TE WHARE WĀNANGA O
AWANUIĀRANGI

NGA REREKETANGA I ROTO TE HAUORA: MĀORI NURSES' EXPERIENCES WORKING IN THE NEW ZEALAND PRIMARY HEALTH CARE SYSTEM

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ABSTRACT

One of the *New Zealand Health Strategy* (2000) objectives was to improve the health outcomes of Māori, resulting in the introduction of changes within the health system to enable Māori to be cared for in a culturally safe and sensitive manner, and ethics in nursing to enable the safe treatment and care of all New Zealanders. However, despite the focus on improving care and health outcomes for all New Zealanders, poor health statistics for Māori, both in morbidity and mortality, remain high in comparison to non-Māori.

This thesis acknowledges that inequity for Māori exists within the health sector and that, although the New Zealand Health Strategy (2000) and other subsequent policies have committed to addressing the situation, inequities remain and are being complicated by other circumstances. For instance, one solution to address health inequities has been a call from Māori communities over the past decade to produce services developed 'with, by and for Māori'. Central to that strategy is the employment of more Māori into the nursing healthcare profession, and the implementation of culturally appropriate practices and decision making driven by Māori. However, a high proportion of Māori nurses are leaving the nursing workforce, further disadvantaging services relating to Māori health care in communities that are already under pressure. Thus, government health policies and strategies have not been able to address issues raised by Māori about Māori health care.

Drawing on a Kaupapa Māori research methodology (Smith, 2012), this thesis explores the experiences of Māori nurses in the profession, including why they are leaving it. It does so by interviewing (via in-depth qualitative expert/practitioner's interviews) eight Māori registered nurses working in primary health care. The research raises a range of issues identified by the participants, including working conditions, discrimination, workloads and staff turnover within the health care sector. What the research reveals is that, regardless of the emphasis in the profession on modelling good nursing practice through dialogue, debate and the sharing of resources, this is not necessarily working to reach, support or enable Māori nurses to thrive in their practice. The research focused on uncovering critical features that influence nurses' practices and decisions and presents a vision for an intervention to keep Māori nurses in the profession.

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and I wish to acknowledge my tipuna.

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Glossary

Māori kupu	**English word**
Awa	River
Awhi	Support
Hapū	Sub-tribe
Hui	Large social or ceremonial gathering
Iwi	Tribe
Kainga	House
Kaiāwhina	Person who assists
Karakia	Prayer
Kaumātua	elder
Kaupapa	Māori agenda or approach
Kawakawa	Native shrub specific to New Zealand
Kōrero	Talk, chat, conversation
Koroua	Grandfather
Kanohi ki te kanohi	Face to face
Nannies	Grandmothers
Mahi	Work
Manaakitanga	Kindness
Māori	Indigenous people of New Zealand
Marae	Meeting grounds
Maunga	Mountain
Mihi	Welcome
Mokopuna	Grandchildren
Pākehā	Non- Māori
Pepeha	Introduction
Rangatahi	Youth

Rereketanga	Difference
Tangata whenua	People of the land
Tamariki	Children
Taonga	Treasure or something of value
Tawhetatanga	Struggle
Tēnā koutou katoa	Greetings to you all
Te reo	Māori language
Tikanga	General behaviour, guidelines for daily life and interactions in Māori culture
Tīpuna	Ancestors
Waka	Canoe
Wāhine	Woman/women
Waiata	Hymn
Whakawhanaungatanga	process of establishing relationships in a Māori context
Whare	Home
Whānau	Family

Explanation: English is my first language, but not the only language of Aotearoa (New Zealand). However, I use a wide variety of Māori kupu (words) in my everyday language as do my participants. Therefore, this research contains te reo and although those words are used in a glossary, it is important to note that "defining Māori terms in English, can be a difficult task given the multiple meanings and understandings that each term carries" (Pihama, 2001, p. 29). Except for direct quotes and the names of publications, macrons are used within the work to signify a double vowel as recommended by Te Taura Whiri I Te Reo Māori (Māori Language Commission, n.d.).

Tēnā koutou katoa

Ko Tainui taku waka

Ko Tainui taku iwi

Ko Ngati Pou taku hapū

Ko Taupiri taku maunga

Ko Waikato taku awa

Ko Potatau te Wherowhero te tangata

Ko Marshall – Foote taku whānau

Ko Ooraeroa taku Marae

Ko Ani McCleland taku ingoa

Tēnā koutou, tēnā koutou, tēnā koutou katoa.

CHAPTER ONE: Setting the Context

E hara taku toa I te toa takitahi, engari he toa takitini
My strength is not as an individual, but as a collective
(Our vision aronga Matua, 2020).

1.0. Introduction

I stand as a Tainui[1] woman. My doing, being and thinking is from a Māori world view, however, I am also of Pākehā[2] descent and often feel trapped in a space between the two worlds (see Syljuberget, 2016). That feeling of being trapped also extends into my work-life.

I have been a registered nurse for a number of decades and have a well-developed passion for nursing. My work has located me within Māori work environments that have, unfortunately, operated on the margins of healthcare, thus creating 'Māori spaces' in a system framed by westernized organisations and thinking. I know those two worlds well.

I am from a large extended whānau, brought up with strong Christian ethics and a philosophy of fairness and supporting others. Most of my life has been spent in the service of caring, whether it has been whānau with health concerns in secondary care, Māori nursing students experiencing struggles within a westernized tertiary education institute, or more recently, whānau and Māori registered nurses living and working in the community. I have worked for 50 years as a nurse in Aotearoa[3] in the hospital environment, 25 of those years in nursing education and, for the last seven, in primary health care. My work in primary health care has been as a registered nurse providing clinical oversight within a Māori health provider and also providing clinical supervision for Māori nurses within primary health care. Consequently, this work has involved working alongside Māori registered nurses and whānau in need (the latter living mostly in high deprivation areas). This is hard work, with many tensions and challenges.

This led me to an insight into a special type of nursing, critical nursing and from this insight many questions began to emerge. Hence, the research question is, *what are the experiences of Māori nurses working in primary health care?*

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[1] Tainui: Iwi or tribe located in Waikato region.
[2] Pākehā: non-Māori.
[3] Aotearoa: the land of the long white cloud. The original name for New Zealand.

My many years of nursing began as a seventeen-year-old student, far from home at a large provincial hospital. My experience was 'rooted' in secondary health care, an apprenticeship in observations of 'hands on care', and entrenched in a hierarchical, patriarchal system. This system was based on an old, established medical model which was reductionist and focused predominantly on the physical being of the individual. On reflection, it was also a dehumanizing model, but we knew no alternative. Nursing at that time was heavily influenced by the teachings of the pioneer, Florence Nightingale, who worked in the filth and infectious environment of the Crimean War. Her practice dictated cleanliness and ventilation without draughts. Hence, our wards were spotless, the beds were aired every morning, and rarely did we see a wound infection. It was a rigid, hierarchical rule-bound system, and one in which nursing was tied to structure. For instance, the junior nurses carried out bed bathing, emptying bedpans and delivering the meals, whereas mid-level nurses completed wound dressings, 'medicine rounds' and tasks more suited to nurses with experience. However, night shifts were different as the lone nurse did everything.

I remember being in charge of an isolation ward on night duty as I began my second year of 'training'. I had a 'runner' who ran between three wards and a night supervisor who I saw twice during the night and whom I could phone for help. At one stage, I struggled with a young female patient with a mismatched blood transfusion. She was periodically fitting[4] and I couldn't get help. I can still hear her drip tapping on the bed cot sides as she began fitting again and I hurried to comfort her.

I also had a ward full of long term Tuberculosis (TB) patients and what seemed to be a multitude of babies and toddlers with diarrhoea and vomiting who needed rehydrating, so my first task was to wrap each child in a towel so they couldn't wriggle, put a ryles naso-gastric tube down into their stomach and feed them, then change their nappies. This enabled the children to sleep well during the night, but that task had to be completed by the time the antibiotics were due for the TB patients at midnight. I vomited from stress most mornings when I arrived back in the Nurses' Home, but no one ever knew. It was all just part of what we did, an example of working under stress, about learning on the job for instance, 'hands on learning'.

This stratified health system had all sorts of rules based on hierarchy. For instance, the nurse stood up in the hospital ward office if a nurse of higher ranking or a doctor entered

[4] Fitting is in contemporary times known as seizures.

the room and stood back if a higher-ranking nurse approached a door she was entering. Nightingale's teachings emphasised obedience and we were required to comply.

Our nursing practice required us to be judgemental and insensitive to other cultures. Nursing was based on westernized thinking that focused on the individual and did not recognise the patient's family. As a young Māori woman, far from home, this initially caused culture shock and made me feel isolated and uncomfortable because Māori is about being part of a collective and focusing on caring in a different way. There was little thought in nursing practice for the needs of others. Nursing was task orientated, a far cry from the holistic care focused on today. Māori patients were treated the same as non-Māori, which meant if the patient was seriously ill or deceased, they were only allowed two visitors at a time during designated visiting hours and at the convenience of the nursing staff.

The Māori whānau who came to say farewell or spend time with their loved ones were seen as a nuisance and made to wait outside the hospital ward. They would likely have no idea that the deceased was going to be moved to a morgue and into a refrigerator unit. This westernized process was against Māori cultural practice and interrupted the grieving process. Accordingly, I always made sure the whānau knew what the process was. Did they want the undertaker to come straight up to the ward, and transport the body to the Marae (the courtyard of the Māori meeting house)? Did they want to be involved with the body preparation, such as washing, and would they like to cleanse the room after the body was removed? These were seen by other nurses as unnecessary practice.

In 1985, nurses marched in protest for higher wages in a 'Nurses are worth more' campaign, where nurses tried for the first time to use industrial clout and public opinion to sway the government for improved wages. There was a feeling of unity and power amongst nurses. We wore our uniforms and marched through the streets, some even pushing beds with creatively made up patients on them! I remember the feelings of excitement, even liberation and we thought we had the public backing us. How wrong we were! The general public were initially horrified. 'How greedy, isn't nursing about caring, self-sacrifice?' There were negative comments made to us in the street, in the wards, amongst our whānau and our elders. There was an unexpected backlash. It was a long time before the general public understood and regained their trust in nurses. Florence Nightingale's model of nursing had certainly influenced perceptions about its practise!

Much later, I was coerced into nursing education, a change I never regretted. It was 'fashionable' to have 'a' Māori nurse in the faculty, especially one who was obedient. At

that time there was an explosion of nurse theories impacting on nurse education. Theorists were striving to move nursing practice from dehumanising patient care into a humanistic, holistic based profession. Nursing theory had a huge impact on nursing, developing nursing education from simple nurse registration into a tertiary diploma qualification and then into an undergraduate degree. These theorists included, Jean Watson and her Caring theory (Watson, 2008), Sister Callistra Roy and her Adaptation model theory (Vandermark, 2006), Madeline Leininger and her Transcultural theory (Murphy, 2006). In Aotearoa, Irihapeti Ramsden (a New Zealand nurse and nurse educator) had developed her theory of cultural safety for Māori patients (Ramsden, 2002). I attended and became influenced by Ramsden's initial 'cultural safety' development hui in Palmerston North in 1989.

Cultural safety quickly became an important part of the New Zealand nursing curriculum development. After several upsetting personal experiences involving unsafe treatment of whānau in hospital, I took the opportunity to become involved in the development of cultural safety in nursing education. By this time, I had become a nursing manager within a Polytechnic system. I worked on three Bachelor of Nursing curriculums (and later a Master of Nursing curriculum) which initially included a lot of dialogue and debate amongst seven tertiary institutes and universities. The curriculum development happening at this time signified huge growth for nursing faculties, as teaching staff were brought 'on board', nursing staff were upgraded to Bachelor of Nursing degree qualifications and then, later, Master of Nursing degrees. It also promoted a new, holistic way of thinking for nurses in primary and secondary health care. This was a time when nursing moved from an apprenticeship style training to a professional education degree.

However, not everyone was happy with the change and some saw the newly graduated degree nurses as a threat. This meant that many of the practising registered nurses were reluctant to change. They were trained in a hands-on apprenticeship model, with a focus on the physical aspects of care, and did not understand holistic care. Hence, this sometimes provided negative experiences for nursing students in clinical situations. Interestingly, many of our colleagues teaching in Universities where also unhappy about Polytechnic institutions teaching nursing degrees (Maureen Holdaway, personal communication, 1990). However, several of us in Polytechnics led the way by gaining higher qualifications. I gained a Bachelor of Arts, Diploma in Tertiary Teaching, Master of Nursing and Master of Arts. This widened my knowledge base and gave me an understanding of others trying to study and juggle family, extended family and full-time

employment. More recently, nursing education has moved into online education platforms with less face to face learning. In my observation, this has been harder for Māori students regarding their learning as oral kanohi ki te kanohi (face to face) is their preferred learning style.

Another major influence on nursing practice was a heightened focus on ethics, which was triggered by an horrific episode of medical misconduct involving Dr Herbert Green and his staff at Greenlane Hospital in Auckland. These medical workers carried out experiments on patients and foetuses without patient consent or knowledge, sometimes resulting in the early death from cancer of women patients. This was an example of medical arrogance and dominance, where medical specialists used their power to make decisions about women's health and lives without their knowledge. Unfortunately, the nurses involved remained subservient and silent, just as they had been 'trained' to do. This misconduct was labelled 'an unfortunate experiment' and was presented to the general public in the magazine *Metro* (June 1987) by prominent women's health advocates and writers, Sandra Coney and Phillida Bunkle (1987). The *Metro* article led to an inquiry proceeded over by Judge Sylvia Cartwright, known later as the Cartwright Inquiry (Ministry of Health, 2009; Davidson & Tolich, 2003). What resulted was a huge public outcry and the medical and health care industry had to change attitudes, policies and procedures around what care meant and how health professionals should operate. This resulted in a requirement that health care professionals show empathy, respect and support towards each other and their patients.

Nurse education then included a focus on ethical practice and informed patient consent. One of Judge Cartwright's recommendations was the appointment of a Health and Disability Commissioner (Else, 2010). However, Coney (2009) noted that Cartwright's greatest contribution to New Zealand health care was "to make the women's experience central and to shape her recommendations so that they would protect and empower patients in the future" (p. 70).

At this time, while transformations in health care were rapid, they were not easy and meant that health care workers had to now be accountable for every decision they made. The transformations also meant that informed consent was an expectation, patient advocates were available, research had to be approved by a reputable ethics committee, and a number of other changes occurred. By this time (1990s) nursing education was being funded by the Ministry of Education, and the Ministry of Health funded health care

through the hospitals. This had ramifications for health funding because hospitals lost their unpaid student labour force.

At present, health funding in primary health care is issued by central government and developed into contracts by the District Health Board and then distributed amongst the Primary Health Organisations. Primary Health Organisations are health care providers that are funded on a capitation basis by District Health Boards. They include not-for-profit organisations with a focal point on population health. Māori health providers fall into this category. The main point is that primary health care occurs in the community and tertiary care is provided by the hospital.

As I mentioned earlier, a focus on cultural safety was an important change in nursing. Initially the Nursing Council of New Zealand, under Irihapeti Ramsden's guidance, developed cultural safety[5] into their legislation, which included competencies and policies. This involved cultural safety becoming an important part of nursing care and the recognition of tangata whenua[6] and their health needs.

There was also discussion at the time regarding the cultural safety of Māori nursing students, and the key to this was an understanding of biculturalism. The thinking behind that concept was that if nursing students understood their own culture, and then biculturalism, they would be better able to nurse people from any culture. Sadly, over the years, that vision has been lost and 'cultural safety' is no longer about kawa whakaruruhau. The concept includes nursing care that is sensitive to all cultures, including the deaf, blind and gay, just to name a few. This has meant a move away from regarding cultural safety via a Māori perspective when considering Māori health needs and the recognition of their poor health statistics. This step, I believe, does not enable an understanding of Māori health needs and often leads to subtle discrimination.

I also believe that, without cultural safety for Māori patients, there is no healing and without cultural safety for Māori nurses there is no learning (McCleland, 1998). Learning is part of personal and professional development in nursing, whether a nurse is a novice or expert. Māori nurses working under the stress of discrimination, bullying or without appropriate support, are working in a culturally unsafe environment (McCleland, 1998) and are therefore not enabled to learn, strive and develop.

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[5] Cultural safety: kawa whakaruruhau.

[6] Tangata whenua: people of the land.

There was, initially, reluctance by nursing colleagues to embrace cultural safety. But with patience and understanding, slowly over many years the change process occurred, and that unfreeze, change and refreeze happened (Lewin, 1997). However, the struggle continued for both Māori nurse educators and Māori students as they were captured in a westernized organisation. This was evident when one of my students stated, "I have put my culture on hold for three years" M. Puna (personal communication, July 22, 2000) and another new graduate at a hui stated that her Bachelor of Nursing Education had given her only ten per cent of the preparation needed for primary health care as a Māori registered nurse, H. Waitoa (personal communication, June 4, 2005).

1.1. Other voices and narrative

Some of the stories that nurses tell about their nursing experiences are positive and full of hope. These are the stories from Māori primary health care nurses, whom I have provided clinical supervision for (reproduced with their permission).

i) A Good Story

Hineroa is a Māori registered nurse. Initially, when she became fully registered, the only employment available for her was as a care giver in a elderly people's Rest Home. Even though she was a registered nurse who undertook wound dressings at the 'Home' she was only paid caregiver's wages. How could the organisation use Hineroa, a qualified registered nurse, but only pay her the equivalent of an unqualified caregiver? Later Hineroa became employed by a Māori health provider as a school based nurse covering five schools in a low decile area. She constantly exclaimed "I love my job", as she quickly built networks with other nurses, upskilled and built a rapport with the communities she worked with. She knew the whānau in need within her schools and they trusted her. She opened the doors for the Public Health Nurses where they were once refused entry by Māori whānau. The whānau's insensitive treatment by Pākehā nurses (according to Hineroa) raises the question, are Māori whānau assurred of a culturally sensitive health service?

Hineroa had many stories to tell. One was of a shy little girl who, when she spoke, covered her mouth because her front tooth had broken off. Her parents could not afford dentists' fees, and so the child was told to "live with it". Hineroa arranged to have the tooth reconstructed.

In one of her schools, teachers complained that the health consent forms were not being returned to the school, therefore, Hineroa could not work with the tamariki (children). So she spoke to the tamariki, stating she would be back the next day with an ice cream for those tamariki who brought signed consent forms. She had 100% consent forms returned. She said, "Ann, I know the sugar treat was not a good idea but I needed to treat the tamariki" H. Wilson (personal communication, Sept 8, 2017).

Later, when there was an explosion of head lice infestations in schools, Hineroa formed a team and checked each child's hair in her five schools, identifying who were head lice carriers. She went into the homes with treatment and educated the whānau on how to cope. While she was there she spoke about the importance of breakfast and the availabilty of breakfast at the schools. She offered to make herself available if they needed her. Each school commented on how the children were now settled in class, able to concentrate and learn, and there was less bad behaviour. Hineroa was a trusted member of the community.

ii) Another Good Story

Debbie is a mobile nurse. Debbie's 34-year-old client was released from prison. She was overweight, her self-esteem was low and her blood sugar levels were elevated as her diabetes exacerbated. Debbie worked with her, assessed her, immunised her, carried out a cervical smear, helped her with her self-confidence and monitored her sugar levels, nutrition and exercise routine.

Over several months, the client gained confidence. Her sugar levels stabilised and she began to lose weight. Debbie's client was healthier, enjoying walking, and had joined a computer course held several kilometres away which she walked to, as the first step towards gaining employment. Debbie helped her to prepare for employment by helping her develop a Curriculum Vitae (CV) and discussing interview techniques. Hence, with Debbie's assistance, her client gained employment, managed her own diet, weight and with confidence reconnected with her whānau.

Debbie empowered her client and worked within three Treaty principles[7]. She encouraged her to *participate* in her own care (monitoring her own weight), she worked in *partnership* with her (in setting out her care plan) and *protected* her (stabilised her

[7] Three of the Treaty principles relevant to Nursing are participation, partnership, and protection (Nursing Council of New Zealand, 2017).

blood sugar levels). Given the right support and resources, Debbie's story shows that the intentions of the health system can work.

iii) A Good and Bad Story

Heather is also a mobile nurse. One Friday she had visited one of her clients in hospital and as she returned to her car she noticed an elderly Māori man with a suitcase huddled at the bus stop. She walked over to see if he needed assistance. He explained that he had been discharged from hospital and a hospital orderly had left him at the bus stop to find his own way home.

She offered him a ride home and helped him into his home. She found he lived in a little flat which was crammed full of items of importance to him but made it difficult to move around within his home. The flat was filthy, and he was clearly not managing. She drove him to the supermarket, and he purchased stores for the weekend.

She visited him on a regular basis and built up a rapport with him. She had his medications reviewed, and also found that he had no whānau close by, so was managing alone. She gained his permission and contacted a local Māori Pastor and explained her client's situation. Together they gained permission to bring in a team, and with the elderly man as the supervisor, decluttered and gave the flat a complete spring clean, which included washed curtains and bed linen.

This man was very lonely and isolated. Heather arranged for home care for him but he needed more assistance, so she took him to his general practitioner and arranged to have him assessed for approval to be placed in a Rest Home. This was approved, and he was happily placed where he received good care and much needed social interaction. He thrived. In a society that purports to care well for its elderly why had he slipped through the system?

iv) A Bad Story

Hineroa's practice was not easy. Her practice was holistic (holism from a te ao Māori perspective) so she dealt with many health concerns within the whānau when she visited them, educating them and listening to them, but she was also constrained by the needs of bureaucracy. There were contracts with rules that made her practice task orientated. Along with this, other non-Māori nurses undermined her.

In one instance, she was to attend a nurses' meeting. She arrived in the car park and sat in the car for ten minutes trying to gain the courage to join her colleagues. She was sick of the racist comments regarding her work and the organisation that she worked for. Finally, she didn't go into the meeting but instead went back to work. At the same time

her popularity within the community grew. Then, her Public Health nurse ‘colleagues‘ reported her for not following best practice. This turned out to be untrue and without evidence, but the incident undermined her confidence. In a society that purports to abhor and have no tolerance of racial discrimination, how could this happen?

I was asked by the Public Health nurse management why Hineroa didn‘t attend the prior meeting and I explained what had happened. Their next monthly meeting was a workshop on racial discrimination. Is there a need to examine cultural safety for Māori nurses?

Her employer/managers did not support her and her paperwork piled up. The situation all became too hard and Hineroa resigned. This left a gaping hole in the community and a barrier for the replacement nurse, who needed twelve months upskilling before she was able to begin her contract. This meant that the community was without support. They did not trust Pākehā nurses and they could not afford doctors‘ appointments or prescriptions. This crisis also left Hineroa without the confidence to gain re-employment and it was several years before she worked as a nurse again. In a system where the support of Māori nurses is advocated, how could this happen?

1.2. Declaring my position in this research

I have heard the voices of my colleagues, of other Māori nurses struggling within a system that purports to support patients but undermines, often unwittingly, the positions of those whose job it is to do so, the nurses. I have tried to support my colleagues in difficult situations and have wept when they finally give up and leave nursing.

As I have mentioned before, I have been in the nursing profession for 50 years, so I have a wealth of experience. I have seen many changes but not all of them have been for the betterment of nursing. Thinking about what I have seen, about the changes, the potentials and the possibilities of nursing, has spurred me to do this thesis. What I have experienced has helped to influence my thinking for this research, not as a disgruntled participant, but an informed critic who has the desire to see the health system improved because that will also improve the experiences of Māori nurses working in it.

This research is an opportunity to frame the changes that have occurred, and to ponder and reflect on the significance of those changes. I think it is also time that someone asked what skills, knowledge and attitudes will nurses need to provide high quality health care and work collaboratively with other health professionals into the future?

As I begin this research, I have a feeling of discomfort as I analyse where I stand in the world from an individualistic position: whereas my life has been one of being part of a collective, of service and caring for others, with caring ingrained into my core. My position is inescapable, with, as Stuart Hall (1991) alludes, multiple realities and identities. I hold different positions in different circumstances. For instance, one with my whānau, one with my students, one with friends, one on my Marae[8]. These different positions all include a collective consciousness.

However, within that collective consciousness, each part holds differing experiences and distinctive knowledge. This collective consciousness includes multiple connections with others, including the research participants, tipuna, colleagues, environment, land, and the universe.

I am reminded by the sociologist, Emile Durkheim, who used the notion collective consciousness to refer to how we think in common given our shared culture, through the collective engagement of rituals that remind us of the values we share in common and of our group affiliation (Durkheim, 1997). This research, then, relates to real life issues concerned with my professional practice, and draws on the collective experience of registered Māori nurses' practices in primary health care. So, the concepts that drive the research include, 'who I am' (my foundations) and what I believe in. These concepts include notions of justice, fairness, loyalty, honesty, and caring. They are the core of my being. I cannot separate me away from the research, nor should I (Johnston, 1998). The research is based within an environment in which I have been located for many years. It is about Māori; it is done from a Māori perpective; it is about health and nursing; it is about community. These concerns have been the passion that drives me – I am inextricably linked to it.

During the past five decades, there have been major changes in the nursing field. I have been fortunate to have had 'a ring side seat' which has given me knowledge, understanding and affected my practice as a nurse and an educator. As a participant, I have had to deal with these changes as I watched them unfold. Underlying many of these changes has been the influence of government policies which this research will explore. Although not always embraced by nursing, they include: the development of cultural safety and holistic nursing care in the 1990s; ethics and informed consent of patients; the

[8] Marae: meeting grounds.

inclusion of the Treaty of Waitangi (te Tiriti o Waitangi[9]) in terms of principles that drive nursing practices. The recognition of 'bullying' in the workplace'and racial discrimination, particularly against Māori nurses, is a new phenomenon I have had to deal with.

I have witnessed the outcome of those things and their impact on carer, patient and whānau. I have lived through the development of cultural safety from a bicultural perspective, its acceptance by the Nursing Council of New Zealand and its inclusion in the Bachelor of Nursing curricula. I have seen the changes as nursing began to understand Māori whānau needs and wellbeing. But, contrary to this, I have also observed, and continue to observe, the dilution of these practices as biculturalism policy and practice is replaced by multicultural perspectives and actions.

I have witnessed the shift from te Tiriti o Waitangi being seen as a worthless document to it being interpreted for practice, and the recognition of te reo as a national language. The latter helped revive Māori as a culture, and the application of the Treaty of Waitangi to health and education, with emphasis on three of The Treaty's principles[10], protection, participation and partnership, made it more easily embraced by the public.

The Treaty of Waitangi, in government policy and in particular Māori health policy, suggests equality and fairness in health, improvement in Māori health, and building a strong Māori health workforce. Māori communities rely on their Māori nurses who are steeped in a cultural understanding and also understand the needs of their communities, just as our Māori nurses rely on good support to guide and support them through hard situations. However, more and more, these nurses are leaving their employment and the community is left without Māori nurses and appropriate support/care. In a health system that draws on the principles of The Treaty, how could this happen?

Also, as previously described, I witnessed through the media the unravelling of the 'unfortunate experiment' in 1997, whereby doctors and nurses carried out experiments on women patients without their knowledge. The Cartright Inquiry (Ministry of Health, 2009) led to the development of ethical practice protocols and the need for informed consent within nursing and research. It took something significant like this bad medical

[9] I refer to the Treaty or te Tiriti although they are both part of the Treaty of Waitangi – the Treaty is the English version and Te Tiriti in reo is the latter will be used in reference to the Māori version.
[10] Although I refer to the Treaty of Waitangi principles throughout this research and they were documented by the Royal Commission on Social Policy (1988) they are not 'the' Treaty principles but one set, albeit common.

practice for the nursing hierarchy to sit up and take notice of the unethical practices that had been previously occurring.

Having witnessed and experienced bullying in the workplace, I have researched it, and the research led me to further understand this phenomenon. I presented research findings at an International Nursing Conference in Chicago, USA (McCleland & Taylor, 2003). But, I have experienced racial discrimination as well. Bullying in the workplace and racial discrimination have devastating effects and leave the victim powerless, marginalised and experiencing a host of other negative feelings. Both occur within nursing practice and nursing education, as well as affecting patients both directly and indirectly.

Theresa O'Connor (2014), in speaking about truth and power, emphasizes the professional and ethical obligation nurses have to tell the truth about what is happening in the health care system, including the impact of health policies on patients[11]. Consequently, these experiences have driven my desire to undertake this research. These have influenced my practice, my thinking, and what I value. However, I am not neutral in this research. I have a vested interest in what happens in the health sector, especially for nurses. I am passionate about nursing and in particular the work Māori nurses do and the impact of nursing on the Māori community. So, although nursing has experienced radical changes and some have been for the betterment of the profession, from my observations some have not, and major issues remains which impact on Māori nurses, their practice and patients/ whānau.

My knowledge of nursing has also been influenced by the experience of being marginalised and silenced. According to Henry and Pene (2001), philosophical debates about knowledge, what is true and what is real, across time and place, continue to reflect both intellectual and political struggles. I have no regrets about struggles I have experienced as, although they have been hard and frustrating, they have strengthened my values and given me more understanding of others. However, deeply entrenched in my psyche as a nurse, is the over-riding concept of hope.

The methodology I have chosen and the theories that I have drawn on for this thesis 'absolutely' stem from the intersection of what I value, how I experience and interpret

[11] People who access healthcare services are referred to as patients or clients. Client is a person who engages the professional advice or services of another whereas a patient is a person awaiting or under medical care or treatment. Client is synonym for patient (Miller-Keane Encyclopedia and Dictionary of Medicine, Nursing and Allied Health, 2003) in this thesis.

the world, my knowledge, my ethical stance, and as stated above, my core and essence of being a Tainui woman.

1.3. Research Design

The brief stories at the beginning of this chapter highlight the struggles that many Māori nurses traverse in their desire to be effective and caring nurses. Unfortunately, their stories of struggle are not isolated incidences. As the stories indicate, nursing has become an extremely difficult profession as nurses endeavour to meet the needs of their communities while also meeting the requirements of their profession and provide a service in line with specific specifications.

While the thesis focuses on nurses' experiences and asks them the research question *"what are the experiences of Māori nurses working in primary health care?"* it cannot do so without first having an understanding of New Zealand primary health care. Secondly, it is necessary to recognise the role that government policy has played in creating the type of health system that we have today. To understand how the health system operates, how practices are developed and how they impact on nurses, we need to know how policy drove that development in the first place. The link between policy and practice is crucial. The thesis therefore examines relevant health policies or statements to establish those links. By also interviewing Māori nurses, I examine the outcome in practice for Māori.

The focus of the research is on the nurses' voices and their experiences. It examines the experiences of Māori nurses working in the community. These nurses, the research participants, are employed by a Māori health provider in primary health care as either mobile community nurses or school-based nurses.

Kovach (2010) suggests that "indigenous stories are active agents within a relational world, pivotal in gaining insight into a phenomenon" (p. 1669) and so this research is a means to enable the nurses to tell their stories and the truth about everyday practices, issues and problems that they face as registered Māori nurses.

Primary health care in New Zealand encompasses a wide range of nursing roles in a number of different community settings. Taking that into consideration, there are eight participants in this research. All are female Māori registered nurses (I was unable to secure any male participants), employed by Māori health providers (Māori hauora

initiatives) who provide primary health care for whānau with high health care needs. The nurses within this research work in communities with clients who are not only socioeconomically deprived but also marginalised, vulnerable and consequently have high needs. Vulnerability is described here as the co-occurrence of a person's exposure to risks and adverse events, and their susceptibility to harm arising from a limited ability to adapt to such challenges (Loh, et al., 2015), and are related to racial or ethnic minorities (Waisel, 2013).

This research utilises an Indigenous[12] research methodology, a Kaupapa Māori research methodology, which is used as a framework for the research based on the positionality of being with Māori, by Māori and for Māori (Smith, 1999). The research also considers a wāhine perspective as it gives women a voice and a place to stand in the research. I have chosen a Kaupapa Māori research approach because it has its meanings embedded in Māori culture and is based on traditional Māori ways of doing, being and thinking, encapsulated in a Māori world view (Henry & Pene, 2001). A Kaupapa Māori approach is an important consideration given the focus of this research and the Māori communities involved.

However, this research states upfront that Māori women are located in this research as the 'Other[13]' and challenges the dominant hegemonies and practices that continue to "Other" Māori women (hooks, 1993). The participants in this research are themselves marginalized as both Māori and as woman (Johnston and Pihama, 1995), which places them in a position of vulnerability. Foucault (1982) argues that 'the other' is the one over whom power is exercised, power being the ability to influence or exercise control over another (Allen, 2005). It is noted that, in the context of this research, the participants speak from positions of subordination and powerlessness but, as Johnston (1998) argues, it is what they are able to do in those positions, which is captured for this thesis.

Before I begin on the analysis of the health sector, it is important to ground that analysis by discussing the role of The Treaty of Waitangi/Te Tiriti o Waitangi in terms of being a foundation document for Aotearoa, which includes the health sector. Views and perceptions about The Treaty have driven the inclusion of Māori within the framework of health (addressed in Chapter Four), policies (addressed in Chapter Three) and practices

10: Indigenous is capitalized out of respect.

11: Other written with an initial capital to denote a specific category and space to which non- western people, constructed as inferior through the process of racialisation and cultural essentialism, have been assigned (Quayson, 2000).

for nurses (addressed in Chapter Four). The significance of the Treaty should not be underestimated or underplayed but I would suggest that the role is substantially underestimated by bureaucrats, policy writers, policy analysts and practitioners alike. That is why a discussion about The Treaty of Waitangi occurs here. It enables the positioning of the rest of the thesis within a cultural framework, that enables one to view with a 'cultural lens', what happens for Māori in the health system.

1.4. Te Tiriti o Waitangi/ The Treaty of Waitangi

i) What the Treaty promises

Te Tiriti set out to protect the rights of Māori to keep their land, forests, fisheries and properties, while handing over sovereignty to the English. The Treaty promised, via its four articles (see Appendix C, p. 220), and significant to this research; biculturalism, and according to the Nursing Council of New Zealand three of The Treaty's principles (Te Tiriti of Waitangi, n.d.). These three principles[14] work towards Māori self-determination and, in nursing practice, the three principles mean: partnership (working with Māori as partners), participation (that Māori participate in planning and the process of our own health care), and protection (that Māori are protected whilst experiencing health care). The three principles have the capability and the power to protect what it means to be Māori. Hence, an understanding of the Treaty articles, biculturalism and the application of the principles, enables cultural safety in nursing practice for Māori people in health care.

The Treaty of Waitangi was a formal agreement written in two versions, both Māori and English. The general view about the Treaty of Waitangi is that it was signed in Aotearoa on and after the 6th February 1840, by representatives of the British Crown and certain Māori Chiefs signed Te Tiriti o Waitangi/Māori version (Orsman & Orsman, 1994). To the British The Treaty (English version) was a way in which they gained sovereignty of Aotearoa but to Māori Te Tiriti/reo had a different significance (Orange, 1987, 2015).

The two versions consisted of four Articles (three written and one oral) and were not exact translations of each other but have been the source of considerable debate and conflict in interpretation ever since Te Tiriti/The Treaty was signed. Te Tiriti was seen

[14] Three of the Treaty principles will be referred to as the three principles and are explained above.

by Māori, firstly as a form of protection, especially for our taonga[15], and a way in which to keep our resources, way of life, culture and identity intact, which included self-determination[16]. Whereas, for the Crown, The Treaty (English version) outlined the terms and conditions in the English settlement in Aotearoa, and defined this emerging new relationship (Orange, 1987).

Over a century later Te Tiriti was brought into legislation by The Treaty of Waitangi Act (1975) and the Government then established the Waitangi Tribunal. This Tribunal made it possible for Iwi[17] to lodge claims regarding Crown breaches of Te Tiriti as well as grievances. It also gave Te Tiriti recognition in New Zealand law for the first time. Te Tiriti intent was to enable a relationship based on justice.

Two developments in the 1980s shifted calls for tino rangatiratanga (self-determination) and full Māori participation in Government decision-making from a protest arena to the legal and policy making sector. Rangatiratanga was not only self determination but high order leadership, an ability to keep people together and an ability to maintain and enhance the mana of the people (Mutu, 2010, p. 26) see also footnote p. 69).

The first development was a hui of Māori leaders in 1985 at Turangawaewae (Blank, Henare & Haare, 1985) to discuss the current status of Te Tiriti o Waitangi. It was confirmed at this hui that Te Tiriti was a living modern text, a founding document and a framework on which to build a bicultural New Zealand society. The second development was the publication of a four volume Royal Commission. *The Report on Social Policy* 1988), outlined a detailed analysis of New Zealand society. The Royal Commission Report was important for Māori development as the report introduced the concepts of partnership, protection and participation (Treaty principles) as a way of making The Treaty current, applicable and acceptable to New Zealanders (Richardson, 2010). These principles were not the only Treaty principles but those adopted officially by the Royal Commission on Social Policy (1988) as partnership, protection and participation and later adopted by the Ministry of Health.

The importance of Te Tiriti o Waitangi, is that at present it has an impact on all health care services and it informs the way our nation state operates. As the founding document

[15] Taonga: treasure or something of value.
[16] Self-determination: Tino Rangatiratanga

of Aotearoa, Te Tiriti and The Treaty are relevant documents for both Māori and non-Māori.

ii) What The Treaty Provides

The Treaty is referred to in a number of health-related legislations and policies. It is written into government policies, and The Treaty principles are included within health documentation (for example, the Nursing Council of New Zealand's Domains of Practice). This sets out to enable the application of the principles so that Māori are able to participate in the decision making, planning, development and delivery of our own care.

He Korowai Oranga: The Māori Health Strategy (see Chapter Four) (King & Turia, 2002a), for example, sets out directions for the principles to be incorporated into health care, ensuring that Māori are protected and have the same level of health as Pākehā[18]; safe guarding Māori cultural concepts, values and practices; and the Strategy works in partnership with Māori to develop strategies for Māori health gain and appropriate services.

According to Don Brash (the then leader of the National Political Party in 2004), in his infamous speech at Orewa, a popular interpretation of the Treaty is to treat everyone, both Māori and Pākehā the same, which he sees as fair. However, this 'sameness', as Johnston (1998) argues, does not recognise differences, so sameness is actually treating everyone according to the dominant Pākehā culture, which disadvantages those that do not belong to that culture. Bishop and Glynn (1999) argue that The Treaty should instead be a model and metaphor for power sharing and change.

iii) Te Tiriti in Health

The Crown and its agents (publicly funded health services and health care providers) have an obligation to meet Te Tiriti terms. Wilson (2004) proclaims that under the terms of Te Tiriti, the health interests of Māori have not been protected, or equally funded, although, she states that *He Korowai Oranga: The Māori Health Strategy* is a step in the right direction in addressing those concerns.

Gifford et al. (2017) also argue that the current health care system, except for the services of Māori health providers, is not meeting the needs of Māori, nor recognising their different ways of viewing the world and is therefore not applying the Treaty principles. This includes nursing, as the importance of understanding the Treaty/te Tiriti

[18] Pākehā: non-Māori.

is acknowledged by the Nursing Council of New Zealand's requirement, and that Te Tiriti, is included in the Nursing Council of New Zealand's Standards and guidelines (Domains of competence). Competency 1.2 states that "the nurse demonstrates the ability to apply the principles of the Treaty of Waitangi Te Tiriti o Waitangi to nursing practice" (Nursing Council of New Zealand, 2017, p. 10).

iv) Te Tiriti in Contemporary Times

One of the most controversial concerns in health has been the application of Te Tiriti into health care practices and the raising of the question, what do the principles actually mean? Chapter Three will examine more implicitly the relationship between Treaty thought and Treaty practice as articulated and discussed by Māori nurses.

Contemporary implications of Te Tiriti for health have been summarised by Durie (1998) in terms of partnership and participation. What this look like when applied to nursing, is summarised in Figure 1.

On the left side are the implications for Māori and on the right-hand side for Tauiwi (non- Māori). This figure also displays the texts and their relevance to health.

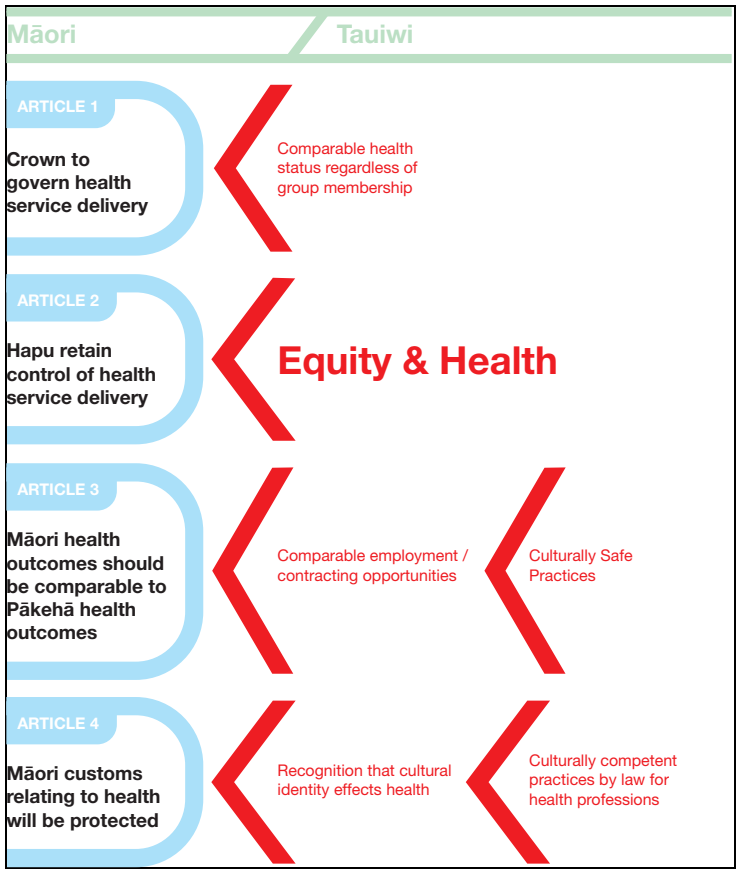

Figure 1: The Treaty of Waitangi and Health (adapted from Treaty of Waitangi and health, n.d.).

The Treaty of Waitangi is written into most health policies. As a means to test the congruence between policy intent and nursing practice, this thesis explores the factors that influence the nursing practice of Māori nurses working within Māori health providers in primary health care.

New Zealand health policies/policy statements offer Māori nurses a strong Māori workforce, a decrease in health inequity for Māori, fairness through te Tiriti, the ability to work in collaboration with other health professionals, and the Nursing Council of New Zealand promises cultural safety for Māori experiencing treatment in the health care system. In this thesis the focus is on Māori nursing practice relevant to primary health care.

1.5. New Zealand Primary Health Care

i) The influence of the World Health Organisation

The World Health Organisation (WHO) plays a major part in world health. Situated as a specialized agency of the United Nations, WHO first met in 1948 and currently has 194 member states, who are concerned with international public health.

