One additional unpublished dissertation exploring 'Thriving as Pacific and Māori Allied health professionals in the first two years of practice' was also included (Tofi, 2022). Due to the dearth of literature available, the search strategy was widened to include all Pacific health professionals. Two further primary empirical articles were included, one describing Pacific and Māori health leaders' experiences working within health advisory groups (Came et al., 2019). The second article was from the perspective of Pacific Nursing Leadership and focused on strengthening the Pacific nursing workforce in Aotearoa (Smith et al., 2021).

A consistent theme within the scant body of literature highlights that a collective worldview is fundamental to Pacific people's existence. An Aotearoa-based qualitative study utilising Talanoa was undertaken with Pacific mental health service providers and found that Pacific mental health outreach services have not yet impacted Pacific communities. Pacific communities have inequitable access to knowledge of the available services and mistrust these services (Fa'alogo-Lilo & Cartwright, 2021). Building a personal connection and relationship building were identified as both a barrier and support for Pacific people accessing and engaging in mental health services. Non-Pacific providers often struggle to fully comprehend the importance of collective cultural values to provide equitable access and care to Pacific people. This significantly impacts their ability to provide care in a culturally responsive way (Fa'alogo-Lilo & Cartwright, 2021). A collective worldview is highly valued within Pacific cultures and plays a significant role

in the differences observed between how Pacific and non-Pacific interact with the Western healthcare system (Fa'alogo-Lilo & Cartwright, 2021). These researchers highlight that a collective worldview is one of the main reasons why non-Pacific healthcare professionals must provide culturally safe care and emphasise the need to continue to work towards an ethnically representative workforce (Fa'alogo-Lilo & Cartwright, 2021).

Understanding culturally responsive care from the perspective of a Pacific allied health professional is challenging because there is such a dearth of literature focused on understanding the Pacific workforce. In a strengths-based qualitative study, Mullane et al. (2022) hosted focus groups with healthcare workers to understand how they supported diabetic Pacific people to achieve equitable outcomes in Aotearoa. Included in the focus groups were three Pacific dietitians and two Pacific community health workers. Due to the strength-based nature of this study and the inclusion of five Pacific healthcare staff, this study has been included in this literature review. Caution must be taken not to make sweeping generalisations from this small study focused only on understanding the workforce supporting Pacific people with diabetes. Mullane et al. (2022) highlighted the importance of building good relationships with the people they were working with as a crucial requirement across their focus groups in providing equitable care. Mullane et al. (2022) emphasised the need to make ongoing culturally meaningful connections that are continuously built upon while maintaining boundaries. The need to understand the importance of a Pacific collective worldview was discussed. Additionally, the need to engage the family collectively to achieve engagement and, ultimately, better health outcomes was concluded as vital by these researchers (Mullane et al., 2022).

There is a recognised need for more Pacific healthcare professionals in Aotearoa. In a study of 21 healthcare professionals, including eight Pacific staff working in bariatric surgical care, the under-representation of Pacific staff was identified as a barrier to the inclusion and retention of Pacific bariatric patients (Taylor et al., 2019). The researchers discussed that the absence of understanding of the importance of the relational nature of Pacific people and Pacific health beliefs further hinder the inclusion and retention of Pacific patients. Taylor et al. (2019) found that non-Pacific clinicians needed to understand the importance of the collective nature of the wider family involvement in

decisions pertaining to healthcare and well-being. Taylor et al. (2019) concluded that a Pacific-led, culturally informed bariatric service would benefit from further exploration.

The absence of Pacific diversity extends beyond healthcare organisations and into academic institutions training health professionals. Waiari et al. (2021) describe the issues facing Pacific students as similar to those experienced by the Pacific health workforce. These researchers identified elements that act as barriers for Pacific students entering healthcare qualification pathways. For example, the highly valued collectivist approach for Pacific peoples is the opposite of the individualised focus required to achieve academic success (Waiari et al., 2021). Pacific students tend more towards aligning with the individualistic social norms of the university environment rather than engaging with collaborative Pacific support options (Waiari et al., 2021). Academics must work to minimise the hierarchies limiting Pacific student interaction in the classroom, in this case, by creating human connections and sharing personal snippets of information to create an inclusive classroom. Waiari et al. (2021) also discuss the importance of programmes such as the Tuakana-Teina network, a model for buddy systems, an older or more expert tuakana (sibling or cousin) helps and guides a younger or less expert teina (younger sibling or cousin). A culturally-centred Tuakana network in tertiary institutions provides a safe place for Pacific students as ethnic minorities to enrich their Pacific identities (Waiari et al., 2021). To support Pacific student success in health qualifications, cultural identity and a sense of belonging must be fostered, and Pacific knowledge must be integrated into all aspects of academic institutions (Waiari et al., 2021).

The emphasis on literature about Pacific people has rightly so been focused on the patient perspective and achieving health equity for Pacific. Tofi (2022) completed a dissertation that explored the concept of thriving as Pacific allied health professionals in the first two years of practice in a district health board setting. In this study, a strengths-based approach was taken in the positive framing of what enables Pacific allied health to thrive. The researcher conducted three wānanga talanoa sessions with 11 participants. The researcher put forward four overarching enablers of thriving: cultural support, leadership, allyship and valuing the unique skillset of Pacific allied health professionals (Tofi, 2022). The researcher provided further detail of the enablers in the form of recommendations made to allied health leaders and executive leadership at one

district health board. Tofi (2022) recommended establishing and resourcing a cultural supervision programme, a Tuakana-Teina framework. The development of Pacific career development and leadership pathways for Pacific allied health, including accountability through projected targets for Pacific senior allied health leadership positions. The importance of allyship is recognised as an enabler for Pacific allied health. The associated recommendations for allyship included mandatory training programmes, such as cultural safety, Te Tiriti o Waitangi, health equity, anti-racism, decolonisation, and being a good ally training (Tofi, 2022). The final recommendations were the appropriate remuneration and recognition of the cultural intelligence, knowledge and skillset that Pacific allied health professionals offer. This includes access to culturally appropriate professional development and incentivised research opportunities for Pacific allied health to continue to build on the work completed by this researcher (Tofi, 2022).

The lack of literature explicitly relates to the Pacific allied health workforce and the explicit racism faced by staff. In Aotearoa's health context, institutional or systemic racism shows up alongside personally mediated racism and tokenistic inclusion of ethnic minority groups within health advisory groups (Came et al., 2019). Pacific leaders who participated in the research by Heather Came and her colleagues in 2019 shared their experiences of being involved in health advisory boards and steering groups. The senior leaders' participation in these various forums was designed to ensure a Pacific perspective was presented and actively considered to improve outcomes for priority populations (Came et al., 2019). Even though these leaders were invited to attend and participate, they all encountered negative experiences. Came et al. (2019) detailed these leaders' negative experiences, including suspicions of tokenism and witnessing and experiencing racism. Senior leaders' battled to have their cultural intelligence recognised in an environment that prioritised Western knowledge and science (Came et al., 2019). Despite these negative experiences and the racism faced in an ongoing nature, the leaders were all determined to remain engaged in these groups for the greater good of equitable healthcare and health outcomes (Came et al., 2019). The level of commitment to continue to be involved speaks to the heavy sense of cultural responsibility and load Pacific health professionals feel.

Covid-19 impacted Pacific people and communities more severely due to the pre-existing structural inequities and systemic racism. During a scholarly Talanoa

between one academic and two Pacific nursing leaders, the imperative for strengthening the Pacific nursing workforce in Aotearoa was discussed (Smith et al., 2021). The scholarly Talanoa took place following the Delta outbreak in August 2021 that affected Pacific communities disproportionately and informed critical recommendations concerning the Pacific nursing workforce that apply to the broader Pacific health workforce. The first recommendation included the need for career development pathways, career progression for Pacific with professional and cultural development opportunities, mentoring and access to cultural allies as colleagues and leaders acting as champions for Pacific nurses. The second recommendation was the need for Pacific approaches to be acknowledged and embedded in undergraduate and postgraduate pathways to promote health equity. Smith et al. (2021) conclude that Pacific health workers are essential in achieving health equity for Pacific populations because Pacific engagement is so culturally nuanced and must respect Pacific worldviews.

Summary

This chapter has presented a review of the scant literature and summarised the available literature. The importance of building meaningful relationships and cultural connections with Pacific people is evident in the literature. There is a need to address the significant underrepresentation of Pacific people in allied health. The uniquely Pacific collective worldview and the relational nature of Pacific people are vital to understanding to engage effectively with Pacific. The literature offers suggestions, including the development and implementation of culturally appropriate mentoring and networking utilising the concept of a Tuakana-Teina framework. There is a need to demonstrate the value of Pacific knowledge in the training institutes and professional development opportunities and remunerate Pacific staff accordingly. Anti-racism and cultural allyship training would benefit non-Pacific allied health staff to shift the burden from Pacific allied health staff meaningfully. There remains a significant gap in the literature around understanding the specific challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa.

Chapter 3: Research Design and Method

Introduction

This research aimed to understand the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa. By employing qualitative research methodologies, I seek to understand perspectives and capture individual participants' voices in an authentic way that can be safely shared. This study utilises a combination of Talanoa methodology along with thematic analysis. This chapter will outline the Talanoa methodology underpinning this research and discuss the justification for selecting this research method. It will describe the participant selection and recruitment process and a brief overview of the data collection method and thematic analysis. This chapter also describes the measures taken to ensure ethical considerations were managed and trustworthiness ensured.

Methodology

This research utilised in-depth Talanoa, a traditional Pacific Island storytelling process, to undertake the research using semi-structured interviews to guide the conversation (Tupou, 2018). Talanoa can be referred to as an informal or formal conversation, an exchange of ideas or thoughts. Talanoa is best face-to-face. A literal translation means to have a conversation and interact without a rigid framework guiding the discussion. "Tala means to inform, tell, relate and command, as well as to ask or apply. Noa means of any kind, ordinary, nothing in particular" (Vaioleti, 2006, p.23). Talanoa allows for rich discussion and engagement without a rigid structure (Vaioleti, 2006). A Talanoa approach was used to add value in enabling the research to be undertaken with and alongside Pacific allied health colleagues (Vaioleti, 2006). Research in the context of Pacific health should aim to build and reinforce the existing Pacific knowledge base, be responsible to and give back to the community (Health Research Council of New Zealand, 2014; Vaioleti, 2006).

In order to hear Pacific stories, Pacific research and researchers must demonstrate respect and understanding of Pacific ways of knowing, generating knowledge, and their diverse worldviews (Sanga & Reynolds, 2017). There is a risk that research that restricts indigenous expression and that does not acknowledge Pacific

people may result in silencing ways of knowing and experiencing, therefore, devaluing the Pacific knowledge base (Farrelly & Nabobo-Baba, 2014).

