Thriving as Māori & Pasifika Allied Health Professionals in the first 2 years of practice in a DHB setting

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Rongowhakaata, Tufulele, Vaipuna

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Karakia

He hōnore he korōria ki te Atua

Honour and Glory to God

He maungarongo ki te whenua

Peace upon the Earth

He whakairo pai ki nga tatou katoa

Goodwill to us all

Tihei Mauri Ora

Tatalo

E muamua lava ona si’i le vi’iga ma le fa’afetai i Le Atua mo lona agalelei ma lona alofa

Firstly, I give thanks to God for his kindness and love

Ua mafai ai ona fa’ataunu’u lenei fa’amoemoe

That has blessed and protected my journey

Ia ia te Ia pea le viiga e fa'avavau, fa'avavau lava

Let us praise him forevermore

Amene

“Pacific Islanders should write their own histories, their own versions of their history. Histories written by outsiders, no matter how fair they've been, are still views of foreigners, still views of other people about us. In many ways, those histories have imposed on us views of ourselves that have added to our colonization. We should write our own histories in order to be free of those histories written about us, those images created by other people about us, not only in history books, but in fictions they've written about us.”

Albert Wendt

Abstract

Allied Health professionals (AHP) make up the second largest health clinician group in the New Zealand health system (Ministry of Health, 2021) with **Māori** making up 6.3% and **Pasifika** 3% respectively (TAS, 2021). Despite the growing evidence and widespread acknowledgement of the inequities that exist within the New Zealand health system, minimal research currently exists regarding **Māori** and **Pasifika** health professionals.

This project explored perspectives regarding factors that enable **Māori** and **Pasifika** AHP employed at Counties **Manukau** District Health Board (CMH) to thrive. Drawing on shared values of **Māori** and **Pasifika** research methodology and aspects of appreciative inquiry, this research consciously incorporated a strengths-based approach to investigate the experiences of 11 **Māori** and **Pasifika** AHP.

This study has identified the significance of cultural support and development, appropriate leadership, allyship, and having cultural knowledge and intelligence valued, as key, to enabling **Māori** and **Pasifika** AHP to thrive at work. Felt and perceived institutional and personal racism, barriers to cultural development opportunities, lack of value ascribed to cultural knowledge and practice alongside clinical skillsets, were shown to negatively impact participants ability to thrive in the workplace. This study provides recommendations for change, while also, highlighting the need for further research pertaining to the perspectives and experiences of **Māori** and **Pasifika** AHP, and allied health professions more broadly.

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Attestation of Authorship

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

Signed

Vaea Ulima Tofi

Ngā Mihi: Acknowledgements

To the many who give their time and energy to the aspirations and advancement of **Māori** and **Pasifika**. I acknowledge you, **he mihi nui**, **malo lava**. And to all those who have been part of my journey, I know who you are, and I am grateful for what you have given me, knowingly and unknowingly. **Fa'afetai tele lava**.

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To my participant **whānau**. Thank you all for entrusting me with your knowledge and stories. Your generosity is inspiring and I am thankful for your friendship. I humbly pray that this dissertation be used as a tool for positive change, so that we may all be able to thrive. **Fa'afetai tele lava**, **Malo aupito**, **Meitaki maata**, **Fạiakseʻea**, **Ngā mihi nui**.

To my loved ones that are no longer with us. I love you and miss you all dearly. Thank you for continuing to inspire and guide me.

To my family, I am reminded of the saying: ***E le sili le ta'i nai lo le tapua'I.*** *Those who complete the feat are no more important than those who prayerfully support the feat*. So, to **whānau**, my **aiga**, and especially my parents – I love you. The example you have shown, the lessons you have taught and the unconditional love you continue to provide can never be measured.

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Ethics Approval

Ethics approval was obtained from Auckland University of Technology Ethics Committee (AUTEC) and was approved (AUTEC Number 20/377). 27th January 2021. Thriving as **Māori** & **Pasifika** Allied Health professionals in the first 2 years of practice in a DHB setting

CHAPTER ONE: Introduction

This dissertation utilises a qualitative approach to explore experiences of **Māori** and **Pasifika** AHP to understand what enables them to thrive as Indigenous practitioners within the health sector. This chapter provides an overview of the historical and current contexts that have given rise to this research, and will outline the definition used for AHP used in this project. I will then discuss my positionality and outline the organisation of chapters.

Throughout this dissertation you will notice three things. Firstly, **Māori** and **Pasifika** words have been **bolded**; secondly, the intentional use of **Te Tiriti o Waitangi** (**Te Tiriti**) to refer to the partnership document of **Aotearoa** between **Māori** and the Crown; and third, English translations have not been provided for **Māori** or **Pasifika** words. These choices have been made for the following reasons. The first is to privilege Indigenous languages, and the **Māori** version of **Te Tiriti** to both celebrate and give priority to Indigenous communities. The other reason is to create space for those who read this research and encourage them to seek out new knowledge. The majority of **Māori** and **Pasifika** terms in this paper are commonly used and therefore English interpretations are likely accessible online.

Historical Context

Before we examine the enablers of **Māori** and **Pasifika** AHP thriving within a healthcare work place, we must first consider **Māori** and **Pasifika** histories in relation to their respective experiences with the Crown, the New Zealand government and colonial New Zealand.

In 1840, **Māori** and the Crown (later to become the New Zealand Government) entered into a bipartite agreement called **Te Tiriti o Waitangi**. **Te Tiriti** provides four domains under which **Māori** health should be prioritised. Article One; **Kāwanatanga** involves sharing power, and establishing mechanisms that ensure **Māori** are represented in the decision-making process and that health services and delivery are acceptable to **Māori** (Came, Cornes, & McCreanor, 2018). Article two; **Tino Rangatiratanga** equates to **Māori** being in control of individual and collective aspirations, and removing barriers to **Māori** success such as racism in all its forms and other obstacles (Came et al., 2018). Article three; **Ōritetanga,** pertains to achieving health equity for **Māori** and aligns with decision making that reduces health inequities and addresses broader determinant of health (Came et al., 2018). Article four, the verbal Article; **Te Ritetanga** safeguards **Māori** values, practices and concepts (Came et al., 2018).

Te Tiriti guaranteed and protected the rights and aspirations of **Māori** as **Tangata whenua**. However, since the signing of **Te Tiriti**, **Māori** have continued to carry the burden of the Crown's unmet guarantees and unfulfilled promises of this partnership. Consistent and on-going breaches of **Te Tiriti** by the New Zealand government through legislation and forced assimilation have resulted in the purposeful demise of **Māori** culture. For example, legislation such as the **Tohunga** Suppression Act of 1907, outlawed traditional **Māori** healers and thus, the legitimacy of **Māori** knowledge, and holistic health and healing (Durie, 1997). Such legislations, moreover, have resulted in intergenerational trauma for **Māori** exemplified by the loss of cultural resources, knowledge and identity which, in turn have led to disproportionate levels of poverty, alcohol and drug addiction, incarcerations rates, as well as inequitable outcomes for educational and health (Came & McCreanor, 2015; L. T. Smith, 2013).

Despite the above, **Te Tiriti**, through its aspirations of inclusion and justice remains the keystone to achieving health equity for **Māori** and other underserved communities. The **Wai** 2575 **Waitangi** health inquiry and resulting **Hauora** Report (**Waitangi** Tribunal, 2019) recommended the principles of **Tino Rangatiratanga**; Equity; Active Protection; Options and Partnership replace what has been known as the 3P's (Partnership, Protection, Participation). It is argued that these recommendations provide a contemporaneous health view of **Te Tiriti** (**Waitangi** Tribunal, 2019) and shifts the focus from a reductionist perspective of the 3P's to a by **Māori**, for **Māori**, with **Māori** approach that affirms and enables **Māori** aspirations.

Pasifika peoples have shared similar health burdens and have endured their own negative outcomes as a result of New Zealand government legislations. The 1918 influenza epidemic that killed approximately 25% of the entire **Samoan** population (Tomkins, 1992), the unprovoked killings of peaceful protestors of the **Mau** movement (**Meleisea**, 2019), and the Dawn Raids are events the Government has since formally apologised for (Adern, 2021; Clark & Minister, 2002). Similar colonial legacies can be felt across many **Pasifika** nations such as **Fiji**, **Rarotonga**, **Niue**, and **Tuvalu** (**Salesa**, 2017) of which many descendants now call **Aotearoa** home.

Current Context

Nationally, **Māori** and **Pasifika** peoples make up approximately 16% and 8% respectively of the entire **Aotearoa** population (StatsNZ, 2018). In 2020, the Health and Disability Systems review was released (Health and Disability System Review, 2020). This review reinforces the role of central government in providing equitable health outcomes that are fit for purpose, and meet the needs of those the health service is intended to serve (Health and Disability System

Review, 2020). This view is supported by several recent reports highlighting that the current health system is inherently racist, and **Māori** and **Pasifika** communities disproportionately carry the burden of this (Health Quality & Safety Commission, 2019, 2021; Ministry of Health, 2020 ; **Waitangi** Tribunal, 2019).

Auckland is often referred to as the largest Polynesian city in the world, and at the heart of this assertion is South Auckland. The Counties **Manukau** region is home to a combined **Māori** and **Pasifika** population of approximately 38% (Ministry of Health, n.d). For all the wonderfully unique Polynesian aspects this environment provides, many **Māori** and **Pasifika** live with complex chronic health conditions that have detrimental impacts on their wellbeing. Growing and developing a **Māori** and **Pasifika** health workforce has long been viewed as one way to improve health outcomes for **Māori** and **Pasifika** (K. Brown, 2016; CMHealth, 2019). Having a health workforce that is linguistically and ideologically representative of **Māori** and **Pasifika** communities can improve service design and delivery (Health Quality & Safety Commission, 2021; **Waitangi** Tribunal, 2019), and uphold the principles of **Te Tiriti** through rights and needs based approaches. Counties **Manukau** District Health Board (CMH) is committed to achieving a workforce that reflects the community it serves; which means employing a minimum of 14.7% **Māori** and 21.9% **Pasifika** AHP (CMHealth, 2019).

Māori and Pasifika Allied Health Professionals

In **Aotearoa**, the allied health workforce consists of over 43 health disciplines that are separate to the medical, dental, nursing or midwifery professions (Ministry of Health, 2021). The allied health workforce includes professions that fall under the Health Practitioners Competence Assurance Act 2003, or are self-regulated by a professional body (Ministry of Health, 2021). For the purpose of this research, **Māori** and **Pasifika** AHP are defined as those who self-identify as **Māori** or **Pasifika** peoples who work at CMH, as either a Physiotherapist (PT), Occupational Therapist (OT), Speech Language Therapist (SLT), Pharmacist (PH) or a Dietitian (DT). Although AHP encompasses over 30,000 health professionals across Aotearoa and nationally makes up the second largest health workforce behind nurses (Ministry of Health, 2021), very little research has been undertaken specifically looking at Physiotherapy, Occupational Therapy, Speech Language Therapy, Pharmacy or Dietetics as key contributors to the District Health Board (DHB) Allied workforce sector in **Aotearoa**.

Māori and **Pasifika** peoples who pursue careers in Allied Health, can often have increased levels of family or community responsibilities and be regarded, sometimes hesitantly, as

leaders - within their families, communities and profession. Given the low numbers of **Māori** and **Pasifika** currently practicing, joining an already under represented workforce may present unique stressors such as cultural isolation, cultural safety concerns, racism or discrimination and the pressure of "being **Māori** or **Pasifika**" in a dominant western-centric biomedical health system (**Ratima** et al., 2007).

Systemic racism, as highlighted by both the **Hauora** report (**Waitangi** Tribunal, 2019) and **Bula Sautu** (Health Quality & Safety Commission, 2021), and long standing health inequities experienced by **Māori** and **Pasifika** (Health and Disability System Review, 2020) compound the challenge for **Māori** and **Pasifika** AHP. These findings suggest an extra layer of potential challenges for **Māori** and **Pasifika** staff, particularly those in their early years of practice when adjusting to new roles and organisational systems (Stoikov et al., 2020). Despite this, there is an absence of research seeking to explore their experiences and perspectives and how they can successfully navigate these complexities in practice. Therefore, the aim of this study was to explore perspectives and experiences of current **Māori** and **Pasifika** AHP with respect to what enables them to thrive or flourish within CMH with a particular focus on their first 2 years of practice.

Thriving at work is characterised by a shared sense of learning and vitality (Kleine, Rudolph, & Zacher, 2019; Prem, Ohly, Kubicek, & Korunka, 2017; Spreitzer, Sutcliffe, Dutton, Sonenshein, & Grant, 2005). There is increasing interest in this concept as it applies to health professionals, with evidence emerging from nursing that explores strategies and experiences which allow nurses to thrive in demanding and challenging settings (McDonald, Jackson, Vickers, & Wilkes, 2016; Pabico, 2015). Although there is limited research specific to AHP and **Māori** and **Pasifika** populations, the ever-increasing healthcare needs, and demands faced by AHP highlight the need to explore this further (Hall, 2020; Harris, Cumming, & Campbell, 2006; Santos, Barros, & Carolino, 2010).

The concept of thriving has been chosen as a starting point for this study, two considerations must be noted. Firstly, in **Aotearoa** there is limited Indigenous focussed research about thriving, compared to flourishing (**Kingi**, Durie, Cunningham, Borman, & Ellison-Loschmann, 2014; Rolleston, McDonald, & Miskelly, 2021). Secondly, the appropriateness of thriving as a term for this research will ultimately be determined by the participants themselves. Although both flourishing and thriving pertain to an individual's growth and development, flourishing tends to focus more on psychosocial and emotional wellbeing, while thriving also encapsulates performance and both mental and physical health (D. J. Brown, Arnold, Fletcher, & Standage, 2017). The thriving concept was chosen for this study largely due to

pragmatic reasons; first, alignment with a growing body of work coming from the nursing profession, and second; thriving captures performance, mental and physical health, which are increasingly important given the issues facing the health system today.

Position of Researcher

I am not an individual,

I am an integral part of the cosmos.

I share divinity with my ancestors, the land, the seas and the skies.

I am not an individual because

I share a **tofi** (an inheritance) with my family, my village, my nation.

I belong to my family and my family belongs to me.

I belong to my village and my village belongs to me.

I belong to my nation and my nation belongs to me.

This is the essence of my sense of belonging.

Tui Atua Tupua Tamasese (**Efi**, 2003)

The above assertion encapsulates how we **Samoan's** view our place in the world, as deeply interconnected, reciprocal beings who operate as a small part within the whole interwoven tapestry of the universe. Being **Samoan** and **Māori**, this **Samoan** worldview resonates with my **Māori** perspective, and guides the way I engage in all facets of life, including my professional career.

As a **Māori Samoan** male AHP I have chosen to undertake this research partly due to my personal experiences navigating a health career, within a non-**Māori** non-**Pasifika** working environment, and, in part due to time spent listening to my colleagues sharing similar experiences. Along with my **Māori** and **Pasifika** colleagues, I have experienced daily challenges and struggles that impact on our ability to thrive. This includes unspoken expectations to provide cultural support to patients and non-**Māori** or **Pasifika** colleagues, feeling isolated as the only **Māori** or **Pasifika** person in the team, and feeling at odds with delivering the prevailing western-centric health model. However, despite these challenges, we continue to turn up every day doing our best for the organisation and patients.

This led me to question what could be done differently to honour the contribution that my colleagues are making. The changing face of health and the shift towards community-based health services means these stories are critical for us to understand what we need as **Māori** and **Pasifika** AHP to succeed and thrive within these environments.

Chapter Organisation

This chapter provided background context for this study and my positioning as a researcher. Chapter two provides an overview of the literature relevant to thriving at work and the experiences of **Māori** and **Pasifika** health professionals. Chapter three introduces the research methodology including **Kaupapa Māori** and **Pasifika** research approaches, and data collection and analysis methods. Chapter four presents the findings and outlines the themes and sub-themes constructed through data collection and analysis. The fifth and final chapter discusses these themes further, drawing on the Sea of Islands concept. Key recommendations for CMH and other health organisations that could enable **Māori** and **Pasifika** AHP to thrive within the workplace are also provided.

CHAPTER TWO: Literature Review

Introduction

Literature suggests a skilled, reflective workforce can contribute to improving health disparities and is a key component in overcoming health inequities (**Ratima** et al., 2007). This perspective however primarily focuses on recruitment as a key mechanism for producing a reflective workforce, even though this is only one aspect of producing a diverse workforce (McClintock, Stephens, Baker, & **Huriwai**, 2018). Although much emphasis has been placed on the benefits of increasing the number of **Māori** and **Pasifika** health professionals (Curtis & Reid, 2013; Curtis, **Wikaire**, Stokes, & Reid, 2012; O'Brien, Scheffer, van Nes, & van der Lee, 2015; **Ratima** et al., 2007; Southwick & **Solomona**, 2007), there is an equal responsibility to look beyond 'target numbers' and consider one's ability to thrive within a profession and specific work environment (Hall, 2020; Kleine et al., 2019). A focus on understanding the experiences and aspirations of **Māori** and **Pasifika** AHP may contribute to a wider and more meaningful perspective of work force sustainability.

Employee retention rates have been used to demonstrate the effectiveness of an organisation to retain staff (Das & Baruah, 2013). High or low retention rates can be interpreted to demonstrate whether an organisation is well-functioning and responsive to the needs of staff (Das & Baruah, 2013), the inference being, if people stay they must be happy. However, retention in isolation does not provide a clear understanding of the reality or challenges employees face. Retention data shows us how many are staying; however, this does not provide insight into the factors that make them stay, or furthermore, enable them to thrive.