For example, one major global health concern is malaria and, during the 1960s and 1970s, it was apparent that WHO's ongoing war against malaria globally was not succeeding because there was no chemical prophylaxis and particular immunization. There was also criticism (Angulo, 2015) of the WHO's use of a hospital-based health care system in developing countries and it was questionable whether it would be more appropriate to promote preventative health care instead of the traditional medical model. This led to the term 'primary health care' being mooted by that organisation, creating a change in thinking and a preference towards a more holistic model of health, moving away from the then primarily bio-medical models of health.

Other organisations have contributed to changes in health care globally. For example, in 1974 the Canadian Lalonde Report proposed four determinants of health: biology, health services, environment and lifestyle (Cueto, 2004). The focus was one of prevention. Others also challenged the popular belief at that time that the overall health of a population was due to medical interventions, suggesting instead that population health was more likely to be due to better living standards and nutrition.

In 1978, WHO called an international conference on primary health care at Alma Ata (Russia). The outcome from the conference was a declaration known as the Declaration of Alma Ata. Attended by 134 governments and 67 international organisations (Cueto, 2004), the primary focus of the conference was primary health care, and the resulting guidelines set out to enable participation and usage by all countries. The declaration further emphasized that private and public health institutions work together, which included working with traditional healers.

The Alma Ata Declaration was criticised as being too broad, and hence the Ottawa Charter in 1986 built on to the principles of the Alma Ata Declaration by focusing more specifically on health promotion. The Ottawa Charter strategies included five areas for action: building healthy public policy; reorienting health services; creating supportive environments for health; strengthening community action; and developing personal skills (Ministry of Health, 2003a.). This charter became the blueprint for world governments to put health care into practice, and from this New Zealand's Primary Health Care Strategy was developed (King, 2001).

ii) The history of New Zealand's primary health care development

New Zealand's health care system was created via the landmark New Zealand Social Security Act, 1938. The visionary principles of the Act argued that health care should be universal and free from financial and other barriers, and that all New Zealanders should have equal access to the same standard of treatment. Furthermore, the Act outlined that the health care system should be integrated and preventative rather than curative in focus (Gauld, 2014)[19]. This Act was ahead of its time and emerged before the Alma Ata Declaration and the Ottawa Charter were developed.

The New Zealand health care system is similar to Great Britain's National Health System and the Australian Universal Health Care. The latter aims to ensure that all people can access the health services they need without suffering from financial hardship (Tenneti, 2016). Like New Zealand's, the structure of Australian health care is complex, with a web of services, providers, recipients and organisational structures. However,

[19] Gauld suggested that New Zealand has since deviated from the 1938 Social Security Act principles through policy compromises in the implementation process. However, these principles are close to what many of the world's policy makers aspire to today (Gauld, 2014).

unlike New Zealand, all Australians are covered by an insurance scheme (Medicare) covering treatment in public hospitals, part payment for certain professional health services and subsidised medications.

Like New Zealand, Australia reduced its government spending in some areas of health care, doing so to reduce unnecessary care in some areas and further improve care in others by the better allocation of health funds (Tenneti, 2016). Most countries are facing a crisis in relation to the costs of their health care systems, while at the same time experiencing the effects of rising global health care costs such as the increasing price of medications and an aging population. These create pressure on the health system in terms of funding.

New Zealand's health care system is unique in comparison with other developing countries health care, as it is informed and guided by its founding document, the Treaty of Waitangi. Whereas, New Zealand is guided by the Treaty of Waitangi, Indigenous people in other countries have access to guidance by the United Nations Declaration on the Rights of Indigenous Peoples.

The term 'primary health care' in New Zealand, is care that occurs within the community. Primary health care initially planned to provide comprehensive coordinated services to enrolled populations with the aim to reduce inequalities in health status (King 2001). These primary health care services provide essential health care based on practical, scientifically sound, culturally appropriate, socially acceptable methods, which involve community participation integral to, and a central function of, New Zealand's health system (King, 2001). Further services include health assessment, education, and health promotion. These aim to teach healthy lifestyles and early detection of disease, and intervention to prevent the need for secondary[20] and tertiary health care.

iii) A move of nursing from the medical model of care to a holistic nursing model

As noted previously, the move to primary health care also supported a move away from the dominant medical 'interventionist' model of health, providing for a more holistic focus on the human body. The difference between the two models is that the former traditional bio-medical model is mechanistic in its approach and characterized by its focus

[20] Secondary health care is care provided by hospitals; it is care that occurs after infection or injury and is specialist medical care in comparison to primary health care which focuses on prevention and health promotion.

on the physical or biological aspects of disease and illness, while the latter is an integrated approach that treats the whole person and includes a mind, body and spirit connection, not simply symptoms and disease. This paradigm shift in some sectors, moved away from the westernized medical model, a reductionist approach that lends itself to task orientation rather than a person's needs.

However, nursing's holistic focus on the human body differs considerably from a Māori view of holism. A Māori holistic view is on holistic health from a te ao Māori perspective that connects to whānau, te reo, to the land and there is a stronger recognition of the spiritual component. In other words, Māori working in health care as Māori, grapple with two world views (te ao Māori, Māori world and te ao Pākehā, the Western world) as they attempt to straddle the two cultures. This is reflected in both Wakaiti Saba's (2007) and Maria Baker's (2008) research involving Māori registered nurses working in mental health.

Māori models of health invariably include the whānau as a central element, reinforcing the indivisibility of whānau well-being from individual well-being (Love, 2017)[21]. This is an area of major conflict for Māori nurses in primary health care as they try to work with the principles of a Kaupapa Māori approach and fit this to a westernised contract.

1.6. New Zealand Health Model

In New Zealand, Primary Health Organisations were introduced in 2001 (Ministry of Health, 2016). They received capitated funding but were required to: undertake population health initiatives alongside patient-centered primary care; broaden the range of providers and skills used in integrated primary health care delivery; improve access to services for disadvantaged populations and ensure community participation in health care service decision-making and governance (Abel, Gibson, Ehau & Tipene-Leach, 2005, p. 2). This made for a very complicated model of health care.

For example, most services are paid for by the patient or recipient, except for specific services paid for by the District Health Board. The latter include free hospital services and specific services for population health such as influenza immunisation for the elder

[21] See for example Rose Pere's (1997) Māori model of health (Te Wheke) which emphasizes the importance that the whānau is central to the person, and her theory has eight specific dimensions of health which are all integrative to the whole.

person, cervical smears for women from 20-70years, mammograms and prostate cancer checks. However, access to hospital services is based on a grading system of priority as a means to meet the ever-reducing budgets available for 'health care'.

The Ministry of Health provides the vision, policy and funding for health services to the District Health Board. The District Health Board develops the contracts, funds the non-government organisations and Primary Health Organisations and monitors their services. The non-government organisations interact with nurses, their patients, and provide the services to the community.

i) Ministry of Health

Health care in Aotearoa is initially funded by the New Zealand Government. The Government sets out its statement of intent on future health care, which results in health policies developed by the Ministry of Health (2015b.). Once the health policy is established, a major responsibility of the District Health Boards is to put into practice the policy intent. The Ministry of Health, however, retains responsibility for the bulk of public health funding (Ashton, 2005). The policies include parameters for the delivery of health services, but it is ultimately the role of the District Health Board to set out contracts, fund them and monitor them to enable the health sector to operate.

Health policies and their strategies in primary health care set out to provide guidance for high quality health care for the community. They have an extensive influence on Māori nurses. Hence, five relevant health policy statement/objectives will be examined below (see p. 63).

Figure 2 (below) illustrates the structure of the New Zealand primary health care system and the way that health care is funded and organised in New Zealand. It shows the three levels of the health care structure. For instance, Level 1 is the Ministry of Health, Level 2 the District Health Boards and Level 3 the non-government organisations.

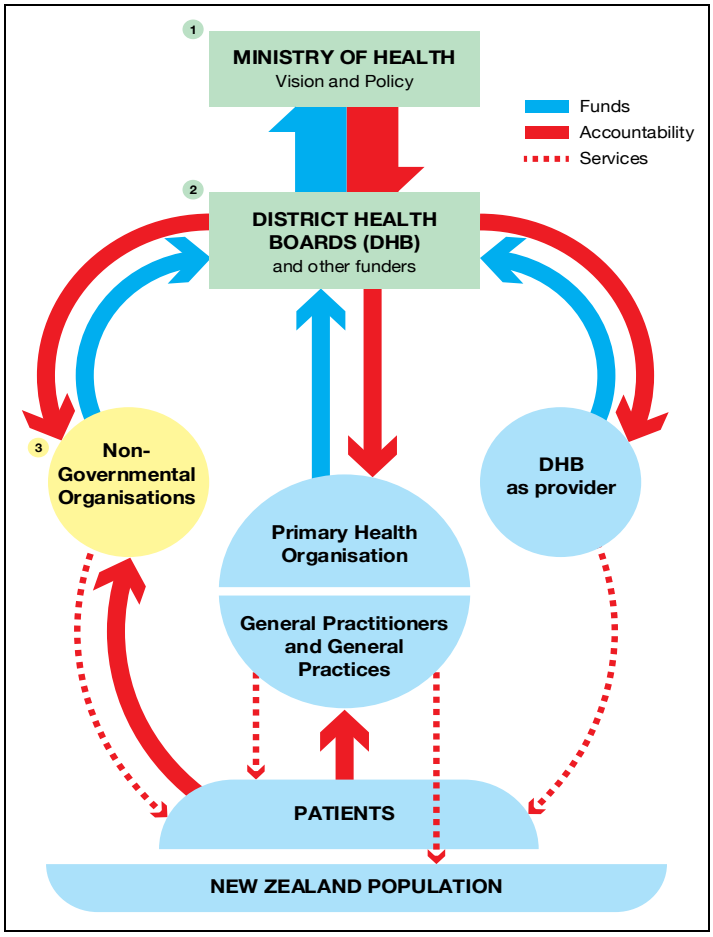

Figure 2: Structure of New Zealand Primary Health Care System. Primary Health Organisation's Source adapted from Cumming et al. (2014, p. 12).

Each year, the trend has been for the financial aspects of the healthcare system to be trimmed by Government, health policies are 'tinkered' with and contract specifications become more demanding. The New Zealand Council of Trade Unions estimated that $2.3 billion was needed to restore health funding levels for 2017/18 to 2009/10 levels (Rosenberg & Keene, 2017). They also stated that, while the 2017 budget listed services to receive more funding, most of this was paid for by reductions in other services. This had a huge impact on nursing care and community health. It also impacted on clients/whānau and community who could not reach their potential regarding their health. When nursing care becomes more complex, the individual patient suffers and the burden of care falls on the whānau.

The Government and District Health Board funders hold power through fiscal control (French & Raven, 1959 cited in Sullivan & Decker, 2009, p. 92), in the form of legitimate, reward and coercive power over the health services. Came (2012) suggests that power is also linked with organisational racism.

ii) District Health Boards

District Health Boards hold contracts and agreements with health organisations that provide the health services required to meet the needs of their District Health Board regional population. District Health Boards are publicly funded via the government, and the share of their funding is based on the size and demographic mix of their population and their population's past use of health services.

The District Health Boards were established in January 2001 by the 2000 New Zealand Public Health and Disability Act (New Zealand legislation, 2020). Although they may differ in size, structure and approach, all twenty District Health Boards have a common goal, and that is to improve the health of their population by delivering high quality and accessible health care. Their functions include funding for the planning of services, monitoring and provision of services. Those functions have an important influence on nurses working in primary health care.

Finlayson, Sheridan and Cumming (2009) found that one of the factors that increased demands on nurses' time in primary health care was the large administrative burden and time to comply with reporting requirements, plus maintaining professional quality with ongoing training and education. At the same time, nurses are dealing with a large number of very sick patients, completing immunizations, and meeting increasing demands and expectations from health consumers.

The administration burden on nurses has increased as there is a greater expectation by Government and District Health Boards that the nurses will supply a multitude of reports regarding their work. For instance, this entails reports capturing the type of work they do, the numbers of clients they have been in contact with, clients' narratives and keeping Med Tech data (see p. 87 - Footnote) up to date.

I mentioned the development of the Primary Health Care Strategy and its importance to the structure and process of health care in New Zealand. That is because the implementation of the Primary Health Care Strategy required the development of performance indicators by District Health Board funders to ensure that key objectives are met. Although interim indicators were developed in 2003, these were target specific rather than enabling a focus on holistic health. The indicators included nine clinical and five administrative indicators. These include achieving specified rates for immunization,

cervical and breast screening, disease and smoking status coding and service utilization (New Zealand Doctor, 2003).

The District Health Board have the mandate to choose who are to be given certain contracts or which existing contracts are to be instantly cut. This can be done if and when they choose, regardless of whether targets are met or not. Power is the possession of control, authority, and influence over others (Kock, 2007, p. 20). The control of health care contracts results in an uneasy relationship between the Māori health providers and the District Health Board, as the latter set out the rules for services which may not coincide with how Māori health providers would like to operate.

This also means that Māori health providers are in competition with other providers for funding and their registered nurses live in fear of losing their employment with the ongoing threat of contracts being terminated. This concern was signalled by the Primary Health Care Nurse Innovation Evaluation Team (2007) when they suggested that, "it is important that attention to teasing out how service contracts and subsequent funding streams contribute to the fragmentation of primary health care nursing services and inhibit the full utilization of nurses' skills" (p. 5).

According to Able et al. (2005), the indicators have been developed by a Technical Advisory Group with minimal Māori representation and have been amalgamated with indicators from referred services (for instance, Laboratory and pharmaceutical services) into a single Primary Health Organisation Performance Management Programme with a strong fiscal focus.

The performance indicators cover financial, clinical and process performances, with target measures said to be agreed upon between the local District Health Board and Primary Health Organisation, using national guidelines and funding assigned to agreed targets (Ministry of Health, 2003a). With this in mind, a comparative study of primary health care models in New Zealand, Canada, United Kingdom, United States of America and the Netherlands concluded that improved interaction between researchers, policy makers and professional groups contributed to more effective primary care reform (Naccarella, 2008).

iii) The non-government organisations

There are a number of sub-categories at the level of non-government organisation indicated in Figure 2 (p. 34). Those examined here include:

a) General: non-government organisations,

b) Providing a health service for Māori,

c) Māori health providers,

d) Primary health organisations.

a) General: non-government Organisations

A non-government organisation (see Figure 2, p. 36) is a not for profit, independent community organisation that is not affiliated with central or local government, although they may receive financial and or other support from the government. In December 2001, the Government signed a "statement of Government intentions for an improved Community-Government relationship" (Hanley, 2009, p. 2). The purpose of this was to build a strong, respectful, innovative and proactive relationship between the Ministry of Health and the Health and Disability Non-Government Organisations, including Māori non-government organisations (Ministry of Health, 2014c). Hence, in 2002, the government set up a Health and Disability Non-Government Organisation Working Group with representatives from non-government organisations across the sector. In the same year, the Ministry of Health also set up the Reducing Inequalities Contingency Fund (RICF). The fund's purpose was to improve access to primary health care and to fund the development of innovative services to reduce inequalities in health (Walton, 2007).

In 2012, the Health and Disability Sector Non-Government Organisation Working Group produced a report outlining potential barriers to their success and described how the environment impacts on innovation and collaboration within the Health and Disability Non-Government Organisation sector. The Working Group initiated forum workshops that involved 80 Non-Government Organisation participants and sent out surveys to which 46 non-government organisations responded. Many issues arose from the survey findings, especially the need to eliminate multiple audits as these were a drain on public resources (Health and Disability Sector non-Government Organisation Working Group, 2012). They also highlighted the need to eliminate duplicate services; to enhance information and health sector intelligence; the absence of Non-Government Organisations organisations input to health sector planning; and the need for better coordinated contracting processes (ngo.health.govt.nz, 2015). In December 2015, the Health and Disability Sector Non-Government Organisation Working Group identified priorities and issues for 2016 (ngo.health.govt.nz, 2015).

According to Fitzpatrick (2013), many of the issues identified in the report also related to increasing financial pressures on non-government organisations which had implications for their financial viability, the quality of service delivery, long term sustainability and the health and well-being of their communities. The Health and Disability Sector Non-Government Organisation Working Group were concerned with the consequent impact on the morale and retention of staff (Fitzpatrick, 2013). Within this context the Government plays a major role and, although it supports health organisations, it has a powerful influence on certain aspects of care within the community.

Fitzpatrick (2013) further argued that, as part of its contractual obligations with the Ministry of Health, the Health and Disability Sector Non-Government Organisation Working Group also identified a number of issues affecting non-government organisations. These issues included: pay parity; compliance costs; the costs of professional development; regional differences; and inequities in the level of District Health Board funding for similar programmes across the country, resulting in increasing inconsistencies in service delivery. These issues had the potential to impact on the implementation of the Primary Health Care Strategy and on clients and communities. Fitzpatrick (2013) also suggest that, as non-government organisations, they have traditionally been committed to the reduction of inequalities in health. Their clients are often those who most need to receive the benefits of additional primary health care funding.

Fitzpatrick (2013) suggests that the lack of consideration for the financial implications of policy changes on non-government organisations has not been an oversight, but a deliberate strategy to reduce the number of non-government organisations working in the sector. The Health and Disability Sector Non-Government Organisation Working Group warned that vulnerable clients would be most affected if non-government organisations ceased to exist. Funding formulae, governance issues and internal primary health organisation relationships have also been stumbling blocks (Fitzpatrick, 2013).

The Health and Disability Sector Non-Government Working Group highlighted important concerns regarding primary health care services. Some of those concerns have been addressed but many still need to be, especially as those services impact on the Māori community.

b) Providing a health service for Māori

The non-government organisations of particular concern in this research are the Māori health providers who provide the services to Māori patients, whānau, communities and population. Frameworks have been developed to take a Māori worldview in measuring the effectiveness of public policies and health services for Māori (Durie, 2003). One of these (He Taura Tieke) was developed under the guidance of the Ministry of Health, following research and consultation with Māori. It is structured around three key components: technical and clinical competence; structural and systematic responsiveness; and consumer satisfaction (Abel, et al., 2005).

Within each of these components, are several areas around which a service's effectiveness from a Māori perspective is defined and then measured using a range of questions. The framework examines evidence of Māori-appropriate services on several dimensions, including competence and safety, monitoring health, a philosophical framework, Māori development and Māori workforce development, access, information and participation (Durie, 2003).

Abel et al. (2005) argue that, despite a framework being developed within the Ministry of Health, the framework has not been fully applied at the District Health Board level and does not form the basis of District Health Board contractual requirements or performance indicator assessment. Rather, it has primarily been used by providers to gauge the effectiveness of their own services. Although a little bulky, this framework has clearly structured components and checklist questions that take a Māori perspective on health, and it could serve well as the basis for Māori health provider performance indicators (Abel et al., 2005). Nevertheless, Māori involvement in the health sector has a long history. Beginning at the start of the twentieth century, Māori leadership played a key role in developing health promotion and disease control within Māori communities (Ellison-Loschmann & Pearce, 2006). This began with the appointment of Dr Maui Pomare as the first Māori Medical Officer of Health of the Department of Health in the early 1900s. At this time, the development of a strategic objective by Government to improve Māori health was inserted into 1993 legislation (Bill of Rights Act, 1993). This was an important marker in history and included recognition of te Tiriti in this Act.

c) Māori health providers

Māori health providers are amongst many non-government organisations competing for contracts or a share of the health funding in order to provide services to Māori communities. To be successful, these services, along with relevant health policies, are required to fit with the needs of the community.

By late 1993 the number of Māori health providers in New Zealand had increased to twenty (Ministry of Health, 2017e). In the same year the restructuring of the health system opened new opportunities for Māori health provider contracts, under the newly established Regional Health Authorities (McLean et al., 2009). The number continued to grow through successive restructuring, so that by 2004 there were 240 such providers throughout the country (King, 2004). While, today, many providers hold small specific contracts, others offer a wide range of services, including medical, nursing, allied health professional services and community care. All, however, have contractual relationships with District Health Boards.

Irrespective of the size of these provider contracts, the commonalities have been the "ownership" of the provider by a tribal or community-based group, the lack of medical dominance in governance and the use of tikanga[22] Māori or Māori-defined frameworks for understanding health and delivering health care (McLean et al., 2009). Also, Māori health providers have generally focused on providing easier access to services for their clients, motivated by the evident disparities in health between the Māori and non-Māori communities (Reid, Robson & Jones. 2000; Ajwani et al., 2003). Both foci are features of the Primary Health Care Strategy and remain so despite political challenges in the efforts to address inequalities in health.

Influential individuals continue to make an important impact on Māori health providers. They include those within Government who control relevant policies and funding decisions, and District Health Boards that control the development and oversight of contracts. The funding includes the use of taxpayers' money, therefore the amount and use of this funding must be transparent and people held accountable for their actions. *Korowai Oranga: The Māori Health Strategy* (Ministry of Health, 2014d.) state that the Ministry of Health will continue to develop, in collaboration with the sector and Māori health providers, but where is the evidence of this? This also means that some have power,

[22] Tikanga: many meanings, Māori way of doing things. Derived from tika or doing things right.

and some do not. There appears to be an ongoing lack of Māori representation in that collaboration between the sector and Māori health providers. My concern is how that power is used in decision making.

d) Primary Health Organisations

The primary health organisations are mainly general medical practitioners who provide a service for people who are enrolled with them. The patients/clients pay general practitioners a fee for their service which is also subsidized by the District Health Board.

The establishment of primary health organisations initially (at least in principle) engaged many Māori health providers with mainstream primary health providers. For the latter to meet some of the government criteria to become a primary health organisation they had to develop strategic relationships with their local Māori health providers. However, in 2003, an examination of how the development of primary health organisations might impact on Māori health warned of some potential risks for Māori providers (New Zealand Institute of Economic Research, 2003). Not least of these was that enrolment criteria disadvantaged providers without front-line medical services, as is the case for many Māori health providers. Since many Māori health providers were small, they potentially did not have the capacity to provide the required range of services without forming alliances that jeopardize their autonomy. Nevertheless, while the risk of marginalising Māori health providers within some primary health organisations remained, some of the larger Māori providers were able to transition into a primary health organisation relatively easily. These organisations maintained strong positions, particularly where they were the major or sole partner within the primary health organisation (Able et al., 2005).

Since the introduction of the Primary Health Care Strategy in 2001 and the establishment of the first primary health organisations in July 2002, significant changes have occurred within the primary health care sector. The establishment of primary health organisations has occurred much more rapidly than Government originally intended. Although the original timeframe in which to enrol the entire New Zealand population was expected to be eight to ten years, by October 2004, 91 per cent of the population were enrolled in 77 primary health organisations (Able et al., 2005).

However, as noted previously, enrolment in specific non-government organisations often meant reduced costs for health services. Over three-quarters of Māori, and almost 80 per cent of those in the most deprived areas, were enrolled into the primary health organisations, and services were available at reduced or low cost to approximately half the general population (King, 2004; Spencer, 2004).

While there has been general support from providers for the overall direction of the reforms, some of the implementation processes have been challenged, not the least being the inconsistencies amongst the 20 District Health Boards in the allocation and monitoring of contracts with primary health organisations (Austin, 2003; Perera et al., 2003). The District Health Boards also fund non-government organisations such as Māori health providers. At the heart of the primary health care system is the funding and contracting of the health care services.

Figure 3 (below) outlines the complex funding system of primary health care services in New Zealand in 2015. The primary health care funder is the Ministry of Health with most of the funding (as population-based funding) flowing down to the District Health Boards. Hence, the District Health Boards are responsible for providing or funding the provision of health services in their district. The funding is then distributed out from the District Health Boards largely to 1012 General Practitioners, 32 Primary Health Organisations, 977 Pharmacies, Non- Government Organisations and Māori Health Providers. Public hospitals are also owned and funded by the District Health Boards.

However, for the funding period of 2020/2021 a total of $3.92 billion is also allocated to the District Health Boards to provide additional support in health over the next four years and another $125.4 million over four years to meet further cost pressures on planned care (Ministry of Health, 2020).

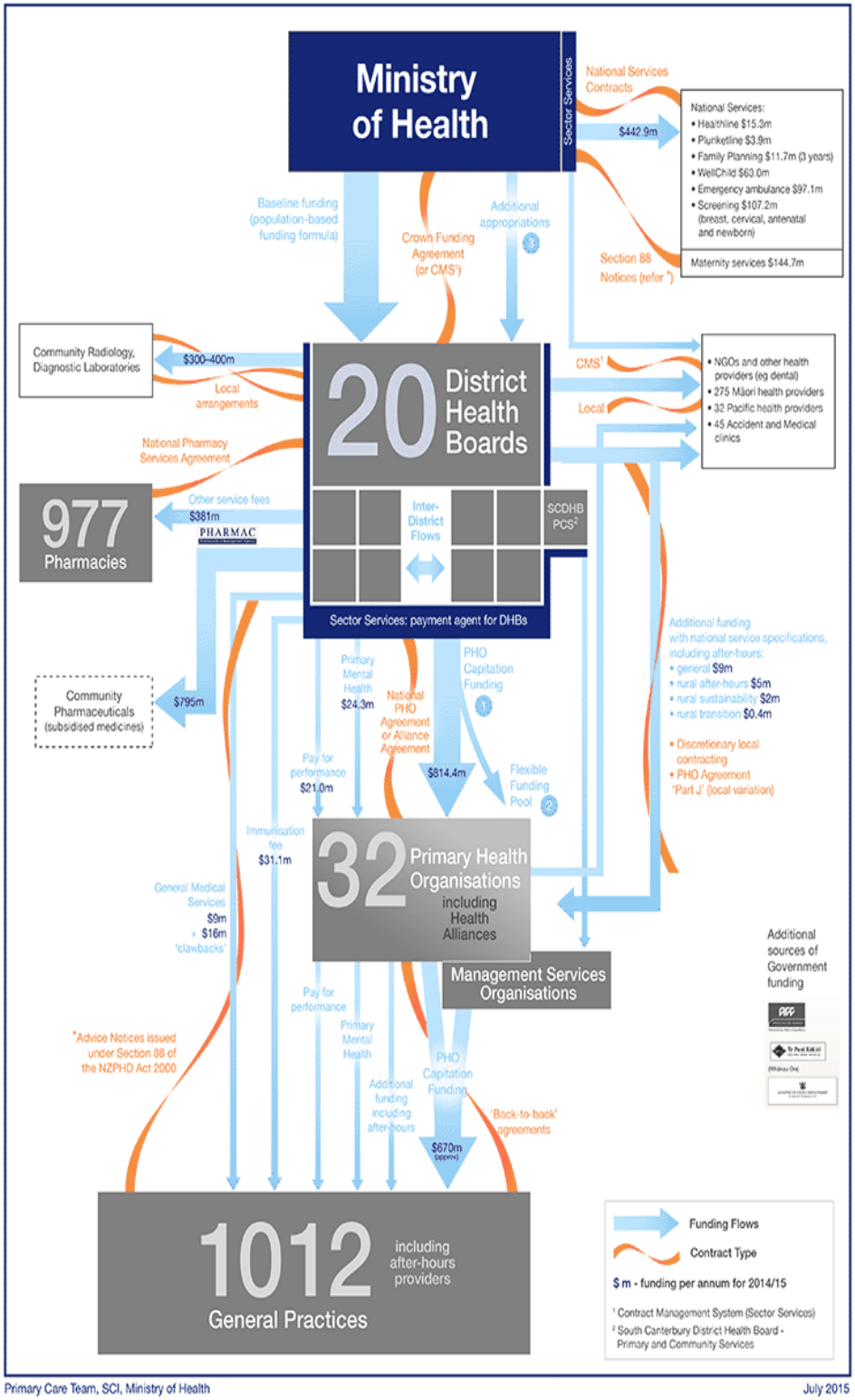

Figure 3: New Zealand Primary Health Care Services – funding and Contracts. Source: Ministry of Health (2015a).

1.7. Contextual questions that influence the broad research question and design

How does the research question tie in with the methodology?

Initially it would appear that the research topic and its question (What is the experience of Māori nurses working in primary health care?) could be considered too broad. However, how can the focus be entirely on just one issue, such as racism, when the experiences of Māori nurses in the community is the question? That was the kaupapa given to me and my participants by the Māori community and Māori health professionals. On reflection, how could the uniqueness of the nurses' practice be ignored? Hence, there were several foci within the kaupapa under the umbrella of the nurses' experiences. My concern was that, by honouring the Kaupapa, would I enable the nurses' voices to be heard, or would the kaupapa be swamped by the westernized bio medical voice of health policy?

It is evident that health policy plays a major role in Māori nursing practice. Health policies written in Aotearoa are written from a westernized thinking/approach. They are, at times, written to alleviate a deep-seated problem. For instance, after years of colonialism and the after-effects of that process, the policies are now trying to deal with the resulting health and social inequalities. The main health policy referred to in this research is the Māori health policy which seeks to improve the health of Māori in a number of ways. One approach is through *He Korowai Oranga: Māori Health Strategy*. This contains a number of policies/statements/objectives. For instance, the building of a stronger Māori health workforce (which will be further examined in Chapter Three).

Cultural safety is another important issue. It is incorporated in a Nursing Council of New Zealand policy that Irihapeti Ramsden (a renowned nurse educator) fought hard for, one which would enable non-Māori health professionals to gain an understanding of the needs of Māori in health. The international literature suggests that racism often subtly occurs within the health profession (Garcia & Sharif, 2015; Sakran, Hilton & Sathya, 2020). This prompts the question: Is cultural safety education a key to a better understanding of Māori nurses and their practice? The international literature suggests that the Indigenous nurses[23] are trying to use different strategies to cope with this and

[23] Indigenous nurses of New Zealand are referred to as Māori.

racism (Grant, Felton-Busch, Elston, & Saunders, 2009; Williams & Cooper, 2019). The international literature also suggests that the nurses are deeply entrenched in their communities (Etowa & Vukic, 2011; Valaskakis, 2009).

Westernised health policies do not sit well with a Kaupapa Māori process. They do not encourage self-determination, cultural aspiration or collective philosophy. How have the policies shaped nurses' practice? Such questions will be further examined in Chapter Three. To add to this, in examining the District Health Boards contracting and funding process, the intermediary between the process and the application of the health service to tangata whenua is the Indigenous nurse. The nurse has dual competencies and hence is thinking from a Māori perspective, for instance supporting their whānau in rongoa[24] Māori when that is the whānau need. Unfortunately, in many ways the nurses te ao Māori models of health and Māori philosophy/principles do not fit with a westernized model of contracts, targets and thinking. Bearskin et al. (2016) state that Indigenous knowledge is fundamental to the ways that Indigenous nurses undertake their practice, regardless of the systemic and historical barriers they face in providing care for others.

The Kaupapa Māori research approach includes Māori principles (see p. 50) which are the bases of the research. Māori nurses ideally claim through Te Tiriti, tino Rangatiratanga (self-determination) which should encompass ako[25] Māori and taonga tuku iho[26]. However, there is tension between those concepts and the Pākehā way of thinking and acting. The principles of whānau ata, working from a collective and mediating socio-economic concerns, are also at the centre of the nurses' practice. Hence, Kaupapa Māori principles and their constructs are the backbone of the research, relevant to Indigenous research, Indigenous nursing and Māori nursing.

For years I have struggled with the two ways of thinking. In my private life it is easy and includes respect and negotiation. In my work life it is not that easy as I often straddle two cultures (where there often is not the respect or give and take of my home life) in trying to support Māori patients/whānau as a nurse and as an educator supporting Māori

[24] Rongoa Māori: the traditional healing system of Māori (including herbal remedies).
[25] ako: both to teach and to learn.
[26] taonga tuku iho: the purpose of taonga tuku iho in nursing is to foster the growth of Rongoa services and improve Māori well-being.

nursing students. The students are often 'second chance[27]' students, grappling not only with family responsibilities but also with new ways of thinking in a westernized educational institution. The tertiary institutes all vary in their cultural support for their Indigenous students and the depth of their cultural education. This, in my opinion, has a huge influence on the Māori nurse graduates, their ability, confidence and their ways of practice in the community.

1.8. The Thesis Layout

This thesis is set out in six chapters.

Chapter One backgrounds the research and the context in which the topic is set. It begins with four vignettes of the nurse's experiences. It discusses the Treaty of Waitangi and outlines the three levels of the New Zealand's primary health care system. It sets out the role of the Māori health providers, non-government organisations, Primary Health Organisations, government health care funders and primary health care.

Chapter Two outlines the research methodology and methods. The research explores an Indigenous methodology: a Kaupapa Māori methodology. It then lays out the research process and discusses the methods and techniques for gathering information.

Chapter Three initially covers five selected policies/policy statements that impact on the Māori nurses' practice in primary health care and hence on Māori health. Each policy focus is examined and then a level of analysis is applied to the participants' data, using questions drawn from a Kaupapa Māori perspective. The chapter then discusses the findings relevant to health policy.

Chapter Four explores the New Zealand Primary Health Care System. It sets out the role of the Māori health providers, non-government organisations, Primary Health Organisations, government health care funders and primary health care. This chapter identifies major influences on the nurses and their practice, which include health organisations, Māori nursing as a unique nursing practice and health policy. These major influences (health organisations, health policy and nursing practice) in turn led to five themes in this research. These are administrative workloads, pay and support disparities,

[27] Second chance students are students who return to education with the potential of gaining a qualification. In nursing there are a high percentage of students who are studying while caring for a family.

the value and tensions of working with Kaupapa Māori health providers, exposure to racism and discrimination, and practising outside the contracts from these the research highlights and explores two outcomes from the themes: power and racial discrimination. Both are important influences on the nurses' practice. The first two themes are covered in this chapter.

Chapter Five examines the politics of nursing. It discusses conceptual frameworks that influence the health care system and consequently impact on Māori. They include power, racism, and Whānau Ora. It further examines the notions of institutional racism, power and powerlessness as a means to sit down and explain how it is that Māori nurses are disadvantaged in their profession. This chapter explores nurses' issues which include the retention of Māori nurses, power and powerlessness as a means to explain how it is that Māori nurses are disadvantaged in their profession. Finally, it analyses the value and tensions of working with Kaupapa Māori health providers, exposure to racism and discrimination, and practicing outside the nurses' contracts.

Chapter Six is the concluding chapter that summarizes the main themes within the research. It includes issues such as difficulties with contracts, lack of support and racial discrimination. The need to fund the health system as a priority is highlighted.

The next chapter explores the methodology and methods utilized to engage with the research. The chapter explores an Indigenous methodology: a Kaupapa Māori approach, outlining the research process, methods and techniques.

CHAPTER TWO: Methodology and Methods

I came to theory because I was hurting – the pain within me was so intense that I could not go on living. I came to theory desperate, wanting to comprehend – to grasp what was happening around and within me (bell hooks, 1994, p. 590).

2.0. Introduction

There are many choices of methodologies and methods available for researchers to use, however, the methodology, theory and methods used in research should align with the research question and the method drawn from the researcher's selection of methodology. A methodology is the overall approach to research linked to a philosophical stance or a theoretical framework, whereas a method refers to the research process, which includes the procedures or tools used for the collection and analysis of data (McKenzie & Knipe, 2006).

A variety of methodologies were explored for this research and informed the research question. However, through broader discussions, in keeping with Indigenous research, the needs of the participants were considered in the selection of a methodology and a number of core principles were identified. The participants were Māori and at the centre of being Māori is Māori culture, philosophy and principles. Hence, I chose a Kaupapa Māori approach to guide the research. I am examining the experiences of nurses in one specific region of New Zealand (and for confidentiality reasons I will not name) hence the findings are applicable to that region only.

The Kaupapa Māori methodology, using qualitative methods[28], worked well with the Indigenous participants and researcher, ensured that Māori voices were respected (Pihama, 2002; Te Awekotuku, 1991) and met the needs of the research. The methodology drew on a range of influences. These included: Māori values; expectations around ethics and therefore tikanga; Māori cultural practices; Māori knowledge; the place and status of Māori language and culture in society and the world. Hence, it was informed by Māori women and women of colour writers. However, I have used a critical social

[28] A qualitative research method is used to understand people's beliefs, experiences, attitude and interactions. It generates non-numerical data, whereas a quantitative method is based on numeric and methods that can be made objectively (Pathak, Jena & Kalra. 2013)

methodology in the past, and this could influence my thinking during analysis and the development of recommendations. In saying that, Graham Smith (1997) asserts that, although Kaupapa Māori is connected to Māori philosophies and the principles of te ao Māori[29], it is acknowledged that its founding ideologies are likened to critical theory, where "the notions of critique, resistance, struggle and emancipation" are promoted (Smith, 1997 p. 85). However, although Kaupapa Māori research is a form of resistance it is an indigenous methodology. It is research that is conceived, developed and carried out by Māori and the outcome is for the benefit of Māori (Walker, Eketone & Gibbs, 2006).

2.1. PART A: Methodology

This qualitative study uses a Kaupapa Māori methodology. Kaupapa Māori is a discourse that has emerged and is legitimated from within the Māori community. Smith (1992) describes Kaupapa Māori as "the philosophy and practice of being and acting Māori" (p. 1). It assumes the taken-for-granted social, political, historical, intellectual and cultural legitimacy of Māori people, in that it is a position where "Māori language, culture, knowledge and values are accepted in their own right" (Smith, 1992, p. 12). Further, Kaupapa Māori presupposes positions that are committed to a critical analysis of the existing unequal power relations within our society. These include "a rejection of hegemonic belittling, 'Māori can't cope' stances, together with a commitment to the power of conscientization and politicization through struggle for wider community and social freedoms" (Smith, 1992, p. 26).

At the same time, historically the nursing profession has been infused with structural, linguistic and social practices that serve to colonize rather than liberate (Kurtz et al., 2017, p. 8). According to Battiste (2013), both the nursing profession and health care system contribute to socially minimizing the cultural well-being of Indigenous nurses, resulting in loss of identity, rupturing of cultural practices and adapting nursing curriculum and pedagogies into assimilative spaces.

Kaupapa Māori addresses what Michel Foucault terms "the productive function of power-knowledge" which is to "populations by describing, defining and delivering the

[29] Te ao Māori: represents the world of Māori, their beliefs, values, and principles that drive the Māori world view.

forms of normality and educability" (Foucault, 1980, cited in Olssen, 1993, p. 5). To Foucault, it has been the modernist mission of the human sciences, with their beliefs in truth, objectivity, linearity and inevitable progress, which have constituted normality of some and marginalisation for others. Nonetheless, Kaupapa Māori can be seen as the deconstruction of those hegemonies which have disempowered Māori from controlling and defining (researching) their own knowledge within the context of unequal power relations in New Zealand (Bishop, 1991).

For the researcher, the methodology was a tool, an Indigenous way of thinking that enabled new knowledge to emerge. There was a need from a Māori perspective to, as Bishop (1991) stated, expose new knowledge within the context of unequal power relations. I hoped that if I could just 'hook' others into understanding the uniqueness of Māori nurses' practice then more Māori would be supported to become registered nurses and, secondly, the nurses would be enabled to work in the community providing a much needed culturally competent appropriate health care.

My experience of being Māori gave me the passion to initially start this research. However, I was also concerned about what I had observed regarding Māori nurses working in primary health care.

The key principles of Kaupapa Māori, which is the participants' familiar space, are:

1. Tino Rangatiratanga (the principle of self-determination);
2. Ako Māori (the principle of culturally preferred pedagogy);
3. Taonga Tuku Iho (the principle of cultural aspiration);
4. Kia pike ake I nga raruraru o teainga (the principle of Socio-Economic Mediation);
5. Whānau (the principle of extended family structure);
6. Kaupapa (the principle of collective philosophy);
7. Te Tiriti o Waitangi (the principle of the Treaty of Waitangi);
8. Ata (the principle of growing relationships) (Smith, G., 1990; Smith, L. 1999; Pihama, 2001; Pohatu, 2005).

However, Graham Smith (2003) states that the core principles are "the crucial change factors in the kaupapa Māori non-lineal transformative praxis" (pp. 8-11).

Hence, the above principles are ingrained in the research. I struggled initially to explain how I used Kaupapa Māori principles in my research. I had to step back as this was my

embodied knowing, in other words what I did unquestionably. This 'knowing' is informed by tikanga Māori or Māori ways of doing things, and of being a wāhine.

Table 1 (below) shows key Kaupapa Māori methodology constructs and the constructs explanations.

Construct	Explanation
Mentorship	Involves the "mentorship of elders" (Irwin, 1994, p. 27) and is an important part of Māori research. It is also part of consultation. My kuia (Māori advisors) kept me safe and were always there for support and guidance.
Whakawhānaunga-tanga	It is used metaphorically in this research to give voice to a culturally positioned means of collaboratively constructing research stories in a 'culturally conscious and connected manner' (Bishop, 1995). The participants become a 'whānau of interest' through a process of spiral discourse (Bishop, 1995) in other words after the initial interviews the data is drilled down into through an analysis process and then brought into the second interviews, it is discussed and built on, then again the data is transcribed, pulled into findings and discussed in the final interviews.
A modern concept of whānau	The research group is referred to as a metaphorical whānau (Metge, 1990). This concept of whānau attempts to develop practices based on similar principles to a traditional whānau. These principles involve a series of rights and responsibilities, commitments and obligations and supports that are fundamental to the collectivity (Metge, 1990). These include aroha (love), awhi (helpfulness), manaaki (hospitality) and tiaki (guidance) (Bishop & Glynn, 1999). The traditional whānau concept is a group of people connected by kin.
Connectedness	Refers to many facets including connection with the land, with whānau /extended whānau, with the data, with the research whānau.
Networking	Entails making a connection with other Māori, especially regarding this research, so that Māori kaumātua, colleagues, educators, nurses and significant others are kept informed regarding the process and progress of the research.

Following protocol	Is important and includes presenting appropriately by introducing myself properly so that others can make a connection with me, and also so that at non- Māori presentations I can ground myself properly.
Participation	Involves the participants within the work and includes ongoing dialogue and co-construction of the findings. Participation also involves connection through whakapapa and meaning related to being Māori.
Challenge	Can be negative or positive. I have always experienced challenge as a positive process. Normally the speaker is allowed to complete the kōrero and then may be challenged from the floor regarding more information regarding his or her kōrero. I perceive challenge as someone caring about my work or making sure that I am doing it according to the 'rules', keeping in this research participants and myself safe or suggesting ways of 'doing things better'.

Whakawhānaungatanga involves establishing and maintaining relationships by means of identifying, through culturally appropriate means, your bodily linkage, engagement, connectedness and hence (unspoken) commitment to others (Bishop, 1996). It is a fundamental, often extensive and ongoing part of the research process.

The establishment of relationships in a Māori context addresses the power and control issues fundamental to research because the research involves participatory research practices. Hence, the group works together through an ongoing process of examining relevant data and commenting on the data until a finished product is developed and agreed upon. This will be explained more clearly as the process is worked through step by step through the methods.

Graham Smith (2003) suggests that the lesson of a Kaupapa Māori approach is that transformation has to be won on at least two broad fronts: a confrontation with the colonizer and a confrontation with 'ourselves'. This is what Smith (2003) labelled as the 'inside-out' model of transformation – in this sense, as Paulo Freire (2005) suggested, first we must free ourselves before we can free others. Although Smith and Freire's words resonate with the research, this process takes time. It is an ongoing process, involving reflection and korero amongst researchers, research participants and the Māori advisory group. Kaupapa Māori theory influences matauranga Māori and the basis of Māori

understandings. Because the research participants are Māori women, wāhine thinking resonates with the research objective and their voices inform matauranga Māori.