Although qualitative research approaches often 'trouble' the insider position, it is appropriate for research with Pacific people. Talanoa acknowledges the importance of the relationship between the researcher and participant and the benefits of the researcher being an insider to the research. The concept of relational vā (space) is essential as it culturally connects and separates those involved in research through Pacific spirituality and hierarchies such as gender, age and social status (Vaioleti, 2006). The strength of the relationship and my ability to convey empathy is crucial in maintaining the relational vā (space) and minimising the distance between the participant and I (Fa'avae et al., 2016; Farrelly & Nabobo-Baba, 2014; Vaioleti, 2006).

The importance of the relationship between the researcher and the participants flows into the data collation and analysis (Vaka et al., 2016). The researcher is reliant on the essential first steps within Talanoa of mihimihi (introductions) and fakafehokotaki (engagement). Pacific people do this by sharing Pacific-specific information, such as their parents, grandparents and kainga (extended family), making meaningful connections and strengthening the relationship (Lacey et al., 2011; Vaka et al., 2016).

For this study, a blend of in-person Talanoa and e-talanoa was used. The ability to e-talanoa and establish vā in an online forum, such as Zoom, in recent years has been considered by Pacific researchers (Faʻavae et al., 2022; Faleolo, 2021). The context of a global pandemic and the need for physical isolation has required a different approach. It remains essential to continue Pacific research approaches to Pacific people's experiences of the pandemic. However, e-talanoa is complex and should not be solely relied upon as a Pacific research method, instead utilised alongside Talanoa to strengthen findings (Faʻavae et al., 2022; Faleolo, 2021).

Gathering good data is relational, as my ability to collect and analyse stories for commonalities and themes to produce new knowledge relies on the quality of the relationship built and, therefore, the data shared (Vaka et al., 2016). The thematic analysis complements Talanoa by allowing the participants' information-rich experiences shared with the researcher to be collectively analysed and enhancing the depth of their collective meaning (Tupou, 2018; Vaka et al., 2016; Vaka, 2014). This

meaning can be shared safely and collectively to address and ultimately answer the research question; what are the challenges and opportunities for Pacific allied health staff to provide care in a culturally aligned way?

Ethical considerations

Ethical approval was sought before undertaking this research from the Auckland University of Technology Ethics Committee (AUTEC) and approved on 17th June 2022, AUTEC Reference number 22/128 (see appendix A). Consultation took place with Auckland University of Technology (AUT) academic supervisors, one of whom is a health and academic leader within the Tongan community. Consultation included a culturally informed expert in my workplace. The AUT Code of Conduct for Research guided the process of addressing actual and potential ethical issues (AUTEC, 2019). As a physiotherapist with Tongan whakapapa, I was an insider to this research, and my positionality as the researcher plays an important factor in undertaking this research (Shaw et al., 2020). Power is one of the profound ethical considerations; Talanoa was utilised to empower the allied health staff involved (Vaka et al., 2016). I empowered the participants by actively and purposefully redistributing the power away from me. Ethically, I was cautious of participants feeling obliged to participate. To avoid this ethical issue, participants were recruited through my professional networks.

Sensitive issues

It was possible that this research would bring up some distress for the participants. Participants were reminded of the Employee Assistance Programme (EAP) and their ability to access this if the Talanoa caused distress. None of the participants expressed significant distress. However, if they had reported distress or shown any signs, I would have paused the Talanoa, asked about their readiness to continue, and stopped if the participant expressed the need to (Oliver, 2010). Given my experience level, I am used to hearing stories of frustration and upset while supporting colleagues. Although my role is different, these skills are transferable. I did not anticipate any personal distress, given my years of clinical practice and experience. However, the option to debrief with my academic supervisors and free access to counselling through AUT student counselling was available, although they were not needed in this study.

Participant Selection and Recruitment

Recruitment took place over several weeks and commenced immediately after the approval of research ethics. Participants were recruited through my professional networks, including advertising through Pasifika Allied Health Aotearoa New Zealand (PAHANZ) (see appendix B). This approach to recruitment was not deemed coercive and was approved. This allowed the participants to willingly express their interest in participating in this research process (Bullock, 2016). Interested individuals were invited to contact me directly.

I anticipated the inclusion of a range of clinicians from new graduates to senior experienced clinicians with a variety of clinical backgrounds. I aimed to explore their perceptions of what impacts their abilities to provide culturally aligned care. Including clinicians from a range of clinical settings, including community, outpatient, or hospital-based clinicians from physical and mental health environments, would provide rich data. Participants were purposively sampled from a range of allied health professions. This was important as this allowed for information-rich examples and insights into these professions and issues within allied health and avoided generalisation that may occur from random sampling (Braun & Clarke, 2022; Liamputtong, 2020). Information power was utilised to determine the recruitment and Talanoa with five Pacific allied health staff. This is a concept used by qualitative researchers to help determine the appropriate sample size. Information power considers the aim of the study, sample specificity, established theory, quality of dialogue, and analysis strategy (Alvesson & Sköldberg, 2018; Malterud et al., 2016). Data collected utilising a Talanoa method provided rich data and therefore lowered the number of overall participants needed. The five study participants worked as allied healthcare professionals for at least four years and up to a maximum of 20 years.

Pacific allied health participants were invited to participate in Talanoa at a suitable time and location. The option to participate outside the workplace and via video conference call was provided, although preference was given to in-person Talanoa. It was not always possible due to competing professional and personal priorities. Refreshments were provided for the Talanoa that took place in person, further demonstrating Pacific values.

Informed Consent

Participants were provided with an information sheet via email. This document outlined the purpose of the research and its expected outcomes (see Appendix C). An informed consent form (see Appendix D and E) was also sent. The opportunity for participants to ask questions was provided immediately before confirming their participation in the study and signing the informed consent form. Participants were provided with my contact details, the contact details of my academic supervisors, and the AUT student counselling contact details. Free sessions of confidential counselling support were available to participants if required.

To maintain voluntary participation and inclusion in this research process, several key steps were taken to ensure that participants understood that they were not obliged to be involved. Participants were reassured that their participation or non-participation would neither advantage nor disadvantage them. Participants were able to withdraw from the study. If they decided to withdraw from the study, they were offered the choice between having their data removed or allowing their data to continue to be used. However, they were advised that removing their data would not be possible once the findings were produced. Participants were informed that study findings would be disseminated in relevant healthcare publications and forums.

Confidentiality and anonymity

Confidentiality was strictly upheld to demonstrate respect to the participants who volunteered their time and energy to be involved. Due to the small numbers and percentages of Pacific allied health staff, and the nature of the topics being discussed, it was crucial to include multiple allied health professionals from a range of organisations to protect and honour the privacy and confidentiality of the research participants (Braun & Clarke, 2022). Many staff are actively involved in representing and supporting other forums on behalf of allied health staff, patients, and kainga (extended family), therefore, I was mindful of not adding to these clinicians' workload to understand their worldviews better. Participants were interviewed individually and no information regarding other participants was shared. All identifiable information was removed from the recorded participant data. The participants were identified by numbers one to five to transcribe and write the report. Voice recordings were immediately downloaded, and transcribed,

and audio was deleted following the interviews. All information was stored in accordance with AUTEC's data management plan. The gender, role and specific Pacific identities are not reported in order to maintain confidentiality given the small number of participants in this research.

Data collection

Data was collected through five semi-structured interviews utilising a Talanoa method and provided information-rich, specific, and relevant data to the research question being answered (Rabionet, 2011). Each Talanoa was between 60 to 80 minutes long, conducted in the privacy of a meeting room or a private office and audio recorded for transcribing the Talanoa by me. Brief handwritten notes were recorded during the Talanoa, however, the primary data collection method was the audio recording and subsequent transcription. Each Talanoa started with a lotu (prayer) to set the scene for the participant and I, followed by the utilisation of the hui (meeting) process, including an initial greeting and fakafehokotaki (engagement) to allow for initial connection (Lacey et al., 2011; Rabionet, 2011). The reciprocal nature of Talanoa encouraged the development of solid and trustworthy relationships, adding significant value and quality to the research as I feel a strong sense of responsibility to the research participant with whom I have formed a strong connection (Vaioleti, 2006).

I led the Talanoa by guiding participants through a series of questions utilising the topic guide Talanoa schedule (see Appendix F), with a relaxed and informal approach, allowing the individual participants to direct the flow (Rabionet, 2011). This relational approach meant each Talanoa was unique to the individual, a relaxed process overall, and led by the participant's own experience as much as possible (Vaioleti, 2006). The opening questions for each Talanoa were as follows "From the time you began your allied health career, did you notice anything different about being a Pacific allied health staff member? Did anything stand out for you? Can you give examples of what stood out for you and the difference between yourself and non-Pacific allied health staff?"

The research must represent stories by Pacific peoples for Pacific people (Vaka et al., 2016). Use of Talanoa to undertake this research with Pacific allied health staff aligned and allowed an excellent method of incorporating Pacific values and protocols to build rapport and help to mitigate power imbalances (Smith, 2012; Vaioleti, 2006). A

semi-structured interview approach using open-ended questions allowed participants to guide the discussion and share the stories perceived as the highest priority to them (Vaka et al., 2016).

Data analysis

Thematic analysis was conducted to identify and analyse the findings and organise the data into a series of codes and critical themes (Byrne, 2021). This approach allowed me to start with the raw data and follow a step-by-step approach to seek out significant similarities and themes that may be able to be drawn from the rich data set collected (Braun & Clarke, 2022). The process is divided into a six-phase process for thematic analysis. The initial phase is becoming familiar with the data by re-listening to the audio-recorded Talanoa and transcribing the data. Each consequent review made the audio recordings and transcriptions deeply familiar. As I reviewed the data, I made notes about significant or interesting things but avoided drawing early conclusions. Instead, I highlighted or noted particular sections and continued through the data. As the primary researcher, I generated initial codes, with several codes identified and created during this step. Two research supervisors triangulated the coding with the final codes being agreed upon, this again, avoided drawing early conclusions from the coding alone. Themes were generated based on the initial codes, extracts, and discussions between two research supervisors and myself. Potential themes were reviewed and were initially titled "cultural values", "effective communication", and "time". The next step was to refine these initial themes alongside the research question and aims, with the purpose being to define and organise the resulting themes and sub-themes informing the report that follows (Braun & Clarke, 2022; Byrne, 2021).

Research rigour and quality

To demonstrate rigour, I employed strategies such as thick description, audit, and reflexivity (Liamputtong, 2020). In rigorous qualitative research, consistency must be demonstrated between the topic, aim, methodology, methods, and analysis (Nayar & Stanley, 2014). The practice of reflexivity is important to ensure there was no risk of imposing my personal beliefs upon the participants or findings. I maintained a research journal to document my values, thought processes, emotional responses, and beliefs regarding the research process. Supervision sessions, and the perspectives of my Tongan

supervisor, supported reflexivity. Transcripts were shared with supervisors to independently code and develop themes prior to being discussed to add rigour. The practice of reflexivity aims to minimise and reduce the findings being markedly shaped by individual bias and beliefs (Liamputtong, 2020).