Strong evidence supports the notion that workforce diversity can produce multiple benefits for organisations and communities (O'Brien et al., 2015; Saxena, 2014). These benefits include; increasing access to a larger talent pool; increased exposure to different cultural perspectives; opportunities for diverse innovation and creativity; and enhanced problem-solving strategies. Additionally, the potential for greater connection to the local community is attainable for organisations who value and actively pursue workforce diversity (**Ratima** et al., 2007).

It has also been found that increased workforce diversity is associated with early and appropriate access to services; design and delivery of health services which incorporate holistic perspectives; improved patient satisfaction, experience and cultural concordance, and

improved treatment selection and adherence (Brownie et al., 2021; Curtis & Reid, 2013; Curtis et al., 2015; Curtis et al., 2012; O'Brien et al., 2015; **Ratima** et al., 2007).

In an **Aotearoa** context, anecdotal evidence suggests several obstacles that must be overcome if thriving at work is to be realised for **Māori** and **Pasifika** health professionals. There is however a lack of empirical evidence exploring this in more depth. The following evidence provides an overview of the concept and rationale for thriving at work. This will be followed by reviewing evidence to identify the work experiences of **Māori** and **Pasifika** health professionals and to identify potential gaps in the available literature or knowledge base.

Thriving at Work

Thriving at work has been described as a state of a shared sense of both learning and vitality and a key indicator of someone's growth and progression (Kleine et al., 2019; Porath, Spreitzer, Gibson, & Garnett, 2012; Prem et al., 2017; Spreitzer & Porath, 2014; Spreitzer, Porath, & Gibson, 2012). Learning is about an individual feeling that one is getting better at their craft by developing new knowledge and skillsets while vitality is associated with feeling energised, passionate and alive at work, fuelled by joy for what they are doing (Spreitzer et al., 2012). This can provide a spark for both the thriving individual and others around them (Spreitzer et al., 2012). Furthermore, Porath et al. (2012) suggests thriving is strongly related to the context of existing social systems and constructs (Porath et al., 2012). Spreitzer & Porath (2014) go on to state that for individuals to thrive, growth must occur both psychologically and physically, underlining the importance of thriving as a key indicator of an individual's positive advancement.

In their seminal paper, Spreitzer et al. (2005) offer key reasons as to why thriving is an important concept, particularly as it relates to challenging work environments such as working in the public healthcare system. First, thriving recognises an individual's ability to be able to self-regulate based on how they are feeling. This internal cue is helpful as it creates a space for individuals to consider whether what they are doing, and how they are doing it, is promoting a sense of positive progress - characterised by a feeling of growth, development, and the ability to adapt to varied or difficult work environments (Abid & Ahmed, 2016; Porath et al., 2012; Spreitzer et al., 2005). This acknowledgement of the internal drivers and ownership of thriving recognises the importance of autonomy as an individual's ability to determine their own direction of adaptability.

In the context of this paper, assertions made by Spreitzer et al. (2005) would appear to reaffirm the position of **Māori** and **Pasifika** AHP ability for self-determination in responding to their own notions of growth and progress in their working environments. Self-determination is concerned with the drivers behind people's choices and is characterised by a sense of autonomy, feeling capable and feeling connected (Spreitzer & Porath, 2014). While autonomy, competence and relatedness have all been identified as key nutrients to thriving at work (Spreitzer & Porath, 2014), increasing evidence tells us that we are still not getting it right for **Māori** and **Pasifika** communities, including health professionals (Health Quality & Safety Commission, 2021; McClintock et al., 2018; **Waitangi** Tribunal, 2019)

Second, Spreitzer et al. (2005) propose that thriving has positive implications on one's health and wellbeing. This is advantageous for healthcare workers particularly as they are tasked with caring for sick and vulnerable groups, while at the same time navigating challenging work environments and trying conditions. Spreitzer et al. (2005) contends that when individuals have a sense of vitality, they are less likely to suffer from anxiety, depression or burnout and are more likely to report healthy mental and emotional states. Consistent with this, Kleine et al. (2019) found a moderate and positive correlation between thriving at work and subjective health outcomes including a reduction in the risk of burnout (Kleine et al., 2019). As a consequence, Kleine et al. (2019) recommended practitioners cultivate environments conducive to thriving.

In the context of this research, cultivating environments conducive to thriving, may be easier said than done when considering, the on-going impact of colonisation, racism and the low numbers of **Māori** and **Pasifika** AHP. This difficulty becomes more apparent when a utilitarian approach is adopted. A utilitarianist view accepts some degree of harm as an inevitable consequence of providing the greatest good for the greatest number (Fadyl, 2021) which is ominous for marginalised groups such as **Māori** and **Pasifika**. Fadyl (2021) suggests caution should be exercised when applying this approach as evidence suggests there is a pattern in terms of who is disadvantaged.

Although thriving at work, as defined by the evidence, provides a good theoretical framework for positive progression, it is also dependant on factors largely outside the control of many **Māori** and **Pasifika** AHP working at CMH. Therefore, exploring **Māori** and **Pasifika** perspectives of thriving at work is imperative to ensuring any initiatives developed are fit for purpose.

Search Method

A literature search was undertaken to identify existing evidence pertaining to the work experiences of **Māori** and **Pasifika** AHP. A search as conducted using CINAHL, EBSCO, MEDLINE and Google Scholar. A keyword search strategy was developed using the following terms: Allied Health OR Allied Health Professionals; **Māori** OR **Maaori** OR **Maori** OR indigenous; **Pasifika** OR pacific peoples OR Pacific Islander OR **Pasefika**; and Experience* and Thriv*. To further refine the results limiters were applied which included a focus on full text literature published in the last 10 years, and in the English language. The remaining article headings were scanned for relevance and abstracts read if an article title suggested possible alignment.

Perhaps unsurprisingly, very few articles were discovered pertaining to allied health more broadly. Generally, literature was related to barriers and facilitators to recruitment, fostering resilience in health professionals and was primarily focussed on the overall health workforce, not allied health. Further, the search strategy did not yield a single study exploring work experiences of **Māori** & **Pasifika** AHP and what factors enabled a positive or thriving work environment.

Given the limitations and lack of relevant literature a broader search seeking evidence pertaining to the experiences of **Māori** & **Pasifika** health professionals (versus AHP more specifically) and the experiences of Indigenous allied health professionals (versus **Māori** and **Pasifika** more specifically) was undertaken. Further, given limited research was identified through a formal search strategy, a broader approach was taken, including a grey literature search to look for unpublished research, theses, and strategy documents.

Western academia has long privileged the systematic review approach over other forms of evidence. However, it has been argued they tend to be better suited to addressing narrowly focussed questions and summarising data (Greenhalgh, Thorne, & Malterud, 2018). In contrast, when utilised, a narrative review can produce greater understanding and deeper meaning about the research question specifically, but also the approach underpinning a research topic (Greenhalgh et al., 2018). Given an intent of this research is to produce work that affirms the validity of Indigenous knowledge systems, and on gaining insight into the experiences and perspective of **Māori** and **Pasifika** AHP, adopting a narrative review approach seemed a natural fit.

The evidence identified via these means was synthesised and is presented below in three key sections including: a) thriving at work; b) experiences of **Māori** and **Pasifika** health

professionals; and c) Indigenous experiences of AHP. The chapter concludes with a summary highlighting the opportunities to strengthen the evidence base and rationale for this research.

Experiences of Māori and Pasifika Health Professionals

There is a lack of literature that specifically explores the experiences of **Māori** and **Pasifika** health professionals in the workplace. Rightfully so, much of the research focus has explored health inequities, barriers and facilitators to services and the experiences of **Māori** and **Pasifika** patients and their **whānau** when engaged in the public healthcare system (N. Brewer et al., 2019; Dalbeth et al., 2013; **Foliaki**, **Pulu**, Denison, Weatherall, & Douwes, 2020). The general conclusion from this existing research is that many **Māori** or **Pasifika** have negative experiences, and experience feelings of isolation and hostility during their interaction with the public health system (Graham & Masters-**Awatere**, 2020; Wilson & Barton, 2012). Although these findings are not focussed on the **Māori** and **Pasifika** workforce, they do highlight that the experiences of **Māori** and **Pasifika** more generally are less than ideal.

Of the few papers that explored the perceptions or experiences of health professionals, the focus was more on the experiences of working with **Māori** or **Pasifika** communities (Harding & Oetzel, 2019; Humphrey et al., 2016). Other research highlighted the fact that the majority of health professions are non- **Māori** or **Pasifika** and points to the importance of cultural safety within the workplace (Humphrey et al., 2016; McClintock et al., 2018). However, very little research explicitly aimed to explore the experiences of **Māori** and **Pasifika** Health Professionals. As such, research exploring **Māori** and **Pasifika** experiences in Health adjacent roles has been included below.

A 2019 article highlighting the experiences of six **Māori** and **Pasifika** leaders in government health advisory groups showed health system inequities were prevalent throughout the system. Common experiences included feeling isolated and under-valued, frustration with not being taken seriously, and overall discomfort with the meeting processes and environments. This is despite all six individuals having advanced experience, knowledge and credibility in governance roles (Came, McCreanor, **Haenga**-Collins, & Cornes, 2019). These feelings reflect those voiced by the **Māori** and **Pasifika** health workforce (Brownie et al., 2021; **Ratima** et al., 2007).

Research exploring **Māori** scientists' experiences found that they operate across two worlds - their professional world and their cultural world. Although **Māori** scientists felt a sense of cultural obligation to take on extra responsibilities as conduits between their workplace and

Māori communities, this inevitably resulted in detrimental consequences, as these cultural responsibilities usually extended beyond the job description or long after a project had ended. This resulted in increased pressure and higher workloads that led to a lack of career progression, due to a lack of time to produce and publish work. It was also argued to contribute to health issues such as burn-out and stress, and ultimately to **Māori** scientists leaving the profession (Haar & Martin, 2021).

While this research looked at **Māori** scientists, these findings point to a broader cultural commitment many **Māori** and **Pasifika** carry with them into their workplace, including the invisible weight of responsibility and obligation many experience in their roles. It highlights the need for employers to be conscious and intentional with how they support and nurture **Māori** and **Pasifika** staff, while at the same time, actively seeking opportunities to interrogate structural issues and improve resourcing to offload typically overworked **Māori** and **Pasifika** staff, especially those early in their careers.

In contrast to findings which outline the challenging reality of being **Māori** or **Pasifika** in differing work settings (Came et al., 2019; Haar & Martin, 2021), a survey of **Māori** health workers found that two-thirds of the 2331 survey respondents were satisfied in their work and that they felt valued in their workplace (McClintock et al., 2018). The ***Te Iti me te Rahi****: Everyone Counts* report (McClintock et al., 2018) was conducted in response to the information gap on the experiences of the **Māori** health workforce, necessitated by the need to develop capability across the sector. Interestingly, while McClintock et al (2018) revealed the majority of respondents felt valued and satisfied, only one-third of this group reported an adequate cultural supervision plan was in place and only two in five people felt their salary reflected their contribution. These reports echo the findings from both Came et al (2019) and Haar & Martin (2021) who suggest given the additional skills, and workload, that many **Māori** and **Pasifika** possess, employers have the opportunity and obligation to recognise **Māori** and **Pasifika** as precious human resources who should be rewarded as such.

Experiences of Indigenous Allied Health Professionals

Allied health, sits alongside Medicine and Nursing to form the three main clinical groups that most health professions fall under (Chadwick, 2018). For this paper PT, OT, SLT, PH and DT were chosen as the focus professions as each of them reflects the same chronic under-representation of **Māori** and **Pasifika** practitioners. Despite accounting for a large proportion of all health workforce in **Aotearoa**, the experiences of **Māori** or **Pasifika** AHP are all but invisible in the literature.

Although still emerging, there is a solid evidence base both in **Aotearoa** and abroad being cultivated by Indigenous allied health researchers and clinicians. The existing literature explores issues such as the influence of racism, implications of cultural competence, on-going impact of colonisation, Indigenous perspectives of health, and **Māori** and **Pasifika** health workforce development challenges as avenues for reducing health disparities (Emery-Whittington & **Te Maro**, 2018; **Hoeta**, Baxter, **Pōtiki** Bryant, & Mani, 2020; Magnusson & Fennell, 2011; Main, McCallin, & Smith, 2006; **Ratima**, Waetford, & **Wikaire**, 2006; **Wikaire** & **Ratima**, 2011).

Research exploring the experiences of **Māori** OTs choosing and completing OT training highlighted the importance of cultural competence and cultural safety for **Māori** OT students (Davis, 2020). These findings are consistent with previous allied health research in PH, SLT and PT, which identified cultural competence and safety as critical to enhancing the ability of AHP to contribute more effectively in addressing health inequities (Aspden, Butler, Heinrich, Harwood, & Sheridan, 2017; K. Brewer & Andrews, 2016; **Ratima** et al., 2006) for **Māori** and **Pasifika**. While the above research clearly outlines the significance of cultural safety and culturally safe environments for **Māori**, successfully achieving cultural safety will also produce positive benefits for **Pasifika**, and other marginalised groups (Curtis et al., 2019).

These findings mimic overseas research that highlights similar experiences. Racism and discrimination, workforce under-representation at all levels, the weight of serving complex populations, burn-out, and the lack of appropriate support mechanisms are all experiences routinely faced by minority and Indigenous AHP (Conway, Tsourtos, & Lawn, 2017; Gibson, 2020; Lai, Taylor, Haigh, & Thompson, 2018; Manton & Williams, 2021; Vazir et al., 2019). While there are strong foundational pieces to draw on, overall, the literature as it pertains more broadly to the workplace experiences and perspectives of Indigenous AHP is limited.

Conclusion

Despite widespread acknowledgement of the importance developing a diverse health workforce carries for addressing inequities in **Māori** and **Pasifika** health, there is an absence of strengths-based research exploring how **Māori** and **Pasifika** AHP are enabled to thrive as health professionals. To date, research has mainly centred on experiences of **Māori** and **Pasifika whānau** in the health system, or the experiences of health professionals working with **Māori** or **Pasifika** communities. Although there is a growing body of evidence highlighting the consistent failures of the health system in addressing the needs of **Māori** and **Pasifika** more broadly (Health Quality & Safety Commission, 2021; McClintock et al., 2018; **Ratima** et al.,

2007; **Waitangi** Tribunal, 2019) the overall evidence base as it relates to allied health and thriving is limited. There is nothing specifically exploring the experiences of **Māori** and **Pasifika** AHP; examining what enables them to thrive; or what influence this may have in the initial two years of practice.

This study aims to contribute to the identified literature gap by highlighting the work experiences of **Māori** and **Pasifika** AHP at CMH. It is anticipated that giving voice to this group, will provide insight as to what is needed to enable thriving in the workplace, particularly in the initial years of practice. It is expected these learnings will inform and guide a shift to culturally supportive and safe environments that embrace **Māori** and **Pasifika** Indigenous AHP practices and values. I hope this study will help form the foundation of more specific research that explores **Māori** and **Pasifika** AHP experiences.

CHAPTER THREE: Methodology

This study draws on principles of Appreciative Inquiry and both **Māori** and **Pasifika** cultural frameworks. A qualitative approach was chosen as it provides a suitable medium for rich storytelling and experiential narratives to emerge (Sofaer, 1999). Qualitative approaches empower participants to share their experiences and suits the intention of this study – strengthening Indigenous perspectives to bring life to the experiences of **Māori** and **Pasifika** AHP working in the DHB system.

Kaupapa Māori

The specific elements of **Kaupapa Māori** research can be difficult to articulate, given the diversity and range of interpretations that the term **Kaupapa Māori** represents (Durie, 2004). However, at the core is an approach founded on **Māori** worldviews, **Māori** philosophies and **Māori** practices (G. H. Smith, 1992; L. T. Smith, 2013; Walker, **Eketone**, & Gibbs, 2006). A **Kaupapa Māori** approach offers overarching principles that inform conduct, rather than a set method providing flexibility and adaptability for research to occur (Durie, 2004; **Hiha**, 2016).

Kaupapa Māori principles position **mātauranga Māori** and a **Māori** worldview as the central tenet to research, aimed at empowering **Māori** and progressing **Māori** aspirations (H. Barnes, 2000). G. H. Smith (1992) adds that a **Kaupapa Māori** approach is a lived philosophy and takes for granted the **Māori** reality as normal and legitimate. Furthermore, **Kaupapa Māori** has a focus on **Māori** advancement by reasserting **Māori** aspirations for **Tino Rangatiratanga** and **Mana Motuhake** (**Pihama**, 2012; **Pihama**, Cram, & Walker, 2002; L. T. Smith, 2013) providing a positive platform for achieving **Māori** aspirations, in ways defined by **Māori** themselves (Lawton et al., 2013).

A **Māori** centred approach has been said to be informed by key principles that include **whanaungatanga**, **rangatiratanga, manaakitanga**, **kaitiakitanga**, **wairuatanga**, **te reo**, **whānau**, **kotahitanga** and **tikanga** (Cram, Phillips, **Tipene-Matua**, Parsons, & **Taupo**, 2004; Durie, 2004; Henry & **Pene**, 2001; **Hiha**, 2016; G. H. Smith, 1992; L. T. Smith, 2013; Walker et al., 2006).

As noted earlier, a **Kaupapa Māori** research approach can vary in terms of application or expression across a range of different settings. This research intentionally grounds itself

within cultural values, customs, and processes to ensure a safe and positive experience for all **Māori** involved in this research.