However, it is important to acknowledge our tane who, as Māori male nurses, also struggle as they work in the community under the same conditions as their female counterparts. It is also important to flag the concern that there is a shortage of male nurses (McLachlan, 2014).

A Kaupapa Māori approach enables change. According to Linda Smith (2012) systematic change requires multiple skills including capability, leadership, support, time, courage, reflexivity, determination and compassion. Paulo Freire (2005) referred to this as praxis; theory, action and reflection, whereas Graham Smith (2003) referred to it as "Indigenous transforming praxis" (p.xiii). A Kaupapa Māori methodology enables transformation as it works through the process of dialogue, debate, support and sharing of resources along with Indigenous transforming praxis (Smith, 2012). This process helps make sense, allows new ideas and ways of looking at things, and 'peeling back' to enable a "sense of reality" (Smith, 2012, p. 40). However, it is important to note that reflexivity involves a dynamic continuation of self-awareness, whereas reflection is more about thinking about something after the event. Reflection in this research is a time to stop and think at certain times of the research (perhaps to ask a question but not need an answer) before moving onto the next point.

This methodology also enables enlightenment, which in turn is empowering and can lead to emancipation. Hence, external networking along with internal reflection enables understanding. This in turn builds self-esteem and courage to make changes and to gain a voice – to move from the margins to the centre and to create space for discussion (Wane, 2008). It can also challenge and enable systemic change, for instance, in the way primary health care in the community is managed and how District Health Board contracts are organised. The methodology gives nurses their voice and, in the long term, could lead to better health care for their clients/ whānau. Again, in the important words of Smith, (2012), this research will enable transformation as it works through the process of dialogue, debate, support and sharing of resources along with Indigenous transforming praxis.

Smith (1999) said, when Indigenous people are the researchers and not merely the researched, the activity of research is transformed. Questions are framed differently,

priorities are ranked differently, problems are defined differently, and people participate on different terms.

The methodology enabled me to be myself, a Tainui wāhine. It enabled the participants and myself to use te reo, which we were comfortable with. Although not all of the participants were fully fluent in te reo, they all used it in their everyday language, so that kupu[30] such as whānau, for example, were used with a Māori understanding, meaning more than the English interpretation of kin family.

2.2. On Reflection: Philosophy, principles, constructs, culture and the research questions

How did the research questions tie in with the methodology?

Initially it would appear that the research topic and its question (What is the experience of Māori nurses working in primary health care?) could be interpreted as too wide but how can the focus be entirely on just one area such as racism when the experience of Māori nurses in the community is the question? On reflection, how could the uniqueness of the nurse's practice be ignored? It had to be exposed to allow others to understand, or the unfairness of pay disparity had gone on for too long and needed to be rectified or the trauma of the nurses struggling with their workload was a dilemma. Hence, there were several foci within the kaupapa under the umbrella of the nurse's experience. But my concern also was that by honouring the kaupapa would I sacrifice the depth needed within the thesis.

It is evident that health policies play a major role in Māori nursing practice. Health policies written in Aotearoa are written from a westernized thinking/approach. They are at times written to alleviate a deep-seated problem, for instance: after years of colonialism (and the after-effects of that process) the policies are now trying to deal with the resulting health and social inequalities. One policy focused on trying to build a stronger Māori health workforce (Ministry of Health, 2016) but was there adequate pay and support to consider in order to encourage Māori into health practice? Where did te Tiriti fit with its aim of fairness and rangatiratanga?

[30] Kupu: words.

Cultural safety was another policy considered: and if applied in education would enable non-Māori health professionals to gain an understanding of the needs of Māori in health. Although international literature suggests that Indigenous nurses are deeply entrenched in their communities and work hard for their communities they endure subtle racism (Hall et al., 2015). This prompts the question: Is cultural safety education a key for a better understanding of Indigenous nurses and their nursing practice, and in this research, Māori nurses and their practice?

These westernized health policies did not sit well with a Kaupapa Māori process. They did not encourage self-determination, cultural aspiration or collective philosophy. How have the chosen policies affected Māori? How have the policies shaped nursing practice? These questions will be further examined in chapter three in order to answer the research question.

In examining the District Health Boards contracting and funding process, the intermediary between the process and the application of the health service to tangata whenua is the Indigenous nurse. The nurse has dual competencies and hence is thinking from a Māori perspective, for instance supporting her whānau in rongoa[31] Māori when that is their need. Unfortunately, in many ways the nurses' te ao Māori models of health and Māori philosophy/principles do not fit with a westernized model of contracts, targets and thinking. Bearskin et al. (2016) state that Indigenous knowledge is fundamental to the ways that Indigenous nurses undertake their practice, regardless of the systemic and historical barriers they face in providing care for others.

The Kaupapa Māori research approach includes the above principles which are the basics of the research. Māori claim through Te Tiriti, tino Rangatiratanga (self-determination) which should encompass ako Māori and taonga tuku iho. However, there is tension between those concepts and the Pākehā way of thinking and acting. The principles of whānau ata, working from a collective and mediating socio-economic concerns, are also at the centre of nurses' practice. Hence, the Kaupapa Māori principles and their constructs are the backbone of the research, relevant to Indigenous research, Indigenous nursing and tied into Māori nursing.

[31] Rongoa Māori: the traditional healing system of Māori (including herbal remedies).

For years I have struggled with the two ways of thinking. In my private life it is easy and includes respect and negotiation. In my work life it is not that easy as I often straddle two cultures (where there often is not the respect or give and take of my home life) in trying to support Māori patients/whānau as a nurse and as an educator supporting Māori nursing students. As mentioned earlier the students are often second chance students as they grapple not only with families but with new ways of thinking and a westernized educational institution. The tertiary institutes all vary in their cultural support for their Indigenous students and the depth of their cultural education. This in my opinion has a huge influence on the Māori nurse graduates, their ability, confidence and their way of practice in the community.

My research question was left broad and refined to '*What are the experiences of Māori nurses working in primary health care?'*

2.3. PART B: Method/s

A research method is defined as the techniques or processes used to conduct research whereas the methodology is the discipline, or body of knowledge that utilizes these methods (Kinash, n.d.). The first part of the research process is to identify ethical issues and gain ethics approval.

My reasons for using the methods I chose were participant driven. For example, I initially wanted to include focus group discussion as a means of generating data but the participants in my research did not. Instead, they asked for individual he kanohi ki te kanohi interactions. The one-on one, semi structured open-ended interviews that eventuated included questions that allowed the women's voices to be heard. They all had stories to tell and sometimes concerns to be spoken about. Listening to their stories was a humbling experience. My simple way of data analysis was easily understood by the participants. This procedure enabled me to, firstly, construct concepts on to a board. From these, three major influences appeared and from there themes emerged. Finally, two major outcomes were apparent which enabled a visual and fuller understanding of the data.

Research journaling was an ongoing method I used which enabled reflexivity. Reflexivity is an important tool that enabled me to stay engaged in critical self-awareness throughout the research process. It is the embodiment of an epistemology in which the

knower is always present, a way of looking that gazes outward at what is taking place while sustaining an inward gaze at inner thoughts (Probst, 2015). Hence the journaling also enabled me to look back and reflect on earlier thoughts.

Documentary analysis was another research method used (see Chapter Three). Documentary analysis may focus on one or more of three layers of meanings, those which are overt and explicit in the document, those which reflect the rhetoric of the policy environment and the government's intentions; and those which reflect the ideology, usually implicit underpinning policies at local and/or national level (Shaw, Elston & Abbott, 2006). This comment is reflected and expanded on in Chapter Three.

2.4. Data

The methods for data collection utilized in this research cover two specific areas:

a) Interviews with various members of the health profession included eight Māori registered nurses, a District Health Board employer (referred to as the funder) and two nurse managers (employed by Māori health providers) to gain primary data. Data gathering occurred over two years (June 2015-June 2017),

b) Policy documents for analysis to gain secondary data.

i) Interviews

Semi-structured in-depth interviews are the most frequent qualitative data source for health services research. This method typically consists of dialogue between the researcher and participant, guided by a flexible interview protocol which is supplemented by follow up questions, probes and comments (Dejonckheere & Vaughn, 2019).

a) Potential participant inclusion criteria

The inclusion criteria for the research participants, were that the potential participants identified as Māori, were registered nurses and that they worked in primary health care in the community (rather than at a clinic) in the employment of a Māori health provider, in a provincial area of New Zealand.

b) Gaining participants

In order to recruit participants, the proposed research was presented to Māori registered nurses working in primary health care. This was a time for karakia[32], waiata (Māori song or hymn), maanakitanga (kindness), and whakawhaungatanga.

Those interested in becoming research participants were given an information sheet and a consent form and they could then email me, of their own free will, with a request to join the research group without feeling overly coerced to do so. The first eight respondents became the research participants. I then emailed them the interview questions.

It was intended that the eight participants meet in a focus group interview, however the participants did not want to do this because of time constraints. They were all interviewed individually through three individual interviews (approximately an hour in duration, using open ended semi structured questions). The three interviews were approximately six months apart. A focus group would have allowed initial whakawhānaungatanga or the establishment and maintenance of whānau relationships (metaphorically and literally) among all participants. It is a fundamental, extensive and ongoing process of research and involves research as a lived experience. Metge (1986) suggests that whānau (in this case the research whānau) attempt to develop a traditional whānau. This is used to identify a series of rights and responsibilities, commitment, obligations and support that are fundamental to the collective. However, the face to face individual interviews had their own advantages such as enabling an ability to build a rapport quickly.

The research involves the establishment of a 'whānau of interest' (Bishop, 1995) which includes this research's participants, researcher and advisory group, through a process of 'spiral discourse'. In other words, the way in which the findings from the interviews went back to the participants for agreement of the content as well as for further korero and hence further interviews. At the same time mentorship occurred as dialogue continued with elders (the Māori Advisory Group, see p.70).

[32] Karakia – incantations and prayers, used to invoke spiritual guidance and protection.

In spite of the fact the participants knew each other, as many of them studied their Bachelor of Nursing degree together and had met occasionally at hui, at this stage they were unaware who the other participants were in this research because of the careful ongoing maintenance of anonymity. Some of the stories were removed from the initial interview data as they could have been connected to the participant. Later, they became aware of each other's stories through reading the research findings and then discussing the main points of those stories during the third interview or in the email feedback. They were very interested in other's experiences and the development of the findings. There was connectedness through story and connectedness between researcher and participants. However, connectedness is deeper than my simplistic comments.

It was more than highly probable that I would know some of the participants, and this was the case. Many years ago, in my role as a Māori nurse educator, I attended nine annual Māori nurse student hui, attended conferences and for 25 years taught in a Bachelor of Nursing degree programme.

The eight participants were Māori registered nurses. They had completed a three-year full time Bachelor of Nursing degree and passed a State nursing registration to meet the requirements of New Zealand Qualifications Authority and the Nursing Council of New Zealand to become a New Zealand registered nurse. They were all wāhine.

c) Interview process:

The interview included:

1) a venue, time and date of the participant's choice.
2) a mihi (greeting) to begin the introduction.
3) A pepeha (introduction), a sharing of a little bit of where we come from and who we are related to. Often a pepeha links us to a common ancestor and/or land. This is a time to show respect, through the language used and the accompanying actions.
4) Karakia at the participant's choice: a prayer to keep both the researcher and participant safe.
5) Kaputi[33] and kai (food): to lift the tapu of the ritual, so that we both become noa and enjoy each other's company. The kai is a small koha[34].

[33] Kaputi: cup of tea.
[34] Koha: offering, gift, donation.

The introduction to the research included an explanation of the purpose of the interview, clarification of the topic under discussion, format of the interview, approximate length of time of the interview, and assurance of confidentiality, even though they had previously received a copy of the proposal and confidentiality documents. I also restated the purpose of the digital recorder, that the interview would be audio-taped with their permission, which would enable the participants to stop the interview if they wanted to. I asked the questions in a conversational manner, and at the end of the interview, asked the participant if there were any matters they wished to discuss further I reminded them that they would receive a transcript of the interview for them to check, comment on and amend any information they had provided. All participants agreed to the process.

Whakawhaungatanga is important not only on a first interview but in ongoing interviews. The initial connection of mihi or sharing whakapapa is paramount to the tikanga of the whole process and the essence of a Kaupapa Māori methodology. Hence, it is important to take time in an interview to initially settle, reconnect and be respectful through-out the interview process. My prior experience of travelling a long distance to an interview, and rushing the interview because of tiredness and time constraints, was a good lesson on how not to miss out on valuable data and not build the rapport needed. It is important to work in partnership with the participant in a collaborative and reciprocal process, as well as conducting the interviews and data analysis in the right way. In the research process, an advisory group of Kuia guided the research process regarding tikanga.

The interviews were ongoing and consisted of semi-structured open-ended questions (see Appendix B. p. 219). The interviews were one on one, face to face interviews. The transcripts initially were transcribed verbatim then reviewed to remove anything that would identify the participant or their place of work. The transcribed transcripts were then sent to the participants, who checked them for accuracy and representation, and their feedback was either emailed to the researcher or discussed at the following interview. From this, new, semi-structured, open-ended interview questions were developed in order to ‘drill down’ into the data. These second interview questions were a general set of questions for all of the participants generated from the first interviews. These were emailed to the participants and the process as above was repeated once more.

The rationale for doing three interviews with each participant was because the total number of participants was small (eight nurses). This gave the researcher the opportunity to gain in-depth, highly reflexive data, and to ensure that saturation of data was reached. It also enabled the participants time to reflect on the questions and their responses via the transcriptions, and to develop their thoughts for further discussion. The participants received a copy of the findings, knowing that there would be changes as I further analysed and fine-tuned the work. I received positive feedback from each of the participants about the truthfulness of the interpretation of the data. They also received the preliminary findings while the work was in its initial stage of data analysis and then again as the findings evolved. This latter process enabled member checking of their own participant quotes and also to enable the participants to comment on and discuss the analysis. Hence, the third interview was a discussion of the findings as I had reached saturation within two interviews.

Further data was gathered from an interview with a District Health Board employer (referred to as the funder) who writes up and monitors the Māori health provider's contracts. This interview produced data regarding the process of developing contracts, signing them over to the providers and monitoring their progress.

Data was also gathered from interviews with two visionary nurse managers employed within the region under study. This data displayed the nurses' visions for Māori nurses working in primary health care into the future.

The participants worked in suburban communities except for Participant 4 who worked in a rural township. Participants 1, 5 and 8 had worked in public health clinics prior to working for a Māori health provider. Over the two- year research process period, only two of the eight participants remained working with a Māori health provider. Three now work in General Practices and three are unemployed. All of the participants are mature nurses and have families. I also interviewed two nurse managers (Kathy and Clare, employed by Māori health providers) and a District Health Board funder (Henry). I used the same interview process as the process used for interviewing the Māori nurse participants, but I interviewed Kathy, Clare and Henry only once and used pseudonyms.

For the purposes of recording the interviews and data in the chapters the participants will be referred to as P, for instance (P 1). The key regarding participants and interview

numbers attached to participant comments are: Participant 2 Interview 3 becomes (P 2/3). The participants were either mobile nurses (MN) or School based nurses (SBN).

Table Two (below) identifies the participants, their pseudonyms, employment, an approximate length of time they have been in their present work position and whether they have experienced mainstream nursing prior to their present position.

Participants – ko wai ratou?[35]

Name	***Time in Position***	***Previously in main stream nursing***	***Type of work***
Funder (Henry)	One year	No	DHB
Manager of Māori health provider non-Māori (Clare)	10 years	Yes	M
Manager of Māori health provider Māori (Kathy)	20 years	Yes	M
Participant 1 (Kelly)	10 years	Yes	SBN
Participant 2 (Tem)	2 years	No	SBN
Participant 3 (De)	10 years	No	SBN
Participant 4 (Jane)	5 years	No	SBN/MN
Participant 5 (Anahera)	5 years	Yes	MN
Participant 6 (Kay)	1 year	No	SBN/ MN
Participant 7 (Maia)	5 years	No	MN
Participant 8 (Lizzie)	1 year	Yes	MN

Table 2: Participant Profile Table

Key**:** M=Manager, MN = Mobile Nurse, SBN = School Based Nurse, DHB = District Health Board**.** The Funder and two nurse managers are interviewed once and have pseudonyms whereas the nurse participants named above (with pseudonyms) are referred to as participants as they are interviewed three times.

The use of pseudonyms for the Māori nurse participants was to assure them that confidentiality is maintained plus I feel uncomfortable using numbers to identify the participants who mean more to this research than being just a number. As a nurse, patients are not identified as an identity number or a room number but by their name, similar

[35] Ko wai ratu – who are they?

principle in research. However, for coding purposes within the thesis P 2 is simpler, whereas on computer interview data and files the pseudonym applies.

ii) Policy Documents:

Data was also drawn from the policy documents/objectives listed below and analyzed for this research:

1. Build a strong Māori health workforce (Ministry of Health, 2016b),
2. Reducing inequalities in health for Māori (Ministry of Health, 2011),
3. Recognising and respecting the principles of Te Tiriti o Waitangi (Ministry of Health, 2014b),
4. Better sooner, more convenient health care in the community including more collaboration between health professionals (Ministry of Health, 2011),
5. Cultural safety (Nursing Council of New Zealand, 2017).

Chapter Three examines each policy focus and then applies a level of analysis using questions drawn from a Kaupapa Māori perspective by asking:

a) *What role did the Treaty of Waitangi play in informing policy?*

b) *What was the involvement of Māori and where did it occur?*

c) *What were the recommendations made for Māori?*

The analysis of these policy statements/objectives using the above three questions, will be achieved by drawing upon relevant literature and the researcher's own observations/analysis (as opposed to the interview findings).

2.5. Ethical Issues

Kaupapa Māori research has guidelines, including the principles and constructs outlined earlier, that are unique to Māori and guide the entire research practice and process. These guidelines are founded on tikanga. The approach to carrying out research under the principles of tikanga are pre-eminent in the definition provided by Professor Hirini Mead:

> Processes, procedures and consultation need to be correct so that everyone who is connected with the research project is enriched, empowered, enlightened and glad to have been a part of it (Mead, 2003, p. 318).

As an Indigenous researcher within Aotearoa, I work within a set of ethics underpinned by my own Indigenous knowledge base which has regard for respectful relationships with individuals, communities and the environment (Smith, 2012). This is whakawhānaungatanga[36]. I had to consider ways to do the research that would not put the participants at risk. This was performed by using language the participants understood, placing the dictaphones out of sight of the public and conducting the interview in private, not within the hearing of others. The interview transcripts were hand delivered to the participants to keep them and the participants' stories safe, and to keep the participants informed. I followed these principles by transcribing the interviews myself, discussing my findings with the participants, by keeping all data in a password-controlled computer, adhering to the kaupapa and by seeking the advice of my Māori advisors. Also, I was lucky as I worked with participants who were employed by organisations that I had no connection with.

All research should be conducted in a responsible and ethical manner. With this in mind, the participants chose the venue, the time of the interview and were in control of turning the Dictaphone on and off.

Participant safety was maintained through ensuring their anonymity and confidentiality by the use of codenames which later changed to participant numbers (for instance, P1) when referring to data, within the thesis and not including any information that would enable the identification of a participant. Confidentiality and anonymity were important to my participants - their stories are important. I am privileged to be able to use their data. Hence, as explained above, I was careful that the data did not contain information that could be traced back to individuals. The participants were nervous of being identified and did not want their employment in jeopardy through the interpretation of their stories. They also checked all transcripts and the findings for accuracy and to ensure they were happy with what was included in the research findings. They had the interview questions sent to them for interviews one and two as I 'drilled down' and went into depth with some of the themes. I had reached saturation point by interview three, hence interview three was a discussion regarding the findings.

Secondly, informed consent was gained from participants in the research, who each signed a consent form after receiving an information sheet. I was careful to explain why

[36] Whakawhānaungatanga: a process of establishing whānau links initially through cultural means of identification and then through cultural methods of engagement and commitment (Bishop, 1995).

I had entered into the research, my aim, the research process, and to provide my supervisor's contact information if the participants had any questions about the research process.

Thirdly the information sheet included the participant's right to withdraw from the research at any time and there was an explanation at the initial hui of the benefits to the participants. The safety of the data was enabled by the researcher transcribing the data and the data was stored on a password accessed computer. The data will be retained for five years then destroyed.

Ethics approval was gained from the Ethics Committee Te Whare Wananga o Awanuiarangi (see Appendix A, p. 218).

2.6. Data Analysis

i) Data Analysis Process

An approximately total of 30 hours of recorded interview data was collected by dictaphone from eleven participants. The interview data was fully transcribed and a dictaphone copy of the relevant transcription was given to participants at their request. The recordings were listened to immediately after the interview and notes were taken while the participants' non-verbal reactions, such as body language and facial expressions, were still fresh in my mind.

The data were then transcribed verbatim into transcripts which contained the participants' chosen pseudonyms, the number of the interview and each line of raw data was numbered or coded. This allowed for reference to the data during the data analysis and writing up of the data within the thesis. The transcripts had all identifying material removed. Two copies were made, one copy was couriered by the researcher to the participant and the other copy was used in data analysis.

The process of analysis involved identifying main concepts emerging from the data and initially these were noted on sticky pads ('post its') and pinned to a large board. The sticky pads also had the interview number, participant number and line number to enable easy identification of the data segment for further analysis and later reporting. This process was repeated after the second and third interviews. Again, the concepts and main

points from the data were noted on the board, themes emerged and relevant excerpts from the data were included in the findings.

The participants were mostly satisfied with the transcripts, however, when they read the findings several asked for some data to be removed as, although names and places had been removed, the participants perceived that they could be identified through the specific stories.

As the participants checked their transcripts and the findings and made comments, the question arises "who controls the research?" This research is a process of negotiation, as control is closely aligned to power (Barnes, 2000).

Therefore, it is important in terms of rangatiratanga[37] that although control of the research is in the hands of the researcher, that all participants within the research are co-researchers.

My plans for disseminating the findings, are that initially the findings will go back as a hard copy thesis to the participants. The findings will then be taken to hui, and then onto conferences. The findings will be written in the form of journal articles and put forward to be critiqued for publication.

ii) Data analysis discussion

The data was initially analysed briefly. This included making notes on any observations made. This initial analysis was later refined. After the data was transcribed verbatim into transcripts it was analysed according to a code designed to analyse the information. The coding and categorising of data according to Denscombe (2006) consists of "breaking down the data into units for analysis …[and] categorising the units" (p. 271). Denscombe's wording tends to sound reductionist, which is a move away from a holistic perspective. However, in keeping with an Indigenous methodology it was important to 'tread carefully' in order to retain the voice of the participant, keep the stories intact and at the same time bring structure into the findings to enable analysis to occur.

[37] Rangatiratanga: Chieftainship, according to Maaka and Fleras (2006) rangatiratanga is a term situated within the context for indigenous people of Aotearoa and their struggle for self-determination.

Kovach (2010), an Indigenous researcher, suggests the use of description and thematic grouping but warns about the conflict of the latter with making meaning holistically. Therefore, although some of the stories were condensed and linked to what others were saying, for instance the dangers of working in the environment, some of the data is maintained in quite large paragraphs in order to capture the essence of the story. Kovach (2010) suggests that in westernized research this analysis would be referred to as the findings, however, as is fitting for an Indigenous methodology these chapters are more about description which Kovach (2010) refers to as condensed stories and thematic groupings.

It is also important to go over the raw data transcripts again and again, and to jot down any new information that comes to light, as new information/ideas may emerge as relevant, or new interpretations might be given to the data (Denscombe, 2006). As the researcher at this stage, I was also trying to identify themes or interconnections that recurred between the units and categories that emerged (Denscombe, 2006). The participants and I were looking at the data from a Māori perspective - wāhine eyes and thinking.

The refining of the analysis also took into consideration the reliability and validity of the findings and the reflexive account on the part of the researcher regarding the data analysis and findings (Denscombe, 2006). However, some of the data is documented in story form within Chapters Four and Five, in order to retain the voice and language of the participants. In this form the participatory consciousness and connectedness within a Māori discursive is captured (Bishop, 1995).

I treated the transcripts as taonga, as I was privileged to hear the participants' stories. Plus, the confidentiality of the participants was of utmost importance. Hence, the transcripts were delivered by the researcher in confidential envelopes. In one setting where two participants were employed, I made two different trips on different days to deliver the transcripts when I knew only one participant was working. This was to ensure confidentiality to the best of my ability.

Part of the process of working as a collective is for the researcher and participants to work together, especially in the analysis of the data. The process of emerging knowledge, therefore, comes from a collective effort and remains true to the gaining of maatauranga Māori. The analysis of data and the development of knowledge is set in the primary health

care context of nursing in this research. Reflection and reflexivity are also important parts of the analysis process.

iii) Reflexivity

To reflect on something is to try and understand it more deeply whereas reflexivity involves a "more immediate, dynamic and continuing self- awareness" (Johnston et al., 2015, p. 1). It could be seen that reflection and reflexivity are at either ends of a continuum. Both reflection and reflexivity play important roles in this research. Researcher journaling has enabled reflection through the process of ongoing thinking about the methods used and emerging data as the research has developed.

Reflexivity has shaped my thinking and, to a certain extent, the participants' thinking also. It is a process involving not only self-reflection but also ongoing dialogue and analysis, as the position and development of the findings changes and move towards a new understanding. This in turn shapes perceived reality. It influences the ontological state of the knower and can move them from false to true consciousness. It also involves seeing the interrelationships between the sets of assumptions, biases and perspectives that underpin parts of the research. 'It includes my critical analysis regarding the assumptions I struggle with'. It is easy to reflect on the pieces of this research, but it is more difficult to understand the connections and the melding together of the components. This study enabled change in my understanding, attitude, values and knowledge base. It was to be neither an easy nor short process.

As Mann (2016) suggests, reflexivity involves being self-aware, "examining your assumptions, beliefs, 'conceptual baggage' and preconceptions and how these affect the interactions and dynamics of the interview" (p. 27). Reflexivity in research is also considered an important part of ensuring that research is ethically and rigorously conducted (Searle, 2012).

iv) Rigour

I believe that the rigour of this Kaupapa Māori research methodology is evident in the ongoing networking, gaining consensus, dialogue and debate that was a pivotal part of the research. This began before the proposal was written and will continue, no doubt, well after the research is completed – it is about collective wisdom. My reflexivity explained above is part of the rigour of this study.

Although the findings of the research cannot be generalised to all Māori registered nurses working in primary health care, they do satisfy the criteria for scientific rigour. Credibility and trustworthiness are more appropriate terms for this type of research (Carter, Bryant-Lukosius, DeCenso, Blythe & Neville, 2014) than the traditional notions of validity and reliability.

To achieve trustworthiness, data must be credible to the participants, they must be applicable to similar settings and confirmable through examining the characteristics of the data by a number of research methods. Transferability is also important and allows another researcher (in this case Māori) to be able to follow the research method in this study and arrive at similar conclusions. This has been attempted by describing above, in detail, the processes and procedures followed for data collection and analysis. Careful documentation of the research process and the planning and ethical stages provide a recognisable audit trail. Documentation included the initial proposal, the ethics application, transcripts of all audiotaped interviews, journalised personal reflections, notes regarding feedback from hui, and many drafts of the thesis.

Credibility means having confidence that the findings represent plausible information drawn from the participants' original data and, hence, a correct interpretation of the participants' views (Korstjens & Moser, 2018). Korstjens and Moser (2018) also suggest that strategies to ensure trustworthiness can include triangulation, member check (as discussed above), thick description, audit trail and the use of journaling.

Data triangulation (Cope, 2014) occurred by using various data sets – the use of raw material, the use of codes, the use of concepts and theoretical saturation. Hence, data triangulation was established in two ways. Firstly, the participants were sent the transcripts for verification which enabled the authenticity of what was said during the research process to be checked. Then follow up interviews strengthened the process and enabled the findings to be confirmed and expanded on. The time that elapsed between the interviews (approximately six months) also allowed time to reflect and remember additional information. Secondly, one of the ways authenticity was checked was by asking the same question in different ways and at different times during the interview process. Investigator triangulation involves several primary researchers involved in the data analysis. In this research, one researcher mainly analysed the data, however, as stated above, the transcripts and findings were delivered to the participants for their verification

and comments, so that had a major impact on the findings. Another strategy regarding rigour was the use of thick description. This describes the participants feelings, experiences and the context in which they work, as documented by the research, so that the findings can become meaningful to an outsider. Ensuring rigour in qualitative research ensures the quality of the research process. However, rigour from a Kaupapa Māori perspective includes: the initial sharing of ideas and planning with whānau, tipuna, iwi, Māori nurse colleagues, hui, potential research whānau, professional doctorate colleagues and Te Whare Wānanga o Awanuiārangi staff. Rigour encompasses Māori colleagues suggesting topics to be researched and making the challenge to get it done. It includes networking, debate, dialogue and ongoing korero. Rigour entails producing quality research that can be read and used within the vast community of health, government, colleagues (both Māori and Tau iwi) and whānau within the community. Rigour also includes the guidance and dialogue with a Māori Advisory Group.

2.7. Māori Advisory Group

Elders, Indigenous researchers, and Indigenous participants provide insights into the ethical grounding and engagement of the research and how it is shaped and shared (Kutz et al., 2017). A Māori advisory group was set up, consisting initially three well known Kuia/ Kaumātua from the community. However, the Kaumatua died in the proposal stage of the research. They worked with me, firstly with the proposal and ethics application, they suggested the title for the thesis and guided me with my analysis and development of my findings regarding tikanga. In practice, they read each chapter as it was written and then discussed with me their thoughts and feelings. They developed the research title and, hence, they guided me in all aspects of tikanga[38].

2.8. PART C: Reflections on the Research Design

On reflection: as a Māori researcher, gathering data from a collective perspective was a humbling experience, especially when the participants stated: ‘we just want to help you Ann’ and ‘this work is too important’. I humbly accepted the narrative as a taonga and treated the stories with respect, also treating the participants with respect and as taonga. I

[38] Tikanga: a set of beliefs and practices associated with procedures to be followed in conducting the affairs of a group or an individual (Mead, 2003, p. 16).

remembered, as I progressed through the research, that as part of a collective I cannot let my participants down and I have to weave the data with that in mind. The aim was to try and be successful in the work so that the stories could be heard and not left on a shelf somewhere. This process was more than an obligation but deeper. That connection with the participants is similar to that which is reflected in the nurses' connection with whānau in the community (whānaungatanga).

The analysis and writing of the findings are about privileging the participants' voices. The voices being heard may lead to changes being made that enhance and enable Māori nurses' practice.

The method at times included humour as part of the korero. Listening and silence were also part of the process, as was time. Although I had stated the interview would take an hour because of the participants' time constraints, taima[39] was at the participants discretion. In one instance, I shared a meal with my participant. We sat in the sun at a restaurant and enjoyed a korero and kai, the open-ended questions moved into stories, sometimes sad stories, mostly good stories. These were the taonga that I was privileged to hear; these were the voices, the stories I had to protect. When we reached the end of an hour of the interview, I signalled that the hour had been reached and my participant waved it aside and kept talking. So, I ordered more coffee and we spoke for two and a half hours.

The formulation of the research question was easy, if not broad in hindsight. But I had talked to Māori nurses and had worked with them, so I knew what they needed from me and the kaupapa of interested Māori within the profession and community. However, it was important not to enter into the research with assumptions but allow the data to do the informing.

The next chapter initially covers five selected policies/policy statements that impact on the Māori nurses' practice in primary health care and hence on Māori health. Each policy focus is examined and then a level of analysis is applied to the participants' data, using questions drawn from a Kaupapa Māori perspective. The chapter then discusses the findings relevant to health policy.

[39] Taima: time.

CHAPTER THREE: The New Zealand Primary Health Care System

Nga hiahia kia titiro ki te timata, a, ka kite ai tatou te mutunga.
You must understand the beginning if you wish to see the end (Jackson, 1988).

3.0. Introduction

The government influences Māori nursing practice through health policies. Health policies and their strategies (as noted earlier) in primary health care set out to provide guidance and the intent of high quality health care for the community.

In Part A, the chapter identifies five relevant policy statements/objectives.

In Part B the chapter analyses Ministry of Health policy/policy statements (see level one Figure 2, p. 34) using an analysis developed from a Kaupapa Māori approach.

In Part C, the chapter discusses the impact of health policy on Māori nurses and their practice. The conclusion identifies recommendations from this chapter's findings.

3.1. PART A: Key Health Policies/policy statements

As outlined in Chapter One the key research question is, '*What are the experiences of Māori nurses working in primary health care?'* In order to expand the answer to that research question, the research investigates the following question:

How does health policy support the development of the Māori nurse's workforce?

Māori health policy sets out to improve the health of Māori. In this chapter it begins by critiquing five policy statements/objectives (relevant to the Māori health policy), by defining their context, stating their associated problem and discussing evidence from the literature (Bardach, 2012; Collins, 2005).

I refer to The Treaty of Waitangi at times and Te Tiriti o Waitangi at other times although they are both part of the Treaty of Waitangi – the Treaty of Waitangi is the English version and Te Tiriti o Waitangi in reo is the Māori version hence Te Tiriti will be used in reference to the Māori version. Both versions have differing meanings or interpretations.

The Treaty of Waitangi is foundational to health policy in Aotearoa (Came, Kidd & Goza, 2020). The main policy influencing Māori health is the Māori health policy, in which four of the five policy statements/objectives below belong. However, Came et al. (2020) completed a critical Tiriti analysis and found that there was limited alignment with Te Tiriti and Māori health policy. They stated that Indigenous content needed to be strengthened to address inequalities (Came et al., 2020).

The five relevant health policy objectives/health policy statements focus are as follows:

i) *To build a strong Māori health workforce (Ministry of Health, 2016b)*

ii) *Reducing inequalities in health for Māori (Ministry of Health, 2011)*

iii) *Recognising and respecting the principles of Te Tiriti o Waitangi (Ministry of Health, 2014b).*

iv) *Better sooner, more convenient health care in the community including more collaboration between health professionals (Ministry of Health, 2011).*

v) *Cultural safety (Nursing Council of New Zealand, 2017).*

This section examines each policy focus and then applies a level of analysis using questions drawn from a Kaupapa Māori perspective by asking:

a) *What role did the Treaty of Waitangi play in informing policy?*

b) *What was the involvement of Māori and where did it occur?*

c) *What were the recommendations made for Māori?*

In doing so the thesis intends to establish to what degree Māori/ Māori nurses have been accounted for and enabled within the policy processes thus enabling Māori nurse workforce development and influencing the Māori nurse and their practice.

3.2. PART B: The Critique: Analysing the Policy/policy statements

i) Building a strong Māori health workforce

To *Build a Strong Māori Health Workforce* (Ministry of Health, 2016b) sets out to develop a strong Māori health workforce that works in partnership with Māori. This indicates that that workforce includes a commitment by non-Māori as well.

The intent is to enable Māori to become healthy and reach their potential as individuals and whānau. As Mantell (2003) states, workforce development is a social process that requires shared involvement, collective action, leadership and innovativeness, which would result in a meaningful strategy for Māori. Because as Kaupapa Māori defines, Māori need to be involved as partners in their development (Mantell, 2003).

What role did the Treaty of Waitangi play in informing policy?

The role of the Treaty of Waitangi in workforce development is through the application of the principles of partnership, participation and protection. These principles underpin the relationship between the government and Māori. The principal partnership involves working together with Māori to develop strategies for Māori health gain and appropriate health services (Ministry of Health, 2014b).

What was the involvement of Māori and where did it occur?

One way that Māori was involved was through *He Korowai Oranga*. This Māori health strategy aimed at Māori workforce development and included Māori participation in the health and disability sector. One of its objectives was to increase the size and improve the skills of the workforce. *Raranga Tupuake: the Māori Health Workforce Development Plan* (Ministry of Health, 2006b) had a vision of 10-15 years and set out to realize the above aim of He Korowai Oranga: Whānau Ora.

What were the recommendations made for Māori?

The Tiriti o Waitangi Article One states - a sharing of power between Māori and the Crown. As a result, He Korowai Oranga sets out that the health system will work with Māori with an aim to empower whānau by placing them at the centre of services. This will enable whānau to make decisions and take opportunities about what they need and how they access services. At the same time the Ministry believed that Māori would

achieve better outcomes in areas such as health, education, housing, employment and income levels (Ministry of Health, 2018).

Health Workforce New Zealand (Ministry of Health, 2014b) was set up in 2009 to provide strategic leadership to New Zealand's health and disability workforce challenges. This group flagged many concerns, these included that nurses registering needed employment and the development of a workforce needed to reflect its population makeup.

The policy 'to build a stronger Māori health workforce' enables many options and the literature identifies several of those options in its quest to build the workforce (Durie, 1999). More recently, Ratima et al. (2007) undertook comprehensive research about the Māori health and disability workforce documented in *Rauringa raupa: Recruitment and retention of Māori in the health and disability workforce*. They stated that six areas contribute to workforce development and provide a useful framework. They are workforce development infrastructure; organisational development of health care providers; training and development; workforce information, research and intervention evaluation; plus, recruitment and retention. The latter impacts heavily on Māori nurses in primary health care. However, the six areas are not clearly evident in workforce development.

There have also been development plans set out by the government, in order to meet the policy needs and build a 'strong Māori health workforce'. These have included *Te Uru Kahikatea* (Ministry of Health, 2010b) the national workforce development plan. The plans timeline was 2011-2017, and it set out to support growth and development of the public health workforce. The plan compliments and progresses the work of the Phoenix research (2004).

Whereas the *Raranga Tupuake: Māori Health Workforce Development Plan* (Ministry of Health, 2006b) set out to build a competent, capable, skilled and experienced Māori health and disability workforce over 10-15 years. Its goals were to increase the number of Māori in the health and disability workforce; expand the skill base of the Māori health and disability workforce and enable equitable access for Māori to 'training' opportunities. Its actions included examining retention issues for the workforce and encouraging Māori health providers to support career pathways for their staff. The latter is occurring, but retention remains a struggle for Māori health providers who employ registered nurses.

Lastly, *E Ara Tauwhaiti Whakarae: National Māori Public Health Workforce Development Implementation Plan* which was completed in 2007. Hence, the Government has explored a variety of strategies in order to improve the Māori workforce and make a difference to health disparities. However, there has been little change. Possibly the reason behind this is because the Phoenix Research (2004) who surveyed several nurses in its survey (and whom the government drew on for its information), did not include Māori nurses in its development plans. Nor were Māori nurses invited into Mantell's (2003) shared involvement, collective action, leadership and innovativeness in the development of a Māori workforce. However, when developing a strong Māori health workforce, Māori nurses are an intricate part of that team and the following four health policy statements are relevant to building a strong Māori workforce and in particular and relevant to this thesis a strong Māori nurse workforce.

ii) Reducing Inequalities in health for Māori

The policy objective to *reduce inequalities in health for Māori* (King, 2001) is written into most government health policies as it is well known that social, cultural and economic factors cause substantial inequalities in health (Griffiths, 1998; Hill & Fox, 2013). Inequalities in health refers to the health status of Māori in comparison to non-Māori and displays a disparity for Māori in health.

The problem is that disparities in health are not being addressed because the measures are being applied equally across all groups with 'cultural additions' supposedly providing inclusion of Māori. The literature suggests that inequalities of health are illustrated in studies which measure mortality, morbidity, disease and the burden of risk (Russell, Smiler, & Stace, 2013) therefore it would seem pertinent to address more explicitly the needs of Māori as central to the policy focus rather than as additional. While this policy enables strategies to be developed (that focus on breaching the gap between the health of Māori in comparison to the health of non- Māori), there are fundamental problems which suggest that this will not be the case.

What role did the Treaty of Waitangi play in informing policy?

As noted previously, the role of the Treaty of Waitangi in health policies is through three of the principles - partnership, participation and protection which underpin the relationship between the government and Māori. In this instance, protection involves the government working to ensure Māori have at least the same level of health as non-Māori

and safeguarding Māori cultural concepts, values and practices (Ministry of Health, 2014e).

What was the involvement of Māori and where did it occur?

Participants of a hui held at Hoani Waititi Marae Auckland, in March 1984 aired concerns about the state of Māori health. This hui was well attended by Māori health professionals and focused on several concerns, including the need for Māori involvement in health service design and delivery (Ramsden, 2015). The hui also voiced further its concern regarding the need for government to recognise the growing body of evidence that Māori health and disease issues were different from Pākehā and so required different strategies to address health issues. This hui was one of many where Māori were asking for change.

What were the recommendations for Māori?

Since the introduction of the New Zealand Primary Health Care Strategy in 2000, there has been a requirement of both the Ministry of Health and the District Health Boards to reduce disparities by improving the health outcomes of Māori (Russell et al., 2013) in comparison to non-Māori but according to Mauri Ora Associates (2008) this has not occurred.

iii) Recognises and Respects the Principles of Te Tiriti o Waitangi

Recognises and respects the principles of Te Tiriti o Waitangi (Ministry of Health, 2016b.) refers to the recognition and respect for Te Tiriti by health professionals in their practice whilst working in partnership with Māori, in a protective manner and enabling the individual/whānau to participate in the planning of their care. Te Tiriti is written into health policies within the health organisations (mainly as mentioned above, with three of the principles, that of partnership, participation and protection). Te Tiriti is also linked with ethics and cultural safety in nursing practice.

In practice however, Wilson (2004) (as mentioned above) proclaims that in terms of te Tiriti, the health interests of Māori have not been protected, or equally funded. She argues that ***Article 3*** of Te Tiriti establishes the right of Māori to experience the same health as other New Zealanders, nevertheless health disparities remain. As Reid and Robson (2006, p. 3) assert, "Māori have the right to monitor the Crown and to evaluate Crown action

and inaction". They maintain these rights derive from both the rights of Māori as Indigenous peoples and as partners to Te Tiriti o Waitangi.

In theory the model works well, but in practice (as evidenced by the nurses interviewed), it is not always adhered to. For instance, Te Tiriti states in ***Article 4*** that Māori customs relating to health will be protected. From a nursing perspective, this means that culturally competent practices are required by law for health. Hence, there is an expectation that Māori nurses will provide a service, that meets the needs of the Māori community.

What role did the Treaty of Waitangi play in informing policy?

The Treaty role in this policy statement/objective should be to ensure that Māori have equitable health outcomes through access to high-quality health services that are responsive to their aspirations and needs (Ministry of Health, 2014b). However, as Wilson (2004) alluded, this is not happening adequately.

iv) Better sooner, more convenient health care in the community

The *Better, sooner, more convenient health care in the community* statement sets out to deliver a more personalised primary health-care system closer to home (Ministry of Health, 2011). The Better, sooner, more convenient statement does not outline a specific strategy or position on Māori health. However, this policy is relevant to Māori health as it directs everyone in the health and disability sector to work collaboratively and provide high quality and effective services (Ministry of Health, 2016b).

Whilst one of the aims of the statement is to create 'Better' services for patients in primary health care, this includes a need for primary care and secondary care to work together collaboratively – sharing patient information more readily and working together with patients (Ministry of Health, 2011, p.3). The health professionals referred to within this sector include nurses, general medical practitioners, pharmacists and social workers.