Summary

This chapter has outlined the design and method used in this research and the rationale for a Talanoa approach to conducting the participant interviews. The participant selection, recruitment process, data collection method and thematic analysis have been described. The chapter highlights the measures taken to ensure ethical considerations were managed. Issues about rigour, including trustworthiness, are also presented in this chapter. The following chapter explores the study's findings.

Chapter 4: Research Results

Introduction

This chapter presents findings from a qualitative study exploring the challenges and opportunities for Pacific allied health staff to deliver culturally responsive care in Aotearoa. The four main themes and 13 sub-themes identified through thematic analysis from transcribed qualitative data are outlined and supported by intelligent verbatim quotes from Talanoa participants. Theme one, Cultural Capability and Capacity, has three subthemes: isolation and hierarchy, absence of support and cultural attunement, and developing confidence and experience. Theme two, Pacific Values and Responsibilities, has three subthemes: values and commitments, leadership and identity, and surviving versus thriving. Theme three, "I struggle navigating white spaces", has three subthemes: health equity, cultural safety and nuances, and cultural support and supervision. Theme four, Emotional and Cultural Intelligence, has four subthemes: fakafehokotaki (engagement), tensions with time, a'u tonu (face-to-face) and health literacy.

Cultural Capability and Capacity

Practising as a Pacific allied health clinician in a predominantly Western healthcare system presented challenges for participants. Participants' examples highlighted the cultural competence and capability they brought to their roles. However, these clinicians often worked in isolation due to low numbers within the Pacific workforce and minimal cultural allyship.

Isolation and Hierarchy

Participants shared their perspectives on what it is like to study and work in these areas of isolation. The following participant highlighted their early awareness of how culturally isolated they were in their education programme:

There was like six people who were either of Māori or Pasifika descent. My whole year is like over 100, and only six of us looked like me. We had similar experiences. (Participant Five)

Another participant also commented on their awareness that standing out as a distinct minority was likely to be ongoing:

Noticing the lack of diversity in a [clinical] school cohort, knowing that, that's probably going to be what it's like when you go into the real workforce. (Participant Four)

The above quotes highlight the feeling of isolation and hint at the sense of being 'other' and the impact of the lack of diversity on allied health professionals.

Job interviews and the professional opportunities available highlighted the value of being a Pacific allied health clinician. Participants indicated advantages in being part of a now desirable minority however, there were also drawbacks. One participant described the shift from being an outsider to a commodity:

As soon as I qualified, everybody wanted a piece of me…. they all said to me… varying degrees of this same phrase, and in terms of "You would be a valuable asset to us". (Participant Five)

Another participant spoke of being aware of their unique status as being the only one in their professional group:

"We need you in this space".… I find that they're reaching out to me to do these workshops because I became that one person who's Pacific and [an allied health practitioner]. (Participant Three)

The following example illustrated the tension participants experienced because although they were appointed to significant roles, they were typically isolated within the position. Anything deemed culturally related was seen as solely their responsibility:

I was the Pacific Lens, across the projects, it's really difficult when everybody's already established and in relationships, and I'm a newbie. And my only supports are in [city A], and I'm in [city B]…. the CEO at the time, got no cultural lens… my understanding you go to your leadership, you ask… when I went to her, she goes, "well that's your role! Sort it out!" (Participant One)

Participants perceived their leaders commonly had only a superficial appreciation of the nuances of the cultural components of the work:

> *There's a lot of work that needs to be done, in terms of management, in Pacific…. I think we've relied more on [Pacific] colleagues rather than management…. our manager at the time, a nurse… didn't know protocols for [allied health profession]…. in other words, not much support. (Participant Two)*

The participant experiences illustrate the isolation faced by Pacific practitioners working within a Western healthcare system, where being employed and holding their position is deemed as enough by these organisations.

Absence of Support and Cultural Attunement

Throughout the data set, participants provided examples of drawing from a cultural value of service that enabled them to engage graciously with colleagues despite the tensions around limited support. The following participant highlighted the perceived lack of structured support provided to Pacific allied health:

> *Hell No! I've had no support whatsoever apart from, I suppose, collegial support…. Nothing. I didn't even know that they existed [Pacific Health]… until I was like, "Where are all these Brown people from?"… because it was like the language weeks (Participant Five).*

A participant spoke of the early additional career responsibilities they had from the second year of their degree to act as a mentor for other Pacific students, which this participant saw as both worthwhile but an additional burden:

> *We were often pulled in, I think, as you became, like, a year three, year two, you would be pulled in to tutor the ones below. So yeah, which was fine and great. But, you know, in terms of longevity, and like, keeping that kind of thing going. In order to have that work, you need to have more coming through to then be able to sustain that kind of stuff. Otherwise, if you're only having one come through every year, then that one person is expected to teach the other student below. It's not really gonna last long. And then it's a big ask for those students to take on that responsibility as well to teach the younger ones. (Participant Four)*

The same participant also indicated their moral responsibility to ensure more Pacific people were represented in their profession. This was echoed by another participant and the sense of responsibility:

> I'm trying to do my bit. I'm trying to raise awareness. I'm trying to encourage students to come and study [allied health]…. But at the same time… when did this become my responsibility? (Participant Three)

One participant highlighted the daunting responsibility to be seen as the cultural expert:

> That's amazing that I'm given this opportunity, but at the same time, I have to be, I have to meet the standard… my knowledge of Pacific knowledge has to be up to par to ensure that when I go back and educate these upcoming people that they know… a lot of the things that they don't know about Pacific, so I had to go in on my own self-journey, and my own… academic journey to ensure that I'm actually a relevant person that can go back and teach. (Participant Three)

Pacific allied health professionals, and Pacific people have variable experiences in the healthcare system. As the researcher, I was struck by the participants' demeanour of humility, graciousness and cultural attunement throughout the interviews. Pacific healthcare professionals actively live the Pacific values of care and support despite the perceptions shared about the need for improvement.

Developing Confidence and Experience

Participants reflected on their ability to speak up as they gained experience as a Pacific allied health professional. One participant, over time, developed the confidence to move between world views and callout processes that are not achieving equitable outcomes or demonstrating cultural safety:

> I suppose I've set a little bit of a reputation… because I am both Māori and Pacific. People just expect me to… they've accepted me for who I am. Not only do I come with the qualifications… in the mainstream, to be accepted, you need to come with your piece of paper [qualification]. And I've managed to come with my pieces, pieces of paper [qualifications]. So, I can sit in that world, and I can sit comfortably. But I come with the innate knowledge of the other two worlds [Māori and Pacific] … that's the new currency. They need to know my currency,

and they're looking at me for guidance. But the really cool thing is, and this is part of being culturally safe, I know it is not my job to educate them. (Participant Five)

Another participant expressed the confidence to advocate for their patients, including the need to have difficult conversations with their colleagues:

I've come to realise that we are, you know, we're in a place to be the voices for patients and be able to speak up for them when, you know, a clinician is saying something, but you can see that actually, that person does not understand or does not grasp that and being able to say, actually, why don't we step back and look at this a bit better and be able to approach things better. So, it's about us calling out other colleagues as well. (Participant Four)

Their upbringing in the Pacific church gave one participant the confidence to speak up about types of leadership and opportunities to demonstrate leadership by Māori and Pacific colleagues:

The next question they said was, "In what ways have you showed leadership in your workplace?" And then I said, leadership in my workplace? And I said, to be honest, I didn't learn leadership from my workplace. If anything, I learned leadership at home…. I had learned quite from an early age, you know, what it means to be a leader in the church…. I had to become a good leader… if I'm being honest, the Māori and Pacific Island values, the way we see leadership is not in the workplace. The workplace is the last place you probably see leadership. (Participant Two)

There are very few Māori and Pacific in healthcare leadership roles. One participant reflected on their broader leadership experience and the many opportunities to demonstrate leadership, including within kainga and kainga lotu. The confidence to have these conversations and to challenge practice has only strengthened with experience, as outlined in the participant quotes above.

Pacific Values and Responsibilities

Values, responsibilities, and commitments that relate to family, church, and cultural traditions were all reflected by participants in varied ways. The participants' perceptions were that the organisations these clinicians work for benefit from these values daily.

Values and Commitments

Values and commitments play a considerable role in how participants interact with their peers and navigate the systems they work in. The following participant considered that the early and multiple responsibilities in their life prepared them for their workplace responsibilities:

> *They [non-Pacific peers] all had support systems that looked a lot different to mine. Whereas they all had support systems, I was the support system…. the responsibilities only grown over time in terms of my family's dependency on me. If they hadn't instilled, if I didn't have the upbringing I had, then I wouldn't have been able to set up the base that they now rely on…. But all of my experience, my upbringing, my values, everything, all of it allows me to do what I'm doing now [at work]. (Participant Five)*

Another participant reflected on the family hierarchy and how this impacted their professional and personal roles and responsibilities:

> *Because working with young people and working with, you know, our tamaiti [child] is… my area of expertise. And that's just from growing up… in South Side, you know, having a lot of family members…. I am the third. I am in the middle. But at the same time… I became one of the older ones… I pick and choose… so when there are responsibilities, then I'm the middle child. But when they get to be the first person, I'm like… I'm the older one here. So, it's the [allied health practitioner] in me. I can pick and choose. Depends how my mood is. (Participant Three)*

One participant outlined their experiences and expertise in what it means to be Pacific and how they learned these attributes:

As we grew older, we knew how to speak [Pacific language] more because we were immersed in church… I went to school in [the Pacific] for a year. So that sort of helped me with learning cultural norms. And the language especially… we're so involved in… events and processes… your obligations and your role… we actually live it [Pacific values]. (Participant Two)

This participant experience references the nuances between Pacific Islanders who were born and raised in the Islands versus New Zealand-born Pacific peoples:

You have a moral duty… your family, your responsibilities within your family… you can't run away from it…. I've found a lot in regards to… the dynamics between New Zealand-born, cause I'm New Zealand-born [ethnicity] and learning the history and why some of the things that we do now, it's not about today it was past years. And the relationship just honouring the sacrifices that were made at that time. And, it wasn't about who can give the most. It was about being present. (Participant One)

Participant Two acknowledged that when working in a team of Pacific peers versus non-Pacific, there is a difference in the values that are upheld:

I think it's easier in a Pacific team [to hold on to your Pacific values], a bit harder in mainstream… because… you're the minority. (Participant Two)

This participant also highlights some of the tensions associated with Pacific values, identities, and the challenge of being perceived as an outsider:

You actually live it [Pacific values] every day! I think that helped. But what didn't help was that… it's the identity issues between… when you go to [Pacific Island], you're classed as European… and then when you're here, you're classed as [Pacific Islander], so it's finding the balance. Yeah, I always call myself New Zealand [Pacific Islander] because that's what I identify as. (Participant Two)

Despite the participant being very clear about their identity, cultural norms mean that there are many nuances when it comes to the perception of identity.