Pasifika Paradigm

The Pacific is vast and diverse and is made up of numerous sovereign states with distinct languages, cultures, customs and resulting worldviews. With many **Pasifika** people now calling **Aotearoa** home, shared values and commonalities have emerged and continue to evolve. It is worth noting that an increasing number of **Aotearoa** born **Pasifika** peoples adds further layers of diversity. **LeVa** (2009) listed the following as essential considerations when working with Pacific peoples:

- Pacific people and their respective cultures are unique, and that each culture has its own distinctive values, protocols, processes and language.
- Pacific families possess a broad spectrum of cultural, historical, social and political diversity.
- The concepts of family, the structural make up of Pacific families and traditional Pacific authority systems and acknowledges the existence of the extended family and is sensitive to cross-cultural and intermarriage contexts.
- Recognises contemporary Pacific sub-cultures and their influence on traditional Pacific cultures.
- The value of spirituality and ancestral honour that underpin some Pacific family and community relationships.
- Acknowledges that Pacific people's sense of identity and belonging may be connected to family, village and church.
- Acknowledges that Pacific cultural processes are relationally bound and so require sufficient time to be carried out appropriately.
- Understands the value of, and difference between, ethnic specific and pan Pacific approaches to service delivery in Pacific mental health, and the influence of these within clinical and organisational contexts. (p.21) (**LeVa**, 2009)

Samoan academic, **Tui Atua** proposes that a **Pasifika** worldview places the individual within a multi-layered and multi-directional holistic tapestry connected to all things living and non-living, seen and unseen (**Efi**, 2003). Accompanying this connectedness is an unspoken responsibility to, and for, all other connected beings. Therefore research, conducted from a **Pasifika** paradigm duly acknowledges that participants do not come merely as individuals,

but rather, engage as connected, multi-layered beings who draw on multiple knowledge sources and perspectives which provides a layer of authenticity to this research.

As such, in addition to the above considerations, **Pasifika** centred research is founded on the premise that research within **Pasifika** communities should have relevance, do no harm, and add value to **Pasifika** communities (Health Research Council, 2014). Key **Pasifika** values including Respect, Reciprocity, Relationships, Collectivism, and Service (Bennett et al., 2013; Health Research Council, 2014; **Naepi**, 2019) should be adhered to when conducting research with **Pasifika**.

It is important to note that the intentions of this research are to not perpetuate colonising behaviours and thus the need to acknowledge that the term Pacific has largely been used for the convenience of grouping purposes (**Tunufa'i**, 2016) and is not an Indigenous self-given term. The dominant discourse of Pacific research literature comes from **Samoan**, **Tongan** and **Fijian** perspectives, so caution is advised when thinking about application across the diverse and proud Island nations.

As cited in Ferguson, Gorinski, **Samu**, and **Mara** (2008), **Samu** (1998) advocates for the term '**Pasifika'** as a beacon of unity and empowerment amongst Pacific communities. She proposes this word, rather than Pacific Islanders, as a mechanism of self-determination and asserting our own power and control. Although this is not a universally agreed notion, even amongst Pacific academics (McRae, 2021) this resonated with me as a means of shifting focus back to a place of collective strength and inclusiveness. So, the use of the term Pasifika in this study is intentional, while being aware both of its limitations and criticisms.

Tangata o le Moana – A Shared Approach

A subtle but important difference of note is that this research will be guided by shared aspects from both **Kaupapa Māori** and **Pasifika** research paradigms. This honours my shared lineage and the legitimacy of Indigenous knowledge systems more broadly; is authentic to my worldview; and offers an opportunity to prompt thought and discussion around shared methods and approaches. Thus, by adhering to an agenda of Indigenising, it is hoped this research will also contribute to an agenda of decolonising; that is, at all phases, processes are conducive to **Māori** and **Pasifika** ideals, values and aspirations while also challenging the dominant discourse.

Culturally fundamental concepts including the importance of nurturing and building relationships, connectedness between each other and the environment, reciprocity,

spirituality, and service to one's community, **whānau** or **aiga** all underpinned this research. Incorporating a shared framework provides a higher degree of cross-cultural responsiveness that celebrates the strength of similar cultural perspectives, while at the same time recognising and protecting unique and special teachings of **Māori** and **Pasifika** worldviews.

Teu Le Va

Teu le va is one such culturally fundamental concept. According to **Anae** (2010), the **Samoan** phrase, ***Teu le Va***, can be interpreted as to value, cherish, nurture and take care of the **Va** or space; as in the space or relationship between people and things. This concept focusses on the central tenet of reciprocity in relationships (**Anae**, 2010; **Suaalii-Sauni**, 2017), and is commonplace among many **Pasifika** cultures (**Anae**, 2010; **Anae, Mila**-Schaaf, Coxon, **Mara**, & **Sanga**, 2010; **Suaalii-Sauni**, 2017). Albert Wendt (1999) describes **Va** as the connecting space between us while Poltorak (2007) adds that in a **Tongan** context, **Vaha'a** can be viewed as the relatedness between people (Poltorak, 2007; Wendt, 1999).

The **Va** concept underpins that we, and all things are connected and interlinked through the space in-between, for it is in this space that we share commonalities (**Suaalii-Sauni**, 2017; Wendt, 1999). Rather than the space being viewed as something that divides or separates us, this cultural framing allows us to begin from a position of unity and acceptance. My understanding and interpretation of **Teu le Va** concept, in a **Māori** and my **Samoan/Pasifika** contexts is key to this research for two primary reasons. First, as the researcher, I am responsible for, and to, the research participants. Given that all participants were known to me prior, it was important that I cared for and nurtured these relationships throughout and beyond the study, as I would when applying **whanaungatanga, manaakitanga** and **kaitiakitanga** under a **Kaupapa Māori** lens. Second, the **Va**, in the context of this research approach, which draws on the shared space between **Māori** and **Pasifika** research values, would provide the perfect place to ensure each approach is able to flourish and thrive separately, and together.

The use of Indigenous concepts such as **le va**, ensured data is collected in a way that honours the origins of both **Tangata whenua** and **Pasifika** knowledge systems. More importantly however, **le va**, and similar **Māori** concepts dictate a commitment beyond just research purposes, but in all aspects of how **Māori** and **Pasifika** AHP relate to each other ensuring a positive relationship at its core (H. Smith, Wolfgramm-**Foliaki**, & Gillon, 2021).

Advisory **Whānau/Aiga**

The primary researcher has sought on-going guidance from an advisory **whānau aiga** made up of **Māori** and **Pasifika** AHP that sit outside the inclusion criteria for this research. The advisory **whānau** are individuals who have strong cultural and professional connections across a variety of Allied Health disciplines in **Aotearoa** and across the Pacific.

This group provided an external soundboard to ensure ongoing involvement and support of the researcher and to ensure the study remained consistent with the ideals and values of **Māori** and **Pasifika** communities. Advisory **whānau** have included:

- Dr Teah Carlson (Co-Chair **Ngā Pou Mana**)
- Alexis Cameron (Co-Chair **Pasifika** Allied Health **Aotearoa** New Zealand- PAHANZ)
- Fred **Fata** (Co-Chair **Pasifika** Allied Health **Aotearoa** New Zealand- PAHANZ)
- Dr Martin Chadwick (Chief Allied Health Professions Officer)
- **Fatitauai Atuatasi Tavita Aofia Tofi** (Clinical Psychologist- Retired)
- **Riki Nia Nia** (Executive Director, **Māori**, Equity & Health Improvement at **Waikato** DHB)
- **Hanuere Tofi** (Ministry of Education Manager Learning Support)

For practical, and logistical reasons, the researcher connected with individuals as and when appropriate rather than viewing them as a single functioning unit. Engagements were largely informal and unstructured. Early-stage discussions helped refine the research question by focussing on the initial two years of practice, and having a focus on shared Māori & Pasifika principles. The value of the advisory **whānau** was evident throughout the research. For example, at times when the researcher felt disillusioned or frustrated by certain procedural and academic constructs, advisory **whānau** members encouragement and support helped the research to keep going. Ultimately, the advisory **whānau** was a source of nourishment for the researcher providing inspiration, reassurance, challenge and opportunity for critical reflection.

Appreciative Inquiry (AI)

Appreciative inquiry (AI) is a methodology used to promote organisational change that traditionally involves four steps: Discovery, Dream, Design, and Destiny. Given the constraints and scope of this study, the full AI methodology was not employed. Rather, the general tenants of AI will be drawn on more broadly with a focus on the Discovery and Dream steps given their fit with the research intention. Rather than focusing on deficits or problems, AI offers a positive, affirming, strength-based approach to transformation, one that asks how could things be different rather than what's wrong with things (Cram, 2010; Trajkovski, Schmied, Vickers, & Jackson, 2013b). **Māori** and **Pasifika** communities have been subjected (unintended or otherwise) to deficit research resulting in stigma and negative perceptions. As such, the strength-based approach embedded within AI allows for a more positive framing. Further, committing to a solutions-focus, and asking "how could things be different?" allows a move beyond exploratory work to identify actionable insights for CMH.

AI was first developed by Cooperrider and Srivasta in the 1980's and has long been used by organisations as a way to advance systems, processes, services and practice (Cooperrider & Srivastva, 2017) by focussing on what works well and utilising these aspects to create a strength-based change approach. Key aspects of AI align well with the intention of this research to support the repositioning to strengths-based solutions by **Māori** and **Pasifika**, for **Māori** and **Pasifika**, with **Māori** and **Pasifika** groups.

Discovery

Trajkovski et al. (2013b) assert that the discovery phase seeks to explore and discover what specific factors give life to the individual, and their workplace and the organisation in any given scenario. This phase of AI allows individuals, or organisations, to drill down on the very 'best of what is', regardless of how many or how few, moments there may actually be. Fundamentally, even amongst the most challenging scenarios there is light to be found. So, it is through the Discovery phase individuals and organisations can recognise and appreciate those 'best' moments. By drawing intentional focus to these moments of excellence, it allows for them to be highlighted and explored. Ludema, Cooperrider, and Barrett (2006) add that by valuing the "best of what is" organisations can illuminate new pathways to better futures by consciously reframing existing deficit-based constructs. The appropriate use of AI displaces the dominant deficit discourse with one that focusses on the positive "best of what is" and allows space for individuals to consider new possibilities within their organisation.

Dream

The second phase of AI is the Dream phase which builds on the findings of the Discovery phase (Trajkovski, Schmied, Vickers, & Jackson, 2013a). This phase is aspirational in that it seeks to explore "what could be". This phase encourages participants to work together to envisage new ideas for the future (Trajkovski et al., 2013a) and as participants start to contribute, different perspectives emerge, constructing new possibilities of different futures. A relevant strength of the dream phase is it enables participants to free themselves of existing boundaries and barriers of "what it is" and shift to a space where positive, self-determined visions of the future exist (Ludema et al., 2006; Trajkovski et al., 2013a, 2013b).

Key Principles of AI

Five key principles underpin the Appreciative Inquiry approach (Richer, Ritchie, & Marchionni, 2010; Trajkovski et al., 2013b; Trajkovski, Schmied, Vickers, & Jackson, 2015) and are briefly outlined below:

1. The Constructionist principle recognises that our knowledge, language and actions are linked; what we say, what we think and what we do.

2. The Simultaneity principle acknowledges that inquiry is intervention. Meaning the opportunity to plant the seeds of change can happen from the very first question we ask, hence asking or framing questions in a hopeful way to sow positive seeds of change.

3. The Poetic principle acknowledges that a story or event is constantly being written and re-written. This highlights the notion that as individuals we perceive, and thus recount the same event differently.

4. The Anticipatory principle pertains to the image we hold of the future, guides our current behaviours. Positive framing increases the likelihood of a positive result, and equally, a negative framing increases the chance of a negative outcome.

5. The Positive principle states the more positive the approach, or line of questioning, the more likely a positive outcome will occur. Furthermore, by involving people or the groups concerned in the process, there is an increased chance of the positive changes being more sustainable.

Common critiques of AI include an overly simplified view that everything will be ok; the difficulty some may find in maintaining a positive position; that AI does not promote robust evaluation and discourages critical analysis and it fails to examine negative issues (Cram, 2010; Dematteo & Reeves, 2011; Richer et al., 2010; Trajkovski et al., 2015)

This study does not adhere to the strict application of AI phases, rather, it draws on elements of both the Discovery and Dream steps concurrently. That is, data collection focused on both exploring the best of what is (discovery) and the idea of what could be (dream) in a single data collection phase (Ludema et al., 2006; Trajkovski et al., 2013b). The Discovery and Dream stages align with the purpose and scope of this study as it aims to understand how **Māori** and **Pasifika** AHP thrive and can be enabled to thrive at CMH.

Participants and Recruitment

This study consisted of three **wānanga talanoa** sessions with a total of 11 participants. To be eligible, participants needed to identify as **Māori** and or **Pasifika**, be currently employed at CMH, and be practising as either a PT, OT, DT, PH, or SLT.

Purposive sampling was used to capture a diversity of experiences, stories, knowledge and teachings of **Māori** and **Pasifika** AHP. This was to ensure participants possessed the adequate mix of political and cultural understanding to allow for robust and dynamic contributions to the research. Participants were selected on key sampling characteristics such as ethnicity, profession, work setting within the DHB, gender, time since qualification, stage of career, stage of life, and level of cultural knowledge. After discussion with the supervision team, 12 potential participants were identified through existing professional networks and invited to take part by email. Drawing on existing relationships recognises the interconnectedness of Indigenous peoples and practises. The consent form (see Appendix B), participant information sheet (see Appendix C) and participant demographics form (see Appendix D) were sent by email to those who expressed an interest in participating.

Information power was drawn on to determine sample sufficiency (Malterud, Siersma, & Guassora, 2016). This concept argues that sufficient power can be gained from smaller participant numbers and provides five criteria that should be considered when determining if you have sufficient information power including study aim, sample specificity, established theory, quality of dialogue and analysis strategy (Malterud et al., 2016).

Data Collection

Wānanga

Wānanga is a traditional form of transmitting knowledge through discussion, song, prayer and incantation that have formed the basis of **Māori** pedagogy since the creation story (Mahuika & Mahuika, 2020). Like many **Māori** words, the term **wānanga** can have multiple interpretations. In the context of this research, **wānanga** is used as a marker to define the Indigenous context within which participants engage, as well as an Indigenous framework which allows and encourages layers of discussion and the sharing of knowledge, ideas and experiences through **kōrero** (Elder & Kersten, 2015; **Mahuika** & **Mahuika**, 2020; L. Smith et al., 2019). The implementation of ancient cultural protocols such a **karakia**, **mihimihi**, **whanaungatanga**, **take**, **kai** and **poroporoaki** provide safe and familiar grounding rooted firmly in **Te Ao Māori**, but also intentionally positioned within an Indigenous frame (L. Smith et al., 2019). L. Smith et al. (2019) contend that these processes indicate the expectations of participants to actively engage in discussions, contribute to the collective thinking and problem-solving process, rather than just being a 'talk'. Furthermore, **tikanga** that accompany these contexts provide additional layers of cultural, emotional and spiritual support beyond a 'focus group discussion'.

Talanoa

Talanoa is becoming widely recognised and utilised in research within **Pasifika** communities, and can be viewed as both a methodology and a method (**Otunuku**, 2011; **Vaioleti**, 2006), albeit, not without challenge (**Tunufa'i**, 2016). It is important to acknowledge that there are several different forms of **talanoa** with an array of protocols and expectations dependant on the context, themes and significance of participants involved (Farrelly & **Nabobo-Baba**, 2012). **Vaioleti** (2006) described **talanoa** as an informal discussion, conversation or sharing of ideas. In **Samoan**, as with several Pacific language's **tala** means to talk, discuss or conversate while **noa** equates to the ordinary, common, or void. Thus, at one level, **talanoa** can be viewed as an informal discussion where people talk about nothing in-particular (**Vaioleti**, 2006), although **Tunufa'i** (2016) contends that from a **Samoan** perspective, **talanoa** is a full and complete term of its own and does not need deconstruction to highlight it's meaning (**Tunufa'i**, 2016). **Naufahu** (2018) adds **talanoa** is a method of co-creation for knowledge and ideas while **Nabobo-Baba** (2008) highlights **talanoa** as a space for offloading. **Talanoa** is seen as a suitable approach for working with **Pasifika** communities because it allows the cultivation of safe spaces (physically, spiritually, and culturally) to be created

through the development of trust. This allows **Pasifika** to engage in relational dialogue, to share deep experiences and stories, realities and aspirations freely (**Matapo** & Baice, 2020; **Otunuku**, 2011; **Vaioleti**, 2006). The use of **talanoa** as interpreted above, underlines the appropriateness of **talanoa** as an approach for the purposes of this research and the needs of the participants.

Wānanga Talanoa Sessions

Consistent with the intention to draw on both **Māori** and **Pasifika** practices, data collection took the form of **wānanga talanoa** sessions. **Wānanga talanoa** sessions were guided by the researchers' cultural responsibilities and obligations acknowledging the shared, yet unique cultural processes of each. A fluid approach delicately interweaving aspects of both **wānanga** and **talanoa** was adopted to honour each traditional, yet culturally separate space, and ensuring all participants were able to express themselves within the contemporary context for this research.

There were three data collection sessions in total, two group sessions of five participants in each group which were conducted at a CMH conference room, and an individual session at the participant's home. For the individual **talanoa**, being a visitor in the participants home meant I was prepared to follow their process. As it transpired, we opened with **karakia/lotu**, moved into re-connecting, and then on to exchanging **kōrero**.

Group sessions were between 60 and 80 minutes and were all audio recorded. Each session was opened with a **karakia lotu**, then **mihimihi** for introductions, **whanaungatanga** to connect or re-connect, then **kai** to extend **whanaungatanga** to nurture relationships within the groups. Once settled, all participants were reminded of the research question and aims which then led into a facilitator led **kōrero** about establishing a shared **tikanga** regarding expectations of self, of others, what we wanted to offer the **wānanga talanoa**, and how we wanted to demonstrate care for each other in the **wānanga talanoa**. This ensured **wānanga talanoa** were grounded in transparency, safety and commitment to each other. Additionally, rather than maintain a researcher-facilitator position during the sessions, cultural obligations required the researcher to actively engage in **kōrero** by contributing his own stories and experiences to further nurture the relationship.