An associated problem within the primary health care sector is there is a 'silo mentality' (McCartney, 2016) and the actual health care service delivery tends to be fragmented (Cumming, 2011). Hence, health professionals tend to work in silos and therefore information is not shared. This includes poor communication occurring between

services especially primary and secondary care (Cumming, 2011). However, if health professionals are not working together and services are fragmented there is a likelihood that Māori are not involved in the participation of their health care.

Evidence in the literature identifies that thousands of New Zealanders seek advice or treatment from health services every week (Ministry of Health, 2011). Ninety per cent of those interactions occur in primary health care. International literature also suggests that primary health care orientated health systems are more effective, equitable and efficient (Starfield, 2011).

What role did the Treaty of Waitangi play in informing policy?

The role of the Treaty of Waitangi in health policies again, is through its principles of partnership, participation and protection which underpin the relationship between the government and Māori. However, because *Better, sooner, more convenient health care in the community* did not have a strategy for Māori, the role of the Treaty in informing the broader strategy was minor/negligible.

What was the involvement of Māori and where did it occur?

The policy objective encouraged more personalized primary health care that resulted in the devolution of services to Māori communities and the development of Whānau Ora models of care to improve Māori health (Cumming, 2011). The aim of Whānau Ora was to see the patient rather than the organisation at the center of service delivery. Māori providers from various sectors (social and health) were encouraged to work together so that a coherent approach would enable whānau development. Māori involvement should also include consultation with Māori.

What were the recommendations for Māori?

Although there was no strategy specifically for Māori, the policy enabled for Māori to have access to health care that is readily available, affordable, in their community and of a high standard. This was provided by Māori health care services.

Māori health providers provide high quality and effective services, but these are not always used by Māori in need of health care as they tend to use hospital Accident and Emergency services. However, the Ministry of Health (2011) argues that while the new approach is removing barriers and creating a continuous health service, they are of the opinion that from the patient's point of view, they don't necessarily know (or care) who

the person treating them is employed by – but they do care about whether the services they receive are good.

However, as will be demonstrated later in this research, this statement by the Ministry of Health, contradicts data from the interviews, where some Māori state they prefer Māori nurses (P 2/1)[40]. The removal of barriers and creating a continuous health service are, however, a positive move.

The 'Sooner' aspect of the policy "… involves less waiting time for patients. By providing more services in the community and creating a smoother flow between different parts of the health service, patients get treatment more quickly" (Ministry of Health, 2011, p. 2). However, 'More Convenient' – most people live closer to their general practitioner than they do their local hospital. It is almost always easier to arrange a time and day that best suits a person at their local general practitioner than it would be at a hospital (Ministry of Health, 2011) however hospital care is free.

This inter-professional collaboration has become accepted as an important component in today's health care and it is widely accepted that collaboration amongst health professionals improves client outcomes through enhanced communication and increased accessibility to services (Engel & Prentice, 2013). But this will not occur whilst nurses are experiencing discrimination from other health professionals. Working together requires a partnership in which equality and human rights are reinforced (Kurtz et al., 1917). Attitudes have to change, amongst health professionals and this links into health.

Consequently, with non-Māori unaware that their racist comments are distasteful to their Māori colleagues, collaboration in practice is difficult. Cumming (2011) suggests that a focus on changing cultures and attitudes and the need to take the time to develop co-operation and collaboration are critical to success.

v) Cultural Safety

The Nursing Council of New Zealand's policy *cultural safety* is also a concept that threads through the research, linked to patient safety and Te Tiriti o Waitangi. The associated problem within this research is the concern that cultural safety education in

[40] P 2/1: Participant 2/ interview 1 refer p. 65.

nursing has moved away from Irihapeti Ramsden's vision of nursing education that prepared nurses to care for tangata whenua (Indigenous people of the land). It is important that nurses provide competent cultural care for all patients. However, if nursing is serious about breaching the gap between Māori and non-Māori patient's health status then learning about cultural safety for tangata whenua is paramount. On reflection, if nurses fully understood the culture of tangata whenua, would racial discrimination towards Indigenous nurses fade away?

In the literature, cultural sensitivity is concerned with having knowledge about ethnic diversity (Ramsden, 2002). Ramsden states that "this seems to be the basis of misinterpretation of the concept of Cultural Safety. The term 'culture' is read as 'ethnicity' …" (2002, p. 118).

Richardson (2010) defines cultural safety as a partnership between a nurse and her patient/whānau and the provision of effective and safe care that meets the person's health care needs in a way that maintains the patient's personal, social and cultural identity (p. 34).

What role did the Treaty of Waitangi play in informing policy?

The Nursing Council of New Zealand's code of conduct requires nurses to practice in compliance with the Treaty of Waitangi (Nursing Council of New Zealand, 2017). Hence the role of the Treaty is to work with nursing practice through its principles of protection, partnership and participation. This is a positive step as the Nursing Council of New Zealand endorses the role of the Treaty, perhaps even more so than Government.

What was the involvement of Māori and where did it occur?

In partnership with the Nursing Council of New Zealand, Irihapeti Ramsden refined the concept of cultural safety and its application into nursing education. This occurred as a result of questions being raised by Māori about nursing care. For example, at a Māori nursing student hui (Waimanawa in 1988), one student is reported to have asked "legal safety, ethical safety, safe practice/clinical base and a safe knowledge base were all very well to expect from graduate nurses, but what about cultural safety" (Wepa, 2005, p. 17). Irihapeti Ramsden was at that hui and pulled together many hui involving the consultation of Māori nurses and iwi[41] in a process to develop the concept cultural safety.

[41] Iwi: tribe.

What were the recommendations for Māori?

The paradigm shift in nursing education which included cultural safety was a relief for Māori nurses, as whānau were finally to receive culturally competent care. For Māori patient's cultural safety enabled safe care and their needs seen to. The intention of a culturally safe environment enabled recruitment drives that encouraged Māori to consider enrolling in nursing as a career.

It also includes cultural safety and the Māori registered nurse practicing in the community working with and implementing the policies, including te Tiriti and cultural safety. Health policy (as seen below in Figure 4) has an impact on Māori nurses, as it is the government's blueprint regarding the process of health care for the community.

Figure 4 (below) sets out the framework for the working relationship for the policies, te Tiriti as the founding document of New Zealand and its principles.

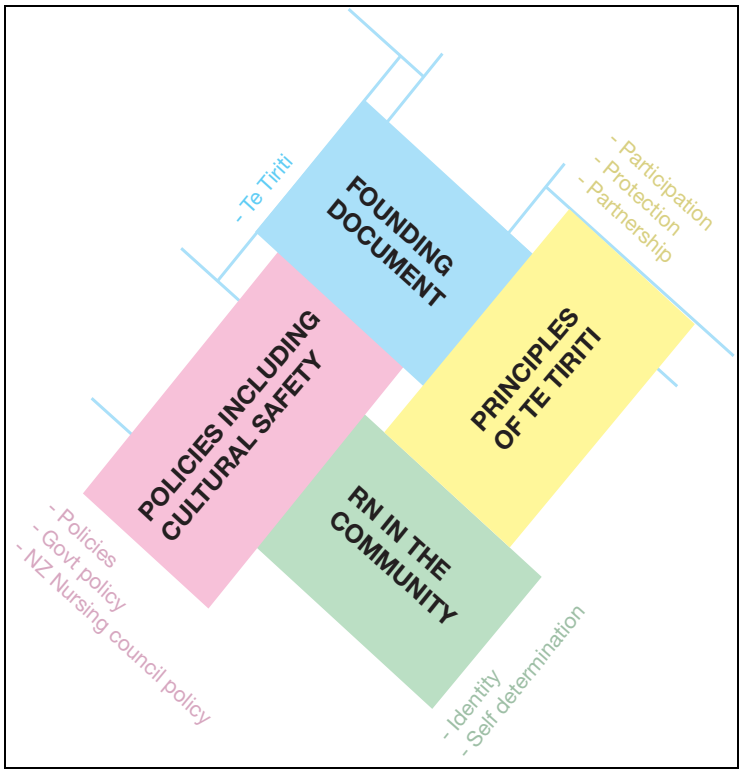

Figure 4: Policies, Cultural Safety and Te Tiriti o Waitangi (adapted from the research)

Hence the New Zealand Health care system plays a major role in Māori nursing, from government health policy down to working at the 'coalface'. However, for all of the good intentions of government health policy, Participant 2 states "*you know there is someone*

at the top in Wellington making the decisions, and they don't fit with us at the bottom, they are not Māori" (P. 2/2).

3.3. PART C: Discussion - The impact of policy on the Māori nurse workforce development and practice

Wilson (2004) suggests that the main role of health policy is to set and determine the direction of health services and their delivery, and to influence the access and use of health services. These policies are developed from best practice but can be interpreted in many ways and can be used by politicians to their own advantage. In Aotearoa, policy is the government's blueprint for the process of health care for the community. Hence, the selected health policies have an enormous effect on the nurses at the 'coalface'. In fact, all health policies have an effect on nurse's practice both nationally and internationally (Taft & Nanna, 2008; Salvador, 2010).

The findings from this research suggest that although policy is tied into nurse's practice, nurses struggle with many challenges associated with those policies. For example, while nurses strive to make a difference, (to improve Māori health and alleviate the *disparities in health* for Māori), they are often under resourced and unsupported resulting in a difficulty to achieve their health goals and targets. Furthermore, while the policy to 'reduce inequalities in health' is written into most government documents, the government in the past years has continued to ration health funding, making it difficult for those in the health services to also obtain this goal.

The *Raranga Tupuake: Māori Health Workforce Development Plan* (Ministry of Health, 2006b) promoted equitable access for Māori to training opportunities and student loans. For nursing equitable access generally works well, with Māori health providers supporting their nurses in further educational development.

There have been many programmes set up by government to encourage Māori workforce development. However, not all of these programmes have been useful for Māori. For instance, NEtP (Nurse Entry to Practice; a District Health Board education programme for new nursing graduates) has contained barriers, which can hinder Māori nurses from attending and upgrading their career pathway. A significant barrier is that there are insufficient places in the programme (New Zealand Nurse Organisation, 2017b).

Furthermore, the programme is pitched towards furthering competencies in secondary health care, and not so relevant to nurses working in primary health care.

The environment at times is difficult to negotiate but most of the time very rewarding as the nurses make a difference to many people's lives and develop a passion for their work. However, there is a high turnover of Māori nurses leaving the Māori health providers. This has a domino effect as new nurses take time to "train up" to provide high quality care, build rapport with their client base and gain trust within the community.

The policy to 'build a strong Māori health workforce' is important. The literature identifies that the percentage of Māori nurses in the workforce should reflect the Māori population numbers. However, as Māori in the community request health care to be provided by Māori nurses, Māori nurses struggle to gain employment and there is a high turnover of Māori nurses in primary health care.

Discrimination, prejudice and institutional racism disrupt any chance of the policy fulfilling a *collaboration of health professionals working with Māori nurses in the community.* The nurses are marginalised and hence trust and sharing of resources, knowledge and skills with other health professionals is often made impossible. That results in hindering nurse's ability to *build* and be part of *a strong Māori workforce.* Hence, the policies become just rhetoric and do not line up with the nurse's practice or the nurse's expectations of care and ability of making a difference to the health of the Māori community.

Hence, the Treaty of Waitangi should protect Māori. From a nursing perspective cultural safety should guarantee Māori culturally competent health care. The role of The Treaty through its principles is to enable Māori participation in their health care. Te Tiriti should also enable Māori partnership in decision making in health right from policy making down to health care in the community. Therefore, it is about the power to protect what it means to be Māori.

Each year the financial aspects of the health system are further trimmed, health policies are 'tinkered' with and contract specifications become more demanding. The New Zealand Council of Trade Unions estimated that $2.3 billion was needed to restore health funding levels for 2017/18 to 2009/10 levels (Rosenberg & Keene, 2017). They also stated that while the 2017 budget listed services will receive more funding, most of this will need to be paid by reductions in other services. This has a huge impact on nursing

care and community health. This also has a domino effect on clients/whānau and community who cannot reach their potential regarding their health, where nursing care becomes more complex, the individual suffers and the burden of care falls on the whānau.

The Government and District Health Board funders through fiscal control hold power (French & Raven, 1959 cited in Sullivan & Decker, 2009, p. 92) in the form of legitimate, reward and coercive power over the health services. Came (2012) suggests that power is also linked with organisational racism.

The funders are in the position to stipulate the terms of the nurses' contracts and the use of targets, which leaves the nurse concerned about their ongoing employment and low wages. This in turn signals unfair treatment of Māori nurses, a breakdown of *the Treaty principles* and a good example of unequal power relationships between Treaty partners. After all the Treaty principles are intended to be built on relationships, and those relationships are based on justice.

Māori have at times been involved to some degree in the development of health policy, health care and culturally competent care, for instance, Doctor Irihapeti Ramsden's dedication to the development of cultural safety. However, the present health inequities do not display success in this area. This lack of understanding in part has led to racial discrimination and an unsafe health care environment for Māori. Therefore, it is important that non-Māori nurses are able to demonstrate culturally safe and sensitive practices whilst working alongside Māori nurses and their clients, creating a safe work environment, ensuring respect, and avoiding unintentional discrimination (Gwynne & Lincoln, 2017; Katz, O'Neal, Strickland & Doutrich, 2010).

The *development of a strong Māori workforce* has been mentioned for decades. Pomare as the Minister of Health in 1909 spoke of a workforce strategy to develop a strong network of community health workers. He also advocated for more Māori nurses, and for them not to work in isolation but alongside community workers, one bringing clinical skills and the other leadership and a first-hand knowledge of Māori aspirations and existing conditions (Durie, 1999). Durie (ibid) also points out the nurses would be stronger working as a collective. From those initial thoughts much has been done in order to strengthen the Māori health workforce.

Nonetheless, there is a need for more Māori nurses, but Māori nurse retention is a concern. The retention of Māori nurses is hindered by several determinants such as pay

disparity and a lack of support and mentoring. The loss of Māori nurses is unfortunate as the knowledge and skills that Māori nurses bring to their clients in primary health care is the key to quality care and the potential for good health. Stuart and Nielson (2011) state that Aboriginal nurses are the most suitable nurses to provide optimal cross-cultural care for Aboriginal patients, due to having similar cultural backgrounds. While anecdotal evidence exists about how Māori nurse's practice differently and the challenges and layered complexities they encounter in their daily practice, little empirical research exists that captures their experiences.

Finlayson et al. (2009) stated that there is a concern that Māori registered nurses are hard to retain, and this is exemplified when future statistics of population expansion are explored. In the region under research, in the 2014/15 period the population grew to over 157,000 and compared to Aotearoa averages there is currently a higher proportion of Māori (twenty six percent versus fifteen per cent) and more people living in relatively high material deprivation (twenty-six per cent versus twenty per cent) (Ministry of Health, 2014d.). This also means a population experiencing more poor health and co-morbidity**.** The baseline demand estimates that demand for primary health care nursing service delivery will grow twice as fast as the population over the next twenty years, and twice as fast as the nursing workforce growth over the same period (Health Workforce New Zealand, 2010). The percentage share of European within the population is expected to decrease over the next twenty years as other ethnicities increase. The Māori population will increase by 1.7 percent of the total population by 2029. The Pacific population will increase by 1.4 percent of the total population by 2029; The Asian population will remain reasonably constant based upon current immigration policy. That is, the groups with the greatest health disparities (Māori and Pacific) are expected to undergo the highest population growth (Health Workforce New Zealand, 2010).

There remains a demographic mismatch between the nursing workforce and the general population. The percentage of Asian Registered Nurses exceeds that of the Asian population in sixteen of the twenty District Health Boards whereas Māori nurses are under-represented in all District Health Boards (Ministry of Health, 2014a). The percentage of Māori nurses is slowly increasing, from 3.6 percent in 2009 to 6.6 percent in 2014 (Ministry of Health, 2014a) to 7 percent in 2016 (O'Sullivan, 2016). New Zealand's Māori population is ageing and has high levels of complicated health conditions, for which the government agency Health Workforce New Zealand said there

needed to be a tripled Māori workforce by 2035 (O'Sullivan, 2016). Hence, according to North et al. (2013) the need for high quality nursing is urgent, however the retention of nurses is dependent upon multiple factors such as employment context, nursing leadership and workload management.

Another factor influencing the retention of Māori nurses is the isolation in which they work, (this was also noted in Conway et al.'s (2017) Indigenous Australian study). Although the Māori nurses are supported by their organisation, they often have little contact with other Māori nurses. The Māori registered nurses working with the Māori providers appear to rarely communicate to share resources, discuss case studies and mentor/support/awhi new nurses joining their geographical region. Wenger and Snyder (2000) warn that practitioners should not manage their knowledge in isolation, as this hampers growth and development. It seems that new registered nurses learn on the job with minimal preceptorship, and their new position involves a new language, including new ways of 'doing things' (for instance, Med Tech[42] software). This includes the creation of new knowledge but again to a degree in isolation even though new policy has tried to deal with this (Ministry of Health, 2011).

Research has identified a need in primary health care for collaboration between different nursing groups; these professional networks assist collegiality and improve professional practice (Finlayson et al., 2009). For non-Māori nurses this can lead to an understanding of cultural difference. With Finlayson et al.'s research in mind, it is suggested that Māori nurses' network within a supportive environment such as a Whānau of Practice or known internationally as a Community of Practice. This entails a professional group accessing resources and networks that create a safe working environment and includes the modeling of good practice through dialogue, debate and the sharing of resources (Wenger et al., 2002). It also enables the instigation of change and enlightenment through understanding. A Whānau of Practice is relevant to Aotearoa as it takes into consideration the cultural needs of Māori nurses, for instance a karakia (prayer) before a meeting begins.

The research further revealed that a Whānau of Practice would provide the nurses, with much needed support. But the reality was that when a Whānau of Practice was established in the area under research the nurses did not attend. The nurses worked full time, had

[42] Med Tech: a computer package which enables health professionals to share patient health data.

work and whānau commitments, and some had to travel a distance to attend hui, hence attendance was difficult. They needed to be supported to attend.

Kulig's (2006) quantitative study of Canadian Aboriginal nurses identified a need for a supportive environment to enable ongoing training and education to support the nurse's retention. However, only 15.5% of the Aboriginal nurses stated their agency was adequate in meeting their learning needs (Kulig, 2006). As noted earlier, Vukic, et al. (2012) in their Canadian study found that being Indigenous enabled the nurses to gain the trust of Indigenous patients and to provide culturally safe care in the community settings. However, it would appear that in New Zealand, Māori nursing in primary health care – a unique nursing practice designed for Māori is not valued and retention is a concern. The nurses' dual competencies are not recognised and their importance to the Māori community is not acknowledged. In Huria, Cuddy, Lacey and Pitama's (2014) research, Māori participants identified a lack of acknowledgement of dual nursing competencies: while their clinical skills were validated, their cultural skills – their skills in hauora[43] Māori were often not.

As the health system has grown and developed over the past 20 years, health initiatives have developed to account for disparities for Māori, for instance, Whānau Ora (see p. 79).

International evidence suggests that enhancement of primary health care services for disadvantaged populations is essential to reducing health and health care disparities (Browne et al., 2012). However, *health disparities* in Aotearoa have not occurred overnight, and certain factors have led to the ongoing injustice health disparities has on Māori.

It is worth noting that traditionally the New Zealand Government provided health care from 'the cradle to the grave' (Prince et al., 2006) under the mantel of a welfare state. Since the mid-1980s there was a gradual shift to an economy driven agenda, which saw increasing user-pay health services introduced by successive governments. This has resulted in the need for health insurance. Meanwhile, those in need of health care/treatment particularly the elderly (who are living longer) or low decile groups are finding that treatment is unavailable. For those in need there are ranking systems that state who will get certain health care and when. These changes are fiscal in nature and result in extreme tensions in the health sector.

[43] Hauora: health.

Annette King the health spokeswoman for the New Zealand Labour party in 2015, stated that according to 2015 data (commissioned by Labour), health cuts showed that the Government was squeezing too hard and that the Government had cut $1.7 billion in the last 5 years off the health budget (Kirk, 2015). This meant that most of the District Health Boards were running at a deficit. This has also had a domino effect on the resources available to the nurses in the community.

A shortage of monetary funds is also prevalent, as surgical lists are slashed and secondary care struggles with a lack of money. This results in hundreds of thousands of New Zealanders living in pain and unable to access health care due to long waiting lists (Bagshaw et al., 2017). This impacts on Māori communities heavily as many occupy a lower tax bracket group, which includes the unemployed, homeless, those on sickness benefits and those employed on a minimum wage.

Although Māori led Primary Health Organisations have had a higher utilisation of their health care services many Māori are putting off seeking health care until they are extremely sick or have more complex disabilities than previously (Russell et al., 2013). The lack of health care is a barrier to reducing the gap in health inequities between Māori and non-Māori. Nurses understand this dilemma, as they struggle to meet the needs of their clients and continue to try to improve the health of Māori with limited resources.

Cram and Ashton (2008) suggest that in New Zealand, inequities in health are regarded as avoidable, unnecessary and unjust. Reducing inequities is therefore one of the main objectives specified in the New Zealand Health Strategy (Cram & Ashton, 2008). Widodo (2007) proposed that access to health for Māori was also a barrier and suggested that New Zealand policies reduce the inequalities of access to health care. But in New Zealand that struggle continues today, as many Māori still do not have access to health care and Māori health statistics remain a concern.

Negative attitudes towards Māori feeds into the myth that the cause of disadvantage is that Māori have not 'adapted' or have failed to grasp the opportunity that society offers, and that poverty is the fault of the poor (Puao-te-ata-tu, 1988). They continue that the fact is that monocultural organisations manifest a bias and the culture which shapes and directs that bias is Pākehātanga.

The reality is whānau find accessing health care services, challenging for many reasons including poor understanding of the health care system, lack of confidence in their general

practitioner, lack of transportation, limited education, and limited financial resources (Russell et al., 2013).

In New Zealand, poor chronically ill adults even with a community services card[44] pay exorbitant payments for primary care services and will avoid seeking care for that reason (O'Brien. 2005). Hence, Crengle et al. (2005), McCreanor and Nairn (2002), and Jansen and Smith (2006) suggest that the solution to reducing the lower level of Māori access to primary health care services would involve addressing typical barriers such as costs and policy, also improving communication skills and attitudes of health care providers. Jansen and Smith (2006) suggested that primary care providers, like other health professionals, may unwittingly provide less care to those with the greatest health needs because of lack of cultural or social concordance. They added that doctors and nurses lack of understanding inhibits the therapeutic relationship, and this in turn impacts the care received (Jansen & Smith, 2006, p. 299).

Lee (2012) found that solo Māori mothers also faced many barriers when accessing community health care. These included: unhelpful attitudes of health professionals, stigmatisation and marginalisation, and the need for Māori health professionals and culturally safe healthcare. The need for Māori health professionals is also reflected in the comment "Primary care providers … may unwittingly provide less care to those with the greatest health needs because of lack of cultural or social concordance" (Jansen & Smith, 2006, p. 299).

To add to this, the Māori Asthma Review (Pomare et al., 1991) reported that conscious or unconscious attitudes of health workers contribute to a reluctance by Māori to seek medical care for their asthma until it was absolutely necessary. Another study reported barriers to accessing diabetes care among Māori, included unsatisfactory previous encounters with professionals and experiences of disempowerment (Simmons, 1998).

While services to improve access to care and service utilization rates are considered performance indicators, nonetheless from a Māori health provider perspective these indicators do not consider some of the other dimensions of health care that are important to Māori communities, such as levels of whānau and spiritual wellbeing, culturally appropriate service delivery and a prioritised commitment to Māori workforce development. As Durie (2003) has stated, "In moving from input and output measures to

[44] Community services card: is a card which entitles the holder and their family to a reduction in the cost of some health services and prescriptions.

measures of outcome, … there is a corresponding need to frame indicators around Māori perspectives of health" (p. 6). These comments suggest that health care is incompatible for Indigenous people when planned from a solely monocultural focus.

Therefore, access to Māori nurses in the community becomes important, and often the nurse transports the client to the general practitioner (or specialist) and accompanies the client to advocate or interpret for them. Providing a service that is user friendly for Māori is paramount. This includes using a Māori model of health care which is traditionally holistic and includes considering the whole whānau not just the individual (unless that is the clients wish).

The Government has established workgroups to develop tools that will deal with and monitor the inequalities in Māori health. These include the Health Impact Assessment which is a tool designed to produce evidence-based recommendations to inform decision-making about proposed policies in order to maximise their positive and minimise their negative impacts on health (Haigh et al., 2015). Another tool is The Whānau Ora Health Impact Assessment Tool which was developed for use by policy makers as a tool for assessing the positive and negative impact of their policies on Māori and to identify ways in which these can be enhanced or adapted (Ministry of Health, 2017a). Health Equity Assessment Tool is also a tool used extensively by policy makers, funders and others, it's aim is to promote equity in health in New Zealand (Signal et al., 2008). Health Equity Assessment Tool's questions cover four stages of policy, which are: understanding health inequalities, designing interventions to reduce inequality; reviewing and refining interventions and lastly evaluating the impacts and outcomes of interventions. However, health statistics to date suggest this policy has not had an effect.

According to Russell et al. (2013) the status of Māori health is well researched in Aotearoa (New Zealand), with emphasis being given to outlining Māori health trends, disparities in Māori health, and comparing Māori health status with other population groups. Understanding the complexities underpinning disparities, and ways in which inequalities can be addressed, has been a key concern for many Māori health researchers (Kilbourne et al., 2006; Artinian et al., 2007). King (2001) recognised the need to address health inequalities as a priority, and the Treaty of Waitangi and the Government's role in meeting its obligations as a Treaty partner.

The challenge of resolving ethnic inequities[45] is complicated by the historic and some would say (Jackson, 2000; Mowbray, 2007) ongoing role of the state in both generating and perpetuating such inequalities[46] through their policies and practices (Came, 2014). Sheridan et al. (2011) believes that New Zealand health equity is firmly embedded in health care policies, with Māori as the population most explicitly prioritised because of Te Tiriti status. Just one opinion as regardless, these policies include rhetoric (often in the form of empty talk) or in other words, the policy maker has considered how they intend to 'sell' or convince others, or make the policy acceptable to society, therefore rhetoric plays a role in the policy process (Asen, 2010).

Doctor Heather Came suggests that the present health system disrupts service provision for those in need and fuels health inequalities (Awarau & Webby, 2017). The health disparities between Māori and non-Māori are a concern as the clients are presenting for treatment sicker as they are not seeking health care early enough. They cannot afford medical care, they do not have access to their general medical practitioner, or they do not feel confident in their general medical practitioner.

Reid and Robson (2006, p. 26) states there are three main pathways that contribute to ethnic inequalities in health. They are differences in disease incidence; differential access to health care; and differences in the quality of care received. The point here is a 'for Māori by Māori' workforce which enables high quality health care, health education and health promotion through home/Marae/Hui visits and/or better access to general medical practitioners and specialists would narrow the present disparities in health and have a positive long- term effect on chronic health conditions. It also means that whenever the health of Māori lags behind that of other New Zealanders (including the underutilisation of health services relative to need) this is a breach of Te Tiriti o Waitangi and of Indigenous rights (Forrest et al., 2011, p. 5).

Government health policies which are written from a Pākehā perspective, are not performing as intended for Māori nurses and their nursing practice. Although the health policies state that they will do a number of things – in actual fact they are failing to a build strong Māori workforce, lessen Māori health disparities, enable the use of the Treaty principles or protection by Te Tiriti, provide cultural safety for Māori, provide health care

[45] Inequitie: injustice or unfairness (www.meriam-webster.com).
[46] Inequalities: an instance of being unequal (www.merriam-webster.com).

that is better sooner, closer, more convenient care in the community and enable the collaboration between health professionals.

The New Zealand Health Strategy (King, 2001) and the New Zealand Health Strategy Future Direction of 2016 also aims to recognise and respect the principles of Te Tiriti o Waitangi (Ministry of Health, 2016b). Kingi (2006) suggested that by first examining the Treaty text, it is clear that both versions (Māori and English) make particular references to health. Nonetheless, the two versions can be interpreted differently. In the English version of the Treaty ***Article 2*** emphasises property rights and ***Article 3*** stresses individual rights.

In the Māori version of te Tiriti there are similar objectives to the non- Māori version however, due to translation the versions differ. ***Article 2*** places emphasis on Māori control over "things Māori" and further uses the words "taonga katoa" implying a connection between the Treaty and Māori social and economic development. ***Article 3*** in te Tiriti states that Māori are guaranteed the right to be treated equally under British law.

There has been a lot of debate regarding te Tiriti and its texts, within that debate there has been references to the Principles of te Tiriti as they are not included in te Tiriti texts. However, recognising and respecting the principles of Te Tiriti o Waitangi is included as a strategy within many government policies. In applying the principles, *He Korowai Oranga* supports a Māori holistic approach to health and wellness and aims to support Māori as they take control to improve their own health (King & Turia, 2002a).

Linked to the Māori view of health and Treaty principles, *He Korowai Oranga* seeks the following outcomes: that whānau experience physical, spiritual, mental and emotional health and have control over their own destinies; that whānau members live longer and enjoy better quality of life; that whānau members participate in te ao Māori[47] and the wider New Zealand society (King & Turia, 2002a). Still, Māori outcomes have never matched those of non-Māori – not only in health, but also within a full range of socio-economic indices.

Durie (2001) suggests "the continuing disparities in standards of health between Māori and non-Māori are clear indicators that much remains to be done" (p. 54) in order to fill the obligations of the third article of te Tiriti (which affords Māori state protection).

[47] Te ao Māori: Māori society.

The gap remains wide between Māori and non-Māori income, health status, educational attainment and employment, and indicates that Māori have not had reciprocal benefits guaranteed under Te Tiriti. The long- term concern of disparity regarding the health of Māori (morbidity and mortality) in comparison to non-Māori remains a Treaty issue**.** However, Te Tiriti suggests that the health of Māori needs to be protected (Wilson, 2004) as the third principle of The Treaty is protection. Protection involves the Government working to ensure Māori have at least the same level of health as non-Māori and safeguarding Māori cultural concepts, values and practices (Ministry of Health, 2017a).

Te Tiriti initially set out to provide for Māori equality of access to all society's goods, which included health, education and the necessities of a good standard of living. However, New Zealand health statistics suggest Te Tiriti o Waitangi is not providing a korowai[48] of protection, for Māori experiencing health concerns. According to the Crown and its agents (publicly funded health services and health care providers) have an obligation to meet Te Tiriti terms. However, Belgrave (2013) suggests that Te Tiriti o Waitangi has been watered down, as individuals interpret Te Tiriti Articles in different ways. For some, it is easy to believe that Te Tiriti settlements are all that is needed to right the wrongs of the past. But attitudes need to change from Government right through to the grassroots community, for an understanding of Indigenous people to occur and Te Tiriti to be honoured.

Hence, support for Māori in health care is important. It is an ethical requirement of nurses that they treat all people with fairness, beneficence, respect for autonomy, non-maleficence, justice and truthfulness. Nurses have a clear ethical component included in their knowledge and practice, and as Watson (1990) argues nursing is fundamentally a moral endeavour.

Cultural appropriateness and responsiveness are also pivotal in primary health care. Objectives, models and methods that reflect beliefs, values, aspirations and tikanga also lead to better engagement and better outcomes for Māori (Durie, 2006; Malony-Moni, 2006; Maniapoto & Gribben, 2003. Services that focused on whānau and their potential, rather than individuals and her/his problems have been shown to be successful (Maloney-Moni, 2006).

[48] Korowai: traditional Māori cloak.

Linked to a moral endeavour is that the nurses understand the cultural needs of their patients. Familiarity with a patient's cultural heritage has been shown to be associated with improved patient care (Laveist & Nuru-Jeter, 2002) thus rendering cultural competence is "essential for high quality healthcare" (Bloomfield & Logan, 2003).

The understanding of another's culture is also relevant for non-Māori nurses when they work and communicate with Māori nurses. In other words, a misunderstanding can result in devastating long-term effects as seen in Hineroa's story in chapter one. Māori nurses can be personally at risk through the experiences of prejudice, racial discrimination, and organisational racism.

Familiarity with a patient's cultural heritage has been shown to be associated with improved patient care (Laveist & Nuru-Jeter, 2002) thus rendering cultural competence "essential for high quality healthcare" (Bloomfield & Logan, 2003). Although the initial focus was on the cultural safety of Māori clients/ whānau from a Nursing Council of New Zealand perspective, my findings suggest that Māori nurses are also not culturally safe in many aspects of their mahi. This occurs in many forms such as the experience of racial discrimination, organisational racism and prejudice. Stewart (2011) found that there were workplace demands related to cultural safety for Māori staff. She believed that building a culture of respect and valuing te ao Māori through building cultural competence for all staff in the workplace was necessary. Perhaps, one of the keys in improving cultural safety for Māori clients, would be to once again look at biculturalism, once again look at nurse's attitudes and work towards a partnership with Māori (Crengle et al., 2004).

While the *'Better, sooner, more convenient health care'* statement aims to create several points including "an environment where health professionals in the community are actively encouraged to work with one another" (Ministry of Health, 2011, p. 3) - this is not happening. At the same time, this also includes hospital-based clinicians working with primary health care clinicians, with "a focus to deliver health care in a co-ordinated and co-operative manner" (Ministry of Health, 2011, p. 3), aimed at a seamless system between primary and secondary health care. A system where all health professionals share information, resources and respect each other.

What should be measured to gauge the effectiveness of services for Māori, and who decides what these measures are, has however not been outlined. Crampton et al. (2004) have noted that the increasing complexity of primary health care calls for more

performance measures that accommodate differing perspectives. Reid (2004) goes on to say, “It is no longer sufficient or appropriate to measure the levels of immunization, cervical smears, and recording blood pressure in a general practice – however a much broader approach to the evaluation of ‘quality’ is necessary” (p. 813).

The drive to put primary health care solely back into the community as hospitals had become overloaded with non-urgent primary health care clients, was a strategy to reduce the demand on expensive secondary care and reinforce the health policy of enabling people to stay in their homes. This also involved elderly clients, who were flooding the expensive alternative of elder rest-home care. Hence, the move to deal with primary health care in the community also saved labour costs, as the single largest budget item in hospital care are nurse’s wages (North & Hughes, 2012).

Part of the positioning of primary health care back into the community has been the setting up by government of a Health and Disability non-Government Organisation Working Group (2012) (which includes Māori health providers) at policy level. Initially this group identified many concerns as discussed in Chapter Three however, these concerns continue without any change.

I have belonged to many nursing and educational advisory groups including a Tiriti Monitoring Unit, and the Nursing Council Māori Advisory Group. These groups have been made up of highly experienced knowledgeable people. But the frustration for me is that the excellent work undergone within these groups by Māori has amounted to nothing. Suggestions and recommendations have fallen into a hole somewhere and hours have been wasted going over old information. The organisation concerned have ticked the box to state that they have a Māori Advisory Group in their midst, but the reality is that the group cannot make change or are simply not listened to.

Cultural safety is a pivotal part of the Nursing Council of New Zealand’s policies and it is also incorporated into nursing care as an evaluated competency. Cultural safety was initially developed by Irihapeti Ramsden in response to negative health care experienced by Māori (as mentioned in Chapter One). Cultural safety in nursing care has now become a normal part of nursing care. In fact, Māori Ora Associates (2009) noted an increase in the demand for culturally appropriate health services among young Māori.

Historically, there had been a growing concern about the state of Māori health, and this was reinforced by the participants of a hui held at Hoani Waititi Marae Auckland, in

March 1984. This hui was well attended by Māori health professionals and focused on several concerns, including the need for Māori involvement in health service design and delivery (Ramsden, 2015). The hui also voiced its concerns regarding the need for government to recognise the growing body of evidence that Māori health and disease issues were different from Pākehā. This hui was one of many where Māori where asking for change.

Following that, at a Māori nursing student hui (Waimanawa in1988), one student is reported to have said "legal safety, ethical safety, safe practice/clinical base and a safe knowledge base were all very well to expect from graduate nurses, but what about cultural safety" (Wepa, 2005, p. 17). Irihapeti Ramsden was present at the hui[49] and from there organised further hui, from which the concept of cultural safety was developed. Irihapeti Ramsden stated however, that cultural safety was not about the patient but about the nurse's behaviour and attitude toward patients and their ability or otherwise to create a trusting relationship (Ramsden, 1992). She also stated that cultural safety should begin with Māori.

Cultural safety is the effective nursing practice of a person/whānau from another culture that is determined by that person/whānau (Nursing Council of New Zealand, 2017).

A previous decade of Māori development (1984-1994) had highlighted historical issues related to access and equity for Māori using health services (Durie, 1992; Ellison-Loschman, 2001; Ramsden, 1993). Events at this time, surfaced the reality of health disparities between Māori and Pākehā and radical calls were made for Government to take action and deal with these inequities (National Council of Māori Nurses, 1987; Ngati & Pomare, 1992; Poata-Smith, 2001; Walker, 1990). As an analysis of Māori health status in studies such as the Hauora: Māori Standards of Health; Decades of Disparities I, II, and IV; Tracking Disparity series and the Tatau Kahukura Māori Health Chart Book (Ajwani et al., 2003; Blakely et al., 2004; Ministry of Health/Manatu Hauora & University of Otago, 2006; Blakely et al., 2007) all reported Māori had significantly higher morbidity rates than non-Māori, leading in almost every disease category; having a higher prevalence of chronic diseases than non-Māori; and experiencing higher mortality rates as a result of chronic disease.

[49] Hui- in Aotearoa this is a large social or ceremonial gathering.

Hence, to provide more appropriate care for Māori, in 1991, Irihapeti Ramsden developed cultural safety guidelines for nursing. A number of hui then occurred and cultural safety was further refined. Agreement was reached that culturally unsafe practices included actions which diminish, demean or disempower the cultural identity and wellbeing of person/whānau (Ramsden, 2002). Cultural safety set out to recognise, respect and nurture the cultural identity of the people of the land, and safely meet their needs, expectations and rights (Ramsden, 2002). These two points became the core of cultural safety.

The Nursing Council of New Zealand then brought in their Cultural Safety Policy. In other words, nurses would provide 'culturally safe' practice, and ensure that all patients were culturally safe when in the health care system. In primary health care, this included culturally safe practice in the community and when working in the whānau whare[50]. Cultural safety provides a structure which guides and assists the nurse to provide and manage care in a way that protects and sustains a person's identity and wellbeing (Richardson, 2011). Richardson defines cultural safety as a partnership between a nurse and her patient/whānau and the provision of effective and safe care that meets the person's health care needs in a way that maintains the patient's personal, social and cultural identity (Richardson, 2011).

There are many references to cultural safety in the literature (Ramsden, 2002; Wepa, 2005; Wepa, 2015). Richardson (2011) states that with the presence of other cultural concepts of health (for example cultural competency) cultural safety is at risk of being marginalised or misrepresented. She also suggests that Madeline Leininger's (1978) theory known as transcultural care leans towards a Eurocentric view of culture as 'other', and the culture and power of the nurse remains unexamined. Leininger's transcultural theory is a theory used widely in international nursing especially in North America. Her theory also, does not take into consideration the complexity of providing nursing care in cultural contexts such as New Zealand or from an Indigenous perspective. However, later Cultural Safety was changing from a bicultural focus to a multicultural focus, which is the focus today in New Zealand nursing.

Wepa's (2015) action research examined the experiences of cultural safety educators. She found that the participants not only coped with the stressors of everyday teaching but had to deal with recruitment and retainment of Māori nursing students, preparing cultural

[50] Whare: home.

safety lectures without support and coping with macro-issues such as dealing with their iwi (Wepa, 2015). Whereas Brascoupe and Waters (2009) from a Canadian perspective, explored both the concept of cultural safety and its practical implications for policies and programmes, developed to improve the health of Indigenous people and their communities. They found that cultural safety helped communities at risk and in crisis, engagement in healing and also led to lasting change. De Souza (2015) also examined the concept of cultural safety. She found that cultural safety is an Indigenous New Zealand nursing approach derived in response to inequalities for Māori, whereas cultural competence [which Nursing Council of New Zealand uses for assessing cultural safety competencies] is an imported paradigm derived from a multicultural context (p. 125).

Stewart's (2011) quantitative/qualitative thesis examined occupational stress amongst Māori health workers. She suggested that there were workplace demands related to cultural safety for Māori staff. She believed that building a culture of respect and valuing te ao Māori through building cultural competence for all staff in the workplace was necessary. Her participants noted that knowledge of support for Māori issues needed to start at management level; employing a clinical advisor, staff education and Treaty of Waitangi training, bi-cultural codes of practice, and that training and education about cultural safety was a necessity. She suggested that a workshop on cultural safety five years previously was not enough training to enable cultural safety for clients to occur and therefore there was a need for more regular updates (Stewart, 2011).

Genat, Bushby, McGure, Taylor, Walley and Weston (2006) also found that Indigenous health professionals may have the added pressure of a lack of cultural safety in the workplace, fellow staff and services that are not culturally informed or appropriate, battling embedded institutional racism, and a lack of recognition and respect for their status. Whereas a supportive and culturally safe workplace fosters cultural respect for Indigenous nurses (Thackrah & Thompson, 2013; Durey & Thompson, 2012). Aboriginal nurses also recommended that cultural respect be embedded in the workplace to improve retention (Cosgrave et al., 2017; Health Workforce Australia; 2011; Browne et al., 2013).

One of the main strategies regarding cultural safety is to involve client/patient/whānau in identifying their needs and the decision making of their care, both of which aid in enabling health professionals to maintain cultural safety within the health sector. The literature suggests that Māori are marginalised within the mainstream health system

(Barton & Wilson, 2008). It is crucial that Māori patients/clients/whānau experience competent cultural care when they are receiving treatment within the health care system.

The participants have displayed a unique nursing practice as Māori work and care for Māori. This is a kaupapa Māori practice, based on Māori culture, philosophy and principles. One which enables growth and healing, empowerment and mana. But one which differs from westernized practices. Indigenous people have specific needs, their needs are different. It is a colonization tact to group the care of Māori into the care belonging to all cultures.

Controversially, Ellison-Loschmann and Pearce (2006) point out that cultural safety education is an example of an initiative that has emerged within the context of macro-level government policies and has been shown to promote or greatly hinder the health status of Māori. Perhaps their latter point is because the Nursing Council of New Zealand's concept of cultural safety has changed immensely since Ramsden's (2002) initial definition. Ramsden (2002) stated that cultural safety is not about patients, it is about nurses, their behaviour and attitudes toward their patients and their ability or otherwise to create trust. Richardson and Williams (2007) suggest that the concept cultural safety provides recognition of the indicators of power ingrained in any interaction and the potential for disparity and inequality within any relationship.

This leads to the question, "How can safe nursing practice be assessed?" The New Zealand Nurse Organisation and the Nursing Council of New Zealand's codes and scope of practice standards have required registered nurses to demonstrate cultural safely practice and yet there is little concrete evidence or structure to assess this, and Ramsden (2002) cautions that although "nurses' own estimation of their practice is accepted and valid commentary it is a dubious form of evaluation"
(p. 171).