Leadership and Identity

Pacific values, such as loyalty, leadership, and identity, are instilled in very young. One participant discussed the value of leadership and the importance placed on being a leader as a Pacific allied health professional:

If you're Pacific, ah, it doesn't matter what role you hold. You lead… you're in leadership now. So, I don't really care if you're an undergrad or you just started yesterday. You can now identify yourself as a leader…. Especially those that kind of don't look Pacific… because I have a thing where it doesn't matter if you have a little bit of blood, a lot of blood… you're Pacific, you're Pacific. (Participant One)

Participant Four reflected on the difficulties associated with their Pacific identity, only being 'half' [half Pacific Islander and half Pākehā], especially when working in areas of isolation:

I was born Pacific… I'd start with that… I'm on my own journey… I talk about it a lot with the students that I… mentor, or the Pacific… clinicians that come through is, you know, I am only half [ethnicity]… I'm [ethnicity] because I was born that way… I'm born with that blood… Just because I am half [ethnicity] doesn't make me lesser. And I think often, you can feel that way. (Participant Four)

Participant Two reflected on balancing the tensions between cultural values and providing respectful leadership and management to their elders:

Getting along with our traditional-born [ethnicity] clinicians. It's interesting as well because… if you have a leadership role, and then you have an older, older generation under you, you still need to show respect as part of culture… trying to merge that in with the professional world. (Participant Two)

The weight of the cultural expectations placed on this participant conflicted with their identity as Pacific against their professional identity:

Okay, to be a really good [allied health professional], I know, I have to do this. But at the same time, that wouldn't make me a good Pacific Island person because that's against the values or how I was raised. (Participant Three)

The participant demonstrated real tension between moral obligations and the differences in values between personal and professional identities.

Surviving versus Thriving

Pacific allied health clinicians reflected on the differences between thriving versus surviving in their workplaces and the places where they felt comfortable and supported to question social norms or not. One participant highlighted the ethical dilemmas that Pacific allied health clinicians are faced with when it comes to their values:

> *Surviving isn't the goal. I think thriving is the goal. You know, we want to thrive. Pacific clinicians, we want to thrive in the workplace that we're in, and we want to do the best that we can. But I think I've probably just been surviving and adapting those values. (Participant Four)*

This participant discussed their Pacific scope to thrive as an allied health professional and to see their patients thrive by providing an equitable approach:

> *I'll see how I can utilise my network to… point you [the patient] in the right direction or bring these people in to help all these other things that are not within my [allied health professional] scope, but they're within my Pacific scope… it's my job as a Pacific… indigenous person to help. (Participant Five)*

The ability to practice culturally responsive healthcare to see Pacific populations thrive was expressed through the following quote:

> *Understanding that from a Pacific clinician… we're actually in a really great space to be able to share knowledge from… both perspectives, being a clinician and being Pacific. And so I think, stepping up and being able to speak out when… people aren't being culturally safe when you see something happen that… doesn't look appropriate or doesn't fit with… a Pacific worldview. (Participant Four)*

Across the dataset, participants highlighted that they thrived in workplaces where they could advocate for and see Pacific populations thrive.

"I struggle navigating white spaces"

Participant Three's comment is used to name this theme, "I struggle navigating white spaces". This theme includes the subthemes that highlight topics including health equity, cultural safety and nuances and addressing the professional and cultural boundaries that Pacific allied health professionals find themselves constrained by.

Health Equity

Equitable health outcomes are the marker for a system that is performing well. Despite many initiatives over the last decade, there continue to be significant differences in life expectancy between ethnic groups. One participant shared their experiences and purposively targeted approaches to working with Pacific patients:

> *I adapted my approach to make sure that if the patient standing in front of me was Pacific or Māori, my approach was way more tailored to trying to achieve some kind of equity for that person and the time that they shared with me. (Participant Five)*

Participant Four highlighted the tensions to providing equitable healthcare and the importance of accurately adjusting for a genuine approach:

> *I do [treat Pacific patients differently]. I know people think you're favouring, but actually, no. You're tailoring your treatment and your approach to reduce inequities, which is so important… I would… approach it in a different way just because… if you have more of an understanding… of a culture and a way… things should be done. And you utilise those skills… to benefit the patient…. They're happy to just get anything. But actually, they need a lot more, and they don't know what's there. So, I think tailoring the way that I would approach something, particularly with Pacific. It's important. (Participant Four)*

Participant Three echoed the systemic concerns below and their motivation to pursue an allied health career:

> *That's kind of pushed me… our… system doesn't really provide equal outcomes, in all honesty. And so that's kind of sparked my pathway into [allied health]. (Participant Three)*

Participant Three reflected on being isolated in their workplace and the obligation felt to stay due to the lack of diversity and cultural competence:

I struggle navigating white spaces… because I'm the only Pacific Islander… I have a hard time navigating my way around, you know, the brown person in the white space, but there are no workshops on that. There's no workshop. It's always the other way around…. It was definitely just a kind of white space. I've had to learn how to navigate that space… I'm in the office of 156 people, but I'm the only [ethnicity] in this office. And I've been the only [ethnicity] for, like, the last few years…. I knew that there needed to be somebody in that space. (Participant Three)

The following participant comment emphasises the pressures experienced by Pacific allied health clinicians to not only have all the information but the expectation to educate others too:

I draw a line. I'm happy to help, and I'm happy to say, hey, look here, look here, but it's actually not my job to educate you on my culture. It's your job as a health professional… allied health, to go and find that information and understand what it means for your practice. (Participant Five)

One participant detailed the importance of understanding the cultural and historical contexts that create potential barriers to engagement:

You might build rapport, but you might take maybe one emotion from that they are still feeling angry, they're still feeling unsafe. Because you know, it takes more than one visit to go through all these emotions. So that's the way I kind of do it, but because for your exact reason, when they teach cultural competence, they don't unpack…. I still have to work through that list of emotions, just like you [non-Pacific allied health] have to work through the emotions. I still have to build rapport with my families, just like you have to rapport build with families. (Participant Three)

Participant One described the positive impact of a new role for Pacific people in primary care. However, the development of Pacific capabilities is required:

The health improvement practitioner role is really positive in regards to… if Pacific have not so good access to secondary services, they do access primary care services. The problem is we don't have the skill level to have that Talanoa with them… (Participant One)

Participant Four reflected on health inequities and the utilisation of this knowledge to connect and ensure meaningful engagement:

It helps me to build rapport, you know, with Pacific communities and not just [ethnicity] but, you know, other Pacific patients that come through, I think, I understand the inequities, you know, that they have faced. (Participant Four)

Pacific clinicians not only understand and experience the disparities, but they are also well-equipped to address them.

Cultural Safety and Nuances

Cultural safety and the nuances between Pacific cultures must be considered to avoid making generalisations and incorrect assumptions. Participants discussed the concepts of safety in numbers, being the 'exotic other', and the associated struggles. Participant Four reflected on their sense of responsibility to ensure cultural safety by speaking up at either an individual or a higher level as needed:

It's about having a safe place, having lots of us there, and then being able to have a safe and supported network to feel confident to pull up those things. Because you know, if I could say something, but if I don't have anyone else to back up what I'm saying, then you know people are going to say, "You're just one Pacific person saying something". But if there are lots of Pacific people saying something saying… pulling things up, you have a little bit more sway…. And that's part of being culturally safe as well as a Pacific clinician… I take that responsibility as well on myself. (Participant Four)

One participant highlighted that staff retention appeared strongly linked to having a Pacific network in the workplace:

There are not that much Pacific… [allied health professionals] out there. So, when the time came around to get taught about, you know, Pacific models, and Pacific

wellbeing models, they struggled to find people to come and teach us…. I think that that's what maybe drives people out of the workforce a lot, too. So… I can understand those five people who were registered but are no longer practising. Because they had to be the one person in the spaces like this for a long time. (Participant Three)

Participant Two shared their idea that non-Pacific allied health professionals could consider or adopt to provide care in a way that fosters cultural safety:

Building more networks in the community… I just see a lack of that… Because I know that they're [non-Pacific allied health]… so concerned with hospital and acute services. But I think what's lacking is that community… they need to build more community networks in order to build that foundation for our referral, so when we refer all, we refer to community organisations that can actually work with them [Pacific patients] long-term… I think that's lacking, specifically with allied health. (Participant Two)

Participant Five reflected on a collective approach being crucial to priority setting:

Whānau voice isn't just about one whānau or individual members of whānau. It's the collective whānau voice that determines… health priorities, that represent the needs and aspirations of people within… that community, regardless of whether they're Pacific, Māori, Pacific, you know, Tongan, Samoan. Wherever. (Participant Five)

Participants identified that isolation occurred despite the presence of other Pacific colleagues, given the diversity between these cultural groups:

There are actually many different kinds of nuances between the Pacific Islands, you know, some people have this assumption that… the Pacific Islands are all the same, but actually, you know, Tongan, Samoan, Fijian, they all have some slight differences…. because culture is so varied. There are different ages, there are different religions, and there are so many different types of cultures within a culture as well that you also have to be aware of (Participant Four)

Participant One reinforced this and expressed the importance of demonstrating empathy irrespectively:

> *I'm Pacific, but I've got to cover Tongan and Niuean… but I'm [ethnicity]…. people don't care what you say, what you know, they just want to know that you care. (Participant One)*

Pacific cultures share commonalities, such as a collective worldview. However, it is crucial to note each culture's subtle but significant differences.

Cultural Support and Supervision

The dataset highlighted the importance of appropriate cultural supervision. Participant Four identified that when cross-cultural supervision was provided, they left much unsaid as there was the perception that the absence of a shared understanding was too problematic to try to bridge:

> *A professional supervisor wants to listen, but they don't know… what to say because they're not from that culture, or they don't really understand it, and they don't know how to approach that. And so I kept a lot of those situations… things that would happen to me on the ward or whatever, I kept those quiet. And I wouldn't share that with anyone. So if I had had someone around or a place to be able to share that from a cultural perspective… I think that would have helped a lot. (Participant Four)*

Another participant described the tensions between their Pacific values and the expectations of their professions, their colleagues, or the organisations that they work for:

> *But there are tricky times when I get Pacific Island cases… my supervisors saying no… you have to do this… my cultural hat is saying, I know I shouldn't be doing this. But as a Pacific Islander, that's like a huge no, no, and I can't do that. And so, at those times, is where I wish I had that extra support, in terms of my Pacific cultural lens, because even though my supervisor understands me as a person, but her knowledge is based on, you know, the core competencies around [allied health]… but for me… I'm a [Pacific Islander] first before I'm an [allied health professional]. (Participant Three)*

Participant Three reflected that it had taken time and experience to succeed in seeking out cultural supervision outside of the organisation where they are employed:

> *We are all Pacific, and we are all [allied health professionals]…. for me, I find my group around that [external Pacific allied health supervision group], that's where I probably seek a lot of my cultural supervision… so I do have that support. It just probably took a while to find that…. sometimes it's that part where I need to get that extra support from people like [Pacific allied health supervision group], and we all do it for each other. We all help each other out. And that's great. And so, yeah, so I think I've learned now how to navigate my support systems here at work, which is working for me at the moment. (Participant Three)*

One participant discussed the professional development gained in seeking supervision from colleagues within their cultural networks:

> *We work alongside a lot of the Pasifika providers in the community, as well as other DHBs… if they have cases that they need our assistance with, then we would connect with them…. I had to call on some of them to actually engage with this individual [patient]. And it was so good to watch…. Something that I probably need more to develop… I do receive cultural supervision, and so that is probably the main person. Other than that, that would have been senior [allied healthcare professionals]. Not only [ethnicity] but Samoan and Cook Island, who helped me throughout the years. (Participant Two)*

Participant One reflected on the value of establishing a culturally informed network and the importance of kai:

> *I do a Rōpū of Pacific staff come together, and I bring them together mainly… to build their confidence up, and they do the presentations to us… some of us are seniors, some of us aren't, some of them more cultural… for us to ask questions… and they get confident…. these are Pacific people… you can establish your own network, that we would have monthly breakfasts… no one can argue when you're eating. (Participant One)*

Although this is a small group of professionals, the participants highlight the importance of leadership within the group rather than waiting for external leaders to support networking.