Sessions were encouraged to be informal, relaxed and organic. The opening question asked at each session related to "when you're at your best what does that look like, feel like, mean to you?". A list of question prompts was also developed (see Appendix E) and were used to help generate or guide discussion to ensure **wānanga talanoa** remained within the research aims.

Critical to developing and maintaining the safe space for **kōrero** was the appropriate and subtle use of cultural markers and protocols. Providing a warm welcoming physical and non-physical environment; **karakia lotu**; protecting space and time for **whanaungatanga**, using **Māori** and **Pasifika** languages and terminology; sharing my own journey; appropriately applying humour and challenge/provocation and the sharing of **kai** were all crucial to allow participants the freedom to communicate verbally, physically, emotionally, and spiritually. Each session followed a similar format, layered by cultural protocols and markers which ensured each session elicited its own unique feeling, different to the other but no less authentic, humbling or insightful.

Audio recordings of both the group and individual interviews were transcribed using an external **Māori** transcriber recommended by AUT staff. This was useful as the transcribers own cultural knowledge and leanings allowed for direct transcription of **Māori** terms and more importantly an understanding of the **Māori** participants contextual use of **te reo Māori** and **Māori** concepts. Transcripts were both read and listened through twice. Each re-familiarisation provided an opportunity to gain deeper understandings of what was being shared to thematic development.

Data Analysis

A thematic analysis approach that draws on inductive, semantic and realist forms of analysis through a six step process was adopted (Braun & Clarke, 2006).

Step one - Getting familiar with the data: Each audio recording was listened to twice, and each transcript read twice, allowing a deep familiarisation with the data. With subsequent engagements I highlighted sentences or terms, and made notes as thoughts came to mind. I was conscious of trying not to jump to immediate conclusions, but rather allowed the data to lead me.

Step two – Coding: I used the research questions to guide my initial coding which resulted in the creation of several different codes, and extracts from the **wānanga talanoa**.

Step three- Generating initial themes: Codes and extracts were examined followed by broader codes and the process of grouping into rough themes. As an example, this examination of codes resulted in the generation of “leadership”, “support” and “service” as potential themes.

Step four – Reviewing themes: This step required me to check and review the initial themes against the research question and aims, with the goal of refining, and then organising the

generated themes into themes and sub-themes. During this stage, themes were identified to have lots of overlap and I found it challenging to decide where some of the ideas from the **wānanga talanoa** best fit. At this stage, I questioned and reflected on my process for reviewing the themes. At times I found it difficult not to get lost in my own experiences, assumptions and views as it related to themes, I found myself privileging. I was conscious of needing to stay true to the participants voice and found an anchor through revisiting the data, especially the audio recordings, as they provided grounding in tone, context, and emotion, which guided theme selection.

Step five – Defining and naming themes: By this stage, four main themes developed. Braun and Clarke (2006) urge developing and determining a narrative for each theme and deciding on informative names for each. It Takes a Village, Valuing Cultural Intelligence, Thriving or just Surviving? and Being at our Best are the four themes constructed from the data.

Step six – The write up: As the name suggests, this step involves writing up of the key findings under the aforementioned four themes. A description of each main theme and associated sub-themes are presented in the next chapter.

After **kōrero** with members of my advisory **whānau**, I was reminded that in a Western context, data can be viewed as both a possession, and as pieces of individual information or statistics to be analysed. In a **Fa'a Samoa** context however, what is termed 'data' are people's stories, thoughts and experiences. Furthermore, **Fa'a Samoa** dictates this 'data' is not mine; it has been gifted to me for safe keeping, and therefore, it is my responsibility as a **Samoan** to ensure the findings accurately represent those who entrusted their 'data' to me. In a **Samoan** context, this means engaging with participants throughout the data analysis process to ensure the interpretation of findings reflect the shared stories.

Overall, I found that by underpinning Braun and Clarke (2006) six step process with the aforementioned cultural frameworks, and drawing upon my understanding of shared **Māori** and **Pasifika** principles I was able to uphold the integrity of **Māori** and **Pasifika** knowledge through the data analysis process.

Ethical and Cultural Considerations

Ethics approval was obtained from Auckland University of Technology Ethics Committee (AUTEC) and was approved (AUTEC Number 20/377) (see Appendix A). An email was sent to all potential participants along with participant consent form (see Appendix B), information sheet (see Appendix C) and demographic information form (see Appendix D) prior to agreeing to

participate. The participant information sheet clarified the research purpose, session protocol, that participation was entirely voluntary, and they could withdraw at any time. It also clarified how participant confidentiality and privacy would be protected.

The application of ethics through a cultural lens relevant to **Māori** and **Pasifika** participants and communities was paramount for this study. As most of the participants were known to the researcher, the protection of these relationships added another layer of importance. The concepts of **whanaungatanga** and **teu le va** as previously mentioned provided the Indigenous framework that ensured safety throughout the entire study process.

Finally, I took care to acknowledge in the research processes that: a) **Māori** are culturally diverse and experience a broad range of cultural realities; b) **Māori** and **Pasifika** cultures and cultural practices possess their own uniqueness, and c) **Pasifika** are not a homogenous group, but rather are a collection of proud and diverse cultures that all call **Vasa Pasifika** home.

CHAPTER FOUR: Findings

Introduction

This chapter presents the findings from conversations with 11 **Māori** and **Pasifika** AHP. These findings highlight the participants perceptions of enablers of thriving, as well as their experiences, challenges and opportunities relevant to thriving as **Māori** and **Pasifika** in their first two years of practice.

In this chapter I begin by providing an overview of participants, followed by a detailed discussion, with supporting quotes, of the four themes constructed through my analysis. Pseudonyms are used to maintain privacy. The themes presented in this chapter provide crucial teachings into the unique pressures **Māori** and **Pasifika** AHP face when working at CMH as well as possible solutions.

Participants

Eleven AHP currently employed by CMH consented to take part. Of these, four identified as **Māori**, four as **Pasifika** and three as both **Māori** and **Pasifika**. Two participants were raised in the Pacific Islands, nine identified as New Zealand born. The group consisted of two DT, two PH, one SLT, four PT and two OT with a length of service at CMH from five months to 15 years. Although this research was specifically interested in the initial two years of practice, it was felt that experienced participants who have the benefit of being able to step back and reflect on their experiences as a new grad, would add immense value and align with the cultural frameworks underpinning this research. In the context of this study, wisdom gained through experience cannot be understated. This is especially true for **Māori** and **Pasifika** societies where elders play a vital role in guiding, shaping and protecting those younger (or less experienced). Similarly, it was imperative to have experienced AHP involved to ensure a culturally reflective space where senior experienced colleagues, or **matua**; could provide a similar role of guiding, supporting and protecting the less experienced colleagues.

As previously mentioned, the information power concept proposes a five criteria framework to help ensure sample sufficiency in qualitative research (Malterud et al., 2016). For this study, the specificity of the research aims coupled with purposive sampling of the 11 participants ensured a high level of participant diversity across a range of variables. This is evidenced in the representation of each profession and the breadth of clinical focus areas and experience. The quality and richness of dialogue; the gender, age range and life stage

combination of participants would suggest adequate information power despite the relatively small sample. I would suggest having a greater gender mix from specific professions, and ethnicity mix from others would strengthen the study's information power, however this was not possible given the workforce representation issues previously highlighted.

As a **Māori Samoan**, I acknowledge that my own lived experiences provide me a degree of familiarity and comfort within **Māori** and **Samoan** concepts, however my understanding with other **Pasifika** cultures represented by participants was less certain. As such, it was important that the differing worldviews of the participants were uplifted, safe guarded and respected.

Themes

As noted above, four themes were constructed through my analysis. A brief overview of the themes will be provided before discussing each in more detail, with supporting quotes.

It Takes a Village

This theme relates to the participant **whānau** all identifying the importance of having the right support throughout their careers as an enabler for positive experiences.

Valuing Cultural Intelligence

This theme relates to the innate cultural knowledge that participants felt they brought to their work setting. It touches on the relevance of **Māori** and **Pasifika** cultural identity, values, and worldview in relation to practicing as an AHP. This theme also highlights the high value participants placed on connection and commitment to serving the local community. Reasons for this commitment included; innate holistic perspectives that the participants felt **Māori** and **Pasifika** possess by virtue of their upbringing; the importance of cultural congruence in achieving positive health outcomes; and the influence cultural identity has in caring for others.

Thriving or just Surviving?

This theme highlights the current and lived realities for participants and challenges to thriving they all faced.

Being at our Best

This theme proffers suggestions for a better tomorrow and outlines possible solutions about what 'different', or 'better' could be or look like to enable thriving in the context of CMH.

Theme One: It Takes a Village

This is based on the well-known proverb '*it takes a village to raise a child*'. In this context it refers to the many factors, components and people who must contribute as a village to support the "raising" or nurturing of **Māori** and **Pasifika** AHP. Several sub-themes emerged including *The Right Stuff*; *Leadership Matters; The Collective; Role of Allies* and*; Giving Back.*

The Right Stuff

Overall, participants shared a view that having appropriate mentors, supervisors, and support people around them, or being placed in the right team setting, plays a role in promoting positive and advancing learning experiences.

> *I think being supported is really important. And believing, people believing in me. I think that's probably where I am my best*. **Tasi**

Lua shared the importance of support that utilised reflective practice, goal setting and structured or protected time as an example of the right support:

> *In my first two years of practice, I had either no support at all or I had consistent support that was organised, that was purposeful. So someone who took the time to sit down and allow me to reflect on my practice is what worked for me...the right support was somebody who actually took the time to set time to reflect on things and set goals and really allow me to see if I was doing the right thing or not. That's what it looked like.* **Lua**

Tasi talked about the overwhelming sense of support and comfort she received in her formative years as an AHP as part of a predominantly Māori team and the impact it had on her practice:

> *They just embraced me, and because I was the youngest in the team, they really took on looking after me and mentoring me and showing me the ropes. It was a very family environment.* **Tasi**

Leadership Matters

Participants put forward the role and example of management and leadership, and some participants spoke about the positive aspects of having culturally aligned managers and team leaders:

> *I think the big thing that allowed us to get results that we got was that we had an awesome culture, because of our management and our team leader, who allowed us the ability to work the way we work*. **Hongofulu**

> *But I suppose having a **Māori** team leader or manager then I'm given, I'm allowed to practice in more a holistic and probably a **Māori**-centric way*. **Tasi**

Tolu emphasised the positive mentorship he had with a senior **Pasifika** colleague and felt a key difference compared with other experiences was that he and the mentor came from a similar value system and had a shared cultural understanding:

> *She wanted me to be my own clinician and she created that safety net for me. Whereas like I felt confident enough to go off, because she trusted my clinical reasoning. So I felt confident enough to go and see the patients, come back, feed back to her, and she's like, Okay, thumbs up, I'm happy with that.* **Tolu**

Lua provided a unique perspective as someone who worked in two separate roles with two different managers, both non-**Māori** non-**Pasifika**:

> *The manager in this role, although she's European, she is a lot more open to understanding who I am. So in that sense I feel comfortable enough to share my family, my situation, what I believe in, what I don't believe in with her. I feel really safe in this job, because I know that if I do challenge the status-quo I have support behind me […]. I'm in a good space, because I'm under understanding-leadership*. **Lua**

Whereas:

> *In my other role, […] I've been really disappointed. Like it's a manager who's known me almost my whole career, but doesn't seem to understand me… I'm not like my manager, let's just say it, put it that way. And because of that clash and her not understanding where a lot of what I do comes from, I don't enjoy it there*. **Lua**

While having **Māori** or **Pasifika** leadership was something that participants reported as being beneficial, positive and empowering, there were also examples and opportunity for non-**Māori** and non-**Pasifika** leaders and managers to show a level of understanding of and connection with **Māori** and **Pasifika** AHP that can also be empowering and create safe and supportive working environments. This concept becomes even more important when we consider the number of non-**Māori** non-**Pasifika** who occupy team lead roles with CMH Allied Health services.

Many participants who had experienced positive examples of support, mentoring or supervision felt it helped build self-confidence and instilled an increased sense of belief for self-advocacy:

> *I was reaching out to someone and they were able to provide some, a space just to talk about it and that's when I kind of turned my thinking around and I was kind of like I need support. I remember talking to anyone that I could that kind of understood that side of my life and how that affected my work life. And that made a big difference, is having the right person to be there and to listen and to understand. And not to make excuses for what I was saying, but to guide me along ways, in a way that's gonna be*

> *productive. And then that's when it turned around, and it took me probably two or three years as well to fully be confident in myself and to be able to stand up and advocate for myself*. **Fa**

However, even when the appropriate support mechanisms were in place, there was a clear awareness as to the challenge of embedding these support systems:

> *I think I need what I had last year, which was having time with someone like you who's outside my clinical kind of practice area to bounce ideas off. Making time to meet up with other likeminded people who share the same values to give me the confidence to go back and have those conversations. But it's hard to connect, if there was a regular time, a regular space that was safe to be able to voice these things, bounce ideas, and then go back into that environment and feel confident to say those things or to bring up conversations that are uncomfortable*. **Nima**

Although all participants agreed that the right support was crucial, the newer AHP seemed to be more forth-coming in sharing their recent experiences about the negative impact of not having the right supports in place early in their practice:

> *The first three years is like, it's touch and go and if you don't have that support, if no one takes you under their wing, you kind of like go through what I went through, like doing all the unnecessary stuff and running yourself down*. **Tolu**

The newer AHP shared how the right kind of support served to potentially mitigate self-doubt, common with new graduates and compounded in marginalised groups like **Māori** and **Pasifika** due to prevailing attitudes and systems:

> *I find myself second-guessing a lot of my capability and if I'm meant to be here, like if I'm smart enough. And just also feeling like I can't do much independently. I'm definitely quite an independent person. I think that's been tricky, but I'm learning.* **Ono**

The Collective

Participants spoke of the varied sources of support they drew on, beyond just professional colleagues. They pointed to the importance of broader **whānau** support systems external to CMH:

> *Being able to have people who I can talk to, just whatever's on my mind and if there's any dilemmas or anything. So that's really important is to get it out of my head. And so, my husband is mainly the one, but then I have my supervisors (academic and cultural) and then I have mentors and then I've got family members. I have a, it's like a circle around me of people*. **Tasi**

Role of Allies

Another prevalent sub-theme was the role that allies, non-**Māori** non-**Pasifika** colleagues, contribute as part of the broader village. Participants described this support manifested in several ways and included both conscious and unconscious behaviours:

> *The other thing that, like not necessarily what I've done, but what a colleague has done, and finding allyship as a big thing. So I have a colleague who's doing the reo **Māori** course at, like in the hospital, and having her do that meant that I wouldn't get asked for **Māori** translations. But she is then promoting **te reo Māori**, which like even in it's, like that's her 1% but it's 1% off me. And that is, that to me like it means support that she probably doesn't even know she's giving me, because she might not even know that that was asked of whoever's in the room when you're there. So having like an allyship rather than me having to teach anyone*. **Vitu**

For some participants, allyship also encompassed the efforts of colleagues to understand them better as a **Māori** or **Pasifika** person, not just homogenous AHP:

> *Being surrounded by colleagues who make the effort to understand who I am as a **Samoan** who lives [locally]. I feel like they are more understanding of the fact that institutional racism and racism exists. So therefore, they're making an effort to be more culturally responsive*. **Lua**

Ultimately, for other participants it was as simple as having their non-**Māori** non-**Pasifika** colleagues offering words of support and encouragement. This indicated a recognition of the invisible load **Māori** and **Pasifika** AHP carried:

> *And I definitely appreciate when I have people around me who support me. So having allies who are, who can maybe give me some heads ups or just give some words of support or like, Yep, you're doing the right thing, this needs to change. So those are important.* **Tasi**

Giving Back

A common thread was the notion of giving back, which is grounded in **Māori** and **Pasifika** values of **manaakitanga** and reciprocity. All participants spoke of someone who believed in them at some stage, whether at school, university or across their work life, and the importance of passing that on to the next person:

> *If people didn't care about me and if people didn't take time to spend with me in those first years, it would've been a bit different. And I think, I've had a lot of people who've invested time into me and energy. And so, I try as best I can, I know I can do better, but I try to return that by doing it with other people and spending time with other people*. **Tasi**

It was also evident that participants felt a sense of responsibility to both the local community and the **Māori** and or **Pasifika** community more broadly. This included being role models for

the community and providing avenues to nurture the next wave of emerging **Māori** and **Pasifika** AHP:

> *But I hope to be that for someone, like a good role model and like encourage more of our people to get into these roles and change the way we look after our people*. **Walu**

Theme Two: Valuing Cultural Intelligence

For the purposes of this study, cultural intelligence refers to **Māori** and **Pasifika** worldviews, values, customs and ways of doing, knowing and being. Additionally, cultural intelligence relates to the South Auckland nuances that participants observe, possess and exchange in. All participants spoke of working at CMH as a responsibility, and for some, a calling built on a commitment and connection to the area, and the large **Māori** and **Pasifika** populations who call South Auckland home. The sub-themes were: *Connection and commitment to the community*; *Being valued and recognised for their unique skillset*; *Bringing innate **Māori** and **Pasifika** ways of being to life in practice*; and *culture and identity.*

Connection and commitment to the community

Several participants cited having family connections to the area as a key driver in their connection and commitment working at CMH:

> *I'm here [CMH] because I was born and raised here in South Auckland. I'm here [CMH] because I'm from here [South Auckland] and because our people are here [CMH] and I don't want our people to be here [CMH]. I want them out there thriving. Being healthy. Making the right decisions. That's why I'm here [CMH]. What keeps me here [CMH] is exactly that, is trying to role model for other, for kids. But mostly just to do our best for our people and try and, in our little way, to even up those health disparities*. **Lua**

Rather than it be a case of locals only, similar sentiments were offered by participants who had grown up outside South Auckland but still carry a strong desire and commitment for the local community, especially **Māori** and **Pasifika** groups:

> *I'm not from Auckland, I'm from [elsewhere]. Counties was the only DHB I applied for, because of the population demographics, I wanna help my people*. **Ono**

> *I'm not from South Auckland, I didn't even do my placements here as a student. I said, I'll come to Counties, surely there'll be heaps of **Pasifika** and **Māori** staff and also, I'll get to see **Pasifika** and **Māori** patients. And so that's what brought me to this DHB in the first place, […] thinking that I could be an advocate for our people*. **Fa**

These comments illustrate a deep conviction of why many **Māori** and **Pasifika** AHP decide to take their considerable talents to CMH. There is an understanding that although they may not

be from the region, the population in South Auckland needs them, and there is a sense that this is a place where they will have the privilege of caring for their own.