3.4. Conclusion

The five policy/policy statements above have important influences on Māori nurse practice. They call for a strong Māori workforce, an improvement in Māori health statistics, protection by te Tiriti o Waitangi, a culturally safe health environment for Māori and better collaboration between health professionals.

However, there are still gaps in these policy objectives. Caring and cultural safety for instance, are taught to nurses in tertiary institutes and universities from a westernized perspective. It is the belief of the Nursing Council of New Zealand that if nurses and prospective nurses know their own culture and have a little knowledge of Te Tiriti o Waitangi then they are prepared to care for people belonging to all cultures. However, the present nursing curriculum's (as each tertiary institute's nursing faculty has a different curriculum) does not prepare nurses to care for tangata whenua.

In conclusion, the recommendations developed from the policy analysis and nurse interviews are:

Policy One: A strong Māori workforce

Recommendation: That District Health Board funders re-examine the health contracts (specifications) in partnership with Māori health providers:

Firstly. enable pay parity for Māori nurses in line with mainstream nursing.

Secondly, develop an on call professional support system for Māori nurses.

Lastly, support monthly clinical and cultural supervision for Māori mobile nurses and School Based Nurses and provide an on- call support service.

Policy Two: Health disparities/Reducing Inequalities

Recommendation: That Māori Nursing Groups with the support of Te Kaunihera o Nga Neehi Māori, Nursing Council of New Zealand, College of Nurses and New Zealand Nursing Organisation set up Whānau of Practice groups. This would include not only monthly hui but, include a sub- group to develop networking via a website, texting and emailing. This would include the sharing of resources, upcoming events, availability of scholarships and financial assistance for study purposes and to present or attend conferences, case studies and the possibility of a tuakana teina (Māori buddy system) relationship developing.

Policy Three: Treaty of Waitangi

Recommendation: That the District Health Boards demonstrates a system that considers the needs of the Māori clientele and the potential for Māori to be cared for by

Māori nurses. Treaty of Waitangi honouring/implementation plans to strengthen commitment.

Policy Four: Better, sooner, more convenient health service

Recommendation: That the Nursing Council of New Zealand create opportunities amongst non-Māori nurses for discussion on institutional racism and racial discrimination in Aotearoa.

Policy Five: Cultural Safety

Recommendation: that the Nursing Council of New Zealand support the reassessment and redevelopment of nurse education on cultural safety regarding Māori clients/whānau, Te Tiriti o Waitangi and racial discrimination. This nurse education is to be included in the Bachelor of Nursing degree, annual registered nurse updates and in the Contemporary Nursing Certificate (a certificate for nurses re-entering the nurse force and overseas nurses entering the New Zealand nurse force for the first time).

This chapter examined five policies and their impact on Māori nurses and their practice. An analysis of these policies clearly linked them to the two major outcomes discussed in chapters four, five and six (power and racial discrimination). Through the analysis of these policies recommendations were developed which will also be reflected in the themes recommendations.

The next chapter continues to explore the New Zealand Primary Health Care System. It sets out the role of the Māori health providers, non-government organisations, Primary Health Organisations, government health care funders and primary health care. This chapter identifies major influences on the nurses and their practice, which include health organisations, Māori nursing as a unique nursing practice and health policy.

CHAPTER FOUR: The influence of other Health Organisations on the Nurses and their practice

4.0. Introduction

The focus of this research is on nursing, in particular Māori nurses and their experiences in the health care system. This chapter outlines the experiences of Māori nurses and how they relate and engage with the issues and challenges presented by the complex health system of Aotearoa.

PART A identifies several health organisations and how they impact on nurses and their practices and examines those relationships more explicitly. It draws on the literature and on the experiences of Māori nurses as told to the researcher during the interviews. The organisations examined are:

i) The Government

ii) The District Health Board

iii) The Māori health provider

PART B discusses two main research themes that emerged developed through the analysis presented in PART A of this chapter. They are pay and support inequities and administration overload.

PART C discusses Māori nursing practice as 'a unique nursing practice', one in which nurses provide a service for Indigenous people with high needs. This practice encounters power and powerlessness, a theme that will be further developed in Chapter Five, but also provides job satisfaction and the opportunity to overcome hardships to make a difference for whānau.

4.1. PART A: Health Organisations and their impact on the nurses' practice

i) The Government

The government influences Māori nursing practice through its health policies. Health policies and their strategies in primary health care set out to provide guidance and the intention to provide high-quality health care for the community.

Evidence from the interviews suggests that, when examining the connection between Māori nursing practice and health policy, there are two major forces that have ramifications for the nurses and their practice. One is the poverty that nurses see within their community. For instance, Participant 7 said,

> *You go into a home, you see a child that is half naked and doing it really hard …you know the cupboards are bare and the house is cold …I didn't know how to offload …what's my next step …so I think it was not having the resources to off load and you get a bit drained but it took me three years to realise that though* (P 7/2)

The other is the financial constraints that come through restricted government funding. "*It's interesting, aye certainly learn to live with no resources"* (P 3/2).

Nurses struggled with health policies that were failing them. Qualified Māori nurses were not being employed within the health care system as Participant 4 suggests,

> *There is something going wrong … I am saying it is like the emperor's new clothes …they are there so why are you not employing them …and they are asking where are our Māori workforce … six months after sitting State they have to leave, I just don't know where is going wrong* (P 4/2).

Or they are not being well supported or resourced and are therefore not able to adequately treat whānau in need, thus exacerbating health disparities. Participant 3 described how Māori nurses are not being treated fairly and are discriminated against, *"we are looked down on, not by the whānau but by other nurses … that happens all the time"* (P 3/1).

Under the terms of te Tiriti the health interests of Māori had not been protected or equally funded (Wilson, 2004). If the present New Zealand government was serious about health disparities, developing a strong Māori workforce, dealing with poverty and applying te Tiriti o Waitangi to health, then the New Zealand health care system needs to be fully funded as a priority, fair treatment as advocated by te Tiriti o Waitangi.

In September 2015, the Productivity Commission looked at ways to improve how government agencies commission and purchase social services. The Productivity Commission is an independent Crown entity, set up to provide advice to the Government on improving productivity (Productivity Commission, n.d.). In this report, they suggested

that silos had occurred because of the separate agencies for health, education, and justice. This fragmentation meant that no-one had visibility of the whole, of the system and its performance. They suggested that, by working together, the services would be more responsive, client focused, accountable and innovative.

In 2017 the Health Workforce New Zealand's Annual Report to the Ministry of Health, 2015 July 1st to 2016 June 30th (Ministry of Health, 2017c) recommended that:

1. 1500 nursing students graduate annually and need to be retained in the New Zealand Workforce,
2. New graduates need to find employment and Health Workforce New Zealand, (2010), are working to improve the positions to match population need,
3. New Zealand needs an additional 10,209 Māori nurses (Ministry of Health, 2017c).

On March 6th, 2017 the Ministry of Health announced, in its Health Workforce New Zealand strategic intent and priorities, its 'Engagement Philosophy' (Ministry of Health, 2017b.). This is a set of principles that guides the Ministry of Health in its work with the health sector. It includes: leadership; working with the whole of the health workforce including key occupational groups (including nursing); working for, with and through key stakeholders (District Health Board and Non-Government Organisations); and working with stakeholders to develop the best data and information sets (Ministry of Health, 2017b.). The Nursing Council of New Zealand is one of those stakeholders. The examples above are just a few of the developments instigated by the government.

There is a shortage of Māori nurses which means that there are deficiencies in the service provided by nurses in the community. Evidence of this situation is the ongoing resignation of Māori nurses working for Māori health providers. While nurses build rapport, connect and work closely with whānau, they leave for various reasons such as the offer of higher wages and better support. When a nurse resigns, this results in the disruption of health care provided for his/her Māori clients within the community and the employment of a new nurse. The new nurse needs to be upskilled, needs to build networks and learn about the community needs. For whānau, a change in nurse is about waiting for the new nurse to be employed, upskilled and learn a new routine. Hence, with a high turnover of nurses and when nurses change frequently, whānau become hōhā with the whole healthcare service.

For that reason, whānau would rather work with a strong Māori workforce (Stewart, 2016) and a workforce that is stable. However, and ironically, many Māori nurses are not

being employed and also a high turnover of Māori nurses persists, even though Health Workforce New Zealand, (2010) suggested New Zealand needs another 19,209 Māori nurses by 2028. Carryer (2016) (Chair of the Nursing Workforce Governance Group) suggested that the need was more urgent and in 2016 stated that an extra 4252 Māori nurses were needed to match the current proportion of Māori in the population.

Recruitment into nurse training, however, may be futile if qualified nurses are not being employed or retained. The retention of nurses is reliant on the nurses being supported (Ministry of Health, 2006a.), and when emotional support is lacking there is more chance of bullying behaviour by employers and peers (McCleland & Taylor, 2003).

Nurses experienced other difficult situations such as dealing with family violence as Participant 1 explains,

> *I arrived early for an appointment, just to see the mother crossing the road, she had two black eyes. The daughter was unusually quiet as I worked with her and her baby. I was aware there was a man in the house* (P 1/1).

Plus, working in situations they felt were uncomfortable (P 1/2) (the presence of guns on the table); discrimination (P 2/1; P 5/1; P 8/2) (often from other health professionals) situations that left them with feelings of powerlessness as Participant 1 states:

> *the mother wasn't home when I visited and a little girl was standing on a chair heating up some soup on the stove, she had obviously heated soup up before and she had two smaller siblings with her* (P 1/3).

The safety of the tamariki were uppermost in the nurse's mind and dealing with this was the nurses first task. But the nurse knew the whānau, she knew the difficulties they faced with both parents working and no money for caregivers. She felt powerless and unable to enable change. These were experiences when the nurse needed a debriefing, guidance, and support. Those nurses needed an experienced nurse to discuss strategies with as Participant 7 exclaims, "… *what's my next step, where should I go"* (P 7/2). This for them was unfinished business, that they took home and struggled with (P 7/3). The high turnover of nurses is indicative of the lack of support for them (the present support is not working) and the pressures of their job.

Māori nurses' dual competencies make them even more valuable to mainstream nursing care. Dual competencies[51] enable an understanding of Māori and an ability to provide a unique service to people that are disadvantaged. Hence, Māori nurses are being 'poached' by mainstream organisations who are paying higher wages, after they have been upskilled and have gained higher qualifications at the expense to the Māori health providers (Forrest et al., 2011). The District Health Board is one of the organisations that continue to shoulder tap these highly skilled experienced nurses from the Māori health providers (Henry, District Health Board Funder). This 'drawing off' of Māori registered nurses from Māori health providers disadvantages the providers, who then need to train and upskill new nurses which takes time, is expensive and leaves a gap in the health service of the community.

Māori nurses are using their initiative and are trying to support both new graduate nurses and their more experienced colleagues, through strong networking. However, Māori nurses are not receiving support or an awareness of what is available for them as is indicated above by the participants interviews (P 7/2).

Information from the interviews with nurses refutes the policy "to provide a strong Māori workforce". Their comments highlighted the dissonance between the Māori health policy and the nurses' practice a reality which Participant 2 described as "*a disjointed mess*" (P 2/2). Although the government states it wants to build a strong Māori workforce, the experiences of the participants suggests this is not happening. Inferences may be made from the findings that there are gaps between policy intent and practice demonstrated above by: a shortage of Māori nurses in the workforce (P 5/2); a lack of appropriate support (P 7/1) and disparity in the salaries of Māori nurses whilst in employment (P 6/2); feelings of insecurity (P 6/2); a high turnover of Māori nurses working in primary health care (P 2/1); and many Māori nurses remain unemployed (P 5/1).

The present Māori health workforce is diverse, ranging from people with highly specialised expertise to those that have low levels of formal qualifications. These fall into two categories, which are referred to in the industry as a regulated and a non-regulated workforce. The regulated workforce (which includes Māori registered nurses and doctors) are health professionals who have an active practising certificate. The majority of the Māori health workforce, however, is made up of non-regulated health workers (NZQA,

[51] Dual competencies: New Zealand nurse registration and Māori cultural competencies.

2013) meaning that many Māori involved in the health sector are not health professionals, nonetheless they are educated and skilled in their work. They often work with or under the supervision of a regulated worker and also maintain the Code of Health and Disability Consumer Services Rights. Generally, the sector is made up of people who are committed to making a difference to the health and wellbeing of Māori whānau, community and general population health.

Māori health workers are seen as leaders within their whānau, hapū, iwi and Māori communities. Consequently, a potential workforce that is strong and powerful can lead to gains in Māori health (Gillies, 2006). Nevertheless, despite the gains that have been made, Gillies suggests that Māori remain under-represented in most socio-economic indicators such as employment and this is reflected in the Māori nurse workforce (Gillies, 2006). The need to more fully involve Māori in the care of Māori is well recognised, but the shortage of Māori nurses and doctors remains one of the biggest issues in health care (Russell et al., 2013). Both professions (Māori nurses and doctors) remain an integral part of a Māori health workforce, provide a unique service and understand the needs of Māori. Māori registered nurses are considered to be the most approached by clients of the medical profession (Gillies, 2006) and are often the first point of contact for Māori communities, whānau and individuals needing health care.

Literature from the Ministry of Health (Ministry of Health, 2006b, Ministry of Health 2017d) suggests that the main focus for building a strong Māori workforce is pitched at the non-regulated workforce. Hence, there remains a huge concern regarding the support and development of Māori registered nurses and doctors. Thus, many of these professionals leave their employment and leave gaps in the regulated workforce[52]. Crucial to developing a strong workforce is recruitment and retention (Ratima et al., 2007). To complicate the recruitment and employment of Māori nurses, tertiary institutes are pressuring the health providers to take more graduate Māori nurses and at the same time are flooding the market with overseas registered nurses mainly from Asia. Tertiary institutes are upskilling overseas nurses for huge financial gain and finally putting them out into the workforce. This makes employment of New Zealand new nurse graduates

[52] Regulated workforce: every health practitioner who practises in a regulated profession in New Zealand must be registered with the relevant responsible authority and hold an Annual Practising Certificate issued by that authority.

and experienced Māori nurses difficult. Hence, there are highly skilled[53] Māori nurses that remain unemployed (New Zealand Nurse Organisation, 2017).

However, Māori nurses working in primary health care are more and more being asked to 'step up' and take a greater role as the needs of the community become more complex; secondary health care is pushing their patients back into the community sooner, and the shortage of doctors increases. The point here is that support and guidance for Māori nurses in the community, and for ongoing professional development, especially career pathways, needs to be fine-tuned towards Māori nurses' needs in primary health care.

According to the Primary Health Care Innovation Evaluation Team (2007), nurses require clinical competence and confidence to practice independently and, to be effective, they rely on links and/or support from general practitioners and other primary health care providers. This is relevant for Māori primary health care nurses, who often work in the community independently. Isolation means they do not always have the professional support or links to connect with and these are barriers that hinder the development of some of the policy strategies. Curtis and Reid (2013) state that eliminating Māori health disparities, including those in workforce development, requires a commitment to the Treaty of Waitangi and the Indigenous rights of Māori as tangata whenua of Aotearoa.

ii) The District Health Board

The first organisation to be discussed is the District Health Board. Health professionals employed by the District Health Board also have an influence on nursing practice. As noted previously, the Government's role is to fund and monitor the health and disability sector. This situation places the District Health Board funder under pressure and in turn, the District Health Board funders also place the Māori health provider under pressure through the development of contracts and the way they are monitored. This pressure encompasses managerial accountability as the Māori health provider struggles to meet the demands of the Government and District Health Board funder. The provider also feels the strangulation of ever-increasing monetary cuts and fiscal policy as the Government indirectly targets services by influencing that money supply.

[53] Highly skilled: refers to Māori nurses that have New Zealand Nursing Council nurse registration.

From the interviews undertaken with nurses, there was an understanding that such pressure exists. As one participant stated: *"I sometimes feel sorry for them [Māori health provider] cause, I always feel like I am under a microscope with some of the expectations with the contracts that we have"* (P 3/1).

Four main concerns relevant to the District Health Board arose from the nurse interviews:

a) Contracts
b) Administrative workload
c) Pay and support inequities
d) Power and powerlessness

These are discussed as follows.

a) Contracts

Contracts are the documents (agreements) that contain the specifications for how nurses' services will be carried out. Once the contracts are developed, different organisations compete for the contract applicable to their areas/locations and available skills. Each different service has a separate contract (for instance, a school-based nurse contract differs from a cervical smear service contract). Also, as Participant 8 suggests, the contracts, although they fulfil a specific role, are often different as Participant 8 explains:

> *In comparison, where I was working before there was nothing. Even when I signed up with the GPs[54] there is a one pager that covers everything and very simple and you just sign it. Cervical smears - nothing. I think the Ministry of Health ask for too much [of Māori] and it can be simplified* (P 8/1).

With the Māori health provider there where consent forms, health care plans and assessment documentation to complete. Also, for example the Māori health provider nurse's School Based Nurse (SBN) contract may be reviewed after twelve months, whereas the Public Health nurse's contract may be reviewed after five years. Nurses work

[54] GP: General Medical Practitioner.

hard to fulfil their contracts even though at times the contract wording was difficult to understand.

Public health service specifications form the basis of current Government public health contracting processes, and according to Came (2014), they have a strong mono-cultural western bio-medical focus. She continues, "these specifications do not reflect Māori ontological understandings of hauora [health], nor Māori public health traditions in either their structure or substantive content" (p. 249). Therefore, the services are less effective for Māori as the specifications within the contracts only reflect a mono-cultural viewpoint and are therefore incompatible with Māori thinking and understanding of health. Hence, the nurses struggle to apply the contract philosophy to Indigenous needs. Participant 3 states:

> *... there is all these tick boxes but it doesn't quite fit what you are actually doing it makes no sense to me. You are working holistically ... when I first started my target was for the school- based nurse was 600 children and I had to go back and say well actually there are not 600 children within those 6 schools. So, this has been in their contract for I don't know how many years and I thought "what are they talking about?"* (P 3/3).

To add to this, a Nurse Manager revealed that the wording of the contracts was annoying. She explains:

> *And I think, I will get sick now hearing the word health literacy, All I understand is that families need to have enough food, be warm, be safe in an environment, where they are not beaten up and have a roof over their heads and have hope and you don't need health literacy for any of those things. I thought somebody has thought this up in some other world. Contracts they need to be simplified* (Kathy, Nurse Manager).

This manager grappled with clients who needed basic care, but the detail of the contracts used the present day 'buzz word', health literacy, which the Nurse Manager felt had no relevance to the actual health context.

The present practice of allocating primary health care contracts through the District Health Board funder is part of a population health focus. As a means of monitoring the contracts each organisation is set up with targets, for instance, Kathy explained, "*one of our ... [targets] is for one thousand and eighty-six clients a month"* (Kathy, Nurse

Manager). In reality targets are reductionist and ethically difficult for a nurse to focus on exclusively. For instance, as a real case scenario, a nurse might go into a home to complete three cervical smears, as per the contract target, and find family violence in the home, a mokopuna[55] with asthma and an elderly kaumātua with uncontrolled diabetes. From a nursing perspective, this scenario made it difficult to deal only with the cervical smears, using a reductionist approach, when the whānau needed care from a holistic approach and time to deal with whānau needs competently.

Henry (District Health Board funder) explains contracts from his perspective and states that:

> *You've got reporting, your contract has your intent in what you are trying to achieve, they should have some achievables and there should be some indicators and measures that you are reporting against, those are collected, collated, and analyzed* (Henry, Funder).

Cold hard facts from a funder, a necessity because of monetary constraints, however, for the nurses, kanohi ki te kanohi (face to face) makes it much more difficult to deal with 'just a target' when the whānau have more complex health issues often needing urgent care. Participant 6 explains:

> *... I don't know if they are a true reflection, like the box that we have to tick for our targets, but I have done four or five different other things for that person, [but] ... there is no box to mark, I have tried these many times. You are finding the needs and you are meeting them* (P 6/2).

Hence, Participant 6 is having to work outside her contract. Participant 3 added:

> *... no sense to me, just a numbers game, I think they just make it all up myself, I don't think there is a formula ... It's hard to do, what I guess the challenge ... will be ensuring that we are not just ticking boxes, I always think that targets are ... a monitoring tool benchmark - I think it's one tool of many but I don't think necessarily that targets are (the complete focus). Whereas if we focus more on households and work more on competencies to be able to meet needs and households then we might meet targets* (Clare, Nurse Manager).

[55] Mokopuna – grandchild.

"we do and then it's turned into a numbers game" (P 3/1).

From the above manager's perspective, targets are a "monitoring tool benchmark" (Clare, Nurse Manager) and should not be the whole focus. Nevertheless, a monitoring focus on targets means that the nurse has no time to deal with the complexity of the wāhine[56] or whānau. Managers trying to guide their nurses to reach their targets, to maintain the contracts, are also under pressure from the funders. At the same time, the nurses who have been educated into caring for the holistic needs of their patients find themselves in an ethical dilemma. They have to deal with tasks and not the needs of the whole person, and/or from a Māori model of health, that often includes the whole whānau's needs.

Kathy (Nurse Manager) worked towards fulfilling the specifications of the contract and meeting the needs of the whānau and explains:

> *I feel it's about being able to care for Māori whānau in a manner which suits them, so even though we have a descriptive contract, the way that we do the contract enables ourselves first of all to meet the requirements of the contract but also fulfills a need in Māori who may not necessarily feel comfortable with the delivery of a service that doesn't quite match what they want. I feel we are a little bit different in the style and manner of what we provide, and I believe it fits the needs of those people, our own people. Being Māori helps too* (Kathy, Nurse Manager).

But the nurses had a different perception to that of the manager. They definitely believed that the focus was on targets rather than the needs of the whānau, and therefore they were under pressure to reach those targets. They had been told, if the targets are not reached the contract will be cut, … *and if numbers are low* (P 4/1) targets are not met. Hence, they felt their employment may be in jeopardy, so, the nurses felt an urgency to meet their targets. One of the nurses explained the measure the nurses went to in order to gain targets:

> *We would just spend the whole day door knocking … up to thirty houses, but then we might have only done 5 smears and we may have booked about ten, and no guarantee that those ten are going to keep their appointments* (P 7/1).

[56] wāhine: woman.

The nurses were frustrated by the amount of work put into reaching their targets with little results. They covered a large number of people by door knocking. The nurses' clientele was difficult to reach, difficult to tie down, often did not appear (DNA) and rarely visited the general practitioner. Nevertheless, the nurses were concerned with the time constraints and Participant 7 added: "*There are people behind those targets and those people have deeper issues than what we are targeting"* (P 7/1).

Participant 7 was concerned that the focus was on targets to the detriment of clients who had more complex needs and required more time than the target time allowed. Her clients were not just numbers but 'real' people, hence she could not just reduce her clients down into numbers. Many of these clients were the whānau she had connected and built a rapport with. It raised the rhetorical question, "what is the most urgent task, for instance, a cervical smear or dealing with a child's exacerbation of asthma"? Participant 1 agrees:

> *If you definitely take the time and you give that genuine relaxed time, where you can actually communicate with someone and they know you are genuine, you're not just coming in there to tick off some boxes, it is sort of like completing all the mahi stuff* (P 1/1).

The reality is that, while the contracts dictate reaching the targets is the focus, time is restrictive. There is a huge disconnection between quality Māori holistic nursing care and that of a short, targeted house call. Working holistically with whānau is essential to nursing practice. Although the Māori health providers emphasize the need to reach the targets, to satisfy the funders they also work from a kaupapa Māori philosophy in which service to the collective is important. This includes a holistic approach, that enables Māori to feel good about themselves – spiritually, mentally, physically and socially in whānau connection.

Clients, however, are often difficult to reach and contract reporting asks for complex details which adds to the complexities when dealing with a vulnerable community with different needs. This leads to another point, the nurses experienced two types of nursing. The Māori health providers clientele were often hard to contact and experiencing difficulties finding appropriate shelter, adequate nutrition, employment and good health. In comparison, the Māori nurses working in general practitioner clinics worked with a clientele that attended clinics every three months and were compliant with treatment. An

example of the differing needs of different communities was given by Participant 7. This nurse's face lit up as she spoke about her new role as a practice nurse:

> *I love the practice nursing because I don't get to see how they are living. I just get to see them, do what I need to do with them, give them some advice, do some education with them and then they leave. Then I might see them in another three months then I just do the whole process again* (P 7/1).

Whereas, her prior role involved a totally different clientele, where it was common for the whānau to live in a home, where the cupboards were empty and the house was cold (P 7/1). Clare (Nurse Manager) added:

> *As opposed to a mainstream practice where patients present three monthly, very good at self-managing and, like, they are adherent to the system, whereas we don't always work with a population which is adherent to the system* (Clare, Nurse Manager).

The nurse's account of her new role sheds light on those two extremely different scenarios, one experienced in her former role as a mobile nurse working for a Māori health provider and the second in her present role working in a mainstream General Practice. In her role as a mobile nurse, employed by a Māori health provider, her clientele often lived within complex situations, were often homeless and lived with social disparities that caused them stress and tension. Therefore, the patient profiles that the nurses dealt with fell into two separate categories, those who could attend clinics regularly, and those that the nurses had to chase up. Hence, when Henry, as a District Health Board funder, explained that, overall, the contracts are expected "*to manage the population's health"* (Henry, Funder) the term, 'population health', is an 'ideal' from a government perspective but does not always fit neatly with the clientele needing a service. It also means that, although the wording of contract specifications may be very similar, or even the same, as are some of the School Based Nurses contracts, they do not necessarily fit the types of clientele who have different needs.

As a consequence, nurses faced major personal dilemmas when contemplating a change of employment. This entailed choosing between caring for 'your own' (Māori caring for Māori), working in difficult environments, working under pressure and staying silent about the inequities, versus caring for those in 'mainstream' health organisations, experiencing higher wages, a more supportive working environment and compliant

clients who can care for themselves regarding employment, good diet and warm dry homes. These were two entirely different scenarios.

In the meantime, the New Zealand Government and the District Health Boards continue to 'tinker around the edges' of policy, strategies and contracts as they try to work within fiscal constraints. For instance, Henry (District Health Board Funder) states, "*ok, what are you delivering right now that you can disinvest from to reinvest in this?"* when discussing the reallocation of funds within the Māori health providers contracts. This is an indication that, at present, no new money is being allocated out to these services. This indicates the complexities of funding (see Figure 3, p. 43), the contracts system and the specifications the nurses are working to. It can unfortunately lead to the nurses working outside their contracts.

The nurses endured disparities in pay and professional support, racial discrimination and prejudice, often pushing them to a 'tipping point' where they resigned. This leads to concerns for the retention of nurses in the workforce, which further impacts on Māori communities who then do not have access to Māori nurses.

b) Administrative workload

Because of contract pressures within nursing, and a concentrated focus on targets, the effect experienced by the nurses includes an overload of administrative paperwork through extensive reporting and auditing. Targets are part of the contract specifications used as a monitoring tool to assess delivery of health services. Extensive and excessive paperwork draws the nurse away from her time with her clients. This causes frustration, as Participant 8 explains the detail needed for a simple cervical smear and health check:

> *If someone comes in for a cervical screen and they want a health check, that's an hour appointment. … for the cervical screen, If I take a blood pressure then I have to fill out a RT6 and a ST4. An ST4 is a consent form, that is a three-page consent form. I can see the people glaze over when you get to sentence one. And then after that I have to go through ST6 and then they have to have a whānau plan, even if they just come in once. [The] whānau plan has to be printed out, then signed and then scanned back in and then you manually have to put it into the actual outbox whānau plan, so that's huge paperwork* (P 8/1).

This reporting puts the nurse behind a computer, which is time consuming. Often the multiple med-tech screens ask for repetitive information. Kathy comments:

> *The difficulty in our work is that we are over audited, we have to over count our stats, we have to count widgets and gidgets and digits and pidgets. [And the reporting is over excessive] an example would be how many first- time women receiving STI*[57] *antibiotics, how many second time, these are under 18year olds, how many are receiving first treatment for STI, Under18, how many are receiving second treatment STI and under 18 receiving third treatments for STI, under 18 receiving 4th time treatment for STI. ... Why would you count that when it's irrelevant, it's a waste of time* (Kathy, Nurse Manager).

The paperwork is not only confined to reports and med-tech documentation but there is additional workload created by audits. Auditing is seen as a necessity, but Clare (Nurse Manager) argues that Māori health providers are over audited. Clare describes how her organisation is overloaded by paperwork:

> *I think we were audited nine or ten times in the last financial year. I've worked in mainstream and here, so it would be fair to say I think we are audited more than mainstream services ... I certainly started to have concerns about some of the data we weren't able to provide and the decision making, being made based on that data which didn't seem right* (Clare, Nurse Manager).

Clare assumes that the extra requirements are because the service delivery is by a Māori health organisation. Why this level of scrutiny? An example of system racism. These concerns indicate another form of powerlessness. Nurses were frustrated by the excessive work, especially when they knew that non-Māori health organisations are not asked to comply with excessive paperwork to the same extent. The nurses articulated that differing sets of rules were occurring for two different organisations. However, one nurse suggested the funders did not trust Māori nurses and hence the overzealous need for reporting (P 2/2). The problem is that nurses struggle with heavy administrative workloads that reduces the amount of time they can focus on working with clients/ whānau.

[57] STI sexually transmitted Infection

c) Pay and Support Inequities

One issue to arise from the interviews with nurses was that of pay parity. The public expectation is that nurses will care regardless of their employment conditions. However, nurses throughout New Zealand protested in 1985 for higher wages in their 'Nurses are worth more' campaign, where they tried for the first time to use industrial clout via a nationwide strike to sway public opinion and the government. The general public initially were horrified. So, more than thirty years later, again there is a similar dilemma, 'where nurses are worth more', and this time it is Indigenous nurses that are being treated unfairly. Participant 6 is disheartened as she states:

> *How can providers attract and keep good quality nurses if they are not paid the same? It sets them up to fail, as you are only going to get new grads or not the leftovers but … it becomes about your self- worth, it gets depressing. I was getting less than the new grads even with my level two and I thought shucks I have done a lot of work to get up to this level. So, let's be real … It's not fair* (P 6/2).

Although the New Zealand Nurses Organisation's (NZNO) Māori voice Te Rūnanga suggests that building a sustainable and properly paid Māori nursing work force is essential to address inequities in Māori health (Nuku, 2017), the Māori health provider's employees are not covered by the New Zealand Nurses Organisation multi-employment collective agreement (MECA). MECA negotiates nurses' wages in Aotearoa for nurses belonging to the New Zealand Nurses Organisation. Because the Māori nurses are not covered, they cannot call on support from MECA regarding their wages. One nurse explains the response when she attempted to gain a reasonable wage:

> *[For better wages] I have literally had to jump from job to job to get my worth. Because we [employed by Māori health providers] are not supported by the MECA that makes it even worse* (P 5/2).

The employers are sympathetic to the employees but maintain that the District Health Board funders do not pay enough for the contracts to enable a pay rise. Kathy, (Nurse Manager) states*: we have never had pay parity as a NGO,* a Māori *NGO, Māori provider, we have never had pay parity from day dot*. Contrary to this, the Ministry of Health in 2014, when questioned about pay parity for Māori health provider nurses, sidestepped the issue and directed the Māori health providers and employees to work through MECA

(Bootham, 2014). Nevertheless, the Māori health providers do listen to the nurse's concerns, and mostly support them.

Pay parity has been a concern for many years, with Māori nurses employed by Māori health providers paid less than their colleagues working in mainstream employment. Finally, in June 2016, Kerri Nuku (Hawkes Bay co-leader of the New Zealand Nursing Organisation) took her concerns to the United Nations Indigenous Permanent Forum and lodged a 'formal intervention' over a twenty-five per cent pay disparity for Māori nurses working in primary health care who make up 7% of the nursing workforce (O'Sullivan, 2016, p. 1). However, years later, there is no change.

Came (New Zealand Activist Scholar) was interviewed by Awarau and Webby (2017) and stated that it was not that the Māori health providers did not want to pay the nurses more, but it was the way that the contracts were set up. She also stated that, when the Ministry of Health was asked about this, they stated that the process was Māori focused and the District Health Board are required to consult with Māori!

Nurses have traditionally been underpaid for their service (Black, 2013). The emphasis in nursing is on caring, hence, in a service of caring, in my experience there is the belief that you don't ask for more money. Nursing originally had a disreputable past which was transformed into an acceptable career by Florence Nightingale in the 1800s with the principles of obedience and subservience (Shetty, 2016). Her legacy lives on today in nursing, for instance, Ogle and Glass (2014) found that nurses informed by dominant organisational discourses actively participated in constructing and reinforcing their own subjectivity and submissive identity. This has occurred within Māori nursing, where the nurses passively accept pay disparity.

However, pay disparity means a higher turnover of nurses within primary health care, as they change to an employer who will pay them more (P 7/2). This high turnover of nurses is problematic, as the community and other nurses comment negatively on the constant turnover of staff. Staying loyal to the Māori health providers is also made increasingly difficult as nurses are being shoulder tapped by mainstream health care providers taking their skills, qualifications and experience with them. Kathie (Nurse Manager) understands the nurses dilemma and sympathizes:

you are doing all of the mahi yourself, so after awhile that does wear you down so if you get offered a really cushy job with twice as much money, a car, and a better clientele that are going to rock up to appointments, sure you are going to take it (Kathy, Nurse Manager).

There are two points that stand out about pay parity, one is the blatant racial discrimination of Māori being paid, on average, twenty-five per cent less than their Pākehā colleagues. These nurses all have the same qualifications and do the same work. However, the second point is the tokenism etched out in policies when the government states they want more Māori caring for Māori, that they want to grow the Māori workforce, and that in nursing the workforce should be in line with Māori population, for example if the Māori population is 10% then there should in line with that be 10% of the nursing population as Māori nurses in the nursing workforce. Lastly, Māori nurses are not being treated fairly and their rights have been eroded when they are poorly reimbursed for their services, a symptom of a Tiriti that is failing.

The nurses struggle silently with poor wages, and work in a community which is sometimes dangerous and leaves them with feelings of powerlessness. They feel the pressure from their management (Māori health providers) as they struggle to meet targets and deal with burgeoning documentation. The nurses are driven by the satisfaction of looking after their own - Māori caring, guiding and enabling Māori. They have said in their interviews that they in turn learn from whānau, so the relationship is often of reciprocal learning and satisfaction as they endeavour to empower whānau. Nonetheless, this service can be a burden as the nurse struggles in silence. Their need for support is desperate.

Most of the nurses stated they did not have support or know where to get support from when facing ethical dilemmas and concerns (P 7/2; P 2/1). However, the Māori health providers allocate monthly clinical supervision (as documented in their policies) for their nurses. But is it happening? The interviews suggested for some it is not. In my experience, clinical supervision is a service which enables the nurse to have a monthly, hour-long session in deep reflection with another expert nurse. This is a time to explore concerns, discuss case studies and professional development. The contents of the supervision are confidential, unless there is a concern regarding client safety. The overall outcome is that nurses experience salary inequities and powerlessness**.**

d) Power and Powerlessness

The literature discusses the different elements of power (Sullivan & Decker, 2009; Lukes, 2005; Foucault, 1977) and power dynamics are identified within the research data. Power has many faces in this research. It is an important influence in nurses' practice and operates at many levels, which Lukes (2005) describes as dimensions of power. It begins with the nurses having expert power (knowledge and skills) as they carry out their role; they also have mana within the community which is referent power; and to a certain extent reward power, such as if they gain their targets the organisation retains their contracts. That power changes as they go into lower decile whānau homes of people who are under stress and the nurses then find they cannot make a difference - they are left feeling powerless.

The dichotomy of power and powerlessness were two mutually exclusive, interactive experiences which intermittently impacted on the nurses' practice. Power is a personal resource inherent in all of us. Seeking, getting and preserving power is a dynamic process that reflects a person's ability to achieve a desired goal in the face of personal, social, cultural and environmental facilities and barriers (Efraimsson, et al., 2003). The nurse visiting the kainga[58] had power with their experience and knowledge which fed into the service they provided, but that power was neutralized by two factors: the poor conditions the whānau were experiencing and or the discomfort from witnessing whānau using addictive substances, family violence and/or the presence of firearms. Therefore, the nurses are in positions of power initially as they make decisions for the whānau, refer them to other services, support them and educate them. They have that power through their expertise. At the same time, the environment and the space or situation that the whānau are in, results in the neutralisation of the nurse's power and the nurse leaves the kainga with the burden of powerlessness. She is left feeling helpless, as Participants 5 and 7 explain (P 5/1; P 7/1),

I was taking a lot of that stuff home with me, didn't know how to off load it so you are getting a bit drained, it took me three years to realise that though - I couldn't make a difference (P 7/1).

[58] Kainga: home, a place of belonging and connection.

The phenomenon of powerlessness can be triggered by perceptions of unease and "*helplessness*" (P 8/2). That powerlessness is not only happening between the nurses and the people that they serve but on another level the nurses themselves are left vulnerable and powerless because of the prejudices around them in terms of the type of work they do (P 5 /2). So, although Efraimsson et al. (2003) states that the gaining of and maintaining power is a dynamic process, dependant on a person's ability, this ability is often neutralised by the enormity of the nurse's client/ whānau situation, the lack of resources available to the nurse and the interactions of other health professionals.

The managers of the Māori health providers also experienced the influence of power as they too struggled with changing contracts and the burden of paperwork. That power entailed legitimate, coercive and information power held by District Health Board funders. The providers also displayed powerlessness as they grappled with pay parity for their nurses, the need to keep ahead of the needs of the community and deal with the constraints of the contracts. Hence, both managers interviewed agreed that the contracts were top heavy in auditing and reporting (Kathy, Nurse Manager; Clare, Nurse Manager, see pp. 123-124).

Whilst the District Health Board funders hold power regarding developing, controlling and monitoring the contracts, they also set the contracts out as a competitive process for the Māori health providers (Henry, DHB funder). This power enables them to provide a purse that is, in fact, underfunding nurses and can be seen as discriminatory against a Māori nurse workforce. Whilst, at the same time, the government suggests that policy regarding building a stronger Māori workforce needs to be strengthened and encouraged. However, the District Health Board funders, in turn, are dictated to by the government as they deal with the policies and write the contracts. Through this process the District Health Board experience legitimate and coercive power as they answer to the governments demands. In Henry's words, they are also monitored and punished if indicators are not met add the quote. Hence, power plays a pivotal part in the overall process of nurses' experiences in primary health care. Kathy makes an interesting point as she suggests, "*Māori health is a multi-million-dollar industry, therefore do those in power really want to fix the disparity in health between Māori and non-Māori*?" (Kathy, Nurse Manager).

Powerlessness is also connected to stigma, and this is experienced by the nurses who are employed by the Māori health providers. This stigma is imposed upon them by a small percentage of mainstream nurses (P 5/3; P 8/2). As Participant 8 states:

> *I now work in A and E, and hear small discriminatory remarks regarding nurses who work for Māori health providers or I am questioned about why I previously worked for a Māori provider* (P 8/2).

According to Link and Phelan (2001) stigma is defined as the occurrence of labelling, stereotyping, separation, status loss and discrimination in a context in which power is exercised. Symptoms the nurses experienced (P 2/3; P 5/2) along with negative comments from clients as Participant 5 suggests "*This is a show pony organisation, not a real hospital"* (P 5/2). This type of stigma diminishes power and is based on negative perceptions held by society. It also effects the victim's health, as Participant 2 stated when she explained how she felt stressed and had taken a lot of sick leave due to comments and the negative attitude of three public health nurses "*getting on top of her*" (P 2/3). Stigma also affects Māori clients as Hatzenbuehler et al. (2013) suggest there is a connection to health inequalities among members of stigmatized groups.

Mixed in with the feelings of being stigmatised are the feelings of caring, including the rapport that the nurse has built with the whānau. These are contradicted by the emotional response when nurses feel unable to make a difference, as Participant 7 explained "*I just feel helpless"* (P 7/2). These factors, along with pay disparity, paperwork overload, discrimination, and the emphasis on targets, often leads to an ongoing struggle and, finally, to the nurse resigning (P 4/2, see page 123). Manojlovich, (2007) suggests that powerless nurses are ineffective nurses. They are also less satisfied with their roles and more prone to burnout and depersonalization. Over an eighteen-month period of this research, six of the eight participants left the employment of the Māori health providers where they were working when initially recruited.

Nurses, however, whether they carry power and have the ability to advocate for their clients or have feelings of powerlessness, remain focused on providing a service to a vulnerable community that requests the care of Māori nurses.

The District Health Board plays a powerful role in administering contractual agreements, ultimately deciding who 'wins' a contract and with having the ability to

cancel contracts as they see fit. Steinmo (2001) stated that experiences with other organisations are mostly positive but can be negative as organisations "… define the rules of the political game and as such they define who can play and how they play. Consequently, they ultimately can shape who wins and who loses" (p. 2).

The New Zealand Government, in 2004-2006, funded a group of health professionals, The Primary Health Care Nursing Innovation Evaluation Team (2007), to evaluate eleven primary health care nursing innovation projects. They flagged a concern when they stated that, "it is important that attention to teasing out how service contracts and subsequent funding streams contribute to the fragmentation of primary health care nursing services and inhibit the full utilization of nurses' skills (p. 5).

The performance indicators in the health contracts set out by the District Health Boards cover financial, clinical and process performances, with target measures to be agreed between the District Health Board and Non-Government Organisations using national guidelines and funding assigned to agreed targets (Ministry of Health, 2004). A focus on targets, as mentioned above, fragments nursing care because it is task orientated and does not fully utilize the nurse's skills. Nurses are educated to care for the whole person, not just one physical aspect of the person or to do one task such as an influenza injection.

Slater et al. (2016) agrees that health service contracts focus on individuals and illness, which is inconsistent with Māori world views, as Māori emphasis is on holistic wellbeing and a collective approach to health involving the whole whānau. I agree with this statement, but in fairness to the funders, the health service contracts awarded in the region where this research took place focused on individual wellbeing and also primary health care. Primary health care involves health education, health promotion, health assessment and prevention, whereas a focus on illness suggests an emphasis on secondary care.

The setting of targets is also an example of how District Health Board decision making is culturally disjointed. An emphasis on targets leads to westernized practices which Māori nurses find themselves participating in, far from the optimal care they wish to pursue. Communication is essential not only with the District Health Boards but also amongst the different primary health organisations.

District Health Board contracts are written in such a way that they hinder the ability to improve the quality of work-life of Māori nurses and their ability to advance the health

and health care of Māori. Therefore, the focus needs to shift to quality care for those in need and include holistic whānau focused care, not just a fixation on targets.

One nurse manager struggled with the wording within the contracts. She used health literacy as an example, claiming there was a huge emphasis on the wording health literacy when she was struggling with her client's survival. The Ministry of Health (2010) advocates for health literacy and states that improving health literacy, with the client having the knowledge to make well informed decisions about health as part of their daily living, is linked to the client's ability to obtain, process and understand health information in order to make informed and appropriate health decisions. The Ministry of Health (2010) also states that people with poor health literacy are less likely to use prevention services, have less knowledge about their illness, treatment and medications, less likely to manage long term conditions, more likely to be hospitalised, more likely to use emergency services and are more likely to incur workplace injuries (Ministry of Health, 2010). Contrary to this, Sorensen et al. (2012) states that, although the importance of health literacy is increasingly recognised, there is no consensus about its definition or conceptual dimensions, which limits the possibilities for its measurement and for comparisons to be made.