Emotional and Cultural Intelligence

Participants highlight that engaging effectively with patients and their kainga is crucial to provide high-quality healthcare interventions. More than clinical expertise is needed to secure confidence. Participants drew attention to the value of connecting using the process of fakafehokotaki (engagement) and meeting with patients a'u tonu (in-person or face-to-face). Reflecting further on the tensions experienced with time and utilisation of health literacy skills in busy clinical environments.

Fakafehokotaki (engagement)

Participant Four reflected on the value of their non-Pacific colleague taking the time to understand the community and what is culturally appropriate in this locality:

> *She [my non-Pacific colleague] doesn't assume that everyone that comes through is going to want to do that [open with a lotu/karakia], but she offers it, and it's not pushed on anyone…. And then this patient came up to me and was like, "Look, I have never been asked that ever before, and I've never felt comfortable to share any of this information",… and they continued to come [back to the clinic]… there's so many different situations that you can be culturally safe. (Participant Four)*

Another participant highlighted the difficulties with the lack of initiative demonstrated by non-Pacific colleagues to effectively engage and problem-solve before referring to Pacific services:

> *It's one of the challenges is trying to make others, well not make, but it is sort of provoke thinking for them, for other services…. They're always coming to us [Pacific Health] for solutions without even trying first. So, I think that's one of the biggest challenges… for our service. (Participant Two)*

Participant Three reflected on the need to build rapport, especially with those who have experienced trauma and the pressure of timelines. This has the potential to limit cultural competence:

> *So my rapport has to be really tight… a lot of my time goes into rapport building rapport with families, sometimes your ministry timeline is not that long, and you have to get results ASAP…. it's not on my time that I would feel that rapport is right. This has to be on their time and effort. If they were a traumatic family who've been through a lot of trauma, it could easily take six months, it could easily take a year, because who am I to tell them…. "You should trust me by now". I've seen you every day for one month. You can't say that, you know, it has to be family lead. And that's the cultural kind of competencies. They don't like to talk about, highlight or emphasise in workplaces like this. (Participant Three)*

Pacific staff highlighted that they work with an ongoing irreconcilable tension because the fast-paced turnaround in health care does not fully allow for culturally appropriate relationship building. There appears to be a need for more clarity on the importance of building and maintaining relationships to achieve health outcomes carefully. Participant Five echoes the need to have a level of emotional and cultural intelligence to engage effectively:

> *There's this emotional intelligence stuff because how are you supposed to be able to understand other people's cultures if you can't even understand the way that you think about yourself and your own culture…. And engagement… being able to communicate effectively is also another skill that… to a lot of Pacific comes… naturally, there's just because we are told to communicate effectively. (Participant Five)*

The importance of knowing the specifics of the population that you are providing care to and being able to tailor the approach to meet their needs was identified by the following participant as crucial in achieving engagement with services:

> *As allied health, we've got… to know our communities. We can't know all communities. We just need to start in our locality. Like if you know [city] got a*

high population of [ethnicity], and if you go to [city], you got a high population of [ethnicity]. (Participant One)

Despite the pressures of working in a large public hospital, this participant identified and met Pacific patients' needs by understanding their priorities:

Only going into, like, in 15 minutes, to see people… I used to take my time with Pacific people… in terms of getting them to engage in getting the most out of the session, I felt that was needed…. Because it's important… we're going to start with getting to know each patient and learning about where they come from and their culture, or we're going to do it this way… that's not always perceived from every person and in a positive light. (Participant Four)

Participant Two reflected on their ability to make meaningful connections in the early stages of working with a Pacific person to influence their healthcare interactions positively:

I'd take more time in the relationship building rather than, you know, tick box assessment. And our assessment is all over the place, really, as you know, with Talanoa. Sometimes you can't put a time restriction on it. You have to take the time to build that relationship in order to gain that trust. So, I think that's the point of difference when you're working with Pacific. (Participant Two)

Building relationships is fundamental in the Pacific community, and if clinicians do this well, it can help reduce barriers to healthcare.

Tensions with Time

Participants discussed time in two ways when considering how they practice as individuals and within the services they have worked in. Either reflecting on the time pressures created by systems and processes or referring to the gift of time given towards achieving equitable outcomes. Participant Five describes managing the clinical caseload and the expectations of their managers:

I was never one of those [allied health professionals] that… was able to go see all of my patients. So I get a list of 30 patients that I'm supposed to see in one day,

in eight hours, but I'm also supposed to have lunch, attend some meetings… have my two 10-minute breaks… all of that nonsense. (Participant Five)

Participant Four reinforced the fact that they felt it was more important to spend time with patients than it was to meet the simple numerical or time targets:

Spending time with patients, and I, you know, I've had… working on the wards and having to see ten people, and getting certain times. (Participant Four)

The second way that participants spoke about time was when either they took their time or the effectiveness observed of their colleagues gifting their time. Participant Five described the positive impact and influence this has on the healthcare professionals around them:

They make the patient feel at ease, and then the nursing staff around them are just mirroring that energy and that vibe, and the patient just feels like, you know, I'm actually being listened to…. It was quite validating to see that… these senior clinicians who… in the hierarchy of the hospital, are way up there to see that they were taking the same approach… they care more about how the patient feels while they're in their care. And that was, I suppose, my mentality as well. How much of a difference can I make at this point in time for you that may have a massive effect on your wellness journey later on? (Participant Five)

One participant connects the importance of fakafehokotaki (engagement) and dedicating time to ensure that this is well established from the outset and in a meaningful way:

Really take the time in the beginning. When you greet somebody, it's not just greeting. You're also talking about the environment. You're talking about others that are around you. You're talking about the actual environment. You're also talking about… where they come from trying to make connections back to… the islands. Yeah. So that you can find that common ground. (Participant Two)

Participant Four echoed the positive patient and clinician experience when time is taken to connect:

I would love to spend time having a conversation… taking time to just have a conversation with someone or a patient. Whereas, I could tell that other colleagues probably didn't have that… weren't that interested in that side of… things, which was different. And so that can be perceived from… other people, managers, and other seniors as being… slow or… not being fast enough, but actually… I got more out of a session, or they [the patient] progressed a lot better because of that, so I saw it as a positive rather than a negative. (Participant Four)

There is a lot of pressure on healthcare professionals to meet expectations around time limits and the volume of patients seen. Participants' perceptions emphasise the importance of a tailored approach with Pacific patients.

A'u tonu (face to face)

An important aspect of Pacific allied health professional development is connecting through varied culturally informed forums. One participant highlighted the positive impacts of attending sessions that were purposely designed for Pacific and provided by Pacific:

I felt more comfortable… practising in a [Pacific] group like that when I did have those sessions. So, they were valuable in terms of having, you know, it was a good laugh. We would eat afterwards… it was a really comfortable setting… I probably engaged in a lot more than I would have if it wasn't culturally specific. (Participant Four)

Participant Two reflected on the ability to spend time with Pacific colleagues and the positive impact on their practice:

Things like consultation and observing experience... it's just amazing what I've observed from them [experienced colleagues]…. There are times where I've had to pick up… some of their practice and add it to mine. So… it's how they've taught me how… to initially engage with Pacific. (Participant Two)

Another participant highlights the importance of being able to connect in person and the advantages of doing this first to fully understand an individual before simply completing a clinical assessment:

There are so many things that you can do before you have to come down to a paper test to tell you what's wrong with you. There's so much rapport making, there is so much ways you can get face-to-face, and I'm a face-to-face person…. to provide culturally relevant care… your rapport has to be there with your Pacific families, it's the rapport, that's the feeling safe, it's the trusting you with vulnerable information…. There's ways that you can understand the family, the culture, the systems… where you are in the family line, what roles you play during your life, and what expectations did you have. There's so much things that we can find out rather than relying on a questionnaire to be able to tell that. (Participant Three)

One participant highlights the importance of reconnecting with Pacific colleagues, particularly the need to do this in person to experience the actual benefits of networking:

I ended up studying… then [university] was the only one who said to come and have an interview, we would like to talk to you. But I was blessed with kind of the leadership there, so [manager one], so I had an interview with him, and then I had an interview with [manager two], and then it was a whole group of Pacific, and then so I went through a couple of… meet and greet and just kind of introduced myself to them. (Participant One)

If it hadn't been for the ability to connect personally and create connections, Participant One might not have gained employment. Participant Three reflected on the need to build and maintain relationships with colleagues and services that are regularly referred to:

Connecting with them face to face because I know that's having that time, which I guess we haven't had time to sit down and build those networks. We've tried that with our other Pacific teams here… like the mental health team, which is great. But then sometimes you lose touch, and then you've got different people in different roles, just high turnover, and you just don't know who's who. So, it's, it's keeping those connections for you. (Participant Three)

Participants reflected on the crucial need to build and maintain professional relationships, particularly where they could connect a'u tonu / kanohi ki te kanohi (face to face).