The gravity of quality connections was not lost on the participants as some spoke about the importance of initial connections with **Māori** and **Pasifika** clients for subsequent care:

> *It's actually about the quality of your interaction with a person that's gonna set them up to be comfortable to come back to you again. Or to be comfortable to come back to hospital and seek help if they need it*. **Fa**

Some participants also voiced that being connected to the South Auckland community whether through family and friends, or church, sporting, cultural activities or otherwise provided a level of authenticity for clients, and reminded participants who they were there for:

> *I do make sure that I keep connected to my community, because it keeps me humble. It reminds me that I can make a difference on a patient level but also on a population level in this other mahi that I'm doing. But that there's that person at the end of the decisions that I helped influence in this space and that to me is powerful, it's all connected. So, it keeps me again grounded so that I remember I'm not up here in the clouds, whitewashed or colonised.* **Iwa**

Being valued and recognised for their unique skillsets

The participants expressed common sentiments regarding the unique experiences and skills they have. Participants reported that although these critical skills were repeatedly drawn by colleagues and management, there was a consistent lack of tangible value and recognition for their specialist skills. For example, participants shared how there was no consideration given to reallocation of time, remuneration or caseloads. Rather, it is an unspoken expectation that participants would take up extra responsibilities on top of their core duties.

This had the potential to create tensions for participants as, despite feeling taken advantage of, and undervalued by their work environment, there was a felt sense of obligation to carry on due to their commitment to the community, and their colleagues:

> *I can't give up 'cause otherwise it's not fair on everyone else [other **Māori** and **Pasifika** colleagues] who are trying really hard too.* **Nima**

Several participants spoke of the extra language skills they brought as clinicians and how on many occasions this was of benefit to both the team and client. It also became evident that without these additional skills things could have deteriorated:

> *And so I double as an interpreter for our service […] a couple of months back I got a call from the house officer […] he wanted me to see a patient for him and do a cognitive assessment. And he was like, Oh I need you to see this guy, he's having troubles with*

> *word finding." And I went in and had a chat to the man and like English is not his, like his first language, so he has trouble finding words 'cause he doesn't know what word it is. And I was like these guys already sort of gave this guy a title like cognitive impairment that he's gonna carry for the rest of his life, but he's fine. Like he just needs an interpreter.* **Tolu**

As with understanding a different language, different cultural practices or cues is a non-generic skill that very few AHP possess, particularly as it relates to **Māori** and **Pasifika** languages and practices:

> *Exactly and it's like, yeah it's hard because I, for colleagues when I do doubles with them and just like, and so like the new, one of the boys he's new and he goes in and sees a* ***Samoan*** *family and you can tell what the family's trying to say and where they're going with the conversation, but for the brother it's hard for him to kind of catch on. And so he comes out with kind of like misinformation on his assessment. And it's those type of things that I find here.* **Tolu**

In line with potential ramifications for a wrong diagnosis as a result of a lack of appropriate skillset, **Tolu** talked about what he believes could happen with more **Māori** and **Pasifika** AHP:

> *So with them like misunderstanding the whole situation and not being able to relate to our people that I find that, if you have a lot more PIs and* ***Māori*** *going through and seeing all these patients that come through, there would be a different outcome for sure, yeah.* **Tolu**

Some participants voiced their frustration at not being recognised for the many intangible skills they bring. Specialist skills such as cultural knowledge, language, the ability to connect, relate and build relationships with clients are not acknowledged even though they are scarce skillsets that are often called upon:

> *The fact that you can speak a different language, you can engage with these patients better than the rest of your colleagues and paying you for it, and recognising you as a, recognising that as a skill. Instead of saying, Oh, you can do that too and so we'll just take advantage of that. Especially as a new grad.* **Iwa**

For others, it was a moment of realisation that these are unique and rare skillsets and should be acknowledged as such:

> *Yeah, I never thought about that perspective. But it makes sense, doesn't it? It is a skill, lived experience is, and yeah, your chance to be able to connect with other people so that they can engage the service to get a good outcome for them. And a lot of health professionals can't do that, for whatever reason. Whether it be their ethnicity or their lack of communication skills or their inability to just relate and be empathetic, sympathetic. Yeah, I've never thought about that, but I think that's so true.* **Hongofulu**

Bringing innate **Māori** and **Pasifika** ways to life in practice

Each participant expressed positive experiences and outcomes when they were able to apply their innate cultural skills to their practice. This could include patient and/or **whānau** engagement strategies, trust building and development techniques, and holistic practice. Applying their knowledge to these situations created the context for them to work in ways that brought their cultural practices to the forefront, merging clinical and cultural divide that is so critical to thriving.

All participants spoke of their ability to build rapport, and all had received positive feedback from non-**Māori** non-**Pasifika** colleagues. There was general agreement that this was a common skill amongst the group, and it was the norm, rather than consciously applied. Participants felt it was due to cultural norms and practices that prioritise connection and value relationships:

> *It's that connection, that commonality, like those kinds of stuff that we all understand that that's part of how we are and who we are.* **Sefulu Tasi**

The ability to seamlessly intertwine humour to enhance engagement, was another unique skill that the group possess and utilise frequently with all clients, as a way to support, settle and comfort patients:

> *We're social people and that's why it's so easy to build rapport with patients, even the **Palagi's**. They love it, and they love to joke. Humour goes a long way when you see your patients. I guess it's a good ice breaker.* **Tolu**

When reflecting on her experience, **Sefulu Tasi** felt praise from non-**Māori** and non-**Pasifika** colleagues, and working with predominantly brown patients, gave her license to incorporate her cultural intelligence by building relationships in a way that is natural to her cultural experience:

> *Being here allowed me to sort of be like, Oh hey, I can stretch a little bit this way. Or I can use the way that I, I didn't realise I was using, these rapport building skills, because everybody in the white world was like, "You're so good at this." And I'm like, I am so good at this, but also why, like it's 'cause you just, you meet someone, like, "Hey, bro, where you from?" And they don't really understand that it's not rude when we ask you where you're from and who your parents and all that. That's us trying to get to know you and bond with them. Whereas some people might consider that like invasive and rude, but you can do that here because most of the patients here would be, they'll understand that that's what you're asking.* **Sefulu Tasi**

All participants spoke of an overarching acknowledgement of the interconnectedness of all things. This holistic view is held by Indigenous cultures worldwide including **Māori** and

Pasifika. This outlook enabled participants to see opportunities for care on the periphery, and approach patients with a mindset of progression:

> *I feel like I see things more, the whole person rather than just a diagnosis.* **Tasi**

> *I might not provide [clinical] treatment, but I might be able to connect them to a social worker or connect them to someone that actually can help them with what their actual problems are. So that's what keeps me is that.* **Fa**

Spirituality plays a substantial role in many cultures ways of being, **Māori** and **Pasifika** included. Acknowledging the role of spirituality when providing holistic care for patients and pro-actively seeking opportunities to bring this in for their clients was something the group felt comfortable and confident with:

> *A lot of what we do as **Māori** and Pacific comes from a faith background. We are very spiritual people and a lot of people are, and I think there's a lot of healing and help and support where we can help people connect spiritually.* **Hongofulu**

The statements above highlight nuance and subtle skillsets that many **Māori** and **Pasifika** AHP innately carry with them. It can be about sharing the same language, but many of the examples highlighted above were about practices, behaviours, and the ability to traverse the clinical and cultural divide. The ability to connect with patients and their **whānau** is not a given and those who possess the skills to effectively engage become exponentially more relevant when working with **Māori** and **Pasifika** groups.

Culture and Identity

When considering various factors that could enable participants to thrive in their workplace, all agreed that a strong sense of identity and or connection to culture helped guide and inform their clinical practice. Participants shared that work settings which encouraged or supported their cultural identity provided a sense of assurance which in turn enabled them to contribute authentically, and effectively, to their patients and teams. Operating from this context is critically important for **Māori** and **Pasifika** AHP to thrive because it increases their self-confidence by being empowered to draw on their innate ways of being. Those that had a strong cultural upbringing spoke about the ongoing influence this had when working with patients:

> *My upbringing, my values, everything I was taught in this life, personifies how I treat my patients. You treat them as your own. They're not related to you by blood but you have a connection to them that you can't explain, but you share that space.* **Iwa**

One participant expanded on culture and spoke of their faith as a key foundation for their practice:

> *But then also spiritually, like I, before I'm [ethnicity], I'm a son of God. That's my first priority. So that trumps being […] and that trumps being […] or my culture. I very much value the spirituality.* **Hongofulu**

Some participants shared that although they had not grown up immersed in their culture, they still carried a clear sense of pride, and expressed their culture gave them a certain strength and confidence to face challenges:

> *I'm on a journey learning my own culture. Obviously 'cause I'm [mixed ethnicity]. So, I was brought up by my […] mum and so I think learning from intermediate up to high school how my mum was like, "I'm [ethnicity one] but you're [ethnicity two] so you need to learn that, you need to, it's valuable, you're unique, you have more of this culture and language behind you and that makes you different from other people.* **Fa**

While participants shared their frustrations at not having cultural intelligence valued by their workplace, they also shared insight into the value they placed on it as individuals, viewing it as a treasure or **taonga** to be cherished and protected. At times however, some participants felt the need to actively resist stereotypes and push back, especially for those that didn't look or sound "brown enough". These instances were particularly distressing when coming from colleagues, as at times some participants felt their **Māori** or **Pasifika**-ness was being questioned:

> *But coming into spaces where I'm wanting to rep being **Māori** and then people telling me I'm not brown enough or I'm not, I don't know the language, so what do I know. But just remembering that it is like those core values that make me **Māori**. The core understanding that makes me **Māori** and no one can put like a label on how **Māori** I am.* **Ono**

Despite the many challenges and frustrations, a common thread for all participants was the strength each drew from their own sense of culture and identity. This was regardless of the depth of cultural immersion they had experienced, and rather, due to a deep conviction and commitment to **Māori** and **Pasifika** groups that guided practice:

> *I'm **Māori** first and then a [profession] second that's the way it is.* **Tekau ma rua**

> *I will never stop being **Māori** but I could stop being a [profession]. And so I'm never not gonna walk in the room and not be **Māori**.* **Vitu**

Several participants talked about the value of knowing their own culture and/or identity and the influence that has on how they cared for patients of a different culture to their own:

> *I think it's influenced by understanding what culture means and how to kind of relate to someone and how to kind of make them feel like their culture is important. Making them feel empowered by their culture, making them feel like that matters.* **Nima**

> *There're actually other cultures out there that I'm still trying to get my head around and understand so I can work better. So, I think that because I'm **Māori** I'm able to be more sensitive to other cultures and not, "They're just doing it the wrong way," or, trying to understand, so. I think that's definitely a benefit of being **Māori**.* **Tasi**

Theme Three: Thriving or just Surviving?

This theme refers to challenges and barriers participants faced in their workplace and the implications these obstacles have on their ability to thrive as **Māori** and **Pasifika** AHP. The sub-themes were: *Racism*; *Lack of culturally safe settings and increased cultural burden*; *All the extra stuff*; *Fitting in* and *Organisational Issues*.

Racism

This was the most common theme to emerge from the data and encompasses structural and institutional racism, personally mediated racism in the form of racial stereotyping and micro-aggressions, and, internalised racism manifesting in the erosion of self-belief and confidence. This theme reflects the constant disadvantages, barriers and challenges **Māori** and **Pasifika** AHP experienced multiple times daily, on top of routine challenges that come with working in health care, especially in the formative years of one's career:

> *Not having to deal with little racist remarks and even, procedures or how things are done. So not having to fight those kinds of things and not having to deal with those aggressions in the day-to-day.* **Tasi**.

Tolu highlighted the internal struggle he contends with when this happens:

> *I'm like is there something that I have to do that's, to kind of compensate for […] the colour of my skin? But there isn't, yeah.* **Tolu**

Despite the rhetoric of workplace safety and cultural responsiveness, and the increased focus on rights and needs based health equity, there seems to be clear contradictions with what organisations say, and how employees act:

> *I do get a sense that non-**Māori** think that it's just a waste of time. So, there's those different, where is that person actually coming from? Do they need support? Or are they just blatantly not caring for things **Māori**?* **Tasi**

And this has a marked down-stream effect on **Māori** and **Pasifika** AHP ability to thrive:

> *If I'm stuck worrying about trying to push **Māori** stuff, basic stuff, then I'm not allowed to actually think creatively of how can we actually do this kind of stuff.* **Tasi**

Lack of culturally safe settings and increased cultural burden

Most participants were the only **Māori** or **Pasifika** person in their team, and felt this could be associated with cultural and professional risk. Overall, participants spoke about not feeling culturally safe; being put into culturally unsafe positions by seniors or colleagues and thus carrying an increased cultural burden. In response to being the only AHP in her profession, **Tekau ma rua** highlights an experience she recalls:

> *I was first couple of years I was doing everything for anyone. I was like was a PSA [Public Service Association] delegate, doing **tikanga** best practice for [the entire profession] here and realising now that that was a big waste of time.* **Tekau ma rua**

When asked about why she was doing all these extra duties in these early years she added:

> *It did feel like the right thing to do at the time and who else was gonna do it? There wasn't anyone else to do it and I just didn't, hadn't learnt then how to say no, I guess…Like when you're new and you're, […] a minority, you don't know that the way you think isn't right […], or you think it's because you're new, rather than it being a cultural thing. Yeah, and so you feel like your diversity is wrong, I guess. […] it is hard to stand up when you're a new grad.* **Tekau ma rua**

Some participants spoke of a clear difference of support offered between clinical and professional development, and cultural development. This difference may be perceived as institutional racism, as professional or clinical skills are valued for professional development, yet no such mechanism exists for cultural development. The participants agreed that a lack of cultural support and development, as a perceived expression of racism, stifled their ability to thrive at work, especially in their initial years of practice as it did not consider them as a person, only as a clinician:

> *I think my clinical skills and all that, they're well taken care of, yes. But me as a person, me as a [mixed ethnicity] person, I ain't getting that from nowhere.* **Sefulu Tasi**

A lack of culturally safe spaces, forums or allies was an issue raised by several participants. This impacted their ability and confidence to speak up or resulted in them feeling worn down as described by **Nima**:

> *And I've thought of many different ways I can try and bring it up, but I don't have the confidence to bring it up. I don't know how to or whether or not it's safe enough to bring it up. So I have just left it.* **Nima**

Vitu alluded to a sense of weariness or exhaustion caused by the lack of culturally safe spaces or colleagues she could turn to for something to change:

> *Because there's only so many times one person can advocate for themselves. Like if it's a new grad. You [suggest] something. It comes back. You try again. Think this is a cool*

> *idea, doesn't go forward. So having somebody outside of your clinical space to advocate for you in a cultural way that understands the clinical space, that you don't then have to do your own backing for each fight, because it's the shutting, the getting shut down. The, like getting told that's, like this is not the space for that. That this is not as important. That wears me out more than anything […]. I shouldn't have to advocate for our people, advocate for myself and try and change policy, when I'm a third year. Yeah. And those are the burdens that like I feel I get, I take on myself, because I don't have anywhere else to put them.* **Vitu**

Another common concern was the ever-increasing cultural expectation participants felt as one of few **Māori** and **Pasifika** AHP at CMH. This often resulted in participants feeling like they were tasked with fixing issues that were not their responsibility and should have been addressed by management and leadership:

> *It's hard because the burden that is placed on you culturally is massive, especially when you are like one or like very few. And being the only one since 2017 has taxed me emotionally, it took me a long time to actually learn that it wasn't my job to upskill or educate these people. It took me a long time to realise that that wasn't my burden to bear. That was a failure in the system and it was the system's job to fix it, not mine. It got to the point where I was like, "Nah, stuff all of you." But then that goes back to how do you make your practice more sustainable after you leave, after you rotate out. But then like why is that your job? It should be your person sitting above you's job or the professional lead's job or, you know?.* **Iwa**

In line with culturally unsafe spaces, participants reported attitudes of colleagues could be particularly draining and questioned if there was much point in having those debates:

> *I think it's really hard to rationalise and explain to someone who doesn't understand as well. Sometimes you're faced with a question that I'd be here all day trying to explain it and you still probably wouldn't understand and you probably wouldn't care either. So sometimes you just, you do it 'cause you know it's the right thing and that's the way you know this person would benefit from being treated, and probably give them the best possible outcome. But then to have to explain it to a colleague who looks at the more scientific approach that's based off European data, and you have to explain it to them. We don't have grounds for it, there's no, I can't refer to a research project or I can't refer to something. And so you kind of just shut up and you kind of just take that in and then you can't really let it out.* **Nima**

Overall, while there was consensus that thriving was a good aspiration or goal, the lived reality of many of the participants was an overarching sense of survival. These participant experiences offer some sobering insight in to the lived realities of **Māori** and **Pasifika** AHP working at CMH:

> *It's very much about surviving. And it's just getting through day-to-day or week-to-week. And so, I really like the idea of thriving.* **Tasi**

> *I can really relate to the word survive. Rather than thriving.* **Nima**

All the extra stuff

Many participants talked about '*extras'* that come with being a **Māori** or **Pasifika** AHP working at CMH. This was due to the fact that there were so few **Māori** or **Pasifika** in practice. Some senior clinicians felt this more acutely, while suggesting the issue wasn't about junior staff, but the organisations expectation, that they would provide support, without protected time, structural supports, or appropriate remuneration that recognised *extra* responsibilities **Māori** and **Pasifika** AHP were expected to undertake:

> *There's not enough of us senior clinicians to support all the younger ones and then that puts the burden on us and leads to us burning out as well. So, there's not enough acknowledgement of that sort of support that we're doing.* **Tekau ma rua**

With **Iwa** adding:

> *Cause it's expected*. **Iwa**

Participants shared examples about colleagues (nurses, doctors or other AHP) expecting them to put their own work aside in order to provide interpreting services, notwithstanding the fact that none are trained interpreters, and usually have little to no notice; or being expected to see all **Māori** or **Pasifika** patients:

> *It brings up an experience I've had recently that I spoke about picking up Pacific Island and **Māori** patients off a waitlist. And I have different feelings about it and one of them is it's fantastic that I get to give these patients that experience, but who's going to do it after me? Why is my manager saying, "Pick up all the Pacific Island and **Māori** ones"? Why me?* **Nima**

Vitu highlighted the tension she feels:

> *Yeah, like I love being **Māori**, but sometimes I hate being **Māori** here. Here it's shit to be **Māori** 'cause then you're the point of call for everything and it's a tick box for everyone else.* **Vitu**

This indicates unfair and unethical practice expectations placed on **Māori** and **Pasifika** AHP. This impacts how staff feel about themselves, and how they feel they are being perceived by their colleagues. It also alludes to an organisational failing which, rather than providing an uplifting environment for **Māori** and **Pasifika** to thrive, contributes the direct opposite.