The funding role of the Ministry of Health is complex. However, the Ministry of Health is a monopsony, a single 'dominant' purchaser negotiating with many small sellers (O'Brien, 2005) and therefore has enormous power and influence over the whole health care sector. However, the District Health Board also plays a powerful role in the Māori health provider's service. As discussed below this often led to the powerlessness of the nurse.

Figure 5 (below) depicts government funding and, in summary, shows the government's influence on the contracts with policy intent and funding. Secondly, it shows how that funding is then handed down to the District Health Board as a primary funder for Māori health providers. The funding entails the development of contracts, noting that, as a way to monitor the contracts, targets are developed by the District Health Board within the contract specifications.

Thirdly, Figure 5 (written in black) displays the impact those contracts have on the nurses.

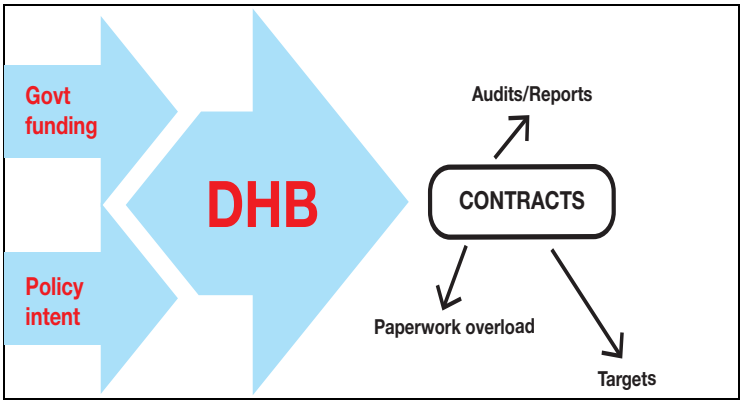

Figure 5: District Health Board funding (developed from the research)

The formation of targets and constant evaluation by audits/reports to ascertain how well providers are delivering to their objectives leads to administrative overload and struggles within a system that does not fit with a Kaupapa Māori health care approach. Participant 1 explained,

> *I do struggle with the whole target focus making whānau fit the criteria as opposed to having a whānau solution model of empowerment* (P 1/3).

iii) The Māori health provider

The second group of organisations that influenced the nurses' experiences of their work were the Māori health providers. The Māori health providers provide employment, cultural support, guidance, resources and ongoing professional development to enable the nurses to provide a service for the community. This is crucial support and enables the nurse to be 'nurtured' in a special whānau setting.

Participant 7 moved from a Māori health provider to a large general practitioner clinic and stated, when employed by a Māori health provider previously, that she had enjoyed commencing the day speaking her own language and joining her colleagues in karakia (prayer) and singing waiata (hymns).

> *I miss working for … because I don't get karakia anymore, I don't get waiata anymore and I don't hear the reo as much as I would normally … that part I really miss* (P 7/1).

Participant 1 additionally stated that, in working as a collective group, the cultural aspect of working for a Māori health provider included:

... tikanga every fortnight, which we learn more about Māori culture and how we implement that into our mahi. ... it's a very connected way of supporting ourselves to support others working for a Māori provider (P 1/1).

She discussed the positive way in which a Kaupapa Māori influence met her needs within the organisation. She added:

... safe, I feel culturally safe. I feel confident safe ... I feel like I can grow for just the environment and the awhi. It's just a more relaxed way, not regimental – compared to some other environments I have worked in (P 1/1).

Māori health providers deliver services based on Kaupapa Māori philosophy and practices that seek to restore and enhance the well- being of Māori (Moeke-Maxwell, 2008). Although Māori health providers provide cultural support, and a nurturing environment, their situation can easily turn into one of stress and pressure. This is because Māori registered nurses who work in primary health care out in the community often work alone, in 'silos'. They belong to organisations, "*which support them culturally and with resources, but they do not always provide an understanding of the nurses needs within their practicum"* (P 1/1).

Māori registered nurses try to align their services with the needs of the District Health Board's contracts. Unlike their colleagues working in tertiary health care, the nurses do not have colleagues to bounce ideas off or debrief with. However, Participant 7 struggles without appropriate support. *"I think I didn't know how to network, to off load or who do I go to, to off load"* (P 7/1).

The point made is that most of the nurses had no-one to off load to or consult with on issues where they needed support. The nurses struggled with difficult cases so having support was important. Although one nurse felt she had a coping mechanism for what she called '*sad stories'*, Participant 7 struggled for the right support:

... I didn't feel like I was a speaking to the right person, cause your colleagues are your colleagues but it just seemed like they were the person to talk to about it, but that wasn't going to give you any strategies or anything to ... what's my next step, where should I go now (P 7/2).

Nurses believe that their managers did not understand their role, the difficulties they encounter or the complex nature of the community they serviced. *"If management*

understood really how the community is, … but mainly the manager, if she could have understood, it was always like there's a timeline for everything" (P 7/2). She continues:

> *Someone is at home but they won't answer the door. … that was one of the main things, that our manager, to her it seemed like we were not doing our work,* (P 7/2).

Participant 7 stated "*we had to make our own resources"* (P 7/2) as she spoke of the lack of resources perhaps due to the provider's budget. There also appeared to be a lack of communication which led to the nurse's perception that her manager did not trust her. This led to feeling under-valued which most of the nurses spoke of (P 7/3, P 1/3 and P 5/3). Nevertheless, the Māori health providers did try to protect their nurses from dangerous situations and had strong policies on preventing and dealing with incidents or '*near misses'* (P 1/2).

At the same time, managers guide and monitor the services as they have to, according to Henry (funder) "*provide results …"* which places the nurse manager in a difficult situation. On the one hand, the nurse managers are constantly monitoring their staff and trying to reach the expected targets written into the funder's contracts, while on the other hand they are trying to support their staff and the work that they do. This often leads to the nurse manager being caught in the middle and misinterpreted by the nurse. Participant 7 states:

> *I miss the people … you had to be really flexible. The structure was all over the place sometimes I didn't know what I was doing and what I could do or couldn't do in the community* (P 7/1).

4.2. PART B: Discussion

Health organisations were identified by the participants as having an influence on Māori nurses' practice. From this, two main research themes emerged and were developed through the analysis of this chapter. They were pay and support inequities and administration overload.

i) Health Organisations

Health organisations influence the nurses and their practice in several ways. The organisations include: the District Health Board (the funder that sets up the nurse's

contracts); the Māori health provider (the employer who provides support for the nurses) and health professionals (who network with and support the nurses). The data explored, firstly, the role of the District Health Board, their contract processes and the influences the contracts have on the nurses' practice. Secondly, it explored the Māori health providers role and their interactions with the nurses. Nurses also interact with other health professionals. This interaction is discussed in Chapter 5. However, power and powerlessness effects different groups in different ways.

The District Health Boards are under pressure as their services are monitored by the government, and the Māori health providers are under pressure as their services are also monitored. But two of the main pressures experienced by the nurses were pay and support disparities.

a) Pay and support disparities

There is a scarcity of registered Māori nurses as a high number leave their employment prematurely. A Māori health workforce report (Moeke-Maxwell, 2008) examined retention amongst non-government organisations and Māori providers and identified salary issues as a barrier. The report stated that it was difficult to compete with both the District Health Board and overseas salaries and if salaries were more competitive, then recruitment would become easier. The District Health Boards, who fund the Māori health providers through their allocation of District Health Board contracts, determine the nurses' salaries by the size of the 'purse' accompanying the contract and therefore play a pivotal role in pay disparities.

The New Zealand Nursing Organisation's, MECA (Multi-Employment Collective Agreement) negotiates nurses wages in Aotearoa. Initially MECA worked on behalf of nurses in secondary care (District Health Board or nurses working in hospitals). Then, in 2005, MECA successfully negotiated higher wages for District Health Board nurses working in secondary care. This resulted in a depleted primary health care nursing workforce and led to the reduction and in some cases the cessation of some services (Finlayson et al., 2009). However, MECA is now available to primary health care nurses through the New Zealand Nurses Organisation but many Māori nurses suggest that their low salaries mean that they cannot afford union fees and therefore cannot use the New Zealand Nurse Organisation to work on their behalf.

The Māori Party signalled their concern regarding pay parity in their 2014 election campaign (Head, 2014), and stated that they would analyse pay parity for Māori nurses working in Māori health initiatives if they were put back in power. Following this, Bootham (2014) interviewed Hemaima Hughes (President of the National Council of Māori Nurses) in October 2014. In the interview, Ms Hughes stated that she works part time for a District Health Board, but if she was doing the same job for a Māori health provider she would be earning $18,000 less a year and that sort of discrepancy is a disincentive for Māori nurses (Bootham, 2014). Hughes said she agreed with the New Zealand Nursing Organisation that suggested that Māori nurses can earn up to twenty five percent less if they work for Whānau Ora agencies, and that payment for their services forced nurses to choose between helping their people and earning enough to survive (Bootham, 2014). She stated that Māori nurses have dual competencies as they can care for their own people while adhering to tikanga. The Ministry of Health sidestepped this discussion and said that Māori and iwi providers have a MECA which has been negotiated with the New Zealand Nurse Organisation on behalf of its members, and therefore salaries are dependent on negotiations between the nurses and the provider organisations (Bootham, 2014).

In June 2016, Kerri Nuku (Hawkes Bay co-leader of the New Zealand Nursing Organisation) took her concerns regarding pay parity for Māori nurses to the United Nations Indigenous Permanent Forum and lodged a 'formal intervention' over a twenty-five per cent pay disparity[59] for Māori nurses, who make up 7 per cent of the nursing workforce (O'Sullivan, 2016, p.1). She said the action was necessary because of the New Zealand Government's inaction on closing the pay gap between the nurses working for District Health Boards and those working for iwi and Māori health providers. She also said that the Māori health professional body, Te Poari, had lodged a complaint with the New Zealand Human Rights Commission over the pay gap and was considering whether it was a Treaty of Waitangi breach.

Pay disparities between District Health Board employed nurses and Māori primary health care nurses also have implications for the primary health care workforce in terms of recruitment and retention (Primary Health Care Nurse Innovation Evaluation Team, 2007). Aboriginal nurses also suggested that renumeration and salary parity were pivotal retention strategies (King et al., 2012; Roche et al., 2013). Canadian Aboriginal

[59] Disparity: discrepancy, inequality.

nurses working in Aboriginal communities also resented receiving lower pay than mainstream nurses and felt that they were not valued (Vukic, Etowa & Perley-Dutcher, 2014).

The literature suggested that Māori nurses were also disadvantaged in their profession as they were poorly supported, and they were not paid fairly in comparison to other nurses (Moeke-Maxwell, 2008). Also, their administrative workload reporting, for instance, the services they provide and client assessments, was more than the nurses were asked for in mainstream nursing. Finlayson et al. (2009) also found that many primary health care Māori nurses were overloaded with paperwork.

b) Administration overload

The healthcare service funder demands extensive reports and med-tech[60] reporting as a means to monitor service delivery and fulfil the contracts. Keeping the reports and med-tech documents up to date is time consuming. Some of the reports are quarterly, often monthly. This 'cuts' into the nurses' time at the expense of time working on the client's needs.

The Government uses audits to monitor performance through external auditors to ensure contracted services have been provided, financial processes are robust and quality assurance systems and processes are in place.

The contracts, reporting and audits consume the nurses' time and appear to be more complex and demanding in comparison to the paperwork requested by the Government and District Health Board funders of other mainstream health providers (P 8/2; Kathy, Nurse Manager). Regardless of administration pressure, which takes the nurses away from their face to face mahi (work) with their clients, they strive to provide a unique nursing practice.

4.3. PART C: A Unique Nursing Practice

Indigenous nursing practice across the world is unique. I acknowledge the indigenous nurses, writers and researchers who have made an important contribution to indigenous knowledge within the global community. This research has used the work of indigenous nurses Vukic et al., (2012), Kurtz et al. (2013), Browne et al. (2012), Etowa & Kennedy

[60] Medtech: software programme for reporting.

(2012) and Deroy and Schutze (2019) to compare and strengthen the findings of this research.

In Aotearoa, it was evident that caring is the essence of nursing, but for Māori nursing it is about caring from a collective position, of being loyal to the kaupapa. It is complex, and includes whānaungatanga, manaakitanga and whakamana. The participants spoke of five areas that were essential parts of their practice: the community context; the uniqueness of caring for Māori; the experience (and ability) of working in an often-dangerous environment; a dark side of caring and holistic care. Nurses reflections displayed a passion to make a difference for Māori and the connections that are made with whānau, which drives the nurses working within this sector.

A unique Māori nursing practice emerged, that included nurses struggling with many challenges but carrying a passion to make a difference for vulnerable Māori. Just as I stated in my introduction, that the passion that drives me is linked to being Māori and being inextricably linked to health, nursing and the community, this is the experience, emotions and connection that drives the nurses. Hence who better to care for Māori than Māori?

Kurtz et al. (2013) suggest that the idea that Indigenous healthcare provisions should be provided by Indigenous healthcare professionals is critical in that they bring a unique understanding of Indigenous culture, knowledge, and lived experience pertaining to the complexities of health and social issues commonly interrupt or deny health equity (p. 3).

Indigenous nurses throughout the world provide a unique service for their people through language, communication and understanding (Finlayson et al., 2009; Vukic, Jesty & Etowa, 2012). In primary health care they also share similar barriers/struggles. For instance, Finlayson et al. (2009) in New Zealand found increasing demands and expectations from health consumers as Māori clients/whānau relied heavily on their Māori nurse's care. Vukic et al.'s (2012) Canadian research referred to this as the cultural context of work-life. They found that there was an expectation from their people that the Indigenous nurses would remain loyal and not abandon their communities, as well as remain true to their Aboriginal culture and beliefs.

Other circumstances also influenced the Indigenous nurses' practice in comparison to non-Indigenous nursing practice. Finlayson et al. (2009) found that specific factors increased demands on Māori nurses' time. These included: a large administrative burden

and time to comply with reporting requirements; maintaining professional quality with ongoing training and education; dealing with a large number of very sick patients; completing immunizations; and meeting increasing demands and expectations from health consumers. Cumming et al. (2005) also identified issues of workload and hours of paperwork as a concern. Hence, the nurses providing a unique nursing practice struggled with the above burdens and this often led to resignations and concerns with retention of the workforce.

The request 'with Māori, by Māori, for Māori' (Smith, 1999/2012) care is being overlooked. Whilst there is a high turnover of Māori nurses employed by Māori health providers, many of the Māori nurses who resign from Māori health provider positions, although highly qualified, remain unemployed. This has a big impact as new nurses may take time to 'train up' to provide high quality care, build rapport with their client base and gain trust within the community. The community as mntioned becomes hōhā[61] with the constant changes of nurses, with the broken connection, and the resulting lack of support and guidance. Therefore, what part do organisations have in enabling or hindering Māori nurses as they strive to provide a service for Māori in the community and improve health disparities in vulnerable communities?

Caring from a Māori perspective gives the nurses' practice a uniqueness when working face to face with whānau. Heidegger (1962) argues that caring is an essential part of being human. While nurses have been educated about the importance of caring during their nurse education, caring is different in the corporate world of health care because of the differences in the quality of experiences. Caring tends to be an over-used word, with meanings that appeal to a variety of westernized institutions and scenarios. Rhetorically, this raises the question of just how much 'caring' can exist in any given situation when care is governed by finances?

Māori nurses draw upon personal and professional perspectives influenced by unique worldviews and informed by theoretical knowledge of nursing and Māori health concepts (Barton & Wilson, 2008). This knowledge is specific and a necessity when working with whānau as there are complexities in the health and social aspects of whānau life. That takes a great deal of understanding to weave through the client's different actions and understand their needs and/or reactions.

[61] Hoha – annoyed or angry.

The key to these interactions is connection, and in particular, whānaungatanga. Whānaungatanga embraces whakapapa with attention to relationships, however it can include relationships with non-kin people who share experiences and work together (Mead, 2003). One of the interviewed nurses remarked on the importance of whakapapa when building rapport and gaining confidence with whānau.

Whānaungatanga provides people with a sense of belonging. Whānaungatanga may occur easily, other times it takes time, however Mead (2003) contradicts this and suggests, "although a high value is placed upon whānaungatanga and its obligations the ideal is difficult to achieve" (pp. 28-29). Because the nurses' focus is on the person and their whānau (Barton & Wilson, 2008), that focus makes it easier and enables the connection of their nursing care with that of Māori cultural values and the principles of whānaungatanga and manaakitanga (Simon, 2006; Te Pou, 2014).

Caring and connection are also important parts of holistic care. Holism intercalates every aspect of Indigenous epistemologies[62], including an understanding of the self, the person's relationship with the community, other living things, the earth and a higher power (Morcom, 2017). These factors are considered holistically in a Kaupapa Māori approach to care. Non-Māori nurses also strive to provide holistic nursing care, but their care is different from that of Indigenous holistic care. Their care is holistic but influenced by westernized thinking in comparison to a Māori understanding of holistic care. Nursing purports holism, however, nurses mainly work within biomedically driven health services that make practising holistically difficult or impossible.

Further to that, a small percentage of non-Māori nurses have entrenched attitudes, justifying their stance with claims they treat all patients the same (Wilson & Baker, 2012). This is a reasonable claim if they are referring to being non-judgemental and listening to each of their patient's needs or concerns but that is not what they mean, they are not considering difference. The difference for me as a Māori woman, reflecting on the needs of a Māori patient, is - *I need a few minutes of quietness and privacy in order to settle my stress levels and say my karakia before I am wheeled into surgery*. This is a task that is important for healing, a task in a busy pre-operation ward that is easily put into practice, a task that is rarely considered.

[62] Epistemology: the theory of knowledge.

However, the data reflected that the Māori nurses working with whānau do take into consideration the differing needs of the whānau, their differing perspectives, experiences, and coping mechanisms. As mentioned in the whānau assessment the nurse has the ability to understand the client/whānau differing reactions to different situations, and the expertise to gauge where their whānau 'is at'. This gives the Māori nurses an advantage in comparison to nurses working within a westernized paradigm. The reality is, as Mikaere (2003) suggests, no matter where you come from or what your upbringing is, Māori women are all "connected to whakapapa, to one another and to our Māoriness" (p. 141).

The nurses already had a variety of experiences of caring as students, due to having spent at least 1100 hours of their nursing education in practicum experience. Many had learnt from their registered nurse preceptors that if they got on with their work, stayed silent, and were compliant rather than activists, they passed their practicum evaluations with ease (McCleland, 1998). Their preceptors were ideally their caring role models, however that was not the 'norm' as they experienced and witnessed non-caring behaviour. McCleland (1998), studying the experiences of nursing students on practicum, found that there was distortion in communication between students and their preceptors. This had its origins rooted in history, tradition, ideologies and nursing culture. Although the culture of nursing included caring, students often experienced a dilemma when they observed and/or experienced the non-caring behaviour of the preceptor (McCleland, 1998, p. 46). The students often "passively shut down" (Giroux & McLaren, 1989, p. 160) and become silent, when experiencing non-caring behaviour. Students identified this action as a "learnt protection" (McCleland, 1998, p. 46).

Tiaki is a Māori concept that also enriches the concept of caring and has many meanings, including guardian of the environment, plus to protect, foster, preserve, to care for and shelter (Bishop & Glynn, 1999). Caring is more complex from a Māori health holistic perspective than westernized holism. Tiaki and whānaungatanga were two of the concepts that emerged from the nurses' stories of their experiences. These enabled a deeper understanding and connection between the nurses and whānau/clients. For instance, Levack et al. (2016) researched pulmonary rehabilitation and found that culturally appropriate communication and relationship building (whānaungatanga) was deemed so important by some Māori participants that, when it was absent, they felt dissatisfied or struggled to attend rehabilitation. Whakamana and manaakitanga were also

important concepts that enriched the connection between the nurses and whānau. The above concepts added deeper meaning to caring and connection, and the mahi of the nurses. Hence, there are consequences in the community from the high turnover of Māori nurses.

For the Māori nurse, working with whānau is often complex, and more and more often the nurses are encouraged to 'step up' to provide a more in-depth skilled practice as the shortage of general medical practitioners widens. They are expected to visit whānau in the community and be able to take on a multitude of roles, to be able to problem-solve and work independently. But, on the other hand, their contract specifications are restrictive – as they focus on tasks. This along with criticism against their practice and/or their organisation leaves them disillusioned about their place as a Māori nurse and the value of their role. This dichotomy for some is about struggle for identity and self-determination.

The nurses work within a Māori community with high needs and with patients who are struggling with poor health, unemployment, poor housing/homelessness and the side effects of the latter. The nurses play a pivotal role with many whānau living within high deprivation communities. This service, as seen in the findings, is unique and complex and requires a lot of experience and skills to manage. The nurses provide a culturally safe nursing practice to a vulnerable community. The essence of the work is whakamana, whānaungatanga and manaakitanga. Nevertheless, as stated earlier the high turnover of Māori nurses in this community leaves the community hōhā, as they struggle with ongoing new nurses who are often inexperienced, unsure and do not know their patients' stories.

The nursing service provided by Māori health providers is hindered by a westernized funding approach that is focused on targets and overall population health. This often puts the nurse behind a computer with an endless order for reports and audits, and feelings of paper overload. These constraints do not take into consideration holistic nursing from a Kaupapa Māori perspective, and the needs of Māori communities.

Taima is a concept used in this research context in many ways. The most important thing to understand about taima is that it is about time (management, process, and taking the 'time'). This includes the allowance of time that the whānau needs to process information; time to process a situation; time for the nurse to leave the whare and return

when the whānau is ready; and time to just kōrero over a kaputi. Time is important to Māori, it can't be hurried. In urgent situations, it does not fit with targets/westernized appointments or meetings. If the nurse puts the whānau on 'hold' during a specific need, she will miss that connection and weaken valuable trust and rapport with the whānau and possibly lose the chance to provide his/her service. Taima is critical in Māori nursing practice and a concept that does not fit with westernized contracts in health care. Hence it is a unique part of nursing practice, and that unique nursing practice is also influenced by health policy.

4.4. Conclusion

The discussion in this chapter followed themes that arose from the eight participants', two nurse managers' and the funder's interviews and included extracts from that data. Hence, the main points of this chapter were:

Firstly, primary health care provides comprehensive coordinated services to enrolled populations with the aim to reduce inequalities in health status (King 2001) and lessen the need for secondary and tertiary health care.

Primary health care is complex in Aotearoa as it struggles with an ageing population and inequity in health between Māori and non-Māori.

Primary health care consists of three levels. In level one the government sets out its intent, policies and funds the health care system but carefully monitors those funding the services. In level two the District Health Boards pick up that funding and, through service specifications, set out contracts and monitor how those services are carried out. Both levels one and two have a powerful influence and work from a westernized perspective over level three which includes the Māori health providers. This power is displayed through the need for excessive reporting and auditing leading to administration overload.

Secondly, this chapter argued that funding and the way the government sets out its health funding is complex. It appears that funding is driving decision-making and that throws some questions on the role of the Tiriti o Waitangi and its ability to 'influence' policy and health. This research recommends also that there is a shift in the way Māori health services are funded with more and longer-term funding of health contracts and positions required to improve the salary levels and job security of the nurses providing those services.

Thirdly, while the philosophy of health care is inclusive of Māori perspectives regarding health care, the practices do not necessarily reflect a Māori philosophy. In

reality, a majority of health care persists, using the traditional, westernized medical model.

Finally, there are areas that impact on Māori nurses and their practice. These include health organisations, health policy, and Māori nursing as a unique nursing practice works within community of need. The influences on the nurses and their practice included administrative workloads which displayed inequities that have been ignored for years and influence nurse retention. Administrative workloads suggested that the nurses were under pressure by the District Health Board and government administration demands which were often overly requested in comparison to mainstream administrative needs. Another influence, pay and support disparities, displayed inadequacies in both support and pay renumeration. This chapter recommends three main strategies for change:

Administrative workloads

Recommendation: Create a workable workload for Māori nurses by developing longer in time contracts, less paperwork (Auditing and reporting) in line with mainstream health organisations. organisations. Create contracts that work with a Kaupapa Māori approach rather than an emphasis on targets.

Pay and Support disparities

Recommendations: Enable pay parity for Māori nurses in line with mainstream nursing. Develop an on call professional support system for Māori nurses. Support monthly clinical and cultural supervision for Māori mobile nurses and School Based Nurses and provide an on- call support service.

A Unique Māori nursing practice

Recommendation: The need to recognise the unique practice of Māori nurses that actually requires differentiation in work conditions (e.g. 'taima' to allow for the processes that work best and produce greater quality outcomes for our whānau).

The next chapter examines the politics of nursing. It discusses conceptual frameworks that influence the health care system and consequently impact on Māori. It further examines the notions of institutional racism, power and powerlessness as a means to sit down and explain how it is that Māori nurses are disadvantaged in their profession. This chapter explores nurses' issues which include the retention of Māori nurses, power and powerlessness as a means to explain how it is that Māori nurses are disadvantaged in their profession. Finally, it analyses the value and tensions of working with Kaupapa Māori health providers.

CHAPTER FIVE: The Reality for the Māori Nurse at the 'Coalface' of Primary Health Care

5.0. Introduction

Poor health statistics for Māori[63], resulting from health inequities in primary health care, makes the need for high- quality, Māori-focused health care urgent. The role of many Māori nurses is pivotal to address the needs of Māori in the community and the poor health statistics for Māori.

In Chapter Three, I analysed five health policies/policy statements and their potential influence for Māori nurses. The analysis argued that although health policy results in positive health outcomes, the Māori health policy still needs development to enable nurses to provide high-quality, culturally safe care that narrows the gap between Māori and non-Māori health statistics.

In Chapter Four, I examined the New Zealand primary health care system and established that the District Health Boards held significant power through the development and monitoring of service contracts for nurses. I highlighted that westernized views pervading the contracts resulted in Māori nurses struggling to provide a service that fitted the health needs of their Māori community.

In drawing on the material from Chapters Three and Four, this chapter reports directly on the experiences of nurses more explicitly. It does so by conveying the nurses' stories and the ramifications for them of the structural and organisational aspects for health in the New Zealand context, the policies that drive them and their impact on Māori nurses and their practices. In keeping with the format of the former two chapters, Chapter Five is organised into three parts:

Drawing from the literature, Part A examines conceptual frameworks and other influences which impact on Māori nursing in primary health care. Part A raises issues associated with power and powerlessness (Lukes, 2005), racism and discrimination (Came, 2012) and the impacts these issues have for the retention of Māori nurses in the workforce (Finlayson et al., 2009). Part A also examines Whānau Ora (Turia, 2011) as an opportunity to investigate a kaupapa Māori approach (a 'Māori for Māori by Māori'

[63] In comparison to non-Māori.

nursing service) that reflects Māori values and a Māori view of health to ascertain whether or not such a focus 'makes a difference' for the nurses.

From the interviews with Māori nurses, Part B presents an analysis of the research findings relating directly to the experience of the nurses, the impact of those experiences on the nursing industry and Māori nurses more explicitly.

Part C is a general discussion that includes recommendations for Māori nursing moving forward.

5.1. PART A: Conceptual frameworks that influence the health care system

As noted in the introduction, there are several key concepts that frame views about the role of Māori nurses, their 'places' in nursing, beliefs about their experiences and how they should operate, which results in challenges for them. The first of these frameworks relates to ideas about power.

i) Power

'Power' is a key theme discussed through the literature in relation to nursing (Joyce, 2010; Ponte et al., 2007; Schira, 2004; Sullivan & Decker, 2009; Zilembo & Monterosso, 2008). Definitions of power are numerous, but those addressed here refer to relationships and the inter-personal power that operates within organisations. French and Raven (1959 cited in Sullivan & Decker, 2009, p. 92) for example identify the following forms.

The first is legitimate power, which is used by those in a position of authority. Steven Lukes (2005) refers to this role of power in terms of a *One-Dimensional view.* Johnston (1998) identifies this as, how power is produced and maintained overtly and exercised through the action of groups and individuals. The one-dimensional view seeks to explain how power modifies the behavior of groups and individuals in specific ways (Johnston, 1998, p.72).

According to Johnston (1998), the central aspect of the *One Dimensional View of Power* is to see who prevails in decision making situations (p.72), which Lukes (1974) argues is perceivable through several mechanisms that operate to enable legitimate power to function. He refers to these as: *coercion*, what Sullivan and Decker (2009) claim is a system based on penalties that might be implemented if nurses do not comply with instructions; a*uthority*, in which employees accept their managers' position in the

organisation and the authority of their managerial role to give directives; *influence*, where managers are able to get employees to change their course of actions without threat; *force,* in this context observable through contracts and legal mechanisms; and *manipulation*, where nurses comply in the absence or recognising such compliance (Johnston, 1998, p.72).

Sullivan and Decker (2009), in detailing power specifically within the nursing profession, highlight several other aspects of power not covered explicitly by Lukes (1974). They refer to these as: Expert power, based on an individual possessing expert knowledge and other individuals recognising that; Referent power, which is based on respect for the person because of their knowledge or experience; Information power, based on access to information which others might not be privy to; and Connection power, where a person has contacts to other influential people. (French & Raven, 1959 cited in Sullivan & Decker, 2009 p. 92). However, all of these latter forms of power can be recognised in Lukes (2005) *Two-Dimensional and Three-Dimensional Views of Power.*

Within both views, Lukes (2005) critiques behaviour. In the *Two-Dimensional View of Power,* however, he is more interested in how 'power' operates to affect outcomes, which are not achieved by physical or observable conflict as is witnessed through the *One-Dimensional View of Power*. Thus, the examples of power portrayed by Sullivan and Decker (2009) clearly demonstrate that recognition for the experiences of others, the knowledge and information that individuals hold can also contribute to compliance by employees.

Lukes (2005) further outlines that what gets discussed - the agenda - becomes a significant aspect associated with power and control. For example, what gets to be on the agenda, and discussed within a policy or organisational framework, and what does not make it onto the agenda, is a way of identifying who holds power. In utilizing Sullivan and Decker's (2009) examples of power, recognition of expertise would mean that potentially, what is recognized by Māori as adequate health services for them, may be negated by western views of what counts as knowledge, information and experience. The former does not make it onto the agenda. Indeed, that it has taken so long for changes in health care to incorporate Māori ways of knowing and doing is evidence of Māori having no control over the agenda.

Lukes (2005) argues that the first two views of power are inadequate, claiming that the three-dimensional view is a better means for the investigation of power, particularly in terms of understanding the role of relationships. This view also stressed that power may

not entail observable conflict but, rather, latent conflict, and that the behavior regarding power may be unconscious and result in inaction. This is a good point and is often also used in reference to racial discrimination (see next section), however this could be seen as an excuse for negative behavior by those in positions of power.

One social theorist who has studied power within human relations and dominant systems is Michel Foucault. Foucault (1977) argued that power involved particular techniques which emerged from human sciences. The purpose of these techniques was to create "docile" or "disciplined" bodies that conform in behaviour to an expected norm. Certainly, the teachings of Florence Nightingale are a good case in point here. Foucault (1977) provided examples of this type of application of power as being that used to solidify hegemonic disciplines such as prisons, hospitals and the military. The power techniques described by Foucault (1977) are applied at the micro-level of activities, for example, dress codes and prescribed behaviours. Individuals are compared to an established norm to determine if they meet the norm. The individual is often unconscious of the conditioning that influences their behaviour. Levy (2017) refers to this as implicit attitudes which are not able to be deployed at a personal level but influence cognition in a way that escapes conscious control.

Power is a complex concept however powerlessness is equally as complex. Wilkinson (2005) states that, "powerlessness is the perception that one's own action will not significantly affect an outcome; [it is] a perceived lack of control over a current situation or immediate happening" (p. 386). Therefore, powerlessness as observed in primary health care is not about corruption or that powerlessness is contagious. Powerlessness is often a feeling of anxiety, ineffective coping or helplessness. However, American writers, Gibson (1991) and Farley (1990) interpret powerlessness differently. Gibson (1991) suggests that people who are powerless are less likely to empower others. Instead they are likely to seek control, thus gaining for themselves a sense of security and perhaps autonomy. Farley (1990) argues that powerlessness, not power, corrupts and is more contagious than power. Whereas Kornhaber and Wilson's (2011) Australian descriptive phenomenological study suggested that feelings of powerlessness affect nurses' perceived ability to provide quality care and contributed to moral dilemmas and burnout among nurses. Their participants were burnt out nurses who also experienced feelings of inadequacy, apprehension, vulnerability and frustration (Kornhaber & Wilson, 2011).

Swedish researchers, Berglund et al. (2015) also stated that their participants, who were nurses that cared for older adults living with long term pain at home, expressed feelings of frustration, inadequacy and hopelessness. They suggested that a potential cause of the nurses' feelings of powerlessness is the low priority and negative attitudes in society toward the provision of health care to older adults. They also suggested that regular clinical supervision be used as a way to support the nurses (Berglund et al., 2015). Hence, powerlessness, according to the literature, can lead to a form of control or, as later studies suggest, can have a detrimental effect on nurses and their practice, needing greater supervision and support.

The importance of positive and productive relationships has also been discussed at length within nursing literature (Brookfield, 2005; Cummings et al., 2010; Sullivan & Decker, 2009). The impact of power-relationships that influence decision making not only affects Māori health providers but has implications for the nurses working in primary health care and has a 'trickle-down' effect on the individuals and whānau that they work with. Power-relationships are important also in the service provided by nurses. What is evident from the literature is the similarity of experiences of Māori nurses and nurses in other countries.

Research has established that Indigenous nurses are crucial for successful primary health care in Indigenous communities. However, they are often affected by high rates of stress, burnout and staff turnover which in turn affects service delivery to Indigenous peoples (Deroy & Schutze, 2019). Browne et al.'s (2012) Canadian research found that high rates of stress amongst nurses led to staff resignations. Vukic, Jesty, Mathews, and Etowa's (2012) research into Indigenous nurses' experiences in the Canadian health care system found six major themes impacting on the participants' nursing experience. They included: cultural context of work-life; becoming a nurse; navigating nursing; racism and nursing; and the socio-political context of Indigenous nursing. These themes were also reflected in the participants interviewed for this research. The Canadian nurses shared some of the strategies they used to respond to overt racism and to feelings of 'Otherness'[64], and stated that being Indigenous enabled them to gain the trust of Indigenous patients and to provide culturally safe care in the community settings.

64: Otherness written with an initial capital to denote a specific category and space to which non- western people, constructed as inferior through the process of racialisation and cultural essentialism have been assigned (Quayson, 2000).

In more recent times the humanistic perspective of power within nursing has been mooted (Gillespie & McFetridge, 2005; Jooste, 2004; Sullivan & Decker, 2009). Durey et al. (2016) evaluated community engagement between local Aboriginal people and health providers across five districts in Perth, Western Australia. In these communities, the District Aboriginal Health Action Groups (DAHAGs) drew membership from the local Aboriginal community to form a collaboration with health providers to design culturally - responsive healthcare. The purpose of the strategy was to improve local health service delivery for Aboriginal Australians. Because the initiative was driven and owned by the Aboriginal community, community participation in decisions about their healthcare lead to increased access and trust in local health service (Durey, et al., 2016). The evaluation concluded that this process of actively engaging the Aboriginal community was a key element in improving local health services, increasing Aboriginal people's trust and access to care.

Hence, power is complex, with a variety of levels and interpretations. It affects nurses in many ways, from power over them, to personal power, to powerlessness. For Māori belonging to a collective[65], identity and mana are all forms of power that can strengthen and weaken depending on outside influences. The Whānau Ora model has a focus of working with iwi, hapū and whānau and working toward quality health for that collective. This is a model that lends itself to the sharing of power between the health service and its recipients. The amount of sharing depends on the needs of the whānau. It can mean most of the power is held by the whānau, as when te Tiriti is used appropriately and the health service steps back from dominating to guide, educate and provide resources for the whānau in need.

ii) Racism and discrimination

Ideally, power can be used in a positive way, but in health care, power can be used in other ways and can emerge as racism or racial discrimination. Racism can be blatant or subtle. Racism operates in many forms including prejudice (Spoonley, 1993). Power is often linked to racism which is systemic, maintained by policy inaction and results in culturally unsafe care. This is because the power to make decisions, to take collective action, and to allocate resources resides at a higher level (Vukic et al., 2012), such as at the government and District Health Board levels.

[65] Collective: collective identity refers to a person's sense of belonging to a group.

Institutional racism is well covered in the literature (Radford, 2003; Came, 2011; Phillips, 2011). However, most academic research on racism focuses on describing and quantifying racism and the effect on those being targeted (Duckitt, 2001; Lentin, 2008). Published academic research on resistance to racism and anti-racism praxis is scarce and racism is infrequently evaluated (Pederson et al., 2005; Gillborn, 2006). Peacock (2011) suggests racism manifests itself in different ways, including unintentional racism, unconscious racism, institutional racism and internalised racism which is a form of self-hate.

In 1985, the then Minister of Social Welfare (the Honourable Ann Hercus) charged a select committee to investigate and report to her on the operations of the Department of Social Welfare from a Māori perspective. The resulting document *Puao-te-ata-tu* (Rangihau, et al., 1988) suggested three broad forms of racism: personal, cultural and institutional, with personal racism manifesting as attitude or action. *Puao-te-ata-tu* made thirteen recommendations which included an objective,

> to attack all forms of cultural racism in New Zealand that result in the values and lifestyle of the dominant group being regarded as superior to those of other groups, especially Māori by: a) providing leadership and programmes which help develop a society in which the values of all groups are of central importance to is enhancement; and b) Incorporating the values, cultures and beliefs of the Māori people in all policies developed for the future of New Zealand (Rangihau, et al., 1988, p. 26).

Furthermore, research suggests that racism may be a major determinant of health (Harris, et al., 2006). Came (2012) suggests that "institutional racism [is] a pattern of differential access to material resources and power determined by race, advantages one sector of the population whilst disadvantaging another" (p. 1).

Huria et al. (2014) studied the effects of racism through the narratives of fifteen Māori registered nurses, and found that they experienced racism on institutional, interpersonal and internalized levels, leading to their marginalisation and being overworked and undervalued. The nurses also identified a lack of acknowledgement of dual nursing competencies. While their clinical skills were validated, their cultural skills in Hauora Māori were often not (Huria, et al., 2014). West, Usher and Foster (2014) refer to dual competencies as a set of unique skills, knowledge and understanding of health service delivery.

Racism, at every level, can be seen as highly influential in the retention and practice of Māori nurses, and the experience is a commonality (Huria, et al., 2014). Huria et al.

suggested that support was needed for Indigenous nurses to develop and implement indigenous cultural clinical competencies (Huria et al., 2014). Stewart (2017) assessed the stress levels of 130 Māori health workers, some of whom were nurses, and suggested that institutional racism was often caused by misunderstandings and a lack of cultural competence which added to Māori health workers' stress-loads. Stewart (2017) stated that institutional racism was related to workplaces playing lip service to the Treaty of Waitangi and she related policies aimed at improving health outcomes for Māori.

Māori persist in calling for culturally appropriate services (Durie, 1998; Reid et al., 2000), maintaining that issues underlying Māori health status are reflective of culturally unacceptable and inappropriate services. A growing body of literature (Bophal 2001; Browne & Fiske 2001; Karlsen & Nazroo 2002; Kirchheimer 2003; McKenzie 2003; Reid et al., 2000; Reid & Robson, 2006; Holland, 2011) points to a detrimental connection between health disparities and personal and institutional racism and associated discriminating practices, indicating that racism is a public health issue.

Bophal (2001) maintains that racism is the most disturbing of the potential explanations for the reasons for health inequalities. As racism is communicated through attitudes, behaviours and language, nurses need to self-reflect and explore the negative impact that attitudes and behaviours may have on Māori women (Bophal, 2001, p.1504).

Although this thesis pushes for Māori to care for Māori, in reality there is currently a shortage of Māori nurses. This means that non-Māori nurses have to fill the gap and hence cultural safety becomes a necessity as a way to minimise racial discrimination and provide culturally safe care. However, Bearskin (2011), in her American study, suggests that "nurses find it difficult to uphold their moral integrity through genuine engagement with those who hold cultural beliefs that differ from their own" (p. 1).

Spence (1999) found in New Zealand that notions of prejudice, paradox and possibility can be used to describe the experience of nursing a person from another culture. Hence, the nurse can influence the care of the Indigenous patient by a negative attitude and displays of prejudice. For instance, covert or overt thoughts are inconsistent with quality care. Spence suggested in 1999 that, against a background of Māori resurgence and the development of the concept of cultural safety in New Zealand, nurses have been challenged to recognise and address racism in their practice (Spence, 1999, p.1). Many years later, racism in nursing is still a concern. However, self-reflection by the nurse can lead to better understanding and sensitive culturally safe care. In examining Indigenous communities from Australia, Rix et al. (2014) suggest that reflexivity is crucial for non-

Indigenous nurses working with Indigenous people. International literature also suggests that Indigenous people feel safer when working with an Indigenous health workforce as people work better with their 'own people' who understand their culture and needs (Morley, 2015).

Institutional racism can also appear as actions that reproduce marginalisation or inaction, and appears within policy making, decision making and service delivery. This disadvantages Indigenous groups such as Māori and contributes to inequitable health outcomes, representing a barrier to realising aspirations for health equity (Public Health Association Inc., nd).

On examining Aboriginal communities in Australia, Rix et al. (2014) suggest that Indigenous patients must negotiate a health services system where racism and victim blaming are institutionalised. But, by non-Indigenous nurse health professionals adopting a framework for relational accountability that incorporates respect, responsibility and reciprocity, the nurse can provide safe health care for Indigenous people (Rix et al., 2014). Rix et al. (2014) suggest that strategies may also assist clinicians and policy makers to develop ways for improving quality of care.

Failure to address personal and institutional racism within a health service perpetuates the ongoing process by health care providers in maintaining racism. Contemporary language and behaviours shrouded in political correctness enables contentious issues to be more palatable, and denies the realities that women, and particularly Māori women, may experience. Wilson (2008) argues that not dealing with the negative effects of racism could be considered a failure in the duty to care and does little to facilitate the engagement of Māori women in health services.

In Wilson's (2008) research, '*Weaving of health and wellbeing'*, she interviewed 38 Māori women and set out to understand the importance of determining Māori women's cultural worldviews and practices in health when assessing and planning effective interventions. Wilson's (2008) research provides a model that employs the metaphor of weaving (). This metaphor brings together dimensions identified with each of her core categories and necessary for the health and wellbeing of Māori women. Hence Wilson's 'weaving' helps to explain the perspectives of Māori women regarding their health and well-being, and how this impacts on their ability to engage effectively with 'mainstream' health services (Wilson, 2008, p.135). Wilson also identified three categories important to the women and their health. They were mana wāhine, 'the way it is' and thirdly

engaging with health services (Wilson, 2008, p. 235). She found that Māori women felt that their beliefs and practices were frequently not recognised and were devalued by 'mainstream' health care providers, and generally not included as part of their health care experience.