Health Literacy

A health-literate health system reduces these demands on individuals and builds health literacy skills in its workforce and the individuals and kainga who use its services (MoH, 2015). Participant Five described the strategies used when interacting with Pacific patients to ensure that both parties communicated effectively:

> *It didn't matter what language that person spoke. I was still able to communicate with them and communicate effectively, as well as meaningfully in some way, shape, or form, whether it was writing stuff down, whether it was like body language, hand gestures, you know, like talking to the person through a patient and organising an interpreter. You know, those were the lengths that I was willing to go to to make sure that they understood me, and I understood them. So that there was meaningful engagement. (Participant Five)*

Participant Four highlights the need to advocate for patients who are not aware of their entitlements, ensuring equitable access to healthcare by providing education and, in effect building health literacy:

> *From a health literacy education point of view… one of my passions… is to be their advocate and to kind of help them to understand what's available in the health system. (Participant Four)*

Participant Two reflected on their Pacific knowledge and skills used to navigate a scenario that put Western and traditional approaches up against each other:

> *Child protection is critical. I would class it as critical in terms of just traditional ways of healing and medicine… there would be that rare occasion where you'd have… a [Pacific] baby with jaundice, severe jaundice. And I know… traditional methods of healing for them. So, the mother was my age, which was great as well, and this worked in our favour. And then we had the neonatologist, so trying to navigate the medical professionals understanding that, some of it, some of that is still valid to us…. there was a misunderstanding, and she [the mother] thought that they [the*

neonatologist] didn't take into account the traditional methods, which they did, but because it [jaundice] was so serious. (Participant Two)

Participant One shared a kainga experience to highlight how information can be misinterpreted:

Mum was overdosing my Dad for years. And because he had mental health issues and epilepsy pills when he ran out of epilepsy pills, Mum would give him the mental health pills and when they ran out of mental health pills, just so they can budget their finances. She goes, "Oh because the doctor said two pills". (Participant One)

Another personal example highlights the use of their own kainga experiences to inform health literate care:

Because my dad is, you know, he's got perfectly good English. But if you speak too fast, he misses the point, and then he just goes, "mm-hm, mm-hm", even though… he's not taking any of it in, and so knowing that my dad is prone to doing that, I just make sure that you know, especially particularly when there's a language barrier there that I take, make the extra effort to communicate effectively. (Participant Five)

Navigation of the public health system is fraught with many challenges for Pacific populations. Health literacy can often be referred to as something the patient lacks, but it is clear from these examples that healthcare professionals need to do better.

Summary

This chapter has presented the research findings of a study aiming to understand the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa through Talanoa with five participants. Four main themes and 13 sub-themes were supported using intelligent verbatim quotes. It was established that participants are aware of the need for more support, including unsustainable approaches to recruiting and retaining Pacific allied health. Participants are committed and willing to support the achievement of a more representative workforce for the greater good of better patient care and health outcomes. In participating in Talanoa with the researcher, participants displayed immense graciousness and respect for the

organisations and people they work with. Participants appeared deeply reflective in their engagement with the Talanoa process, evidenced by thoughtful pauses and appreciative comments about the personal value of participating. The Talanoa process seemed to provide the space for in-depth dialogue.

Chapter 5: Discussion and Conclusion

Introduction

This qualitative study was undertaken to explore the challenges and opportunities for Pacific allied health staff to enable culturally responsive care in Aotearoa. The research aimed to provide insight into the perspectives of five Pacific allied health professionals. The following research question was posed:

- What are the challenges and opportunities for Pacific allied health staff to provide care in a culturally aligned way?

Following individual Talanoa, a reflexive approach was taken to guide the thematic analysis. The four main themes and 13 sub-themes that were identified from the data are as follows:

- Cultural Capability and Capacity – isolation and hierarchy, absence of support and cultural attunement, and developing confidence and experience.

- Pacific Values and Responsibilities – values and commitments, leadership and identity, and surviving versus thriving.

- "I struggle navigating white spaces" – health equity, cultural safety and nuances, and cultural support and supervision.

- Emotional and Cultural Intelligence – fakafehokotaki (engagement), tensions with time, a'u tonu (face to face), and health literacy.

In this chapter, a discussion of the main findings in relation to the literature will be provided. Three key overarching meta-themes were identified: cultural isolation, cultural intelligence, and cultural load. In addition, recommendations for future practice and a discussion of the study's limitations will be presented.

Discussion of Findings

Cultural Isolation

Cultural isolation was referred to throughout the data set in the context of low numbers of Pacific colleagues and the low numbers of Pacific allied health staff. The findings in this current study were also evidenced by Waiari et al. (2021). These researchers recognised the need for Pacific allied health students to be a long-standing issue for undergraduate pathways to qualification. The sub-theme generated in this current study of working in cultural isolation and a lack of culturally safe environments is supported by Mullane et al. (2022) and Harwood et al. (2022). They found that a lack of Pacific healthcare workers is a barrier to equitable diabetes and stroke care, respectively (Mullane et al., 2022; Harwood et al., 2022). The findings in this current study drew attention to the emotional burden of being the only cultural person. In congruence, Taylor et al. (2019) and Fa'alogo-Lilo and Cartwright (2021) also highlight the shortage of Pacific healthcare staff acting as a barrier to trust and emotional safety for Pacific patients.

Common amongst participants in this study was the acknowledgment that when seeking employment, there was a perceived demand for a Pacific workforce. Curtis et al. (2015) referred to a requirement to grow a representative health workforce, acknowledging that this is driven by the necessity to increase the general health workforce. In this current study, the experience of Pacific allied health participants is that non-Pacific leaders only hold basic knowledge and understanding of the cultural nuances and the cultural attunement required to work safely. Fa'alogo-Lilo and Cartwright (2021) report similar findings that non-Pacific people need to gain an understanding of the importance of Pacific culture's collective nature and values.

This study's participants referred to the value-added but the extra pressures, requirements, and expectations, including mentoring other younger students. Study participants recalled stepping into these mentoring roles much earlier than their tauiwi colleagues and peers when they were students. This is referred to as the Tuakana network by Waiari et al. (2021) and is further supported by research undertaken by Tofi (2021), who noted a key recommendation as the need for a Tuakana-Teina framework

to act as a cultural supervision model to better support Pacific allied health working in district health boards.

The findings in this current study demonstrated a culturally centered moral responsibility that leads to Pacific healthcare professionals taking up mentoring, teaching, and leadership roles. Matafanua Fa'asalele, the chief adviser for Pacific Health, reflected on her experience in an interview with Teresa O'Connor in the Kai Tiaki nursing journal (2018). She explained that despite not actively seeking leadership roles and being 'petrified' when offered the ministerial position, she knew stepping up would encourage other Pacific to challenge themselves (O'Connor, 2018).

Across the dataset, it was evident that as Pacific allied health professionals developed experience and confidence, they were comfortable with challenging, difficult situations and their colleagues. These results are similar to those highlighted in Jackson et al.'s (2020) study. These researchers noted that experienced allied health professionals might be considered experts within their professions, and it may be this expertise that allowed experienced Pacific allied health professionals to express themselves effectively. Participants in this current study noted the need for improvement in undergraduate training contexts and workplaces, but their cultural values meant they remained humble and gracious, including tolerating current standards. In the same way, Waiari et al. (2021) described a 'disconnect' between university culture and Pacific culture. The longstanding culture of academia calls for a focus on the individual and self-reliance, whereas Pacific cultures are interdependent and reflect the collective nature of kainga. The disconnect can potentially negatively impact Pacific students by demanding they live and study in two completely different worlds (Wairari et al., 2021).

Participants in this current study expressed the strong sense of service felt to advocate for patients and kainga by calling out behaviours not aligned with Pacific values. Experience gained through leadership in roles at home, with kainga, and in the church was relied upon when expressing confidence in their ability. The lived experience of Talanoa participants reflects those reported by Came et al. (2019) of Pacific leaders working alongside government advisory groups. The researchers noted the high level of

commitment, determination, and reliance on Pacific values required to remain engaged due to their experiences of tokenism and racism (Came et al., 2019).

Cultural Intelligence

In this current study, early and multiple cultural responsibilities were expected of participants. Their place within the family structure impacted their interactions with colleagues and patients outside the home. The eldest children in Tongan families, particularly, are raised with cultural expectations and responsibilities, including additional responsibilities for younger siblings (Oranga Tamariki, 2015). These results are similar to O'Connor (2008) and O'Connor (2018) who refer to a strong sense of responsibility that comes with being Pacific, especially concerning leadership and representation. Participants in this current study reflected on the expectations they felt of themselves and the expectations they held of other Pacific colleagues, referring to the tensions associated with identifying as Pacific and displaying and living Pacific values. Pacific identity and values impact how Pacific individuals view themselves and interact professionally. This finding is consistent with Came et al. (2019), who reported on privileging Western biomedical approaches over indigenous knowledge and the self-identified need for Pacific leaders to firmly establish and share their academic and cultural credentials to be respected. Came et al. (2019) further acknowledged that democratic decision-making approaches do not serve Pacific populations, especially when the Pacific leaders are often a minority voice in advisory groups.

The participants in this current study considered their ability to express cultural values that sometimes clashed with leadership and professional identities. Participants acknowledged in leadership roles the need to uphold their deeply Pacific importance of respecting their elders while continuing to provide leadership and management responsibilities. Hughes (2018) suggested that a combination of emotional intelligence and cultural safety leads to culturally intelligent healthcare providers relying on their ability to understand and interpret social and cultural cues to culturally constructed differences.

Participants in this current study reflected that thriving is the goal for clinicians, patients, and kainga, including utilising their Pacific scope to inform equitable care. Similarly, Tofi (2022) explored the topic of Māori and Pacific allied health professionals

thriving in a district health board setting and found the need for culturally informed support to enable thriving. If the organisations that Pacific allied health work for placed greater value on the cultural knowledge that they bring, this would enable thriving too (Tofi, 2022).

In this current study, Talanoa participants accepted that they do not always have all the answers and abilities individually. However, they relied heavily on the cultural values of reciprocity and commitment to the greater good to allow them to function effectively as healthcare practitioners. Similarly, Ioane et al. (2021) and Waiari et al. (2021) reported the need to utilise Pacific knowledge, practice, and protocols to engage with Pacific people effectively. Despite the differences between Pacific cultures, similarities in relational values, reciprocity, a collective worldview, and shared Pacific protocols, there are benefits to planning an approach to Pacific healthcare that incorporates Pacific indigenous knowledge with the Western system (Ioane et al., 2021).

Talanoa participants in this current study recognised times when their non-Pacific colleagues had made a positive difference in the engagement of Pacific kainga. Participants expressed frustration when their tauiwi colleagues unnecessarily referred to Pacific Health services without attempting to assess, treat, or explore problem-solving approaches with Pacific people. Ioane et al. (2021) demonstrated the need to acknowledge the fundamental principles and protocols that define a Pacific approach, for example, the utilisation of karakia or lotu when working with Pacific patients.

Participants in this current study discussed occasions where they would strategically allow their interactions with Pacific kainga and clients to extend beyond their allocated times or to take longer with Pacific patients, despite the feeling that they were being judged or not meeting the expectations of their colleagues. These findings concur with the research conducted by Mullane et al. (2022) and Fa'alogo-Lilo and Cartwright (2021), acknowledging that culturally safe practice requires time. Mullane et al. (2022) report on 'time for equity' by allowing appointments to go as long as necessary. Fa'alogo-Lilo and Cartwright (2021) agree that there is a need to integrate Pacific values to take one's time and treat the person with respect and dignity to achieve equitable health outcomes.