The delicate balance between home and work life was another area several participants spoke of as a constant source of additional responsibility. Many highlighted family responsibilities as a real barrier to thriving at work. For many, home life was a struggle which inhibited their ability to thrive:

> *At home, I have to keep, I have to sort of compartmentalise it, because home is a struggle and it's not much we can do about, so I'm sort of treading water there, I guess. And so sometimes I'm coming to work for a rest or a break or get away from the home stuff*. **Tekau ma rua**

> *Trying to make sure that you're balanced across whatever sphere has any influence on your life is tiring. And trying to hold those pieces so that you don't drop anything is, it takes masses of energy, of time, of, you know? There's heaps of, I suppose, responsibility on my shoulders at the moment, so I'm, I come into work for a little bit of a break.* **Iwa**

Hongofulu offered some insight into a dual tension that others were familiar with:

> *I've struggled recently with doing more for other people than I do for my family. In my family we have diabetics, we have obesity, we have all those things, people that, oh sorry, family members who are not healthy at all and yet I see them every day of my life and I do nothing about it. But yet I come into work and I put a 110% into helping strangers who I've never met before*. **Hongofulu**

What this theme suggests is the often-employed compartmentalisation approach – keeping home at home and work at work, may not be as straight forward for **Māori** and **Pasifika** AHP. Although some participants spoke about the workplace as somewhere to get away from their home life, there is a clear sense of "out of the frying pan, and into the fire". There is also an element of guilt some participants spoke of, as they reflected on feeling like they do more for others than their own **whānau**. The responsibility that participants placed on themselves was immense, and it seemed that workplaces and team management's need to recognise and pro-actively support employees.

Fitting In

Participants described a predominance in approach, thought, feeling and attitude which resulted in either having to fit in and conform or having to change the way they interact in the workplace. **Tasi** reflected on her experiences and recognised this reality in her own behaviour:

> *In different environments, say at home or with my clinical team or in a meeting with the big wigs and all this stuff. That I actually change my approach to things or, and I've recognised over the years is that when I was in a very **Pakeha** environment, I would try to act in that same way so that I'm accepted into that group and so that they will listen to me. But what that did is that it cut away the, my **Māori** view on things or seeing it from that perspective and so I've had to actively work on that and I call it decolonising. That I have to, because I've been so many years, "Oh I'm in a white space, I have to act white." And so, I've had to actively work on that. Of, no, I can be myself and I need to advocate and it's hard, it's really hard. It's hard acting white, but it's also, it's harder being the different one in the room and pushing things that people won't be happy with.* **Tasi**

Other participants spoke of their struggle and suggested broader systemic issues that impacted the ability of marginalised groups, such as **Māori** and **Pasifika**, to thrive when trying to retro-fit a pre-determined framework:

> *What makes it tricky is just feel like I'm trying to fit into a place that's not made for me to fit into that. I don't see many people like me fitting into that. I'm expected to be a certain way but I'm not that way. So, it's hard to fit in. And if I don't try and do what they want me to do then I'll never thrive.* **Ono**

Other participants suggested lack of profession-specific role models contributed to difficulty fitting in:

> *I know there's a need for me and people like me and us to be here, but at the same time, it's just me. Like I don't have any forefathers or people to sort of, you know what I mean? Like yes there's my wider team and the senior [AHP], but they're different from me.* **Sefulu Tasi**

Other participants reflected that difficulty fitting in resonated with their experiences in other environments, suggesting it may be a reflection of society generally:

> *I think being bicultural and kind of navigating the world, uni, high school and working in a DHB has always been difficult. Not easy.* **Fa**

Fa provided further insight and suggested when thinking about fitting in she saw it as an opportunity for deep critical reflection:

> *I think it really hinders you and it gets you to think about your values and challenges your core values as a new graduate and a Pasifika to be like that doesn't fit with my values that well*. **Fa**

Organisational issues

Institutional racism, systemic barriers, operational attitudes and organisational priorities all exist and combine to stifle the ability of **Māori** and **Pasifika** AHP to thrive at CMH. There was agreement from participants that these manifested in various ways. Some participants spoke of lack of organisational support for things **Māori** or **Pasifika**, and lamented the fact that promising initiatives were not adequately supported:

> *It's individual people that have the strength to actually push for it and get it done. When they leave, it falls over. So, it's not embedded in policies or procedures or this is what every team has to do. When people leave then it falls apart. I suppose if the people above them, their managers and stuff had it strong in them, then they would make sure it keeps going, but because we're talking about middle management or actual like people who work on the ground floor, it's when they leave then it doesn't carry on. I think that's the, yeah that's the story with lots of things actually*. **Tasi**

Others referred to an organisational system that was difficult to navigate, but also counter-productive and disempowering to **Māori** and **Pasifika** AHP:

> *You start to realise how the system is just not, that it's not, it's not supporting those values and aspirations that we have. There are so many systems and policies in place and roadblocks that tend to knock you down. And that can often, it doesn't change why I'm here. It doesn't change that I still wanna do that, but it does open your mind to the different ways that you have to approach these topics and these things, in whatever team and environment you're in, it just opens your mind a bit more into like okay this is gonna be hard*. **Fa**

The importance of **Māori** and **Pasifika** being in the right positions to meaningfully influence decision-making was considered critical to improving the experience of patients and staff alike. Several senior participants spoke of their need to effect change from leadership and senior positions within the organisation, to reflect progress at the patient facing level:

> *The longer I've been here, the more I've realised that on the floor's cool. It does a lot for the heart. But the overall difference you make is probably relatively small, and if I'm wanting to make more significant difference, you've gotta start punching and kicking from higher up, which I'm starting to do*. **Lua**

Both **Tasi** and **Hongofulu** alluded to an existing organisational culture that limits the opportunity to contribute new ideas that differ from the status quo:

> *I'm still trying to figure it out, but I get a sense that maybe there's a particular culture at Counties and so I feel privileged that I have outside people who I can kind of reflect with, who are not in Counties. To see, is the way it's meant to be or not, or, so I feel like I'm lucky to have people who are outside. Who know the health system, or who've worked for other DHBs and so I can have, get a little bit of a comparison around things*. **Tasi**

> *If you voice it, there's a high percentage that you'll get shut down for doing that, because it's not the way things are done. And I think most of the time, new grads, I know there's a lot of times I don't speak up and say, "I think it should be done this way"*. **Hongofulu**

However, in-spite of the many barriers, challenges and struggles regularly faced by **Māori** and **Pasifika** AHP, a steadfast commitment to giving and serving remained:

> *I feel rejuvenated or empowered when I give and it sort of makes you wanna give more. And you feel like you're able to give more. I know, I think logically it doesn't sort of make sense, 'cause you're expending energy and so you should be burnt out. But I think there's something concerning other people and seeing other people happy, kind of like feeds you. Enables you to be able to increase your ability to give and to serve.* **Hongofulu**

This passage encapsulates a quiet grace and humility that all participants shared, but which is often misunderstood, taken for granted, or went unseen in their workplace.

Theme Four: Being at our Best

A key aspect of this research is to provide a strengths-based platform for participants to offer solution focussed ideas that would enable them to move from surviving to thriving in the workplace. This gave participants an opportunity to share what and how thing could be transformed into environments conducive to **Māori** and **Pasifika** AHP thriving. Sub-themes were; *Eco-system for success*; *Support us to thrive* as ***Māori*** *and* ***Pasifika*** *Allied Health Professionals*.

Eco-system for success

There was a common trend amongst participants suggesting the environment they work in, and the energy they picked up from those around them, were major factors in being enabled to thrive at work:

> *Yeah, I think it's having the safe space to come to or where you feel that your voice like is listened to. That you feel safe in being able to be yourself*. **Ono**

Fa reiterated the importance of intentional and dedicated forums adding:

> *Being confident to be, to safely express who I am and what's important to me as a person but as a clinician as well. I think if that space, that we love as Pasifika people and that we love to nurture is provided to be nurtured, then that would've made me maybe a better new grad*. **Fa**

The value of **Māori** and **Pasifika** staff in visible and accessible clinical and leadership positions was identified as important as they served as role models, guides and sources of encouragement and inspiration:

> *I think that main thing that worked well for me was actually being around other* ***Māori*** *health professionals. And so, I think that it doesn't have to be in the same profession, it's just* ***Māori*** *health professionals and having, just hearing their stories and how, like the social workers were amazing, just strong advocates for our* ***Māori whaiora***. **Tasi**

There were also specific suggestions to enhance existing support models:

> *I think that cultural peer supervision is a good thing even if it's like a group supervision or even when you're having like, crossing MDTs supervision is a great idea. 'Cause sometines there's just things you wanna talk about or things that in your own clinical practice you're trying to sort of communicate, but it's not hitting or the person who's, they're trying their best to sort of understand you, but then they're not quite getting there. But you're not able to sort of rearticulate yourself, which is something that I've had to learn to do over my long long life is to change how I think to help them. So I think if there's just more of that then it'd be easier and less scary. And if you've got a sounding board of someone who's from the same perspective as you, but can see it*

> *more subjectively, while understanding who you are, you kind of almost talk yourself into your solutions and then learn from each other*. **Sefulu Tasi**

Participants also spoke of opportunities to implement Indigenous frameworks into allied health teams and services, adopting more compassionate and collaborative approaches:

> *I know that as **Māori** and Pacific people, we're quite collective. We like to do things together. We like to help each other. We like to reciprocate. If at the very least, we can get teams, people to start thinking more like we do in terms of family, collectiveness, helping each other, reciprocating.* **Lua**

Support us to thrive as **Māori** or **Pasifika** Allied Health Professionals

There was agreement that a key contributor to early career thriving was the opportunity to have spaces to develop and grow cultural understanding and identity, along-side clinical skillsets, as part of any career development plan for **Māori** and **Pasifika**:

> *I really got to develop myself as a **Māori** health professional. Not as just a health professional. And so that was great. We got to, I suppose it really helped me develop my own cultural identity and how I can use that in the practice that I'm doing. It was like continuous professional development, in terms of being **Māori** and working in the health area. So, things like that don't seem to happen anymore, but that just strengthened my identity as a **Māori** health professional very quickly*. **Tasi**

Furthermore, participants unanimously agreed that being encouraged, and supported to practice as **Māori** and **Pasifika** AHP, as opposed to AHP that were **Māori** or **Pasifika** would be a significant element in them thriving at work:

> ***Māori** and Pacific work well in the right environment, with the right supports. Under the right leadership. The right values. We can definitely thrive; we can get awesome outcomes for **Māori** and Pacific. If given the right, the appropriate resources and allowed the ability to do things the way we do things, in our way, for our people.* **Hongofulu**

Vitu, when asked about thriving summed it up fittingly:

> *Thriving, sounds like **rangatiratanga** to me, but not in the sense of like **rangatiratanga** of one person being in front. It's with everybody by your side*. **Vitu**

Conclusion

This chapter has presented the views and experiences of a group of **Māori** and **Pasifika** AHP. Several themes arose highlighting the struggle between aspiration and reality, optimism and frustration, commitment and disillusionment. For **Māori** and **Pasifika** AHP to thrive at CMH they must be able to practice as their Indigenous selves. There must be an organisational shift in what knowledge and skills are valued and how they are recognised. **Māori** and **Pasifika** must

be able to see themselves throughout every level of the organisation and be purposefully supported and encouraged. Non-**Māori** non-**Pasifika** colleagues need to be better allies and function in ways that support **Māori** and **Pasifika** advancement, as determined by **Māori** and **Pasifika** themselves.

CHAPTER FIVE: Discussion & Conclusion

Introduction

This research explores insights into what enables **Māori** and **Pasifika** AHP to thrive at work, with particular focus on their initial two years of practice at CMH. Gaps in the existing literature were identified, showing the need for purposeful and specific research, to bring to light experiences of a precious, yet undervalued group of AHP. It is only by documenting these workforce stories and perspectives that they can move into common spaces, in which they will be discussed and debated. If we don't know about it, we don't talk about it, and if we don't talk about it, nothing will change.

This chapter begins by introducing the Sea of Islands concept. This concept is then used as a frame of reference, as I move from discussing challenges evidenced in participants stories (surviving - conceptualised below as 'Islands in the far sea'), to exploring their ideas and dreams, and how it could be different (thriving – conceptualised as the 'Sea of islands'). I will then summarise key recommendations towards supporting **Māori** and **Pasifika** AHP to thrive in CMH. Finally, I will reflect on key strengths and limitations of the study, and identify areas for future research.

Sea of Islands Reframing

In his seminal 1995 offering, Sea of Islands, Pacific academic **Epeli Hau'ofa** rallied for a conscious shift in the way people, particularly **Pasifika** peoples perceived themselves and their island homes. He presented the prevailing discourse of the Pacific Islands as tiny, under-developed, dependent states, that at best, were seen as providing major nations with strategic economic, political or military advantage, and at worst, considered as largely inconsequential, or not seen at all (**Hau'Ofa**, 1995). This view, **Hau'ofa** contended, was largely derived from Euro-centric colonial perspectives that viewed many Pacific nations only in terms of their land area, economic ability, and aid requests. This dismissive perception of the Pacific was compounded only by the fact that these nations were separated by the vast ocean; they were seen as isolated, needy and poor (**Hau'Ofa**, 1995).

Hau'ofa (1995) cautioned this was problematic for the region, and its people could fall victim to internalising these negative descriptions, and prescribing to these limiting notions. Rather, **Hau'ofa** put forward the "Sea of Islands" concept, in which, the sea was actually what connected us to each other across the region. By re-imagining the deficit view to a strengths-

based position, the "Sea of Islands" provides communities across **Vasa Pasifika/Te Moana-Nui-a-Kiwa** a renewed sense of empowerment and pride. Personally, it also serves as a point of encouragement and reassurance.

As noted, I will draw on the key elements adapted from **Hau'ofa's** "Sea of Islands" and outlined in Table 1 as a framework through which to discuss my findings.

Table 1: Epeli **Hau'ofa** (1994) as cited in (**Pilisi**, 2020)

Islands in the far sea	**Sea of Islands**
The sea separates the islands leading to isolation and disconnection	*The sea is what binds us together*
The sea is carved up by imaginary boundary's that restrict movement	*The sea has no boundary's*
The sea keeps us confined to our tiny island homes	*The sea is our home*
Small Islands, small scale economies, lacks significant resources	*A richness of love, culture, language, relationships and service*
Small scale economies mean dependent on overseas aid and relatives in the diaspora	*Interdependence and reciprocity*

This is not thriving

While I set out to provide a strengths-based, solutions-focussed perspective with respect to enablers of thriving for **Māori** and **Pasifika** AHP, it also felt **tika** to give space to participants lived realities of working as AHP at CMH which inevitably highlighted a number of negative experiences. As noted in theme three, participants shared stories of racism, cultural burden and expectation, and lack of fit, which all impacted on their experience of thriving. At times, thriving did not even feel a viable or achievable option in their workplace. Rather, racism, and the resulting non-Indigenous paradigms, which are used to determine normal practice, both clinically and societally, was the common thread.

In 2000, Dr Camara Jones presented a theoretical framework for understanding three levels of racism; Institutional, Personally mediated and Internalised racism (Jones, 2000). Jones (2000) defines institutional racism as "differential access to the goods, services, and opportunities of society by race" (pg, 1212). Although this form of racism does not typically manifest as overt verbal or physical acts, the silent and insidious form it takes as a prevailing monocultural perspective is no less destructive (Came, 2012).