Wilson (2008) suggested that while preparation of nurses in cultural safety and competence is essential in terms of a reflexive process, like Ramsden (2002) suggests, the measurement of whether a nurse's practice is culturally safe or not is problematic. The evolution of cultural safety to include a framework to develop and assess cultural competency is timely. It offers a way to reducing the dissonance between nurses' and Māori women's perceptions of a nurse's practice, and their practice to be better assessed (Wilson, 2008). It could also mean a better understanding of Māori nurses and their practice.

For example, Vukic, et al. (2012) interviewed 22 Indigenous Canadian nurses on the quality and nature of nursing work-life. They found that the experiences of Indigenous nurses illuminated the need to understand the interplay of race and racism in the health care system. Although some of the nurses identified experiences and observations of overt racism, they expressed uncertainty around naming racism. The nurses also talked about fitting in, belonging and being accepted in mainstream nursing.

These nurses also had to prove they would not abandon their communities and that they would remain loyal to their communities. At the same time, there was also a high expectation by the community that they would be effective in making the community better. The nurses remained silent when overhearing discriminatory remarks in the hospital setting but defended personal racist remarks.

Finally, racism was a common thread in the stories of these nurses. The various manifestations of racism (blatant, subtle and personal) demonstrated the painful reality of everyday experiences of discrimination in nursing and the magnitude of this systemic issue (Vukic et al., 2012). Systemic racism is supported by policy action (or inaction) regarding persistently compromised health outcomes of people in positions of disadvantage (Etowa & Keddy, 2009). A strategy to provide a service to Māori that is user friendly and does not support racism is the use of a Whānau Ora model.

5.2. PART B: Findings and Analysis of the Interviews

While conceptual frameworks such as power, racism, and the model Whānau Ora (see p. 79) have an important impact on Māori nurses' practice within primary health care,

what Part A highlighted was that power occurs in many forms. Racism is often connected with power. Racism is detrimental when it occurs in nursing and is used in many negative ways.

Part B outlines the interactions of Māori nurses with those conceptual frameworks of power and racism and indicates why retention of Māori nurses in the health system is such an issue. Because the nurses expressed issues associated with racism, discrimination and power, and the inextricable link of all those three concepts with each other, I have discussed them as the nurses talked about them, rather than in separate sections.

Power for the nurses fluctuated across a continuum of having power and not having power and feelings of powerlessness. At the same time the nurses' focus was always on the whānau in need. Participant 1 spoke about empowering the whānau,

> *There's always a solution for every problem and it's getting to know the family, what they want ... opening up opportunities ... empowering them, - that they feel supported and can manage within their whānau, within their whare. They can build like a momentum to build strength within themselves and find this mana. It's always been there but it hasn't had an opportunity because of their surroundings, their environment* (P 1/2).

Hence the nurse was enabling the whānau to have power by building rapport, sharing knowledge and resources and 'being there' for them.

While the Treaty of Waitangi should have ensured protection and fairness for Māori, this chapter suggests that this did not happen. Also, the policies which set out to rectify health disparities, build a strong Māori workforce and provide a health service that was closer, convenient and culturally safe fell short of their target. Both the Treaty and the health care policies should have empowered Māori but instead, often left us with feelings of powerlessness.

Racial discrimination was evident in the research data. Houkamau (2016) suggested that some Māori receive and perceive unfair treatment based on their ethnicity, indicating discrimination contributes to inequalities in health outcomes between Māori and non-Māori. The literature also suggested that racial discrimination had been documented for decades (Carmichael & Hamilton, 1967). Institutional racism was eluded to, when the nurses spoke of mainstream nurses not accepting referrals, slowing down the process of client referrals and general practitioners not following up on referrals (P 8/2; P 5/2).

Prejudice and personal racism were mentioned in most of the interviews. *Puao-te-ata-tu* (1988) suggests there are three broad forms of racism: personal, cultural and institutional racism. Personal racism appears by attitude or action and it is often easier for the nurses to ignore comments than to 'make waves', This was seen in Hineroa's story (Chapter 1, p. 17) which lead to her feelings of powerlessness. As Hineroa found, this also led to a loss of confidence and self- esteem.

Discrimination imposed on the nurses from other health professionals came through differing power techniques as described by Foucault (1977). He stated these are applied at the micro-level of activities, for instance, prescribed behaviours, where individuals are compared by the perpetrator to an established norm to determine if they meet that norm. Foucault (1977) suggested that the perpetrator is often unconscious of the conditioning that influences their behaviour. This was also an observation of Clare (Nurse Manager). Clare states: "*Yes I do think there is definitely organisational racism, and it's an unconditional bias …* (Clare, Nurse Manager).

The various manifestations of racism described by the participants demonstrate the everyday experiences of racial discrimination in nursing and touch on the magnitude of the problem. While some of the nurses spoke of subtle racism or personal racism others spoke of witnessing Māori patients experiencing discrimination. Participant 8 reiterated her experience:

> *My patient's GP hardly spoke to my patient and didn't explain clearly what he was 'doing' – I am going to take your B/P meant nothing to my patient. However, another patient was given a thorough assessment even though the GP didn't utter a word to me. The patient told me later as I transported him home that he had never had such a good doctor's visit. So really I don't care how I am treated as long as my patient is given good care"* (P 8/2).

Systemic racism is supported by policy action and inaction regarding persistently compromised health outcomes of Indigenous people (McGibbon & Etowa, 2009).

Vukic et al. (2012) found that Indigenous Canadian nurses had to prove to their people that they would not abandon their communities, that they would remain loyal to their communities and they would remain true to their aboriginal culture and beliefs despite their mainstream schooling. The participants in this research also struggled with the dilemma of remaining loyal to their communities versus a better lifestyle, when they were offered better working conditions and higher pay by mainstream health. They also tried

to stay true to being Māori and Māori holistic nursing whilst working with Māori health providers, even though this did not fit with their westernized contracts (P 3/2). The Indigenous Canadian nurses responded to discrimination by using strategies such as; proving oneself, establishing credibility, educating others, passing as non-Indigenous or confronting the issue directly (Vukic et al., 2012). Some of the participants in this research also spoke of proving themselves (P 2/2), "*educating others"* (regarding the occurrence of racism within nursing) (P 8/1) and "*passing as non-Māori"* (P 8/2).

However, recently in Aotearoa, a Waitangi Tribunal claim has been lodged alleging Māori nurses experience racism and pay disparity in the health system (Parahi, 2018). Dr Heather Came (2012) reiterated this when she researched institutional racism in the health sector. She implied that there was empirical evidence of racism also against Māori health providers compared with other public health providers in relation to public health funding practices. She noted that the scrutiny on Māori providers was more intense, they were monitored and audited more frequently (Smale, 2016) which was also agreed upon by Clare (Nurse Manager). Came also stated that the Māori health providers had shorter time frames for their contracts, in comparison to mainstream contracts, which made it harder for the providers to plan for and recruit, but over and above that to get a foothold in the community for ongoing community development (Awarau & Webby, 2017).

Came's (2012) research indicated that funders were more likely to subject Māori health providers to greater levels of financial accountability and thereby impose proportionally higher compliance costs. She also found that Māori health providers reported more difficult experiences of contract negotiation than those of other providers. Being subject to poorer contract conditions also noted by Participant 8 (P 8/2 see p.11). These inconsistencies of government practice and "cultural blindness enable a system that systematically disadvantages Māori health providers" and privileges their competition and is a sign of "institutional racism and its privilege" (Came, 2012, p. 252).

Discrimination filters through the contract processes and can be seen when important Māori concepts are ignored. Taima, as mentioned earlier, is a concept from a Māori perspective that cannot be rushed. For example, it is time with the client that may mean sharing a kaputi or kai, but it is seen to be impolite or bad mannered to rush the process. Rix et al. (2013) agreed and suggested a lack of time spent with Indigenous patients is culturally disrespectful.

In order to spend extra time working with whānau, rather than the time limited by a quick home visit, often meant that the nurse missed meal breaks or was late for a meeting

(P 2/2). Short visits did not allow for care which included assessment, treatment, referral and health education, or transporting whānau to their General Medical Practitioner, health specialist or pharmacy. But the contracts state that the nurse must reach x number of tasks, for instance cervical smears, in order to complete a contract and that leaves the nurse in a dilemma. The dilemma is to complete the tasks in the time allotted or work outside the contract and provide holistic care for the client and their whānau. Contracts which focus on targets lead to short visits and individualistic task orientated care, a move away from Whānau Ora and holistic (te ao Māori) care. As Participant 6 explained,

> *Out in the community it is the whole whānau, it's not just the patient, not just the single patient so you are working with the whole whānau. And we have to admit, something has slipped out there, somethings lost whether the grandmother has stopped teaching the mother how to care for their child. You know somethings missing out there. Their needs are different. Like that's what I kind of want to help them to learn again. It's just looking after the children, putting the focus back on that family thing. It's so hard because there are two parents working now, you can't really do it like how they did it back in Nan's day. Mum doesn't even know anymore… So, that's what I would like to help try and fix. You can cry about the colonisation because that's where we have lost it. It's been taken away from us. But instead of crying about it I think it's better if we just get on with it and try to fix it* (P 6/2).

This was a dilemma for the nurses, who made visible the roots of their indigenous identities and their own distinct approaches to holistic nursing practices. They incorporated their values into their practice where possible:

> *But since I have been out, I have tried to put more tikanga into my mahi in the way I have been brought up and I don't want to lose it* (P 3/1).

When a nurse visits a kainga to complete a cervical smear and finds a whānau in need, this then becomes more than a quick visit and is more than caring for an individual. This is care driven from a whānau foci. In other words, that care when looking through the lens of Pere's (1997) Te Wheke model of health has the whānau as the centre or focus of care. Participant 2, for instance, spoke of visiting a kainga to drop off lice medication for a child and finding not only the whānau but also extended whānau struggling with head

lice infestation. She needed to teach several of the wāhine [66] living in the home how to deal with their bed linen, comb and care for the tamariki's hair, which led onto discussions about nutrition, warm homes and te mea te mea (so on). The nurses provide a unique service, one in which connection/ whānaungatanga of Māori to Māori is key to unlock or free communication, as Participant 1 stated:

> *…its finding and allowing them to talk … rapport building is so huge, to eliminate barriers and to talk to them (it's about this connection with Māori), to find out where your historical whakapapa comes from and things like that, You make that connection and that like opens up a huge area, where if they weren't relaxed they feel a lot more relaxed, it's like finding that place where they feel ok …they trust you, you're genuine, and you can be of help to them,* (P 1/2).

Māori nursing practice embraces the health needs of the whānau. A process that excludes racial discrimination and allows healing and development. Hence, care for the whole whānau is important and the focus of the Whānau Ora model.

According to the Ministry of Health, (2016b), the concept of Whānau Ora focuses on whānau as self-managing, living healthy lifestyles and confidently participating in te ao Māori (the Māori world) and in society. Whānau ora is a model that works well with the nurses and their kaupapa Māori nursing approach. The nurses spoke of working with whānau,

> *"It's enjoyable, they can understand you and you can understand them, every day is different, it's challenging … but you can also make that connection"* (P 5/1).

> *… you get to a certain understanding when somebody really wants or trusts you …. They really want to make a shift in their lives and are quite proactive. But you get glimpses of pro-activeness, because they're searching, they're searching they're wanting to know things, they're asking questions, but that comes with a lot of experience and you learn a lot about people. … it's where people open up and you can tell that they're really wanting to find something, wanting to help themselves* (P 1/2).

[66] wāhine: women.

The nurses had already had a variety of experiences. As students they had spent at least 1,100 hours of their nursing education in practicum experience. In practicum, many had learnt from their registered nurse preceptors that if they got on with their work, stayed silent, and were compliant rather than activists, they passed their practicum evaluations with ease. Their preceptors were ideally their caring role models, however that was not the 'norm'. McCleland (1998) studied the experience of nursing students on practicum and found there was distortion in communication between students and their preceptors. This had its origins in history, tradition, ideologies and culture. McCleland (1998) found that, although the culture of nursing included caring, the student often experienced a dilemma when she/he observed and or experienced the non-caring behaviour of the preceptor. The students often "passively shut down" (Giroux & McLaren, 1989, p. 160) and were silent, when experiencing non- caring behaviour. According to the students, this was a "learnt protection" (McCleland, 1998, p. 46). This silent, learnt behaviour continued when the Māori nurses reacted to racism experiences.

Although the nurses in this research had been indoctrinated into the necessary trait of caring, and many had experienced non-caring behaviour in practicum, they soon became 'hooked into' caring for their own in the community. As Kathy (Nurse Manager) explained "*you became part of the community*" … Participant 5 also declares her passion, "*I love working with our people, our Māori people, I have a real passion for it …*" (P 5/1).

The community that the nurses work in is predominantly a Māori community in need. The majority of whānau in the community where the nurses work are poor and some experience: family violence; lack of money or unemployment; crime, poor health, and or drug and alcohol related incidents. The whānau are often living without hope and are struggling. In Kathy's community, most of the whānau are not working.

Kathy explains: *But you know, I have been working in the community, this year is my 21st year, and I'm seeing – situations are getting worse. They are not getting better, you know 21 years ago you had grandparents and most people had a roof over their head, and someone in the household was working, somebody, anybody, but today nobody is working. Nobody's got a roof over their heads, they are in rental properties, they are not even in state houses anymore, they are just existing and there's no sense of hope and now for most of them there's nothing* (Kathy, Nurse Manager).

In this changing community there were more Māori homeless. People appeared to be poorer, many whānau were unemployed, and those that were employed consisted of both parents working to enable the whānau to function, thus adding to the concern of after school care for the tamariki. Many of the whānau used illegal drugs, and it was not uncommon for the nurse to find firearms on the kitchen table. Many Māori grandparents previously supported the whānau by caring for the tamariki, however, many are now in paid employment or the whānau are living away from extended whānau, their traditional support system. Participant 5 also speaks of a changing community and the dangers she perceives:

> *The good thing or privilege is that I'm from here … and even in the undesirable areas I can still make that connection somehow …but not all the time…nowadays a lot of people are on heavy drugs …and even the ones I do know, the relationship is not the same…the scary part is that it can be very unpredictable …I am a bit weary now* (P 5/1).

The changing community housed more gang whānau. But most of the public health nurses will not go into those homes, so our more vulnerable whānau are without support. However, the New Zealand Government has a policy focus on supporting the most vulnerable children, and the children of gang-involved parents have been identified as vulnerable children (The Treasury, 2014). Those whānau have been identified by policy makers as a 'hard-to-reach' or underserved group in Aotearoa (Ministry of Justice, 2010). In contrast, Participant 3 was connected to the community. She had worked in the community for many years and had built up a rapport with whānau. She also lived in the community and understood the gang community. Those that have had previous connections with gangs fare better. They know how to work with the young whānau. Participant 3 reflects:

> *… and you can come across young parents who are gang related, they've got that stand over look and I got to a point that I was so used to it that I would say exactly what's on my mind and I tell them this is what needs to be done (Int.1) … I have been there I am not fazed by the gangs they know me* (P 3/2).

Participant 5 explains her experience of danger in the community:

> *… in the community in their homes … drugs is definitely a big one. You go to a home and you can smell instantly marijuana they have just finished, or they have got*

utensils…lying around…. but then you kind of get in - especially if it's the first time meeting the family you know you are going to have a long- term relationship with them. You've got to be very careful about how you go about things. And whether you know is it worth just waiting a little bit [to talk about the drugs] because you don't want to lose that relationship, because once you've lost that then you're out. So, you've got to think what's for the betterment of the child (P 5/2).

However, often this did not occur, as Participant 2 explains:

I am called in by the public health nurses as the whānau don't want them in their homes or ... says they feel that the Pakeha nurses look down on them ... I learnt that in the community [we] help the public health nurses, like when doors weren't opening, they would phone me "... we are trying to get into this house" whether it was my approach or the colour of my skin, the doors opened. Māori people work good with Māori people (P 2/1).

Participant 3 agreed with Participant 2 and stated:

... most whānau prefer Māori nurses and I'm just going by my own experience especially our younger generation from thirty years and down, they are wanting more connection with Māori nurses and I think, from the public health side of things, they often feel intimidated. It is intimidation that scares our younger ones off... Definitely Māori prefer Māori (P 3/2).

The reality is, as Mikaere (2003) suggests, no matter where you come from or what your upbringing is, Māori women are all "connected to whakapapa, to one another and to our Māoriness" (p. 141).

This is about cultural safety, it is about whānau being safe, but also being able to plot their own course. Previous interviews have reflected the nurses working with the whānau and taking into consideration the differing needs of the whānau, their differing perspectives, experiences, coping mechanisms and the care that the nurses take in working with whānau and their differing reactions to different situations. The Māori nurses have an ability to gauge where their whānau 'is at'. This gives the Māori nurses an advantage in comparison to nurses working within a westernized paradigm.

Lee (2012) found that solo Māori mothers faced many barriers when accessing community health care. These included unhelpful attitudes of health professionals, stigmatisation and marginalisation, and also the need for Māori health professionals and culturally safe healthcare. The role of discrimination and racism in health care is not new

but has been receiving increasing attention for more than 30 years (Krieger, 2003; William, Neighbors & Jackson, 2003; Geiger, 2003). The Māori Asthma Review (Pomare et al., 1991) reported that conscious or unconscious attitudes of health workers contribute to a reluctance by Māori to seek medical care for their asthma until is absolutely necessary. Another study reported barriers to accessing diabetes care among Māori included unsatisfactory previous encounters with professionals and experiences of disempowerment (Simmons, 1998).

As mentioned above, sometimes the community environment was dangerous, however a bigger stressor that often kept the nurses awake at night was the dark side of caring. The nurses found it difficult, to personally deal with whānau struggling and tamariki in need. They entered the whānau whare with skills, knowledge, experience and the power to enable change. However, they left feeling powerless, and unable to make a difference. They left the whānau struggling with a host of different concerns. This involved tamariki, and many of the nurses had tamariki of similar ages which made the situation even more distressing for the nurse. Participant 6 suggests *"... occasionally I will have some sad stories and I will lose a bit of sleep but it's not all the time"* (P 6/1). Participant 7 found it harder to deal with as she reflects:

> *I took a lot of that stuff home with me and I found it hard to off load it ...You go into a home you might be there for another reason but you see a child that is like half naked it's really hard – running around in a nappy then another one that's got a big bruise and it's like you are looking thinking now how am I going to do this. It's all that sort of stuff that you take home ... I think I didn't know how to network to off load or who do I go to, to off load* (P 7/1).

Hence, caring included another side, as the nurses struggled with working with whānau who lived in cold damp homes, had no money for food and clothing. The nurse had relevant knowledge and expertise, which from the whānau's perspective, gave her power. They needed her knowledge, her education, her support, her guidance regarding their health. Hence, she built a rapport with the whānau, with the aim of making a difference for them, but was left feeling powerless. After a day's work, the nurse went home to her own whānau who were well cared for and happy. Sometimes the powerlessness became unbearable, a burden and the nurse changed her employment away from working with Māori whānau in need. This was a loss not only to the nurse, but to the whānau. The powerlessness weighed heavily on their minds and as Kathy (Nurse Manager) stated:

One of the RN nurses, who did my Tamariki Ora and immunizations ... after about twelve months she said you know what ... I really love working here ... and I love working with the girls, you have a great team, but I can't come to work every day and see the poverty and go home at night and see where I live and my happy healthy kids in my home and sit back and enjoy it. ... it's so stressful to know that somebody 5kms from me - little kids are going home and not being fed, families have ... no stove, they have got no heater. She said I can't live with myself knowing this day in and day out. I'm awake half the night worrying about them, it wears you down she said, you know that you are not making any difference. You're only doing an immunization but they're going back to a place where there are five families sleeping in the lounge, no hot water, no heater, they're all just on their body heat and no food, no regular meals (Kathy, Nurse Manager).

Most of the nurses felt the same. There was a real burden in dealing with the feelings of powerlessness. However, Participant 6 felt differently. She had a different approach which enabled her to cope with working in the community. She explains:

We have all got different worlds ... it's frustrating seeing the inequalities, gives you a bit of fire in your belly if something's not right or someone's being treated wrong. I feel like I'm actually in a position to do things to help rather than just being at home frustrated by it (P 6/1).

Hence, the nurses found caring in the community a dichotomy between power and powerlessness as they struggled to work with whānau in crisis. Although they entered the whare (home) with power to provide a service, they often left struggling with a feeling of powerlessness. In these circumstances, they felt they could not make a difference. Being powerless for the nurses was lacking in influence, ability and power (Manojlovich, 2007) and hence not being able to help.

Participant 5 speaks about powerlessness when working with the homeless:

... it really feels like you can't do much, a lot of their health issues stem from social issues which is far beyond my control. So yes, I did feel powerless lots and I still do. It feels like a lot of the time you are just band aiding a lot of their health problems because that's at the root of it. For instance, we have people come in unwell with children with respiratory problems mostly, and it's not until you dig a bit deeper - you

know, thing is, you ... keep talking about house insulation that's where the conversation starts and then in fact you find that they don't have a home, you know, these ones were living in a car and ... no support and very limited family support because they are in the same situation ... you're trying to do your job well. But at the end of the day you know they are going to be stuck in that situation for quite some time (P 5/1).

Participant 5 continues:

When you are educating for like, diabetes and nutrition, their number one priority is trying to feed the whole family, trying to get them to eat an ideal healthy diet, a balanced diet is unrealistic so again you feel powerless, again because you are giving information when you know realistically they are going to go home and it's not going to be - so I mean you keep working on it and you try and make the best of the situation (P 5/2).

Some of the whānau are more fortunate, if someone in the whare is employed, so the nurses' goals change. One of the aims of the nurse working in the community was to put the community in a position where they can heal themselves and empower them. They are also made aware of Rongoa (Māori medicine) and other traditional treatments/therapies. The nurse's skills in working with healthy whānau then becomes mainly health education and health promotion**.**

Māori women play a critical part in whānau, hapū and iwi as whare matauranga[67]. They pass down essential knowledge to the next generation, traditionally through oriori (waiata) (Ruwhiu, 2009). This is not always happening now, and wisdom is being lost, but some of the Māori nurses are fulfilling the role of passing down essential health knowledge as the opportunity arises.

Participant 8 gets satisfaction from seeing just small changes in her clients:

Seeing the little changes, just before you came in there was a client we picked up and she has been sort of on the streets plus with another service, and when she came in she had rotten teeth, bad eyesight, high blood pressure, hadn't had a smear, hadn't had a breast screen, hearing loss and it's taken three months to convince the GP she actually

[67] whare matauranga: repositories of knowledge.

needed to go on anti- hypertensives [medication] as her blood pressure was sitting on 210 over 190. It beats me to wonder why that is a problem to give anti-hypertensives however she is on it now and she's coming back in… but she's got glasses, she's waiting to have her teeth out with the hospital, she's had a breast screen, she's had a cervical screen and she's different when she comes in. So, that's it, just the small things (P 8/1).

At the same time, the nurses that stay with the organisation are gaining in confidence, finding their voices, becoming advocates and proud of what they do. They are shifting from the margins, advancing less cautiously. According to Finlayson, et al. (2009), Māori nurses reported developing strong and trusting relationships, facilitating movement through services, and encouraging other members of the hapū to utilise health services.

There is an expectation in the lower decile communities that Māori nurses are available to care, guide, support and educate. The clients make contact with the nurses through the schools, the Māori health provider's clinic, on the street or at hui. The community expect highly qualified, skilled nurses. However (as mentioned above) they become hoha when there is a high turnover of nurses.

Participant 3 discusses the unique position Māori nurses are in when they work with whānau. She suggests:

I think whānau feel a lot more comfortable around Māori nurses only because they know we can speak the same language and a lot of us have had similar lifestyles so I think that makes an even bigger difference and they feel comfortable. I think another thing is we can read Māori quite easily[and] pick up when they are interested and when they are not, so, you learn to ask certain questions and when not too, otherwise they will shut you down and especially our younger whānau are wanting more Māori nurses (P 3/2).

Just as the participants found satisfaction in working in the community and making a difference, Participant 7 also found that working with young people in the community gave her great satisfaction. However, her work with grandparents who were caring for mokopuna also gave her satisfaction, as she monitored their health and taught them the importance of regular check-ups. She explains:

With the rangatahi[68] , although they weren't using their ears but they were still in there, still wanting swabs done still wanting checks done and still being treated and still spreading the word about how to practice safely, that would be the rewarding thing and just seeing that (P 7/1).

The Māori nurse plays an important role in the community. She carries the power as she carries expertise and knowledge and she gains great satisfaction in the work that she does. However, at times she feels powerless and, when working with a whānau in crisis, she does not see herself in a neutral position but has no energy to become an activist as she is often in survival mode. As Freire (1985) stated, "Washing one's hands of the conflict between the powerful and the powerless means to side with the powerful, not to be neutral" (p. 122).

Caring is an essential part of being human (Heidegger, 1975). There are different levels or depths of caring, and there are different factors that 'drive' caring. Caring comes in many forms: hands on (for example showing a wāhine how to deal with head lice); awhi (support); guidance; mentoring; teaching and others. From a Māori perspective, it is about whānaungatanga (connection), whakamana (empowerment) and manaakitanga (kindness).

Caring emerged as the primary theme of this cohort of nurses, as the participants told their stories about why they worked in their role as either mobile nurses or school-based nurses in the community. Caring and connection were two bridges that enabled positive experiences in the Māori nurses' practice. Lachman (2012) refers to these bridges as a transpersonal caring relationship, which is described as a nurse's caring consciousness and moral commitment to make an intentional connection with the patient. Caring appeared as a primary thread for this cohort of nurses. Caring is the core of the nurse's experience and involves the reason why they practice with Māori whānau in primary health care and are employed by Māori health providers. They spoke about the community context, the uniqueness of caring for Māori, cultural safety, the experience of working in an often-dangerous environment, a dark side of caring and holistic care.

The Māori community in which the nurses work, experience disparities in health when a comparison with non-Māori is made. According to Ellison-Loschman and Pearce

[68] Rangatahi: teenagers/young adults.

(2006), the reasons for these differences are complex and associated with the availability of health care, socio-economic and lifestyle factors, and discrimination. Research showed that 38% of Māori reported problems in obtaining necessary health care in their local area (Shoen & Doty, 2004), and cost was a significant barrier to accessing health care (Baxter, 2002). Hence, their cultural safety and health care is of utmost importance.

At the centre of the nurses' experiences in primary health care is the whānau. Whānau is more than just family, it is about extended family connection and belonging to a collective. It is about te reo, Te Tiriti, the experiences of broken promises, and white privilege. In the communities where the participants work, whānau is about white privilege in health care and Pakeha believing they know what is best for Māori. It is about the aftermath of colonisation, and hence the loss of language, loss of land resulting in the experience of unemployment, poor education, poor housing, poor health and subtle racism - that's what the experience of being whānau means. It is about being on the back foot and not getting all of the relevant information, it is about self-worth, feeling and being powerless.

However, to be able to help whānau at that vital moment when they want a shift in their lives is a life changing experience for nurses. The nurses provide a service that deals with a variety of health concerns within the community, often in the schools and homes. But, in providing primary health care, a large part of their work is health promotion and education. For most of their clients the nurses are the first point of contact. Each nurse creates a significant role in providing quality Māori health services.

Research states that many Māori do not access health services for a variety of reasons (Ellison-Loschmann & Pearce, 2006), an important statement considering Māori lags behind non-Māori in health statistics. This leaves the nurses breaching the gap in supplying health care for those in need, with a long-term objective of improving Māori health.

Māori nurses working in the community experience great satisfaction, as stated earlier their caring is the essence of what they- do. To put it another way, many of our nurses 'have a finger on the pulse', they know inherently what their patient/client or whānau needs, they draw from embodied knowledge and they are there when their patient/client /whānau is in crisis. They know when to advance and when to pull back, they give back

to their whānau, their community and this is reflected in their interviews. As Participant 1 recounts:

> *The whole point of why I want to be where I am is to make a difference for the whānau, and I really take that to heart because I've seen a lot of suffering, a lot of families under stress, a lot of broken families, families not able to access health care … it might be just a lack of knowledge to open up many doors for them and my thought is if I can help one person to make a shift in their life now, it will have a huge effect later on down the track for themselves, for their family and for the journey ahead to help other families…[you need to know who is their] support around their upbringing , the pillars in the family … where is the structure for those families, those children, for the mum and dad, for the grandmother and grandfather that take care of them, ok, this has happened …* (P 1/2).

The nurse's relationship with their whānau/community is important. It is the driving force, community paced and whānau paced! It is more than population health, as the funder suggested (Henry, District Health Board Funder) it is being able to weave through barriers to give the whānau support during crisis. It is about knowing what the whānau needs and/ or building a connection so that they feel confident in stating their needs. but at the same time enabling The Treaty's principles (participation, partnership and protection) to occur. As participant 6 suggests*, "it is about empowerment, helping the whānau to participate, make their own decisions, work in partnership with them and resource them"* (P 6/1). It is also about protection especially regarding tamariki (children) in the whānau.

The Māori health providers also played a pivotal part in the nurses' practice with support, guidance and resources. There was value in working for Māori health providers. Participant 7 spoke of the loss of cultural care when she changed employment to a general practice. Daily karakia, waiata and te reo reinforced the nurses' values and provided support for the nurses within the Māori health providers' practice.

Contrary to this, the participants spoke about managers they perceived who didn't trust them, didn't value them and didn't understand their workload. Further to this, Katz et al. (2010) found that Indigenous North American nurses were more likely to remain in their roles if they felt valued, respected and trusted.

Several of the participants changed their employment, not just for higher wages but also for more structure in their mahi and better support. According to Chamorro-Premuzic (2013), the biggest organisational cause of disengagement is not pay but incompetent leadership. However, disengagement can also occur in response to the experience of discrimination (Richman & Leary, 2009). All of the participants except one had experienced discrimination.

5.3. PART C: Discussion

The research findings of this thesis emulated those found in other research highlighted in the literature. For instance, Vukic et al. (2012) identified experiences and observations of racism but their participants were reluctant about naming racism. Instead they spoke about 'fitting in', belonging and being accepted by mainstream nursing. The participants in this research had also expressed the same experiences. Similar experiences occurred also as Indigenous Canadian nurses worked with Indigenous communities struggling to obtain basic living conditions. These challenges for the nurses resulted in poor job satisfaction and a high turnover rate (Stewart et al., 2005; Rahaman et al., 2016).

At the same time, some of the findings appear to be only experienced in Aotearoa. These include, pay and support disparities (see theme two in chapter three), the value and tensions of working with an Indigenous health provider, the Indigenous nurses working outside their westernized health service contracts in order to provide Indigenous nursing practice that fits with the whānau needs. The nurses also struggled with coping with a large administrative burden and time to comply with over exuberant reporting requirements (see chapter three).

The main ideas and influences in this chapter are summarised and relate to the major themes of power and racial discrimination.

i) The Value and Tensions of Working with Kaupapa Māori Health Providers

The nurses enjoyed working with the Māori health providers. The providers supported them in all aspects of their cultural needs although some of the nurses suggested that their managers did not understand or value their clinical work out in the community and they often worked in silos and felt isolated.

Their community work was similar to that described in Vukic et al.'s (2012) Canadian study which was couched in a distinct socio-political context. This context, which entails working with whānau who are struggling to meet their health needs, makes the nurses work at times difficult and causes tension. Katz et al. (2010) interviewed nine native American nurses and identified three themes; 'paying the price to fulfil my mission', being and connecting holistically, and transcending the system, issues that were echoed by the participants in this research.

Part of that deep connection of working with whānau and the community involved power and powerlessness. The nurse had the power in the form of knowledge, skills and expertise but this was quickly neutralised when they were faced with working with whānau experiencing complex social and health realities. At times the nurse could not make a difference and was left feeling frustrated and powerless. Participant 5 spoke of educating a male client on house insulation only to find he was living in a car. She spent days referring him to other agencies in order to gain him shelter, without success.

The nurse from a westernized perspective is ethically obliged to see to the needs of the client. But from an Indigenous perspective that caring is deeper than an obligation to a client, as the nurse is part of the community. The participants spoke of working with 'their people', of 'trying to make a difference for their whānau' and of 'understanding the needs of the whānau' from a Māori perspective. They spoke of awhi mai, awhi atu (providing support for one another) and that they learnt as much from whānau as whānau learnt from them. Hence, their mahi with whānau was often a reciprocal process. That work was also supported by their employers, the Māori health provider.

One model that works and supports Māori nurses working with whānau is the Whānau ora model. Whānau Ora is a government initiative launched by Tariana Turia (the then Co-leader of the Māori Party of New Zealand Government) in 2010 to improve Māori health and social outcomes. It was designed to support collaboration and effective service delivery by Māori non-government organisations to Māori communities in the face of continual appalling Māori Health statistics. Whānau Ora is a model designed by Māori, to address the shortfalls in health care for Māori, by embracing aspects of Māori culture, knowledge and experience (recognisable to Māori) within a multi-faceted framework. Firstly, in recognising the importance of whānau, Whānau Ora is set out as an investment in whānau, enabling whānau capacity and capability (Turia, 2011). Secondly, the development of Whānau Ora is based on kaupapa Māori principles and is a response to the poor progress made by whānau health statistics. Thirdly, Whānau Ora also sets out

to empower Māori to take charge of their lives and build on their strengths and aspirations because it provides a new way of whānau taking responsibility for their own development and for services to be tailor made to meet their requirements (Dyall, 2010). It is a policy that enables whānau, hapū and iwi development.

Whānau Ora is an approach to health and wellbeing that puts the whānau, as the central driver of their own development (Whānau Ora, 2016) and this is a key aspect of the model. In drawing from the discussion in section a) of this chapter, Whānau Ora enables Māori to be in power and take control.

According to Campbell-Knowles (2012) participants in her research acknowledged that Whānau Ora is broader than just health and wellbeing for Māori: it is about collective wellbeing. This is important in recognising that well-being is not just about the individual, it is about the health and well-being of the collective. She found that whānau inclusive practices when normalised resulted in Whānau Ora goals being set out to achieve progress in overcoming inequality and decolonising practices (Campbell-Knowles, 2012).

Kara et al.'s (2011) examined the experiences of kaumatua in the health system[69] and found that Whānau Ora has many interconnecting facets, including some tension around the notions of interdependent whānau and individual health care needs. Whānau Ora recognises the holistic aspect associated with caring that involves the collective whānau involvement and enables 'for Māori by Māori' nursing care to occur. In Kara et al.'s (2011) research, the participants prepared health plans as part of taking charge of their lives and identifying their strengths and aspirations. Whānau plans were seen as a useful tool for increasing whānau capability and that relationships between whānau and health and social services became more effective (Controller-Auditor - General, 2015).

Whānau Ora is a successful contemporary Indigenous wellbeing initiative, driven by Māori cultural values, which is working successfully and could be taken wider (The Whānau Ora Review Report – Tipu Matoro kit e Ao, 2019). But Whānau Ora is just one of many health initiatives available within primary health care.

Other health initiatives include Smoking Cessation (Auahi kore), Well Child, Green Prescription (a healthy eating and exercise programme), Mental Health, Suicide prevention, Child obesity plan – just to name a few. However, in those models and programmes, the nurses are educated to deal with health concerns initially and then refer their clients onto specialist groups within their organisation or the community. For

[69] Kaumatua: Māori elder.

instance, the Green Prescription is referred for obesity concerns or the psychiatrist for mental health concerns. Hence, the retention of Māori nurses to provide a Whānau Ora service in the Māori community is paramount. Whānau Ora as a conceptual framework encourages health care as a service to be delivered with the whole whānau as a focus, rather than an individualistic focus, and a framework that does not foster racism but clearly places power within the hands of the collective.

However, the service was weakened by poor clinical support and pay renumeration leading to poor retention of Māori nurses. The nurses that had left the Māori health provider's employment all stated that, if the pay and support improved, they would return to the Māori health providers. They found working from a Kaupapa Māori approach deeply rewarding.

ii) Exposure to Racism and Discrimination

Racism in many forms and racial discrimination had an ongoing detrimental effect on the nurses. Institutional racism 'rocked' the nurses and caused stress in a number of ways. While nurses are providing a unique nursing practice that caters for the health needs of Māori, within that practice they experience the pressures of contracts, the feelings of powerlessness and the stress of discrimination which all point to an unsafe situation for the nurse.

Institutional racism is defined as differential access to societal goods, services and opportunity based on ethnicity (Moewaka-Barnes et al., 2013). Jenny Williams describes institutional racism as "a bridging concept, linking and blurring the distinction between the material and the ideological" (1985, p. 323). Stewart (2016) found that institutional racism, often caused by misunderstandings and a lack of cultural awareness, added to Māori health workers' stress loads. Data from 293 studies found that racism is associated with poorer mental health, including depression, anxiety, psychological stress and various other outcomes (Paradies et al., 2015). Hence, they found that racism was associated with poorer general and physical health. On reflection, I mentioned above that the nurses had mana within the community, however what effect did racism have on the nurse's mana?

Discrimination has many forms. Racial discrimination does not fit with the Treaty of Waitangi principles or the concept of cultural safety. The latter sets out to ensure good communication, which includes respect, sensitivity and safety for the Māori client/whānau. Cultural safety should embrace Māori nurses as well as clients. An

understanding of the culture of tangata whenua, would mean less bullying or racial discrimination within nursing and nursing practice.

This research suggests that the present system is not working, that Māori patients and Māori nurses are experiencing racial discrimination. The Nursing Council of New Zealand need to create opportunities amongst non-Māori nurses to discuss institutional racism and racial discrimination in Aotearoa.

The fact that the nurses' service contracts are written from a westernized perspective with the Māori nurses expected to perform a service for Indigenous whānau in a westernized approach is a form of discrimination. It leads to nurses practicing outside their contracts.

iii) Practising outside the contracts

The contracts affect the nurses' practice in many ways. Came (2012) found that most primary health organisations had evergreen contracts[70] with no expiry dates. Instead, they produced health promotion plans which were submitted annually for the funders' approval, whereas Māori health providers were more likely to have annual contracts. Not only is that practice unfair but annual contracts can put nurses under pressure, with the question of their employment looming at the end of each contract. Cram and Pipi (2001) argue that the term of a contract has a profound impact on the ability of providers to do long term and strategic planning, and on their ability to recruit and retrain staff. Adding to that, Berghan (2010, pp. 5-6) maintained that the accountability processes applied to Māori are "… a lot more rigorous, a lot more strident than mainstream". The participants suggested that the funders did not trust them. Wano (2011) concur, noting in relation to Māori providers, that funders tend to have a low tolerance to risk and strong emphasis on compliance. The differing treatment by funders is also seen in the auditing processes, as Berghan (2010) recalls talking to a Pākehā general practitioner who had been in practice for 25 years and had never been audited. In contrast, a Māori health provider disclosed that they had been audited every three to four weeks in an eighteen-month period over one of their many Crown contracts.

Ashton et al. (2004), in their review of health contracting for the WHO, suggested that good relationships were the key to successful contracting. They maintained there was a

[70] Evergreen contract: an evergreen contract states the contract automatically renews after the expiry date unless otherwise indicated by either party.

natural tension between funders and providers based on perceived imbalances of power between the respective organisations. However, Chief Executive of Te Whānau o Waipareira Trust, John Tamahere, suggested that there are different rules for different 'folks' in this Aotearoa and if you are a Māori provider you are never trusted (Smale, 2016), reflecting the comments made by the Nurse Manager interviewed in this research. Hence, the Māori health providers are under ongoing scrutiny by the funder who demand endless reports and onerous audit requirements. This is time consuming and the providers also sustain the burden of multiple contracts with short time frames which require extensive renegotiations each year (Durie et al., 2010; Ellison-Loschmann, & Pearce, 2006).

Rix et al. (2013) found that Aboriginal nurses felt frustrated and powerless to improve the Aboriginal patient's experience due to the constraints of current service design and delivery. However, although there were tensions for the nurses working with Kaupapa Māori health providers, and these stemmed from the contracts and a focus on targets, there was also value.

The Māori health providers drive a way of practice that differs from mainstream health providers. It is a practice that should leave the nurse feeling culturally safe. It includes daily karakia and waiata, speaking te reo and working together as a collective. It is a kaupapa Māori approach to health care. However, the nurses often find themselves working alone in the community.

I mentioned earlier the concern of the differing clientele. The providers have differing clientele, those who comply and those who do not, but they have similar contracts. This means that the contracts work well for clientele who visit a clinic three monthly and comply with the nurse's instructions, but not so well with clients who are in transition or homeless, with ongoing DNA (did not attend) appointments and without communication links or transport. This means that, while both the general practitioners and the Māori health providers have similar contracts, their clientele may be very different, and this is reflected in the ease or difficulty by which they meet targets and fulfil contracts.

The point here is that the process of developing and monitoring contracts is complex. The complexity of the contracts can cause stress for the nurse. There is a dilemma in providing a service that expects the nurses to spend much of their time behind a computer or visiting whānau in the community briefly within a time limit when their visit needs more time.

The Māori nurses' practice is complex in that they provide an important service to a vulnerable population. But this presents dilemmas when they are driven to work outside the funder's contract in order to provide holistic te ao Māori care. The move towards more use of a Whānau Ora model means that speciality teams within the Māori health providers are working together and slowly a more Kaupapa Māori approach is occurring.

The Māori whānau /community and its needs have a major impact on Māori nurses and the service they provide. This entails Māori nursing as a unique practice, which provides for the needs of Māori 'by Māori, with Māori, for Māori'.

5.5. Conclusion

In conclusion, this chapter examined concepts of power and powerlessness. The chapter outlined how nurses have power in the form of knowledge, skills and expertise but this changes to powerlessness as the nurse is faced with whānau experiencing complex social and health realities. Power and powerlessness work as a dichotomy in nursing. They have a huge influence on the nurses and the nurses' practice and that influence was seen in the last three themes and developed into the following recommendations:

The value and tensions of working with Kaupapa Māori health providers,

Recommendation: That the District Health Board enable pay parity for Māori nurses in line with mainstream nursing and develop an on call professional support system for Māori nurses.

Exposure to racism and discrimination,

Recommendation: That the Nursing Council of New Zealand create opportunities amongst non-Māori nurses for discussion on institutional racism and racial discrimination in Aotearoa.

Practising outside the contracts,

Recommendation: that the District Health Boards develop contracts that work within a Kaupapa Māori approach rather an ongoing emphasis on targets.

The following chapter restates the recommendations and concludes the research.

CHAPTER SIX: Conclusion - Whakarereke: a Time for Change (Let's do things differently)

Ki te whai ao (to the glimmer of dawn).

Ki te ao marama (to the bright light of day).

Tihei mauri ora (There is light).

This whakatauiki[71] speaks of the hope and potential of the dawn as it forms into a new day.

6.0. Introduction

The research topic arose out of my work as a Māori nurse working for a Māori health provider in primary health care. I witnessed several instances at meetings and in the community in which I started to question what was happening in the nursing profession, as I saw several worrying trends. I saw bullying occurring that put the providers in a difficult position and meant that pressure was applied on the nurses to reach targets and deadlines with onerous amounts of reporting and auditing. I saw whānau neglected as nurses rushed in to the kainga to complete a task (often a cervical smear) but had no time to listen to other health concerns.