In this current study, participants reflected on the opportunities and the abilities to connect a'u tonu (face-to-face) or in-person and the positive influence this had in an undergraduate context or on their early years of practice as a Pacific allied health staff member. Similar to the Tuakana-Teina networks written about by Waiari et al. (2021) and Tofi (2022), there is a need for culturally informed networks to create a safe and collective learning environment without external judgment.

Participants in this current study drew attention to the need to ensure they used strategies that enhanced and addressed health literacy issues. These strategies included ensuring that Pacific patients were given access to information in a way that could be clearly understood, including using interpreters, sharing the information with the most appropriate person within the kainga structure, and written resources, as some examples. Taylor et al. (2019) confirm the strong association between culture and how individuals respond to health information and therefore support the need for clinicians to be flexible in delivering information, particularly to Pacific patients.

Cultural Load

In this current study, cultural safety was reflected on, and participants referred to the need to have safe places to be Pacific and to seek support in culturally relevant environments. Similarly, Waiari et al. (2021) described the need for Pacific allied health students to have a safe place to be Pacific without explaining themselves or being judged.

Participants noted throughout Talanoa in this current study that they were offered only generic support that their colleagues received. However, they did not receive support that acknowledged the cultural complexities of their role. Tofi (2022) reported that allied health professionals often felt frustrated at the expectation to provide cultural leadership regardless of the appropriateness for the individual. Specific examples that participants in this current study referred to as creating further difficulties and disconnection from their colleagues were the lack of culturally appropriate supervision opportunities, cultural support and allyship within their allied health professions. As Tofi (2022) discussed, it was challenging to participate in culturally appropriate reflective practice as these cross-cultural approaches could not accurately address key cultural concepts of collectivism, connection, and reciprocity.

Across the dataset, there appeared to be tensions between being 'put on a pedestal' and not being adequately resourced. The weight of expectation as the only Pacific person was felt by participants in terms of the expectations for them as individuals to upskill themselves to be better equipped to teach and support new Pacific colleagues. Mullane et al. (2022) reported enabling a culturally responsive healthcare workforce to better meet Pacific peoples' needs. Kurtz et al. (2018) conducted a literature review on cultural safety education for health sciences students in three countries with colonisation histories similar to Aotearoa. The researchers found that cultural safety improves the health of indigenous populations, attracts more minority practitioners and provides culturally safe services. Cultural safety training must be supported across all levels of institutional leadership by providing time, resources, policy, and community engagement through partnerships with indigenous populations (Kurtz et al., 2018).

The collective nature of the definition of Pacific peoples creates a risk that Pacific clinicians remain culturally isolated and, therefore, culturally unsafe due to the diversity and nuances between Pacific cultural groups. There are varied approaches to cultural, professional development and cultural competency training delivered to healthcare staff (Kurtz et al., 2018; Curtis et al., 2019; Waiari et al., 2021). Very few professional development interventions allow individuals to fully understand the colonial and historical contexts and the reason for mistrust in the systems. Therefore, they need to extend Pacific values strategically in their work. This finding broadly supports the work of other studies in this area reflecting on the need to address systemic mistrust early by healthcare professionals' first understanding and acknowledging the historical and colonial context (Ioane et al., 2021; Mullane et al., 2022). Health professionals must demonstrate fakafehokotaki (engagement) to help break down barriers for patients and kainga as a collective. This ongoing process requires maintaining safe boundaries while building connections (Mullane et al., 2022).

Talanoa participants reflected on their awareness of health inequities and achieving health equity, driving the need for a representative workforce. Participants described this as a key motivating factor to take up an allied health career initially and continue to work in environments of Pacific underrepresentation to provide equitable healthcare and address the long-standing ethnic health inequities in Aotearoa. To

achieve health equity, cultural safety needs to be a key driver (Curtis et al., 2019). Cultural safety initiatives must target individuals and organisations to review and challenge their culture, biases, and privilege. Cultural safety must extend beyond simply acquiring knowledge about another culture that may only perpetuate stereotypes and biases (Curtis et al., 2019).

Healthcare in Aotearoa is currently undergoing significant reforms with the establishment of new entities, Te Whatu Ora (Health New Zealand) and Te Aka Whai Ora (Maori Health Authority), under the stewardship of Manatu Hauora (Ministry of Health). This healthcare reform promises to be beneficial in achieving equity of access, and outcomes, particularly for Pacific people. Te Whatu Ora has recently published Ola Manuia, the interim Pacific health plan outlining the priorities and the enablers for Pacific people. The development of the Pacific workforce is one of the named priorities. However, equity of access, equitable outcomes, and Pacific workforce growth have all been priorities in the previous version of Ola Manuia: Pacific Health and Wellbeing Action Plan 2020–2025 and 'Ala Mo'ui: Pathways to Pacific Health and Wellbeing 2014–2018 before that. Therefore, at the time of writing this dissertation in late May 2023, I am cautiously optimistic and tentatively hopeful that this restructuring will bring about meaningful change, as multiple reviews have so far failed to produce substantive changes.

Limitations

The qualitative nature of this study means participant experiences have been explored in detail. Due to the in-depth Talanoa and sharing of rich data, this provides significant insight into the experience of the participants. By Western standards, the researcher knowing some participants could be interpreted as a limitation; however, in this case, it made it strengthened the fakafehokotaki (engagement) aspect of the Talanoa as trust was established. With a small sample size, caution must be applied. This is a single-city study and does not present a regional or national perspective. The scarcity of literature available documenting the experiences of Pacific allied health professionals meant it was difficult to compare and contrast with the current study's findings.

Recommendations for Further Studies

This current research highlights opportunities and challenges for Pacific allied health in Aotearoa. Further research on the experiences of Pacific allied health professionals at a regional and national level would strengthen the findings of this current study.

Clinical Implications

Pacific allied health professionals require culturally appropriate, organisationally supported mentorship and short and long-term guidance. There is a need for Tauiwi colleagues to act as solid allies advocating for and supporting their Pacific allied health colleagues to enable culturally responsive healthcare.

Conclusion

Culturally responsive care is crucial now and in the future, as Aotearoa transitions through health reforms designed to ensure equity in our health system. The four main themes and 13 sub-themes identified through thematic analysis were identified and discussed in detail. Empowering Pacific allied health clinicians who are clinical experts and offer significant cultural expertise is critical. This cultural expertise is crucial in helping non-Pacific allied health clinicians to recognise, acknowledge and embrace culturally informed and responsive healthcare provision.

Three key overarching meta-themes of cultural isolation, cultural intelligence, and cultural load were identified. This current study has demonstrated clear examples of Pacific allied health professionals identifying the cultural isolation felt. Participants felt their cultural intelligence had been relied upon by their colleagues and the organisations they work for. Participants reflected on the cultural load they felt working in a healthcare system where they are an ethnic minority. Culturally responsive healthcare enables positive, meaningful and culturally relevant connections to be made between staff and patients early, therefore, empowering patients throughout their healthcare journey. This report presents a collective voice detailing the opportunities for all allied health staff to achieve more culturally responsive work and healthcare environments. The research provides a platform that allows my colleagues to build further, more specific

research exploring Pacific allied health professionals' experiences in providing culturally responsive care across Aotearoa.

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Appendices

Appendix A: AUTEC Ethics Approval

Auckland University of Technology Ethics Committee (AUTEC)

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

17 June 2022

Catherine Cook
Faculty of Health and Environmental Sciences

Dear Catherine

Re Ethics Application: 22/128 Understanding the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa

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 16 June 2025.

Non-Standard Conditions of Approval

1.   Inclusion of advice about the exclusion criteria (no direct reports or supervisees) in the Information Sheet.

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 forward updated documents for file.

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: tqv1075@aut.ac.nz; sione.vaka@aut.ac.nz

Appendix B: Advertisement

Mālō e lelei, Ni sa bula vinaka, Fakaalofa lahi atu, Talofa lava, Kia orana, Malo ni and Kia ora koutou,

You are receiving this information as you have previously registered on the Le Va website as a Pasifika Allied Health professional.

My name is Larissa Biggs, and I am the post graduate student carrying out this research study at Auckland University of Technology (AUT). I would like to invite you to participate in my study to understand the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa. This is part of my Master of Health Science qualification. My research supervisors are Associate Professor Catherine Cook and Dr Sione Vaka who are academics and researchers at Auckland University of Technology.

A collective worldview is fundamental to Pacific people's existence. Inequities stem from direct and indirect discrimination of Pacific people. Many Pacific people in Aotearoa continue to be challenged by socio-economic hardship and increasing health needs due to generational hardships. A lack of diversity and representation in the workforce providing healthcare to some of the most vulnerable Pacific populations contributes to the experiences of biases, and racism. The majorities of the Allied Health staff who are providing care to Pacific populations are non-Pacific and have had very little exposure to understanding the generational hardships, their own biases and the impact this has on the provision of care.

A Talanoa based approach will be used, for enabling the research to be undertaken both with and alongside Pacific colleagues. You will be invited to participate in Talanoa at a time and location that suits you. Options to participate outside of the workplace, and refreshments will be provided at all locations. Use of Talanoa allows the incorporation of Pacific values and protocols to build rapport and help to mitigate power imbalances. A Talanoa based approach will be used, for the value added in enabling the research to be undertaken both with and alongside Pacific colleagues. In order to address and completely answer the research question; what are the challenges and opportunities for Pacific Allied Health staff to provide care in a culturally aligned way?

The findings of this research may be used for academic publications and presentations.

You were identified to participate in this study through the existing professional networks of the research team of this study. You are being invited because you are a Pacific Allied Health Clinician who is currently working in a clinical environment in Aotearoa, or you have worked clinically within the last five years. You bring expertise in the challenges and opportunities of Pacific Allied Health clinicians' abilities to provide care in a culturally aligned way.

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

If you are interested in being involved in this research please contact me (Larissa Biggs), on tqv1075@aut.ac.nz or 021 152 2593 to discuss further.

Malo 'Aupito

Larissa Biggs, Associate Professor Catherine Cook and Dr Sione Vaka

Appendix C: Participant Information Sheet

Participant Information Sheet

Date Information Sheet Produced:

14 June 2022

Project Title

Understanding the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa

An Invitation

Kia ora, my name is Larissa Biggs, I am a physiotherapist with Tongan whakapapa. I am the post graduate student carrying out this research study at Auckland University of Technology (AUT). I would like to invite you to participate in my study to understand the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa. This is part of my Master of Health Science qualification.

My research supervisors are Associate Professor Catherine Cook and Dr Sione Vaka who are academics and researchers at Auckland University of Technology.

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

What is the purpose of this research?

A collective worldview is fundamental to Pacific people's existence. Inequities stem from direct and indirect discrimination of Pacific people. Many Pacific people in Aotearoa continue to be challenged by socio-economic hardship and increasing health needs due to generational hardships. A lack of diversity and representation in the workforce providing healthcare to some of the most vulnerable Pacific populations contributes to the experiences of biases, and racism. The majorities of the Allied Health staff who are providing care to Pacific populations are non-Pacific and have had very little exposure to understanding the generational hardships, their own biases and the impact this has on the provision of care.