Personally mediated racism is, intentional or unintentional prejudice and discrimination based on race. It can be overt and take the form of derogatory names or comments, or covert and manifest as a lack of respect, devaluation and dehumanisation (Jones, 2000). The third level, internalised racism occurs when members of the impacted group believe the negative messages said about them. This can lead to degradation of self-worth and self-belief, adopting characteristics of the dominant group or rejecting their own (Jones, 2000).

C. Smith et al. (2021) add Societal racism as overlapping with the three levels as proposed by Jones (2000). This level perpetuates the perceived inferiority of an ethnic or racial group by maintaining and reinforcing negative attitudes, beliefs or stereotypes about that group. Societal racism upholds ethnic privilege by protecting the dominant colonial discourse, leaving no space for these narratives to be critically analysed and deconstructed, and results in systems built to deny "other", ethnic or racial groups access to power and resources (A. M. Barnes, **Taiapa**, Borell, & McCreanor, 2013; Paradies et al., 2013).

The ultimate result of racism in all its guises is that the dominant culture is positioned as the default, or 'norm'. Thus, the resulting systems, policies, practices, mannerisms, attitudes, and beliefs are all informed by this dominant perspective, while minority perspectives become devalued or dismissed.

Participants' **kōrero** highlighted several examples of institutional racism. Many voiced a lack of ongoing or embedded organisational support for initiatives they felt specifically supported their needs as **Māori** and **Pasifika** AHP. Participants expressed disappointment that policies and procedures did not support or protect their need for cultural development, especially those who were in "mainstream" teams and services. There were feelings of disempowerment as many systems and policies inhibited their ability and opportunities to contribute their cultural intelligence in ways that were meaningful to them. The lack of embedded cultural support initiative for **Māori** and **Pasifika** AHP is alarming yet perhaps not surprising, given few **Māori** and **Pasifika** AHP, and even fewer **Māori** and **Pasifika** AHP senior leaders to advocate for such supports. For this to change CMH executive leadership must commit to utilising organisational levers to ensure appropriate and relevant mechanisms are implemented at a systems level, to enable a pathway for **Māori** and **Pasifika** AHP to thrive at work.

Personally mediated racism was a universal experience raised by all participants. Interestingly, it seemed that although these experiences were troubling, participants appeared, almost resigned to this as a fact with an inevitable expectation of these encounters as "just another day at the office". The pervasiveness of racism is supported by a recent survey reporting 93%

of over 2000 **Māori** participants, felt the impact of racism on a daily basis. This indeed left **Māori** with a deep sense of sadness and anger (C. Smith et al., 2021). This report also highlighted racism as a direct attack on **rangatiratanga**, which is a breach of **Te Tiriti** (C. Smith et al., 2021). Participants **kōrero** revealed these instances were committed by both the public and colleagues alike. These reports raise concerns around workplace safety and upholding the principles of **Te Tiriti**, calling in to question, what proactive measures CMH take to ensure staff safety is protected from all forms of discrimination and racism. It is not good enough to "not be racist" as Jones (2000) contends, because racism thrives by acts of commission, but also by acts of omission. In other words, failing to provide a culturally safe work environment.

Internalised racism results in internalising of negative comments that can manifest as low self-worth and self-belief, shame, doubting the ability or motives of those that are from their own race (A. M. Barnes et al., 2013; Jones, 2000). Furthermore, studies identify racism, within the context of on-going colonisation, as a determinant of health for **Māori** (R. Harris et al., 2006; **Talamaivao**, Harris, Cormack, Paine, & King, 2020), and other marginalised groups. The **kōrero** shared by participants suggest an uneasy familiarity with feeling a lack of self-confidence or doubting their abilities, which were more pronounced during the early years of participants' careers.

The influence of negative racial stereotypes across the life-course for this group is important to recognise, both within CMH and in a society that has largely failed to positively portray **Māori**, **Pasifika** or South Auckland (Allen & Bruce, 2017; A. M. Barnes et al., 2012). **Māori** or **Pasifika** AHP are not immune to the insidious effects of racism at any level, adding another layer of difficulty for early stage clinicians to contend with at a more susceptible stage of their careers (Stoikov et al., 2020).

Islands in the Far Sea

Utilising the "Islands in the far sea" perspective, just as imaginary boundary lines divide the sea into territories that restrict movement and development, so too does institutional racism for **Māori** and **Pasifika**. Just as the sea keeps us confined to our tiny islands, so too does personally mediated racism keep us confined and isolated through devaluing our worth. Just as the size of our economies and lack of resources keep us small, so too does internalised racism by lowering our ambitions, aspirations, and self-belief. An "Islands in the Far Sea" perspective may manifest in the way certain policies or procedures privilege and enable clinical supervision, but not cultural supervision. It is also reflected in an environment where colleagues fail to call out racism, or in the lack of visible senior **Māori** and **Pasifika** allied health leadership roles. The

application of this deficit perspective perpetuates hopeless and helpless narratives, too common among non-Indigenous interpretations of Indigenous communities.

Sea of Islands

However, by using a "Sea of Islands" perspective, we are reminded that, the sea has no boundaries, other than human-made. When our ancestors voyaged across the vast ocean, they were not bound by borders and restrictions, but rather by their own understanding and awareness of the environment. As present-day voyagers, exploring new and largely unchartered waters of allied health, so too can we apply the same perspective to limit the effect of racism. We are reminded that the sea is our home and this environment has provided important lessons for navigating vast oceans. We have learned valuable skills to navigate our way through the uncertainty and potential risks of the hospital system. Therefore, rather than being devalued, we recognise all of the beauty that has flourished in the journeying. We are reminded that rather than being a group of small, isolated and needy economies that lack resources, we possess abundant resources with a richness of culture, language, relationships, trade in reciprocity, and interdependence which grounds us in service and purpose. For participants, a "Sea of Islands" re-framing reinforces value and strength of community and connectedness. Participants exemplified such gains are being achieved in the absence of CMH system or structural supports, and it has been the opportunities for **Māori** and **Pasifika** AHP to come together as a collective, utilising resources and systems such as **whanaungatanga**, **talanoa**, **manaakitanga**, **alofa**, **kotahitanga**, and **teu le va** which has proven the greatest impetus for progress.

As previously mentioned, allied health is an umbrella term which encompasses a variety of health professions; while some have clear synergies, many do not, which can lead to tension when vying for positions within the allied health clinical grouping (Chadwick, 2018). It is this preoccupation with difference that has contributed to on-going challenges and limitations. It is suggested however, that by adopting a Sea of Islands approach, this eclectic group of proud professions have the opportunity to view themselves with a fresh and empowering perspective as a collective; each with their own language and knowledge base, that when woven together, creates a formidable, highly capable and complimentary workforce. Similarly, the same is true for richness of diversity and culture that exists within and between **Māori** and **Pasifika** communities; the sea is what connects us to each other, and compels a shared responsibility to support and see each other thrive.

There is no doubt about the negative impact racism has on **Māori** and **Pasifika** communities realising their potential (Health and Disability System Review, 2020; Health Quality & Safety Commission, 2021; **Waitangi** Tribunal, 2019). The issues raised in these reports highlight ongoing failings within the health system and provide compelling evidence that relevant supports, which are appropriately resourced, are much needed, and long overdue for **Māori** and **Pasifika** health workers. Every participant shared experiences and challenges that inhibit their ability to truly thrive as **Māori** or **Pasifika** AHP in their work environment. While some of these challenges may be inevitable, especially in the early years of working, this study shows that many identified issues do not improve with time or seniority, but persist throughout their CMH careers. It is clear from this study that despite the prolonged and on-going effects of racism, the resilience, humility and purpose **Māori** and **Pasifika** AHP demonstrate, are driven from a deep sense of commitment and service to their profession and communities. Therefore, the status quo needs to be challenged, and questions raised regarding as to what organisations, such as CMH are doing to ensure **Māori** and **Pasifika** AHP are safe, encouraged and enabled to thrive.

There is strong evidence showing the impact racism has on health outcomes, with **Māori** and **Pasifika** populations overrepresented in these experiences (R. Harris et al., 2006; Health Quality & Safety Commission, 2021; **Houkamau**, Stronge, & Sibley, 2017; C. Smith et al., 2021; **Talamaivao** et al., 2020; **Waitangi** Tribunal, 2019). Given the limited literature on the implications of racism within the workplace for **Māori** and **Pasifika** AHP, this study has identified a significant need for more research to be undertaken to unpack this further.

I need more of this to thrive

An underpinning aspiration of this research is to document what participants feel they need, to be at their best at work. They described the very real barriers they face. Equally, they provided practical ideas and strategies they believe would support them as **Māori** and **Pasifika** people who work as AHP, thus, enabling them to shift from surviving to thriving at work. This section draws on insights and suggestions generated from the themes; *it takes a village; the value of cultural intelligence;* and *being at our best*.

Within CMH context, participants reported that many supervisors or professional mentors focus on clinical or professional competencies, and have little (if any), knowledge in navigating cultural and related additional issues **Māori** and **Pasifika** AHP face daily, over and above their core clinical duties. Participants identified the need for both cultural and social support, delivered in appropriate and relevant ways within the work setting. In fact improved

workplace success and satisfaction is evident, when employees cultural identity is recognised and uplifted (Haar & Martin, 2021; McClintock et al., 2018). Several participants expressed gratitude regarding the strong clinical and collegial support they received from their respective professions or teams. However, very few participants had experienced cultural and social support as a regular part of their individual development plan.

Additionally, collectivism, connection, and reciprocity, were expressed by participants as key cultural concepts (Roche, Haar, & Brougham, 2018; Spiller, **Maunganui** Wolfgramm, Henry, & **Pouwhare**, 2020) they applied at work, that exist across, and are applicable to, the community, team and collegial levels. Participants ultimately viewed these concepts as crucial to their own growth and self-belief, and key to enabling them to thrive in the workplace. However, a mismatch between the need for cultural and social support for participants growth in their workplace, and what CMH provides to meet this need, remains a point of contention.

Some participants spoke of the positive experiences they had from being involved in previous workplace cultural support initiatives. Unfortunately, this was not universal, as many participants did not have the same opportunities to engage in said initiatives. The fact these positive experiences were not more widespread, indicates a lack of consistent investment from CMH in cultural support initiatives. This also presents an opportunity for CMH to review and improve their planning and funding in this important area. Furthermore, the significance participants placed on collectivism, being connected to their team and local community, highlights these aspects as other potential sources of thriving. When adequately resourced, strengthening cultural safety of the entire organisation will improve connection with, and reinforce engagement and services for, **Māori**, **Pasifika** and other communities (Curtis et al., 2019).

The significance of leadership was spoken about by all participants. In particular, they described the importance of leadership that provides encouragement, understanding and empowerment. These components have been shown to be fundamentally important when considering what positive leadership looks like in **Māori** and **Pasifika** contexts (**Fa'aea** & **Enari**, 2021; **Katene**, 2010; Roche et al., 2018). For example, Roche et al. (2018) highlighted the importance of **Māori** leaders working for autonomy and also developing autonomy and self-determination in others. **Kaitiakitanga** is a **Māori** value encapsulating the notion of leadership through stewardship, highlighting the sense of connectedness and relationality participants felt when they recounted positive experiences (Spiller, **Pio**, Erakovic, & **Henare**, 2011). For CMH allied leadership, operating through a **kaitiakitanga** framework is likely to enable growth, and build **mana** in others (Spiller et al., 2011).

Although it was felt that working in a team led by **Māori** or **Pasifika** enabled a certain degree of freedom to practice from a cultural-centric perspective, participants acknowledged that non-**Māori** non-**Pasifika** leadership could provide a similar sense of comfort, safety and holistic operating models. However, from their experiences this was less common-place, indicating **Māori** and **Pasifika** AHP are fully aware of what they need from leadership that is conducive to them thriving at work.

In their paper, Chong and Thomas (1997) examined cross-cultural leadership styles of **Pakeha** New Zealanders and **Pasifika** peoples. They found leader and follower ethnicity impacted on perceptions of leadership, suggesting that the greater the degree of cultural difference, the greater the chance of sub-optimal leadership. Similarly, Pfeifer and Love (2004) investigated leadership characteristics of **Māori** and **Pakeha**, and the extent to which leadership traits stem from cultural norms and values. They found the differences in cultural values was reflected in the behaviours of followers. The fit between a leader's behaviour and the expectations of those following have been shown to be important for enacting successful leadership (Chong & Thomas, 1997; **Katene**, 2010; Pfeifer & Love, 2004; **Ruwhiu** & Elkin, 2016). The insidious nature of societal racism and the resulting impact of negative stereotypes, attitudes or expectations of **Māori** and **Pasifika** cannot be discounted. To counter, investing in intentional leadership development pathways that specifically nurture **Māori** and **Pasifika** AHP into management and leadership positions, and educating existing non-**Māori** and non-**Pasifika** leaders as to the potential for differences in experiences of **Māori** and **Pasifika** AHP within their care, is one example CMH could implement with this in mind.

Acts of allyship from non-**Māori** non-**Pasifika** colleagues was seen as another important factor in considering their ability to thrive at work. Allies are individuals from outside a marginalised group who pro-actively support the elimination of prejudice, and advocate for the rights of marginalised people, alongside them (K. T. Brown & Ostrove, 2013). Moreover, allies acknowledge, and consciously work to un-do the unearned privileges that come from being part of the dominant group, build authentic relationships with the groups they wish to advocate for, and recognise that to be an ally is an on-going process, rather than a level, one achieves (J. Smith, Puckett, & Simon, 2016). Participants reflected on ally behaviours including, non-**Māori** promoting use of **te reo Māori**, seeking to understand a **Pasifika** worldview, having non-**Māori** non-**Pasifika** colleagues speak up in meetings about cultural issues, and not expecting the only brown person at the table to do the **karakia** or **lotu**. Emery & **Te Maro** (2018) describe allies consciously creating "space" for minority groups to contribute, share, challenge and teach (Emery-Whittington & **Te Maro**, 2018).

Although participants shared examples of ally behaviours, no one explicitly described having allies around them, more that they would like allies next to them. An optimistic interpretation of these occasional acts of allyship may perceive these behaviours as colleagues creating space, recognising prejudice or attempting to build relationships. However, the concept of allyship, including the "how to" be an ally or "what is means" to be an ally, are concepts many of the participants colleagues are likely to have a varying understanding of. Incorporating training with non-**Māori** non-**Pasifika** AHP and other staff to develop their knowledge of concepts like allyship, cultural safety, privilege, racism and anti-racism, local histories, and colonisation, would provide a way to offload the cultural burden for **Māori** and **Pasifika** AHP by increasing confidence and capabilities of non-**Māori** non-**Pasifika** staff to recognise, and eliminate harmful assumptions or expectations, before they happen (Came & Zander, 2015; Curtis et al., 2019; Emery-Whittington & **Te Maro**, 2018).

Participants shared that seeing and feeling the organisation place greater value on the cultural knowledge they possess would be important for enabling thriving. Participants shared stories of being expected to provide cultural leadership or support in their respective settings, regardless of the participants own comfort or suitability. There was a common frustration that although **mātauranga** was a specialised skillset very few people could offer, it was not recognised as valid when compared to a postgraduate qualification or number of years of clinical experience in an area. Additionally, participants spoke of a sense of empowerment that came through leadership recognising, and trusting them to apply their cultural knowledge to improve team interactions and service design and delivery. Finally, participants indicated they would relish the opportunity to grow their own individual cultural capital, which is consistent with previous research regarding **Māori** and **Pasifika** working in health and other contexts (McClintock et al., 2018; **Ratima** et al., 2008). This could be in the form of protected time allocation to develop language and customs knowledge, developing links with **Māori** or **Pasifika** groups, or cultural supervision from experts as identified by participants (McClintock et al., 2018).

It is apparent from participants stories that neither **Māori**, nor **Pasifika** ways of being, thinking or doing are present in the spaces that the majority of AHP work. As already noted, there are numerous obstacles that inhibit **Māori** and **Pasifika** AHP. However, participants offered practical, simple and largely achievable suggestions for existing allied health leadership, and CMH leadership to take note of, and implement. The stories presented, and the available literature, paint a clear picture of both the on-going struggles of **Māori** and **Pasifika** AHP and also, the learnings and insights that must be shaped to create a true shift in the practice reality for this group of highly important, yet severely underserved workforce.

Summary of Recommendations

Rather than merely applying **Māori** and **Pasifika** concepts to this study, it has sought to weave Indigenous knowledge systems of **Māori** and **Pasifika**, and aspirations of **Te Tiriti** into its very essence. By applying customary practices of engagement, connection, story-telling, and idea exchange; and being guided by cultural values such as, commitment to others, the nurturing of **le va** between all things; these **wānanga talanoa** provided the fora for 11 **Māori** and **Pasifika** AHP to courageously share their workplace experiences, vulnerabilities, challenges and aspirations.

In accordance with cultural practice of reciprocity, participants too, graciously provided a collective offering in the form of insights and learnings from their lived experiences of what has or has not enabled them to thrive at work. The following recommendations reflect and summarise **mātauranga** shared by participants. These **meaalofa** or **taonga** were gifted to sustain, not only the 11 participants involved in this research, but the many more **Māori** and **Pasifika** AHP to follow. While some suggestions can be swiftly implemented, others may take time. What is clear however, is that these recommendations will take on-going commitment and conviction from both allied health senior leaders and CMH organisational executive leadership, if they are to be realised.

What enables **Māori** and **Pasifika** AHP to thrive at CMH?