I saw many nurses leaving the providers for better paying employment and better support, therefore the attrition rates of Māori nurses were high. I saw Māori communities struggling as the nurses resigned, leaving them without the support they needed. It was sometimes months before another nurse was upskilled enough to continue the role. Because of my observations and the concerns it raised for me, I decided to look in depth through a professional doctorate at the scenario unfolding for Māori nurses and consequently Māori clients/ whānau in primary health care.

I interviewed eight Māori registered nurses who worked for a Māori health provider in primary health care to answer the question; "What are the experiences of Māori nurses working in primary health care"? The research used a Kaupapa Māori research methodology to guide the focus on a Māori perspective and work within a process that was steeped in Māori culture, philosophy and principles.

[71] Whakatauiki: proverb or significant saying.

The research was set in a provincial setting, where Māori nurses were employed by Māori health providers. The participants in this research worked in the community, either as School based nurses or mobile nurses. They predominantly worked with Māori in low decile areas of the community, Māori who struggle with socio-economic issues and have the highest health concerns and disparities in comparison to non-Māori. Many of these nurses' clients included gang members and homeless people, a clientele of whānau with whom the nurses connected with and provided an important health service.

This research has provided an insight into the experiences of Māori nurses working in primary health care for Māori health providers. It has displayed the struggle these nurses endure through government underfunding and the poverty within the community. It identified the failure of important health policies and their effects on the nurses' practice and the community. It exposed the deficits in the application of Te Tiriti o Waitangi principles and cultural safety in nursing. It has shown an ongoing deficit in health funding, one which leaves the nurses short on resources, inadequate reimbursement for their services when dealing with a clientele who are sicker, have more complex health concerns, more disabilities and are dying younger than other New Zealanders. These factors have left the nurses without power. Power is a necessity in nursing in order to 'get the job done' to empower clients, provide leadership and manage resources. But the research has displayed a unique nursing practice, explained in-depth by eight highly qualified, highly skilled and dedicated participants, who desperately expressed a plea for urgent funding for health care in Aotearoa.

This research found that the practices of Māori nurses are indeed unique. They have a passion for working with Māori in the community, they were inexplicitly connected to whānau in need, and received great satisfaction for their work. While the research data revealed many examples of this, what it also revealed was pressure within the health system for these nurses to perform, but often within environments where they were often under-resourced, lacked support, operated in anti-Māori environments, subject to discrimination and feelings of powerlessness.

Chapter One set the context for the research. It began with stories from nurses - my story and those of nurses working in primary health care. Chapter Two examined and discussed the methodology and methods used in the research.

Chapters Three and Four examined two distinct areas within the health arena: health policies and health organisations. The outcomes from these areas are analysed within the research as major influences on the experiences of Māori nurses and this is discussed. This research highlighted several critical points:

Firstly, that a critical provision of te Tiriti o Waitangi has been pushed to the background. This includes the protection of rangatiratanga, especially after centuries of corrupt and undermining Crown policies, laws, and actions that have devastated Māori.

Secondly, Māori still face challenges, despite the past focus on addressing health disparities by the Crown and health organisations. The District Health Board for example, as the funder for health services provision, developed contracts for Māori health providers that, in contrast with mainstream contracts, are overly audited, demand extensive reporting, have short term expiry dates and are target orientated. This type of contract is contractual racism and has the danger of shifting the nurses holistic Māori orientated practice into a reductionist individualistic task orientated service. It raises the question, is a band-aid service adequate for Māori complex health needs?

Thirdly, Māori nurses are operating under stressful conditions. Although the health organisations and health professionals are there to provide support for the nurses, nevertheless, in many instances, they are the cause of tension. These tensions include heavy workloads, poor pay, and discrimination. Unfortunately, often these tensions led to the nurse reaching a tipping point and resigning from their employment.

Fourthly, although the Māori health providers supported their nurses culturally and academically, most lacked support from a clinical perspective. Also, while other mainstream health professionals supported the nurses, there was a small percentage who displayed attitudes and practices of racism, prejudice and discrimination. In some cases, outright bullying in the workplace was experienced.

The fifth point is that the health of Māori is under pressure as Māori primary health care nurses are directed to work within a westernized model that is reductionist and focuses on a task orientated monitoring process at the expense of holistic care and whānaungatanga. The westernized process does not take into consideration safeguarding Māori cultural concepts, values and practices. Much of culture is invisible or beyond conscious awareness (Pfister, 2009). This invisible part of culture includes non-verbal

communication, family life, social network, beliefs, world view and concepts of health and wellness. According to Pfister (2009), culture is a system of shared understandings. Partnership is not reflected in the District Health Board contract process nor in the specifications mapped out by the funders and presented to Māori. These processes are hindering the work to reduce health inequities and, therefore, are currently failing to fulfil the government's Treaty obligations.

Lastly, government policy aids in maintaining the status quo, with those in power continuing in power and those struggling continuing to struggle. However, in 2001 Kiro (2001) investigated Māori health policy and practice and found that there was considerable innovation on the part of policy makers and funders in an attempt to shift resources down into Māori communities so that they could provide services for themselves. Contrary to this, eight years later, Harawira (2009) looked at whānau decision processes and found evidence that the New Zealand health sector, health legislation and policies are largely unfavourable for guaranteeing whānau engagement in decision making processes. This indicates a breakdown in government intervention as whānau decision making is an overall objective of the government's *Māori Health Strategy: He Korowai Oranga*. In context of the discussion about power and decision-making, Chapter five highlights how a path towards improving Māori health, includes enabling Māori nurses to provide a kaupapa Māori orientated service, a service which is free of racism and hence it is equally important that government get this right and involve Māori in the decision-making process. While the development of the Whānau Ora Model is enabling better whānau decision making in some sectors, this is the exception not the norm.

There has been too much rhetoric, too many empty policies and much discussion about Aotearoa's inequalities in health but these have led to little change. It is unacceptable that poor health statistics for Māori have become normalised.

6.1. The Discussion

In primary health care the nurses were mostly the first health professional contact that whānau encountered. This was mainly because whānau struggled with the high costs of medical care, access to the general practitioner and discrimination from non-Māori health professionals. Lewis et al. (nd) recommend an increase in the number of Māori health

professionals with the rationale that a 'by Māori for Māori' approach would improve access, cultural appropriateness and quality of care.

The research indicates that one way to encourage Māori into the nursing profession is for the District Health Board funders to re-examine the health contracts specifications in partnership with Māori health providers and

a) Enable pay parity for Māori nurses in line with mainstream nursing.

b) Develop an on-call professional support system for Māori nurses.

c) Support monthly clinical and cultural supervision for Māori mobile nurses and School Based Nurses and provide an on- call support service.

Māori health policies 'recognise and respects the principles of te Tiriti o Waitangi' and sets out to protect the health of Māori. The Ministry of Health (2002) state actions to improve Māori health also recognise the Treaty of Waitangi obligations by the Crown. The Nursing Council of New Zealand also has an obligation to Te Tiriti 'to get it right' with the education of their nurses regarding the Treaty, Māori culture, cultural safety and racial discrimination. This strategy would enable Māori nurses to reach their potential and Māori patients/whānau to have their needs met so that they can heal. Hence, under this policy nurses should be providing a service that is Māori orientated rather than one that is set in westernized concepts. The research indicates that one way to alleviate this situation is for the District Health Boards to demonstrate a system that considers the needs of the Māori clientele and the potential for Māori to be cared for by Māori nurses.

The policy objective 'better, sooner, more convenient' health care sets out to deliver a more personalised primary health care service closer to home, and one in which health professionals work collaboratively. However, the clientele the nurses work with are struggling not only with health concerns but socio-economic disparities. They cannot afford to visit the general practitioner and often do not trust non-Māori health practitioners. Hence, the Māori health providers provide a service that fills the gaps in primary health care for them. Funding the health system is an urgent priority. Part of this policy is the collaboration of health professionals in working together. However, the discrimination of Indigenous nurses by non-Māori health professionals puts up a barrier against good communication.

To make changes and improvement on that situation, this research recommends that the Nursing Council of New Zealand create opportunities amongst non-Māori nurses for discussion on institutional racism and racial discrimination in Aotearoa.

The Nursing Council of New Zealand's policy of 'cultural safety' was written initially with a focus on bicultural health care. This concept was aimed at understanding Māori health and Māori patients' needs but has moved to a multi-cultural focus. While initially the intent of the policy was focused on health care for Māori, the interviews demonstrate that the practice has moved away from an understanding of needs and has left gaps in nursing care regarding Māori health.

Cultural safety in nursing is a Nursing Council of New Zealand policy that is linked to the Treaty of Waitangi and therefore relevant when examining the fairness of care to Māori clients. The Treaty demands interdependence. The interdependence of partnership, protection and participation. Hence, the Nursing Council of New Zealand incorporates the three stated principles of The Treaty into the nurse's practice, as well as ensuring 'safe cultural care' along with patient safety. Therefore, the importance of understanding Māori culture and its relationship to health is acknowledged by the Nursing Council of New Zealand's requirement that the Treaty of Waitangi, Māori health and cultural safety are included as Standard Four in the Standards of Registration for Comprehensive Nurses (2002).

However, is nursing education ensuring that nursing students, nurses returning to the workforce and international nurses entering Aotearoa to work, fully understand the requirements of Standard Four? In my experience as a New Zealand Qualification Accreditation monitor, nurse educator lecturer and in working with
New Zealand Qualification Accredited nursing degree accreditation teams, it would appear that nursing education needs to be strengthened in this area. On reflection, would a better understanding of the above lessen the degree of racial discrimination experienced within nursing?

The Nursing Council of New Zealand's policy, 'Cultural Safety', is also a concept that threads through the research, usually linked to patient safety and Te Tiriti o Waitangi. Cultural Safety in nursing is a Nursing Council of New Zealand policy that is linked to Te Tiriti when examining the fairness of care to Māori clients. The Nursing Council of New Zealand is also concerned with the disparities of health between Māori and non-Māori. The Nursing Council of New Zealand as the governing body of registered nurses

in Aotearoa works alongside the government's Health Strategy with health policies that incorporate the principles of the Treaty of Waitangi into its nurses' practice, as well as providing competent cultural care along with patient safety.

Cultural Safety is a key part of the Nursing Council of New Zealand's standards and it is incorporated into nursing care as an evaluated competency. The Māori term for cultural safety is kawa whakaruruhau and is translated as protection from potential harmful or troublesome elements and relates more to the actions and activities of nurses, nursing and health professionals (Richardson, 2011). In nursing, in the development of the concept of cultural safety, there was an initial bicultural focus in nursing practice. This was later changed, and the focus became multicultural nursing care.

When considering the policy statement promises outlined in Chapter One, of a strong Māori workforce, a decrease in health inequity for Māori, fairness through te Tiriti, the ability to work in collaboration with other health professionals, and Nursing Council of New Zealand's promise of cultural safety for Māori, we see these are not upheld for Māori nurses. Although the promises of the policy give the nurses hope, the reality is that, instead of a 'stronger' workforce, it sees low nursing staff retention rates. Also, the disparity in health for Māori in comparison to non- Māori continues, appropriate support and wage renumeration is inadequate, and Te Tiriti decisions in health are over-ridden. Māori nurses still find themselves struggling over decisions influenced by power, such as over-indulgent contract issues and collaboration with other health professionals made difficult by racial discrimination. Furthermore, although New Zealand's Nursing Council promises cultural safety for Māori experiencing health care, both Māori patients and nurses are still experiencing prejudice and stigma. So, health policy does influence Māori nurses and their practice, and this is echoed in the voices of the participants.

To improve non-Māori nurses understanding of Māori culture and needs, this research recommends that the Nursing Council of New Zealand support the reassessment and redevelopment of nurse education on cultural safety regarding Māori clients/whānau, Te Tiriti o Waitangi and racial discrimination. This nurse education is to be included in the Bachelor of Nursing degree, annual registered nurse updates and in the Contemporary Nursing Certificate (a certificate for nurses re-entering the nurse force and overseas nurses entering the New Zealand nurse force for the first time). These gaps in service disadvantage individuals/whānau/community and breakdown the policy statement of better, sooner, more convenient health care in the community.

This research suggests that the present system is not working, that groups are being marginalised, and the health system is reaching a crisis point. Perhaps Aotearoa, as a society, needs to decide that there are some things that need to be prioritised in government funding and the health system is one of them. Rather than trying to run health as a business, run it as a priority for funding. The present system has had catastrophic consequences for Māori in the community. Hence, as a nurse with a vested interest in healthy communities, I suggest that good quality health care is the key to building a strong healthy society and it needs to be urgently funded adequately and differently before to turn around Māori health disparities.

Is the Māori health policy and in particular its strategies/statements/objectives enabling a fair deal for Māori (and in particular the development of a strong Māori nurse workforce) as promised by Te Tiriti o Waitangi?

However, the Māori health policy's recommendation is to encourage Māori to enter health services and hence build a stronger Māori health force. Nonetheless, racial discrimination is a barrier to this and is experienced by Māori nurses and patients within the health care system. A further recommendation of the health policy is for Māori to use and feel comfortable in a health care system that meets their needs.

It would appear that government health policies, which are written from a Pākehā perspective, are not performing as intended for the Māori nurses and their nursing practice. Policy is also open to interpretation. The fact is that, although the policies overlap in parts, they are not succeeding, and this means that Māori continue to struggle with their health. Te Tiriti advocates fairness for Māori, but in the community, where the participants of this research work, there is little sign of this.

One of the answers to heal the disparities in health for Māori is a strong Māori health workforce. However, research states that the regulated practitioners within the Māori workforce are diminishing, with nurses and doctors in short supply (Carryer, 2016). An increase in the number of Māori nurses working in primary health care would improve health disparities amongst Māori. They would be provided with a service that was culturally appropriate and sensitive to their needs. However, Māori nurses desperately need relevant support. This support would enable self-confidence, strong leadership, improved knowledge and hence high-quality health care.

One solution would be that Māori Nursing Groups, with the support of Te Kaunihera o Nga Neehi Māori, Nursing Council of New Zealand, College of Nurses and New Zealand Nursing Organisation, establish provincial Whānau of Practice groups. This would include monthly hui, but also the development of subgroups to develop networking via a website, texting and emailing. This would enable the sharing of resources, upcoming events, availability of scholarships and financial assistance for study purposes and to present or attend conferences, case studies and the possibility of a tuakana teina (Māori buddy system) for relationship developing.

Although the health policies collectively state that they will do a number of things for Māori, in actual fact they are failing to build a strong Māori workforce, lessen Māori health disparities, enable the use of the Treaty principles, provide cultural safety for Māori, provide health care that is better sooner, closer, more convenient care in the community and enables the collaboration between health professionals. It would appear that central to these concerns is the fact that, as Came (2012) suggests, New Zealand health policy is situated in a monocultural domain, dominated by western bio-medical discourses that preclude and under-value Māori, in the conceptualisation, structure, content, and processes of health policies. With this in mind, it is time for nursing to do things differently.

It is apparent that although health policies set out with the right intention, the words become rhetoric as the policies fail. The nurses cannot be part of a strong workforce when they endure racism and are not supported. They cannot enable the health disparities to reduce when they are not given the support or resources for this to occur. They cannot collaborate with other health professionals whilst experiencing prejudice. There are all symptoms of failing health policies. However, it is the responsibility of the health organisations to change this.

Chapter Three examined five policy statement/objectives and their impact on Māori nurses and their practice. An analysis of these statements clearly linked them to the two major outcomes discussed in Chapters Three and Four. Through the analysis of these policy statements, recommendations were developed which are also reflected in the themes recommendations.

Nurses have struggled with health policies that are failing them. Therefore, Māori nurses were not being employed or supported therefore are not being part of a strong

Māori workforce; nor being resourced therefore not able to treat whānau in need adequately, exacerbating health disparities; not being treated fairly and discriminated against therefore not being protected by te Tiriti).

Under the terms of te Tiriti the health interests of Māori had not been protected or equally funded (Wilson, 2004). If the new New Zealand government is serious about health disparities, developing a strong Māori workforce, dealing with poverty and applying te Tiriti o Waitangi to health then the New Zealand health care system has to be fully funded as a priority. There is a need for Fair treatment as advocated by te Tiriti o Waitangi.

The research found that there were three main levels in primary health care that had an impact on the Māori nurse's experience. They included government (their policies and funding), District Health Boards and thirdly, health organisations (including Māori health providers and other health professionals). Whilst examining this health care structure through the experiences reported by the research participants five key themes emerged. These included: pay and support disparities, administrative workloads, working outside the contracts, racial discrimination, and the values and tensions of working with a Kaupapa Māori health provider. From these themes, two major theoretical concerns arose that have a major influence on the Māori nurses and their practice. They were power and racial discrimination.

6.2. Power

Power filtered through the nurses' practice in many forms. For instance, power was reflected in administrative workloads. The infrastructure supporting nurses was onerous. Nurses were pressured by over-zealous reporting and auditing that was also westernized and individualised. For example, it forced nurses to spend time in front of a computer to the detriment of caring time spent with client/whānau where nurses wanted to be.

The influences of power were also evidenced in the nurses' contracts. Contracts have a strong mono-cultural, western bio-medical focus (Came, 2014) which did not work well within a Kaupapa Māori approach to health care. Therefore, the District Health Board contracts need to be reassessed regarding partnership, transparency and with an emphasis on a Kaupapa Māori approach when working with the Māori community. The nurses had dual competencies which was important for a 'Māori for Māori by Māori' health care

approach, but there was no recognition for this special expertise. They were also forced to work outside their contracts in order to provide a holistic, whānau focused service. Hence there is an urgent need to develop contracts that work with a Māori perspective and enable Māori nurses to maintain a unique nursing practice.

Power dynamics within healthcare placed nurse in positions of powerlessness as they struggled with fiscal constraints. The health system has been subjected to ongoing fiscal restraints and cuts despite Māori dying young and suffering with multi and long-term health concerns, a system in which there are disparities in the health of Māori in comparison to non-Māori. Nurses experienced the ongoing fiscal restraints through pay disparity and the lack of resources. These struggles, along with time constraints and targeted outcomes, lead to the nurse working outside her contract in order to provide a service according to the contract specifications. In the meantime, health funding in New Zealand had been slashed by $1.7 billion in the five years up to 2015 (Kirk, 2015).Those who were already disadvantaged through the health system were made even more vulnerable by the cuts. Consequently, there is the need for priority funding of health care**.**

6.3. Racial Discrimination

Racial discrimination was reflected in the fact that the contracts did not enable adequate support and pay parity. Māori nurses lacked support at various levels. For example, they lacked support in the form of collegial networking. Māori nurses' professional development needed to include support such as clinical supervision (Wilson & Baker, 2012). The nurses interviewed, however, struggled without support, showing a need for both collegial and clinical support.

Working within a kaupapa Māori health provider is a valuable experience for Māori nurses but also full of tension. For instance, Māori belong to a collective and are thus supported within the Māori health providers but, while out on clinical practice, they are mostly isolated from other nurses and to work in isolation is stressful. For instance, the participants stated they needed to be able to discuss situations, swap ideas and share resources with colleagues. So, although they need professional clinical supervision, they also need to be able to network with other Māori nurses. The Ministry of Health (2011), in its *Te Uru Kahikatea Report*, identified the development of Māori public health networks as its key priority area number four. Over half of the respondents interviewed

as part of Te Rau Matatini's survey of the Māori public health workforce identified networking as a key professional development need (Te Rau Matatini, 2007). Internationally, a Community of Practice is developed. A Community of Practice is a group of people with a passion for a profession or trade that meets to discuss case studies, share resources or ideas, or gain support from more experienced members (Wenger, 2007). To further develop this concept so that it relates to Māori nurses, a 'Whānau of Practice' could be developed. A Whānau of Practice would be steeped in a Māori approach, for instance, the group would begin a meeting with a karakia. The aim would be to set up a Whānau of Practice and incorporate email, text and a website for members who have work and whānau commitments and have difficulty meeting in person. This could be settled through, a Māori nurse register, where a nurse could contact another nurse on call to deal with situations that need debriefing. Therefore, setting up a Māori 'Whānau of Practice' would provide networking and support for the Māori nurse.

Māori nurses are paid less than their mainstream nursing colleagues 'doing the same job'. Because of this situation, nurses leave the Māori health providers because of poor pay as they struggle to pay house mortgages and student loans. The unique nursing practice that the Māori nurses provide to their whānau needs to be reimbursed appropriately. Pay parity with mainstream nurses would mean that Māori nurses might then see nursing as a more worthwhile profession. However, Health Minister David Clark stated nurses in primary health or iwi providers are usually employed by private employers. While he said he values their work, their pay is not negotiated with the government and the 2018 settlement would not be extended to them (McLachlan, 2018). On reflection, the funder that oversees the health care contracts is the Ministry of Health, a government agency. The statement by Clarkin actuality enables the government to step away from its responsibility to Māori as the rationale is flawed.

Māori nurses in primary health care have a low retention rate. Resources and support are part of the District Health Boards' obligations to the nurses' contracts. However, to neglect those needs is not only discriminating against Māori nurses but sets the nurses up for failure in their service to the Māori community.

By far, racial discrimination towards Māori nurses is an overarching finding of this research, shown in their being paid less, experiencing unsafe practices, and being victims of cultural insensitivity. Nurses were often exposed to subtle discrimination, prejudice and institutional racism through policy wording, decision making and service delivery.

This deep - seated concern within nursing, disadvantages Māori (not only Māori nurses but clients also) and contributes to inequitable health outcomes and represents a barrier to aspirations of health equity (Public Health Association Inc. nd). Dr Heather Came suggested there needed to be a comprehensive national action plan to end institutional racism rather than the existing ad hoc approach (Awarau & Webby, 2017). *Puao-te-ata-tu* (1988) states that affirmative action programmes aimed at reducing monocultural bias in our organisations is an essential ingredient for change. But given the lack of acknowledgement for discrimination and racism, it is unlikely that an affirmative action programme will be implemented. Affirmative action would also be a key to providing a culturally safe environment for Māori nurses. The aim is that the experience of institutional racism and discrimination needs to stop and the recommendations like those in *Puao te ata tu* (1988) need to be implemented.

Racism and the negative experiences of Māori whānau when they require a health service could actually deter whānau from seeking care. One way to combat this situation is to have a health environment that is culturally safe.

In nursing, Ramsden's initial vision and the development of the concept of cultural safety was for a bicultural focus in nursing practice. Internationally, nursing followed suit and developed transcultural nursing which focused on nursing patients from other cultures (Leininger, 1978). One of the main strategies regarding cultural safety is to involve client/patient/ whānau in the decision making of their care and in identifying their needs, both of which aid in enabling health professionals to maintain cultural safety within the health sector. Wepa (2015) states that cultural safety enables power to be transferred from the service provider to the recipient of care.

This transfer of power is also crucial when considering the cultural safety of the individual/ whānau. Cultural safety is a concept that sets out to protect Māori patients. This protection also needs to be extended to Māori nurses. As demonstrated in the research, an understanding of Māori needs and culture by non-Māori health professionals did not always occur. A workshop on cultural safety five years previously is not enough training to enable cultural safety for clients to occur and therefore there is a need for more regular updates. The Nursing Council of New Zealand needs to instigate ongoing conversations and workshops need to be developed to enable an understanding and sensitivity to Māori clients, whānau and Māori nurses' experiences. The principles of te Tiriti and the concept of cultural safety needs to be redeveloped and applied to nursing

practice. Additionally, there is a need to educate health professionals so there is more understanding and sensitivity towards Māori nurses and Māori clients.

Hence, the main theoretical themes of this research - power and racial discrimination - work together, one influencing the other. The organisations holding the power were the Ministry of Health, the District Health Board, other health professionals and, to a lesser degree, the Māori health providers as they tried to service the contracts under the power of government policies and District Health Board contracts.

6.4. Reflection and Recommendations

There are ten recommendations from this research. In the presentation of these recommendations below, they have been grouped according to the agency to which they most appropriately apply and the rationales have been given. They are:

i) The Nursing Council of New Zealand

Firstly, it is recommended that the Nursing Council of New Zealand support the reassessment and redevelopment of nurse education on cultural safety regarding Māori clients/whānau, Te Tiriti o Waitangi and racial discrimination. Nurse education could be incorporated at undergraduate degree level (ie. Bachelor of Nursing), annual registered nurse updates and in the Contemporary Nursing Certificate for nurses re-entering the nurse force and overseas nurses entering the New Zealand nurse force for the first time. *Rationale:* Cultural safety has moved into focusing more on multiculturalism. This needs to be fine-tuned into an understanding of Māori, of difference from a bicultural perspective and of the needs of Māori. *Puao-te-ata-tu* (1988) states the first stage of change to a more culturally inclusive New Zealand is the recognition of Biculturalism. The need for reassessment is emerging as moments of discrimination and prejudice are experienced by the clients/ whānau and Māori nurses.

Secondly, it is recommended that the Nursing Council of New Zealand also needs to create opportunities amongst non-Māori nurses for discussion on institutional racism and racial discrimination in Aotearoa. *Rationale:* To provide a safe environment for discussion, to build understanding and sensitivity, to also alleviate prejudice, racial discrimination and institutional racism. This should enable Māori nurses to practice in a safe including culturally safe and healthy environment, and to enable a better understanding and safe environment for Māori patients/clients/ whānau.

ii) The District Health Board funders

The third recommendation is that the District Health Board funders re-examine the health contracts specifications in partnership with Māori health providers and especially to enable pay parity for Māori nurses in line with mainstream nursing. *Rationale:* To prevent the discriminatory process of pay disparity between Māori and non-Māori nurses and improve the retention of Māori nurses.

The fourth recommendation is that the District Health Board develop an on call professional support system for Māori nurses.

Rationales: 1. To improve the retention of Māori nurses in the community) and support monthly clinical and cultural supervision for Māori mobile nurses and School Based Nurses and provide an on- call support service.

2. To support Māori nurses in time of crisis, in times when they may need to debrief, and when novice nurses need to discuss case studies or situations in which they are unsure or lack confidence.

The fifth recommendation is that the District Health Board demonstrate a system that considers the needs of the Māori clientele and the potential for Māori to be cared for by Māori nurses.

Rationale: To eliminate racial discrimination for Māori clients/patients/whānau and to provide a service for Māori by people who understand and are sensitive to Māori needs and can connect with Māori.

The sixth recommendation is that the District Health Board creates a practically realistic workload for Māori nurses by developing longer length contracts and less paperwork, such as auditing and reporting requirements, in line with mainstream health organisations.

Rationales: 1. Less paperwork to enable Māori nurses to spend more time with clients/whānau). Contracts with a longer time span provide the nurses with more job security and create contracts that work with a Kaupapa Māori approach rather than an emphasis on targets.

2. A contract developed and written from a westernized viewpoint does not take into consideration a Whānau Ora concept or Māori holistic health assessment and care approach. A target focus is a huge disconnection between quality Māori holistic nursing care and that of a short-targeted house call. Nursing care under a target system is individualistic care, time orientated, reductionist and task orientated.

iii) The Government

The seventh recommendation is that the Government develop health policies with strategies that enable the policies relevant for Māori be applied and not 'tinkered with'.

Rationale: 1. The four health policies discussed in this research are relevant to Māori but are failing and demonstrate a fully funded health care system as a priority. 2. to enable the nurses to provide high quality services without the constant changes that accompany the rationing of health funds. Also, this will enable whānau to live their lives with the best possible health, reach their full potential and enjoy good health without health disparities.

The eighth recommendation is for the Government to demonstrate a fundamental shift in the way Māori health services are funded, with more and longer-term funding of health contracts and positions required to improve the salary levels and job security of the nurses providing those services.

Rationale: To provide health contracts that are fair and ensure salary renumeration in line with mainstream nurses and job security.

The nineth recommendation is that the Government develop a plan to eliminate racial discrimination in New Zealand where strategies are established which incorporate:

That change must penetrate to the recruitment and qualifications which shape the authority structures (Puao te ata tu, 1988, p.79);

In affirmative action programmes aimed at reducing the monocultural bias in our institutions (Puao te ata tu, 1988, p. 79).

A more culturally inclusive New Zealand with the recognition of biculturalism, which involves the place and the status of Māoritanga in our institutions (Puao te ata tu, 1988, p.79).

Rationale: To build a nation that works in harmony together and enables Māori to thrive.

iv) The Māori Nursing Groups

The tenth recommendation is that the Māori Nursing Groups, with the support of Te Kaunihera o Nga Neehi Māori, Nursing Council of New Zealand, College of Nurses and New Zealand Nursing Organisation, set up a Whānau of Practice. This would include monthly hui and the establishment of a sub-group to develop social networking for sharing of information. A tuakana teina (Māori buddy system) relationship could also be developed.

Rationale: To provide a high-quality support system for all Māori nurses whether they are novice or experts. This would encourage leadership and Māori nurse retention in primary health care.

6.5. The Kaupapa Māori methodology

For the participants within this research, Kaupapa Māori methodology gave them a vehicle to korero safely. By allowing them to think about and use what was familiar for them, the methodology enabled the nurses to tell their stories, and to korero what was unfair for them in regards to the power relationships they were experiencing.

The methodological constructs worked well with the research method. Firstly, the mentorship of the elders (Māori advisory group) provided guidance with relevant protocol through ongoing dialogue and encouragement, for example with the title of the thesis. The constructs were especially important in the interview process. *Whakawhānaungatanga,* a process of establishing links and *connectedness* between the researcher and the participants, enabled the collaboration of constructing research stories and of providing an understanding of each others' experiences. Whānau principles involved *participation* which included a series of rights and responsibilities, commitments, obligations and support through the process of the interviews and ongoing dialogue with the participants and also ongoing aroha, awhi, manaaki and tiaki. The *networking* continued throughout the development of the thesis, not only in the interviews but with the Māori nursing community, the professional doctorate research group and research supervisor. The *challenge* occurred in several instances, such as an occasion when two nurses challenged the researcher at an academic presentation regarding her right to carry out this research. The lesson learnt from this was that, regardless of who is assumed to be the audience, it is important to begin with an introduction

and include a mihi.

6.6. Further Research Suggestions

There are several areas that this research suggests needs further investigation:

What are Māori patients/whānau experience of safe nursing care?

What is needed in contemporary nursing education on Cultural Safety to meet the health needs of the Indigenous people of Aotearoa?

Although nursing purports holistic nursing it mainly works within a medical model, however Māori nursing provides a unique nursing practice which understands Māori needs and that the Treaty of Waitangi advocates fairness for Māori. What does holistic health care mean to tangata whenua? How can racism in New Zealand nursing be overcome?

6.7. Final Conclusion

As I write the final pages for this thesis, another story comes to light. It is not a good story. It is a story that demonstrates the abusive relationships of power and racism that this research has discussed in terms of nurses, Māori and the community health care. While this story is not directly about nurses in particular, it does involve nurses and again raises yet again the point that we have a long way to go to address the issues for Māori throughout government systems.

This is a story about a young mother struggling with a government agency to stop it from taking her seven-day old baby from her. Her story began twenty months earlier when she was visited by the national government agency for children, Oranga Tamariki, after the birth of her first child in a hospital maternity ward. The agent said they needed to check the baby and removed it from the room. Several hours later, when the mother enquired as to where the child was, she was told it had been 'uplifted', meaning taken from her by the agent.

A video by *Newsroom* (Reid, 2019) recorded in a hospital, shows the pressure a young Māori mother is subjected to as she tries to keep her baby from being removed. The documentary contains detailed footage from inside the mother's hospital room as officials repeatedly attempt to persuade her to give up her child. Her partner, whānau, two lead

midwives (one of which is a nurse who manages a Māori health provider) and a media representative are present over several days during this highly emotional time. There is also a lawyer involved via cell phone as injunctions are laid with the court to stop the process. At one point, Oranga Tamariki officials arrived at night, after the whānau had left her alone to rest with her baby and did not relent until a 2am intervention by a tribal leader and police commander. In the meantime, entry to the hospital was blocked and whānau and lead support midwives were locked outside in the dark. They were in contact by cell phone with the mother who was desperate, exhausted and crying.

The concerted opposition by the baby's whānau, midwives, iwi leaders and the media attention resulted in Oranga Tamariki abandoning at least three attempts to take the baby from the mother. Instead she was allowed to go with her baby to a care facility while the matter was further discussed ahead of a new Family Court hearing in the following week.

While Oranga Tamariki had raised concerns over family violence and drug use among the mother's and father's whānau in the past, the midwives and iwi had stated that those concerns were either wrong or out of date as the whānau has taken direct action to address them. Jean Te Huia, one of the support midwives in this case said, "I believe Māori women in this country have a right to be frightened. I believe these women are racially profiled. They have a right to ask why this is happening to [them] "(Reid, 2019).

As noted previously, despite the policies and 'good intentions' within the health sector to address Māori health needs and the needs of the community, examples like that of Oranga Tamariki continue to suggest that both the health system and other government agencies still have a long way to go. While this this research has provided some insight into the work-life experiences of Māori nurses in Aotearoa, (particularly with the understanding of racism, power and powerlessness in nursing, and how these have influenced their practice). It has also shown that policy rhetoric hinders the unique nursing practice the nurses deliver, hence putting individuals, whānau, hapū, iwi and community at risk. After fifty years of nursing practice, it is evident to me that in 2020 the health of Māori is still in crisis, with much suffering, struggle and desperation and with examples like those of Oranga Tamariki continuing to follow 'racist' practices, there is a need for education and more targeted health care funding.

The demands of health care are calling for a new generation of thinkers, it is a profession for the intellectually curious, lifelong learner (Tiffen, 2013). There is also a need for Māori nurses to become leaders, to lead the way for better health in New Zealand.

At the same time, as nursing continues to evolve with new health care structures, fancier gadgets and political challenges, the heart of the profession stays the same. The job of the nurse will remain as caregiver, educator and advocate for the sick, those in need and vulnerable members of the communities. The next generation of Māori nurses must make a greater difference for patients/ whānau, communities and the national health care environment (Tiffen, 2013). However, for this to occur, the cultural safety of Māori nurses needs to be further researched and their cultural safety should not be compromised.

Aotearoa has some well written health policies (Ministry of Health, 2016b) which, along with their strategies, could provide guidance and a foundation that drives a strong Māori workforce to provides a sooner, closer, better health care for the community. At the same time, it works in collaboration with other health professionals and bridges the gap between Māori and non-Māori health disparities. Enveloping both Māori whānau and Māori nurses should be a korowai known as Te Tiriti o Waitangi. However, the policies including te Tiriti have been 'cherry picked' and the government ministers and their agents in their myoptic vision have used only the 'bits' that suit them to put the policies into practice. This has undermined the true aims of the policies and inhibited their use. Te Tiriti tokenism has not worked for bringing fairness to Māori health and hence the health disparities and discrimination continue.

Promoting hope in clients/patients is seen as a vital aspect of nursing care, hence hope is used as an important aspect of working with others during struggle. Nursing has a glimmer of hope with the change of government, a government which appears to be working from a humanistic viewpoint, a government who has promised to solve the children's poverty crisis, to enable whānau to have warm, dry homes, to create employment, improve education, and improve health. After years of governmental budget cuts, constraints and negativity suddenly that glimmer of hope is becoming a reality.

He aha te mea nui o te ao?
He tangata, he tangata, he tangata.
What is our greatest treasure?
It is people, it is people, it is people.

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Nga Tapiritanga: Appendices

Appendix A: Ethics Approval

TE WHARE WĀNANGA O
AWANUIĀRANGI

18th May 2015

Ann McCleland
1279 Windrift
SHW2 RD2
NAPIER

Tena koe Ann,

Re: Ethics Research Application EC 15-217JM

At a meeting on 20th April 2015, the Ethics Research Committee of Te Whare Wānanga o Awanuiārangi considered your application. I am pleased to advise that you submission has been approved.

You are advised to contact your supervisor and the Ethics Research Committee wishes you well in your research.

Yours Sincerely

Associate Professor Paul Kayes
Acting CHAIR

cc: Professor Patricia Johnston

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Appendix B: Interview Questions for first interview

Primary Health Care Nurses:

1. Tell me about your work.
2. What gives you the most satisfaction?
3. What are the difficult things about your work?
4. Tell me about working in the community.
5. Tell me about working for a Māori Health Provider.
6. What could make your job easier?
7. How much impact do targets have on the service you provide?
8. Tell me about the holistic practice you supply for your clients.

Nurse Leaders:

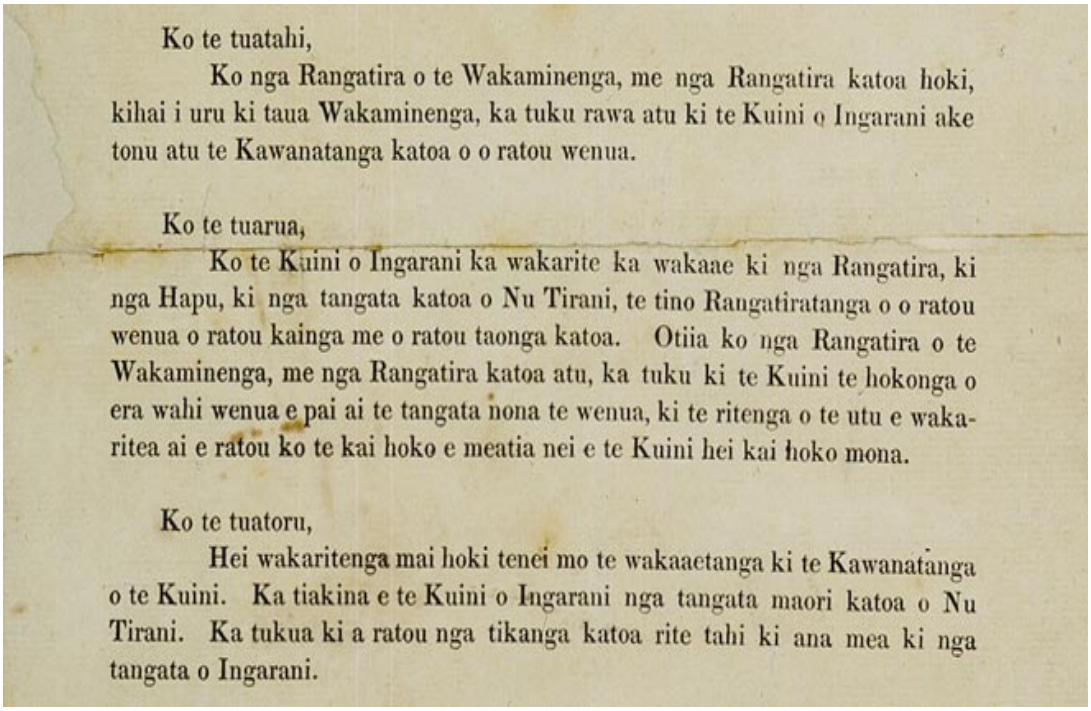
1. Tell me about your work.
2. What gives you the most satisfaction?
3. What are the difficult things about your work?
4. How much do you have to do with the Māori nurses working within Māori Hauora Providers and in what capacity?
5. What is your vision for Māori nursing in the future?
6. Where in primary health care are there needs and in your opinion what can your organisation do to alleviate these needs if any?
7. Where do you think Primary Health Care is heading in the future?
8. How are decisions made and who influences these?

District Health Board Contract developers (Funder):

1. Tell me about your work.
2. What gives you the most satisfaction?
3. What are the difficult things about your work?
4. Tell me about the process of developing contracts.
5. How do you sort out who will be given certain contracts?
6. How are decisions made and who influences them?
7. How do you gauge who are managing their targets?
8. What is your vision for improving health in low decile communities?

Appendix C

THE THREE ARTICLES OF THE TREATY OF WAITANGI



Ko te tuatahi,

Ko nga Rangatira o te Wakaminenga, me nga Rangatira katoa hoki, kihai i uru ki taua Wakaminenga, ka tuku rawa atu ki te Kuini o Ingarani ake tonu atu te Kawanatanga katoa o o ratou wenua.

Ko te tuarua,

Ko te Kuini o Ingarani ka wakarite ka wakaae ki nga Rangatira, ki nga Hapu, ki nga tangata katoa o Nu Tirani, te tino Rangatiratanga o o ratou wenua o ratou kainga me o ratou taonga katoa. Otiia ko nga Rangatira o te Wakaminenga, me nga Rangatira katoa atu, ka tuku ki te Kuini te hokonga o era wahi wenua e pai ai te tangata nona te wenua, ki te ritenga o te utu e wakaritea ai e ratou ko te kai hoko e meatia nei e te Kuini hei kai hoko mona.

Ko te tuatoru,

Hei wakaritenga mai hoki tenei mo te wakaaetanga ki te Kawanatanga o te Kuini. Ka tiakina e te Kuini o Ingarani nga tangata maori katoa o Nu Tirani. Ka tukua ki a ratou nga tikanga katoa rite tahi ki ana mea ki nga tangata o Ingarani.

Most Māori chiefs signed the Māori-language version of the treaty at Waitangi on 6 February 1840 or later in the north and at Auckland. A recent translation of the articles of the Māori version follows:

The First
The chiefs of the Confederation and all the chiefs who have not joined that Confederation give absolutely to the Queen of England for ever the complete government over their land.

The Second
The Queen of England agrees to protect the chiefs, the subtribes and all the people of New Zealand in the unqualified exercise of their chieftainship over their lands, villages and all their treasures. But on the other hand the chiefs of the Confederation and all the chiefs will sell land to the Queen at a price agreed to by the person owning it and by the person buying it (the latter being) appointed by the Queen as her purchase agent.

The Third
For this agreed arrangement therefore concerning the government of the Queen, the

Queen of England will protect all the ordinary people of New Zealand and will give them the same rights and duties of citizenship as the people of England.

As the following official English version of the treaty shows, there were some important differences between the two versions, especially in the terminology of the first and second articles:

‘Article the first
The Chiefs of the Confederation of the United Tribes of New Zealand and the separate and independent Chiefs who have not become members of the Confederation cede to her Majesty the Queen of England absolutely and without reservation all the rights and powers of Sovereignty which the said Confederation or Individual Chiefs respectively exercise or possess, or may be supposed to exercise or to possess over their respective Territories as the sole sovereigns thereof.

Article the second
Her Majesty the Queen of England confirms and guarantees to the Chiefs and Tribes of New Zealand and to the respective families and individuals thereof the full exclusive and undisturbed possession of their Lands and Estates Forests Fisheries and other properties which they may collectively or individually possess so long as it is their wish and desire to retain the same in their possession; but the Chiefs of the United Tribes and the individual Chiefs yield to Her Majesty the exclusive right of Pre-emption over such lands as the proprietors thereof may be disposed to alienate at such prices as may be agreed upon between the respective Proprietors and persons appointed by Her Majesty to treat with them in that behalf.

Article the third
In consideration thereof Her Majesty the Queen of England extends to the Natives of New Zealand Her royal protection and imparts to them all the Rights and Privileges of British Subjects.’

Reference: Te Ara, Encyclopaedia of New Zealand, Retrieved August, 2017 from

https://teara.govt.nz/en/document/4216/the-three-articles-of-the-treaty-of-waitangi

NOTE: There are actually Four Articles (three written and one oral).