A Talanoa based approach will be used, for enabling the research to be undertaken both with and alongside Pacific colleagues. You will be invited to participate in Talanoa at a time and location that suits you. Options to participate outside of the workplace, and refreshments will be provided at all locations. Use of Talanoa allows the incorporation of Pacific values and protocols to build rapport and help to mitigate power imbalances.

A Talanoa based approach will be used, for the value added in enabling the research to be undertaken both with and alongside Pacific colleagues. In order to address and completely answer the research question; what are the challenges and opportunities for Pacific Allied Health staff to provide care in a culturally aligned way?

A summary of the findings of this research will be provided to the committee of Pasifika Allied Health Aotearoa New Zealand (PAHANZ) as a thank you for their recruitment support.

The findings of this research may be used for academic publications and presentations.

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 of this study. You are being invited because you are a Pacific Allied Health Clinician who is currently working in a clinical environment in Aotearoa, or you have worked clinically within the last five years. You bring expertise in the challenges and opportunities of Pacific Allied Health clinicians' abilities to provide care in a culturally aligned way.

How do I agree to participate in this research?

You were approached to participate in this study via email advertisements, or perhaps through one of your colleagues who has already participated. You are not a direct report or supervisee of the primary researcher. You agree to participate in the study by completing the consent form that was provided electronically. 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 a Talanoa of approximately an hour with myself as the researcher. During the Talanoa you will be asked a series of questions to help understand your experience practicing in an Aotearoa context as a Pacific Allied Health professional. The Talanoa will be audio recorded and transcribed, all identifying information, including names, will be removed from the raw collected data and replaced with code names for the purposes of analysis.

You will be given an opportunity to check the transcripts from your Talanoa to ensure that they are correct and inform the researcher if changes are required. There will also be an optional opportunity to review the draft themes of the findings and provide feedback to the researcher.

What are the discomforts and risks?

The researcher anticipates that this is a low-risk study. However, participants might find the Talanoa brings up distressing memories or events. Participants may experience distress from memories of negative experiences, or anger around experiences. Participants could experience distress from memories of their experiences of racism, cultural isolation and unconscious bias, this may lead to personal distress or discomfort.

Participants need to ensure that they do not share any identifiable patient information.

How will these discomforts and risks be alleviated?

At the beginning of the Talanoa, the researcher will inform the participant that they can decline to answer any question, ask to pause or stop, ask for information they did not intend to disclose to be removed from the transcripts, and ask for information they feel is misinterpreted to be corrected or clarified.

Participants will be reminded at the beginning of the Talanoa that they need to ensure that they do not share any identifiable patient information.

All health professionals are legally entitled to be safe in their workplace, if issues of racism, discrimination, or bullying or harassment are raised during the Talanoa the researcher will direct participants to contact the Speak Up (about bullying and harassment) Champions or equivalent within their organisation.

Participants whose employer subscribes to the Employee Assistance Programme, (which includes all District Health Boards and Primary Healthcare Organisations) have access to free counselling and support services which are confidential and free of charge.

AUT Student Counselling and Mental Health is able to offer three free sessions of confidential counselling support for adult participants in an AUT research project. These sessions are only available for issues that have arisen directly as a result of participation in the research and are not for other general counselling needs. To access these services, you will need to:

- drop into our centre at WB203 City Campus, email counselling@aut.ac.nz or call 921 9998.
- let the receptionist know that you are a research participant and provide the title of my research and my name and contact details as given in this Information Sheet.

You can find out more information about AUT counsellors and counselling on https://www.aut.ac.nz/student-life/student-support/counselling-and-mental-health

What are the benefits?

Potential benefits for participants include opportunities for you to recall and discuss your expertise in the challenges and opportunities of Pacific Allied Health clinicians' abilities to provide care in a culturally aligned way. This research will allow time and space to have your voice heard through this research. This will allow an opportunity to honour your experience while also being able to use your experience to draw patterns or themes of knowledge that can be applied in the overall context of this research. The research may provide benefit for current and future Pacific Allied Health staff through identification of potential support mechanisms, which may come through the articulation of current experiences, and conversations.

For the wider community, this research aims to provide data that supports improved patient and whānau experience, ideally in the context of Pacific and Māori whānau. This proposed improvement could potentially come through future professional development opportunities aimed at creating a highly skilled workforce. This correlates to improvements in equity and in patient and whānau healthcare experience.

This is part of my Master of Health Science qualification.

How will my privacy be protected?

Participation in the Talanoa will not be anonymous because you will be involved in discussion with researcher. However, 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.

What are the costs of participating in this research?

It is expected that participation in the Talanoa process will require one hour of your time.

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?

Upon request you will receive a short summary of the findings of this study once it is completed.

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

Any concerns regarding the nature of this project should be notified in the first instance to the Project Supervisor, Catherine Cook, catherine.cook@aut.ac.nz, or 09 921 9999 ext 6651.

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

Whom do I contact for further information about this research?

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

Researcher Contact Details:

Larissa Biggs, tqv1075@aut.ac.nz

Project Supervisor Contact Details:

Associate Professor Catherine Cook, catherine.cook@aut.ac.nz, or 09 921 9999 ext 6651.

Dr Sione Vaka, sione.vaka@aut.ac.nz

Approved by the Auckland University of Technology Ethics Committee on *17th June 2022*, AUTEC Reference number *22/128*.

Appendix D: Consent Form

Consent Form

Project title: Understanding the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa

Project Supervisor: Associate Professor Catherine Cook

Researcher: Larissa Biggs

○ I have read and understood the information provided about this research project in the Information Sheet dated 14 June 2022.

○ I have had an opportunity to ask questions and to have them answered.

○ I understand that notes will be taken during the interviews and that they will also be audio-taped and transcribed.

○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.

○ I understand that if I withdraw from the study then I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.

○ I agree to take part in this research.

○ I wish to receive a summary of the research findings (please tick one): Yes○   No○

Participant's signature: ....

Participant's name: ....

Participant's Contact Details (if appropriate):

....

....

....

....

Date:

Approved by the Auckland University of Technology Ethics Committee on 17th June 2022, AUTEC Reference number 22/128.

Note: The Participant should retain a copy of this form.

Appendix E: Oral Consent Protocol

Oral Consent Protocol

Project title: Understanding the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa

Project Supervisor: Associate Professor Catherine Cook

Researcher: Larissa Biggs

The participant joins the videoconference

○   Do you agree to my recording your consent to participate?

If they agree, then the record function will be activated, and they will be asked the following:

○   Have you read and understood the information provided about this research project in the Information Sheet dated 14 June 2022?

○   Do you have any questions about the research?

○   Do you understand that notes will be taken during the interviews and that the interview will also be audio-recorded and transcribed?

○   Do you understand that taking part in this study is voluntary (your choice) and that you may withdraw from the study at any time without being disadvantaged in any way.?

○   Do you understand that if you 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.

○   Do you agree to take part in this research?

○   Do you wish to receive a summary of the research findings? (please tick one): Yes○   No○

○   Do you want me to send you a copy of the audio recording for this consent? Yes○   No○

○   Please confirm you name and contact details

Participant's name: ....

Participant's Contact Details (if appropriate):

....

....

....

....

I will now turn off the recording of the Consent and then will start a separate recording for the interview.

Approved by the Auckland University of Technology Ethics Committee on 17th June 2022, AUTEC Reference number 22/128.

Note: The Participant should retain a copy of this form.

Appendix F: Talanoa Schedule

Understanding the challenges and opportunities for Pacific Allied Health staff to enable culturally responsive care in Aotearoa

TALANOA / SEMI-STRUCTURED INTERVIEW QUESTIONS

Researcher: Larissa Biggs

Opening Lotu (prayer)

Mihimihi (acknowledgements)

Fakafehokotaki (engagement), including kainga (family) and any other affiliation (confidential)

Introduce topic/consent/confidentiality/positioning/ time frame and follow-up.

Thanks, so much for agreeing to participate in my research…

1. From the time you began your allied health career, did you notice anything different about being a Pacific allied health staff member? Did anything stand out for you? Can you give examples of what stood out for you and the difference between yourself and non-Pacific allied health staff?

2. I'd like to know, when you did your training, were there any other Pacific students or tutors at that time. What was that experience like for you?

3. Since you've qualified, have you had the support of Pacific colleagues or worked in isolation? What is that like? Can you give examples? Do you have access to the Pacific Health Team/support networks within your organisation? If so, in what capacity?

4. You will be familiar with the concept of cultural safety. What does being culturally safe towards whanau or culturally relevant care mean to you?

5. How did you learn/ what helped you know about Pacific / culturally safe care?

6. Do you think you treat Pacific clients differently from other clients? Can you give me an example of how you have upheld a particular cultural value/s for a Pacific client, yourself/or how you might practice differently? (Pacific world views, e.g. customs, values, protocols).

7. Can you tell me about a situation/s where you observed another healthcare provider (registered nurse or another healthcare professional) acting culturally safe (toward clients/patients)? If so, how has that influenced the way you are as an allied health practitioner or your approach to providing care?

8. How would you describe the allied health practitioner who does prioritise culturally relevant care towards Pacific clients/patients? (Pacific world views, e.g. customs, values, protocols). How does that make you feel?

9. How easy or difficult is it to hold onto your own Pacific cultural values with the everyday pressures of work? Are you consistently able to be culturally responsive/culturally safe (to Pacific clients) within the parameters of your job description?

10. Does your current workplace recognise and value proactivity as a Pacific allied health staff member? Can you describe some instances when this occurred/or was recognised (e.g. sharing/contributing to other's Pacific cultural knowledge and Te Ao Pacific - Pacific world view, e.g. customs, values, protocols)

11. Who have been the major supporting influences for you in maintaining your own professional and cultural identity based on your understanding of what this is?

12. In your opinion, what are some of the issues in clinical practice that make it challenging for yourself/or other allied health staff to be culturally responsive (i.e. achieve whanau-centred care or utilise Pacific Models of Practice/ Pacific Health models within their job description).

13. Can you describe situations in clinical practice that challenged your standards of expected culturally responsive behaviour? What cultural challenges have you felt prepared for, and what cultural challenges have come as a surprise? Can you give me some examples? (On reflection of that situation, would you have liked to have done anything differently and if so, what?)

14. Can you describe any situations positive or not-so-positive/critical incidents related to cultural differences between Pacific and non-Pacific? How much was language/ communication an issue? What (if any) effect has this had on you and/or your work?

15. How involved and/or supportive were managers in sorting out Pacific cultural issues/ who supported you?

16. What do you think allied health staff need (to do or to have) to work more effectively with Pacific clients and communities?

17. If you could influence the ways allied health is taught about what culturally responsive practice in healthcare means, what would you like to be added or made different?

Prompts
Can you give me an example?
Could you explain more about what that means in practice?
Could you elaborate?
Could you say a little bit more about that?

Closing Lotu (prayer)