1. Cultural Support

- Establish a progressive cultural supervision programme for all **Māori** and **Pasifika** staff who request it
- Establish and resource an in-house **whānau** network as an extension of cultural supervision programme (**Tuakana-Teina** framework)
- Actively encourage and support participation in the above (e.g. Offer at the outset to eligible participants, protected time to allow attendance)
- Encourage and resource cultural development as a normal and expected life-long practice

2. Leadership

- Offer and provide specific career/leadership development programmes to enable **Māori** and **Pasifika** to transition into senior management and leadership roles

- Set service/organisational targets for numbers of **Māori** and **Pasifika** occupying senior allied health leadership roles
- Support existing allied leaders to adopt a **kaitiakitanga** approach to leadership, focussed on building relationships, trust and enhancing **mana** of those around them

3. Allyship

- Implement mandatory Cultural safety training consisting of **Te Tiriti o Waitangi**, Decolonisation, Health Equity, Anti-Racism, Privilege, Being a good ally, and local history training for all staff
- Adopt and implement cultural models of health as standard practice for all (not just in cultural services)

4. Valuing the unique skillset

- Provide professional development that includes access to Indigenous knowledge development
- Recognise cultural knowledge/intelligence as a specialised skillset and remunerate appropriately
- Incentivise **Māori** and **Pasifika** staff into further research (perhaps on topics identified in this literature)

Strengths and limitations

This study has several strengths and limitations. To my knowledge, this is the first piece of research exploring **Māori** and **Pasifika** AHP experiences of thriving in a DHB setting. Another strength is in its unique positioning that draws on shared **Māori** and **Pasifika** values which underpin their respective worldviews. This dual honouring adds **mana** to the connection of ancient knowledge systems and simultaneously celebrates the uniqueness and strength inherent in the diversity of **Te Āo Māori** and **Pasifika**. Furthermore, by choosing to interweave values fundamental to **Māori** and **Pasifika** cultural perspectives, this research approach becomes a potential stepping stone for other researchers seeking to build on it.

Although, the relatively small sample size could be considered a limitation, the information power concept employed in this study identifies key strengths in the sampling process utilised. This was exemplified by the diverse range of disciplines represented, the mix of **Māori** and **Pasifika** participants, gender and age diversity, as well as life and career experiences resulting in a richness and depth of participant perspectives and offerings.

When I originally started this practice project, I was working at CMH in an allied health equity role. It was important to ensure the scope of the project was viable, so restrictions were applied on the number of AHP included, which of the AHP would be included, and the focus being on a single public health work context (versus including other regions or private practice settings). Consistent with the intent of a practice project, it was expected findings could have practical utility and application within the CMH context in particular. While these choices were intentional at the conception of this research, the findings may be inherently limited given this narrow scope.

By western standards, my prior knowledge of participants may be interpreted as participant selection bias. However, this research encourages approaches that seek to privilege Indigenous perspectives. Having pre-existing relationships with many of the participants meant **whanaungatanga** was already established. In fact, these established connections provided a framework to allow the emergence of **talanoa,** and in-depth sharing to take place. The trust built, aided the level of comfort, freedom and authenticity that participants engaged in, with the researcher and the wider group. The nature of existing relationships ensured a **teu le va** approach to carefully navigate potential ethical tensions.

Other key limitations were the restricted nature of not being able to include higher numbers of participants and; the inclusion of so few AHP that were unknown to the researcher, as their perspectives may have further augmented the findings.

Areas for Future Research

Findings would suggest CMH are in breach of their **Te Tiriti** obligations to **Māori** AHP, and need to urgently take tangible steps to raise the cultural safety of all staff. Speaking about the importance of health equity, and having reports and strategies that espouse the same narrative is not sufficient on its own. Turning this into action is what is necessary. The implication for research is to continue to explore workforce experiences from the perspectives of **Māori**, **Pasifika**, and allied health more broadly. These findings clearly showed that more research is needed to add to, and extend current evidence as it pertains to workforce experiences of **Māori** and particularly **Pasifika,** in allied health as well as across health more broadly. Growing the literature base about the impact of racism, organisational culture, cultural safety in the work place for AHP, allyship for supporting marginalised groups, recruitment and retention of **Māori** and or **Pasifika**, and the application of Indigenous knowledge in public health settings, are all areas for future research to explore. Furthermore, research that explores the impact of implementing the recommendations proposed in this

study would be formative to the development, refinement and implementation of effective strategies to support thriving of **Māori** and **Pasifika** AHP going forward. Ultimately, until these recommendations are implemented, and become normal practice, **Māori** and **Pasifika** AHP will continue to just survive, and not thrive in their work environment.

Conclusion

The motivation for this research was to draw attention to the experiences of **Māori** and **Pasifika** AHP working at CMH. The aim was to explore what enables **Māori** and **Pasifika** AHP to thrive, with a particular emphasis on the first two years of practice. The findings add much needed AHP insights into a growing evidence base, highlighting challenges **Māori** and **Pasifika** clinicians experience in their daily work.

Health inequities for **Māori**, and the reasons for them are well documented (**Waitangi** Tribunal, 2019), and a similar body of evidence for **Pasifika** communities continues to grow (Health Quality & Safety Commission, 2021). The literature review highlighted gaps in research linking the experiences of **Māori** and or **Pasifika** clinicians, and the potential impact those gaps have on their ability to thrive.

Informed by both **Māori** and **Samoan** values and principles, this study purposefully adopted a strengths-based approach, and its significance cannot be understated. Rather than minimising or ignoring the negative impacts of poor health, on-going colonisation and racism has on AHP wellbeing, it highlights collective strengths and solutions for positive change in spite of such adversity (Rolleston et al., 2021).

Overall, the evidence from this study supports suggestions that providing opportunities for cultural development, recognition of cultural knowledge/intelligence, and culturally safe and enriching work environments, are key ingredients to enabling **Māori** and **Pasifika** staff to thrive at work. These findings support previous work highlighting the importance of being able to be **Māori** or **Pasifika** at work (Brownie et al., 2021; Davis, 2020; Hooker, 2015; McClintock et al., 2018; **Ratima** et al., 2007) as well as reinforcing findings outlined by the **Waitangi** Tribunal and the Health Quality Safety Commission (Health Quality & Safety Commission, 2021; **Waitangi** Tribunal, 2019).

As much as this research is for my **Māori** and **Pasifika** AHP colleagues, it is also for health organisations that employ us, for colleagues that sit next to us, and other non-dominant groups that can relate to our experiences. Finally, it aspires to be an anchor, for **Māori** and **Pasifika** AHP to reference when seeking environments that enable thriving; a compass for

organisations to use as a guide to provide safe and fulfilling work spaces for all; and a beacon to highlight opportunities for future research.

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APPENDICES

Appendix A: 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

27 January 2021

Nicola Kaves
Faculty of Health and Environmental Sciences

Dear Nicola

Re Ethics Application: **20/377 Thriving as Māori & Pasifika Allied Health professionals in the first 2 years of practice in a DHB setting**

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 27 January 2024.

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.

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

Appendix B: Consent Form

CONSENT FORM

Project title: What enables Maaori and Pasifika Allied Health Professionals to thrive in the first 2 years of working in a DHB environment?

Project Supervisors: Professor Nicola Kayes, Bobbie-Jo Wilson (Ngaati Tuuwharetoa)

Researcher: Ulima Tofi (Rongowhakaata, Tufulele)

- ○ I have read and understood the information provided about this project in the Participant Information Sheet dated November 2020
- ○ I have had an opportunity to ask questions and to have them answered.
- ○ I understand that identity of my fellow participants and our group discussions are confidential to the group and I agree to keep this information confidential.
- ○ I understand that notes will be taken during the focus group and that it will also be audio-taped and transcribed.
- ○ I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the study at any time without being disadvantaged in any way.
- ○ I understand that if I withdraw from the study then, while it may not be possible to destroy all records of the group discussion of which I was part, I will be offered the choice between having any data that is identifiable as belonging to me removed or allowing it to continue to be used. However, once the findings have been produced, removal of my data may not be possible.
- ○ **I agree to take part in this research**
- ○ I wish to receive a summary of the research findings (please tick one): Yes○ No○

Participant's signature: **Date:**

Participant's name:

Participant's contact details:

Address:

Email: **Phone:**

***Approved by the Auckland University of Technology Ethics Committee on** type the date on which the final approval was granted **AUTEC Reference number** type the AUTEC reference number*

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

Appendix C: Participant Information Sheet

AUT
TE WĀNANGA ARONUI O TĀMAKI MAKAU RAU

PARTICIPANT INFORMATION SHEET

Date Information Sheet Produced
November 2020

Project Title
What enables Maaori and Pasifika Allied Health Professionals to thrive in the first 2 years of working in a DHB environment?

An Invitation
Teenaa koe, Malo Soifua, Malo e Lelei, Kia Orana, and warm Pacific greetings

My name is Ulima Tofi, I am a qualified Physiotherapist and am conducting this research as part of completing a Masters of Health Practice dissertation through AUT University. This research project which aims to better understand and capture what enables Maaori and Pasifika Allied Health Professionals to thrive in the first 2 years of working in a DHB environment and I humbly invite you to take part. Whether you choose to participate or not will neither advantage or disadvantage you. Having you participate in this study would be greatly appreciated.

What is the purpose of this research?
We know Allied Health profesionals play an integral role in the healthcare of our community. We also know that in South Auckland, a large portion of that community are Maaori and Pasifika, many of whom experience inconsistent health care and services. One strategy to improve services is to employ more Maaori and Pasifika health workers.

Literature tells us that health workers are at increased risk of burn-out due, in part to the ever increasing stressors placed on the healthcare system due to things like inadequate resources, unsustainable workloads and inexperience. For many Maaori and Pasifika Allied Health professional this is only compounded by daily cultural isolation and systemic rascim that has plagued the health system for years.

The purpose of this research is to understanding the experiences and insights of Maaori and Pasifika Allied Health professionals and how they can be empowered to thrive is unknown. The purpose of this topic is to listen and learn from current Maaori and Pasifika Allied Health Professionals to better understand what enables thriving in this hospital setting. We also want to explore terminology beyond thriving, which appropriately captures Maaori and Pasifika concepts and values.

Our research aims to highlight what matters most for Maaori and Pasifika Allied Health professionals to thrive, with a particular focus on the first 2 years of practice and utilize the learning as a catalyst for improvement or change. Findings from this study will be put forward to Allied Health leadership as a way to help facilitate cultural safety for these groups. 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 have been invited to participate in this research because you have a) self-identify as Maaori or Pasifika; b) are qualified as a physiotherapist (PT), occupational therapist (OT)T, pharmacist (PH), dietician (DT), or speech language therapist (SLT); and c) are currently practicing at Counties Manukau Health.

How do I agree to take part in the research?
I would be pleased if you would agree to be part of the research. I plan to facilitate a group discussion session of 6 – 10 participants to gather deep and valuable information. If the number of volunteers exceeds my target number of participants, factors like age, gender, ethnicity, profession, stage of registration, level of experience and qualification and area of work will be considered to ensure I select a range of volunteers who represent the diversity of Allied Health professionals at Counties Manukau Health.

I would really appreciate hearing about your experiences. However, 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 can 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.

If you agree, please fill in the consent form and demographic sheet provided within two weeks of receiving the

participant information sheet. This can be e-mailed directly to me.
If you have any questions, please feel free to contact me on ulimatofi@gmail.com or 022 190 2950.

What will happen in the research?
I will hold a single discussion session on-site at CM Health that will last about 2 hours long. The session will draw on shared principles which underpin waananga and talanoa methods; spirituality, love, respect and service. You will be one of approximately 6-10 other Maaori or Pasifika Allied Health professionals from CMH that will share and contribute to the session. If it is your preference, you will also have the option of taking part in an individual interview session which will follow a similar format as the group.

When everyone has arrived the session will be opened with karakia/lotu, whanaungatanga/teu le va will then follow, after which an overview about the research will be presented and then an opportunity for the group to develop its own expectations and session tikanga. From there you all will be invited to share thoughts and ideas about the topic with guidance from the facilitator. Light kai will be provided.

Approximately 1 week prior to the in-person session, you will receive some general questions to help generate your thinking about concepts and questions we will cover. Once the session has been transcribed, if you wish, you will be given a summary of findings which can be provided to you via e-mail.

It is important for you to know that:
- Contributing to this research is completely voluntary and you can withdraw at any time, although it may be difficult to remove your data given the collection method
- Discussions will be audio-recorded
- Confidentiality is strongly encouraged although difficult to guarantee

What are the potential risks or discomforts?
It is not anticipated that participants will be at risk or experience discomfort from taking part in this research. However, it is important to acknowledge that participants may experience some discomfort given, as mentioned previously the cultural burden, isolation, and pressures that some participants may face. Compounding these experiences is the context of structural racism that threatens the ability of Maaori and Pasifika to thrive as AHP. Discussions may bring those experiences to the surface for participants and cause some discomfort.

How will these risk or discomforts be alleviated?
If you do feel any form of discomfort as a direct result of participating in this research, please contact the AUT Health Counselling and Wellbeing service who can offer three free sessions of confidential counselling support. These sessions are available for issues that have arisen directly because of participation in the research and are not for other general counselling needs.

To access these services, you will need to:
- drop into our centres at WB219 or AS104 or phone 921 9992 City Campus or 921 9998 North Shore campus to make an appointment. Appointments for South Campus can be made by calling 921 9992
- 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 http://www.aut.ac.nz/being-a-student/current-postgraduates/your-health-and-wellbeing/counselling

What are the benefits?
There is no direct benefit in participating in this research. However, this research may be beneficial to other Maaori and/or Pacific Allied Health Professionals working in other District Health Board (DHB) settings and may also serve to provide DHBs with tools to improve their understanding and support of Maaori and Pacific Allied Health staff. Finally, this research will contribute to my Master of Health Practice qualification.

How will my privacy be protected?
It has been explicitly outlined to all participants that confidentiality is expected within the group and will be reiterated at the outset of the group session. Additionally, each person has the right to withdraw at any stage through the process. However, given the nature of a group process the researcher cannot guarantee absolute confidentiality.

Information will be stored in a secure manner at all times at through the student researcher keeping all information online in the cloud, secured by Multi-factor Authentication (MFA). Consent forms will be kept separate from all other data that will be secured with the use of encrypted USB and/or secure online cloud storage.

No personal data will be collected from participants other than basic demographics and pseudonyms will be used for participants in reporting. Care will be taken to ensure any identifying information is removed for reporting purposes.

What are the costs of participating in this research?
Aside from giving up your time, there are no costs associated with taking part in this research. The time involved will consist of 20 minutes to read this information sheet and complete the consent form and demographic sheet, and the 2hour group session.

What opportunity do I have to consider this invitation?
Participants are encouraged to contact me within 2 weeks of receiving this information.

Will I receive feedback on the results of this research?
A summary of findings may be sent to participants via email if they wish. You can indicate whether you would like to receive this on the consent form.

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

Ulima Tofi (NZRP), ulimatofi@gmail.com , +64 22 190 2950

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 supervision team:

- Nicola Kayes, Centre for Person Centred Research, nkayes@aut.ac.nz , +64 9 921 9999 ext 7309
- Bobbie-Jo Wilson (Ngaati Tuuwharetoa), AUT, bjwilson@aut.ac.nz, +64 9 921 9999 ext 8465

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.

Your involvement will be greatly valued and contribute to enabling Maaori and Pasifika success

Mauri Ora, Ia Manuia Malo Aupito, Meitaki Maata

Appendix D: Participant Demographics Form

Demographic Sheet

What enables Maaori and Pasifika Allied Health Professionals to thrive in the first 2 years of working in a DHB environment?

Participant Details

1. **Name:**
2. **Age:**
3. **Which best describes your gender?**

   O Female O Male

   O Prefer not to say O Prefer to self-describe _____
4. **Which ethnic group or groups do you identify with (choose as many as apply):**

   O Maaori - *Iwi Affiliations*: _____

   O Tokelau O Tonga O Kuki Airani

   O Samoa O Niue O Paakeha/NZ European

   O Further (please specify) _____
5. **Profession:** _____
6. **Specific Job Title:** _____
7. **Highest Level of Qualification:** _____
8. **Years since Qualification:** _____
9. **Specific Area of Practice:**

   O Acute O In-patient O Residential O Community O Other _____

Appendix E: Wānanga Talanoa Prompt Questions

Wānanga/Talanoa Questions

What enables Māori and Pasifika Allied Health Professionals to thrive in the first 2 years of working in a DHB environment?

Note: These are suggested prompts to help the moderator keep the focus group on track. While core topic areas will be discussed, not all questions will necessarily be used in all cases depending on the group and flow of discussion.

Time (mins)	Topics for discussion
30	**Block 1 – What it is?**
	What enables you to thrive at work? ▪ What does "thriving at work" mean to you? ▪ What would you say were the key features of achieving this concept? ▪ What factors can impact this concept (good or bad)? **Is thriving as appropriate term?** ▪ What does the word "thriving" mean to you? o Does it reflect what is important to you? o Can you think of other words (other than thriving) that feel more appropriate to you? o Which concepts/terms are you more comfortable with or feel better reflect you?
30	**Block 2 – What could be?**
	How important is your culture in your professional practice? ▪ Can you share your views on how your culture would impact your ability to thrive? ▪ How important to you is it to include your culture as a way to enable thriving? o How would/do you like to incorporate it? **When you think about the first 2 years of your practice, are/were you thriving?** ▪ How do/did you know you were/were not? o If yes, why? If no, why? **What could be done differently to enable you to thrive?** ▪ Knowing what you know now – Can you share any ideas on how things could be done differently in your first 2 years of practice?
15	**Exit Block**
	▪ Is there anything you would like to add that we have not touched on? ▪ One final question to finish - given what we have discussed, thinking about your initial years practicing, what would be the two most critical components to enabling you to thrive – what would they be and why?